NHS Borders

COVID-19

Local Mobilisation Plan 3

15th April 2020

FINAL

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Introduction

This is the third iteration of the NHS Borders COVID-19 Local Mobilisation Plan.

The plans have been developed on modelling undertaken locally by NHS Borders staff based on work previously undertaken and published by Imperial College[1]. The local model has subsequently been updated on receipt of national modelling released by Scottish Government on 8 April 2020.

It should be noted that the plans contained within the Local Mobilisation Plan are constantly being reviewed and updated as more information becomes available.

Ventilators and Escalation for COVID-19

Ventilators and CPAP

NHS Borders substantive ventilator capacity was 5 Draeger Evita ITU vents sited within the Borders General Hospital (BGH). Following a request from Scottish Government to quadruple capacity to 20 and following guidance from Health Facilities Scotland to convert anaesthetic machines to be air driven modifications were made to our local equipment which gave a ventilator capacity as set out in the following table:

Equipment	Number
ITU ventilators	5
Anaesthetic machines (Aisys) modified to be air driven	6
Anaesthetics machines (care station 650) modified to be air driven	4
Anaesthetic machines (Drager Primus) donated by Royal Hospital for Sick Children (Edinburgh)	4
TOTAL	**19**

We have had assurances from Scottish Government of additional ventilators to support our existing number so that we can achieve the 20 ventilators within the BGH. We were notified on 2nd April that 5 ventilators would be issued to the BGH by 6th April from stock allocated to Scotland, but unfortunately these were caught up in customs. We have instead been donated 4 anaesthetic machines from RHSC Edinburgh that are oxygen efficient and have high ITU quality ventilators. We have capacity to increase to 20 patients in total using either a transport ventilator or a NIV machine with invasive ventilation capability, although neither of these is an ideal option.

[1] *Ferguson NM et al. Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand. WHO Collaborating Centre for Infectious Disease Modelling; MRC Centre for Global Infectious Disease Analysis; Abdul Latif Jameel Institute for Disease and Emergency Analytics; Imperial College Covid 19 Response Team. March 2020*

It should be noted (and as highlighted in the second iteration of our Local Mobilisation Plan) that using adapted anaesthetic machines to support ITU patients isn't ideal as they need high flows of oxygen, require soda lime and have a large footprint for a small bed space. In the absence of further new ventilators we will be required to continue using the adapted machines noting their limitations.

HDU Plans

On receipt of the ventilators outlined above we will be in a position to increase capacity of critical care beds to 20 along with the creation of an additional Medical HDU with 8 beds. The HDU beds came on stream on 4th April 2020. These beds will initially be staffed through a combination of redeployed clinical nurse specialists and some intensive care staff. It is unlikely however that we will be able to maintain the staffing from the intensive care nurse workforce for long as the demand for them in intensive care will increase and this is a finite workforce resource.

This is a facility where level 2 care can be delivered, including administration of inotropes and non-invasive ventilation for CPAP as a mode to support patients with COVID-19 virus either as a limitation of treatment to their ceiling of care or to support or temporise before requiring invasive ventilation.

Where bed space allows, our plans are to provide CPAP in intensive care as the risks of deterioration to sudden requirement for invasive ventilation appear high. However, as our ventilator number increases and our experience in CPAP for these patients improves we will move these patients to the day procedure unit / HDU that we have transformed. In patients who are not suitable for invasive ventilation and the ceiling of treatment is CPAP, this will be provided in HDU.

Due to constraints in relation to space, nurse staffing and oxygen it will not be possible to increase our critical care beds above the 20.

Oxygen

We highlighted in our previous Local Mobilisation Plans that we were extremely concerned around providing an adequate supply of oxygen per minute to meet predicted demand within the BGH. The key problem is the rate of oxygen flow into the piped supply may be insufficient.

We have been working closely with colleagues from Health Facilities Scotland over this concern and have made all of the modifications to the oxygen plant that have been recommended in order to ensure the maximum distribution of oxygen from it.

In addition, we have undertaken some modelling based on assumptions of how much oxygen additional patients with COVID-19 will use. The model is updated on a twice daily basis using data of how much oxygen such patients actually use. We are using this to calculate the estimated demand for oxygen over time. We are comparing this to the new rated maximum flow of oxygen from the vacuum insulated evaporator (VIE) of 1086 litres per minute (increased from 750 litres per minute before the adaptations were made).

Should the BGH approach the maximum delivery from our plant then we would be seeking urgent discussions regionally / nationally to consider transporting Borders patient to other facilities before compromising the care of patients within the BGH. This would initially be through regional

mutual aid and discussions have taken place between the Chief Executives and Medical Directors of NHS Fife, Lothian and Borders and a commitment secured to supporting each Board as far as is practicable.

We note the development of the NHS Louisa Jordan medical facility being created at the Scottish Events Campus (SEC) in Glasgow. Once the model of care for the facility is confirmed and patient pathways developed we will be in a better position to assess if this could provide contingency support for NHS Borders.

In terms of oxygen cylinders, we are working to ensure that patients on low-flow oxygen are supported with the cylinders rather than putting additional demand on the piped supply. Similarly we are trying to gain as many oxygen concentrators as we can in order to support these patients to reduce the burden on the piped supply.

Nurses in ITU

In earlier discussions regarding ITU there was a commitment to maintain an ITU trained nurse to patient ratio of 1:3 with other nurses or AHP supporting in order to offer good care. In increasing the capacity to 20 ventilated patients we are no longer able to give these reassurances.

We will use the national guidance to have nurse ratios of no lower than 1 ITU trained nurse per 6 patients with other staff making up a total ratio of 1:2 and a supervising nurse in charge. At this level care will be significantly lower than normal and there is a risk that patients may come to serious harm or death.

We are aware of the challenging and difficult working conditions for nursing staff in ITU in terms of workload and the wearing of PPE for long periods. We are putting in various measures to try and improve the conditions for staff.

Medical Staffing

We have increased the amount of medical staff available each day by removing the concept of weekends, cancelling annual leave and maintaining a 12.5 hour shift pattern in order to ensure adequate skill and seniority are available at all times. In addition to this we have built a rota of junior doctors with previous experience in intensive care to support the existing structures consultants and middle grades. The ability to maintain this level of medical staff will be dependent on staff sickness moving forward.

Elective Surgery

Our original intention had been to offer urgent surgery only given that we have no capacity for post-operative critical care except in exceptional cases, and staffing constraints in theatre make it a significant logistical challenge to run an elective list alongside an emergency list. Since then we have been working with Scottish Government colleagues to secure the use of a private hospital in Edinburgh for high priority elective cases, with NHS Borders providing the surgeons and anaesthetists to allow our urgent cancer surgery to be carried out. This is due to commence on 20th April 2020. Work is ongoing to establish the required capacity and whether the level of sessions offered will meet the needs of Borders residents.

NHS Borders COVID-19 Modelling Outputs

As previously highlighted, the earlier iterations of our Local Mobilisation Plan were informed by modelling work undertaken locally by NHS Borders staff. The assumptions and caveats relating to the modelling work are detailed in those previous plans.

Based on the modelling and actual data on increase in demand experienced between up to end March, our Local Mobilisation Plan 2 indicated we would require 300 - 350 general hospital beds to be available for COVID-19+ and suspected patients at the peak of the pandemic. At that stage we had only 10 days of actual data on which to test against the model. We continued to update the modelling work on a daily basis with a rolling 5 day average of actual data.

As at 14 April we now have 26 days of actual data. In addition we are now in receipt of national modelling work commissioned by Scottish Government. We have therefore updated our model and also compared this with the national model which provides an indication of demand beyond the impact of lockdown measures.

The Scottish Government model covers a 23 week period and shows the expected peak point and a subsequent reduction in demand. It is built on assumptions rather than actual data and is at Scotland-wide level only.

The model outlines 4 scenarios:

- 60% compliance rate with ITU admissions at either 25% or 12.5% of hospital cases
- 40% compliance rate with ITU admissions at either 25% or 12.5% of hospital cases

The data is presented on a week by week basis, with a suggestion that Scotland is at week 10 of the 23 week period. This would put peak bed demand at 25th May.

Not all of the underpinning assumptions of the national model were shared with NHS Boards. As a result we have had to make a number of assumptions when analysing the model with actual data from Borders. This has included dividing the Scottish totals by 2.2% to give the Borders population, and adjusting our model to fit the 12.5% national model (our actual average % ITU admissions is 14%).

This has enabled us to identify a best fit scenario for data from week commencing 30th March (actual data) which is a 40% compliance rate with 12.5% ITU admissions and means Borders is potentially in week 12 or 13 of a 23 week period.

Week 13 of the national model predicts we would need 61 general hospital beds to meet the COVID-19 demand whereas we actually required 41. This suggests the national model has a longer length of stay than our experience, which has been averaging at 4.8 days.

Social interventions with 40% compliance (12.5% of hospitalised patients require ICU at some point)	Model	Actual
Concurrent cases	1,928	
Concurrent cases with symptoms	1,314	
Patients requiring admission to hospital	66	69
Peak number of beds required that week	67	31
Patients requiring admission to ITU	8	8
Peak number of IUT beds required that week	9	7
Deaths by week	9	11

If we are at week 13 and the national model and underpinning assumptions are correct, in terms of general hospital beds, Borders demand will peak with 104 admissions w/c 27th April and 117 beds w/c 4/5 or 11/5. In terms of ICU beds, the model predicts we will peak at 17 ITU beds w/c 4th and 11th May.

Our local model had previously indicated that we would peak with a demand for 300-350 beds although no impact of the suppression measures that came into effect in late March had been built into the assumptions at that point in time.

Based on these changes NHS Borders is now planning on the following basis up for the purpose of this version of the Local Mobilisation Plan:

- A requirement of 120 general hospital beds for COVID-19+ patients at the pandemic peak
- A requirement of a maximum of 17 ITU beds for COVID-19+ at the pandemic peak
- An assumption that the pandemic peak in Borders will be w/c 4th May

We will continue to monitor actual demand against the updated model and trajectories on a daily basis so that we can quickly assess if this is diverging from the expected rate. In addition we have built in formal trigger points to review. These trigger points are when demand for general hospital beds is at 100 and separately when ITU bed demand is at 13. If demand does exceed this at the time of the review then we will need to revise our plans and take other measures to flex up available beds. This may include requesting mutual aid from other Health Boards or Scottish Government assistance.

Scaling Up Bed Capacity

General Hospital Bed Demand

Based on the updated modelling work outlined above, we are now predicting a need for approximately 120 acute beds for COVID-19+ patients by 4th May 2020. However, these figures do not take into account the challenges of accommodating (isolating) suspected COVID-19 patients.

Please note Paediatric and Maternity requirements are excluded from these figures and are being assessed separately.

The last iteration of the Local Mobilisation Plan outlined the potential for NHS Borders to scale up beds for COVID-19+ and suspected patients to 230 whilst still retaining a non COVID-19 footprint of just over 100 beds. Achieving the 230 would require some significant steps in order to free up this capacity as outlined in the previous plan.

As previously stated, the local modelling at that time predicted a requirement for between 300 and 350 general hospital beds. A number of scenarios and options were to be looked at in order to increase the bed capacity to meet the modelled requirements. These included:

- Creation of additional capacity through reducing the inpatient footprint for non COVID-19 care
- Utilising non inpatient space within the hospital including the dining room for a nightingale ward
- Vacating between 48 and 96 Community Hospital beds through creation of additional care home capacity within Scottish Borders
- Field hospital in the grounds of the acute hospital
- Use of private hospitals
- Out of Borders capacity

These options would each have had a range of significant risks and implementation issues. A rapid and "light touch" option appraisal process was undertaken in order to identify preferred ways to increase our overall general bed capacity.

However, in light of the revised modelling with the changed assumptions to match the national model and using actual demand (to date) rather than assumed demand NHS Borders is now planning on a reduced number of beds being required for COVID-19+ and suspected patients by the time of the pandemic peak in early May.

The bed numbers we are now projecting we need are outlined below:

Predicted beds required for Covid positive patients at peak week	120
Additional beds required to achieve 85% ward occupancy	21
Assessment footprint (Covid Assessment) beds	30
Total	**171**

We plan to create the required beds through the creation of new beds and re-designation of existing beds as per the following table:

Ward Name	Inpatient surgery plan	Bed Capacity Created	Cumulative Total
CV1	MKU (Full unit)	8	8
CV2	BSU	14	22
CV3	Ward 14	30	52
CV5	Ward 17 / PAU	22	103
CV4	Ward 12	29	81
CV6	Ward 16	16	119
CV7	Ward 15	18	137
CV Assessment	MAU	30	167
CV Assessment	AAU	7	174

The hospital management team will utilise COVID-19 1 – 7 footprint as operationally required. We have confirmed that we do have the ability to scale up to approximately 280 beds on the BGH site, and currently working on a contingency plan to do this, should it be required. We have a total of 105 non COVID-19 beds available in the BGH.

In relation to the number of COVID-19 general beds we require, although planning for the 174 beds, we have built in trigger points to review actual demand against modelled demand, which will enable us to mobilise additional bed capacity if this is required. Actual activity is captured and reported daily, and twice per week the data will be reviewed (modelled against actual for both general hospital beds and HDU). Should we require more than 280 general beds it is assumed these will have to provided through other measures, which could include mutual aid.

We are currently experiencing reduced non COVID-19 related activity, including a reduction in ED attendances of 49% and a 53% reduction in occupied bed days for non COVID-19 general medical patients since 19th March. We have factored some of this reduced activity into our planning at this stage but not all of it as we recognise this may be a temporary reduction.

ITU Demand

Both models are indicating an expected maximum demand of up to 20 ITU beds by mid-May. As highlighted earlier we have identified plans that would allow us to establish a maximum 20 ventilated ITU beds (although as highlighted earlier we are only operating with 19 ventilators available at this time) and our current assessment is that we can staff up to the 20 beds. If actual numbers exceed this level, we would require alternative arrangements for additional patients, such as transfer to other facilities out with the Scottish Borders.

This will also need to be supported by nationally agreed and implemented ITU triage tools that are currently under development.

Staffing Model

NHS Borders has considered the staffing requirements for the additional 120-150 general beds, 8 HDU beds, and 20 ITU beds.

This process has involved a review of all staffing levels related to current beds within the hospital and these have been reduced where possible while still maintaining safe registered nurse to bed ratio. Current staffing level includes uplift for annual leave and since leave has been reduced or ceased the staff who would have previously provided the leave cover have been deployed to staff the additional beds.

Other professions such as AHP's and administration staff have been deployed to cover additional non registered nursing roles.

A system has been agreed where wards have been given a red, amber or green status which flags the level of staff on a daily basis which will allow clinical management to see the areas with the greatest staffing need at a glance. This will allow any additional available staff to be deployed quickly to areas who have reduced number due to sickness.

Working With Partners To Reduce Delayed Discharges

By working closely with NHS Borders and Scottish Borders Council the IJB has already been operating a number of programmes specifically designed to reduce patient delay, increase flow and reduce the number of occupied bed days due to delays.

Building on these programmes, the Scottish Borders Health and Social Care Partnership response to COVID-19 was outlined in the submission made to Scottish Government on 2nd April. The response aims to bolster the locality response to maximise the resilience of our communities to be able to protect themselves, their families and their neighbours. It seeks to increase the capacity of provision, reduce process time and improve efficiency by eliminating all but essential requirements within governance and service operations. This approach will increase the ability of services to deliver to more people but it will still require further investment to increase the number of service hours available to meet the anticipated growth in demand.

All services within the partnership are expected to work across their professional boundaries, reducing the need to cater for households across several services. Data and intelligence sharing has already been agreed and technology enabled care and data transfer is supported both locally and across the Borders.

Our major aim, is to protect people in their homes, enable swift access to services as required, provide treatment and intervention efficiently and return people to their normal lives as soon as practically possible.

In this challenging time, we cannot provide our normal service, and our communities are aware of that. We are ensuring we offer the essential provision that will see our communities through this crisis, mitigating risks as fully as we are able.

The Scottish Borders Response follows six intervention themes as outlined below:

- Reduction of delayed hospital discharges
- Increase the capacity of both residential and home care
- Increase locality resilience
- Provide extensive support to both primary care and community provision
- Reduce administrative burden, quicken decision making
- Improve staffing capacity overall

More detail relating to the specific actions being taken under each area of intervention, along with expected outcomes, staffing implications and projected costs are outlined in the 2nd April submission to Scottish Government.

The steps outlined above are in addition to work that was already underway to reduce the level of delayed discharges in the Borders, which was outlined in the previous iteration of the Local Mobilisation Plan.

The submission on 2nd April included a revised trajectory to reduce delayed discharges in the BGH to 0 by 8th April and in Community Hospitals and Mental Health to 0 by 21st April.

Medicines Shortages

The COVID-19 pandemic has affected services in many ways. The increased number of patients needing critical care has increased the demand for drugs used in both anaesthesia and critical care and this demand will need to be managed carefully.

The UK medicine supply chain has operated on a 'just in time' basis for many years and recently there have been several challenges with medicines shortages. The UK Government has reserved responsibility for supply and NHS England are leading on this on behalf of the UK. Medicines contingency planning is being co-ordinated at UK level with a supply response group being established by the Department of Health and Social Care (DHSC) and includes representation from Scottish Government.

NHS Borders has been acting in line with advice from National Procurement and Scottish Government during this time. The advice was to not stockpile as there was work on going to manage stocks across the UK and any excessive ordering could affect the supply.

NHS Borders medicines supply model has operated with a 'just in time approach'. With the additional critical care beds coming on stream, there have been moves to increase the stock for some critical medicines in an incremental basis so as not to destabilise the supply chain. Attempts to order a significant additional quantity of these medicines has been challenged by National Procurement and at UK level.

Further information has now been made available to NHS Scotland National Procurement on the work being undertaken by the Department for Health and Social Care (DHSC) on sourcing additional stocks of critical medicines. DHSC has contacted all current marketing authorisation holders for at least 12 medicines and have issued a general communication to all pharmaceutical companies in the UK asking if they are able to source/supply key identified medicines, including whether there is non-licensed stock that could be accessed and redirected to UK supply.

Work is being undertaken to calculate how much of each of the 12 medicines would be required for an average critical care bed in order that a fair system of allocation can be used to share the medicines available across UK NHS hospitals. However, because of the range of different strengths and preparations this has proven very difficult. Further discussion has taken place and agreement has been reached with England that the Barnett formula will be used to allocate stock to Scotland (8% of available stock). The one exception is the scenario where evidence suggests that the NHS will completely stock-out of a medicine. In this case, there will be consideration given to current hospital stockholding and occupied beds in calculating the final regional allocation, for the purpose of ensuring stock is exhausted around the country at approximately the same time. As there is currently a lower prevalence of COVID-19 in Scotland compared to the UK as a whole, this is a fair outcome for Scotland.

Scottish Government (SG) and National Procurement (NP) are proposing that Scotland's share of UK procured stock for critical and supportive care medicines is allocated to boards based on **occupied ITU bed numbers**. It is likely that no more than a week's worth of stock will be allocated at any one time. In the last week we have been notified that one medicine – noradrenaline – will be allocated through this revised route. Based on local modeling this may be insufficient for NHS Borders based on maximum critical care bed occupancy, this is being noted nationally.
Week commencing 6th April Pharmacy Services were made aware of a UK shortage of propofol, a medicine used routinely for sedation of ventilated patients. DHSC and National Procurement are urgently sourcing alternative supplies. At present an alternative strength of propofol is available, however, this example demonstrates the fragility of the supply chain.

On 9th April we were made aware by Scottish Government of an issue with Fresenius who supply fluids for renal replacement therapy. NHS Borders has only received half of the order it was expecting and continue to chase for the remainder. The pharmacy team in NHS Borders is closely monitoring the situation.

A national group involving critical care doctors, pharmacists and senior managers has provided guidance on adaptations to first, second and third line treatments in the event that the preferred critical care medicines are unavailable.

In order to mitigate the risks NHS Borders is:

- Reviewing stock levels on a daily basis
- Reviewing and adapting local practice, where demand for certain products is high, including switching to alternative routes of administration
- Considering combining sedatives (e.g. midazolam & morphine, propofol & alfentanil) following discussion with pharmacists.
- Reducing waste by working with clinical pharmacists and aseptic teams to devise safe ways to use all the contents of drug vials and ampoules.

- Liaising with Pharmacy aseptics to prioritise and maximise ready to administer intravenous medicines.

Personal Protective Equipment (PPE)

NHS Borders is in the process of establishing our current demand profile based on judicious application of national guidance across all our care teams, and our Procurement Department are working closely with National Procurement to determine if the national supply chain is able to meet projected demand.

We are also putting in place local controls for PPE Stocks, with 7 day top up arrangements now in place to ensure that each care team has sufficient stock to meet projected daily demand. A review of clinical consumables associated with CPAP and Ventilators is also underway given the potential volume increases with our capacity plan.

A PPE Committee has been established that meets three times a week to discuss, mitigate or escalates any issues that arise.

PPE items that remain of particular concern at this time are:

- Availability of fluid resistant gowns - we continue to monitor.
- Availability of visors/ eye protection - we continue to monitor.
- Availability of hand gel - we continue to monitor.

Mortuary Plan

As it was recognised in the previous Pandemic Plan that additional body storage would be required, NHS Borders has participated in the Lothian & Borders Resilience Partnership sub group on Excess Deaths. In addition we are working closely with Scottish Borders Council (SBC) to monitor deaths and predicted deaths as a result of COVID-19. Taking into account the modelling as at 8th April 2020 and the predicted non COVID-19 deaths in the community, the council has commissioned additional temporary body storage within Borders with effect from 20th April 2020 to support NHS Borders and undertakers' mortuary facilities.

NHS Borders has finalised a mortuary plan for managing and monitoring mortuary spaces during COVID-19 which dovetails with the local authority provision.

Shielding of Most Vulnerable Patients

Scottish Government has arranged that people at very high risk of mortality from COVID 19 receive a letter advising they should undertake 'shielding' by remaining at home for 12 weeks and limiting contact with other people. There are 7 categories of people requiring shielding of which two (4&7) required that individuals where required to be identified locally. Progress as at 10th April 2020:

- 1965 letters have been issued to individuals in the Scottish Borders who fit categories 1,3 & 5
- 611 letters have been issued to individuals in the Scottish Borders who fit categories 2&6
- 320 people have been identified locally as fitting into categories 4 and 7, or are missing from the national list provided by ISD

NHS Borders is currently supporting GP practices within the Borders with contacting all individuals who have received a "shielding" letter, in line with Government guidelines.

Whole System Planning Across Acute/Primary/Social Care

NHS Borders along with colleagues in Scottish Borders Council are working actively to ensure a consistent and cohesive approach and activities across the Health and Social Care system. An SBC/NHS Joint Strategic Group has been established with members drawn from the Council Management Team and Board Executive Team which meets virtually three times per week.

The NHS Borders Strategic Planning group coordinated COVID-19 health planning across the clinical boards and corporate services. Regular sessions were held to update colleagues on acute/primary & community/mental health and LD/social work and corporate service plans and to identify any gaps or points for discussion and clarification.

The Strategic Planning group was stood down on 24 March 2020. The NHS Borders COVID-19 Pandemic Committee (Gold Command) went live on 25 March 2020. The purpose of the Committee is to operationally oversee and manage the response of NHS Borders to the COVID-19 Pandemic.

A meeting of the East Region Programme Board on 27 March 2020 agreed to refresh our commitment to Mutual Aid and to continue to work together across the East Region Boards to ensure consistency of approach to levels of care.

Work underway to mobilise services across Mental Health, Learning Disabilities, Primary & Community Services and NHS Borders Corporate Services is outlined below:

PRIMARY AND COMMUNITY SERVICES (P&CS)

Our primary and community services are continuing to mobilise and respond to COVID-19. Below is a summary of the current position and the approach being taken:

Primary Care

- The COVID-19 Primary and Community Services co-ordinating group is meeting daily with a daily update circulated to Primary Care
- Primary Care issues from all sectors are directed to a P&CS Emergency Planning Mail Box which is manned during working hours. P&CS Covid meeting reviews the queries each morning and agrees responses. At the end of the day key messages are agreed and sent out to GP practices in a daily update

- Key messages for wider P&CS services are included within the daily Staff Update
- A new separate management on call rota to provide seven day Primary Care management has been introduced
- A workforce resilience system and process has been established in P&CS based on a register of available staff capacity. The system supports the collation of staffing difficulties in GP practices and other services each morning and allows speedy deployment of relevant staff to support
- An Infection Control Helpline is in place for practices and services to access COVID-19 advice and support
- Additional 1.0wte senior medical COVID-19 support is in place in P&CS core team
- P&CS has facilitated additional senior medical support to NHS24 and to a COVID-19 group linked to ITU / clinical decision-making

Health and Social Care Partnership

- We are creating 5 multidisciplinary locality hubs – these will be supporting frail elderly, vulnerable and in due course patients who are at highest risk from COVID-19 and will require shielding
- Shielding is being led and coordinated through Public Health with staff from P&CS and Social Care supporting GP practices with patient calls
- Transitional Care facilities have been created at two care home sites to allow patients waiting for care home placements to be transferred from community hospitals to support capacity. Work is currently underway to establish referral and transfer processes
- We have agreement with GP colleagues that care homes will now dial GP practices in hours with clinical concerns rather than NHS 24 111 or 999 to enable speedy and appropriate clinical response and to avoid increasing demand on NHS24. A similar arrangement is in place with local out of hours services

General Practice

- The GP out of hours centre moved out of ED to free up capacity in ED – completed 19th March
- Daily contact by COVID-19 lead in Primary Care and Chair of GP sub committee
- Weekly meeting with GP Executive to update on situation, discuss issues and solutions.GP practices were moved to level 2 of Escalation Strategy at 6pm on 23rd March and have all remained at that level to date
- Negotiation with GPs to rationalise enhanced services as below

We have negotiated with GPs to rationalise enhanced services and the following services have been stood down:

LES	• Prescribing
DES	• Minor surgery • Extended hours • Palliative care

The following services will continue as below:

LES	• DMARD
DES	• Care home – prioritising anticipatory care planning • Community Care – again prioritising anticipatory care planning
NES	• Minor Injury - no longer accepting walk in and telephone triage first, prioritising clinical need to minimise footfall in the surgery • Anti coagulation • IUCD and long term contraception – can be referred to Sexual Health if necessary and prioritising clinical need to minimise footfall by clinical prioritisation • DMARD • Childhood vaccination • Influenza and pneumococcal vaccination

Since moving to Level 2 we have supported four practices with significant staff shortages associated with COVID-19 positive staff members by co-ordinating additional support – this has consisted of admin, nursing and pharmacy support in all four practices and GP support in one.

GPs (local, returning and new) are offering to support the COVID-19 Hub and Assessment Centre. We have an HR process in place to support non NHS Borders employees and have begun to deploy the additional medical resources to appropriate areas:

- A Draft Additional Hours LES is in development
- GP prescribed oxygen has been stood down
- Dispensing Practices driver support has been arranged to support operational processes
- We have clarified the requirements around pneumococcal vaccine for practices

Nursing

- We have identified vulnerable patients groups who will require additional support
- We have re-adjusted rotas to provide robust cover throughout the week and weekend
- Treatment Rooms are seeing essential / urgent cases with an alternative pathway in place to minimise footfall and clinical risk into health centres
- We have redeployed Dental staff and others to shore up stretched services across primary and community services
- We have established a Buddy System for Nurse Team Leads to support resilience
- We are participating in Locality Group Working to prevent admission and work together across the partnership

NHS BORDERS COVID-19 Hub and Assessment Centre

It is a requirement that each Board establish a COVID-19 Community Assessment Pathway, this consists of:

- Telephone Hub with senior decision makers to triage patients over the phone.
- Assessment Unit equipped to assess Covid-related presentations.

Patients who have COVID-19 symptoms are now required to call NHS 24 (111) who will triage the call and pass down to the local telephone hub any patients the are unable to close with advice. The local telephone hub will then triage the patient over the phone with the aim of maintaining that patient at home with the advice of a senior decision maker. Where this is not possible and there are concerns, patients can be given an appointment at the local assessment unit.

The Borders COVID-19 Community Hub was established on 23rd March and is located in the Day Hospital. This area currently provides a Hub office for clinicians to triage patients and 2 consulting rooms for the Assessment Centre. A separate area of the Day Hospital houses the BECS (GP Out-of-hours) consulting rooms and there are arrangements to ensure patients do not mix. BECS covers both general and COVID referrals overnight and at weekends. After review of options, it has been agreed that the Hub and Assessment Centre will remain in the Day Hospital at present.

The Hub and Assessment Centre have worked well to date. Activity has been lower than expected (current activity is Hub average 25 contacts, Assessment Centre average 7 patients) and has not increased, despite an increasing number of people with COVID in the Borders. There has been a slight surge over 7th and 8th April. This may reflect a trend upwards or could be as a result of external influences (PM admission to ITU). The Day Hospital can provide capacity to scale up to approximately 120 patient assessments per day and staffing plans are in place to deliver this.

Current modelling predictions suggest that this will provide sufficient capacity for peak demand. However, if demand increased beyond this point, a plan for a combined ED/COVID assessment area and process has been developed. This would be accommodated in the main hospital entrance (RVS/Discharge Lounge area) and would be run jointly by the two services. Detailed plans are in development. This decision replaces an earlier proposal which would have resulted in a separate temporary building to accommodate the Hub and Assessment Centre by the front door of the BGH.

NHS Borders has been asked to implement an Enhanced Surveillance function for Covid-19 through our Hub and Assessment Centre. This has been scaled by Board size and means that we are required to provide on a daily basis (Monday to Friday) two from the hub and 4 from the Assessment Centre. We are currently in the process of drafting a pathway and are also awaiting clarification from the National Enhanced Surveillance Cell on a number of key matters, including the availability of swabs.

Community Hospitals

- All visiting has ceased
- Walk in minor injuries suspended with an alternative pathway in place
- A relaxation of geographical admission criteria is in place to make best use of limited bed capacity
- Modelling length of stay, estimated length of stay, estimated dates of discharge and delayed discharges within Community Hospitals to ensure capacity and flow is maintained
- A Nurse-led team is working to support timely patient discharge from community hospitals to ensure bed capacity for patients requiring transfer from acute care

MENTAL HEALTH & LEARNING DISABILITY SERVICES

In general all services have moved to a scaled down service, prioritising high risk patients/service users for telephone contact minimising face to face contact and maximising social distancing amongst staff and patients/service users. Some staff have been temporarily redeployed to support services with staffing shortages both within and outwith Mental Health and Learning Disability Services.

Within the Mental Health Inpatient service we have temporarily relocated an older adult's mental health ward into our acute admissions ward to free up in patient capacity within Borders General Hospital. This is currently under review and will remain so as the impact of the Pandemic becomes clearer on the ground. Delayed discharges are a priority focus to create capacity for any new admissions and significant progress has been made in reducing the number

Work is underway to support General Practice in the form of a telephone helpline for Primary Care mental health referrals and to ensure that we coordinate the range of community mental health services available. This support will be available from 20th April. Support is also being provided from within our psychology workforce to focus on supporting staff wellbeing across NHS Borders. A staff wellbeing service has been launched from 9th April.

Additional nursing capacity is being made available to out of hour's services in anticipation of the redeployment of some medical staff into acute medicine and the CMHT's are now managing crisis calls during office hours Monday to Friday.

Within Learning Disability services there is considerable support being provided to commissioned services to maximise the resilience of providers anticipating considerable staffing shortages over the coming 2 – 3 months.

WHOLE SYSTEM PATHWAY PLANNING

A whole system COVID-19 Pathway discussion was held on 9th April involving clinicians from Acute, Primary & Community Services and Mental Health. The purpose of the discussion was to agree in advance pathways for patients with confirmed and suspected COVID-19.

A number of actions were key decisions were made, and action is underway to ensure these are enacted. The agreed decisions are outlined below:

- Discharges from BGH to Community Hospitals would be based on existing discharge protocols / levels of care provided at Community Hospitals. This would include discharging patients "out of area" where a senior clinician to clinician discussion takes place to agree in advance. This approach would be in place until such time as the BGH requires to increase capacity for suspected and confirmed COVID-19 cases.

- A revised escalation plan for the BGH would be developed to include trigger points for increasing capacity internally and to be clear at what point in the escalation plan the discharge approach to Community Hospitals would need to change.

- Primary & Community Services would agree a plan with BGH colleagues on how down streaming COVID-19+ patients would be managed should this be required.

- Mental Health would continue operating with their interim arrangements for Older Adults in the Huntlyburn facility until no later than the 13th April at which point a decision would be made regarding the location of the Older Adults facility.

DIGITAL / eHEALTH

Rapid work has been undertaken by IM&T staff to support the mobilisation of NHS Borders to be able to respond to the COVID-19 pandemic. Staff within IM&T have supported reconfiguration of the BGH inpatient wards supplying additional equipment, Trak configuration and user accounts for access to systems. Similar support has been given to the COVID-19 Hub & Assessment Centre and now to the staff testing service.

A number of additional NHS Borders staff have been provided with laptops to work remotely, either for home working or for district nurses etc working in the community. So far 108 laptops have been allocated and up to 325 people are working remotely at any one time.

GPs and some of their staff have been given remote access tokens to work during isolation. A total of 39 tokens are already allocated with 50 more ordered.

Near Me and MS Teams roll-out has been a priority. Calls using Near Me have increased daily, with Mental Health Services and Children's Services embracing this way to consult with their patients. General Practices are starting to use this and the COVID-19 Hub is using this as part of their triage. We are now working on the priority areas defined by Scottish Government in Outpatients areas and will soon have a central virtual reception up and running to manage and direct patients as the link in for their Near Me appointment. Calls rose to over 340 in total by 9th April and are increasing daily.

MS Teams accounts have been created for over 670 users – mostly for mobile phones but some meetings are now starting to be held via Teams by managers. This remains a priority and some teething problems are being worked through with plans to extend to the rest of the organisation over next two weeks. The contract resource which was due to undertake our mail migration has been used to support this Teams work and so we have a gap in moving mail which will need to be addressed.

Network bandwidth had been increased for the SWAN connection and is due Friday 10th on the BT internet connection which should help some of the challenges with connectivity over the internet.

IM&T are working on an enhanced level of out of hours service to start next week so we have all the necessary skills available to quickly respond to any issues. We are working with P&CS to find a solution so that if a GP Practice is out action, patients still have access to healthcare.

The Business Intelligence team has supported creation of reports to assist in managing and monitoring the COVID-19 pandemic including daily reporting both locally and to Scottish Government. This has been very challenging at times securing the right data to make sure this accurate with significant manual effort – work continues to try to automate and streamline this.

Medical records teams are responding to the different requirements of them – we may run out of work for some of the team as Outpatient activity winds down. They are being offered up to be redeployed. It is an opportunity for us to catch up on library tasks related to casenote storage problems.

Many suppliers have made contact and have offered assistance. We are reviewing these to see what is most helpful and also working with national colleagues to see what we can learn and implement in support of the overall COVID-19 digital response.

There are a number of risks and issues which have been identified at present, and as outlined below:

- As with all services staffing and keeping the team well remains a concern – there is limited cover for some skills

- We have some concerns that the Wi-Fi network can cope with the voice and video traffic and plan to get an external independent review to help us be assured and confident in the configuration to give more certainty of capability

- Cyber security – there is an enhanced threat level and we are being advised (expect to be mandated) to implement ATP –(Advanced threat Protection) – this will mean some of our resources need to be directed to this work and may affect other COVID-19 work

- Trak configuration – the speed of making floor plan changes to Trak has left us with a possible data legacy issue that may take some time to unpick and recover from which could affect all our reporting as we try to go back to more usual definition of beds

CORPORATE SERVICES

Business Continuity plans for all support services are now in full operation with all non-essential business as usual stood down. All Corporate and support services have identified over 170 staff with varying and flexible skill sets to re-deploy to a number of activities.

A number of activities are currently underway in order to ensure that requests are responded to as efficiently as possible:

- The Turnaround PMO have now been set up as a central hub with all requests for additional staff being logged and actioned and allocated
- Call centres are being established for NHS Borders to deal with staff sickness absence, Occupational Health advice and support and any other general enquires
- Accelerated training sessions for staff to be equipped to undertake additional/alternative roles

A number of functions are also now being set up and resourced, these include:

- Staff deployment hubs
- Dedicated Absence line for all staff with appropriate signposting
- Staff accommodation hub
- Patient and family liaison service
- Staff well being
- Volunteers
- Transport hub

Staff Testing

NHS Borders Staff Testing Facility provides a 7 days service to support business continuity of Health and Social Care critical services. It is expected to change depending on changing risk assessment/ national guidance. The availability and timeliness of this testing service is subject to laboratory capacity. Hospitalised patients will be prioritised for testing. Thereafter it will be the household members of asymptomatic key workers. Symptomatic key workers will benefit least from testing due to the shorter period (7 days) needed before returning to work.

The facility is currently sited at Borders General Hospital. Testing is performed whilst the member of staff/household member remains in their car. The test is a throat and nasal swab (undertaken within 72 hours of symptom onset). Testing is held by appointment only and is available 7 days a week.

Current access to the testing facility is open to NHS staff, Pharmacy, General Practice Staff, Scottish Ambulance Service, SBCares Staff, Independent Care Homes and Care at Home Services.

Staff Wellbeing

Staff Wellbeing is a priority within NHS Borders and we have now set up a psychological wellness hub within the Work and Wellbeing Department. This is led by NHS Borders psychological services and overseen by the Head of Psychology. Please see attached Staff Wellbeing Plan (Appendix1).

Early Financial Assessment

The Board has incurred significant costs over the last few weeks linked to COVID-19. The key areas of spend to date relate to PPE equipment and supplies, medical equipment, building and maintenance work to facilitate the creation of increased capacity, stock for our additional capacity in our inpatients areas and additional staffing (including agency staff) to support increased activity, prescribing costs also increased significantly in March. We are working to ensure we have robust financial governance in place around expenditure relating to COVID-19 activities.

Details relating to spend to date and projected overall spend are contained within our weekly return to Scottish Government, the most recent of which was submitted on 10th April. That return

outlined that the overall expenditure we anticipate will be required is now £5m. This includes £2.4m relating to addressing delayed discharges and £600k for COVID-19 social care costs incurred by Scottish Borders Council.

The template includes reference to opportunity cost relating to a delay in our financial turnaround programme which we currently estimate would be in the region of £3m.

Work continues to develop, refine and remodel financial costs as the mobilisation plan evolves and will be reflected in the weekly financial return to Scottish Government. In line with Scottish Government requirements, any spend over £250k must be referred to finance colleagues there for agreement before any spend can be agreed. There are some spend which will be required to seek retrospective approval on by Scottish Government, which we are currently working through.

Next Steps

This is the third iteration of the NHS Borders Local Mobilisation Plan. The plan will continue to be refined and updated as new information becomes available from the services on their responses to COVID-19 and as the pandemic continues.

Early discussions have started in order to identify the key steps we will be required to take to return to normal business after the COVID-19 peak, which will be built into a recovery plan in due course.

15 April 2020

Appendix

Appendix 1: Staff Wellbeing Plan

Staff Practical Support - Well being plan - 09.04.2020.pdf