Borders NHS Board

Meeting Date: 3 December 2020

Approved by:	June Smyth, Director of Strategic Change & Performance, Nicky Berry, Director of Nursing, Midwifery, AHPs and Operations.
Author:	Gemma Butterfield, Planning & Performance Officer

COVID-19 REMOBILISATION PLAN (RECOVERY)/ RESURGENCE – UPDATE

Purpose of Report:

This update paper outlines key areas form the remobilisation/ resurgence plans for NHS Borders services as at 19th November 2020.

Recommendations:

The Board is asked to **note** the update on the COVID-19 Remobilisation (Recovery)/ Resurgence Plans.

Approval Pathways:

The Remobilisation Resurgence Plan Update has been prepared in conjunction with service leads. It has been signed off by the Director of Strategic Change & Performance and the Director of Nursing, Midwifery, AHPs and Operations.

Executive Summary:

The first iteration of NHS Borders COVID-19 Remobilisation Plan (Recovery) was submitted to the Scottish Government (SG) on 25th May 2020, with a second iteration submitted on 31st July 2020. Members of SG met virtually with the Board Executive Team on 7th September to discuss plans to date, following which a formal feedback letter was received, to which we responded along with a further update on our plans. Our plans along with our response to the feedback letter are available on the Board's public website.

There are two issues from the feedback letter which remain unresolved, an update on these is provided below:

Update on Outstanding Remobilisation Issues

Non-Invasive Ventilatory Support (CPAP)

SG has asked that NHS Boards plan to provide non-invasive ventilator (CPAP) capacity outwith the ICU setting, and that CPAP capacity for COVID-19 Pneumonia outwith ICU capacity should match ICU surge capacity.

The maximum level of ICU surge capacity that can be created to meet COVID-19 activity within the Borders General Hospital would be 20 ventilated patients, which is quadruple normal ICU capacity. Unfortunately, due to workforce constraints we are unable to match

that capacity and can only provide CPAP capacity that can be created outwith ICU for 6 patients at any one time. Specifically, given the requirements for appropriately trained Anaesthetic and Medicine Consultants, and nursing staff when the hospital has created 20 ICU spaces, there will be no further staff capacity to increase CPAP capacity out with ICU beyond this level. This has been shared with SG as part of our response to John Connaghan, detailed below in the preparing for winter section; at the date of writing this brief we are yet to receive a response.

Waiting Times Allocation

NHS Borders original waiting times plan as submitted in the Board's Annual Operational Plan (AOP) for 2020/21 was £2.4m. This was composed of £1.1m of recurring / commited costs for 2020/21 and a further £1.3m non recurring related to specific additional activity. It was projected that this would deliver a position at the end of March 2021 of 100 outpatients and 300 inpatient/day cases waiting over 12 weeks.

The standing down of non urgent services during the lockdown earlier this year, and reduced remobilised capacity due to the impact of COVID-19 has meant we are not able to deliver this level of activity. In addition to this, NHS Borders has received a reduced waiting times allocation than was outlined as required in the AOP with only 1.4m being allocated £1.2m for 2020/21 for general access support and a further £0.2m for cancer waiting times.

This funding will support £1.1m of core funding for posts which are already in the system and a further £0.3m which is to provide increased activity. This increased activity provided is an additional 876 Outpatient appointments and support the delivery of a further 4,168 radiological diagnostic tests.

The resultant impact on performance of both the cessation during lockdown of routine activity and the reduced waiting times allocation means that our estimated waiting times position at March 2021 is now 6999 outpatients over 12 weeks and 1561 inpatient and day cases over 12 weeks. This position may change however if the number of positive COVID+ patients in the Borders General Hospital (BGH) exceeds either 18 general beds or 4 ICU beds (as outlined in our remoblisation resurge plans).

Resurgence Plans

Following the submission of our remobilisation plans and with the prevalence of COVID-19 increasing our efforts have turned to producing a Whole System Resurgence Plan, whilst preparing our Winter Plan in the context of COVID-19. This plan has been developed at pace, but with patient safety always in mind, with collaboration from across the system and has factored in lessons learned and best practice from our Mobilisation Plan. It has also been informed by the "collecting our voices" feedback.

Each business unit has refined their resurgence plans based on lessons learned and the latest available modelling data, and these are ready to be enacted if and when required. These plans allow for the creation of 20 ICU beds and over 110 Non-ICU beds in response to any increase in COVID-19 activity. A strategic assessment has been undertaken aimed at identifying our readiness for any resurgence.

A system wide review of staff deployment and priorities has been carried with each business unit producing a service prioritisation list, to allow identification of staff available

for deployment should the need arise. It must to noted that there remains staffing challenges across the system when we get to the later stages of these resurgence plans, options continue to be explored by the business units such as over recruitment of Health Care Support Workers to allow a review of skill mix across wards.

Preparing for Winter 2020/21

On the 22nd October 2020 John Connaghan wrote to all boards asking them to confirm their winter preparedness arrangements to the end of March 2021 caveated against the anticipated risks. Including readiness for a resurgence of COVID-19, surge bed capacity, severe weather, winter illnesses and a no deal EU exit- arising individually or potentially concurrently. This also required us to submit 2 template returns as part of our response; a Winter Checklist and COVID-19 Surge Bed Capacity.

For noting please find attached the letter received from John Connaghan (**Appendix 1**), NHS Borders response (**Appendix 2**) and completed template returns (**Appendix 3 & 4**).

Winter Flu Vaccination Programme Update

The responsibility for the delivery of the majority of influenza vaccinations has transferred to the health board this year. The influenza vaccination programme this year is also quite different to previous years due to increased eligibility criteria, an expected higher uptake and the ongoing restrictions related to COVID-19.

In response to these changes NHS Borders has developed a whole system response to ensure the successful delivery of the programme. GPs have maintained responsibility for the 2-5 year olds and the under 65 at risk, and the remaining cohorts have been the responsibility of the Health Board.

For the majority of the population a series of community vaccination clinics have been established to ensure people receive their vaccination as close to home as possible. In addition, community pharmacies have been delivering vaccinations to social care workers providing direct care and district nursing have been 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 have continued as they have previously done so, with enhanced measures to address COVID-19 requirements and opportunistic vaccinations will be provided to inpatients in the acute and community hospitals.

The first phase of the flu vaccination programme ended in late November and uptake rates were high amongst most patient cohorts. Focus has since shifted to the mop up arrangements required for phase one cohorts and on planning for phase two, although at the time of writing we are yet to receive confirmation from the government that we can proceed with phase two.

COVID-19 Vaccination Programme Update

Nationally the government are continuing to develop the strategic and delivery framework for the COVID-19 Vaccination. They have asked boards to prepare plans to support delivery from 2 December 2020, however it should be noted that the pace of COVID-19 vaccine development coupled with the commercial sensitivity around the vaccines means that our planning at this stage is based on a number of assumptions, which may not be

bottomed out until very close to the start of programme delivery.

We currently anticipate receiving a first vaccine called Courageous at the very end of November and a second vaccine called Talent in early January. The vaccines have very different properties and each has specific storage, transport and handling requirements. Both vaccines need to be administered in two doses 21 and 28 days apart to produce an immune response. SG has provided us with a delivery schedule for both vaccines which shows we will receive an initial allocation of Courageous which remain static for 5 weeks of delivery and then decrease whereas for Talent we will receive a smaller first allocation which will then increase. It is possible that new, more effective vaccines may come on line during the delivery period and we will need to adjust our delivery plans if this occurs.

The government has requested a phased approach to delivery as follows:

- Phase 1 (December to January 2021): older adults resident in a care home and care home workers; those aged 80+; and then health and social care workers
- Phase 2 (February to March 2021): All those aged 75+; those aged 70+; and those aged 65+; high risk adults under 65; and then moderate risk adults under 65.
- Phase 3 (estimated supply for April 2021): those aged 60+, those aged 55+; those aged 50+; and then all other adults.

At this point vaccines have not yet been tested on under 18s and we do not anticipate deploying the vaccine to children at this stage. The dates for each phase are indicative due to the large number of uncertainties.

Within NHS Borders we have established a number of workstreams to progress our planning. A lead has been agreed for each workstream and they are reporting into a programme board twice weekly. At this stage we are planning to deliver the COVID-19 vaccine through the same mechanisms as we have delivered the flu vaccine, so onsite delivery for care/nursing homes and housebound cohorts and walk through clinics for other cohorts (whilst applying a number of 'lessons learned' from the flu vaccination programme).

In the coming weeks, as we receive more detailed information from the government, we will continue to develop and finalise our approach and detailed plans.

Need for Boards to Submit Local Remobilisation Plan 3

NHS Boards have been advised by SG that there will be a requirement to submit an updated Remobilisation Plan (RMP3). It is expected that this will be a one year plan for 2021/22, based on an update of our existing Remobilisation Plan and with the emphasis on asking Boards to focus on the delivery of a limited number of key priorities linked to the Programme for Government. This will in effect replace the AOP for 2021/22.

A commissioning pack will issued by SG to all boards at the end of November 2020 with the expectation of a Draft Plan being submitted to them by 29th January 2021. Once the commissioning pack is received a detailed timeline setting out the preparation of the plan and approval points will be developed.

Impact of item/issues on:	
Strategic Context	The Board is required develop a robust COVID-19 Remobilisation (recovery) Plan which should incorporate

	the annual winter plan. This needs to be submitted to Scottish Government for consideration.
Patient Safety/Clinical Impact	This will be assessed as part of the detailed remobilisation plan discussions currently underway.
Staffing/Workforce	This will be assessed as part of the detailed remobilisation plan discussions currently underway.
Finance/Resources	Work is underway to understand the financial impact of remobilisation but this is not yet complete.
Risk Implications	This will be assessed as part of the detailed remobilisation plan discussions currently underway.
Equality and Diversity	A Health Inequality Impact Assessment is being undertaken.
Consultation	A communication and engagement plan to underpin the Board's Remobilisation plan is being progressed.
Glossary	AOP – Annual Operational Plan RPG – Remobilisation Planning Group SG- Scottish Government RMP- Remobilisation Plan CPAP- Non-Invasive Ventilatory Support

NHS Borders

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John Connaghan CBE
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Date 2020
Your Ref
Our Ref RR/KM

Enquiries to Kim Moffat, PA to Chief Executive
Extension 28220
Direct Line 01896 828220
Email Kim.Moffat@borders.scot.nhs.uk

Dear John,

NHS Borders Response to your Letter Dated 23rd October 2020 Preparing for Winter 2020/21.

Thank you for your letter of 23 October 2020 which requires us to provide evidence of our preparedness for winter.

We have now had an opportunity to review this and will respond to each of these in turn below, we understand Annex C is a reference tool for boards rather than an expected return therefore we have not included as part of our response. We have also taken the opportunity to provide updates on other critical actions:

Test and Protect

NHS Borders continues to work as quickly as possible to have the defined levels of Contract Tracing Workforce in place from 8am to 8pm 7 days a week. This service is currently staffed by existing staff redeployed from other services which is adding pressure to the system, but plans in place to progress further recruit to release these staff back.

Seasonal Flu and Covid Vaccine programmes

With the responsibility for delivery for the majority of vaccinations being transferred to the health boards NHS Borders has developed a whole system response to ensure the successful delivery of the influenza vaccination programme. GPs have maintained responsibility for the 2-5 year olds and the under 65 at risk, and the remaining cohorts are the responsibility of the Health Board.

For the majority of the population, a series of community vaccination clinics have been established to ensure people receive their vaccination as close to home as possible. In addition, selected Community Pharmacies are offering vaccinations to social care workers providing direct care and district nursing are 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.

We are now half way through delivering vaccinations to Cohort 1 and we are refining our community vaccination clinic model in preparation for delivery to subsequent cohorts. We are currently carrying out an urgent stock take of our vaccine supply particularly for the over 65's, due to the high volume of uptake there is a risk that demand will outstrip supply. Support with early release of further vaccines is critical to our ability to meet the demand.

It should be noted that for both Test and Protect and Seasonal Flu we have had to source staff from other clinical and admin roles across NHS Borders. Whilst we are complementing these through external recruitment campaigns it is not expected that we will be able to source sufficient additional staff to resource these completely. This means that the levels at which we are able to remobilise our services will continue to be impacted on as well as other business as usual activities across our corporate departments.

With regards to a COVID-19 vaccine programme we are in the early stages of planning how this will be delivered, applying the lessons learned from the extended Seasonal Flu programme to this locally. It would be extremely helpful therefore if expectations regarding national / local requirements are confirmed timeously so that local Boards have as much time as possible to understand the logistical requirements and work with partners to put in place a robust and well communicated programme for our local population.

Redesign of Urgent Care

Following verbal confirmation at our Annual Review on 7th October that we should progress on the basis that our requested Redesign of Urgent Care' funding bid has been accepted and the funds will be provided. Recruitment is now underway to increase staffing in the Borders Urgent Care Centre (BUCC) which will include the COVID-19 Hub and Assessment Centre, scheduled Minor Injuries service, Ambulatory Care and NHS Borders 'single point of access'. The BUCC is on track to be in place by the revised implementation date at the beginning of December 2020. Readiness assessment templates continue to be submitted routinely.

We have now received our funding allocation for urgent care. Unfortunately this is significantly less than the estimated costs that were submitted. We are therefore going to need to review whether we will be able to deliver the proposed model unless further resources are released. We would request urgent clarification around further funding for this essential workstream.

Funding

We anticipate expenditure of £1.467m will be required in order to fully implement our winter plan. Within this, the single largest component is the creation of a 30 bedded winter ward at an expected cost of £0.98m. In order to meet safe staffing levels it is anticipated that increased bed provision over winter will require supplementary workforce at premium rate (i.e. agency).

Our financial plan for 2020/21 identified internal resources of £0.7m available to support winter plans with the assumption that any further expenditure above this level would be addressed through additional revenue allocation. Allocation of £0.204m is now confirmed, leaving a shortfall of £0.563m against the resources required to fully implement the plan.

There remain other areas of our wider remobilisation plans for which resource allocations confirmed to date do not fully address the expenditure requirements identified within our plans (e.g. tracing team, reshaping urgent care). It is likely that – should further funding not be available – we will need to consider actions available to contain costs within the available resources, including scaling back aspects of our remobilisation where necessary.

Update on the Winter Section of our Remobilisation Plan

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.

<u>Review of Previous Years to Develop the 2020/21 Plan</u>

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

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 Borders General Hospital (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.

This year's plan also aims to avoid admissions when this is not in the patient's best interest. A new mental health community response team aimed at avoiding social admissions for patients with dementia and pulling this patient group out of BGH front door areas will be trialled.

Another key component of previous year's plans will be the opening of a winter beds 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.

Planning staff cover across the two 4-day festive weekends is already underway and aims to ensure sufficient levels to support discharge. Senior site leadership shall be in place across these weekends to ensure safe patient flow is maintained.

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.

Additional Capacity and Resource for Winter

Below are the high level details of areas of additional capacity and resource which we are putting into place for the winter period, as agreed through the Winter Planning Board:

- 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

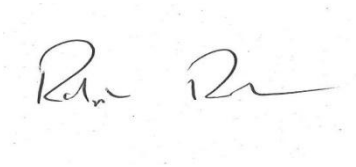
Surge Bed Capacity

Please see **Annex B** for the details of available COVID-19 surge beds within our acute hospital both general and ICU. There remains the ability to create up to 20 ICU beds in response to increase COVID-19 activity and to create over 110 non-ICU COVID-19 inpatient beds. When the capacity is needed for more than 22 COVID-19 inpatients or 4 COVID-19 ICU patients it is expected that our elective profile would need to be reduced. The Health Board is currently exploring how it can deliver CPAP outside of ICU, this is limited due to the hospital not having a High Dependency Unit and the physical constraints of our estate. A plan is being developed that would enable up to 5 patients on CPAP outside ICU.

We hope the above provides the additional information at this stage as requested in your letter of 23 October.

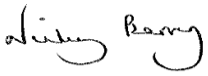
We look forward to hearing from you.

Best wishes,



Ralph Roberts
Chief Executive

Robert McCulloch-Graham
Chief Officer Health & Social Care



Nicky Berry
Director of Nursing, Midwifery & Acute (Chair of the Winter Planning Board)

Annexes

Annex A- Winter Checklist

Annex B- COVID-19 Surge Bed Capacity Template

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Date 02 November 2020
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Dear John,

NHS Borders Response to your Letter Dated 22nd October 2020 Preparing for Winter 2020/21.

Thank you for your letter of 22 October 2020 which requires us to provide evidence of our preparedness for winter.

We have now had an opportunity to review this and have attached a copy of Annex A & B. We understand Annex C is a reference tool for boards internal use rather than an expected return and therefore we have not included this as part of our response. We have also taken the opportunity to provide updates on critical actions identified in your letter:

Test and Protect

NHS Borders continues to work as quickly as possible to have the defined levels of Contract Tracing Workforce in place from 8am to 8pm 7 days a week. This service is currently predominantly staffed by existing staff redeployed from other services which is adding pressure to our wider service. However we are actively progressing further recruitment to release these staff back to their core service as well as ensuring the staffing for Test & Protect is more sustainable over the coming months.

Seasonal Flu and Covid Vaccine programmes

With the responsibility for delivery of the majority of vaccinations being transferred to the health boards NHS Borders has developed a whole system response to ensure the successful delivery of the influenza vaccination programme. GPs have maintained responsibility for the 2-5 year olds and the under 65 at risk, with the remaining cohorts the direct responsibility Health Board staff.

For the majority of the population, a series of community vaccination clinics have been established to ensure people receive their vaccination as close to home as possible. In addition, selected Community Pharmacies are offering vaccinations to social care workers

providing direct care and district nursing are 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. All vaccinations are being progressed with enhanced measures to address the COVID-19 requirements and opportunistic vaccinations will be provided to inpatients in the acute and community hospitals.

We are now half way through delivering vaccinations to Cohort 1 and we are refining our community vaccination clinic model in preparation for delivery to any subsequent cohorts. We are currently carrying out an urgent stock take of our vaccine supply particularly for the over 65's. Current information suggests that as a result of the high levels of uptake that there is a significant risk that demand for vaccinations will outstrip vaccine supply. Support with early release of further vaccines is therefore critical to our ability to meet complete the actual demand in the existing cohorts even before consideration is given to extending the programme to further cohorts.

It should be noted that for both Test and Protect and Seasonal Flu we have had to source staff from other clinical and admin roles across NHS Borders. Whilst we are complementing these through external recruitment campaigns it is not expected that we will be able to source sufficient additional staff to resource these completely. This means that the levels at which we are able to remobilise our services will continue to be impacted, as well as other business as usual activities across our corporate departments. In managing this we will continue to be guided by the priorities set out by the Scottish Government.

With regards to a COVID-19 vaccine programme we are in the early stages of planning how this will be delivered, applying the lessons learned from the extended Seasonal Flu programme to this locally. It will be extremely helpful if we continue to receive information on the planned model as this is developed so that expectations on national / local responsibilities are confirmed as quickly as practical and we have as much time as possible to understand the logistical requirements and work with partners to put in place a robust and well communicated programme for our local population.

Redesign of Urgent Care

Following verbal confirmation at our Annual Review on 7th October that we should progress on the basis that our requested "Redesign of Urgent Care' funding bid has been accepted we have been progressing our plans to put in place a redesigned service. Recruitment is now underway to increase staffing in the Borders Urgent Care Centre (BUCC) which will include the COVID-19 Hub and Assessment Centre, scheduled Minor Injuries service, Ambulatory Care and NHS Borders 'single point of access' ("flow centre"). The BUCC is on track to be in place by the revised implementation date at the beginning of December 2020. Readiness assessment templates continue to be submitted routinely.

We have now received our funding allocation for urgent care. Unfortunately this is significantly lower than the estimated costs that were submitted and we were given reassurance at our Annual review and remobilisation plan review meeting would be funded. We will therefore be urgently reviewing whether we are able to deliver the proposed model. We would therefore request urgent clarification around further funding for this essential workstream.

Funding

We anticipate expenditure of £1.467m will be required in order to fully implement our winter plan. Within this, the single largest component is the creation of a 30 bedded winter ward at an expected cost of £0.98m. In order to meet safe staffing levels it is anticipated that increased bed provision over winter will require supplementary workforce at premium rate (i.e. agency).

Our financial plan for 2020/21 identified internal resources of £0.7m available to support winter plans with the assumption that any further expenditure above this level would be addressed through additional revenue allocation. An allocation of £0.204m is now confirmed, leaving a shortfall of £0.563m against the resources required to fully implement the plan.

There remain other areas of our wider remobilisation plans for which resource allocations confirmed to date do not fully address the expenditure requirements identified within our plans (e.g. Test & Protect, reshaping urgent care(see above) and a sustainable Public Health service). It is likely that, should further funding not be available, we will need to consider actions available to contain costs within the available resources, including scaling back aspects of our remobilisation where necessary, particularly within our planned care services.

Update on the Winter Section of our Remobilisation Plan

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) was formed in 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 well as updating the IJB.

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

<u>Review of Previous Years to Develop the 2020/21 Plan</u>

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

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 Borders General Hospital (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.

This year's plan also aims to avoid admissions when this is not in the patient's best interest. A new mental health community response team aimed at avoiding social admissions for patients with dementia and pulling this patient group out of BGH front door areas will be trialled.

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

The BGH Escalation policy was reviewed and updated in 2018//19. This supported improved patient flow and safety across the site. This policy is currently under review ahead of this winter to incorporate any further 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 winter.

Planning staff cover across the two 4-day festive weekends is underway and aims to ensure sufficient levels to support discharge. Senior site leadership will be in place across these weekends to ensure safe patient flow is maintained.

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 period. This approach will be factored into the waiting times trajectories to ensure that NHS Borders will meet the revised March trajectory, in light of COVID 19.

Additional Capacity and Resource for Winter

Below are the high level details of areas of additional capacity and resource which we are putting into place for the winter period, as agreed through the Winter Planning Board:

- 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

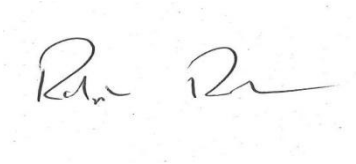
Surge Bed Capacity

Please see **Annex B** for the details of available COVID-19 surge (general and ICU) beds within our acute hospital. There remains the ability to create up to 20 ICU beds in response to increase COVID-19 activity and to create over 110 non-ICU COVID-19 inpatient beds. Within this it should be noted that when the capacity is needed for more than 22 COVID-19 inpatients or 4 COVID-19 ICU patients it is expected that our elective profile will need to be reduced. The Health Board is also currently exploring how we can deliver CPAP outside of our ICU facility, although this is limited because of the scale of our ITU workforce and the physical constraints of our estate. However a plan is being developed and this would allow up to 5 patients on CPAP outside ICU.

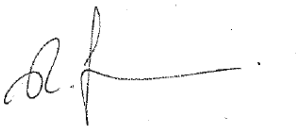
We hope the above, alongside the attached Annexes provides the additional information requested in your letter of 22 October but please do not hesitate to contact us should you require and further clarification

We look forward to hearing from you.

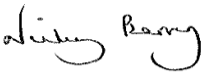
Best wishes,



Ralph Roberts
Chief Executive



Robert McCulloch-Graham
Chief Officer Health & Social Care



Nicky Berry
Director of Nursing, Midwifery & Acute (Chair of the Winter Planning Board)

Annexes

Annex A- Winter Checklist

Annex B- COVID-19 Surge Bed Capacity Template

Winter Preparedness: Self-Assessment Guidance

- Local governance groups can use these checklists to self-assess the quality of overall winter preparations and to identify where further action may be required. This should link to the guidance available for continual provision of service available on the associated web links highlighted on the accompanying paper.

- The following RAG status definitions are offered as a guide to help you evaluate the status of your overall winter preparedness.

RAG Status	Definition	Action Required
Green	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
Amber	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
Red	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	**Resilience Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather, EU Exit and Covid-19 resurgence. These arrangements have built on the lessons learned from previous events, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The Preparing for Emergencies Guidance sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☐ ☐		NHS Borders business continuity plans were signed off in March 2020 on a new web-based planning and management system. Services were requested to review and update these in the light of Covid-19. 90% of reviews are complete. The remainder are due for completion by mid-November 2020. The services were requested to take account of the lessons identified in the response to and recovery from Covid-19. 90% of reviews are complete. The remainder are due for completion by mid-November 2020. The Board's Major Incident plan is under review to take account of Covid-19 pathways, systems and Covid-19 resurgence service changes.
2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios, including Covid-19 reasonable worst case scenarios. Risk assessments take into account staff absences including those likely to be caused by a range of scenarios including seasonal flu and/or Covid-19 as outlined in section 5 and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.	☐ ☐		The business impact analyses (BIAs) for the BC plans undertake impact analysis on five criteria, assuming total catastrophic loss of service and unacceptable downtime is identified. The assessments include staff absence consequence with recovery strategies. Critical activity reports are prepared on the recovery time objectives for each service. Mapping of the business continuity system and the risk register is being undertaken in 2020 to ensure that risks are identified and monitored.

	The Health Board and HSC partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.			Mutual aid arrangements - NHS Borders works closely with other NHS Boards in the east region, Scottish Borders Council (SBC) and other partners on the resilience partnership in a mutual aid capacity as required in risk scenarios. This includes severe weather transport by SBC, other category 1 responders and the third sector.	
3	The NHS Board and HSCPs have appropriate policies in place should winter risks arise. These cover: • what staff should do in the event of severe weather or other issues hindering access to work, and • how the appropriate travel and other advice will be communicated to staff and patients • how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*	☐		NHS Borders Severe Weather Plan and the HR Adverse Policy detail management and staff roles and responsibilities in the event of severe weather. These include travel advice sources and communication arrangements for staff and patients. A staff transport office is set up when the Severe Weather Plan and severe weather management group are invoked. Communications to staff are undertaken in advance of a severe weather event and daily during invocation of the plan.	
4	The NHS Board's and HSCPs websites will be used to advise on changes to access arrangements during Covid-19, travel to appointments during severe weather and prospective cancellation of clinics.	☐		NHS Borders website and social media are employed to provide appropriate information to patients and the public in severe weather events.	
6	The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☐		NHS Borders and Scottish Borders Council has a capacity plan, along with the Local Resilience Partnership and funeral directors to ensure adequate mortuary capacity during the Covid-19 and winter period. Daily monitoring of mortuary	

				capacity is undertaken by hospital and council officers.
7	The NHS Board and HSCPs have considered the additional impacts that a 'no deal' EU withdrawal on 1 January 2021 might have on service delivery across the winter period.	☐		NHS Borders EU-Exit group which reports to the Executive Team is assessing the impact of 'no deal' on service delivery and ensuring adequate contingency planning is in place, along with the Regional and Local Resilience Partnerships. This remains a risk and is therefore rated as amber due to a number of issues outwith of our control.

2	**Unscheduled / Elective Care Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		Clear operational management structures in place including acute site management. Fortnightly meetings include Acute Services and IJB colleagues. Weekly Whole System Winter Operations meetings being established for second year to review system flow measures and take corrective actions.

1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked.	☐		Safety brief, patient flow meetings and escalation plan
1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.* *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*	☐		Safety brief and patient flow meetings, disseminated to ward level and all other business units, separate ICU escalation plan also in place
1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☐		Clear escalation plan for Acute Services. We have step down facilities in place and we require further capacity. The Community plan is being further developed and will address this issue.
2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID activity (both short and medium-term) based on forecast emergency and elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.*	☐		Daily bed requirements from October to March 2021 have been modelled and bed and community capacity have been projected against this to ensure sufficient capacity. COVID-19 capacity plan has been developed alongside this.

	Weekly projections for Covid demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity. *Plans in place for the delivery of safe and segregated COVID care at all times.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*			Weekly COVID-19 projections reviewed at Executive and Operations levels. Non-COVID-19 model is being added to this for single demand projections on a weekly basis. Plan in place for separate COVID-19 pathways beyond front door areas.
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter / COVID surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution.* *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.* *Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical*	☐		See 2.1

	prioritisation and planning assumptions			
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.**			
3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☐		Rosters and rotas in place 6 weeks in advance, management team work with nursing staff and medical staff to allocate festive holidays to ensure resilience in the system. Recruitment ongoing for a winter consultant and nursing staff but will not be concluded by 31st October. Management team have sight on core services to ensure these are covered. Staff resourcing and recruitment for winter plan is in place and annual leave plans are in place for social work and social care. There is senior management on-call rota for every day including the festive and new year period. Multi-disciplinary locality teams will meet according to the RAG rating for services and public health pressures/ delayed discharges. An operational and senior management governance has been established around delayed discharges to ensure pro-active approach.

				Trusted Assessment Scheme is enabled to ensure that AHP can facility discharge to assess more effectively to assist patient flow as identified. Resilience plans have been requested from Care Homes and Care at Home service providers with daily/weekly reporting to quickly respond to COVID19 related outbreaks. System wide reporting is in place to allow the social work service to flex according to the unplanned absences that impact social work and social care services. This reporting is shared across HSCP to enable senior management to take quicker demand/ resource/response decisions.
3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services.	☐		Follows on work above Social Work and Social Care have staff rota's in place for the festive period and beyond. SBC have allowed untaken annual leave to be increased from 5 days to 10 days to flatten demand for annual leave at year end.
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for*	☐		Discussions have been held with SAS and our own BGH Transport Hub relating to winter and the festive period. Cover is agreed and will be implemented for BGH Transport and requests for cover on the Mon PHs over festive period to have

	any change in service provision from partner organisations			Patient Transport however, SAS cannot commit to this as it requires staff volunteering to come in as PHs are not part of their contract. Extra provision will be provided by BGH transport Hub to try to provide as much service as possible. The Third Sector are represented on the Winter Planning Board and opportunities are being explored to ensure support during peak periods.
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☐		In place A Winter Communications and Engagement Strategy has been developed containing our objectives and key messages."- **Be aware of GP surgery and pharmacy closures on public holidays and plan ahead to ensure you have adequate stocks of prescribed medication** **Be prepared for winter** **Seek the right treatment at the right place from the experts in the community** **Only attend the Emergency Department in an emergency** These messages to the public will be reinforced consequent to the development of the Borders Urgent Care Centre and the introduction of a flow navigation process that will introduce the scheduling of patients currently seen in the Emergency Department. This new service is part of a local Reshaping Urgent Care Project and an internal communications plan will support the

				launch of the new service. NHS Borders will raise awareness of public holiday dates and inform all stakeholders and the public of service cover in place throughout this period.
Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of healthcare associated infection and crowded Emergency Departments. **Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.**				
	To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS • A range of other community healthcare professionals. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide visable appointments / timeslots at A&E services.	☐		Plans are being developed to implement this service by the date now specified 1st Dec, we are working to recruit the senior decision maker for the flow navigation centre, progressing IM&T infrastructure Funding allocation does not meet requested amount.

	The impact on health-inequalties and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.			
	Professional to professional advice and onward referral services should be optimised where required Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission.	☐		In place
4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.**			
4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☐		

4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.*	☐		Ongoing work regarding supporting teams for morning discharges, daily dynamic discharge refresh but there is still work to be done to fulfil. Weekend capacity will be enhanced to support discharge. We have arrangements for care homes to admit 7 days a week and we can do care packages 7 days a week.
4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☐		The Discharge lounge will be open in line with modelled demand; discharges will be direct from the wards when closed. Site Assistants will be on duty at weekends to facilitate moves throughout the Site. They work under the Direction of the Site Manage to prioritise patient flow. The discharge Lounge will be open on Monday 28th December, Friday 1st Jan and Monday 4th Jan, public holidays.
4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge	☐		BGH Pharmacy have maintained a 7 day service and extended staff working hours Mon-Fri since March. We will aim to sustain this over the winter period. A number of pharmacist posts have been out to advert over the summer without successful recruitment. We have managed to recruit some

	There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes			technical resource. Pharmacy will prioritise dispensary services, vaccine services, chemotherapy production and ward stock management (where applicable) – but this is likely to mean a reduced presence on wards. BGH Pharmacy is dependent on clear communication from wards on destination for discharge for patients in order to minimise any delays to discharge. The demand for weekend pharmacy services is dependent on what other weekend services are in place (e.g. additional ward rounds; social care etc) – we therefore need organisational direction on this to determine our capacity requirements Discussions have been held with SAS and our own BGH Transport Hub relating to winter and the festive period. Cover is agreed and will be implemented for BGH Transport and requests for cover on the Mon PHs over festive period to have Patient Transport however, SAS cannot commit to this as it requires staff volunteering to come in as PHs are not part of their contract. Extra provision will be provided by BGH transport Hub to try to provide as much service as possible. Social care capacity will be in place at weekends.
5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			

5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions. Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☐		Recruitment in place for reablement teams. Additional post in Rapid Response Team is being appointed. Capacity Modelling is being led by NHS awaiting information this would need additional resource if capacity above current levels is indicated.
5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.* *All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible*	☐		In place
5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☐		Whilst no formal process in place OOH and GPs do use SPARRA- this will be explored on a more formal basis but not completed this winter. All care home residents have an Anticipatory Care Plan in place. An education and supportive programme is in place to further develop COVID ACP for all residents. The current GP Local Enhanced Service includes the completion of ACP for all care home residents and the Pharmacy Enhanced Service also supports regular polypharmacy review of ACP. As part of the supportive improvement programme for care

				homes development is underway to identify methods of sharing care home paper based ACP with Community Nursing and GP records.
5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.*	☐		General Practice and Out of Hours Care currently utilise the KIS and ACP. A recent review has highlighted improvement measures to further utilise the KIS as part of the work underway within the Older Peoples Pathway and assessment and referral to Community Discharge Pathways such as Discharge to Assess, Intermediate Bed Based Care, step down beds, community hospitals and care homes. See above for care home residents. It has been identified that very few clients in Homecare have ACPs' and this is something we want to progress through district nurses and GPs.
5.5	Covid-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November. Turnaround times for processing tests results within 24/48 hours.			NHS Borders is reliant on the implementation of a regional hub in NHS Lothian.
6.0	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*	☐		Communication processes with key partners for both planning and operations are well established

	Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.			
6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around direction to the appropriate service are effectively communicated to the public.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*	☐		Winter Communication Plan in draft and due for finalisation within next month

3	**Out of Hours Preparedness** *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays. *This should include an agreed escalation process.* *Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?*	☐		Long standing escalation process in place.
2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☐		Staffing sought to provide additional cover during expected periods of high demand.
3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☐		GP Sessional rates increased on key dates to minimise risks in respect of shifts not being filled and ANPs scheduled to provide additional resilience.
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☐		ED and OOH work closely in sometimes providing cross cover and/or patient redirection and the clinical administration supporting this practice is being strengthened consequent of the work around reshaping urgent care.
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☐		This is a normal operational requirement and will be further developed as part of the new patient flow navigation system within the redesign of urgent care project.
6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☐		In place.
7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly	☐		In place.

	during the festive period.			
8	Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☐		This is part of the Dental Winter Plan.
9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☐		The plan assumes staff availability, however as is the case throughout Scotland GP OOH cover remains a challenge. The Board is actively considering options in respect of how this risk can be minimised ways of
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☐		Annual arrangements apply. This year there will be additional guidance around scheduling of unscheduled care in respect of which national guidance is sought. Board reps engaging in the national discussions.
11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☐		In Place
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☐		NHS Borders fully engaged in discussions around reshaping urgent care i.e. scheduling unscheduled care.

13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		NHSB has a single system winter planning process. The local Reshaping Urgent Care Project membership involves representation for across the system.
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		NHS Borders Winter Planning Process refers.
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic flu and other emergency plans, including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☐		Completed pre-covid and now being updated

4	**Prepare for & Implement Norovirus Outbreak Control Measures** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☐		Staff can access national infection control guidelines through NHS Borders intranet and the daily hospital safety brief is also used to remind staff of key messages. Compliance with infection control guidelines is monitored on a monthly basis in all wards.
2	Infection Prevention and Control Teams (IPCTs) will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which nursing and care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*	☐		The Infection Prevention and Control Team (IPCT) is represented on the Care Home Oversight Operational Group which meets three times a week. The IPCT is resourced to provide advice and support to care homes.
3	PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards and that frontline staff are aware of their responsibilities with regards prevention of infection.	☐		There is a direct link from NHS Borders intranet home page to the infection control micro site which contains key messages and guidelines.
4	NHS Board communications regarding bed pressures, ward closures, etc are optimal and everyone will be kept up to date in real time. *Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☐		The Communications Team are always invited to attend Problem Assessment Group (PAG) and Outbreak/Incident meetings and communications is a standing agenda item for these groups.

5	Debriefs will be provided following individual outbreaks or at the end of season to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☐		An outbreak report including learning is written at the end of each Norovirus season and progressed through the NHS Borders governance structure.
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker.	☐		Links to the national Norovirus activity data will start to be included in the regular infection control reports from November 2020.
7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.	☐		The IPCT are available and visible to frontline staff throughout the year and routinely attend the daily Hospital Safety Huddle. Advice is regularly sought from the IPCT to support clinical prioritisation of the limited single rooms that are available as well as control measures to implement when it is not possible to isolate individual patients.
8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*	☐		IPCT cover is available 24/7 through the Consultant Microbiologist rota. IPCT annual leave has also been managed to provide on-site cover with the exception of 25th and 26th Dec and 1st and 2nd Jan.
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☐		NHS Borders has a clear surge plan for increasing system capacity in response to pressures.
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.*	☐		The IPCT and HPT have frequent liaison to facilitate clear communication and updates and avoid overlap/duplication.

11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus.	☐		Messaging relating to Norovirus is included in the Winter Communications Strategy.
12	Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of Covid-19.	☐		The Communications Team are always invited to attend Problem Assessment Group (PAG) and Outbreak/Incident meetings and communications is a standing agenda item for these groups. Suspension of routine visiting with associated communications is considered during these meetings.

5	Covid-19, Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMO's seasonal flu vaccination letter published on 07 Aug 20 https://www.sehd.scot.nhs.uk/cmo/CMO(2020)19.pdf *This will be evidenced through end of season vaccine uptake submitted to PHS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.*	☐		Robust staff vaccination plan in place- 51% uptake as at 28/10/20
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.* *Vaccine uptake will be monitored weekly by performance & delivery division.*	☐		Plans in place with extensive use of peer vaccination
3	Workforce in place to deliver expanded programme and cope with higher demand, including staff to deliver vaccines, and resource phone lines and booking appointment systems.			In place

4	Delivery model(s) in place which: • Has capacity and capability to deal with increased demand for the seasonal flu vaccine generated by the expansion of eligibility as well as public awareness being increased around infectious disease as a result of the Covid-19 pandemic. • Is Covid-safe, preventing the spread of Covid-19 as far as possible with social distancing and hygiene measures. • Have been assessed in terms of equality and accessibility impacts *There should be a detailed communications plan for engaging with patients, both in terms of call and recall and communicating if there are any changes to the delivery plan.*			In place for flu vaccination Work ongoing for COVID-19 workforce model
5	The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*	☐		Flu activity anticipated as part of winter capacity plans. Vaccination programme underway with target delivery higher than previous year.
6	PHS weekly updates, showing the current epidemiological picture on Covid-19 and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *PHS and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.*	☐		We are currently building our winter Early Warning scorecard. This will include tracking on influenza rates and norovirus rates from the syndromic surveillance section of Systemwatch as well as other PHS data and reporting. The scorecard will include triggers for response, which feed into clinical services risk status action plans and will be reviewed at least bi-weekly alongside Covid early warning reporting.

7	NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows: • Adults aged over 65 • Those under 65 at risk • Healthcare workers • Unpaid and young carers • Pregnant women (no additional risk factors) • Pregnant women (additional risk factors) • Children aged 2-5 • Primary School aged children • Frontline social care workers • 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household • Eligible shielding households The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This will include regular reporting that will commence from the end of week commencing 12th October. We will adopt a the Public Health Scotland model, which is a pre-existing manual return mechanism that has been used in previous seasons with NHS Boards to collate Flu vaccine uptake data when vaccination is out with GP practices.	☐		Being finalised Risk associated with the availability of vaccine

8	Adequate resources are in place to manage potential outbreaks of Covid-19 and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☐		Plans are established to manage and mitigate the impact of COVID-19, Flu and Norovirus outbreaks. The Winter Transport plan is under review and there will (as usual) be a robust Festive Weekend plan for both weekends.
9	Tested appointment booking system in place which has capacity and capability to deal with increased demand generated by the expansion of eligibility and increased demand expected due to public awareness around infectious disease as a result of the Covid-19 pandemic.			In place from a board point of view limiting factor would be availability of actual vaccine
10	NHS Boards must ensure that all staff have access to and are adhering to the national COVID-19 IPC and PPE guidance and have received up to date training in the use of appropriate PPE for the safe management of patients. Aerosol Generating Procedures (AGPs) In addition to this above, Boards must ensure that staff working in areas where Aerosol Generating Procedures (AGPs) are likely to be undertaken - such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) - are fully aware of all IPC policies and guidance relating to AGPs; are FFP3 fit-tested; are trained in the use of this PPE for the safe management of suspected Covid-19 and flu cases; and that this training is up-to-date. ***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013).***	☐		Staff have been provided with COVID-19 IPC guidance including PPE use along with practical training. The guidance and training covers AGPs and non-AGP activity.

	https://www.hse.gov.uk/pUbns/priced/hsg53.pdf			
11	NHS Boards must ensure that the additional IPC measures set out in the CNO letter on 29 June staff have been implemented. This includes but is not limited to: • Adherence to the updated extended of use of face mask guidance issued on 18 September and available here. • Testing during an incident or outbreak investigation at ward level when unexpected cases are identified (see point 9). • Routine weekly testing of certain groups of healthcare workers in line with national healthcare worker testing guidance available here (see point 9). • Testing on admission of patients aged 70 and over. Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster. • Implementation of COVID-19 pathways (high, medium and low risk) in line with national IPC guidance. • Additional cleaning of areas of high volume of patients or areas that are frequently touched. • Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September. • Consideration given to staff movement and rostering to minimise staff to staff transmission and staff to patient transmission. • Management and testing of the built environment (e.g. water systems) that have had reduced activity or no activity since service reduction / lockdown – in line with extant guidance.	☐		NHS Borders has fully implemented and is compliant with all of these bullet points with the exception of the following:- Additional cleaning of areas of high volume of patients or areas that are frequently touched. This is in place in our hospitals and some primary care facilities. Recruitment is progressing to increase capacity in locations where this is not currently achieved. Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September. Physical distancing and public signage is incorporated into NHS Borders remobilisation processes. However, it has not been possible to implement improvements to the physical distancing within inpatient areas due to constraints of our premises. In accordance with the CNO letter of 22 September, this has been risk assessed.

12	Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf In addition to this, key healthcare workers in the following specialities should be tested on a weekly basis: oncology and haemato-oncology in wards and day patient areas including radiotherapy; staff in wards caring for people over 65 years of age where the length of stay for the area is over three months; and wards within mental health services where the anticipated length of stay is also over three months. *Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-covid-19-healthcare-worker-testing/*	☐		NHS Borders complies with national guidance in relation to staff screening in relation to incidents and outbreaks and also weekly screening of key health workers.
13	The PHS COVID-19 checklist must be used in the event of a COVID-19 incident or outbreak in a healthcare setting. The checklist is available here: https://www.hps.scot.nhs.uk/web-resources-container/covid-19-outbreak-checklist/ The checklist can be used within a COVID ward or when there is an individual case or multiple cases in non-COVID wards.	☐		NHS Borders uses the PHS guidance and checklist.

14	Ensure continued support for routine weekly Care home staff testing This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results.	☐		Work is progressing to facilitate a smooth transition of care home staff testing from NHS Lighthouse to NHS Lothian via NHS Borders.

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☐		Algorithm available in respiratory section of intranet for advice/pathway re exacerbations. National guidelines followed. A/E protocol also available Pathway implemented by SAS – for patients having an exacerbation of COPD.
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐		Service is a Monday to Friday service, this is a development we want to progress but unlikely to be in place this winter
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☐		COPD patients have self management plan, (rescue medication will be suggested as appropriate).Asthmatics have Personal asthma action plan (PAAP) both inclusive of relevant contact numbers for emergency care/support and advice. EKIS (key information summary) under ECS on intranet includes resuscitation status, anticipatory care plan information (updated regularly in primary care). Anticipatory care planning and RESPECT forms currently in use across all services. Advice can be sought by telephone to RSN service or via Respiratory inbox.

				Inhaler advice/technique and prescribing support also available on intranet.
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☐		Local and national guidance/press releases (inclusive of general health advice/vaccination requirements). National charities – CHSS and BLF literature and advice. Current initiative being investigated is CHSS offer "chesty voices" training for COPD patients to keep well/improve quality of life. Current Covid guidance available on national news/social media.
2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the*	☐		All Respiratory patients referred to RSN team will be assessed, a plan initiated and evaluated with discharge plan documented. Assessment will include medication review/inhaler technique/changes to treatment as appropriate, and compliance/concordance.

	review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).			Education and advice/self management. Referral to local support group (if appropriate), referral for pulmonary rehabilitation (currently virtual or on 1-1 basis due to Covid risks). Smoking cessation if required. Appropriate follow up arrangements agreed and documented. 0xygen assessment (if required). All discharge planning supported by use of COPD discharge bundle**.**
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☐		If reviewed by RSN team follow up arrangements will be documented in notes as part of discharge plan, immediate discharge letter will confirm re follow up arrangements.
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☐		The respiratory team inputs information in to anticipatory care plans/update as circumstances change via liaison with primary care/palliative care colleagues. The Respiratory Specialist nurses have undertaken training on completing the RESPECT documentation in collaboration with our Respiratory patients. The Respiratory team are aware of patients who have frequent admissions and those on Long term oxygen therapy at home, and offer additional ongoing support for this group of patients through home visits/telephone

				support/clinic review.
4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			
4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☐ ☐ ☐ ☐		Oxygen therapy is currently prescribed in NHS Borders by the Respiratory team; the current supplier of all 02 equipment is Dolby Vivisol. The current method of requesting is electronic prescriptions (SHOOF). Currently we have 02 concentrators available in all community hospitals – under ongoing review/process in place to increase numbers as winter/pandemic dictates. We have 3 portable 02 concentrators, 1 each held by the Respiratory nurses/palliative care and lung cancer nurses. We also currently hold a “pandemic” stock of 18 x 02 concentrators – (supplied by Dolby Vivisol) Referrals are made via sci-store, Respiratory inbox, or by direct contact with respiratory team.

				02 prescribing guidance available for both emergency and long term use on the intranet, 02 flow charts also available in all medical wards. National guidelines also available via BTS website. Palliative care guidance available on intranet – 02 section.
5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☐		All emergency care points will have access to pulse oximetry, All RSN nurse have an oximeter (for use on domiciliary visits). RSN team have data base detailing patients found to be “02 sensitive”, alerts are in place via, GP/ EMIS &Scottish Ambulance Service, OOH, Documented as alert in medical notes and on TRAK. Patients are issues with COPD alert cards x2 and appropriate 02 mask/cannulae.

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service			In Place
	Nursing / Medical Consultants			In Place
	Consultants in Dental Public Health			In Place
	AHP Leads			In Place
	Infection Control Managers			In Place
	Managers Responsible for Capacity & Flow			In Place
	Pharmacy Leads			In Place
	Mental Health Leads			In Place
	Business Continuity / Resilience Leads, Emergency Planning Managers			In Place
	OOH Service Managers			In Place
	GP's			In Place
	NHS 24			In Place
	SAS			In Place
	Other Territorial NHS Boards, eg mutual aid			In Place
	Independent Sector			In Place
	Local Authorities, inc LRPs & RRPs			In Place
	Integration Joint Boards			In Place
	Strategic Co-ordination Group			In Place
	Third Sector			In Place
	SG Health & Social Care Directorate			In Place

Covid Surge Bed Capacity Template

		Baseline ICU Capacity	Double Capacity and Commitment to deliver in one week	'Triple plus' Capacity Commitment to deliver in two weeks	ICU Max Surge Beds	Y - Correct / N Incorrect with comment	Please list assumptions & consequences to other service provision to meeting these requirements
PART A: ICU	Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out	5	10	19	20	**Y**	COVID ICU cases above 3 is expected to impact the level of routine elective capacity available.

PART B: CPAP	Please set out the maximum number of COVID patients (at any one time) that could be provided CPAP in your NHS Board, should it be required	13	**NHS Borders has 13 CPAP machines; However the capacity available at any specific point will be dependent on staffing and other ICU occupancy. We are currently reviewing where / how this capacity can be provided.**
PART C: Acute	Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID patients (share of 3,000 nationally), should it be required	11	**NHS Borders has a staged plan to increase COVID beds. Cumulative capacity as CV wards opened: CV1- 8; CV2 - 22; CV3 - 44; CV4 - 58; CV5- 88; CV6- 118. Once NHS Borders moves into CV3 we will require to cancel Routine elective activity (CV3 is our current "green" elective ward.**