To:
- NHS trusts and foundation trusts:
  - chief executive officers
  - directors of nursing
  - medical directors
  - chief operating officers
  - directors of IPC
  - IPC leads
- CCGs:
  - directors of nursing
  - medical directors
- NHS England and NHS Improvement regions:
  - IPC leads
  - chief nurses
  - medical directors

cc.
- NHS England and NHS Improvement regions:
  - directors
  - operating directors

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

1 June 2022

Dear Colleagues,

Next steps on infection prevention and control (IPC)

Thank you for everything you and your teams have done over the last two and a half years. We know that the pandemic and associated IPC measures continue to have an impact on your capacity and flow, with numbers of COVID-19 patients still elevated and some additional measures still in place.

IPC guidance has continued to evolve throughout the pandemic, and we are now setting out further changes following updates from the UK Health Security Agency (UKHSA).

UKHSA has updated its UK IPC guidance with new COVID-19 pathogen-specific advice for health and care professionals. This advice should be read alongside the National Infection Prevention and Control Manual (NIPCM) for England and applies to all NHS settings or settings where NHS services are delivered.

Any IPC measures beyond those contained in those publications is a matter for local discretion. We understand that there may be a period of transition as providers make changes to their operating procedures, especially given local variation in COVID-19 infection levels.

Likewise, all healthcare settings should now be transitioning back towards their own pre-pandemic policies on inpatient visiting and patients being accompanied in urgent and emergency care (UEC), outpatient or primary care services, with the expected position that no patient should be alone during their episode of care or treatment unless this is their choice. National principles on hospital visiting and maternity/neonatal services will remain in place for now as an absolute minimum standard.

UKHSA advice for healthcare workers sets out that in health and care settings, non-pharmaceutical interventions (such as mask wearing and enhanced ventilation) may be used, depending on local prevalence and risk assessment, with the aim to reduce the spread of SARS-CoV-2. Based on the most recent guidance from the World Health Organization, please use the below to support you to interpret UKHSA's advice. The exact interpretation will depend on your local risk assessments.

For health and care staff:

- Health and care staff should continue to wear facemasks as part of personal protective equipment required for transmission-based precautions when working in COVID-19/respiratory care pathways, and when clinically caring for suspected/confirmed COVID-19 patients. This is likely to include settings where untriaged patients may present such as emergency departments or primary care, depending on local risk assessment. In all other clinical care areas, universal masking should be applied when there is known or suspected cluster transmission of SARS-CoV-2, eg during an outbreak, and/or if new SARS-CoV-2 VOC emerge.
- Universal masking should also be considered in settings where patients are at high risk of infection due to immunosuppression eg oncology/haematology. This should be guided by local risk assessment.
- Health and care staff are in general not required to wear facemasks in non-clinical areas eg offices, social settings, unless this is their personal preference or there are specific issues raised by a risk assessment. This should also be considered in community settings.

For inpatients:

- Inpatients with suspected or confirmed COVID-19 should be provided with a facemask on admission. This should be worn in multi-bedded bays and communal areas, eg waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient. They are not usually required in single rooms, unless, eg, a visitor enters.

- All other inpatients are not necessarily required to wear a facemask unless this is a personal preference. However, in settings where patients are at high risk of infection due to immunosuppression eg oncology/haematology, patients may be encouraged to wear a facemask following a local risk assessment.
- Patients with suspected or confirmed COVID-19 transferring to another care area should wear a facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination.
- The requirement for patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required or where it causes distress, eg paediatric/mental health settings.

For outpatients, UEC and primary care:

- Patients with respiratory symptoms who are required to attend for emergency treatment should wear a facemask/covering, if tolerated, or offered one on arrival.
- All other patients are not required to wear a facemask unless this is a personal preference.

For visitors:

- In inpatient settings where patients are at high risk of infection due to immunosuppression, eg oncology/haematology, visitors may be asked to wear a facemask following a local risk assessment.
- Visitors and individuals accompanying patients to outpatient appointments or the emergency department are not routinely required to wear a facemask unless this is a personal preference, although they may be encouraged to do so following a local risk assessment.

These supporting principles will be updated if we receive further advice from UKHSA and other public health agencies.

Yours faithfully,

Professor Stephen Powis
National Medical Director

Duncan Burton
Deputy Chief Nursing Officer for England