NHS
Thames Valley

Care Home Winter Preparedness

October 2026

Thames Valley ICB

Housekeeping

This session is for you, to create a confidence in you and your team, therefore please ask the presenters questions, time has been allotted at the end of each session for you to ask.

AI bots will be removed from this session to ensure a safe space. These AI bots can misinterpret the information discussed; therefore we would prefer that you refrain from using them.

The slides will be sent out after this session including other supporting resources.

Programme

- 1.00pm– 1.05pm – Introduction of Care Home Webinar
- 1.05pm – 1.40pm – Simon Ferris – Reporting an Outbreak
- 1.40pm – 2.00pm – Emily Woodward-Stammers and Lucy Abbott – UEC: sign posting & admission avoidance and Respect
- 2.00pm – 2.20pm – Sundus Jawad and Dhara Thacker – Medicines Optimisation
- 2.20pm – 2.30pm – Cate Edwards – Vaccines
- 2.30pm – 2.55pm – IPC team – Winter prep and IPC
- 2.55pm – 3.00pm - Close

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Report an Outbreak

Dr. Simon Ferris

UKHSA



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Presentation attached separately

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UEC: sign posting, admission avoidance and RESPECT

Emily Woodward-Stammers and Dr. Lucy Abbott

Thames Valley ICB



Right service, safer care, better outcomes, positive experience

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⚠ Risks of using the incorrect service

Delays in getting the right care

Residents may not understand how to navigate how to access care, be taken to A&E unnecessarily or miss specialist support.

Inappropriate environment

A&E can be distressing and unsuitable for frail residents, particularly people with dementia, especially an overcrowded A&E.

Increased risk of harm

Long waits and unfamiliar settings can contribute to delirium, falls, infection and deconditioning.

Disruption to continuity

Unnecessary admission can interrupt routines, care plans and relationships with familiar staff.

Impact on staff & resources

Avoidable 999 calls and transfers increase workload and use emergency capacity needed elsewhere.

Choose the right service for the right need

999 / A&E
Life-threatening emergencies only

NHS 111
24/7 clinical advice & referral

GP / PCN
In hours – contact your resident's GP Practice or PCN team

GP
Out of hours via NHS 111 (evenings, nights, weekends)

Urgent Community Response (UCR)
See local details

Hospital at Home / Virtual Ward
See local details

Urgent Treatment Centre
Minor injuries / illness
See local details

Community Services
Nursing, pharmacy, mental health, therapy
See local details

Better for residents

✓ Faster, more appropriate care
✓ Care in a familiar environment
✓ Less time in A&E, reduced risk of infection, delirium and deconditioning
✓ Better experience with less distress
✓ Supports improved health outcomes and quality of life

Better for staff

✓ Clearer escalation pathways
✓ Increase in confidence and safety in decision making
✓ Less time managing avoidable transfers to A&E
✓ More time for person-centred care
✓ Support from specialist community teams

Better for the system

✓ Right care, right place, right time
✓ Reduces avoidable pressure on A&E and ambulances
✓ Makes better use of community and specialist services
✓ Supports sustainable, high-quality care for everyone

Scenario 1

Case scenario: Fall with no obvious injury

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Mr Jones, Age 91

Mr Jones is a resident with dementia and reduced mobility.
A member of staff finds him sitting on the floor beside his bed after an unwitnessed fall.

He is:

- Alert and responsive
- Able to move all limbs
- Not complaining of pain
- Has no visible injury or bleeding
- Not on anticoagulant medication

Discussion point: What would you do before considering 999 or A&E?

Scenario 1

Assessment, appropriate signposting and red flags

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1 Assess and review

- Complete a post-fall assessment as per local policy and monitor observations
- Check for change from the resident's normal baseline

2 Use the right route

Depending on local pathways, staff may contact:

- Falls service
- Community/UCR/CAS
- NHS 111 for clinical advice

🎯 This results in:

- Assessment in a more appropriate setting
- Avoidance of an unnecessary hospital attendance
- Reduced anxiety and confusion for Mr Jones
- Emergency services remaining available for life-threatening incidents

3 Escalate for red flags

Examples:

- Suspected fracture
- Head injury
- Loss of consciousness
- New neurological symptoms
- Severe pain
- Significant bleeding
- Resident taking anticoagulants with potential head injury

A fall does not automatically mean A&E. Assess the resident first, use community alternatives when clinically appropriate and escalate immediately for red flags.

POST FALL PROTOCOL FOR CARE HOME RESIDENTS

RESIDENT HAS A FALL

Before moving the resident, complete an Airway, Breathing and Circulation Assessment. Maintain dignity, check for injury, consider communication difficulties, review ReSPECT form or advance care plan & take action as below:

Level 1
No apparent injury sustained

- No bruising
- No apparent head injury
- No pain
- Mobility unaffected
- No wounds or bleeding
- No limb deformity

- Assist resident to a comfortable place (using hoist/handling aid as appropriate)
- Observe resident for 24 hours using Restore2 chart
- Complete local 'Post Falls Assessment'
- Consider referral of resident to care home MDT for review and onward falls assessment if available locally

Inform relatives and document all actions

Level 2
Minor Injury sustained

- New signs of bruising
- Minor wounds to skin inc. face
- Slight discomfort
- Isolated injury to upper limb
- No apparent injuries but taking anticoagulant / blood thinning medication
- Laid on floor over one hour
- Any other concerns by carer

- Administer first aid and assist resident to a comfortable place (using hoist/handling aid as appropriate)
- Refer to your local urgent care pathway eg SPOA, UCR * am-pm 111 or GP * pm-am
- Complete 'Post Falls Assessment Tool' and observe resident for 24 hours (inc. vital signs) using Restore 2
- Complete 'body map' and document on care plan
- Inform relatives and document discussion

UCR/SPoA contact details - 0*** *** ****

Level 3
Major / Serious injury sustained

- Airway or new significant breathing problems
- Loss of consciousness or unresponsive
- Any seizure activity
- New confusion
- Suspected head injury to resident taking anticoagulant / blood thinners
- Obvious injury to any body region including:
  - Causing significant pain or distress to the resident
  - Significant bleeding or bleeding which can't be managed with first aid
  - Unable to move due to inj
  - Obviou deformity

Call 999 for ambulance service
DO NOT MOVE THE RESIDENT (unless Resuscitation required or concerned about long lie or preventing other harm eg burns)

Follow instructions from Ambulance Control (If/when ambulance crew arrive meet at door and escort to resident)

Inform relatives and record discussion

ANY Change in condition/deterioration causing concern - call back to UCR / 111 / GP to update
Contact 999 should any symptoms in RED box arise

Complete incident report form and consider safeguarding referral

Scenario 2

Case scenario: resident becoming increasingly unwell

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Mrs Smith, age 88

Mrs Smith is a care-home resident with:

- Frailty
- Dementia
- Recurrent chest infections

What staff have noticed over the last 24 hours

- Reduced food and fluid intake
- More sleepy than usual
- Increased confusion
- Temperature 37.9°C
- Mild cough
- No severe breathlessness
- No chest pain
- No loss of consciousness

Discussion point: What would you do before considering 999 or A&E?

Scenario 2

Assessment, appropriate signposting and red flags

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1 Assess and review

- Complete observations and assessment
- Check for change from the resident's normal baseline
- Review the current care plan
- Review ReSPECT or agreed escalation plan where available

2 Use the right route

Depending on local pathways:

- Contact the GP or PCN team
- Use NHS 111 for clinical advice
- Consider UCR where appropriate
- Use other local community pathways

3 Escalate for red flags

Call 999 for life-threatening deterioration, including:

- Severe breathing difficulty
- New chest pain
- Loss of consciousness
- Suspected sepsis
- Rapid clinical deterioration

Deterioration does not automatically mean A&E. Use community alternatives when clinically appropriate and escalate immediately for red flags.

Why proactive care planning matters

Better decisions when a resident's condition changes

Good decisions are easier when staff can quickly find the resident's current plan, wishes, escalation arrangements and key clinical information.

Better for residents

✓ Care aligned with wishes and preferences
✓ More personalised care
✓ Reduced disruption and distress
✓ Better continuity when care needs change

Better for staff

✓ Greater confidence in decision-making
✓ Clearer escalation decisions
✓ Better communication with families and professionals
✓ Less uncertainty when deterioration occurs

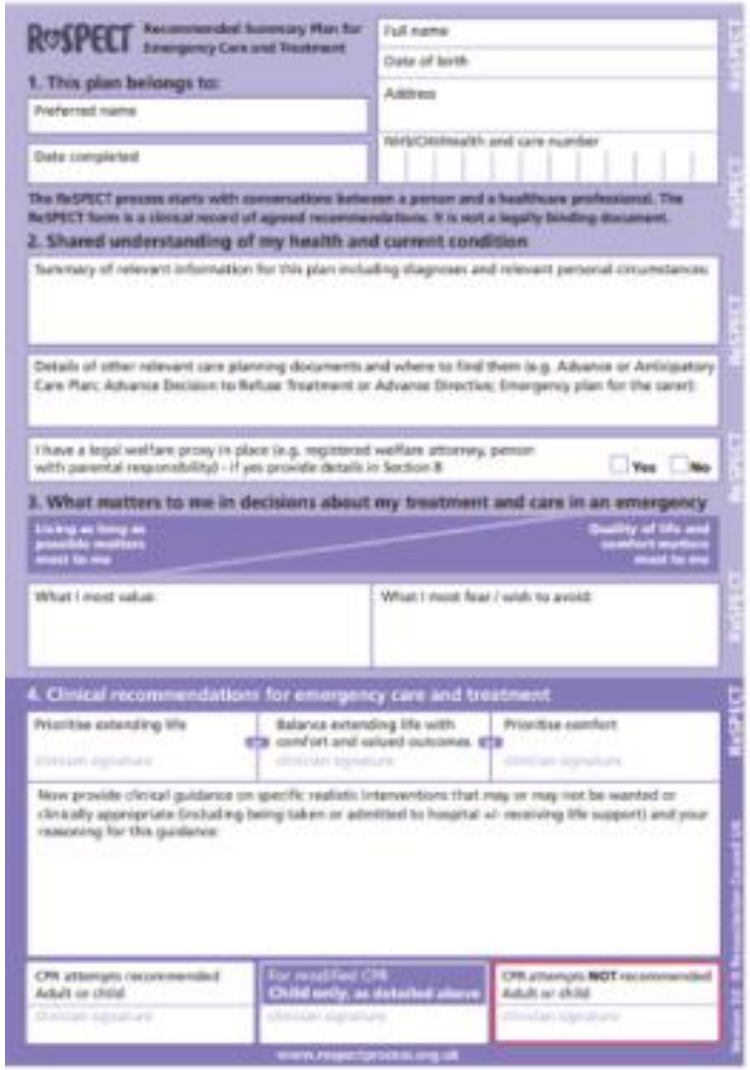
Better for the system

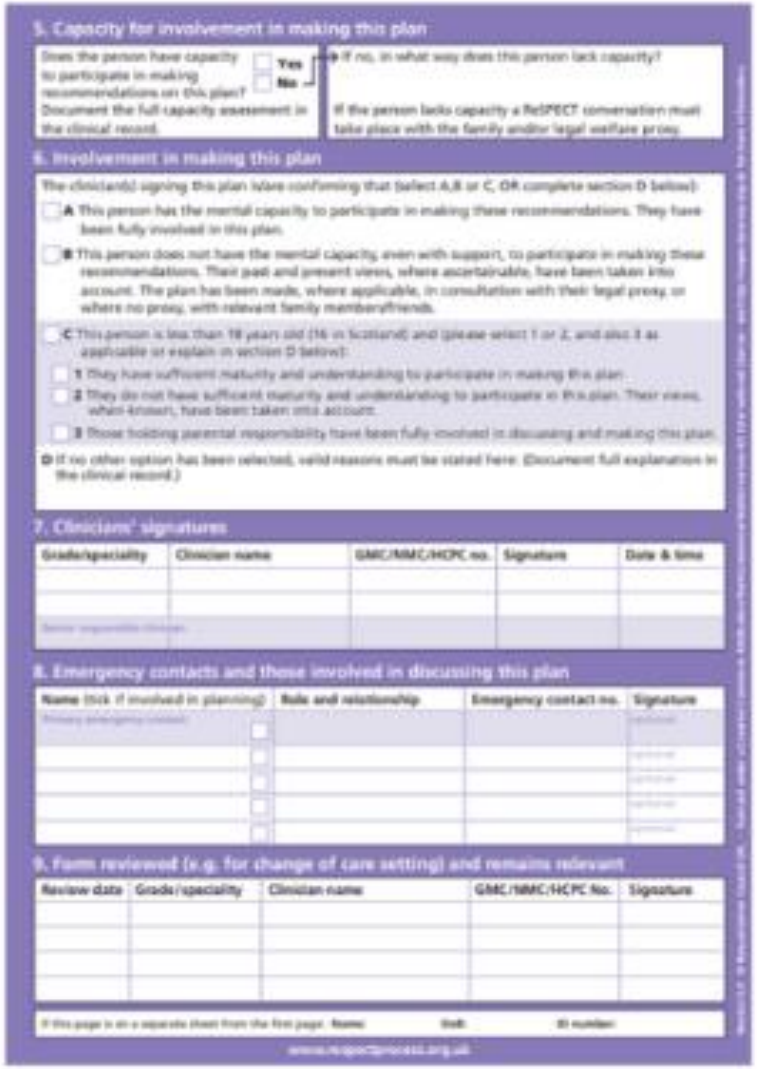
✓ More appropriate use of emergency services
✓ Better coordination between teams
✓ Improved use of community and specialist support
✓ Right care, right place, right time

Good planning does not prevent appropriate hospital admission. It supports better decisions about when hospital care is and is not needed.

ReSpeCT

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STOP AND THINK

Before calling 999

1	**Is this life-threatening?**	Severe breathing difficulty, suspected stroke, unconsciousness, major bleeding or cardiac arrest.
2	**Has the resident been assessed?**	Complete observations, note the change from baseline and identify any clinical red flags.
3	**Is there a care plan or ReSPECT?**	Check the resident's wishes and any agreed escalation arrangements.
4	**Could another route help?**	Consider the GP, NHS 111, UCR, community services or Hospital at Home / Virtual Ward.
5	**What is the safest next step?**	Choose the route that matches the resident's clinical need and escalate if the condition worsens.

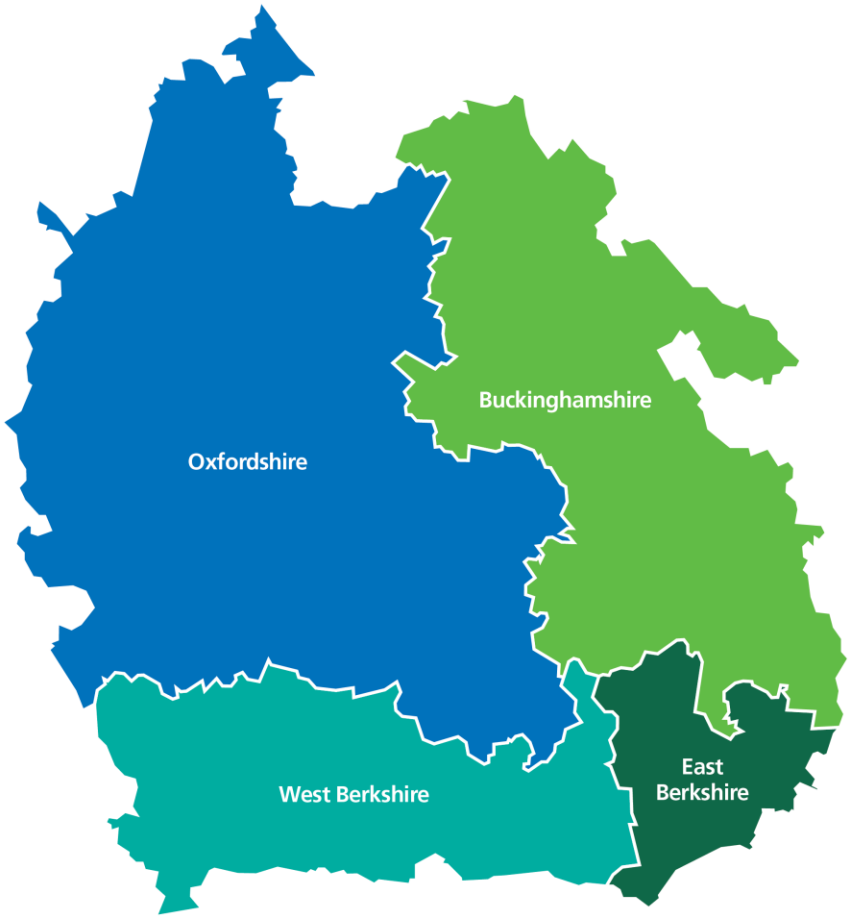
Right care, right place, right time. Use 999 for emergencies and alternative pathways when clinically appropriate.

Thames Valley ICB | Care home & care agency urgent-care alternatives

LIFE-THREATENING – 999 /ED | URGENT, NOT EMERGENCY – UCR / SPA / GP | PRIMARY CARE/OUT OF HOURS – NHS 111

Know your local services and pathways…..

Place	Community and UEC resources
Oxfordshire	Urgent Community Response (UCR) Adobe Acrobat Document Single point of access (SPA) Adobe Acrobat Document
Buckinghamshire	Care home Clinical Assessment Service (CAS) PNG File PNG File
West Berkshire	Care Home Help-line Microsoft Word Document
East Berkshire	Care Home Support Team | Berkshire Healthcare NHS Foundation Trust)



The resources listed here provide examples of services that may support urgent care needs within your local area. They are not an exhaustive list. Care homes should be familiar with the full range of services available within their place, including local community, primary care, urgent care and specialist support, to ensure residents receive the most appropriate care at the right time.

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Medicines Optimisation

Sundus Jawad and Dhara Thacker

Thames Valley ICB



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Vaccines

Cate Edwards

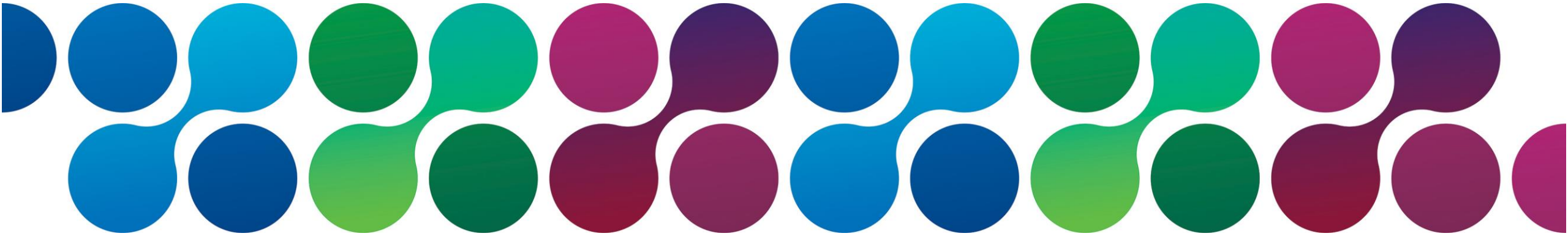
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Care Home Winter Preparedness
Autumn/Winter Seasonal Vaccination Programme

Cate Edwards - Quality Manager for Vaccines



Why should I get my vaccination

In this year's National Flu Immunisation Programme letter, NHS and government leaders set out the importance of staff vaccination:

"To help protect the most vulnerable and keep health and care service running during winter when respiratory viruses reach their peak, it remains vitally important that we continue to increase the numbers vaccinated in all eligible cohorts."

Seasonal Vaccination Eligibility - Flu

until 31st March 2027:

- pregnant women
- children aged 2 or 3 years* and school aged children (Reception to Year 11)
- those aged 65 years and over
- those aged 18 years to under 65 years in clinical risk groups
- **those in long-stay residential care homes**
- carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person
- close contacts of immunocompromised individuals
- **frontline workers in a social care setting** without an employer-led occupational health scheme, including those working for a registered residential care or nursing home, registered domiciliary care providers, voluntary managed hospice providers and those that are employed by those who receive direct payments (personal budgets), or Personal Health budgets, such as personal assistants

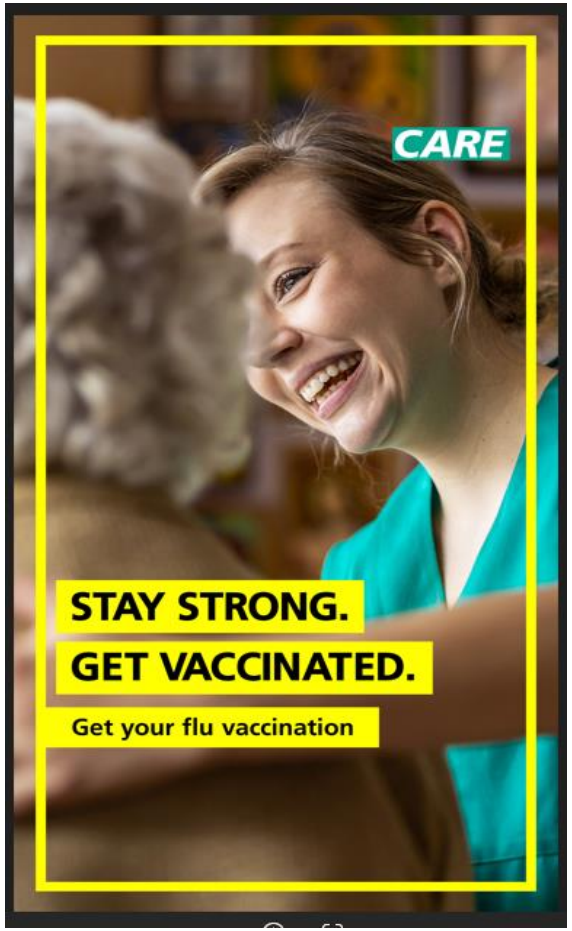
National flu immunisation programme 2026 to 2027 letter - GOV.UK

Frontline healthcare workers

- All frontline health care workers, including both clinical and non-clinical staff who have contact with patients, should be offered flu vaccine
- Vaccination is the best protection against flu, which kills thousands each year.
- Healthcare workers are more likely to catch and spread flu to vulnerable patients.
- Getting vaccinated helps maintain essential services during winter pressures.
- Even healthy people can carry and spread flu without symptoms.
- Immunity fades over time and flu viruses change every year. Previous flu illness does not protect against new strains therefore you should get your flu vaccination every year.
- Possible side effects include a mild temperature and sore arm for 1 to 2 days and often side effects are mild and short-lived, especially when compared to the flu illness.
- The vaccination cannot cause flu – there are no live viruses in the vaccine.
- It is important to protect yourself, your patients. residents, and your colleagues this winter. Get your flu vaccination.



Staff Flu Vaccinations



Posters:
Care assets | Health and Social Care Worker flu vaccine | Campaign Resource Centre

Where can I get my vaccine?

- Registered GP practice
- Community Pharmacy
- National Booking System

Book, change or cancel a flu vaccination appointment – NHS

Find a pharmacy that offers free flu vaccination

Flu vaccination guidance for social care workers and carers - GOV.UK

Seasonal Vaccination Eligibility - COVID

Covid Cohorts

From 1st October 2026 until 31st January 2027

- adults aged 75 years and over
- residents in a care home for older adults
- individuals aged 6 months and over who are immunosuppressed

How do I book a flu or COVID-19 vaccine?
If you have received an invitation for a flu or COVID-19 vaccine from the NHS, via text or letter, you will be able to book your appointment via The National Booking Service. People who have not received a notification may also be eligible to book using the service.

You can also call 119, free of charge, to book over the phone.

Care Home Vaccination Visits (Autumn/ Winter 2026)

- NHSE ambition is to visit every care home with flu vaccination offer before the **30th November 2026**, and achieve a 79% uptake rate for flu vaccinations in this cohort across the Thames Valley ICB as a whole
- Vaccination visits will be arranged by either:
  - Your Local GP Practice
  - Local Community Pharmacy
  - NHS Trust

How can the Care Home support with vaccine delivery?

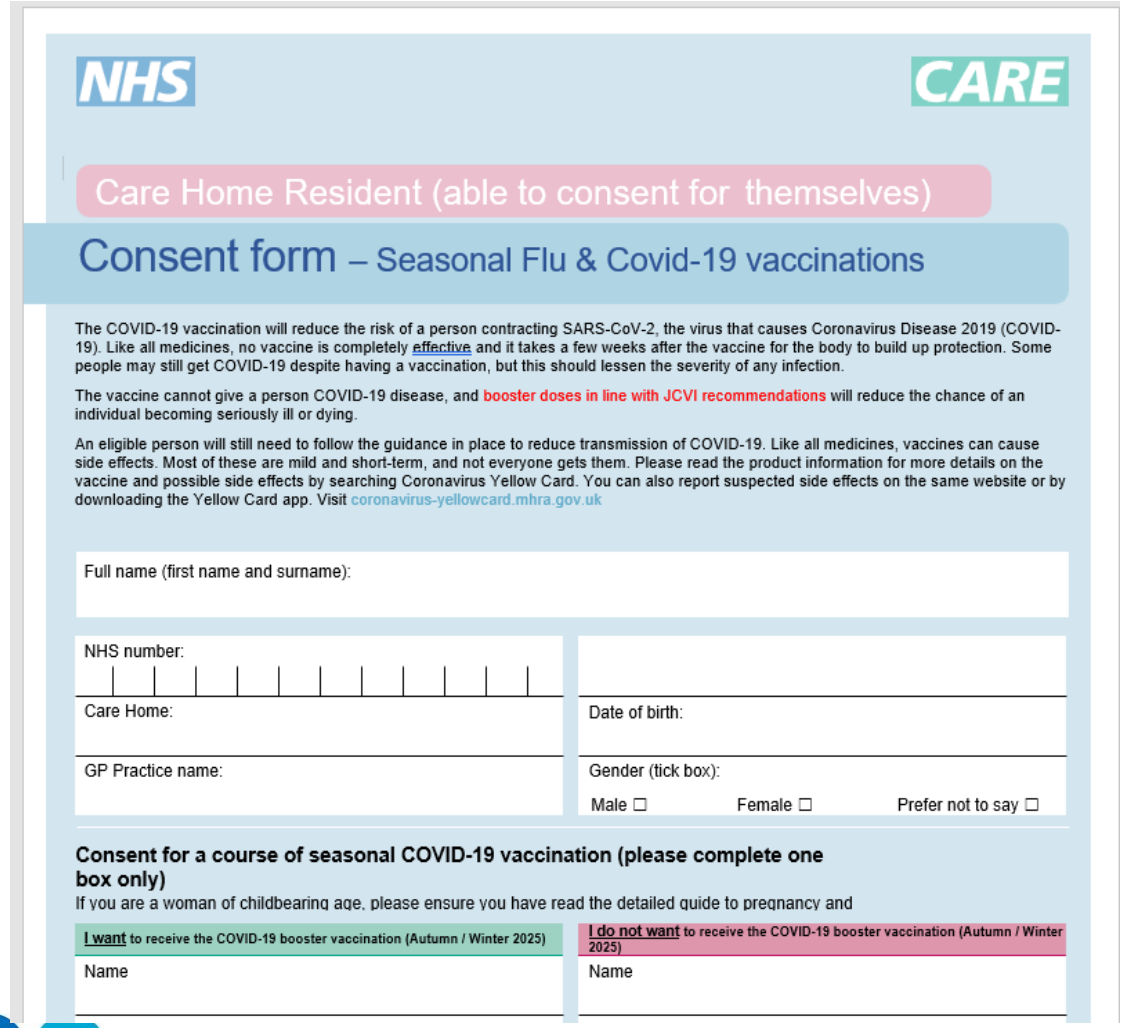
Responding to requests from providers to plan a visit

Ensuring patient consent forms are completed before the vaccination visit

Contact the provider if any issues arise that may impact the planned visit

Any queries or concerns regarding your visit please contact the :TV ICB Vaccines Team **tvicb.vaccines-team@nhs.net**

Consent Forms



NHS CARE

Care Home Resident (able to consent for themselves)

Consent form – Seasonal Flu & Covid-19 vaccinations

The COVID-19 vaccination will reduce the risk of a person contracting SARS-CoV-2, the virus that causes Coronavirus Disease 2019 (COVID-19). Like all medicines, no vaccine is completely effective and it takes a few weeks after the vaccine for the body to build up protection. Some people may still get COVID-19 despite having a vaccination, but this should lessen the severity of any infection.

The vaccine cannot give a person COVID-19 disease, and booster doses in line with JCVI recommendations will reduce the chance of an individual becoming seriously ill or dying.

An eligible person will still need to follow the guidance in place to reduce transmission of COVID-19. Like all medicines, vaccines can cause side effects. Most of these are mild and short-term, and not everyone gets them. Please read the product information for more details on the vaccine and possible side effects by searching Coronavirus Yellow Card. You can also report suspected side effects on the same website or by downloading the Yellow Card app. Visit coronavirus-yellowcard.mhra.gov.uk

Full name (first name and surname):

NHS number:

Care Home:

Date of birth:

GP Practice name:

Gender (tick box):

Male ☐ Female ☐ Prefer not to say ☐

Consent for a course of seasonal COVID-19 vaccination (please complete one box only)

If you are a woman of childbearing age, please ensure you have read the detailed guide to pregnancy and

I want to receive the COVID-19 booster vaccination (Autumn / Winter 2025)	I do not want to receive the COVID-19 booster vaccination (Autumn / Winter 2025)
Name	Name

NHS England

Vaccination Consent Form
(includes Care Homes)

PATIENT DETAILS	
Name of Patient:	Date of Birth:
NHS Number:	Gender:
GP Practice:	Care Home:
PRE-SCREENING QUESTIONS	
Have you been provided with information about the vaccine?	
Do you have any history of reaction to a vaccine?	
Do you have a history of allergies?	
CONSENT FOR PATIENTS WITH CAPACITY	
I want to receive the full course of vaccination. Vaccine1:	I do not want to receive the full course of vaccination
Name:	Name:
Signature:	Signature:
Date:	Date:
VACCINES	
I want to receive the full course of vaccination. Vaccine 2:	I do not want to receive the full course of vaccination
Name:	Name:
Signature:	Signature:
Date:	Date:

Vaccination Eligibility – One dose vaccinations

RSV

adults aged 75 and over

all residents in care homes for older adults

adults aged 65 to 74 with a long-term lung condition (such as poorly controlled asthma, COPD or cystic fibrosis) or a weakened immune system due to disease or treatment

pregnant women (to protect their newborn babies)

Shingles

aged 65 and over (eligible until 80th birthday)

immunocompromised

Pneumococcal

aged 65 and over

babies (16 weeks and a year)

clinically at risk

people experiencing homelessness

Older adult vaccinations - RSV

- Adults aged 75 and over and residents in a care home for older adults (anybody who is a resident in a care home for older adults will be eligible for the RSV vaccination regardless of their age) can get an RSV vaccination this autumn/winter.
- RSV vaccinations are offered all year around, but infections peak in the winter.
- RSV is a major cause of lung infections like bronchitis and pneumonia, and can be particularly dangerous for older adults leading to difficulty breathing hospital admission
- The RSV vaccine helps to prevent severe illness in those most vulnerable to RSV, helping to cut the risk of being admitted to hospital and protecting lives.
- The vaccine has been shown to provide strong protection for older people.
- A single dose of the vaccine helps to provide protection for a few years (its full duration of protection is being measured in real time).
- You do not need to have your RSV vaccination each year, like you do for flu and COVID-19 vaccinations.

RSV Vaccination impact

GOV.UK

Home > Health and social care > Public health > Health protection > Immunisation

News story

Newborn ICU admissions drop 50% in first full year of RSV maternal vaccine programme

While around 60% of women giving birth every month are vaccinated, UKHSA warns many thousands of babies still at risk.

From: UK Health Security Agency

Published: 13 August 2026

Newborn ICU admissions drop 50% in first full year of RSV maternal vaccine programme - GOV.UK
Use this instead

RSV vaccine offered to Pregnant women from 28 weeks - to protect newborn baby

RSV Vaccination Impact – Older adults

Vaccine impact

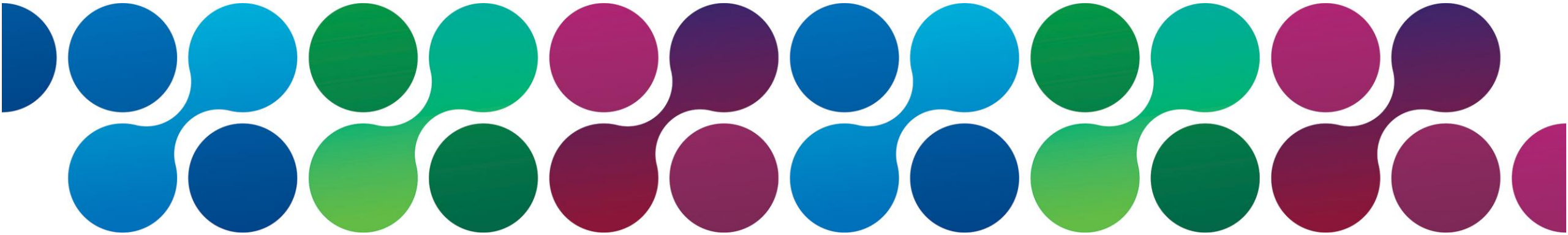
England

The first analysis on the impact of the RSV vaccination programme in older adults in England was published in March 2025, using a Regression Discontinuity Design (RDD). A 30% reduction in RSV-associated hospitalisation in older adults eligible for the vaccine was found in comparison with those non-eligible, at a time when vaccine uptake was around 40%. An updated version of this analysis following the second RSV season following introduction of the RSV vaccination programme, with data collected up to 31 March 2026.

There was a discontinuity in hospitalisation rates, corresponding to a 43% reduction (95% CI 37% to 48%, p-value <0.001) in those aged 75 to 80 at the start of the programme (the catch-up cohort), and a 28% reduction (95% CI 13% to 41%, p-value <0.001) in those aged 74 at the start of the programme (the routine cohort) (Figure 45).

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Any questions?



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Care Home Winter Preparedness

Infection Prevention and Control

Thames Valley ICB



Be prepared…

- Have a stockpile of personal protective equipment (PPE).
- Keep a supply of NHS COVID-19 LFD tests for residents eligible for COVID-19 treatment.
- Know where your UKHSA Combo Rapid LFD tests are.
- Ensure all residents and staff are immunised against flu.
- Ensure all care home residents are offered COVID-19 vaccination.
- Ensure all adults living in a care home for older adults are eligible and anyone 75 years and older are offered RSV vaccine.
- Ensure your residents age of 65 and over are immunised against pneumococcal infection.
- Ensure adults turning 65, those aged 70-79 and those 18 and over with a severely weakened immune system are offered the shingles vaccine.
- Ensure you have reviewed your infection control policy, and staff are aware of the procedures.

UKHSA Winter Readiness

Preparation Checklists

☑ Care Home Vaccination Checklist

Section	Checklist Item	Date Completed	Completed By
COVID-19: Vaccination & Testing	Ensure the care home GP (or alternative provider) offers COVID-19 vaccination to all eligible residents, available from 1st October 2026: • Adults aged 75 and over • Residents in care homes for older adults • Individuals who are immunosuppressed (aged 6 months and over)		
	Note: Frontline health and social care workers (HSCWs) and care home staff will **not** routinely be eligible for COVID-19 vaccination under the autumn 2026 national programme.		
	Ensure a supply of **NHS COVID-19 LFD test kits** is available to test residents eligible for COVID-19 treatment, if they become unwell. Kits are available from participating pharmacies.		
Flu: Vaccination for Residents and Staff	Ensure the care home GP (or alternative provider) offers flu vaccination to all eligible residents and encourage frontline staff (including agency workers), available from 1st October 2026: • People aged 65 and over • Adults aged 18–64 in clinical risk groups • Residents in long-stay care homes • Frontline workers in social care settings		
	Advise any pregnant staff that they are eligible for the seasonal flu vaccine (available from 1st September 2026).		
RSV: Vaccination for Residents and Staff	Advise any staff who are **28 weeks pregnant or more** that they are eligible for the RSV vaccine (arranged via their GP).		
	Ensure RSV vaccination is offered to **all residents in a care home for older adults OR anyone aged 75 and over OR those aged 65 and over with a severely weakened immune system,** who have not been previously vaccinated. (This is a **one-time** vaccine.)		
Pneumococcal: Vaccination for Residents and Staff	Ensure pneumococcal vaccination is offered to **residents aged 65 and over** who have not been previously vaccinated. This is usually a **one-time** vaccine although some people at higher risk may require extra doses.		
	Advise members of staff **aged 65 and over or those at higher risk of getting seriously ill** at any age that they are also eligible for this vaccine and should discuss with their healthcare provider. This is usually a one-time vaccine although some people at higher risk may require extra doses.		

UKHSA Winter Readiness

Preparation Checklists

☑ Care Home Checklist: Planning for Norovirus (Winter Vomiting Bug)

Section	Checklist Item	Date Completed	Completed By
Infection Control Precautions	Ensure infection control policies are up to date, read, and followed by all staff		
	Conduct a handwashing audit and educate staff on correct handwashing technique and importance		
	Ensure liquid soap and disposable paper towels are available in all toilets, communal bathrooms, and ensuite rooms		
	Ensure PPE is available – gloves, aprons, and masks		
	Check that linen management and clinical waste systems are in place, including foot-operated bins		
	Display the Norovirus poster (attached to pack)		
	Remind staff with symptoms to stay off work until 48 hours after symptoms have stopped		
Reporting to Health Protection Team (HPT)	Ensure you know how to recognise an outbreak (2 or more cases of diarrhoea and/or vomiting within 48 hours among staff and/or residents)		
	Know how to report suspected or confirmed outbreaks to your local HPT — even if local guidelines are already known		
	Be ready to maintain records during outbreaks: prepare a staff/resident list with name, DOB, and room number to track symptoms and onset dates during any outbreak		

UKHSA Winter Readiness

What to do if staff are unwell?

Acute Respiratory Infection

Staff who have symptoms of **respiratory infection** and who have a **high temperature** or **do not feel well enough** to go to work are advised to stay away from work and try to avoid contact with other people.

They should not use the combo Rapid LFD

Return: They should not return to work until they no longer have a high temperature (if they had one) or until they no longer feel unwell

Gastrointestinal Infection

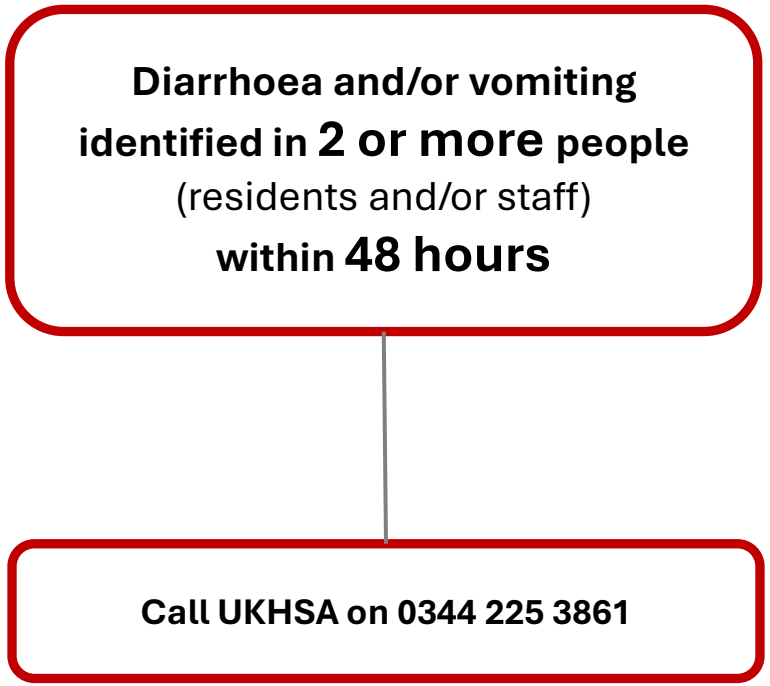
Any member of staff who has **diarrhoea and/or vomiting** should be **sent home immediately**.

Return: They should not return to the care home until **48 hours after** normal bowel habits have returned and any vomiting has stopped.

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What to do if a resident is unwell?

Gastrointestinal Outbreak



- Do not use the Report an Outbreak system for gastrointestinal outbreaks

Acute **Respiratory** Infection Outbreak Algorithm

NHS Thames Valley

Individual eligible for COVID treatment

CMDU GP comms July 2026.pdf

Positive COVID – individual NHS LFD Kit

Contact CMDU for COVID treatment

Respiratory symptoms identified

Test using UKHSA Combo Kits

COVID Positive LFD for **2 or more residents**

Influenza Positive LFD for **1 or more**

Negative LFD in symptomatic for 2 or more

Complete UKHSA Report an Outbreak online

Supporting information:

Management of acute respiratory infection outbreaks in care homes guidance - GOV.UK

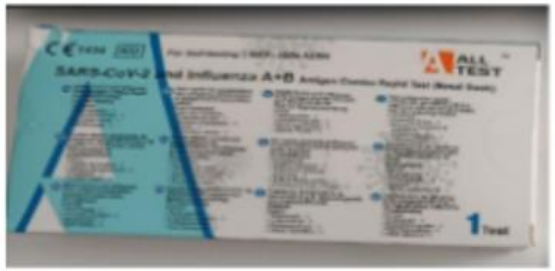
COVID outbreaks – Treatment only for those eligible (dotted line path). Remaining residents supportive and IPC measures

Influenza outbreaks – Antivirals will be required to support outbreak, plus IPC measures

ARI outbreaks – Supportive and IPC measures

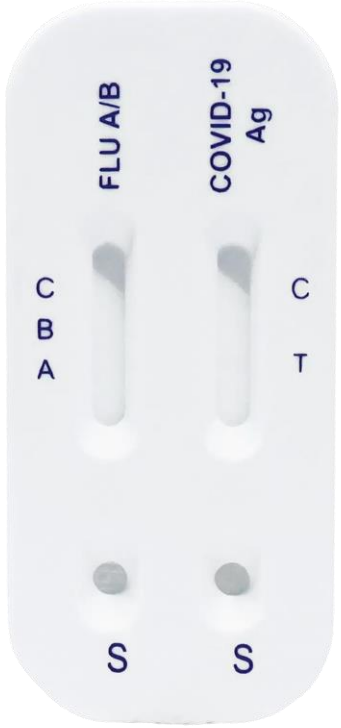
UKHSA Outbreak LFD Service





Last year UKHSA trialled the use of Combo LFD kits to help Care Homes identify what respiratory infection may be contributing to an outbreak; ensuring swift treatment where necessary

The combo LFD will allow you to test, with two test lines, for influenza and COVID.
Five kits will be posted directly to each home; you may still have some kits from last year.



COVID LFD Kits for those Eligible

NHS Thames Valley

Lateral Flow Device (LFD) Service - Community Pharmacy England

The Lateral flow device tests supply service for patients potentially eligible for COVID-19 treatments (LFD service) was commissioned as an Advanced service from 6th November 2023.
On 26th March 2026, NHS England confirmed the service would continue to be commissioned during 2026/27.



5 Supporting information on risk factors for progression to severe COVID-19 | Nirmatrelvir plus ritonavir and tocilizumab for treating COVID-19 | Guidance | NICE

- Down's syndrome and other genetic disorders
- Solid cancer
- Renal disease
- Liver diseases
- Haematological diseases and recipients of haematological stem cell transplant (HSCT)
- Immune-mediated inflammatory disorders
- Respiratory
- Immune deficiencies
- HIV/AIDS
- Neurological disorders
- Solid organ transplant recipients

To access COVID treatment for eligible individuals:
Contact the COVID Medicines Delivery Unit (CMDU) on 03000 24 0000

CMDU GP comms July 2026.pdf

Participating Pharmacies, to access the LFD kits - list available here

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Hand Hygiene

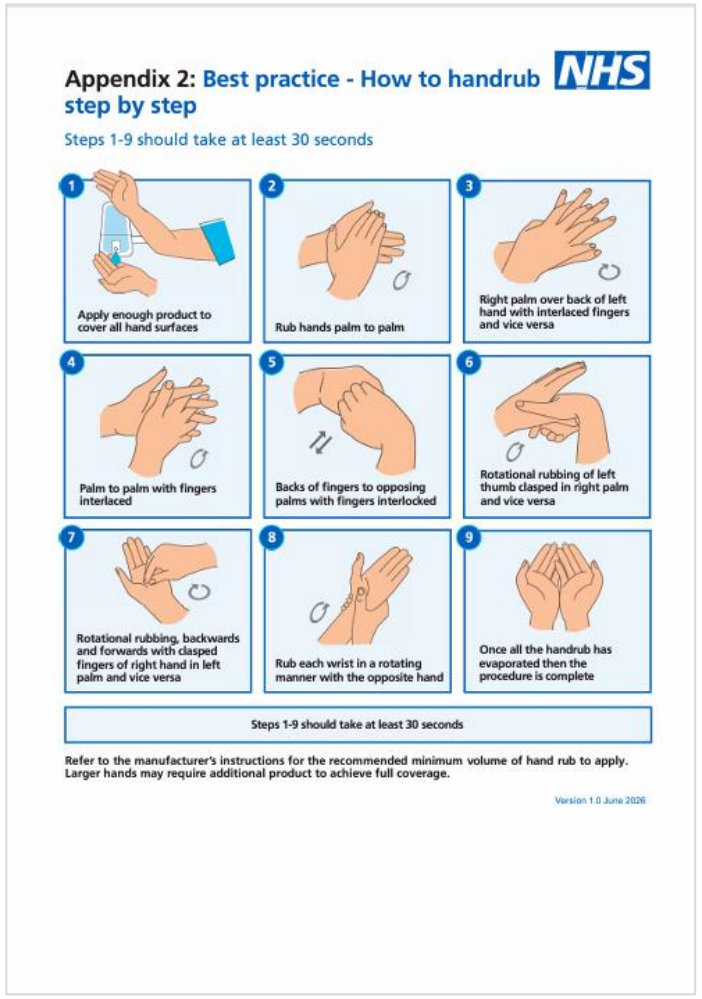
Hand Hygiene



Best practice – How to hand wash, step-by-step images

Hand hygiene is key during an outbreak

During a norovirus outbreak only use soap and water



Best practice - How to handrub step by step

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Personal Protective Equipment

Personal protective equipment (PPE) when applying standard infection control precautions (SICPs)

SICPs	Gloves	Apron	Gown (ambulance staff use coveralls)	Fluid resistant surgical mask (FRSM)	Eye/face protection
No anticipated exposure to blood or body fluid, mucous membranes, or non-intact skin.	✗	✗	✗	✗	✗
Exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated but **NO risk of splashing or spraying.**	✓	✓	✗	✗	✗
Exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated **AND risk of spraying or splashing**.	✓	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated.	✓	✓

Hand hygiene must be performed before putting on and after removal of PPE.

Where to put on and remove PPE

If required as above, PPE should be put on within the patient room/care area.

Gloves are not an alternative to hand hygiene. Gloves must always be removed after each task on the same patient and hand hygiene performed as per the 5 moments for hand hygiene.

All PPE must be removed and disposed of before leaving the patient room/care area on completion of care episode.

NB. Universal masking using FRSM may be indicated as a source control measure during outbreaks of respiratory infectious agents.

Appendix 5a (england.nhs.uk)

Personal protective equipment (PPE) when applying transmission-based precautions (TBPs)

TBPs	Gloves	Apron	Gown	Fluid resistant surgical mask (FRSM)	Respiratory Protective Equipment (RPE)	Eye/face protection
Contact precautions	✗ Unless exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated or footnote 1 applies[1]	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated	✗ Unless risk of splashing or spraying of blood or body fluids is anticipated or footnote 2 applies[2]	✗	✗ Unless risk of splashing or spraying of blood or body fluids is anticipated
Droplet precautions	✓	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated	✓	✗	✓
Airborne precautions	✓	✗	✓	✗	✓	✓

Hand hygiene must be performed before putting on and after removal of PPE.

[Appendix 5b (england.nhs.uk)]

Where to put on and remove PPE

Gloves are not an alternative to hand hygiene. Gloves must always be removed after each task on the same patient and hand hygiene performed as per the 5 moments for hand hygiene.

Contact precautions: required PPE should be put on within the patient room/care area immediately **before** direct contact with the patient or their environment and should be removed and disposed of **before** leaving the patient room/care area.

Droplet and airborne precautions: required PPE should be put on **before** entering the patient room/care area. Unless there is a dedicated isolation room with anteroom, gowns, aprons and gloves should be removed and disposed of before leaving the patient room/care area. Eye/face protection and RPE (if worn) must be removed and disposed of **after** leaving the patient room/care area.

Appendix 6: Putting on and Removing Personal Protective Equipment (PPE)

Before undertaking any procedure or task, staff should assess the risk of likely exposure to blood and/or other body fluids, non-intact skin, mucous membranes, or any equipment or items in the care environment that could be contaminated, and wear PPE if required. PPE must protect adequately against the risks associated with the procedure or task. The items of PPE worn will vary based on the type of exposure anticipated, and not all items of PPE may be required.

Putting on Personal Protective Equipment (PPE)

Before beginning, check which items of PPE are required and that these are available in the correct size.

The order for putting on PPE is Apron or Gown, Fluid-Resistant Surgical Mask (FRSM)/ Respiratory Protection Equipment (RPE) (FFP3),[1] Eye Protection, then Gloves.

1



Apron: Pull over head and tie securely at the back.

2



Gown: Fully cover torso neck to knees, arms to end of wrist and wrap around the back. Fasten at the back.

3



FRSM or RPE (FFP3)[1]: Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Respirators must be fit checked if being worn.

4



Eye Protection (Goggles/Face Shield): Place over face and eyes and adjust to fit.

5



Gloves: Pull on taking care to minimise contamination of the outer surface by holding gloves at the wrist opening only. Extend to cover wrist (over gown cuffs, if applicable).

Steps on removing PPE are continued on the next page.

Removing Personal Protective Equipment (PPE)

When removing PPE, the correct technique is essential to avoid touching the most contaminated areas of PPE e.g., the outside of gloves and front of aprons/gowns, eye protection, and FRSM/RPE.

The order for removing PPE is Gloves, Apron or Gown, Eye Protection, then FRSM/RPE (FFP3)[1].

6



Gloves: Pinch and lift the outside of the glove in the palm area with the opposite gloved hand; peel off while turning inside out. Hold the removed glove in the gloved hand. Slide two fingers of the ungloved hand under the remaining glove at the wrist. Peel the second glove off over the first glove and discard.

7



Apron: Unfasten or break neck ties and allow apron to fall forward. Unfasten or break waist ties and pull apron away from the body touching the inside only. Fold or roll into a bundle and discard.

8



Gown: Unfasten neck, then waist ties. Remove using a peeling motion; pull gown from each shoulder towards the same hand turning gown inside out. Hold removed gown away from body, fold or roll into a bundle and discard.

9



Eye Protection (Goggles/Face shield): Handle eye protection only by the headband or the sides. Face shields/glasses should be removed by grasping sides and pulling directly forward, away from face. To remove goggles with an elasticated headband, tilt head forward and grasp the headband with index fingers and thumbs, lift the headband upwards whilst pushing frame away from face, lower goggles away from face and discard.

10



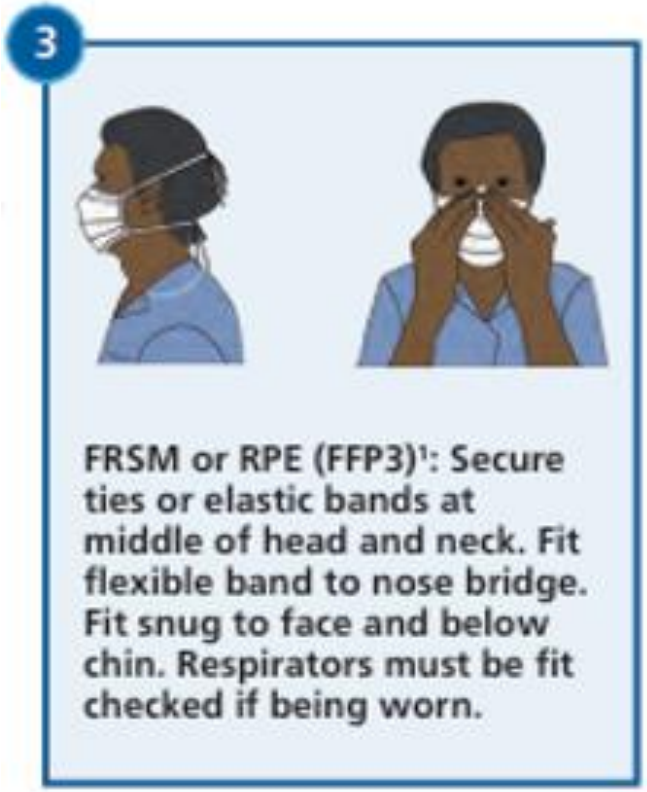
FRSM or RPE (FFP3)[1]: Unfasten the ties - first the bottom, then the top or, if elasticated, pull top and bottom elastics together. Handling the ties/elastics only pull away from the face without touching front of mask/respirator and discard.

- All PPE should be removed before leaving the care area and immediately disposed of directly into the appropriate waste stream, or a designated receptacle for reusable PPE.
- Perform hand hygiene immediately upon removal of PPE.

1. Reusable RPE including powered hoods may require a different order for putting on and removing, refer to your local policy if applicable.

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Masks, FRSM, Type IIR…





PA Department of Human Services on Twitter: "Wearing a mask helps keep you and others safe! Remember to keep your mask over your mouth and nose when in public. Learn more about #MaskUpPA from the @PennsylvaniaGov COVID-19 guide: https://t.co/igZZ3vBDif https://t.co/2KkrvTvaxh" / Twitter

Coronavirus **COVID-19**

To wear a face covering safely, avoid pulling it down

Coronavirus **Covid-19** Public Health Advice



Exposed area



The inside of the face covering will be contaminated



Mouth & nose may become infected by virus

When you want to eat, drink or do any activity where you need to remove your face covering, just remove it completely.

HSE

Rialtas na hÉireann
Government of Ireland

https://twitter.com/roinnslainte/status/1525747997585420288

Masks

NHS England » Universal masking decision support tool

NHS England Universal masking decision support tool, was developed to support health and care organisations in making informed, evidence-based decisions regarding the implementation of universal masking.

It is designed to support decision making by considering factors relating to the risk and impact of pathogen transmission, while taking account of local population needs, service demands, and existing IPC measures. The tool should be used alongside the accompanying guidance (Universal masking decision support tool guide).

Probability	
The probability questions included in the universal masking decision support tool are intended to guide the assessment of the risk, severity, and likelihood of pathogen transmission at local, departmental, service or facility level and inform the corresponding need (priority) for universal masking.	
Question 1: Is there evidence of increased transmissible respiratory infections or gastrointestinal infections with diarrhoea or vomiting in the local community or healthcare setting, reflected by rising admissions or presentations? (Links to local and regional data can be found in the universal masking decision support tool guide)	
Question 2: Do you have clearly defined pathways to identify and manage patients with respiratory symptoms or gastrointestinal infections with diarrhoea or vomiting?	
Question 3: Has ventilation been maximised? (if no mechanical ventilation or air changes per hour are unknown, or no windows that can be opened, answer no)	
Question 4: Is the patient or healthcare worker population susceptible to respiratory or gastrointestinal infections? for example, are they immunocompromised or immunosuppressed, are there behavioural considerations including cognitive or physical impairment or is staff vaccination uptake satisfactory?	
Question 5: Is staff vaccination uptake satisfactory?	
Question 6: Is the pathogen (or suspected pathogen) involved highly transmissible?	
Probability total	Ans
Probability RAG Status	

Total score probability	Risk
0	Very low
1-2	Low
3	Moderate
4-5	High
6	Very high

Impact	
The impact questions included in the universal masking decision support tool are intended to guide the assessment of the risk, severity, and likelihood of pathogen transmission at local, departmental, service or facility level and inform the corresponding need (priority) for universal masking.	
Question 1: Will disease following exposure be severe in the patient or healthcare worker population?	
Question 2: Are a significant number of the wider patient or healthcare worker population susceptible or at risk?	
Question 3: Is there evidence of increased staff absences due to respiratory infections or gastrointestinal infections?	
Question 4: Will the pathogen have a negative impact on current service provision and expected future capacity?	
Question 5: Have effective infection prevention and control measures been implemented? for example, have effective space management and increased cleaning schedules been implemented?	
Question 6: Are effective treatments available?	
Impact total	Answer Questions
Impact RAG Status	

NHS England » Universal masking decision support tool

Probability	
The probability questions included in the universal masking decision support tool are intended to guide the assessment of the risk, severity, and likelihood of pathogen transmission at local, departmental, service or facility level and inform the corresponding need (priority) for universal masking.	
Question 1: Is there evidence of increased transmissible respiratory infections or gastrointestinal infections with diarrhoea or vomiting in the local community or healthcare setting, reflected by rising admissions or presentations? (Links to local and regional data can be found in the universal masking decision support tool guide)	Yes
Question 2: Do you have clearly defined pathways to identify and manage patients with respiratory symptoms or gastrointestinal infections with diarrhoea or vomiting?	Yes
Question 3: Has ventilation been maximised? (if no mechanical ventilation or air changes per hour are unknown, or no windows that can be opened, answer no)	No
Question 4: Is the patient or healthcare worker population susceptible to respiratory or gastrointestinal infections? for example, are they immunocompromised or immunosuppressed, are there behavioural considerations including cognitive or physical impairment or is staff vaccination uptake satisfactory?	Yes
Question 5: Is staff vaccination uptake satisfactory?	No
Question 6: Is the pathogen (or suspected pathogen) involved highly transmissible?	Yes
Probability total	5
Probability RAG Status	High

Impact	
The impact questions included in the universal masking decision support tool are intended to guide the assessment of the risk, severity, and likelihood of pathogen transmission at local, departmental, service or facility level and inform the corresponding need (priority) for universal masking.	
Question 1: Will disease following exposure be severe in the patient or healthcare worker population?	Yes
Question 2: Are a significant number of the wider patient or healthcare worker population susceptible or at risk?	Yes
Question 3: Is there evidence of increased staff absences due to respiratory infections or gastrointestinal infections?	Yes
Question 4: Will the pathogen have a negative impact on current service provision and expected future capacity?	Yes
Question 5: Have effective infection prevention and control measures been implemented? for example, have effective space management and increased cleaning schedules been implemented?	Yes
Question 6: Are effective treatments available?	Yes
Impact total	4
Impact RAG Status	High

Risk = probability and impact	High Risk

Final outcome

Universal masking recommended

When implementing universal masking, it is important to identify and inform all relevant stakeholders, following local protocols.

For example: the Infection Prevention and Control (IPC) team, visitors, and other departments or teams that regularly access the facility or setting (this is not an exhaustive list).

Actions and decision notes

NHS
Thames Valley

Environmental Cleaning

Environmental Cleaning

During an Outbreak

High Touch Point Cleaning – increase of cleaning areas of high frequency use/touch e.g. door handles, door frames, telephones, stair rails. It is advisable to use a chlorine releasing agent for these areas during an outbreak, as you aiming to reduce the spread of the organism.

Non infected to Infected – when undertaking daily cleaning staff should start with those that are not infected finishing those that are infected, this will ensure that the infection does not spread via this route.

Ventilation – Do ensure that windows are opened frequently throughout an outbreak, as this will not only remove the organisms from the air, but also in the example of respiratory viruses enable a better clean of the environment.

Specific advice for gastrointestinal/norovirus outbreaks:

Vacuuming – Do not vacuum during outbreak, as this will re-introduce virus back into the environment; once outbreak is over, steam clean carpet.

Environmental Cleaning

Terminal Cleaning

National infection prevention and control manual for England

Although cleaning of the infected persons room, must be undertaken during their infectious period (reduce viral load), once the resident has completed their isolation period, the whole room should be fully decontaminated.

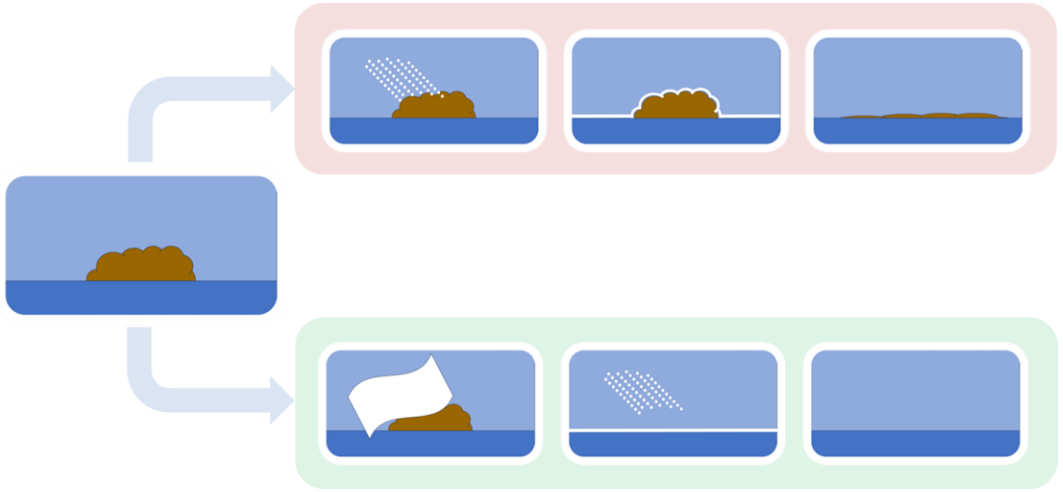
Including where possible:

- Steam cleaning soft furnishings and carpet
- Laundering of fabric items – cushions, teddy bears
- High to low level cleaning – including picture frames, cupboards

Cleaning Products

Detergents

- *Warm water and neutral detergent or detergent wipes are suitable for many cleaning activities.*
- *Select and use a good quality neutral detergent or detergent wipe.*
- *Liquid detergents classed as anionic and non-ionic have the best detergent activity.*



ASEPTIC TECHNIQUE (infectionpreventioncontrol.co.uk)

Cleaning Products

Disinfectants

- *Disinfectants which are virucidal and bactericidal should be used for disinfecting surfaces after dealing with a patient with a known infection, e.g. MRSA, MRGNB or suspected infection. A dual acting product, e.g. Chlor-Clean, Actichlor plus, made into a solution at a concentration of 1,000 ppm of available chlorine, or the use of a wipe, such as Clinell Universal, will be effective in decontaminating the surfaces adequately.*
- *To ensure efficacy, disinfectant solutions must be made up to the manufacturer's instructions, i.e. measure the product and water accurately, no guesses.*
- *Discard solutions as per manufacturer's instructions, e.g. hypochlorite solutions should be disposed of 24 hours after making up*

ASEPTIC TECHNIQUE (infectionpreventioncontrol.co.uk)

Cleaning Products

Specialist products

- *Spillage kits should be used for disinfecting surfaces following a blood or body fluid spillage containing a hypochlorite solution or granules at a concentration of 10,000 parts per million (ppm) of available chlorine.*
- *Alcohol wipes can be used, but as they do not contain a cleaning agent (unless they contain Chlorohexidine), surfaces should first be wiped with a detergent wipe or solution of neutral detergent and warm water. Alcohol is effective against MRSA, but is not effective against norovirus and Clostridium difficile.*

ASEPTIC TECHNIQUE (infectionpreventioncontrol.co.uk)

Cleaning Products

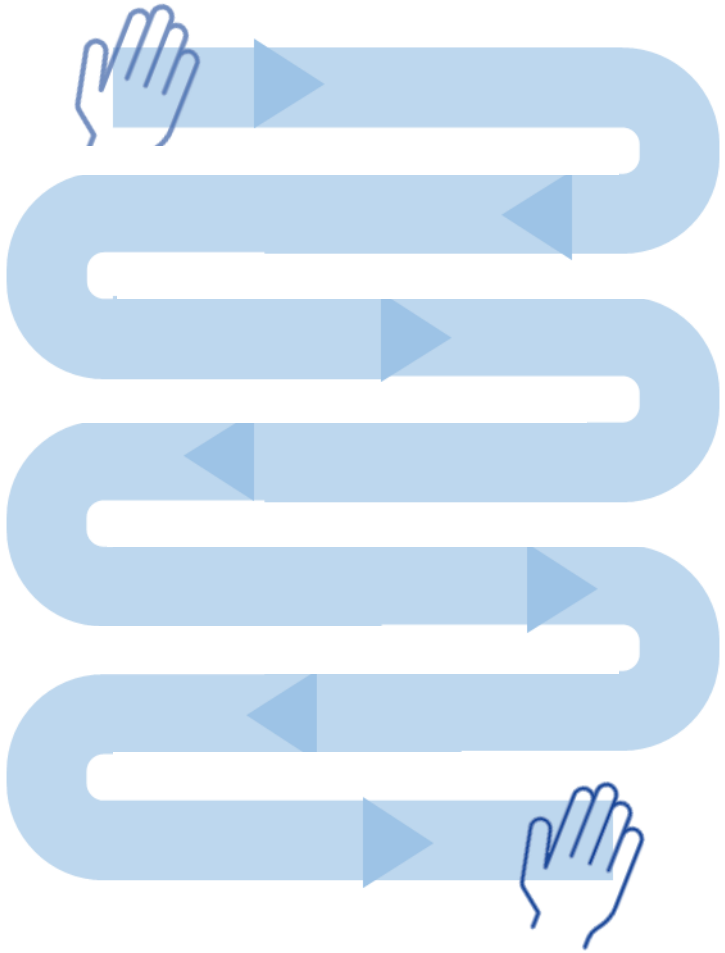
This is not an exhaustive list, and depends on the equipment, surfaces etc that you have within your care home

Examples of products;

General Surface	Detergent wipe Detergent solution
Infected Surface	Detergent/Disinfectant wipe Detergent/Disinfectant solution
Electrical equipment	Alcohol wipe (70% Isopropyl Alcohol Wipes)
Urine and vomit	Spill kit – for urine and vomit
Blood	Spill Kit – for blood

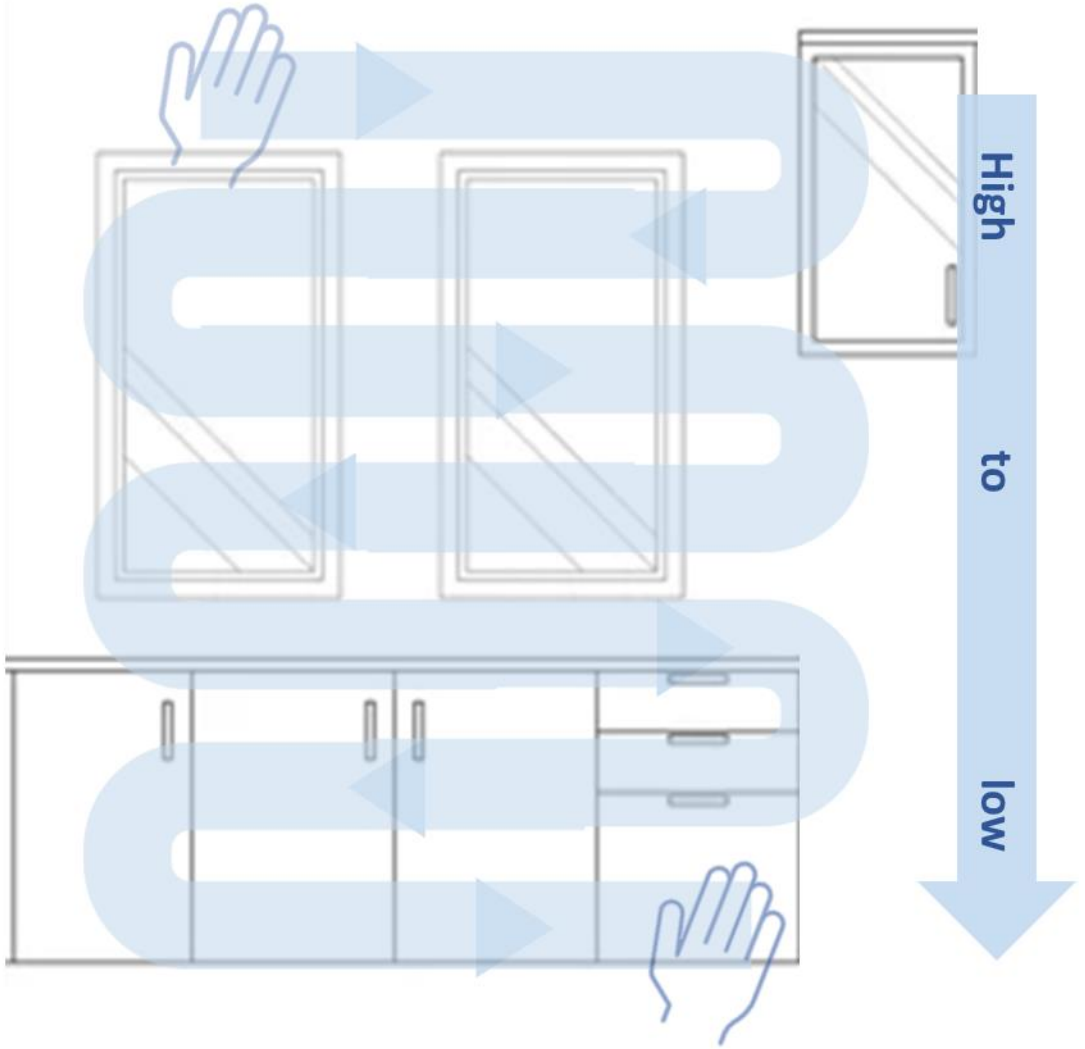
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How to clean a surface

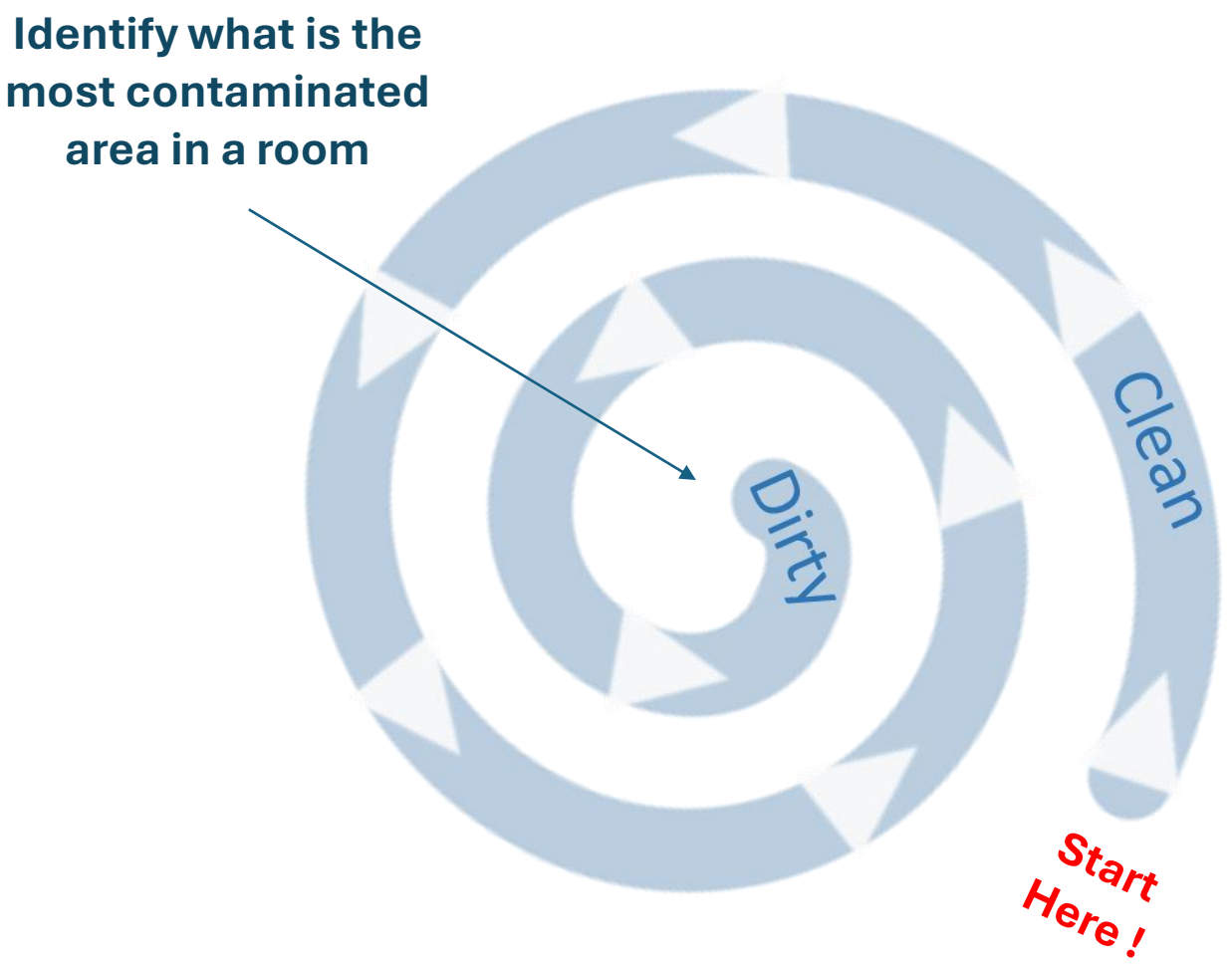


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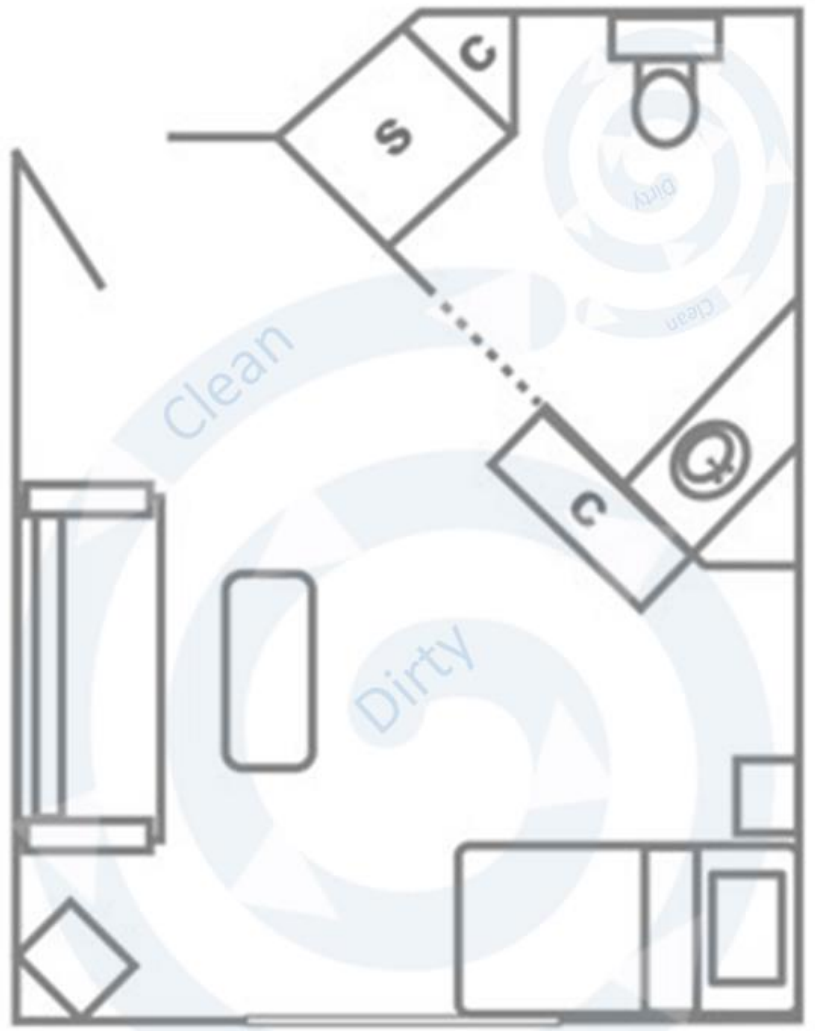
High surfaces to low surfaces



How to clean a room



How to clean a room




clinell
PATENTED FORMULA
UNIVERSAL WIPES
Wipes for cleaning and disinfecting hands, surfaces and equipment
40 WIPES


ECOLAB
Actichlor™ Plus
150 Tablets


Sani-Cloth
70%
MEDIUM WIPE
PDI


Guest Medical
CHLOR-CLEAN™
TABLETS
Chlorine releasing disinfectant tablets with compatible cleaning agent


clinell
ONE-STOP SOLUTION FOR BODY SPILLS
SPILL WIPES


PDI
Sani-Cloth
Active Wipes
Multi Surface
Alcohol Free
200


CHLOR-CLEAN WIPES
Clinical wipes for general environmental disinfection and for blood spillages
For professional use only.
Order Code: H9730
25 WIPES
CHLOR-CLEAN
Clinical Wipes
for general environmental disinfection & for blood spillages
25 WIPES
Please see reverse for instructions
Guest Medical


clinell
innovative solutions professional support
PERACETIC ACID WIPES
Peracetic acid generating wipes for surface disinfection and cleaning of non-invasive medical devices
25 WIPES
KILLS MICROORGANISMS INCLUDING CLOSTRIDIUM DIFFICILE AND NOROVIRUS. CONTAINS DETERGENT. CLEANS AND DISINFECTS IN ONE STEP.


Guest Medical
EFFERVESCENT
HAZ-TAB™
TABLETS
Chlorine releasing disinfectant tablets


SINGLE USE
BIOHAZARD SPILL-PAK
For blood and blood-stained body fluids.
Do not use on chemical spills.
Guest Medical

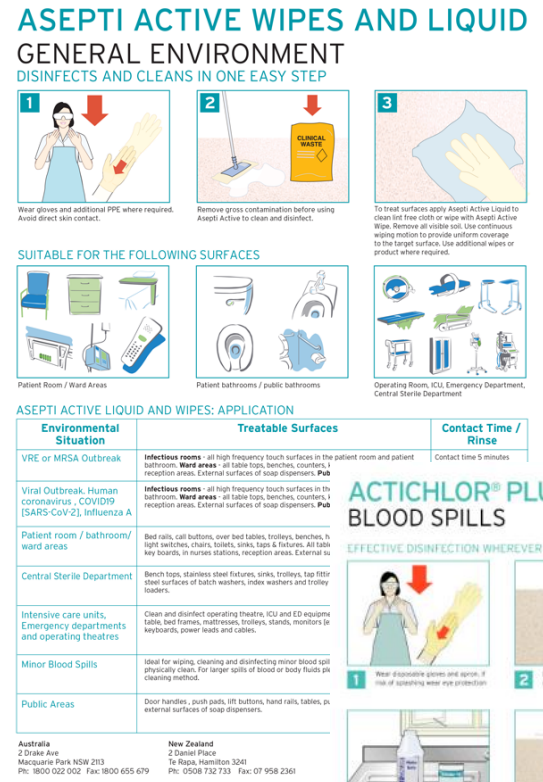

PDI
Sani-Cloth
Detergent Wipes
Multi Surface

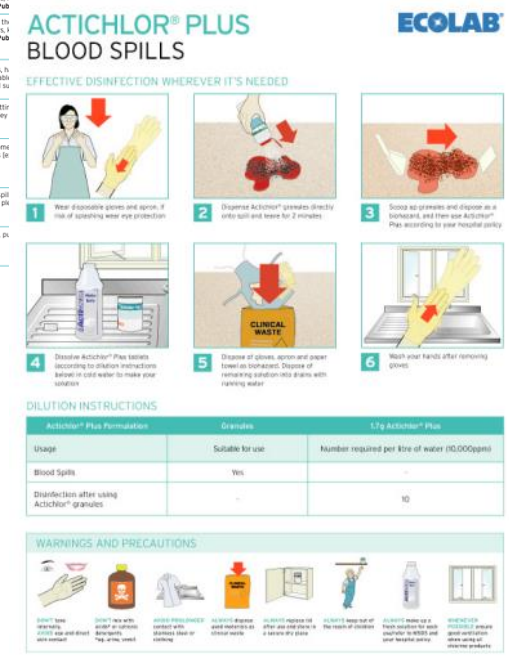
Instruction Posters and videos

[Guest Medical - YouTube]



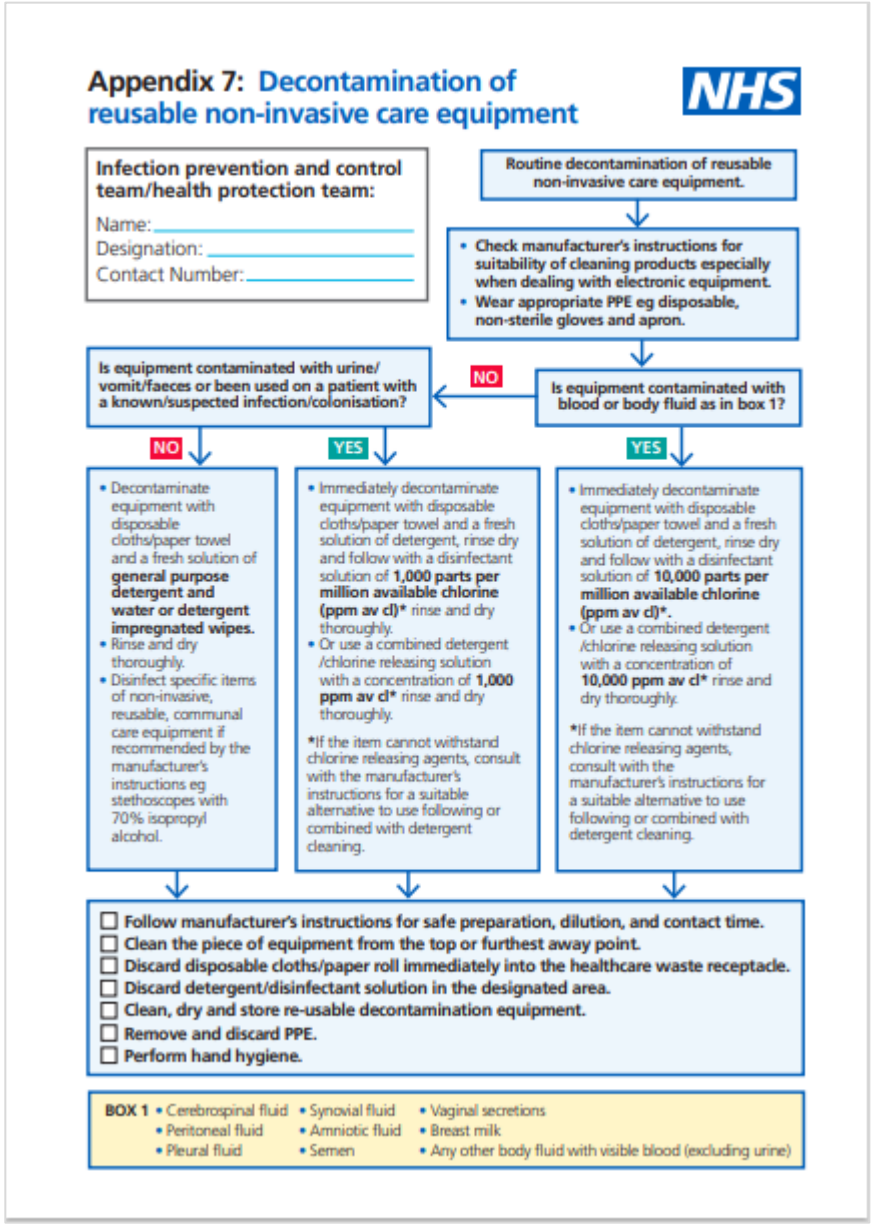






Infection Prevention and Control Manual

[NHS England » National infection prevention and control manual for England – appendices
Appendix 7 (england.nhs.uk)]



Appendix 7: Decontamination of reusable non-invasive care equipment

NHS

Infection prevention and control team/health protection team:

Name: _____

Designation: _____

Contact Number: _____

Routine decontamination of reusable non-invasive care equipment.

- **Check manufacturer's instructions for suitability of cleaning products especially when dealing with electronic equipment.**
- **Wear appropriate PPE eg disposable, non-sterile gloves and apron.**

Is equipment contaminated with blood or body fluid as in box 1?

NO

Is equipment contaminated with urine/ vomit/faeces or been used on a patient with a known/suspected infection/colonisation?

NO

- Decontaminate equipment with disposable cloths/paper towel and a fresh solution of **general purpose detergent and water or detergent impregnated wipes.**
- Rinse and dry thoroughly.
- Disinfect specific items of non-invasive, reusable, communal care equipment if recommended by the manufacturer's instructions eg stethoscopes with 70% isopropyl alcohol.

YES

- Immediately decontaminate equipment with disposable cloths/paper towel and a fresh solution of detergent, rinse dry and follow with a disinfectant solution of **1,000 parts per million available chlorine (ppm av cl)*** rinse and dry thoroughly.
- Or use a combined detergent /chlorine releasing solution with a concentration of **1,000 ppm av cl*** rinse and dry thoroughly.

*If the item cannot withstand chlorine releasing agents, consult with the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning.

YES

- Immediately decontaminate equipment with disposable cloths/paper towel and a fresh solution of detergent, rinse dry and follow with a disinfectant solution of **10,000 parts per million available chlorine (ppm av cl)*.**
- Or use a combined detergent /chlorine releasing solution with a concentration of **10,000 ppm av cl*** rinse and dry thoroughly.

*If the item cannot withstand chlorine releasing agents, consult with the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning.

- ☐ **Follow manufacturer's instructions for safe preparation, dilution, and contact time.**
- ☐ **Clean the piece of equipment from the top or furthest away point.**
- ☐ **Discard disposable cloths/paper roll immediately into the healthcare waste receptacle.**
- ☐ **Discard detergent/disinfectant solution in the designated area.**
- ☐ **Clean, dry and store re-usable decontamination equipment.**
- ☐ **Remove and discard PPE.**
- ☐ **Perform hand hygiene.**

BOX 1
- Cerebrospinal fluid
- Peritoneal fluid
- Pleural fluid
- Synovial fluid
- Amniotic fluid
- Semen
- Vaginal secretions
- Breast milk
- Any other body fluid with visible blood (excluding urine)

UK Health Security Agency

Flu and COVID-19 outbreaks

South East England adult social care residential settings

Do 2 or more service users have the following symptoms within 5 days of each other?

Fever of 37.8°C or above

New onset or acute worsening of one or more of these symptoms:

- cough
- runny nose or congestion
- sore throat
- sneezing
- loss or change of taste/smell
- hoarseness
- shortness of breath
- wheezing
- chest pain

Sudden decline in physical or mental ability

If yes, you might have an outbreak of COVID-19, flu, or other acute respiratory infection (ARI).

Support residents with symptoms to stay away from others; send staff with symptoms home

Test symptomatic service users with UKHSA supplied Combination Flu and COVID-19 LFDs. Residents eligible for COVID-19 treatments should be tested with a COVID-19 LFD available for free on the NHS from participating pharmacies.

Fill in the **Report an outbreak** tool to obtain advice.

Our CQC Location ID:.....
Combination LFD tests kept in:
.....

Report your ARI outbreak:

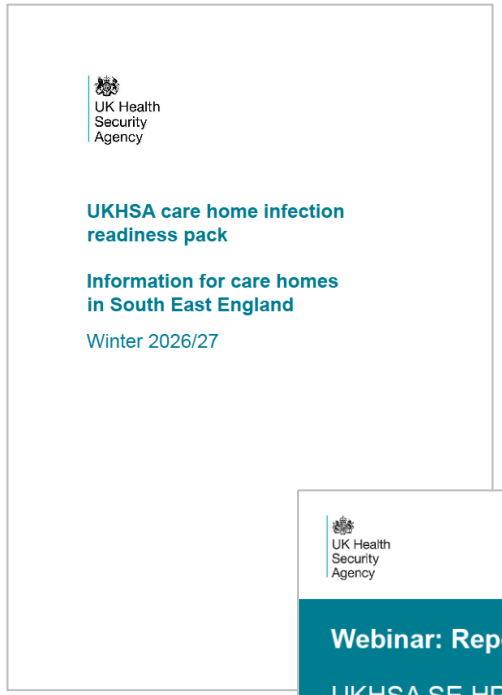
Complete the web-based Report an Outbreak Tool via https://forms.ukhsa.gov.uk/ReportAnOutbreak

OR use the QR CODE

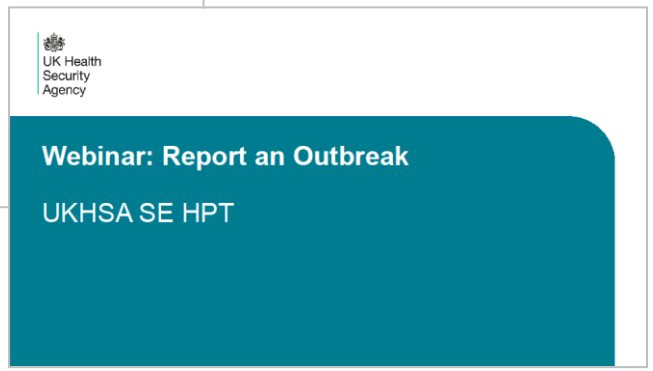
The UKHSA South East health protection team will review the information you submit and provide advice via email or a phone call to help manage the outbreak. **Antivirals for confirmed or suspected flu outbreaks are most effective when started early.**

NHS Thames Valley

Please complete



Double Click to open document



Double Click to open document

NHS
Thames Valley

Infection Prevention and Control Support

The team supports Social Care across the whole of the Thames Valley

We can support you and your team with a range of concerns;

- MRSA
- C.diff
- Influenza
- Norovirus

And many more

If you have any query, please do not hesitate to contact us.

Vanessa Mobile: 07785469880
Josephine Mobile: 07769286224

Email us on: tvicb.ipcteam@nhs.net

Please also contact **UK Health Securities Agency** if you have any notifiable disease concerns

In and out of hours: 0344 225 3861

Email (Mon-Fri 9am-5pm):
SE.AcuteResponse@ukhsa.gov.uk

Email (for PII):

Thames Valley HPT
phe.thamesvalley@nhs.net

