NHS Borders Remobilisation Plan

Key Updates

September 2020

Contents

1 Introduction

NHS Borders submitted the first iteration of its remobilisation plan on 25 May 2020 to Scottish Government, followed by the second iteration on 31 July 2020. Copies of these submissions are attached (see **Appendix 1** and **2**) for information. We understand that formal feedback will be received by the end of September 2020 on the updated plan submitted. As highlighted in that plan, the content provided an update on remobilisation efforts as at the end of July, and we therefore committed to bringing a further local update forward during September 2020.

Significant work has progressed over the past 6 weeks and we are in a position to provide a more detailed picture of our remobilised service levels within this update document. In addition, the update outlines a number of challenges we continue to face as we remobilise services impacted by the onset of COVID-19 and some key assumptions that we have been required to make as we prepare for winter.

It remains extremely challenging to predict or draw firm conclusions as to how the coronavirus pandemic will develop in the coming months. We continue to refine plans so as to maintain service capacity to respond to any further COVID-19 outbreaks whilst simultaneously managing both the risk of nosocomial spread presented by the virus and planning for winter pressures which includes a significantly extended 'flu vaccination programme.

This update outlines where services are as at 10 September 2020. A further updated plan will be developed which responds to feedback from Scottish Government in due course once this is received. Part of the feedback we are expecting is confirmation of the level of resource NHS Borders can expect as part of the COVID-19 remobilisation efforts. Our plans may need to be refined if the resources allocated do not meet the projected costs that this plan as it stands will incur.

2 Underpinning Planning Assumptions

Underpinning our remobilisation planning there are a number of assumptions. These were outlined in our previous plans, they have been refined as new information / guidance has become available. The current planning assumptions continue to be developed but are summarised below:

- Costs include the resources required to support COVID-19 response and remobilisation
- Scottish Government Mandatory Services such as test and trace have been included at estimated activity based on current information and Scottish Government requirements
- Resources required to implement Public Health and Infection Control policy directions are assessed based on local requirements

- Costs have been worked up for the remainder of 2020/21 and it is assumed that the many of these costs, particularly for the SG mandatory services will continue into 2021/22
- Cost have been based on the level of activity currently being provided and any increase in activity would require further funding/workforce
- The Board has currently not enacted all of the plans included and it may not be possible to enact the plans as detailed due to availability of resources e.g. mobile MRI scanner/Workforce
- The costs include a provision for an increased ED department in order to provide for a socially distanced department. Any change in relation to Reshaping Urgent Care Project is likely to require revision to this plan
- All costs have been worked up based on 2020/21 pay rates and midpoint of the scale
- Depending on funding/workforce availability NHS Borders may be required to re-prioritise plans
- Plans for escalation of COVID-19 response in event of a second wave of the pandemic include step down of elective remobilisation plans in order to release bed capacity
- Planning for winter may require remobilisation plans to be amended depending on the availability of resources such as staffing e.g. reduction of elective activity
- Staff will continue to be deployed, in partnership, to mandatory services resulting in reduced service levels being delivered in other services if required to manage our workforce/services safely
- Service remobilisation plans are planned on the basis that core activity deliverable within the funded baseline is diminished as a result of infection control measures and all other relevant changes described in the plan
- Funded baseline is described in the board's Quarter One review and includes assumed revenue allocations in relation to Waiting Times and other non-recurrent resources. These resources are detailed in the Q1 review
- Discussions with Lothian to revisit our Service Level Agreement levels may lead to other changes in activity levels

3 Remobilisation of Services

As at the 10th September all services delivered by NHS Borders have remobilised to a degree, although the level of remobilisation varies significantly depending on a number of factors the most significant of which are available staffing levels and space. The following tables outline the current levels of service being offered within each clinical business unit compared to pre-COVID-19 activity levels, as at 10 September 2020:

Acute

Service	Remobilised service level within current resources
A&E	100%
Inpatients wards	100%
Medicine for Elderly	64%
Cancer Services	100%
General/ Specialist Surgery	50%
Theatre & Critical Care	50% routine electives
Ophthalmology	50% routine 100% unscheduled surgery
Diagnostics (radiology, labs)	50- 60% dependent on modality
Outpatients	60%
Maternity	100%
Paediatrics	100%

Please see **Appendix 3** for further detail on remobilisation of services.

During the response phase to COVID-19 all patients considered urgent continued to be treated, including those with urgent cancer referrals / diagnoses.

As previously highlighted there are a number of challenges facing our services which are preventing all services from remobilising back up to the pre-COVID-19 levels.

These include:

- The requirement to use PPE (donning and doffing) which reduces the clinical time available
- Additional cleaning requirements which reduces the clinical time available
- The continued need to physically distance which impacts on the availability of space for clinical activities, thereby reducing the number of patients who can be seen / the number of appointments
- During response phase to COVID-19 services which were paused deployed some of their staff to other services (including some of the new functions established specifically as a result of COVID-19); some of these staff remain deployed to the COVID-19 functions

All of the services outlined above are operating within their previous funding levels, with the exception of the following areas that have required or will be requesting additional revenue funding:

- Elective recovery plan
- Radiology recovery plan
- BGH Front Door (Emergency Department, Acute Assessment Unit, General Surgical Assessment Unit) Recovery Plan
- MRI replacement
- Furniture & Storage Inventory of Stock

Further information relating to the financial impact of remobilisation from COVID-19 is outlined in Section 7.

Primary & Community Service

Service	Remobilised service level within current resources
Treatment Rooms	75%
Dental Recovery	40%
Oral Health	50%
Optometry Recovery	Continue to follow the Scottish Government Optometry Route Map
Health Visitors	70%
School Nursing	30%
School Immunisation Team	30%
District Nursing	100%
Minor Injuries	0% across Community Hospital units
Day Hospital	60%
Community Hospitals	100%
Borders Emergency Care Out of Hours/Service / COVID-19 assessment hub	100%
AHPs	Inpatients: 100% Outpatients: Physio: 50% OT: 70% Podiatry: 50% Orthotics: 50% Dietetics: 70% Audiology: 40%
Sexual Health	70%

Please see **Appendix 4** for further detail on remobilisation of services.

In March 2020 community pharmacies found themselves in receipt of a significant number of additional repeat prescription requests, far greater than they had previously experienced or were staffed to response to. Our community pharmacy team is working with them in relation to serial dispensing and care and review in the community.

During the response phase to COVID-19 all GP practices continued to be open and operational, all be it with reduced capacity.

As previously highlighted there are a number of challenges facing our services which are preventing all services from remobilising back up to the pre-COVID-19 levels.

These include:

- The requirement to use PPE (donning and doffing) which reduces the clinical time available
- Additional cleaning requirements which reduces the clinical time available
- The continued need to physically distance which impacts on the availability of space for clinical activities, thereby reducing the number of patients who can be seen / the number of appointments
- During response phase to COVID-19 services which were paused deployed some of their staff to other services (including some of the new functions established specifically as a result of COVID-19); some of these staff remain deployed to the COVID-19 functions

All of the services outlined above are operating within their previous funding levels, with the exception of the following areas which have required or will be requesting additional revenue funding:

- School Immunisation and Child Health Recovery
- Infection Control in Health Centres - additional cleaning
- Reopening of Treatment Rooms – additional hours
- Pharmacy Sunday Service enhancements

Mental Health

Service	Remobilised service level within current resources
Community Mental Health Teams	75%
Child and Adolescent Mental Health Services (CAMHS)	60%
Mental Health Older Adult Services (MHOAS_ Community Team	90%
MHOAS Post Diagnostic Support (PDS)	80%
MHOAS Community Hospital & Care Home Assessment Team (CHAT)	80%
Community Rehab Team	95%
Borders Addictions Service	80%
Psychology Services	70%
Crisis Team	100%
Inpatient Wards	100%

Please see **Appendix 5** for further detail on remobilisation of services.

During response phase to COVID-19 all services offered by Mental Health continued to be delivered, all be it with reduced capacity.

As previously highlighted there are a number of challenges facing our services which are preventing all services from remobilising back up to the pre-COVID-19 levels.

These include:

- The requirement to use PPE (donning and doffing) which reduces the clinical time available
- Additional cleaning requirements which reduces the clinical time available
- The continued need to physically distance which impacts on the availability of space for clinical activities, thereby reducing the number of patients who can be seen / the number of appointments
- During response phase to COVID-19 services which were paused deployed some of their staff to other services (including some of the new functions established specifically as a result of COVID-19); some of these staff remain deployed to the COVID-19 functions

All of the services outlined above are operating within their previous funding levels, with the exception of the following areas that have required additional revenue funding:

- Extension of additional medical time
- Additional BAS clinic rooms at Galavale
- Psychology post COVID-19 patients support
- Psychology Hear 4 U support
- Additional Band 5 nursing at Huntlyburn

It should be noted that the remobilisation of Learning Disability Services is being taken forward as part of Scottish Borders Council's remobilisation planning process.

Public Health

Service	Remobilised service level within current resources
Joint Health Improvement Team (Core Team)	50%
Wellbeing Service	90%
Equality and Diversity	0%
Alcohol and Drugs Partnership Support Team	80%
BBV MCN	0%
Screening	Developing as per SG directives
Risk and Resilience	100%

Please see **Appendix 6** for further detail on remobilisation of services.

During the response phase to COVID-19 the majority of Public Health work which was not COVID-19 related, excepting the Wellbeing Service, was halted as managers and staff were deployed to lead and deliver COVID-19 responses.

There are a number of challenges facing our services which are preventing all services from remobilising back up to the pre-COVID-19 levels.

These include:

- Continued requirement for leadership of COVID-19 mandatory services
- Limited access to GP practice rooms for Wellbeing Service
- Inability to work within communities due to social distancing
- During response phase to COVID-19 services which were paused deployed some of their staff to other services (including some of the new functions established specifically as a result of COVID-19); some of these staff remain deployed to the COVID-19 functions

All of the services outlined above are operating within their previous funding levels, with the exception of the following areas that have required additional revenue funding:

- Support to maternal and infant nutrition work (Band 5)
- Health protection (Public Health Consultant 0.6 WTE)

It should be noted that the remobilisation of Learning Disability Services is being taken forward as part of Scottish Borders Council's remobilisation planning process.

Corporate Services

All corporate services have been impacted by the need to remobilise services across NHS Borders. As a result of a number of business as usual activities have been stood down to free up capacity so as to focus on supporting remobilisation efforts. At this stage we are assuming this will be required for the remainder of 2020/21.

COVID-19 Functions

A number of new functions have been established as per Scottish Government Requirements, in order to respond to the COVID-19 pandemic, such as the COVID-19 Hub and Assessment Centre, the COVID-19 testing team and test and protect team.

Given the speed at which these were established virtually all of the staff within these services were deployed from other service areas experiencing reduced activity as a result of the initial COVID-19 response phase.

Business cases have been developed for each of these services which have been robustly scrutinised in order to determine the levels of staffing required for these to continue to operate over an anticipated 12 months. The assumption has been made that all deployed staff will continue to be available to these services until at least the end of December 2020, to enable external staff to be recruited. This is impacting on the available capacity of those services who deployed the staff.

Where significant concerns have been raised regarding the continued deployment of staff a case by case review is undertaken to assess the clinical and service priority. Any staff who do return to their service area will be called upon should an urgent need arise to increase capacity in the COVID-19 functions such as a result of second / further waves of infection.

As at 10 September the COVID-19 functions have an agreed staffing profile of 118.5 WTE. If unable to source staff through external recruitment exercises then the need to return deployed staff to their substantive servicesmay have to be reconsidered.

Remobilisation Process

NHS Borders recognises the need for services and individuals to be agile and responsive to local circumstances. The flexibility to scale up and scale down services is important and we are maintaining a dynamic equilibrium between staffing-up new services (such as the new functions established / required in response to COVID-19)and the need to either bringing established services back on-stream or increasing the levels of services offered.

The internal remobilisation working group considers all resource requests brought forward by services assessed as critical in order for them to either continue to operate as a COVID-19 response function, remobilise services to a greater level than which they are currently operating, respond to winter pressures or to deliver the extended 'flu vaccine programme for 2020.

It is clear that we do not have the staffing, space or financial resources to do everything and therefore clinical prioritisation is critical. The Clinical Oversight group continue to advise on clinical prioritisation of the remobilisation plan at an organisational level, including the allocation of resources and timing and order of recommencement of services. Clinical prioritisation of individual patients continues to take place at service level – based on royal college or other internal guidelines - supported by local Clinical Prioritisation Groups to review the allocation of resources on an individual patient-specific basis. A group has been established to assess patients for surgical procedures using the Scottish Government Guidelines for Prioritisation of Cancer Surgery.

The Clinical Prioritisation Group will continue to inform the work of the local remobilisation group and will report to the Board Clinical Governance Group. The NHS Borders COVID-19 Ethical Advice and Support Group will also provide an ethical perspective and oversight role to ensure due process.

This work is essential in supporting the levels and priority services for services between now and the end of March 2021.

In line with the agreed decision making and governance arrangements relating to remobilisation, all resource requests are considered first by the weekly remobilisation group, with recommendations being made to the Gold Pandemic Committee.

Following a review of published research relating to COVID-19, the local remobilisation group is working through a checklist approach to identify any gaps in our plans in order to ensure these are quickly addressed. This will ensure that plans:

- Actively support COVID-19 prevention
- Directly support COVID-19 management
- Address priority areas of unmet need
- Help preparations for 'flu
- Help address expected post-COVID-19 surges in service demand
- Support the safe management of our workforce
- Support the safe and effective reopening/remobilisation of our services

This continued assessment will inform our on-going remobilisation planning and on our service offering should it be impacted on by further waves of infection or by other winter pressures.

COVID-19 Resurgence Plans

Throughout the COVID-19 pandemic, NHS Borders has monitored the predicted impact of the disease on services, using both national short and longer-term modelling tools and a locally-developed simple predictive model. Escalation triggers provide an early warning of the potential need to implement additional capacity or other measures and a weekly update is shared with Gold Command.

We are reviewing our predictive modelling in light of the need to plan for a potential further peak (or peaks) of COVID-19 demand. This work is informed by national guidance and early warning from Public Health Scotland and UK-wide information, but is also advised and guided by local intelligence and knowledge, particularly from our local Public Health teams, testing and tracing services and the local authority.

Robust plans continue to exist to rapidly increase inpatient capacity should COVID-19 activity increase to a level that impacts on NHS Borders healthcare services.

4 Key Issues and Challenges

There are a number of particular challenges which will impact on our ability to remobilise services any further than that outlined in section 3, or which may require us to reduce our service offering.

Available Workforce

In particular this relates to the availability of a sufficient workforce to deliver services to the levels outlined whilst also continuing to operate the COVID-19 required functions.

As outlined earlier the COVID-19 functions require 118.5 WTE staff in order to fully deliver the required services. External recruitment exercises are underway in order to secure these staff over the next 12 months without the need for deployed staff but it is

unlikely that all of these will be able to be sourced. As a result contingency arrangements are being considered which include retaining staff currently deployed into these functions from other areas. The impact of this on our other services will be assessed as part of this work, and any final decisions will be informed by a clinical prioritisation process.

For those staff who were deployed into the test and protect team, there is a requirement for these to continue to be made available to this service should activity increase, even if they have already returned to their substantive roles. This is in line with Scottish Government requirements.

The need for additional staff for the COVID-19 functions is compounded by our plans for responding to winter pressures as well as the extended flu vaccine programme this year, both of which have identified the need for additional staffing. Whilst external recruitment will be pursued it is recognised that not all posts will be filled. In light of this a number of options are being explored with regards to how to create additional workforce capacity. These include:

- Continued / further deployment of internal staff
- Additional hours for part time staff
- Extensions to short term contracts
- Continued use of bank staff
- Recruitment
- Mutual aid from partners
- Retired staff willing to come back

To date it has been assessed these programmes will require the following additional staff.

Separate plans are being developed in relation to "Reshaping Urgent Care", and therefore are not included in the assessment outlined below:

Team	Capacity Needed WTE	Available NHSB Staff	Gap
Testing Team	16.7	14.39	2.31
Contact Tracing Team	15.5 (+5 flex for surge)	14.48	6.02
Flu Vaccination Programme	40*	TBC	TBC
Winter Plan	41.3	0	41.3
Total Across Areas	**118.5**		

*This is a planning assumption to date and may increase

Work is underway to reassess the workforce requirements so there may be some further refinement of these over the coming weeks.

As highlighted earlier, we have yet to receive confirmation of any additional resources that will be allocated to NHS Borders as a result of the impact of COVID-19. Once received this will be assessed against the additional cost that NHS Borders will incur and may require a revisit of how these essential programmes / functions are staffed.

This will impact on the levels of services we are able to provide and as a result the % levels outlined in section 3 may be reduced.

COVID-19 Resurgence Plans

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ITU

Since the restart of elective surgery on 31st August, we require the critical care capacity for 4 streams of patients:

- COVID (red)
- COVID negative/no screening (blue)
- COVID negative elective screened/14 days self-isolation (green)
- COVID unknown/COVID triage

Ideally all of these patient streams must be kept separate from one another to reduce risk transmission of COVID. Department of Health Directive states we must have capacity to admit further COVID at all times, spare capacity equivalent to 50% of current COVID patient numbers.

The elective theatre recovery plan involved placing COVID negative blue ITU patients in main ITU and green (self-isolated for 14 days) patients in a PACU – critical care facility in recovery. It has been recognised that admission of COVID patients to critical care would be a threat to the green elective pathway as these would require a separate critical care facility. Use of temporary isolation structures is being investigated which may fulfil this need.

During the first wave of COVID in April we managed to contain COVID patients within the main ITU and non-COVID patients in the recovery area of theatre. This was only successful because we had small numbers of non-COVID ITU patients at the time and there was not a requirement to treat surgical cancer patients as a separate group.

Various iterations of housing critical care patients have been explored by our ITU clinicians. In order to continue to deliver elective surgery and continue to look after all patients in need of critical care, in the event of admission of COVID-19 patients to

Borders General Hospital, an escalation plan has been developed by the Elective Theatre Recovery Group driven by clinicians. This plan is set out below:

0 COVID-19 Patients	Business as Usual Elective capacity **50%** Pre-COVID-19 workload
1 COVID-19 Patient	Patient located in existing negative pressure isolation room PACU closes and becomes recovery ITU Increased nursing requirement by 2 WTE Slower theatre throughput Elective capacity **25-50%** of Pre-COVID-19 workload
2-3 COVID-19 Patients	Once COVID-19 patient in negative pressure isolation room and 1-2 patients in side rooms Non COVID-19 patients moved out into recovery ITU Increased nursing requirement by 2WTE 1 elective theatre closed Elective capacity **25%** of Pre-COVID-19 workload
>3 COVID- 19 Patients	COVID-19 patients in ITU ITUs fully split into main ITU and Recovery ITU Escalation into theatres if extra bed capacity required One vertical booking list for elective patients Elective capacity **<25%** of Pre-COVID-19 workload

Unmet Need

COVID-19 pandemic has far-reaching indirect consequences for the health of the population due to changes in economic and social circumstances, impact on mental wellbeing, changes in health related behaviours and disruptions in health and social services. There is likely to be an increased population health loss both now and in the future, as patients may present later with more severe disease which will be harder to treat. In addition there is likely to be widening of inequalities in health.

More recently the eligibility for flu vaccination has been broadened and there is a need to ensure staff and eligible members of the public are aware of this and routes to vaccination.

In summary, there is concern relating to:

- Unmet and possibly increased burden of ill-health
- Increasing inequalities
- Impact of lifestyle and other factors in compounding the above

Role of staff - Health Promoting Health Service

A health promoting health service is a national initiative whose concept is that 'every healthcare contact is a health improvement opportunity'. This has never gained full

currency within NHS Borders to date; however, this approach is now crucial in addressing concerns above as follows:

- All front line staff should be aware of the behavioural risk factors for increased impact of COVID-19 (e.g. obesity, smoking, alcohol) as well as individual unmodifiable risk factors i.e. ethnicity, age.
- All front line staff should be equipped with skills and knowledge to start conversations about behavioural risk factors for long-term health and COVID-19 with individuals, and be aware of routes for onward referral in relation to concerns relating to alcohol, obesity and health living, smoking cessation and mental health.
- All front line staff should be able to discuss ethnicity and age related risks with individuals.
- Relevant staff groups should be able to support financial inclusion.

Supporting Staff Wellbeing

NHS Borders staff will be equally at risk from the same factors which affect the wider population. In addition, staff have experienced significant change in working conditions and experiences. Throughout the pandemic there has been a very useful focus on psychological support for staff members and there is further discussion continuing as to how this support is offered going forward.

The 'Collecting your Voices' report highlighted the importance of good communication, emotional and mental health awareness and is a good foundation for forward planning.

Managers have been required to undertake risk assessments for staff in relation to COVID-19 risk factors and seek to mitigate these risks.

It is likely that many of our staff will live in households which have experienced redundancy and/or furloughing and may be struggling financially.

Changes in the way we work and the necessary move towards home work has impacted on people's social bonds and support in the workplace and, as we approach winter, potentially on fuel and other utilities costs.

Supporting the Public

It is important to note the ongoing positive work regarding communications with the public in terms of:

- Accessing services
- Ensuring people do not delay seeking advice for health concerns
- Re-engaging with routine services e.g. Long-term condition reviews, screening
- Keeping well
- Flu vaccine eligibility and routes to receiving the vaccine

Children and young people

There is a significant impact on children and young people in terms of their own and family experience. At the time of writing, infection control measures in schools prevent adults other than school staff accessing school buildings. This means that school nurses, youth workers and commissioned services are required to continue remote access.

To ensure the impact on children and young people is mitigated:

- Relevant committees should be made aware of this paper, including the Maternal and Child Health Committee and the Children and Young People's Leadership Group
- Access for school nurses and other children's services staff should be kept under review

Reducing inequalities

The local remobilisation group is ensuring health inequalities impact assessments are being undertaken and an equalities focus will continue to be important in ensuring equity going forward.

Services are conscious of the fact that although digital offerings have been very successful in ensuring continued access to health services during this period, there is a risk that those who face barriers to digital inclusion experience inequality of access.

The rapid changes in guidance issued and access routes to services may double disadvantage people with literacy/health literacy concerns. All staff, but particularly service leads, should be aware of the importance of health literacy.

Corporate Responsibilities

It is important to develop models that will continue to operate longer term as well as considering the wider role of health institutions in local economic, and social, recovery and reform.

NHS Boards have been directed to consider promotion of 'community benefits' within procurement contracts as this has been beneficial in the past to provide support for small projects in the area. This support is not necessarily financial, it may be 'in-kind' support e.g. transport to activities or potentially discounted access to facilities and supplies.

We are currently exploring areas to support the organisation's objectives to reduce inequalities; mitigate causes of health inequalities and prepare for winter. A further update on specification actions that will be taken in relation to addressing unmet need will be provided in the next iteration of the plan.

Primary Care - GP Escalation

Across NHS Borders, GP practices are operating at varying levels of escalation. There are a number of key issues to be addressed to enable practices to reduce their escalation level to 0 or 1:

- Estates is one of the main issues with regards to infection control and availability of space, however a plan has been approved by Gold Command and is now operationally in progress. A total of 101 activities are on the plan which includes hand gel, signage, vinyl, blinds, trunking and chairs, across 21 community buildings. Half of these activities are currently in progress
- An escalation committee was held on 7th September which allowed NHS Borders to further consider the support and actions required to further reduce the level of escalation of GP practices
- Additional capacity for GP practices is required, both Clinical & Non-clinical staff, in particular for influenza vaccines which is currently being progressed
- Enhanced vetting is becoming an issue for Primary Care capacity. Increasingly ssecondary care are referring patients back to primary care to reassess, or to undertake examinations or tests on their behalf
- The length of time taken for results of COVID-19 testing, currently >72 hours, which is having an impact on staff to returning to work.

Infection control

On 20th August 2020, updated 4-nations infection prevention and control guidance was published for the remobilisation of services within health and care settings. Since publication, there have been a number of areas where Health Protection Scotland has issued subsequent clarification on the application of the new guidance.

Key messages in the new guidance:

- Patient treatment, care and support to be managed in 3 pathways (high, medium and low risk)
- Sessional use of single use PPE is minimised and only applies to facemasks.
- Physical distancing of 2 metres is considered standard practice in all health and care settings
- Screening and triaging within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. Triage should be undertaken by clinical staff who are trained and competent
- Twice daily cleaning of equipment and environment for all pathways
- Updated guidance on room fallow time following Aerosol Generating Procedures (AGPs)
- In some clinical outpatient settings, such as vaccination/injection clinics, where contact with individuals is minimal, aprons and gloves are not necessary – just hand hygiene and sessional facemask.

Patient pathways:

> High risk relates to our existing approach for confirmed or suspected COVID-19 patients (currently expressed as cohort 1 and 2).
>
> Medium risk relates to all other patients not classified as high or low risk (currently expressed as cohort 3).
>
> Low risk relates to patients who are not thought to have COVID-19 and have a negative test result and have been isolating at home prior to admission (currently expressed as cohort 3).

The low risk pathway primarily relates to elective activity through Ward 17. Although this could also apply to some individual patients in other wards, pragmatically patient flow would make it very difficult to ring fence other specific areas for the green pathway. It is apparent that all Boards in Scotland are working on the vast majority of patients in their hospitals being on the medium risk pathway. The medium risk pathway incorporates such a broad group of patients; some Boards are attempting to create a sub-category to distinguish different risk profiles within this group. There is a need to review NHS Borders current use of COVID-19 cohorting terminology and definitions.

Whilst the guidance describes separation of the pathways (patients, staff, visitors and changing areas), there is acknowledgement that "*As the prevalence/incident rates decline this may not be necessary between pathways providing the IPC measures are maintained".* HPS has subsequently clarified that patients on high and low risk pathways should not be on the same ward.

The guidance on Infection Control measures for the low risk pathway is stepped down to Standard Infection Control Precautions with the addition of face masks for staff. This advice includes switching back to cleaning with just detergent rather than a disinfectant.

There is new guidance on the fallow time required for a room following an AGP. This now uses a calculation based on the duration of the AGP and the air changes per hours (ACH) in the room. The Head of Estates and Facilities is arranging for an external assessment of rooms where AGPs are undertaken to quantify the ACH.

The new guidance includes a number of provisions that Health Protection Scotland (HPS) have subsequently clarified are either not required to be implemented at all or not in the way described.

There remains a significant number of areas where further national clarity is awaited including:

- The national position on elective care preadmission criteria for the low risk pathway
- The suitability and criteria for transferring a recovered COVID-19 patient to a low risk pathway

New guidance has also been published on social distancing including detailed requirements for inpatient areas. Whilst this guidance is geared to mitigating COVID-19 risks through improved social distancing of inpatients, compliance would create additional safety risks when delivering patient care. Further advice is being sought from Scottish Government.

Following this updated guidance NHS Borders will implement the following:

- No sessional use of PPE except masks – this will be addressed through the PPE Committee
- Assessment of fallow time following an AGP. The first stage is to quantify the air changes per hour and this is being progressed by Estates
- Inpatient use of masks when unable to socially distant – this will be addressed through the PPE Committee
- Step down to Standard Infection Control Precautions for low risk pathway - this will be discussed with the Clinical Nurse Manager responsible for Ward 17
- Patient triage to be undertaken by clinical staff rather than admin staff or receptionists - approval to deviate from this guidance will be sought through the appropriate governance committees
- Review NHS Borders current use of cohorting terminology and definitions.
- Social distancing requirements – seek further guidance from SGHD.

Working from Home

As part of the national response to COVID-19 the guidance from the Scottish Government remains very clear that everyone who can work from home should do so. The position for staff for at least the next few months is that if staff can work from home they should.

During initial COVID-19 response phase a number of NHS Borders staff worked at home for at least part of their working week, in addition to those staff working at home due to being shielded. Where staff require to be on site to undertake their roles then assessments have been made on what steps need to be taken to mitigate risks to them relating to being exposed to COVID-19 in the workplace. This also applies to those staff who may have individual circumstances that prevent them safely working from home.

However in order to further extend working from home to reduce risks we are undertaking a follow up exercise to support managers to review with their staff if there are opportunities for more staff to work from home. A space and homeworking short life working group (SLWG) has been established to support the uptake of homeworking, and in the absence of any national policies regarding this as of yet has developed local guidance and support tools for managers to support these discussions.

5 Preparing for Winter

NHS Borders Health and Social Care System have established a robust plan to prepare for the increased demand the winter period brings to healthcare services in an environment dramatically altered by COVID-19. The Winter Planning Board (WPB) formed early this year on the 7th July 2020 and has applied learning from previous years in the development of a plan that has formed a key workstream in the remobilisation of services from the initial COVID-19 wave.

This year's plan has approached alleviating the anticipated winter pressures by engaging the Whole System in the creation of winter capacity and building resilience. All Clinical Boards and services submitted 'bids' aimed at reducing admissions, speeding up patient flow processes, reducing length of stay, reducing any delay in discharge, or supporting care in the community to prevent re-admission to hospital.

The delivery of the Winter Plan is overseen by the Integrated Winter Planning Board, chaired by the Director of Nursing, Midwifery & Acute Services. The Board reports to both the Health Board and the Council.

As with the plan for the Winter 2019/20, this year's plan is very much a joint plan; the membership includes representative from the Scottish Borders Council, Social Care, NHS Borders, the Third Sector and the IJB.

Review of Previous Years to Develop the 2020/21 Plan

In order to understand the expected level of demand on inpatient services, analysis of previous three year's activity was undertaken and a predictive model created that:

- Has been used to understand the level of bed capacity required this winter
- Was used to map projects aimed at meeting the required level of bed capacity to ensure plans will meet demand across the system

Please see **Appendix 7** for the model of anticipated pressures.

A number of components of the previous winter plans have been incorporated into this year's plan; augmenting Emergency Department Medical capacity out of hours, strengthening Medical and Pharmacy cover at the BGH at weekends, extending the Rapid Assessment and Discharge Service, and increasing Garden View capacity.

Summary of Winter Plan for 2020/21

Integrated working and clinical engagement has been at the heart of this year's winter planning process. The 2020/21 Winter Plan aims to achieve the following:

- Providing increased support across the Whole System over winter
- Blended working across Health & Social Care to meet increased demand
- Patient flow will be improved throughout the whole system
- Care will be enhanced in the community and fewer patients will be delayed

- Services will be safer
- Staff wellbeing will improve

The plan seeks to ensure capacity is allocated appropriately to meet demand. Access to alternative care settings when acute care criteria is no longer met is a key focus again for this year's plan. One of the primary changes in this year's winter plan is the introduction of 'Discharge to Assess' which will be implemented to enable patients who do not require an acute hospital bed, to be safely discharged and go home with a multi-disciplinary team providing support to allow for recovery and reablement. The strengthening of the Home First team with AHP capacity across all localities and closer working with Social Care has built the foundations to make this possible this winter.

Another key component of previous year's plans will be the opening of a winter ward at the BGH to ensure sufficient inpatient acute hospital capacity is in place.

The BGH Escalation policy was reviewed and updated two winters previous. This supported improved patient flow and safety across the site. This policy is currently under review ahead of this winter to incorporate learning from last winter. Refresher effective patient flow management sessions are also being delivered across flow critical areas of the BGH ahead of winter to ensure resilient processes as we head into the darker months.

There is an ambition to protect the elective programme and this will be balanced against expected periods of high demand, only re-profiling elective admissions from the end of December 2020 until end January 2021. A day case elective programme will run throughout the winter season. This approach will be factored into the waiting times trajectories to ensure that NHS Borders will meet the agreed March trajectory.

Appendix 8 provides the high level activities that have been approved by the Winter Board.

Financial Plan

The Annual Operational Plan described an expected cost for Winter of £1.0m, to be financed by £0.7m board reserves with the balance assumed against SG Winter allocation. The final plan projects a cost of £1.6m against which resources of £0.83m have been identified, this includes the board reserves of £0.7m and a further £0.13m identified as offsets against committed funds within the IJB transformation fund. The gap of £0.77m is reflected within the Board's Quarter One Review and does not include any assumed funding against SG allocations pending agreement with Scottish Government.

Below are the high level details of areas of additional capacity:

- Borders Emergency Care Service- increased staffing at weekends
- Staffing for surge capacity
- Weekend medical cover
- AHP staffing- extend
- Weekend pharmacy cover

- On-site testing
- Weekend domestic and portering
- Contingency plan- additional surge

Reshaping Urgent Care

The Redesign of Urgent Care programme aim is to direct those whose care requirements are not an emergency, to more appropriate and safer care closer to home, by optimising clinical consultations through telephone and virtual near me consultations. The Flow Navigation Centre (Borders Urgent Care Centre) will offer rapid access to a senior clinical decision maker who has the ability to advise self-care, signpost to available local services such as: Ambulatory Care / Same Day Emergency Care, Mental Health support, Local Pharmacy, primary care (in and out of hours) and the Emergency Department if required. If a face to face consultation is required, this will be a scheduled appointment with the right person, at the right time in the right place based on clinical need, to ensure the safety of patients and staff. This plans to be in place by the 31st of October

Additional and Near Patient Testing

We are expecting an increase this winter on the number of tests required to be carried out as the threshold for testing will be lower due to the need to cohort patients with respiratory symptoms. During this Winter Period, testing for Flu A & B and RSV will be completed on-site within the BGH. This will provide a quicker turnaround of results enabling more robust, flexible management of patients across the site and expedite patient flow.

Primary Care plan to implement a Near Point of Care Testing regime (POCT) across all Localities during this winter period. This aims to facilitate local decision-making, improve patient safety and outcomes, and impact positively on patient flow. This will ultimately improve patient experiences and avoid the need for secondary care referral.

The impact of this will be the need for a GP referral to the BGH for testing, and to reduce visits to the emergency department and subsequent admission to hospital. This endorses the aim of Reshaping Urgent Care; right person, right place, right time.

Flu Vaccination

The influenza vaccination programme this year will look different to previous years, due to more people being eligible for a vaccine, a likely higher uptake and the ongoing restrictions related to Covid-19. The responsibility for delivery for the majority of vaccinations has transferred to the health board. NHS Borders in response to this requirement has developed a whole system response to ensure the successful delivery of the programme. GPs will maintain responsibility for the 2-5 year olds and the under 65 at risk, the remaining cohorts will be the responsibility of the Health Board.

For the majority of the population, a series of community vaccination clinics is being established to ensure people receive their vaccination as close to home as possible. In

addition, Community Pharmacies will be able to offer vaccinations to social care workers providing direct care and district nursing will be supporting the vaccination of care home residents and housebound patients. Alongside this, the primary school programme, the NHS staff vaccination programme and the maternity pathway continues as they have previously done so, with enhanced measures to address the Covid-19 requirements and opportunistic vaccinations will be provided to inpatients in the acute and community hospitals.

3rd Sector Involvement and Support

We are committed to the provision of high quality, person centred services that are safe, effective, sustainable and affordable. In doing so, it is a vital component to actively seek and use the views of patients, their families, carers, the community and our staff to design and deliver services that best meet their needs; and communicate the actions we take as a result of the feedback received. The commitment to engage extends across our Integration Joint Board (IJB), working with Scottish Borders Council (SBC), the third sector and other partners to deliver the best possible health and social care for the people of the Borders.

The membership of our Winter Planning Board includes representatives from the third sector, and the ongoing development of the Winter Plan is founded on a whole health and care system approach. This involves engagement with clinical partners, service delivery partners, the local authority, third sector, patients, carers and service users.

As a health and social care partnership our vision is to provide a seamless, multi agency approach to health and social care services in localities. Focusing on prevention, early intervention, rehabilitation, reablement and hospital discharge. Including, how local communities, volunteers and key partners can all play a valuable role.

At a workshop held last month - with input from partners across the Community Planning Partnership, third sector and public members - the concept of Community Led Support as a basis to provide access points for communities to receive a range of services, health and care services was discussed at length, and this project is progressing. A mix of community based physical and virtual hubs would help to widen access to services all year round, with obvious benefits over the winter period when access may be limited due to external factors including adverse weather.

Measurement and Monitoring

A project management approach is being applied again this year to ensure full implementation of the winter plan to ensure risks are highlighted allowing mitigation plans to be put in place. The Whole System activity datasets that have been used in recent years will be used again this year to assess any fluctuations in how the system is managing so that timely action can be taken when patient flows slow.

Progress against the overall programme will be monitored through the Winter Planning Board, chaired by the Director of Nursing on a weekly basis.

Resilience

Business Continuity Plans are in place with new business continuity planning software currently being implemented throughout NHS Borders and an ai to have all plans reviewed by the end of October 2020.

NHS Borders severe weather plan will be updated by early December along with a staff transport plan and multiagency liaison plans.

Staff rotas and annual leave throughout the winter period are being managed to ensure adequate capacity to maintain patient services with particular focus on the festive period. The Site and Capacity Team (SACT) and Rapid Assessment and Discharge Team (RAD) are working through the festive period. Social Work is providing cover every day except Christmas Day, Occupational Therapy and Physiotherapy services are providing cover every day except Christmas Day and New Years Day.

6 Extended 'Flu Vaccine Programme

We are currently actively planning the expanded 2020/21 influenza vaccination programme, and have allocated additional support to ensure successful delivery of the programme. 'Flu clinics are in the process of being scheduled. The table below outlines, for each cohort, last year's uptake rates, this year's targets, the planned start dates and mop up dates:

Patient Cohort	2019/20 Uptake	2020/21 Target	Eligible Number	Planned Start Date	Mop-Up Dates
Pre-School	70.5%	75%	2,000	1st Oct	December
Primary School	74.9%	75%	10,000	21st Sept	November
Over 65	75.5%	75%	22,000	1st Oct	December
Under 65 at Risk	48.3%	60%	8,000	1st Oct	December
Frontline Social Care Workers	n/a	60%	3,000	1st Oct	December
Healthcare Workers	48.6%	60%	3,700	1st Oct	December
Unpaid & Young Carers	53.6%	75%	1,100	1st Oct	December
Pregnant Women	41%	75%	700	1st Oct	On-going
55-65	n/a	65%	18,000	December	Mid-January
Shielding Households	n/a	65%	1,500	October	December

Fully detailed project plans outlining the planning arrangements for each eligible cohort have been developed.

The table below outlines the planned delivery models for each of the eligible cohorts, responsibility for delivery and the workforce productivity assumptions:

Patient Cohort	Responsibility	Delivery Model Details	Workforce Productivity Assumptions
Pre-School	General Practice	To be delivered by general practice clinics as in previous years.	Increased time per patient to allow time for additional PPE measures.
Primary School	Health Board – School Immunisation Team	Schedule of clinics at primary schools.	Additional time scheduled due to PPE requirements.
Over 65	Health Board	Schedule of community clinics (mass vaccination) throughout the Borders, circa 20 community venues to be scheduled over an 8 week period. Council are supporting with identifying suitable venues. Care/Residential Home – District Nursing Teams. Home visits by District Nurses Teams to housebound patients.	Assumption of 6.5 minutes per patient or 69 vaccinations per person per 7.5 hour shift for mass vaccination clinics.
Under 65 at Risk	General Practice	To be delivered by general practice clinics as in previous years. There is some variance between practices, some have scheduled dedicated weekend clinics, some are considering off site venues to support social distancing.	Increased time per patient to allow time for additional PPE measures.
Frontline Social Care Workers	Health Board	Access to vaccinations at Community Pharmacies. Consideration being	Capacity to be confirmed.

		given to use of community vaccination clinics.	
Healthcare Workers	Health Board – Occupational Health	As in previous years, a schedule of clinics across the organisations, including community sites. Targeted visits to clinical areas and use of peer vaccinators.	Assumption of 5 minutes per vaccination.
Unpaid & Young Carers	Health Board	Schedule of community clinics (mass vaccination) throughout the Borders, circa 20 community venues to be scheduled over an 8 week period.	Assumption of 6.5 minutes per patient or 69 vaccinations per person per 7.5 hour shift for mass vaccination clinics.
Pregnant Women	Health Board	Delivered by the maternity team at pre-natal appointments.	Delivered during scheduled appointments.
55-65	Health Board	Schedule of community clinics (mass vaccination) throughout the Borders, circa 20 community venues to be scheduled over a 4 week period. Extended into January for mop where required.	Assumption of 6.5 minutes per patient or 69 vaccinations per person per 7.5 hour shift for mass vaccination clinics.
Shielding Households	Health Board	Schedule of community clinics (mass vaccination) throughout the Borders, circa 20 community venues to be scheduled over an 8 week period.	Assumption of 6.5 minutes per patient or 69 vaccinations per person per 7.5 hour shift for mass vaccination clinics.

As highlighted earlier, the additional resource requirement to ensure successful delivery of the'flu programme is significant across the whole programme.The most significant risk to the delivery of the programme is the availability of this additional staffing resource.

There is no identified budget for the delivery of the flu programme, the potential additional cost to the Health Board is significant with the need to hire external venues, allocate additional staffing resource and purchase additional equipment/supplies to support the programme.

7 Financial Impact of COVID-19

The full impact of COVID-19 is described within the Board's Quarter One Review forecast. A revised Q1 forecast will be submitted to Scottish Government on 18th September and includes adjustments to the previous forecast in respect of the following areas:

- Covid-19 bed capacity
- Winter plan (including additional Acute beds)
- Redesigning Urgent Care
- Savings forecast (current year)
- Seasonal Flu Vaccination programme

The net effect of these changes is a reduction to the overall forecast deficit of c.£1.3m, however it should be noted that costs of the Winter plan and Seasonal flu programme in particular represent significant increases from the previous estimates. There remain a number of areas where forecasts are subject to further change, notably in relation to ongoing discussions in relation to increased support to the delivery of Tracing services.

The following section describes the specific costs associated with remobilisation activities in further detail. This excludes ongoing costs for delivery of existing actions against the board's Covid-19 response, as well as the opportunity cost of non-delivery of savings and shortfalls against income recovery targets.

Remobilisation Plan expenditure

Since the establishment of the local remobilisation group in May 2020 a number of Board-wide proposals for remobilisation have been brought forward. Some of these proposals have been in relation to extending initial COVID-19 mobilisation(response) arrangements whilst others relate to activity required to remobilise services.

In terms of continuation of mobilisation activity, the projected cost over the remainder of the financial year can be summarised as:

Ongoing COVID-19 Mobilisation	**Current Projected Cost to 31/03/21 £'000**	**Approved Projected Cost to 31/03/21 £'000**
Business Unit		
Acute	0	0
Primary & Community Services	438	438
Mental Health & Learning Disability	0	0
Corporate	909	878
TOTAL	**1,348**	**1,317**

The key areas where ongoing activity is required relate, in the main, to strategic and national priorities. These include leadership and infection control in care homes, PPE, testing and contact tracing (test and protect) and additional transport arrangements. All

proposals, with the exception of additional administration have been approved by Gold Command.

Remobilisation planning remains a work in progress.

COVID-19 Remobilisation Business Unit	Current Projected Cost to 31/03/21 £'000	Approved Projected Cost to 31/03/21 £'000
Acute	1,800	177
Primary & Community Services	451	331
Mental Health & Learning Disability	202	124
Corporate	290	0
TOTAL	**2,743**	**632**

OVERALL TOTAL	**4,091**	**1,949**

To date, Gold Command has approved £1.949m of plans across all business units of the Board. This is the projected cost to 31 March 2021 and any extension of approved activity will be a cost pressure to the Board next financial year. In addition, a number of further plans are still being developed which if they were all to be approved would cost an additional £2.142m to a total of £4.091m.

The full year cost of all plans approved or in development currently amounts to £7.699m although both plans and costs are still being refined.

In terms of the activity supporting these costs of remobilisation, Gold Command has approved a number of workstreams as outlined in section 3 above. Additionally however, plans are being further developed, modelled and costed in relation to a wider range of potential workstreams across our whole system and this includes costs associated with our current winter plan and the 'flu vaccinations plan.

More detailed information relating to the costs associated with the impact of COVID-19 are contained within the financial returns submitted to Scottish Government. Choices will be required, informed by a clinical prioritisation process, if insufficient resource is allocated to NHS Borders to fully fund our COVID-19 response and remobilisation. Once our resource allocation is confirmed we will assess the position and consider any impact on our plans.

8 Next Steps

As previously stated, this paper provides an update on our remobilisation planning and activities as at 10 September. We will continue to refine plans in order to respond to information as it becomes available or as new guidance is issued. We will update the plan further once feedback has been received from Scottish Government on our second iteration and once we have received confirmation of our resource allocation.

In the meantime there are some specific activities that we will be progressing in the coming weeks, as highlighted below:

- Revisiting and reprioritisation of the current Capital Programme for 2020/21
- Revisiting and reprioritisation of the current IM&T Road to Digital Programme for 2020/21

18 September 2020

Appendices

Appendix 1- 25/05/2020 SG Submission

Final 1st Draft NHS Borders Covid-19 Mol

Appendix 2- 31/07/2020 SG Submission

NHS Borders COVID-19 Draft Rem

Appendix 3- Acute Remobilisation Chart

Acute Services Remobilisation Chart.

Appendix 4- Primary & Community Services Remobilisation Chart

Primary & Community Services Remobilisatic

Appendix 5- Mental Health Remobilisation Chart

Mental Health Services Remobilisatic

Appendix 6- Public Health Remobilisation Chart

Public Health Remobilisation Chart.

Appendix 7-Model of Anticipated Winter Pressures

Model of Anticipated Winter Pressures.doc

Appendix 8- High Level Winter Activities

High Level Winter Activities.xlsx