

NHS Lothian Covid-19 Remobilisation Plan

Version 1.0, Monday 25th May 2020



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1. Introduction

This document is the Lothian Remobilisation Plan, as requested by the Scottish Government Health and Social Care Directorates. It necessarily only presents a fraction of the work being undertaken by the Lothian Health and Care system to keep the protection of health and provision of care at appropriate levels for the residents of Lothian and beyond. It is based on a series of principles and key objectives suited to the current emergency footing for NHS Scotland and as such is necessarily and prudently cautious in how it approaches the concept of “remobilising” our resources. It includes summaries of our activities in our acute, mental health, primary care and community, and public health services.

Key to understanding this remobilisation plan is that it is extremely difficult to draw firm conclusions about how the coronavirus pandemic will develop from here. We are still working through the challenges presented to us by maintaining a defensible core of Covid-19 capacity while simultaneously managing the risk of nosocomial spread presented by the virus. Physical distancing helps mitigate this risk up to a point, but it is very important to note that our previous assumptions regarding productivity, throughput, and efficiency are not currently useful in planning for healthcare delivery in the coronavirus era. While we are hopeful that there will be a vaccine sooner rather than later, we do need to remember that “sooner” could be three years hence, and that it is possible that there may never be a vaccine.

What is documented in this remobilisation plan is therefore the latest iteration of our problem-solving approach as we apply it to our range of services and remain focussed on mitigating the spread of the disease across our population. **This is a living document and we will adapt and modify it as we move forward, with reviews weekly.**

2. The Lothian experience of the pandemic to date

To date (11am, 21st May 2020) Lothian has had 2584 positive cases of Covid-19. We have had 945 patients in hospital with a positive test for Covid-19, of which were 817 admitted with Covid-19 as the admission reason. Of those patients we have had 95 admissions into ICU. At 21 May, 2064 care home residents have been tested, 788 of whom were positive. This equates to 15% of all our care home residents in Lothian.

During the peak we had a maximum number of 224 patients in general beds and 41 in ICU – these figures are for patients with a positive test result. The true use of acute beds has been much higher, given the constraints around physical distancing and appropriately managing patients who are symptomatic but not yet confirmed. Therefore our peak provision of general ward beds for COVID-19 patients was 701 and our peak provision of ICU beds for COVID-19 was 48, within a total bed base for the latter of 105 beds being made available.

Ninety care homes have reported outbreaks. The peak in new cases and outbreaks was 23 April. As at 22 May, of the 90 care homes who have required ongoing intensive support, 40 are still requiring this.

To date, we have conducted 25,251 tests, with 14,315 people tested. We have discharged 573 patients.

Regrettably 245 patients have died (excluding care homes), of which 203 deaths were hospital.

Over the last 7 days we have:

- tested on average 308 people per day;
- Seen an average 301 COVID-19-related NHS24 calls from NHS Lothian residents per day;
- Further triaged an average of 92 patients to the Community COVID-19 Hub
- Of these an average of 19 are triaged for a face to face appointment at an assessment centre;
- On average, 7.4 of these have been admitted within 24 hours.

As of 18th May the effective reproduction number for Lothian is estimated at 0.84 (0.79–0.88).

3. Management oversight and our current objectives

The Lothian Health and Care system – NHS Lothian and its four partnerships with local authorities, under the auspices of the 4 Lothian IJBs – has moved to an emergency footing. It is currently managing its operations on a day-to-day basis through a Strategic Management Group – its Gold command – and a series of tactical groups (silver command) reporting into this Gold command.

The Gold level management group has overall responsibility for NHS Lothian’s responses to a pandemic. It is chaired by the NHS Lothian Chief Executive and focuses on:

- Strategic decision making relating to the pandemic response;
- The provision of non-pandemic NHS services;
- Liaison with Integrated Joint Boards and Health and Social Care Partnerships.
- Service prioritisation across primary care, secondary care and social care.

The group meets twice-weekly, with representation from public health, acute services, our 4 Health and Social Care Partnerships, mental health, primary and community care, infection control, occupational health, and our corporate services – finance, eHealth, human resources, and strategic planning.

The silver (tactical) level management groups that support this focus are:

Group subject	Chair	Key areas for work
TTIS	Director of Strategic Planning	<ul style="list-style-type: none"> • Expanding and maintaining Lothian testing capacity • Developing a contact tracing infrastructure locally ahead of the delivery of a national model • Coordinating approaches to isolation and support with local authorities
PPE	Executive Director Nursing, Midwifery and Allied Healthcare Professionals	<ul style="list-style-type: none"> • Encompasses acute, primary care, HSCPs, Outpatients, newly established Covid-19 service and care homes; • Oversees systems and process of management of PPE supply and demand locally and links to national supply chain groups • Escalation of supply issues and clinical risk

Group subject	Chair	Key areas for work
Primary Care	Director of Primary Care Transformation	<ul style="list-style-type: none"> • Coordination of General Practice responses • Support for GPs from broader system
HSCPs	Director Mid Lothian HSCP	<ul style="list-style-type: none"> • All HSCP activity, especially social work • Liaison and coordination with local authorities
Physical Distancing	Director of Strategic Planning	<ul style="list-style-type: none"> • Agreeing overarching principles for physical distancing within services • Coordinate approaches across different parts of the system
Care Homes	Joint Director East Lothian HSCP	<ul style="list-style-type: none"> • Liaison with social work • Liaison with primary care • Liaison with public health • Liaison with providers
Public Health	Director of Public Health and Health Policy & Deputy Director of Public Health and Policy	<ul style="list-style-type: none"> • Deliver and effective and coordinated Health Protection response • Oversee the shielding work programme
Acute Services	Chief Officer - Acute	<ul style="list-style-type: none"> • Oversee mobilisation plans for general and ICU capacity • Point of escalation for service continuity issues • Support the development of remobilisation plans through decision-making and clinical prioritisation • Point of escalation for liaison with internal and external partners on critical business issues

Central to our approach has been strong Partnership engagement at both tactical and strategic levels, and while our formal engagement mechanisms with our Area Clinical Forum and Area Medical Committee (and others) have not operated as usual during the pandemic, it is important to recognise the key role our clinical and non-clinical staff play in the development and delivery of our rapid planning approach and how embedded they have been in our revised management approach. Staff-side representatives are present on all tactical groups.

Overall, the system is working to deliver a shorter list of objectives than it would do normally, and NHSL's Strategic Objectives for the pandemic phase are:

- Protect and preserve life;
- Safeguard health, safety, and wellbeing of staff;
- Plan for increased mortality rates;
- Plan for maintenance of critical services;
- Learn and adapt for early recovery

During this period we have had a series of significant achievements in how we have transformed some elements of our services, as well as in taking strides forward in caring for the mental health and wellbeing of our staff. We have also faced and managed a number of issues through the management structures. These include:

- Managing the risks and issues relating to both hospital and community spread of Covid-19;
- Managing the supply chain for essential items including PPE;
- Establishment and ongoing management of active clinical triage to respond to the priorities set out;
- Rapid reconfiguration of inpatient capacity to support Covid-19 activity;
- Rapid recruitment and reassignment of the workforce to support the delivery of clinically prioritised services and the Covid-19 clinical service.

This approach is explicitly recognised in the use of SBARs through tactical groups and our SMG structure, and the full list of SBARs is reproduced at appendix 1.

4. Systems of Governance:

As a result of the Covid-19 pandemic NHS Lothian has reviewed its governance arrangements and introduced new arrangements. The aims of the new arrangements, as set out a paper to our April Board, are:

- The organisation can effectively respond to COVID-19 and discharge its governance responsibilities.
- The organisation maximises the time available for management and operational staff to deal with COVID-19.
- The organisation minimises the need for people to travel to and physically attend meetings.

As such NHS Lothian determined that it would be inappropriate to convene Board meetings in public during this period, however, little else has changed.

In specific relation to Covid-19, the Board has received reports on COVID-19 at every meeting since this started.

The Board's Healthcare Governance Committee (HGC) has prime oversight of all clinical governance activities, actions and associated risks during the period of Corona virus infection in the UK, both related to Covid-19 and its impact on the provision of non Covid-19 care. In particular, all amendments to services have been made through minuted meetings and the impact of these changes will be scrutinised in the future by HGC. A specific risk related to Covid-19 has been accepted onto the corporate risk register and all other risks are under the process of review related to Covid-19. Adverse event reports are notified weekly to all executives and the Chair of HGC and a specific field has been created on Datix to report any Covid-19 related adverse events.

The Staff Governance Committee has maintained oversight of our staff safety, staff wellbeing and support, and workforce resourcing systems and processes, providing assurance that our duties as an employer have been properly discharged.

The Board's Finance and Resources Committee, on behalf of the Board, has oversight of the financial planning associated with both responding to the pandemic, and supporting the recovery and renew programme. In the first instance this will include a rapid finance led assessment of the impact on the Board's 20/21 Financial Plan, but following quarter one a more detailed review of all aspects of the Financial plan on the outturn for 20/21.

As part of the local financial governance the Director of Finance and Deputy Director of Finance continue to meet with the Chief Finance Officers of the IJBs, the Chief Officer for Acute Services and Director of Facilities, as part of a continuous review of the mobilisation plans.

Governance arrangements will continue to be reviewed as the Covid-19 situation continues to develop and evolve.

4.1 Early warning systems

NHSL's planning, analytics, finance, and HR teams have worked together during the first wave of the pandemic to develop an early warning system, based on the rate of infection in the community, calls to NHS24 and SAS, and observed disease behaviour across the system. This proved to be a useful system to guide when changes to our activity profiling needed to change rapidly, and we have automated this system and shared it with all Scottish Boards. We update this system daily and are now collaborating with Public Health Scotland, NHS Grampian, the Scottish Government, and the University of Strathclyde on refining this further and developing a national system.

5. Working with partners

Key to our resilience during this pandemic and to our remobilisation plans going forward has been working closely with our partners – the third sector, the independent sector, East Lothian Council, City of Edinburgh Council, Midlothian Council, and West Lothian Council. We are grateful for the work they have done in partnership with us to keep citizens and communities safe, and that they will continue to do. We have shared this document with our local authority partners and believe that we will work more and more closely with them over the coming months.

We have also worked closely with our NHS partner Boards. We rely heavily on the work of NHS24 and the Scottish Ambulance Service, and during this pandemic they have shared their planning assumptions and their data with us to ensure the development of safe alternative services, not least in and around our community Covid-19 hub. The data collected by both these organisations is also key to the early warning systems we have developed. We have shared this document with NHS24 and SAS and have been fortunate to see early drafts of relevant sections of their plans.

We are working closely with Public Health Scotland on the development of the national Test, Trace, Isolate, and Support programme and will continue to do so. We have been fortunate to have had the support of NES in the development of both digital services and the development of a national rapid recruitment portal.

We have also worked closely with our regional planning partners in the South-East of Scotland, and these Boards have agreed to include the following statement in their remobilisation plans

“Regional Working

While individual Boards planning for Re-mobilisation will quite rightly reflect and take account of local conditions including continued response to Covid-19 impact, the East Region Boards have agreed that they will work collaboratively to achieve consistency across the Region where possible and appropriate to do so.

As future iterations of Re-mobilisation Plans are developed, we will continue our efforts to apply consistency in areas such pre-admission/pre-attendance preparation and testing; clinical pathways; adoption and deployment of digital technologies; managing unscheduled care, amongst others.

National Messaging

Some of the proposals in these initial and subsequent Plans, seek to build on the positive changes implemented over the last few months in delivering health and care services – changes in the way we manage access to urgent and unplanned care, directing patients to the most appropriate health professional, and reducing the need for face to face consultations in primary and secondary care. In the forthcoming

weeks patients and public will need to adapt and comply with these changes and essential safety measures such as self-isolation and pre-admission testing, social distancing measures and reduced access to hospitals for visiting.

In order to support and consolidate these changes we will require strong and consistent national messaging to patients, carers and the wider public, led by and fully supported by Scottish Government. We have a unique opportunity to influence and direct important changes in the health and care system at this point that will deliver significant long term benefits to the NHSS and the population.”

Finally, the organisation is fortunate that members of its leadership team hold national leadership roles, chairing the national Medical Directors, Nurse Directors, Directors of Finance, and Directors of Planning groups, and that through these networks we have been able to both influence national policy and incorporate best practice from across the country. This remobilisation plan has been shared with all Boards through the latter group.

6. Principles and assumptions

We have tried, throughout the pandemic to date, to be clear *why* we are taking any particular action, in order that we can be clear how that action will support delivery of our overarching objectives. We have worked with our fellow NHS Boards to agree that there needs to be a national approach grounded in common principles and assumptions in order that we can collectively advance the nation's health.

We note the position paper on remobilisation produced by the Scottish Association of Medical Directors and the Scottish Executive Nurse Directors group (reproduced at appendix 2) and are grateful for the clear thought that has gone into this work. From that, we have identified the following principles for our work in the “pre-vaccine” phase of the pandemic.

Our principles for the pre-vaccine phase and remobilisation are:

- The benefit of any face-to-face contact must outweigh the risk. If it does not, we will work to find alternative ways to meet the need if this is clinically required;
- We will operate with an abundance of caution toward the risk of health and care-based spread of COVID-19 and so will carefully phase our remobilisation;
- We will base our approach on mitigation of risk, on the understanding that risk cannot be eliminated;
- We will base our approach on evidence, remaining mindful of the need to observe and act on the signals in our early-warning systems;
- We will prioritise the most urgent requirements for treatment and remobilising the services required to deliver these – cancer services, transplant as examples – before others;
- Our system will remain physically-distanced;
- We will be cognisant of the particular challenges to infrastructure and supplies presented by the speed at which COVID-19 spreads and the risks of nosocomial infection. This means that we need to operate with new interpretations of what constitutes “effectively utilised”;
- We will schedule whatever elements of care and treatment we are able to, and will use digital and more common technologies (such as the telephone) to do so;
- We will minimise the movement we ask of patients (reducing risk to them and to the wider public) by minimising their need to travel outside their local area to access care;
- With all of the above taken into consideration, it is highly unlikely that we will be able to improve performance against national standards and targets.

Flowing from this are a series of assumptions that we believe are appropriate and reasonable;

- We need to keep a separate bed-based for Covid-19 of c.300 general acute ward beds, and 15 critical care beds, with additional beds in critical care laid aside and ready for remobilisation;
- The Community Covid-19 Pathway through NHS24 to local primary care triage, assessment and admission will remain for the foreseeable future;
- We will implement a 2m-radius approach to physical distancing in all of our sites (including independent contractors) and facilities, exempting examinations, tests, and treatments;
- Our physical capacity may be reduced by as much as 50% due to the impact of physical distancing;
- We will have a functioning Test, Trace, Isolate, and Support mechanism across the country;
- Testing, in particular, will remain “not perfect” for the next three months, although being constantly refined;
- Boards will remain financially viable and the financial support offered to date by the Scottish Government will remain in place;
- Social care providers will be sustained;
- Supply of personal protective equipment will be maintained and increased as some services currently “offline” are re-introduced;
- There will be no change to national guidance on shielded cohorts;
- We expect further waves of Covid-19 activity, and that this will be modelled through under the auspices of the national modelling oversight group. To respond to these, we will need to leave significant capacity in all our operations to scale up rapidly. As a proxy for this, we will retain 15 ICU beds and up to 300 acute general beds until the pandemic is over.

7. Our Priorities for the next three months

We will prioritise remobilising;

- Diagnostics and treatment for cancer;
- Urgent treatment for cardiac disease, transplants, renal failure;
- Support and treatment for mental health difficulties;
- Routine treatments where additional delays caused by the pandemic may have made the clinical picture an urgent one;
- Services for children, where the impact on a child's development could be disproportionate;
- Dental and ophthalmic services where significant underlying disease may have built up.
- General Medical Practice capacity to see patients with non-urgent but significant health problems that will worsen over time.

To be explicitly clear, we will continue to utilise active clinical triage and clinical judgement to ensure that we manage the risks associated with delaying treatment.

This goes alongside services we have sustained "as normal" through the first wave of the pandemic, including support for pregnancy, and unscheduled care services.

We note that the number of urgent referrals to acute services in March and April 2020 was 22.7% down on the average for the period over the last three years, indicated that there may be significant unmet need in the system to come forward.

However, in line with the principles and assumptions outlined above, we will seek to minimise the number of people who attend a healthcare facility by using new technologies such as NearMe, and also old, such as the telephone. Some aspects of this will require some time to implement.

It follows from these principles and assumptions that as this stage we do not intend to restart routine face-to-face outpatients and routine elective care during this three-month period. There may be some exceptions, but this will be based purely on clinically-led assessment of whether the risk is outweighed by the benefit for each individual patient.

In primary care we have maintained all of our general practices and community pharmacies (with restrictions on some elements of service and on physical access to premises) and we will continue this. We will maintain our community COVID-19 Pathway hubs and assessment centres in order to support GP practices in

managing non-COVID-19 activity appropriately. However, we are clear that the continuation of physical distancing during this period means that we will not be restarting GP or pharmacy services in their previous ways of working.

As noted above, we are still learning about this disease and so definitions of what constitutes “safe is not completely clear. As the SAMD/SEND position paper notes, this process is about careful risk mitigation, not eradication, and so we will progress the expansion of our services with “all deliberate speed”. This means that it is difficult to be precise with regard to volumes and dates.

This is all summarised in the table below, but it must be stressed that this is indicative only and subject to change.

Service area	Current position	Anticipated position at end July
Cancer Treatment – oncology	Continued at baseline level for urgent treatment	Continued
Endoscopy	urgent only	Urgent only
	Routine	No change from end May
Imaging	Urgent only	Urgent only
Cancer Treatment – surgery	Broadly unchanged – capacity sourced in independent sector	No change from May
Transplant surgery	Urgent only	Full programme
Routine surgery	Only when clinical assessment upgrades from routine	No change from May
Psychological therapies, CAMHS, and mental health	Near-me/telephone and urgents only	Substantial transfer of routines to near-me/telephone
Acute outpatients	Near-me/telephone and urgents only	Substantial transfer of routines to near-me/telephone
Cardiac treatment	Urgent only	Urgent and where clinical risk due for routines
Maternity	Unchanged – routine outpatients by phone/near-me	As May
Children’s services	Urgent treatment only	Urgent treatment and where delay will impact on child development

COVID-19 Community hub	Triage of possible COVID-19 patients from community	As May
Service area	Current position	Anticipated position at end July
General Practice	Primarily by phone and Near-me, face-to-face appointments where required	As May
Urgent referrals	At 77% of previous average	100% of previous average
Unscheduled Care	At 2/3rds of previous; minor injuries provision switching to MIA	As May

8. Risks and risk management

Effective risk management is the foundation of our planning for remobilisation. Central to our risk strategy is the principle that the risk of procedure must be less than the intended benefit and within that, that the level of urgency of the procedure supports proceeding at this time. The clinical risk management approach is principally based on active clinical triage.

A number of system risks overlay this clear clinical risk management directive; and these are captured in our management system risk registers and run inherent throughout this plan. The key risks to remobilisation relate to the system capacity to deliver increased activity, and their likelihood increases as activity increases, thus affecting a higher risk rating.

The key risks to **delivery of this mobilisation plan** at a whole system level are:

Risk of Covid19 demand exceeding Covid19 capacity – There is a risk that predicted demand for Covid-19 capacity, based on modelling tools, will be exceeded. The plan outlines the approach of cautious reinstatement of clinical activity, with no resumption of routine outpatients or routine elective surgery planned at present. This is considered prudent to allow the system to hold inpatient surge capacity and flex them according to need as public measures are lifted and urgent clinical services are reinstated. Further actions to reduce this risk are expected to be reactive.

Risk of nosocomial infection – There is a risk that staff and Covid-19 negative patients become infected within the healthcare setting. The management of this risk is intrinsic in the management of other risks, presented below; as well as the following direct mitigating actions:

- Implementation of adequate physical distancing exempting examinations, tests, and treatments;
- Appropriate and effective use of PPE supported by robust staff education and training, Face Fit Testing, and management of both external and internal supply chain;
- Minimising travel for patients attending for care and treatment; suspension of visiting;
- Rapid access to Covid-19 testing for all staff and their families, and all patients with query Covid19; and the establishment of an effective Test, Trace, Isolate and Support system across Scotland.

Risk of further build-up of 'backlog' – There is a risk that there is considerable unmet need within the system, and that this will continue to build-up during the next period. The summary table at section xx

outlines the current service provision and plans – notably that we anticipate urgent referrals returning to their previous level. This is supported through the remobilisation plans for primary care and initiatives such as the national *'If it's urgent, it's urgent'* campaign.

Risk of reduction in productivity – There is a risk that there will be a significant reduction in productivity of service as a consequence of distancing and other constraints. This risk is considered irrefutable and is highly likely to impact on our ability to perform against national standards and targets.

Risk of adequate and appropriate PPE – There is a risk that NHS Lothian is unable to maintain an adequate supply of PPE. System-wide processes have been developed and are under constant review to ensure efficient and effective use of any allocation however the risk of insufficient supply of key stock remains a possibility.

Risk of staff availability – There is a risk that due to illness, shielded status or other leave requirements, as well as due to staff that are currently reassigned returning to their substantive posts, there will be insufficient staff to deliver services planned for reinstatement including social care and care home services. This risk will be managed on a service-by-service basis through both local and system-wide processes to ensure risk is mitigated through the deployment of additional staff as well as reassignment of staff with specialist skill set where required.

Risk of inadequate eHealth hardware and infrastructure – There is a risk that there is insufficient IT hardware and infrastructure to support the prompt roll-out of digital and digital-enabled service models. Demands are being effectively managed at present, however, due to the dependency on supply chain there remains a risk to provision.

Sector- and Service-specific risks are outlined in the relevant sections within this plan.

This document now moves onto to outline the finer detail in the tactical workstreams.

9. Our Public Health approach

Our approach to the pandemic is based around public health principles and in particular on breaking the chains of transmission. This involves best practice infection control, the implications of physical distancing, outbreak management, and the development of our *Test, Trace, Isolate, and Support* approach.

9.1 Physical Distancing

The implications of physical distancing are significant for all of our services, and indeed for all public services. We have established a tactical group to manage this and are currently trialling a process for mitigating and, if necessary, making alterations to our capacity and physical estate.

9.2 Outbreak management

We are using our health protection team to tackle localised outbreaks, and for the foreseeable future this will continue. It will focus in the short-term (and for as long as is necessary) on an enhanced outbreak response for closed settings, as laid out in appendix 3.

Management of outbreaks and potential incidents in the community are led by the Health Protection Team (HPT) using the guiding principles of <https://www.gov.scot/publications/management-public-health-incidents-guidance-roles-responsibilities-nhs-led-incident-management-teams-october-2011-updated-july-2013/>

Key principles are of a multidisciplinary approach, led by HPT, working jointly with key colleagues such as virology, occupational health, infection prevention, microbiology, infectious diseases, environmental health, HSCPs, Local Authority housing services, the third sector and others as required.

Since 25 April an HPT enhanced outbreak service has been set up for outbreaks with a particular focus on where the incident management team have determined there is a need for enhanced testing of staff and/or residents (ie those without symptoms) as part of outbreak control. IMTs in 21 outbreaks have recommended an enhanced testing outbreak response.

Going forward in the post lockdown era it is anticipated:

- The number of community outbreaks will increase as is seen in other countries. This will include workplace, hostels, schools, universities, ships, community venues eg gyms, and networks of

vulnerable people such as homeless people, sex workers and people with problematic drug and alcohol use.

- There is likely to be an increase in airport incidents (even if not outbreaks), due to pre-boarding passenger screening, mandatory requirements for captains to notify of potential illness on board flights and quarantine for people returning from abroad.
- Many of these will come under the term 'complex' for TTIS and will be referred to HPT. It is important that TTIS systems are able to promptly detect these outbreaks to allow prompt for further investigation and control
- The number of closed setting outbreaks will be low initially (given the high attack rate to date) but reintroduction of a new cohort of care home residents and reintroduction of the virus into these settings will result in a second phase of outbreaks, albeit with anticipated far lower number of cases and deaths.
- The number of non covid incidents and outbreaks will start to increase again. Of particular concern in the usual summer season are STEC (e COLI 0157) outbreaks. These are more likely this year as households may be more likely to cook their own BBQs

9.3 Test, Trace, Isolate, and Support

NHS Lothian currently, at the date of drafting of this plan, can carry out approximately 1200 PCR COVID-19 tests per day, with an "in-hours" turnaround time of 4-6 hours. Our lab services are at the heart of the national approach to expanding lab capacity and are supporting the national drive to deliver 9000 tests per day by the end of May.

We are not a pilot site for the new Tracing App and case management software system, but we are moving forward rapidly with both contact tracing and the staffing support for this work. For the avoidance of all doubt, this work is currently targeted on tracing of symptomatic patients with a positive test, not on what could colloquially be known as "mass tracing".

Our plan is as follows;

Date	Cohort to be traced	Number of tests in this cohort (approximate, per day)
18 th May 2020	Positive cases from community COVID-19 hub	2
25 th May 2020	Closed settings in Midlothian	25
	Staff	12
2 nd June	Closed settings in West Lothian and East Lothian	75
9 th June	Closed settings in Edinburgh	75

To support this, we have identified 12 wte nurses and staff with similar skill-sets who are either shielding or unable to work in their substantive roles, and so we are working with them to upskill them to take forward the specialist “Tier 2” work of contact tracing, for people who have concerns regarding their own previous clinical history or similar. As of drafting of this plan we have identified a potential further 120 additional clinical staff at band 5, 6, and 7, who may be suited to work in this service to get this up and running.

To support the tier 1 work – contact tracing “call handling” work – NHSL has over a substantial number of non-clinical staff who are currently shielding or otherwise unable to work in their substantive roles, and who will contribute to the national target of 1968. Agreement has been reached between territorial Boards that they will aim to contribute a nominal share of the national target for a period of 3 months (and possibly longer). NHS Lothian’s share is 163 staff and we are confident we can meet that target.

9.4 Infection Control

The NHS Lothian infection prevention control team (IPCT) meet weekly with Health Protection Scotland to discuss new and emerging guidance and practical considerations for implementation across Board areas. Senior members of the IPCT support the operational, tactical and strategic COVID-19 response groups to ensure that national guidance is incorporated into local planning and response.

Existing geographical IPC structures provide local specialist advice in real time in relation to clinical investigation and management of patients, outbreak management and environmental controls. This is also supported by the availability of a 7 day duty infection control nurse service through a single point of contact.

The ICPT have contributed to the development and delivery of education and training and provided quality assurance of content of resources delivered by non specialists. The IPCT review or develop local guidance which cover a wider range of procedures and clinical disciplines – all guidance is submitted through the tactical and strategic governance structures for approval prior to dissemination

The IPCT will provide site based review to support development of remobilisation plans on a risk assessed basis. The lead IPCN and ICD provide guidance and oversight of the strategic remobilisation plan to ensure core IPC requirements are included where IPC capacity is unable to support site review.

9.5 Prevention, Inequalities and Partnership

There is clear evidence that the burden of COVID-19 illness and death has been greatest on people from more deprived communities and people from black and minority ethnic backgrounds. Within partnerships, there is evidence of significant social and economic impact from lockdown: financial concerns; unemployment; housing debt; poverty; digital exclusion; domestic violence; social isolation; mental health problems. These determinants of health need to be addressed as part of wider partnership activities that focus on prevention and inequality. In line with national public health priorities, tackling these health determinants needs to be done in a place-based way. Public health partnership with HSCPs and CPPs is key. Dedicated public health teams will work in each partnership to progress this work.

9.6 Shielding

Approximately 25,000 people have been included on the NHS Lothian master list for shielding. The largest group is severe respiratory disease. It is anticipated that people may be advised to continue to shield for several months. As NHS services are re-designed to mitigate risk of COVID-19, it is important that the health care needs of the shielding population continue to be met whilst minimising risk of infection. The Shielding Clinical Advisory Function will support clinicians and managers by providing principles and advice specific to shielding to inform redesign of services in primary and secondary care.

9.7 Screening

Scottish Government has indicated that adult screening services should be re-started as part of recovery and renewal. In Lothian each screening programme is coordinated by a programme board and these boards will oversee the restarting of the programmes when this is indicated by Scottish Government.

9.8 Immunisation

Although child immunisation services have continued through the initial COVID-19 pandemic response phase, other programmes such as the schools based HPV vaccination programme and the shingles vaccination programmes have been discontinued. Work is already underway to consider options for re-starting these programmes.

The 2020 seasonal influenza vaccination campaign is being planned along with HSCPs and Primary Care. A national Scottish Immunisation programme meeting on the 26 May will discuss flu vaccination and COVID-19. It will be necessary to agree a flu vaccination programme for each partnership area.

9.9 Quit Your Way

Smoking cessation services have continued throughout COVID-19 pandemic response. As clinical services are re-established, links with Quit Your Way will be re-designed.

10. Staff wellbeing

10.1 Staff Testing

Staff testing for Covid-19 is solely to support an earlier return to work if coronavirus infection can be ruled out.

Staff testing commenced on 24 March from a single drive through hub at Chalmers Hospital and following successful implementation of the service was expanded to include a second drive through hub at West Lothian College at the end of April. The staff testing services is for all health and social care staff in the Lothian area, which is aligned to the Scottish Governments priority 1 group in terms of key worker and operates seven days a week. Where staff have transport difficulties a fully supported and paid for taxis service is available to enable them to use the drive through facility.

For testing to be of use, it must take place between 24 and 72 hours of symptoms starting. The testing is for staff who are self-isolating because of their own symptoms or for staff who are isolating because of a member of their household is symptomatic. In these cases it will be household member who is tested. If they are negative the staff member is safe to return to work without having to self-isolate for 14 days. Results are confirmed by SMS or telephone within 48-72 hours after testing.

Our early implementation of staff testing has undoubtedly enabled staff to return to work and had a positive impact on our Covid-19 related absence levels.

It is envisaged that staff testing will continue to be a priority throughout our response to Covid-19.

10.2 Wellbeing support

The emotional labour involved in successfully managing our own emotions, whilst attending to the needs and distress of others can be extremely demanding (both at home and at work) during a pandemic. Paying attention to ensuring that we are protecting our staff, hearing them, preparing them, supporting them, caring for them and expressing genuine gratitude is essential to get us through this situation.

A strong focus on staff wellbeing has been central to our response during Covid-19. Wellbeing work has been operating at local, strategic and national levels throughout our response.

Scottish Government made a request that all NHS Boards and Local Authorities identify a staff wellbeing champion and commenced weekly calls with this group at the end of April. NHS Lothian's Wellbeing

Champion (Amanda Langsley, Associate Director of Organisational Development) has been liaising with Scottish Government to share activity going on at board level and contributing to the direction of the national response.

Wellbeing resources and activity has been evolving responsively and at pace across our system. Some of the key activity is set out below:

Psychological and listening support were viewed as key during the initial reactive phase. NHS Lothian's Psychological Services set up and launched the 'Here for You' helpline which was quickly extended out beyond health and social care to include council employees, care home, hospice staff. After a national review of provision the Helpline was extended further to support Scottish Ambulance Service, 3rd Sector and Volunteers. Alongside this response our existing staff listening service, provided by our Spiritual Care Team was switched to a telephone service and the hour's extended to provide a service 7 days a week.

During Covid-19 it has become apparent that an approach centred on the principles of psychological first aid is the most appropriate and is underpinned by an evidence base in relation to supporting staff wellbeing.

We are scoping the potential for the introduction of a staff support element to our Occupational Health Service based on Psychological Therapies. Covid-19 is surfacing the need for an appropriate response to higher than normal levels of trauma and distress in our staff. We are reviewing the options, with there being ongoing provision of the helpline using psychological 1st aid, alongside supportive care and psychological treatment who need more specialist, high intensity input. Therefore we seek to provide a service that responds to this need as a test of change, integrating the additional services with existing provision within occupational health. There is a potential that this test of change could be part funded by the Edinburgh & Lothian's Health Foundation.

Many hospital sites have set up wellbeing hubs. These are physical spaces in which staff can take time out from the clinical area to socialise (at a distance), rest, refuel and hydrate, relax, reflect and access support resources. Edinburgh and Lothian's Health Foundation (ELHF) have been pivotal to supporting the initiation of these areas.

In collaboration with the 4 HSCP Chief Officers a plan to test the concept of a 'Hub in a Tub' for community teams was developed. The concept involves deploying wellbeing boxes out to community hubs containing wellbeing resources and some of the donations that have been focused on acute sites. The Edinburgh and

Lothian's Health Foundation have funded this and week beginning 18th May 120 'Hub in a Tub' boxes were distributed across HSCP locations community locations.

Early on in the response to the pandemic we were able to work with teams to test a range of staff wellbeing resources aimed at supporting staff wellbeing. We developed four key resources:

- Staff Wellbeing Huddle Template
- Before you Head Home Poster
- After Covid-19 I am going to.....poster
- Leading through Covid-19

The evidence based 'Leading through Covid-19' resource has been recognised as an example of best practice by the Institute for Healthcare Improvement. This resource promotes the NES Psychological First Aid e-Learning Module and is supported by a spot coaching conversation service delivered by our Organisational Development Team.

The Edinburgh and Lothian's Health Foundation (ELHF) will receive significant charitable funding in the coming months specifically to address staff wellbeing across predefined themes. We will work with the foundation to build a strategic and coordinated response that best meets our staff wellbeing agenda.

Staff wellbeing and resilience is critical to sustaining our response to the current pandemic and our service delivery beyond Covid-19. Staff must feel protected, supported, cared for, listened to, prepared and valued for their contribution. We need to continue our focus on this during the Covid-19 response but also in the emerging new normal. The staff wellbeing response during Covid-19 has been powerful, however we must be mindful of the impacts of this support and associated resources dropping away as the pandemic subsides and how this will feel for our staff.

There is rightly a huge appetite to learn from Covid-19 and this has been initiated at a local, organisational and national level. We need to be cautious that this activity is managed in a strategic manner that prevents duplication and runs a risk that we survey staff repeatedly.

NHS Lothian have a "tactical"-level staff wellbeing group that will direct this work as appropriate during Covid-19 that will link in to our Staff Experience and Engagement Programme Board.

10.3 Staff experience

Through our Staff Engagement and Experience Programme Board we will begin to look at a refresh of our Staff Engagement and Experience Framework, learning the lessons from our Covid-19 experience and exploiting new practices which have emerged.

10.4 Learning from Covid-19 and Research Studies

A group has been established to form an approach to learning from Covid-19 from an improvement, resilience and organisational development perspective. In addition to this, a mixed methods, longitudinal research study to examine the impact of Covid-19 on NHS Lothian staff mental health and well-being is being commissioned by NMAHP research colleagues, due governance processes are currently being worked through. The Edinburgh and Lothian's Health Foundation has approved a £250K fund in principle to support this work.

11. Additional staffing and mutual aid

At the beginning of the pandemic response NHS Lothian undertook a significant rapid recruitment exercise as well as fully supporting the NES Returners initiative. The response was significant and numbers of staff recruited are presented at appendix 4.

11.1 Nursing and Midwifery

We have established a Covid-19 Nurse Staffing Hub to formalise and co-ordinate requests for additional staffing and to match with the available staffing. The hub also receives all new start information from rapid recruitment (the NES portal will retain deferred NES candidates pending future requirements), retains a record of all staff placements from external sources, and ensures appropriate governance (SLA, honorary contract or secondment agreements) for nursing staff repurposed into NHS Lothian.

We have created a Nursing and Midwifery Workforce Mobilisation Plan to consistently manage the recruitment and deployment of additional resources and a Workforce Template to monitor the resources on a ward by ward / site or partnership basis and track the impact of changes in one area across the wider nursing and midwifery system. This has been informing the financial forecasting reports to Scottish Government.

We have established pools for each acute site and health and social care partnership to collate additional staff into one place. This central information source can then be used to be draw down to specific roster locations and Care Home pools across each of the H&SCPs in order to provide mutual aid.

Sickness levels / COVID-19 isolations have not been as high as anticipated, and together with a lower hospitalisation rate the staffing levels in acute have not been as pressured as anticipated during wave 1. Community staffing started from a lower baseline and whilst the absence rate was equally unaffected the impact of workload has been greater. The number of patients having End of Life Care at home, the extent of the care home support from District Nursing team and the opening of additional beds in community hospitals has utilised most of the additional fixed term local recruitment.

11.1.1 Innovation and Transformation

We are working on an observation study to gain greater intelligence of the nursing contribution required for different patient groups (Covid-19 and Non Covid-19), which will also inform the staffing levels required to safely manage any future reconfigurations of services / reintroduction of services.

Rapid recruitment process has provided an alternate way to manage the recruitment of large numbers of applicants over a short period and the benefits from that will be pulled through to generic recruitment going forward.

There is a risk that services, being supported through an early mutual aid arrangement will be jeopardised if the supporting staff are withdrawn to reinstate core business (e.g. the use of dental nurses to do care home Covid-19 testing if dental work is reinstated; the use of manual handling trainers to do staff testing or the use of eHealth records staff to build OHS staff testing clinics). These arrangements need exit plans or alternative staffing provision to lending service developed in parallel to decisions about reinstatement.

Accelerated recruitment of the graduating student nurse cohort to fill underlying vacancy is underway and will be completed by end of July 2020. This will migrate the band 4 students into band 5 vacant positions but does not create any net gain to the overall workforce in the next 3 months.

The Workforce Template will be maintained to retain a reliable picture of the staffing profile; to allow deployment of staff in the event of a second wave, with planned backfill / support from NES returners; and to facilitate modelling of potential future scenarios including deployment of resource to the NHS LJ

Locally recruited fixed term / bank contracts were end dated 31 July 2020. A process to review requirements, in line with the Workforce Template, will be established to extend and / or make substantive appointments pending due process.

11.2 AHPs

As a result of the recruitment process we have an increased number of bank workers available. Pre-Covid-19 there were 217 AHP's registered on the Staff Bank. The number offered a Bank contract following the local COVID-19 advert in March is thought to be an additional 30.

Priorities for deployment currently are:

- Community rehab of COVID-19 survivors following hospital discharge
- Discharge to Assess teams
- Diagnostic Radiographers and Sonographers
- Particular current need for Physios and OT's in Midlothian HSCP and to a lesser extent East Lothian HSCP

11.3 Pharmacy

A single equitable process has been established to facilitate community pharmacies to request support if they are experiencing significant operational difficulties due to COVID-19. Operational difficulties would include a threat to the pharmacy staying open and/or the ability to provide core services. This process ensures that all options to respond to service pressures have been considered up to and including whether health board deployment is appropriate.

The additional staffing will

- Support the provision of core pharmaceutical services across the single system pharmacy service;
- Support the provision of pharmaceutical care to mental health services at SJH;
- Support the provision of pharmaceutical care to the additional critical care beds across NHS Lothian;
- Support resilient medicines supply in acute.

11.5 Facilities

Recruitment to date has filled the immediate gaps left by staff absence /Covid-19 related and services capacity increases or new services (such as the Covid-19 Assessment Centres).

To date very few of the additional posts have been to cover the changes required of remobilisation which may include additional support way finding, distancing, traffic management, monitoring and cleaning of non-clinical spaces, or reconfiguration of spaces.

It is anticipated that the absence levels may increase as the lockdown lifts and the year progresses, the additionality in the Staff Bank will be helpful in covering these gaps.

The Facilities Directorate will need to monitor the staffing position closely as the plans for remobilisation progress.

11.6 Interpretation and Translation Service

The Interpretation and Translation Service has benefitted from an increasing use of technology to provide interpretation services to clinical areas, including participating in NEAR ME consultations to provide translation.

The Board will consider the development of an interpretation suite to enable remote / virtual translation in coming months as activity picks up.

12. Management of Key Supplies and Infrastructure

12.1 PPE and Essential Supplies

The supply chain for all personal protective equipment (PPE) and critical care essential supplies has been under a significant strain locally, nationally, and internationally. Processes and frameworks has been put in place in NHS Lothian to ensure assessment of supply chains, identify and maintain an overview of risk, make decisions on priority and use of available supplies, and recommend measures such as alternative products required to reduce the impact of the Covid-19 event. Daily PPE Huddles, chaired by Executive Nurse Director, and daily Essential Supplies Huddles, chaired by Critical Care General Manager, were established to dynamically manage urgent issues across the whole system.

A key aspect of these processes and frameworks is recognition of the need, as far as is possible, to maximise staff confidence in NHS Lothian's strategic and operational management of PPE. There has been extensive Partnership engagement throughout the pandemic response and, in acknowledgement of the high level of staff concern surrounding PPE, a joint statement relating to PPE use and management was approved by the Area Partnership Forum and issued jointly by the Executive Nurse Director and the Employee Director in May 2020.

NHS Lothian is almost entirely dependent on the national and international supply of protected PPE and other essential supplies. Despite the current PPE demands in NHS Lothian being met, there remains a risk of possible insufficient supply of key stock in the future as a result of external supply routes being disrupted due to transport (flights) and factory social distancing measures.

12.2 Medicines and oxygen (piped and cylinders) supply chain

The COVID-19 outbreak has had an unprecedented impact on the medicines supply chain, including:

- Extraordinary increases in demand for ITU and palliative care medicines (i.e. a year's worth of demand within two months)
- Changes in prescribing behaviour including a temporary significant increase in primary care prescribing in late March linked to early patient repeat prescription requests, switches to alternative treatment options to reduce the risk of patient exposure to the virus and some increases in prescription duration.

- Disruption in global supply chains caused by a mix of temporary suspensions at some manufacturing sites in the worst affected countries, reduced international transport links and export bans; over 40 countries introduced temporary export bans on certain medicines.

12.2.1 Overview of current supply position:

Updated modelling work has been undertaken at UK level to assess whether the supply of critical care medicines would be sufficient to meet demand up until the end of July 2020; there is a high degree of confidence that there will be sufficient supply to meet needs over the next couple of months including with a return to business as usual (BAU). The assumptions used in the model were conservative and considered 110% BAU in addition to assumed COVID-19 ventilated patient numbers that were in line with England's national planning assumptions (these numbers are significantly greater than current actual COVID-19 patient numbers within the UK).

Within NHS Lothian the Critical Care and Theatres Surge capacity plan has been reviewed against the critical medicines stock held within the health board across acute hospital sites and there are no concerns at present to be able to meet the anticipated demand. Although overall there is confidence in maintaining supply over the next few months, there are product specific issues that will need to continue to be closely managed. Daily monitoring of the critical medicines will continue as core work of the pharmacy service in collaboration with the clinical teams within DATCC team.

Access to real-time hospital usage and stockholding data across Scotland was an issue during the COVID-19 response period. National Procurement Scotland were able to make assumptions using stockholding information manually supplied by Health Board purchasing teams and average ICU bed consumption data but this was less than ideal. England, Wales and Northern Ireland has been sharing the information it has been able to access through the Rx-Info Define and Extend products. Access to real-time usage and stockholding information for hospitals across NHS Scotland would put us in a much stronger position to respond to future COVID-19 surges. The National Acute Pharmacy Service Group and Directors of Pharmacy in Scotland are currently considering options for funding and implementation of this software.

With regard to oxygen supplies, daily remote monitoring and reporting of the fill rate of oxygen tanks across Scotland with proactive top up by BOC continues; and no issues with supply of oxygen cylinders in NHS Lothian has been identified within the hospital setting.

Within community pharmacy setting the prescription activity has returned to pre-COVID-19 levels and the management of supply problems continues.

To support building resilience over the longer term, consideration is currently being given at UK level to building a strategic stockpile of critical and palliative care medicines; more information on this will be available in the coming weeks.

13. Acute services – scheduled care

The remobilisation for acute services describes a service model which delivers ongoing separation of Covid-19 and non Covid-19 patient flow for out-patients, diagnostics, critical care and in-patients. It is recognised that this plan is dynamic and will be aligned to changing pandemic national guidance and clinical prioritisation framework.

Key focus of the plan is balancing the need for adequate Covid-19 and non Covid-19 capacity on all acute hospital sites; to manage unscheduled demand and enable the increase of elective work for clinically prioritised pathways, whilst having the ability to rapidly flex capacity based on demand.

There are significant challenges in delivering this plan considering the requirement for a risk assessed approach of physical distancing and managing high risk patients including those who are shielded. In addition, loss of productivity in some services including theatres and diagnostics due to PPE donning and doffing and turnaround time depending on ventilation.

The process for remobilisation across acute services is governed through individual site tactical groups, thereafter secondary care tactical group with final approval being given at Gold SMG. The guiding principle being that patients should only attend secondary care if the risk benefit is clearly articulated, and technology enabled care should be optimised.

A summary of how we will undertake this across acute sites and supporting services is outlined below.

13.1 Critical Care

A significant focus within acute has to have an expansion plan that is flexible and responsive to meet both covid-19 and non covid-19 demand on each site. There has been in depth planning undertaken ensuring staffing, resources and supportive infrastructure are in place or can be rapidly deployed to meet changing demand. Our critical mobilisation plans support an increase from 29 level 3 beds to 113 level 3 beds. At the peak of the pandemic response a maximum of 41 level 3 beds were occupied.

As outlined, critical care has identified an extremis surge plan of 113 level 3 beds as required. It will now reduce back to it's original base capacity with the capability to deliver a sustained surge capacity of 74 beds if necessary. Separate Covid-19 and non Covid-19 bed areas will continue on each site. Recent assessment

of ventilation have indicated that recovery areas are less optimal in managing this patient case mix so for WGH and SJH new locations for non Covid-19 ICU have been identified and are opening within the agreed bed base. These two additional areas within Critical care have staffing implications, and until; such time that substantive recruitment can take place has a direct impact on theatre workforce.

Detail of this 74 bedded surge plan is as below:

Site	Covid-19 Critical Care capacity	Non Covid-19 Critical Care capacity	Surge critical care capacity
SJH	2	5	12
RIE	8	21	42
WGH	8	10	20
RHSC	8	11	37
Total excl RHSC	18	36	74

All equipment for short notice increases remains available including ventilator / anaesthetic machines and infusion devices. To date there have been no significant issues with medical supplies or drugs, other than PPE. This will continue to be monitored closely.

There has been significant upskilling of ex and non ICU nursing over recent weeks and plans are in place to ensure these staff continue to rotate through ICU areas to ensure maintenance of newly developed skill sets and competency. The additional staffing in supporting the additional beds have come from a variety of specialties including paediatric ICU emergency department, theatres and recovery staff. Currently many staff have now returned to their original working base and will be redeployed back to critical care as the need arises. It should be noted though that as elective work increases the availability of theatre and recovery staff for ICU subsequently reduces.

Medical staffing has been supplemented through the release of anaesthetic PAs in the case of Intensivist staff with combined job plans. In addition anaesthetic staff have been released due to the reduction in theatre activity. Similar to nursing staff as elective work restarts these staff will not be available.

Conversely the interdependency between expanded critical foot print and theatre capacity is very strong with staffing expertise from anaesthetics and theatre recovery teams required to support critical care; therefore if expanded level 3 capacity is required it will have a direct impact on elective theatre capacity.

13.2 Out-Patient Services

The focus for out-patient services is on managing urgent and Urgent Suspicion of cancer referrals. Referrals are triaged and telephone or near me consultations are undertaken where clinically appropriate and face to face consultations only occur with the clinical benefit of attending secondary care outweighs alternative consultation methods.

Routine out-patient referrals continue to be received and these undergo ACRT and assigned to appropriate pathways such as advice only, direct to test, telephone, near me or face to consultation. No face to face routine consultations are being undertaken and will not under current lockdown guidance. The legacy backlog of routine patients are also being re- assessed through ACRT and where clinically appropriate having advice only, telephone or near me consultation. Again no face to face consultations are being undertaken. Administrative keeping in touch for long wait patients and waiting list validation processes are embedded.

Communication went to GP practices advising:

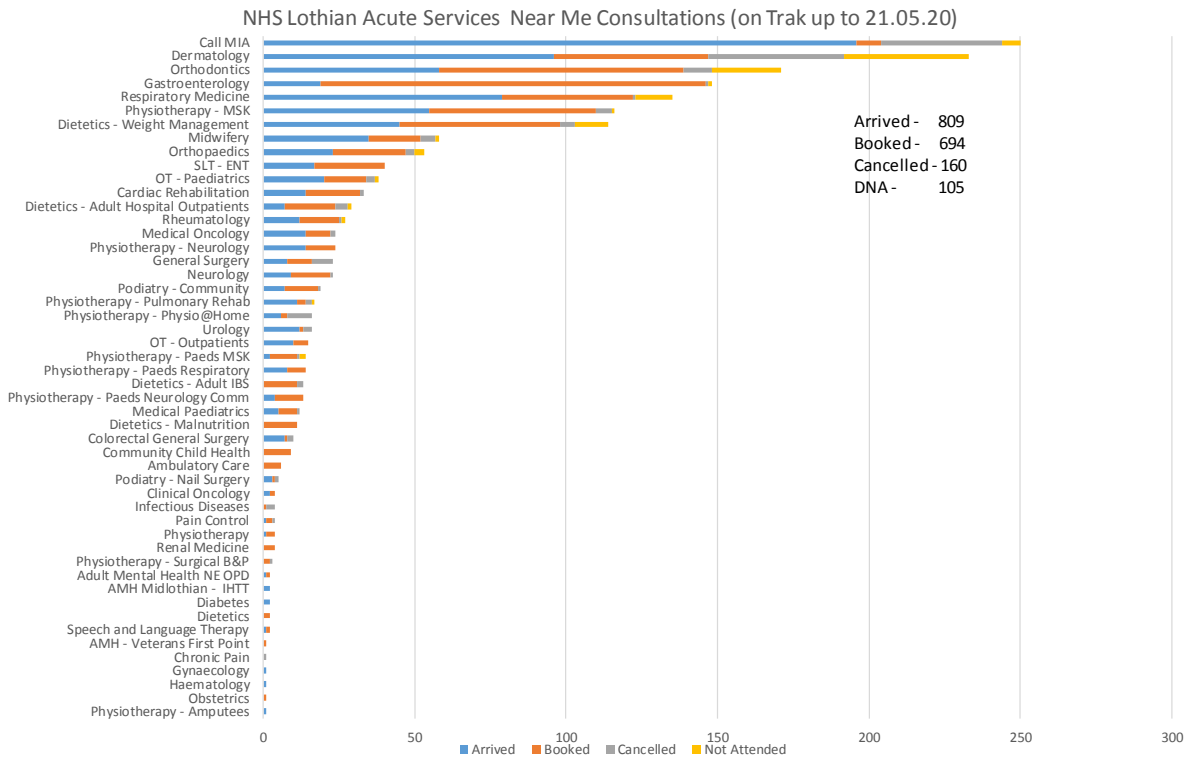
“Out-patients is open to accept routine referrals. At present NHS Lothian Acute Services continue to focus on urgent referrals and patients in line with National guidance.

There are very significant numbers of routine patients on waiting lists which predate the covid-19 pandemic.

Therefore thresholds for future referral for routine non life-threatening problems need to be raised, and be under-pinned by the principles of Realistic medicine. All referrals should adhere to specialty RefHelp guidance. If there are specific concerns you have relating to your patient that will aid the triage of the referral please detail these. All referrals will undergo Active Clinical Referral Triage (ACRT)¹.

A written response giving advice, or telephone/video assessment will be a much more likely outcome than a F2F assessment following referral. Patients need to be made aware of this new way of working and of the extended waiting times for routine referrals, to set realistic expectations”

There is a programme of Near Me roll out across acute services with activity to date summarised in the chart below.



A series of workshops have been undertaken with services to underpin Digital first approach along with embedding full suite of best practice processes such as patient initiated follow up and patient focussed booking, along with modelling alternative access away from acute sites.

An initial assessment of waiting area capacity indicates that only 35% of existing capacity will be available to meet the 2m physical distancing requirement. Practical management of this reduced space, red and green pathways, shielding patients including patient and staff PPE requirements are currently being worked through.

The current impact on out-patient waiting times due to clinical prioritisation is detailed below, and it is anticipated this trend will continue whilst routine patients are de-prioritised.

	Early March 2020	Mid-May 2020	% Change
Waiting List Size – Urgent & Urgent Suspicion of Cancer	7,618	5,576	-27%
Waiting List Size – Routine	52,051	47,997	-7.8%
>12 Week Breaches	21,433	30,952	+44%
>26 Week Breaches	6,886	10,827	+57%
>52 Week Breaches	334	678	+103%

A process of proposed increase in urgent activity is in place through SBARs from acute tactical group to Gold SMG. The increase in urgent activity can be seen as below from April to May and will remain our focus during next phase of this mobilisation plan. With increasing use of telephone and near me there will be an increasing volume of non-face to face routine activity.

	Pre-Covid early March-20	Post-Covid – late March 20	Post-Covid – April 20	Post-Covid – May 20
Average New OP per week – Urgent & Urgent Suspicion of Cancer (USoC)	1,537	1,378	1,636	2,681
Average New OP per week – Routine	3,200	2,120	700	847
Average Return Appointments per Week	14,031	11,868	8,018	Not available

13.3 Cancer

Our focus has remained on providing specialist cancer care where possible.

The Covid-19 pandemic has however had an unprecedented impact on the daily operation of Cancer Services. In managing this evolving crisis, service management teams have been faced with the need to make rapid changes, large and small, to aspects of existing services, treatment protocols, pathways and business practices in order to maintain safe, effective and person-centred care. Notable changes have been made to Cancer Services across complex cancer pathways.

These changes have been designed to reduce frequency of visits to hospital; reduce risk of hospital admission; increase delivery of treatment close to home; improve infection control; and to facilitate remote working of staff. The scale of these changes has resulted in a national change of focus in cancer tracking, from escalation to the accurate recording of patient position within amended Covid-19 cancer pathways.

As the number of patients with Covid-19 infection falls we will embed recovery plans to ensure optimal efficiency and delivery of Cancer Services across the whole pathway. Given the current Covid-19 modelling, it is expected that cancer activity can be safely and gradually increased.

Services within the various pathways will require a flexible approach to optimising use of available capacity in order to provide timely access to care in infection control compliant facilities. This will entail provision of clear clinical priorities and frameworks for step up and step down of service provision, thereby enabling appropriate response to a fluid Covid-19 situation, emerging clinical data and national guidelines.

There will be a recovery phase wherein demand is likely to exceed 'business as usual' rates. For example a number of cancer patients were considered safe to defer for a short period. This has generated a known backlog. These patients will need to re-enter the system soon as they are likely to become time critical in the near future.

In addition, there has been a sustained reduction in the rate of new patients entering the system via USoC referrals or screening programmes. This has generated an invisible backlog. The impact of this is difficult to predict and will be influenced by the timing of key changes such as the reintroduction of screening programmes and business as usual USoC referral rates.

The number of late presentations is expected to increase as a consequence and this may result in a shift of demand from the surgical to the oncology pathway. Although the scale of these challenges may be difficult to predict and quantify with accuracy.

SACT and Radiotherapy Services have maintained close to full capacity throughout the pandemic than expected. Treatment capacity is available in some specialties and recovery SBARs have been submitted and supported to increase SACT, Cancer Clinical Trials, Radiotherapy and Surgery activity and optimise use of available capacity.

Regional and national modelling is underway to predict what any overall cancer backlog will look like and we will take cognisance of this in our mobilisation plans.

	March 2020	April 2020 – <i>provisional data</i>	% Change
>31 Days	96.2%	95%	-1.2%
>62 Days	83.0%	82.3%	-0.8%

13.4 Diagnostics

13.4.1 Radiology

Radiology CT, MRI, General Ultrasound & Barium Studies Pre & Post-Covid-19:-

	March 2020	April 2020	% Change
>6 Week Breaches	661	5,875	+789%

It is vital to remember that the vast majority of radiology requests are routine, and that urgent capacity has been continued.

Radiology is seen as one of our key “pinch points” The radiology service has carried out a clinical triage of referrals with a focus on seeing urgent new and repeat patients whilst maintaining obstetric ultrasound.

The service is currently scoping how they can move some previously unscheduled demand to scheduled care. In addition the service will undertake clinical triage of outpatient requests to ensure suitability for face to face imaging, implementation of a patient-focussed, centralised booking system for X-ray appointments; separate access routes for suspected, confirmed Covid-19 and shielding patients.

Recent clinical prioritisation has created significant delays to patients requiring imaging services. As of 18/05, there are c.7200 unbooked patients, over 75% of whom have been added to lists since March.

Modality	Unbooked Patients
BAR	52
CT	1152
MRI	2409
US	3570
Total	7182

The capacity to clear this backlog, and resume “normal” operations will be significantly impacted by the need to maintain appropriate physical distancing in waiting areas; PPE requirements; and the need for additional cleaning of imaging equipment and waiting areas. It is estimated that waiting area space has been reduced to 40% of baseline capacity across Lothian.

CT/MRI capacity to help address this backlog and capacity constraints is being assessed to optimise use potentially across extended working practice

13.4.2 Endoscopy

Endoscopy services were significantly reduced during March In line with British Society Gastroenterology (BSG) guidance, resulting in only clinically essential procedures being undertaken. This has had a direct impact on the total number of patients waiting and length of wait as detailed below:

Endoscopy Pre & Post-Covid-19:-

	Early March 2020	Mid-May 2020	% Change
Wait List Size – Urgent & Urgent Suspicion of Cancer - Gastroenterology	3,357	3,396	+1.2%
Waiting List Size – Routine - Gastroenterology	766	823	+7.4%
	March 2020	April 2020	% Change
>6 Week Breaches – Upper & Lower Endoscopy and Colonoscopy	2,491	3,693	+48.3%

Actions taken to help mitigate the impact of this service reduction include telephone consultation where clinically appropriate.

As guidance from the BSG has been updated, there has been an incremental increase in the number of urgent procedures being undertaken including a positive bowel screening test, USOC colonoscopy and USOC upper endoscopy

Transnasal endoscopy at Leith Community Treatment Centre will restart when ventilation upgrade completes in the forthcoming weeks, again with a focus on urgent patients.

The national bowel screening programme has been paused. The endoscopy service had 150 positive screened patients waiting for bowel screening colonoscopy. The service reinstated this activity first following publication of the BSG Endoscopy Early Recovery plan and executive team approval of an SBAR which saw activity reintroduced on 11th May 2020.

A further SBAR for urgent suspicion of cancer (USoC) colonoscopy was approved and activity was reintroduced from 18th May 2020. An SBAR to recommence upper (OGD) USoC endoscopy was been approved and activity will commence from 27th May 2020. At present 25 elective patients have been attending weekly. This level of attendance will increase with activity commencing at SJH from this week to incorporate OGD's from 28th May 2020.

Activity numbers per list have been reduced to be able to adhere to social distancing from the patient attending the reception area to discharge, the need for staff to use full PPE and follow infection control ventilation guidance of pausing for 20 minute between cases in units which achieve 15 air exchanges an hour. This level of ventilation is being achieved in the SJH, ELCH and WGH units. The ventilation in RIE unit (4 rooms) is performing at less than 10 air exchanges an hour which requires a one hour pause between cases following the current COVID-19 guidance.

13.4.3 Cystoscopy

	March 2020	April 2020	% Change
>6 Week Breaches – Cystoscopy	599	765	+27.7%

Urgent Cystoscopy patients are being re-triaged by consultants (in date order) with a conversation taking place with patient over phone, resulting in either immediate booking, downgraded or removed. All USOC flexi cysto patients who decline first offer when Covid-19 pandemic started have now been contacted and offered a second appointment – so far 30% up take for appointment. Currently averaging 8-10 lists per week with 8 appointments on each list, focusing on cancers, urgent and urgent check cystoscopy patients.

13.5 In-Patient beds and TTG

The balance between red (Covid-19), assessment (Covid-19) and green (non Covid-19) beds is becoming an increasing pressure as green demand increases both in unscheduled care and increased urgent scheduled

care. Managing high risk or shielding patients in a limited number of side rooms frequently requires beds to be closed in multi occupancy rooms to create appropriate isolation capacity further impacting on available beds.

The ongoing requirement to have designated Covid-19 beds limits capacity particularly for elective activity.

Services are currently undertaking a risk assessed approach to understanding the capacity implications of maintaining 2 metre physical distancing and the impact on services. This impact will be assessed against the need for access to care.

During the peak of the pandemic response there were 701 Covid-19 beds across the adult sector. Current mobilisation plans reduce the number to 231.

Table 1 shows the planned distribution of beds across the 3 acute adult sites and RHSC for remobilisation.

Site	Covid-19 Capacity	Non Covid-19 capacity	Covid-19 assessment capacity	Side Room Capacity
SJH	34	224	14	64
RIE	130	413	34	147
WGH	51	353	26	298
RHSC	16	113		

In-patient activity has been focused on cancer and urgent work, although this has been limited and it is anticipated that this will remain the focus while lockdown measures are in place.

The impact on waiting times is as below, and it is anticipated that this trend will continue.

13.5.1 TTG

	Early March 2020	Mid-May 2020	% Change
Waiting List Size – Urgent & Urgent Suspicion of Cancer	1,677	1,765	+5.2%
Waiting List Size – Routine	9,699	10,289	+6.1%
>12 Week Breaches	3,006	6,689	+122%

	Early March 2020	Mid-May 2020	% Change
>26 Week Breaches	810	1,718	+112%
>52 Week Breaches	61	128	+110%

There is an established process through utilising SBARs where proposed restart is clinically indicated and the capacity has been identified to support increased volumes of urgent activity.

In addition urgent cancer activity continues to be undertaken at Spire Murrayfield for breast, urology and colorectal. We are currently scoping service and activity for the next 3 months, including the option of access to an additional theatre.

13.5.2 Activity to date at Spire

Hospital	Urgent/Cancer	Specialty	Cumulative procedures carried out
Spire Murrayfield	Cancer	Breast	32
		Urology	22
		Colorectal	19
		Total	73

A pre-operative testing process has been developed that includes 14 days of self-isolation and a test carried out 48 hours pre-operatively to optimise the non Covid-19 (green) pathway for surgery. In addition to this a detailed patient information leaflet has been implemented as part of informed consent to ensure patients fully understand the risk of Covid-19 in scheduled care.

13.6 Theatres

The focus of theatre work has been to maintain service to priority level 1a and 1 b and where clinically supported priority level 2 patients.

As the critical beds retract back into base footprint this releases staff - Intensivists, Anaesthetists and recovery nurses back to theatres. This is supporting an increase in the number of category 2 urgent cases that can be undertaken.

Recognising the key interdependencies between theatres and critical care plans detailed modelling work is currently underway to quantify the level of theatre activity that can be safely resumed aligned to level 3 occupancy.

Theatre productivity will remain constrained in the pre-vaccine period due to the impact of donning and doffing of PPE and increased turnaround.

Current modelling shows up to 10 theatres will continue to remain fallow in the pre-vaccine period due to restrictions around staff in higher risk groups who may be shielding, or currently unable to work in clinical areas; PPE requirements; and increased Out of Hours / Weekend provision supporting Covid-19 theatre footprint. Additionally we have implemented an ongoing programme of staff training and exposure to critical care to support rapid deployment if required.

13.7 Laboratory Medicine

Recent sustained increased demand since the advent of Covid-19, driven by growth in requirements for Molecular Virology testing in response to Covid-19 has necessitated a reduction in routine work by 60%. As the need to restart routine work increases, so will demand for Covid-19 testing in response to national drivers around the *Test, Trace, Isolate, Support* Strategy. This will be a significant pressure on Laboratory Medicine for the foreseeable future.

In support of the acute remobilisation plan Laboratory medicine will adapt to ensure social distancing through semi-permanent altered shift systems and adapted workplace environment including provision of PPE where appropriate. Due to an overall increase in demand impact on turnaround times will need to be closely monitored and communicated.

13.8 Medical Physics

In terms of remobilisation Medical physics will continue to support service delivery in line with phased implementation. Recommencing DEXA scanning and nuclear medicine services will be guided by national policy around clinical prioritisation.

14. Unscheduled care

14.1 Scheduled urgent care

We will accelerate plans to schedule unscheduled care. We know that attendances at our acute front doors reduced dramatically in March, however these have been rising again since the end of April. In order to keep attendances at a level that reflects true emergency need and that the department can safely provide care for with appropriate physical distancing in place, we are reviewing how to optimise remote clinical triage models for unscheduled care.

We began a pilot of remote telemedicine minor injuries assessment (Call MIA) on 1 April 2020. This initiative was planned prior to the Covid-19 pandemic, originally focussed on minor injury patients as a low risk group. It is currently running as a 6-month pilot with positive initial evaluation. We are currently viewing to expand this model to a wider group of patients and embed as the 'new normal'. This will allow for initial remote clinical triage with the ability to schedule face to face assessment if required at an acute site.

We have re-started the Access to Urgent Care Short Life Working Group under the Unscheduled Care Programme which has a remit to develop sustainable urgent care pathways that provide the right care, in the right place, at the right time; therefore reducing front door attendances and hospital admissions. It will take a whole system approach to develop:

- community pathways and referral criteria e.g. falls, frailty, respiratory, hospital at home teams
- acute pathways and referral criteria e.g. unscheduled ambulatory care, rapid access clinics, same day access to care;
- an urgent care resource hub to facilitate pan-Lothian access for Health Care Professionals to pathways, including consistent mechanism for professional-to-professional advice (includes collaboration with NHS24 and SAS);
- telehealth and technology alternatives to face-to-face assessments;
- a mechanism for scheduling face-to-face assessments when required, including for Healthcare Professional referrals and self-referrals.

We will build on the role of the Lothian Flow Centre and explore how patients referred by GPs for acute assessment can be provided with a same-day scheduled appointment to better manage demand and reduce the risk of over-crowding.

In addition, our data over recent years clearly shows that older people wait longer in the emergency department as, in general, they have multiple long-term conditions and require more complex care. This is not unique to Lothian and has been well published across the UK. Older people also represent one of the key at-risk groups during the Covid-19 pandemic and therefore there is even more of an imperative to provide care to this group of patients closer to home, both providing better quality of care and patient experience, and reducing the risk of exposure to Covid-19 in a hospital setting. As such the Unscheduled Care Programme Board has agreed to embody the new pan-Lothian Home First principles through an older peoples' work-stream that will develop the best way to:

- increase prevention strategies to keep people well at home, building on the work in Midlothian to identify all frail residents via use of the electronic frailty index
- increase capacity within Hospital at Home services and work to a consistent pan-Lothian approach
- provide community-based elderly medicine teams with a focus on keeping people away from hospital
- provide a separate elders flow through the acute front door, adding to the current minors and majors flows, with frailty units in or as close to the ED as possible
- increase use and capacity of discharge to assess teams to support older people return home or to a homely setting as quickly as possible after receiving necessary hospital treatment

14.2 COVID-19 Community Hubs

The rapid implementation of the Community Covid-19 Pathway service has demonstrated the ability to safely and effectively provide Covid-19 advice and care to patients in the community via primary care telephone triage, with the ability to schedule same day face to face assessments where required. The numbers of patients requiring secondary care assessment has been extremely low with excellent pathways in place from primary to secondary care.

This model has required initial telephone triage by non-clinical NHS24 call handlers, with secondary clinical telephone triage largely provided by GPs. Discussions are taking place with the aim to use a similar primary care 'gate-keeping' model to ensure patients receive the right care in the right place at the right time.

There are a number of challenges to work through how a model used to manage one specific condition could be applied to all conditions presenting that require urgent care, however, the benefits of skilled clinical telephone triage in providing advice, reassurance and access to scheduled same-day appointments are clear to see. The learning from the Community Covid-19 Pathway will feed into the broader work described above

to provide an increased volume of scheduled urgent care, therefore reducing demand at our acute front doors.

15. Primary Care

A Primary Care Tactical Group was established in March 2020. This deals with all issues relating to the 4 independent contractor services and all cross over issues with other groups e.g. Care Homes, PPE etc.

15.1 District Nursing

District nursing (DN's) continues to provide an essential community response to COVID and non COVID pts. Those who were undertaking DN training have been taken out of their training programmes and have gone back to support front line care. We are now reviewing when we can recommence this important training safely as we need a future pipeline of DN's.

District nurses have also been support the endeavours around supporting care homes in their local areas and this will continue and we will look at how we backfill any DN time that might be required to be support through the additional students, returners and those who have registered on the staff bank.

15.1 GP services

15.1.1 In hours

NHS Lothian has worked closely with GP Sub Committee and HSCPs to support and sustain practices including joint development of "practice action plan" templates (covering separation of patients flows, use of PPE, use of phone triage and video consultation), provision of PPE, provision of technology for digital working, agreement of temporary cessation of non-essential services.

Practices have largely completed the initial work required in the Shielding plan including anticipatory care planning conversations with patients/families/carers. Over time new patients will be added to the shielded groups and practices will take the same approach with them. Additional costs of this work have been covered in the £15m additional funding to general practice, and continuation for additional patients may incur additional costs. Scottish Government has already signalled that more funding will be available.

15.1.2 Out of hours

NHS Lothian has sustained the out of hours service (one base was reduced to accommodate a Covid-19 assessment centre). The service has adapted quickly by increasing clinical triage and expanding “near me” use. The service also led work on some aspects of care home support e.g. urgent end of life medications, e-prescribing and worked closely with the Covid-19 pathway.

15.1.3 Remobilisation

A dedicated GMS remobilisation group (in and out of hours) has been set up to manage the next steps. The work will include how to safely manage the upward trend in demand for primary care access following the dip in demand in the early stages of the pandemic, maximising use of technology (total telephone triage, near me, online access) to reduce face to face interactions, longer term premises issues to maintain safe movement of patients and staff, evaluation of temporarily ceased non-essential services, maintaining flow of PPE, planning for the 2020/21 seasonal flu campaign, review of 2020/21 GMS contract plans in light of the pandemic. Some practices in Lothian will have unique issues to address including the Access Practice which has moved to 7 day working and the University Practices which may see significant decreases in list size. It is intended to continue the “practice action plan” approach of providing consistent, strong, supportable guidance to practices.

Practices have been resilient through the early stages of the pandemic, despite spikes in partner and staff absence related to Covid-19. Practices have been supported financially to cover this through the £15m additional funding and changes to the SFE. Going forward there is a risk that "Test, Trace, Isolate, Support" could result in higher numbers self isolating and possibly on multiple occasions. In response to this practices and HSCPs will review their "buddy" plans to ensure they can be brought into action quickly if necessary.

We will review the Covid-19 Pathway hub and assessment centres to ensure capacity matches current demand with 50% flexibility built in to meet the initial stages of any increase in infections, but not as significantly above demand as it at present. This will minimise the call on staffing but ensure a 24/7 service with short notice additional capacity built in

We will also review the work of the Unscheduled Care Resource Hub Board which led the implementation of the Ritchie Report on out of hours services, continue the expansion of “near me”. It is assumed that the Covid-19 Pathway will remain in place and will operate 24/7. The Remobilisation Group will take responsibility for Lothian wide interface issues with other groups e.g. Care Homes.

15.1.4 Interface between primary and secondary care

NHS Lothian has well established interface mechanisms between primary and secondary care through the Lothian Interface Group, the Laboratories Interface Group, the “RefHelp” system and the eLJF (Lothian Joint Formulary). We will review the functioning of these groups as part of the remobilisation planning.

15.1.5 Flu Vaccination Programme

We have begun planning for the 2020/21 flu vaccination programme. We are anticipating a 10% increase in demand for vaccination. Under the MOU for the new GMS contract it had been planned to transfer this work away from general practice, but this will be reviewed for 2020/21 season. The programme will have to take account of social distancing requirements which will prevent some of the previous "mass" clinic approaches and may require a new approach to venues.

15.2 Dental

All General Dental Practices ceased seeing patients face to face in March 2020. All operate a phone triage system and can make referrals to the Urgent Dental Care Centres (UDCCs) provided by the (PDS). There is growing concern that significant underlying disease with symptoms that do not meet the thresholds for the UDCCs is being untreated. NHS Lothian has begun to extend the number of centres and the range of treatments provided in response to guidance from the Chief Dental Officer. The numbers of centres will continue to increase over the next week. The PDS and secondary care dentistry have also severely restricted services and are only seeing emergencies and patients triaged from GDPs. Currently the routine paediatric dental general anaesthetic service has ceased during the COVID-19 response. Re-establishment of this critical service will be a priority for the secondary care team. NHS Lothian has established a dental remobilisation group. This includes GDS, PDS/secondary care, Public Health and Contracting. There are major issues including safety of patients and staff of reintroducing AGPs into dental surgeries, with a particular challenge about surgery “downtime” after an AGP to allow aerosols to settle. There are also limitations of many GDS premises in terms of social distancing, concerns about water security, demand for very different PPE as services are reintroduced and dentists becoming familiar with its use. There are also limitations of the Dental Institute and PDS premises in terms of social distancing (for treatment and particularly for teaching). The structure of the GDS contract with its major item of service element and limitation of services that might be delivered within practices may result in threats to practice financial viability. To a significant extent the work of this group will be driven by national decisions on reintroducing services and remuneration of dentists. These themes are reflected in the most recent letter from the CDO setting out in broad principle a

pathway back into activity for dental primary care with a phased program and an early suggestion that the financial model during the early phases of recovery may not be so focussed on item of service payments.

15.3 Pharmacy

All community pharmacies in Lothian have remained open and worked closely with other services to ensure patients continue to receive their medications safely and in a timely manner. Pharmacies have worked with HSCPs to ensure the most vulnerable patients get their medicines delivered. We have maintained substance misuse services including provision of injectable equipment, planned for prisoner liberation, strengthened Palliative Care Pharmacy Network arrangements and utilised remote solutions e.g. ECS access for all pharmacies, use of clinical mailboxes to communicate with GP / LUCS / Dental and Optometrist prescribers, and enhancing the palliative care network and access to end of life medications. There have been a small number of adaptations to maintain infection control (e.g. risk assessment based reduced supervision of Opioid Substitution Therapy and pausing breath testing and CO monitoring for alcohol and smoking cessation services). NHS Lothian has agreed some flexibility for pharmacies in terms of public facing opening hours to enable the pharmacy to manage prescription volumes and cleaning regimes. NHS Lothian has established a pharmacy remobilisation group including Pharmacy Contractors, the Pharmacy Directorate and Contracting. The issues for pharmacy will centre around the implications of social distancing for premises and staff, how to reduce and safely manage face to face contact. Community Pharmacy is enthusiastic to embrace the new ways of working, to launch Pharmacy First Services, to optimise repeat prescribing systems through serial prescribing and to increase uptake of services such as EHC and smoking cessation through ehealth solutions such as NHS NearMe.

15.4 Ophthalmic

All General Ophthalmic Practices ceased seeing patients face to face in March 2020. All operate a phone triage system and can make referrals to the Emergency Eye Treatment Centre provided by NHS Lothian. There is growing concern that significant underlying disease is being untreated. NHS Lothian has established an Ophthalmic remobilisation group including Ophthalmic Contractors, Ophthalmology and Contracting. There are major issues including safety of patients and staff of reintroducing face to face examination into ophthalmic premises, the limitations of many GOS premises in terms of social distancing, increasing demand for PPE as services are reintroduced, the structure of the GOS contract with its major item of service element and threats to practice financial viability. To a significant extent the work of this group will be driven by national decisions on reintroducing services and remuneration of optometrists.

16. Working with our local authority and integration authority partners – Health and Social Care Partnerships

Our Health and Social Care Partnerships are key to our effective response to this pandemic and their own remobilisation plans are summarised in the following pages. These are all based on the mobilisation plans as submitted in March.

16.1 East Lothian HSCP

16.1.1 Care Homes

Care home access is coordinated by East Lothian patient flow team and social work. The existing East Lothian Care Home nursing team will be extended and restructured to support all care homes within East Lothian through education input and Nurse Practitioner support to anticipatory care, long-term conditions support and to respond to acute illness presentations in residents. The team will link with the GP practices covering each Care Home Care Home for medical advice as required local Service Level Agreements and in line with GMS Local Enhanced Service arrangements.

Governance arrangements for East Lothian are under the oversight of the Chief Nurse as per Scottish Government instruction of 17/5/2020. Care Home occupancy, staffing, infection control and outbreak status will be managed through the Care Home Operational Group.

There will be increased use of telephone assessment by the care homes rather than face-to-face, reducing time delays to assessment and reducing delays to discharge, and ultimately occupied bed days.

Remobilisation resource:

- Increased care home team staffing
- Increased management resource for oversight of all care homes

16.1.2 Social work capacity

Adult social work input will be delivered primarily by telephone and video conference, with any need to conduct face-to-face appointments (e.g. adult protection investigations) risk assessed on a case-by-case basis.

The Social Work Team capacity is monitored weekly, including waiting lists for assessment and allocation. East Lothian is currently experiencing a 30-40% reduction in referral demand. It is however, experiencing increased concerns from informal carers about the ongoing strain of supporting relatives and concern about available alternative arrangements when people return to work.

It is anticipated that additional staffing will be required to facilitate the social work contribution to the Care Home governance and support activity.

It is also anticipated that additional staffing may be required to support assessment and review of individuals who experience reduced independence post COVID-19 infection/shielding.

Remobilisation resource:

- Provision of IT equipment to allow Social Work Staff to work remotely and effectively
- Additional Adult Social Work posts

16.1.3 Social care capacity

Access to social care, particularly care at home for all client groups, i.e. over 65s, people with mental health needs, people with learning disability, people with physical disability/long term conditions is monitored on a daily basis.

All direct service provision is carried out on a face-to-face basis and requires constant risk assessment to ensure safety and wellbeing of all concerned. The service is dependent upon ongoing robust supplies of suitable PPE.

There is a concern about ongoing capacity, once the general workforce begins to return to work. This is informed by the research suggesting people who have been housebound due to shielding, or who have had COVID-19 may need significantly longer periods of rehabilitation and is therefore is at increased likelihood of presenting with a social care requirement for both personal and non-personal care tasks to prevent care home admission. It is acknowledged that older adults, people with underlying health conditions and people with learning disability are all vulnerable.

The expected continuing lack of availability of day care/day support for these groups may exacerbate the need for care at home or similar input.

Teams will require significant input in terms of redesign of their services in order to reduce use of buildings and will need better connections with Care at Home and community resilience groups.

We anticipate support to our care providers will be required to maximise availability of carers.

Care at home capacity could increase with more people seeking to work in the care sector. However, the establishment of the Test, Trace, Isolate, Support approach may reduce the available workforce for a period. This may bring a need to support providers to access 'bank' staff through the Scottish Social Service Council

(SSSC) portal or directly through other agencies or HSCP staff and will require continuing monitoring and risk analysis of services.

Where possible, increased utilisation of telecare and support to providers to make use of it, will be implemented to reduce visit frequency.

The HSCP will provide increased support to Care at Home providers to ensure the maintenance of infection control and prevention through the establishment of a team to oversee social and clinical aspects of service delivery.

Remobilisation resource:

- Establishment of a Support Team to maintain Care at Home standards
- Increase number of Support Workers to meet additional demand

16.1.4 Rehabilitation services

Rehabilitation services are key to maintaining independence, keeping people out of hospital and reducing pressures and costs on all parts of the Health and Social Care system. East Lothian is in the process of a significant increase in population. The services providing rehabilitation support to these patients must increase their capacity in order to meet growing and increasingly complex needs.

Rehabilitation at all stages – in hospital and in the community is critical to keeping the flow of patients moving, freeing up beds and creating capacity to treat more critically ill patients.

The pandemic is highlighting the requirement for a highly advanced level of community rehabilitation. Alongside those recovering from COVID-19 are large numbers of people with long-term conditions, musculoskeletal problems, falls, reduced mobility and a significant increase in chronicity and severity of routine issues that have not been addressed during this time. There will be a requirement to address not just physical complaints, but psychological and cognitive challenges.

In order to provide appropriate capacity to meet need, East Lothian Integrated Rehabilitation Service requires additional staffing to support changes in the way services are delivered.

The service plans to embed Technology Enabled Care in all AHP services and provide access to remote working Advanced Practitioners using the 'Near Me' platform and via telephone. This service change can be met by an additional WTE Physiotherapist and Occupational Therapist, an additional Advance Physiotherapy

Practitioner and an additional Community OT Senior Practitioner to lead and develop the request for assistance model.

Post-COVID-19 Specialist Pain Management will be indicated; for patients who are recovering from Coronavirus, NB central sensitisation; and for those with pre-existing complex health co-morbidities experiencing the secondary effect of increased pain due to sedentary behaviours as a result of self-isolating. A 0.4WTE Band 6 Specialist Pain Physiotherapist would be sufficient to meet the needs of patients across East Lothian.

Post Intensive Care Syndrome (PICS) describes the bio-psycho patient presentation after critical illness. Specialist Mental Health Physiotherapy intervention (1.5WTE) would address this complex condition.

Remobilisation resource:

- Additional Advanced Physiotherapy Practitioner, Physiotherapist, Occupational Therapist posts

16.1.5 Risks

- Workforce stability and ability to recruit, in particular to Nurse Practitioner and Advanced Nurse Practitioner posts
- Increased demand on adult protection and mental health
- Increased acute demand due to reduced routine care access to services
- Deterioration in some long term conditions due to reduced engagement with primary care and specialist clinics
- Significant mental health demand from Covid-19 related anxiety
- Finance pressures from additional costs to operate less efficient services

16.1.6 Delayed Discharges

Continued focus on maintaining an improved performance in relation to delayed discharge and admission avoidance.

Shift of focus from multi-disciplinary team (MDT) meetings to coordinated discharge planning on ward rounds and continue conversations with patients and relatives to fully embed the home first philosophy. This will include working towards fully implemented nurse-led discharge. Through time, this will reduce the need for additional inpatient capacity.

The expansion of the daily safety huddle to include all disciplines to ensure good communication and MDT working to reduce delays.

Additional staffing resources in Hospital to Home (H2H) Discharge to Assess (D2A) and other services already costed in mobilisation plan.

16.2 Edinburgh Health and Social Care Partnership

EHSCP produced a Mobilisation Plan at the end of April which remains extant and has been instrumental in creating capacity and improving flow in acute hospital sites and within community services in Edinburgh. In response to the recent directive issued by the Interim Chief Executive of NHSS, EHSCP has been requested to provide input to the NHSL re-mobilisation plan, which looks out initially to the end of July. This input reflects the current status and emerging activity in relation to key functional areas. In parallel, the Edinburgh Integration Joint Board will be considering its return to transformation programme to ensure that its strategic aspirations as a Public Body remain relevant in response to the ongoing COVID-19 situation.

16.2.1 Care Homes

There are 65 care homes in the City (9 internal) providing 2,734 places for people. The recent Scottish Government guidance on Care Homes is being analysed and implemented accordingly. Problem Assessment Groups (PAGs) and Incident Management Teams (IMT) are in place to support the EHSCP response team, in partnership with NHSL Public Health and Health Protection colleagues, to provide direct support to care homes where there is an identified outbreak or other high risk. The EHSCP response team is in daily contact with our care homes and work closely with our partners CEC, NHSL and Scottish Care. Public Health are conducting a phased approach to staff testing, within current guidance to make best use of resources and reduce the risk of reduced staffing levels due to self-isolation following testing. Each care home is required to have in place its own resilience plan to cope with staff shortages initially and as part of our overall contingency plan, we are also working with NHSL staff bank in order to provide staff to care homes at short notice should first line resilience plans prove unable to close potential staffing gaps

16.2.2 Care at Home

Pre-COVID-19, c105,000 hours of home care **per week** were delivered by a combination of a small (15% market share) in-house care at home/enablement service and around 94 external providers. The EHSCP Mobilisation Plan sets out options to purchase all available homecare; increasing the number of providers working with us to include those private homecare providers not on our contract framework, as well as purchasing on a temporary basis 'Safehaven' beds in private care homes to support people out of hospital. We are in the final week of the 'Delivering One Edinburgh' programme which is facilitated by Price Waterhouse Cooper. This includes:

- Development of a proposal for a central command centre comprising a single scheduling tool and performance dashboard which would enable daily management of carer supply and demand and conversations around care quality.
- A comprehensive communications plan to provide a clear oversight of all relevant stakeholders, the level of engagement that EHSCP will need to offer and how to approach communications throughout the project and in the future.
- Development of a Homecare Assessment and Implementation plan. This will set out what we collectively want to achieve in the future and the key areas for focus along with a clear indication of steps needed and key requirements including resources.

The output from this work will then inform our ongoing conversations with the Scottish Government in terms of next steps. The intent is to optimise the available care provision in the City in such a way as to reach a sustainable and efficient service delivering agreed priorities and value for money.

16.2.3 Risk

A comprehensive EHSCP risk register which informs the EIJB, CEC and NHSL corporate risk registers is updated daily. There is active monitoring of our key risks and contingency plans in place as part of our resilience framework. The EHSCP command centre collates data daily and maintains constant oversight of our operations and with the workforce planning team reacts as and when required to ensure safe staffing levels are applied.

16.2.4 Delayed Discharge

On 9 March 2020 there were **169 delays with 114** of these delays being within acute sites. As part of our mobilisation plan, we accelerated our Home First Edinburgh strategic objective to deliver a high level of co-operation with acute colleagues and the application of a community approach focusing on meaningful conversations with patients and their families. Capacity across the system was also created by mobilisation funding to secure available care home capacity and 'Safehaven' beds. Going forward we will have to consider the impact of those people in 'Safehaven' beds who may or may not require long term care and how best to manage this.

The effect of our mobilisation plan has contributed to increased flow across the system and a reduction in delays with **71 delays, 28 on acute sites**, as at 19 May. In keeping with our strategic plan, the intent is to build on the success of the Home First approach and deliver a sustainable model to endure post COVID-19.

16.2.5 Primary Care

The Strategic Primary Care Team in Edinburgh will continue to respond to EHSCP, NHSL and Scottish Government direction and guidance. The team is facilitating and leading work to support the implementation of TTIS and to ensure the flu vaccination programme can be delivered across the City. The team are helping Practices to reorganise and/or adapt their premises to minimise risk of infection spread to patients and staff and to adjust their ways of working with new technology and the lessons learned during COVID-19. Work is underway to secure a local distribution network for PPE which takes account of variations in supply. There is active work underway to encourage Practices to consider carefully how to support the positive changes in 'health-seeking' behaviour made by patients supported by the ongoing insight work to assess changing workloads and patient demand. The additional needs of vulnerable groups including mental health, substance misuse and the impact of poverty which Practices are likely to experience will be considered as adjustments to the Primary Care Implementation Plan, with an emphasis on encouraging the heightened sense of partnership working which has characterised the response to COVID-19 to date.

16.2.6 Mental Health

The plan to safely reinstate our clinically prioritised mental health services is being coordinated by NHSL as part of the re-mobilisation plan. In addition, EHSCP is:

- Providing weekly updates to stakeholders including statutory services on 3rd sector support and interventions for people experiencing distress and mental health problems
- Ensuring that people who are shielding, and other vulnerable groups who are being asked to self-isolate have access to the national programme delivering distress brief interventions which will be available in Edinburgh from in early June. The programme includes peer led groups, individual support and group support delivered through digital platforms and by telephone
- Introducing fast track opiate replacement therapy in different settings including prison
- Publishing weekly Thrive Edinburgh Briefings which are disseminated widely and feature information and resources on all the wider social determinates of health and wellbeing
- Providing "Bags of Thrive" with activities and self-care products for individuals and families who may not have access to digital resources
- Commissioning research on the impact of COVID-19 on people rights which may already be compromised due to mental health and legislation

- Reassessing community detox including a managed alcohol pathway for the most vulnerable
- Developing options for all homeless people to continue to have good quality single room accommodation with en-suite facilities and high-quality shared space

16.2.7 Adapting our Transformation Programme

The existing framework for our strategic transformation programme is a strong foundation for the strategic change we want to deliver in Edinburgh. Throughout our response to COVID-19 we have been capturing 'lessons learned' from across our teams, to better understand the impacts, challenges and opportunities presented. We are using this 'lessons capture' exercise to inform the review of our transformation programme, ensuring that the scope and phasing continues to reflect our main strategic ambitions and incorporate this valuable learning into our service redesign plans. New priorities are emerging, in particular around opportunities for digital transformation. This includes the potential for additional investment in 'Near Me' technology, which has been used so successfully in Primary Care, to facilitate remote service delivery in a wider range of teams across EHSCP. We are also exploring the concept of a 'One Edinburgh' approach to community planning, which would see the EIJB work with a wide range of partners in the development of a common strategic plan for the City building on the objective set out in our strategic plan of delivering an Edinburgh Pact. Re-prioritising projects within the transformation programme will allow us to re-focus on other core elements such as Three Conversations and our future bed base which are central to our strategic plan. The revised transformation plan will be presented to the EIJB for approval on 21 July 2020.

16.3 Midlothian Health and Social Care Partnership

The Midlothian Health and Social Care Partnership serves a population of 91,340.

Midlothian HSCP produced a Mobilisation Plan at the end of April which continues to underpin much of the activity and investment locally to allow the Partnership to provide an effective and appropriate response to the COVID-19 pandemic. The strategic approach to the Midlothian pandemic was described in the Midlothian COVID-19 Response Plan.

When planning services for the period to end of July as requested by the Scottish Government, Midlothian HSCP acknowledges its joint work with core partners, notably NHS Lothian and Midlothian Council but also organisations that form the Midlothian Community Planning Partnership.

This document provides key areas for inclusion in the NHSL re-mobilisation plan, which covers the period to the end of July.

16.3.1 Care Homes

There are 10 older people and 3 learning disability care homes in Midlothian as well as one older people intermediate care facility. In total there are 536 places for people. One older people care home and the intermediate care facility are internal.

In line with recent Scottish Government guidelines relating to Covid-19 management in care homes and the amendments to the Coronavirus legislation, work will be progressed promptly to agree and establish local clinical governance arrangements.

A daily Sitrep is received from each care home. Problem Assessment Groups (PAGs) and Incident Management Teams (IMT) are in place to support the Midlothian HSCP COVID-19 Management Team, in partnership with NHSL Public Health and Health Protection colleagues, to provide direct support to care homes where there is an identified outbreak or other high risk. Representative(s) Midlothian Care Home Management Team is in daily contact with our care homes and hosts a care home support meeting three times a week at which managers from all older people homes participate. We continue to work closely with our partners Midlothian Council, NHSL and Scottish Care.

Midlothian HSCP has agreed to be a local pilot site for Test, Trace, Isolate and Support. Working with colleagues in Public Health we will conduct a phased approach to staff and resident testing. This should assist to reduce transmission of COVID-19 to and within care homes. This will be arranged in a phased and

managed way. Resilience plans are in place, in particular around additional staffing, should there be a number of positive results

The care home workforce is an area of ongoing development and this will continue. Midlothian District Nurses and the Care Home Support Team now provide a 7 day support service to local care homes from 8am to midnight. Work will continue around the recruitment and redeployment of staff (in care and support roles) and the recruitment of locum staff. Staff training, will continue to be prioritised, as will work on the clinical support worker model.

Each care home has a resilience plan. These are reviewed regularly.

16.3.2 Care at Home

Care at Home continues to be a key contributor to the Partnership's vision for people to receive the right care in the right place, in their home and community as far as possible. It supports efforts to reduce delayed discharges and well as admission avoidance.

Care at Home is currently provided by an in-house service and three external providers. All four work in partnership to coordinate the provision of 2000+ hours of care per week. The referral process has been amended to increase geographical allocation and improve efficiency.

Midlothian HSCP has a Vision for Care at Home approved by the IJB in February 2020. This includes plans to increase care at home capacity and an approach to commission for outcome focussed/person centred care.

The Midlothian HSCP Mobilisation Plan described plans to increase Care at Home staff numbers by 50 wte carers over 9 months. So far 23 posts (many locum) have been recruited so this work will continue for the next 6 months as previously indicated. The recruitment of locum workers has also increased and will continue to be a focus.

16.3.3 Primary Care

The Midlothian Primary Care Team will continue to respond to HSCP, NHSL and Scottish Government direction and guidance.

The team currently supports the work of the Midlothian COVID-19 Assessment Hub and will be crucial to decisions around the future model of COVID-19 assessment and treatment of Midlothian residents.

Primary Care colleagues are also reviewing and developing local services in line with Government guidance including those around physical distancing.

This includes plans to reintroduce services that were temporarily suspended or changed as a result of COVID-19, such as the primary care MSK physiotherapy service.

Work will continue to explore the use of digital solutions when meeting with patients, such as Near Me. The IT infrastructure will be a focus of activity moving forward. This includes telephony capacity and the introduction of digital interfaces such as e-consult.

Communication and engagement with local communities around significant service change is part of the discussions with primary care colleagues.

Expansion of primary care services in Midlothian will need to be progressed – for example the Initial Agreements for South Bonnyrigg and Shawfair/Danderhall and other capital investments identified in the PCIP

Existing premises will require to be adapted to manage risk, in particular around infection control.

The CTAC model and winter planning, such as the flu vaccination programme, will also be progressed in the next three months, being cognisant of ongoing COVID-19 and the challenges that brings. The additional resource that will be required to deliver the flu vaccination programme this year could be significant.

16.2.4 Mental Health and Substance Misuse

The plan to safely reinstate our Lothian in-patient and other central mental health services is being coordinated by NHSL as part of the re-mobilisation plan. This includes plans around LEAP (currently closed) and alcohol detoxification at the Ritson - to open 2 beds in the near future. Referrals have continued, but long waiting list.

Midlothian HSCP will continue to maintain contact with stakeholders, both statutory and third sector, around service provision and managing risk.

We will work with partners in REAS around **psychological therapies**. Patients currently in therapy have been contacted and offered therapy by telephone/Near Me, or the option of putting therapy on hold till face to face contact can be resumed.

Psychology groups for patients have been paused eg. Emotional Resources, Survive and Thrive; there are plans to reinstate these online. Other on-line group meetings are running (mindfulness, SMART, mutual aid) via Zoom (if they have means to do so). Patient access to these need consideration – especially those with limited resource or no access to WiFi.

Midlothian Intensive Home Treatment Team continues to offer a full service.

People with **dementia** will continue to be offered face to face appointments within the social distancing guidelines if they are unable to engage with virtual appointments.

The **Primary Care Mental Health Team** is offering patient assessment and consultation by Telephone / Near Me. Home visits are offered to those requiring such under appropriate guidelines.

All staff caseload has been risk-assessed using a Red, Amber, Green system. We are monitoring staff experience of delivering therapy by telephone as well as staff wellbeing as a result of these changes.

At present peer led groups, individual support and group support are being delivered through digital platforms and by telephone. This will remain under review and a phased increase in face to face support will be planned in line with government guidance and an ongoing assessment of risk

Mental health and substance misuse services will continue to work with council and third sector partners around support to people in **homeless** hostels. Plans to further reduce B&B use for homeless individuals is welcomed although providing support with current restrictions will be a challenge.

People accessing the **Learning Disability Service Patients** have had access to all disciplines within the CLDT. Telephone consultation is the preferred method of contact with home visits taking place if necessary following risk assessment. Moving forward, the need for direct patient care will continue to be risk assessed on an individual basis. The use of Near-Me video consultation for patients/support staff will continue to expand where the appropriate access to technology is available.

16.3.5 Improving flow from acute care

Midlothian Community Hospital: Significant changes to the configuration of Midlothian Community Hospital have been made in response to the COVID-19 pandemic. Work continues to increase beds opened to improve flow from the acute hospitals and to provide care to people closer to home.

Sixteen additional beds will be available once the appropriate workforce is available. The use of the additional beds will be under regular review.

Intermediate care Services: Midlothian's **Hospital at Home** and **Discharge to Assess** services have increased in capacity to support the ambition of Midlothian HSCP to transfer people home from hospital, or avoid admission, at the earliest opportunity. It is the intention of Midlothian HSCP to maintain additional capacity on such services of the next 6 months.

District Nursing capacity has been increased to provide additional support to Care Homes and to support people at home.

16.3.6 Supporting People to Stay Well at Home

A key component of Midlothian HSCP response to the pandemic has been to support people to stay well at home and avoid hospital admissions.

Additional physiotherapy capacity was made available to the **Community Respiratory Team** by redeploying and retraining the primary care MSK physiotherapists. As the MSK physios return to their primary care role, further consideration of support to CRT will be required.

16.3.7 Socio-Economic Impact and Inequalities

There are many groups in society who have been hit harder by the COVID-19 outbreak: not only older people and those with underlying health conditions, but those who are vulnerable simply because they do not have the same opportunities to stay well. These groups are already at the sharp end of health inequalities and most likely to be affected by low paid work, unemployment, zero-hour contracts, overcrowded households, reduced access to resource to aid home schooling and other activities during lockdown, underlying health issues, poorer mental health, and so on.

We know that inequalities impact on people's health and wellbeing. In Midlothian we have made a commitment to tackle health inequalities and have invested in public health. This is an area that will require particular attention moving forward if we are to mitigate some of the impact of the pandemic. In addition we anticipate a greater demand on other services most associate with inequalities such as mental health, type 2 diabetes, substance misuse, heart disease, etc.

At this time it is important that access to **welfare rights support** is as accessible, or more accessible, than ever. Links with food banks and other support, similar to that provided to those shielding, should continue.

While **housing and homelessness** are not directly the responsibility of the HSCP they are important to the ambitions and values of the Partnership and joint working moving forward will be crucial.

16.4 West Lothian Health and Social Care Partnership

The West Lothian Health and Social Care Partnership responded to the Covid-19 pandemic through a range of measures designed to ensure that essential community health and social care services continued. The focus of activities going forward will be on maximising opportunities to prevent hospital admission where possible and the timely discharge of patients from hospital to free beds for acute care. The partnership will continue with activities as outlined below having regard to the need for sustainability, physical distancing and national approaches to testing and infection prevention and control.

16.4.1 Care Homes

The delivery of safe and effective care to people who live in care homes remains a priority going forward. The partnership will work alongside NHS Lothian leads to implement the oversight arrangements for care homes through the measures outlined by the Scottish government. Sustainability of the care home sector is an important factor in delivering high quality care and the partnership will continue to support care homes ensure places continue to be available to those who need them.

16.4.2 Social care capacity

The partnership implemented a new care at home contract on 1st October 2019 and work continues with independent social care providers to develop a sustainable supply of services to meet future demand. Providers have been able to recruit additional staff in recent months which has enabled more people to be discharged from hospital and resulted in a significant reduction in the number of delays. A key priority for the partnership going forward will be continued engagement with providers to maintain this improved supply.

Additional payments are being made to care at home providers to assist with financial and operational challenges. The payments are in addition to budgeted increases to uplifted rates that apply from 1st April 2020. A flexible approach has also been introduced to keeping packages of care open beyond 7 days where discharge is planned.

There is clear focus on the use of technology and phone contacts where possible via a single point of contact for social care assessment. A dedicated resource for securing packages of care for hospital discharges has

been piloted in the Integrated Discharge Hub with positive results. Learning from this approach will be used to develop a revised hub staffing model. A co-ordinated approach is also being taken across health and social care services to eliminate visit duplication where possible and will continue for the coming months.

Work is ongoing to deploy staff from NHS and WLC teams to support delivery of personal and social care. Opportunity to continue this approach may, however, be restricted when services begin to increase capacity and staff revert to their substantive roles.

16.4.3 Risks

Social care providers have reported increased ability to recruit care staff since the beginning of the pandemic which may be in part due to limited employment opportunities elsewhere.

The need for physical distancing will continue to impact the overall capacity of services to increase business activity and will result in an ongoing need for PPE.

There may be reduced capacity for using agency staff where use would result in staff working across services and service providers.

Care homes may face increasing financial risk where business is impacted by empty beds.

The impact of testing on the availability of staff is as yet unknown but there is a risk to service sustainability if significant numbers of staff are required to isolate.

16.4.4 Delayed discharges

A range of concentrated activities have been identified to reduce delayed discharges from a baseline of 65 at 1st March 2020. Enhanced services include:

- A single manager overseeing all integrated discharge hub activity
- The permanent establishment of a Home First Team to prevent admission and facilitate early discharge, ensuring that decisions on future care are made in the most appropriate setting. Acute and community AHPs have been enhanced to support this function over 7 days
- A single referral route and daily huddles to allocate discharge activities
- Establishment of a core social work team to focus on hospital discharges and social work support to ED and the Medical Assessment unit in St John's hospital
- Additional MHO resource to support AWI in the discharge hub

- Increased staffing capacity to enable 7 day working and enable equipment delivery at weekends
- Hospital at Home providing additional rapid community assessments. Additional purchase of equipment to support people with respiratory illness at home. Extended provision of ANP and AHP over 7 days Rehab at home prioritising first assessment and discharge to assess
- Working to establish a permanent Home First team to prevent hospital admission and facilitate timely hospital discharge ensuring decisions on future care are made in the most appropriate setting
- Maintenance of increased capacity within community hospital to enable 6 beds to be maintained for admissions

16.4.5 Other

The partnership will continue to focus on technological solutions and opportunities to reduce face to face contacts learning from the use of new technology such as 'Near Me' .

There will be an ongoing need to support people who are shielded. This has been done up until now via family members and volunteers. The ability to secure support from those groups may reduce as people return to work and no longer volunteer.

The PPE Centre has played an important role in the distribution of PPE to local services. The centre has been staffed by redeploying staff who will return to their substantive posts. Decisions will be needed going forward on the future arrangements for PPE distribution as well as how they are staffed and deliveries made.

There will be a need consider how day services for adults with disabilities are provided going forward. Physical distancing requirements present challenges for the operation of services which will impact service users and their families over the longer term.

Impact of physical distancing on bed space in community hospitals and mental health inpatient services has potential to reduce capacity and increase demand on community health and social care services.

17. Mental Health Services

17.1 Mental Health Services in COVID-19 so far

Due to the diverse nature of mental health services, prioritisation is being given to those within services who present with the highest level of risk, rather than priority being given to one service over another. Throughout the pandemic response, this has meant that we have prioritised keeping our inpatient services operational with as little disruption as possible. Admissions and discharges have been ongoing, our Intensive Psychiatric Care Units (IPCUs) and have remained at full capacity, as have our adult mental health beds, learning disability beds, mental health rehabilitation beds, CAMHS inpatient beds, medium secure inpatient beds, eating disorders inpatient beds and perinatal mental health inpatient beds. Care delivered within our inpatient settings has remained largely the same, however, social distancing and lockdown rules have resulted in less rehabilitation activity taking place, fewer opportunities for patient advocacy and has led to some challenges discharging patients who require supported accommodation. All mental health services across Lothian are following PPE guidelines, however, there have been reports of this having a negative impact on patient care as it can be distressing for those receiving care.

The only inpatient beds that have been affected by the COVID-19 response have been our inpatient detoxification unit, which has been closed to become the 'red' ward for COVID-19 on the Royal Edinburgh Hospital (REH) site, and intermittent reductions in the number of older people's mental health beds available due to patients testing positive for COVID-19 on wards and resultantly having to close wards to admissions. Our future plan for COVID-19 response on the REH site is to make one of the older people's wards the new 'red' ward, enabling inpatient detoxification to resume in a gradual and planned manner. There have also been 4 beds dedicated to the COVID-19 response within the Margaret Duguid Unit on the REH site, which can be used for both younger patients and those with a higher level of need (the ward is staffed at an ICU level).

Our Edinburgh based Mental Health Assessment Service (MHAS) was previously provided from the RIE as well as the REH, however, during the COVID-19 response the service has only been delivered from the REH, with the aim of reducing the number of patients going to the A&E department at the RIE. NHS 24 has been supporting MHAS during the COVID-19 response by providing a telephone triage service, this has been a positive and successful change to date, and we are looking to extend this partnership for the remainder of the pandemic response and beyond.

The Acute Care and Support Team (ACAST) have moved out of the Emergency Department at St John's and are currently seeing ED patients in OPD5 in St John's. This was set up to reduce footfall and pressure on ED. Near Me is being utilised by the Team as well. Longer term, there are plans to expand the working hours of the service and it is anticipated that the service will need a return to ED at some point as OPD5 space is unlikely to be available longer-term.

Community based unscheduled care services have also continued to deliver services face to face based on assessment of risk. Community Mental Health and Substance Misuse Teams (CMHTs), Harm Reduction Teams, Intensive Home Treatment Services (IHTTs), the Rapid Response Team (RRT) and the Perinatal Community Mental Health Team risk assess patients as a multidisciplinary team and decide who should respond, and whether this could be done face to face, via Near Me or on the telephone. There have been reports that some patients prefer to be seen using Near Me due to staff being required to use PPE for face to face appointments.

An Unscheduled Care Service has also been developed within CAMHS to provide urgent response to children and young people experiencing distress at home. This aims to ensure that children and young people are seen as early as possible when experiencing acute distress, with the subsequent aim of reducing harm and hospital attendances.

Face to face appointments within scheduled care services have been suspended during the COVID-19 response to date. This includes CAMHS, Adult Psychological Therapies, Veterans 1st Point, Rivers, Psychotherapy, outpatient psychiatry and the National Deaf Service. These services have been in contact with those currently in treatment and those on waiting lists to update them of the service provision at this time and to direct them to online resources. Some services have had a reduction in capacity due to re-direction of staff relating to COVID-19 which has impacted their ability to see new patients from the waiting list. Staff availability is now stabilising, so staff are able to resume their substantive posts.

Group treatments have been suspended and services are exploring alternative ways to provide these. In a number of services, patients are being provided with 1:1 treatment as an alternative. The Lothian and Edinburgh Abstinence Programme (LEAP) are currently exploring how they can resume their service, which relies on a residential element as well as a number of groups. It is likely that the service will begin with small group numbers and will include digital elements as well as face to face.

Training activities have currently been suspended, which presents a challenge for the learning disability service as in order to facilitate some discharges, hospital staff provide 'Positive Behavioural Support' training

to care staff in the community. The absence of this training may lead to delays in discharge; therefore, the team is currently exploring how this training could be delivered differently. Some assessments have also been suspended, such as cognitive assessments for dementia, and these assessments will be prioritised when some face to face consultations are resumed.

17.2 Use of technology

Lothian mental health services have been at the forefront of rolling out the use of 'Near Me' for consultations. Those in contact with scheduled care services have been assessed via telephone and offered a 'Near Me' or telephone appointment. Services continue to see new patients in priority of risk and in chronological order from waiting lists. Some patients are opting to remain on the waiting list until face to face treatment can resume, therefore there will be some backlog created on waiting lists, particularly for CAMHS and General Adult Psychological Therapies. Therefore, mental health teams across Lothian are exploring how we can begin to re-utilise outpatient space whilst adhering to physical distancing guidelines as soon as possible. Patients are advised to get back in touch with services should their condition deteriorate. We believe that we may be able to deliver 150,000 out of the 500,000 annual outpatient appointments through the use of NearMe and similar technologies.

It is likely that 'Near Me' consultation will remain a key element of our scheduled care service delivery for some time. A Digital Mental Health business case is under development which outlines the key elements of digitally enhancing mental health services. This includes how we enable clinicians to work digitally by providing the space, hardware and software required and sets out a case for paper-lite working.

17.3 Rising demand

Generally, it is anticipated that there will be an increased demand for mental health services post COVID-19, with child and adolescent mental health a particular concern and the subject of College review. We are currently exploring how we model this increase in demand as well as doing all we can to maximise service provision, including sharing online materials and using digital alternatives wherever possible. As the Scottish Government is aware, our services with the highest levels of demand such as CAMHS and Adult Psychological Therapies had stretched resources prior to COVID-19 and had been taking a number of steps to improve performance against waiting times. These steps had started to show improvement in early 2020, however, performance has been impacted by the pandemic response. We are doing all that we can to continue to implement our recovery plans including the recruitment of new staff to both services.

Mental Health services across Lothian are cognisant of the impact that COVID-19 is having on people's mental health. The restrictions imposed are particularly challenging for those being asked to shield, which is why we are providing this group with resources wherever possible. In Edinburgh, we are ensuring that people who are shielding, and other vulnerable groups who are being asked to self-isolate have access to the national programme delivering distress brief interventions which will be available in Edinburgh from in early June. The programme includes peer led groups, individual support and group support delivered through digital platforms and by telephone.

The nature of MH services means that our staff are often in contact with vulnerable families and people living with poverty and at this time we are working closely with third sector colleagues to ensure that the needs of people in these groups are met at this time. Our third sector colleagues are integral to providing support and care to vulnerable groups and we have been working to support their activities whenever possible.

Transitions are an important stage in a person's care, whether that is the transition from young people to adult services or from a hospital to a community setting. Our services manage these transitions sensitively and carefully at all times, but are particularly cognisant at this time of the potential impact of COVID-19.

Mental health wellbeing information, advice and support is being made available to staff and the local population by:

- Sharing resources through NHS Lothian and the 4 IJBs/HSCPs social media
- Sending letters with lists of resources sent to all of those waiting for treatment
- Sharing online resources with and through GPs
- Sharing of additional online CBT resources including new Pain Management treatment
- Developing and sharing mental health community resource websites:
 - EdSpace - <https://edspace.org.uk/>
 - MidSpace - <https://midspace.co.uk/>
 - EastSpace - <https://eastspace.org.uk/>
 - WestSpace - <https://www.westspace.org.uk/>
- Developing online resources for Children and Young People for support during COVID-19 - <https://services.nhslothian.scot/camhs/Resources/Pages/ResourcePacks.aspx>

As well as supporting the local population, it is critically important that we protect the health and wellbeing of our staff during the COVID-19 response. A number of measures are being taken to ensure they can remain psychologically well. As described in section 8, this includes:

- 'Here For You' helpline in place for NHS Lothian, HSCP, hospice and care home staff, staffed by Psychology Mon-Fri 8am – 6pm as well as the Staff Listening Service, staffed 7 days a week. Provisional planning to extend the Here for You helpline and to develop an extended staff support service, working with NHS 24 national helpline, occupational health and spiritual care. 'Mutual aid' is planned for NHS staff from other health boards who prefer psychological treatment to take place outside their employing Board.
- Other helplines and wellbeing resources available on the Intranet as well as additional support based on psychological 1st aid for all teams based at the acute hospital sites.
- Face to face psychological support to staff on the three acute sites
- Development of Wellbeing 'Hubs' on each site to provide staff with a relaxing space
- Lothian Psychology is also providing the East Region support to NHS 24 and Ambulance Service

18. Women's and Children's Services

18.1 Acute Services

18.1.1 Children's Services

18.1.1.1 Current capacity and surge plans

The current position within the Royal Hospital for Sick Children is that within Critical Care, 8 L3 beds are staffed and available; with an additional surge capacity of 16+2 L3 PICU beds.

General Covid bed capacity is currently at 16 beds with the immediate ability to use surge capacity of an additional 8 beds without impacting on priority elective activity.

Ward bed numbers in the rest of the hospital have been reassessed in line with social distancing/ IPCT requirements and are planned to reduce by 25 beds.

Expected emergency activity levels and priority elective activity *over the next 4 months* should be able to be accommodated within these bed numbers, however, when autumn/winter emergency admissions levels rise, this will be a pressure and may impact on elective activity.

18.1.1.2 Unscheduled Care

The RHSC Emergency Department (ED) footprint has been doubled by taking over the adjacent Outpatient Department and is now split into Red and Green assessment zones. It remains essential to have this additional space and division between Red and Green zones, so OPD clinics will remain displaced and a separate plan is now in place for this. An appointment system for attendance at the ED is not considered to be practical because it is difficult to predict how long a child's assessment will take until they are seen.

18.1.1.3 Increasing Surgical Activity

Children's services now plan to start increasing planned surgical activity *from June onwards*, in line with national prioritisation guidelines and on the basis of continued pre admission testing.

It is planned to have 4 of the existing 5 theatres running each day and RHSC already has clear pathways in place for the management of Red and Green patients undergoing anaesthesia and surgery.

A derogation from PHE/ NHSL PPE guidance has been approved by NHS Lothian which allows patients to follow Red or Green pathways.

A significant proportion of paediatric surgery is day case and the Surgical Admissions unit will re open (in reduced size) to support the increased activity. Surgical throughput will be reduced compared to pre COVID, but extra surgical capacity can also be created (although this will get harder as we go into autumn /winter).

18.1.1.4 Outpatient activity

Children's services have been developing a plan to use the Outpatient Department at the new Hospital in order to reinstate the clinic capacity which has been given over to the ED.

The new Hospital facility has been confirmed to be available for use without impacting on the other remedial work being done in the building and because of the size of the new department, it is anticipated that, if required, approximately the same number of children could be seen there as were previously seen at RHSC (c 1,235/week), with each specialty clinic having 2 rooms allocated to it and a maximum of 1 patient every 15 minutes.

Priority will be given to those children who require Face 2 Face consultations/ diagnostics, as prioritised by each specialty.

Clinical teams are very supportive of this plan, although it does mean split site working and we hope to start running the first clinics in the new Hospital by early/ mid July.

18.1.2 Women's Services

18.1.2.1 Maternity

In patient Maternity services at both RIE and SJH have been functioning at normal capacity since the beginning of the COVID-19 situation and appropriate arrangements are in place for RED and GREEN Zone patients. At the royal Infirmary, red zones current provide capacity of 2 beds in Obstetric Triage; 6 rooms in Antenatal/Labour ward; plus one Obstetric Covid19 theatre. At St John's Hospital, red zones provide one

room in the Labour ward (flex capacity available), 5 beds in Antenatal/Postnatal ward; plus one Labour Ward theatre.

The number of COVID positive women/ query positive has been quite low to date, however this may change as lockdown eases, schools return etc, so the service is planning for flexibility to increase RED pathway facilities as required.

There is a need to review the number of beds/ bed spacing in the RIE Post natal ward in particular, with advice from IPCT. It would be difficult to reduce bed capacity given birth numbers, but other actions to mitigate may be possible eg earlier discharge.

Consultant clinics are being carried out by telephone/ Near Me where appropriate.

In relation to Community Midwifery services, ante natal and post natal appointments are being carried out in line with national COVID -19 guidance. The home birth service this was suspended at the start of the outbreak, however, we are now planning to restart the service from 1 June.

18.1.2.2. Neonatal Services

Neonatal services, like Maternity services, have continued to function at normal capacity levels on both the RIE and SJH sites since the COVID-19 outbreak, with appropriately designated RED Zone areas available: at the Royal Infirmary there are currently 2 designated RED ZONE nurseries and ITU and HDU areas are suitably spaced. SCBU spacing is more challenging, so the emphasis is on caring for babies where appropriate on the post natal ward. At St John's Hospital SCBU, there is 1 RED ZONE Nursery; with the rest of the unit suitably spaced.

The Community Neonatal Nursing Team has played a key role in supporting earlier discharge for babies and remains a focus for support and increasing links with Paediatric services.

For neonatal clinics there has been a revised process for delivering these to avoid babies being brought back from home into the NNU. The next step will be to look at the potential to run these in the new Hospital when Children's outpatient services move in July, if there is sufficient space.

18.1.2.3 Gynaecology

The following Gynaecology services only have been running since the COVID-19 outbreak:

- Gynae Triage (both RIE and SJH)
- Gynae emergency surgery (RIE & SJH)
- Termination of Pregnancy service (both sites)
- Gynae Oncology patients (urgents only)
- Urgent diagnostics eg hysteroscopy, biopsies (in theatres)
- Pregnancy support (both sites)

At the Royal Infirmary, the Gynaecology Ward is a GREEN PATHWAY area but space constraints require to be addressed and mitigation agreed. At St John's Hospital, the Gynaecology ward is a GREEN PATHWAY area, the space constraints required to be addressed and mitigation agreed as above. Both wards support sites by taking Boarded patients.

In Gynae Outpatients most routine Face to Face outpatient activity has ceased, with telephone consultation/ Near Me being used instead.

18.1.2.4 IVF services

In line with HFEA guidance, we plan to restart IVF services in June, on a phased basis, following submission of our application to do so to the HFEA on 18/05/20. Patients will be prioritised in accordance with the recommendations from the Scottish IVF services/ Scottish Government.

18.1.2.5 Colposcopy and Gynae Skins 'routine' outpatients

These can only be delivered Face 2 Face and an SBAR has been submitted to NHSL, which is subject to some further discussion about the triaging of urgent patients before this service can resume.

18.1.2.6 Gynaecology inpatient and outpatient activity – next priorities

The service would like to start a phased increase in Gynaecology outpatient and inpatient work (both sites), in line with the Royal College of Obstetricians and Gynaecologists Prioritisation Framework published on 15/05/20.

This would allow procedures to go ahead for eg ovarian cysts thought to be benign but uncertain until removed, symptomatic cysts and other urgent, non cancer work. Patients would require appropriate advice, testing and consenting in line with current guidelines, to minimise risk. The Clinical team intend to re triage all patients previously classified as 'routine', given the length of time some patients will now have been waiting, as some patients may need to be re prioritised.

The service will be submitting an SBAR for consideration shortly, after discussion with Theatres and Anaesthetic services and Diagnostics.

The service is also developing an SBAR for increasing priority Face to Face outpatient activity, including diagnostics like hysteroscopy which was previously was being done mainly in outpatients. This will rely on support from Outpatient services, Diagnostics, Health Records.

18.2 Community Services

From the onset of the Covid-19 outbreak to the present date, children's services across Lothian have made significant adaptations to service provision, in terms of both the scope of services offered and the mode of delivery for those services. This has involved significant alterations to previous working practices, and the rapid redesign of services with the aim of maintaining essential care provision to those children and families with the greatest need. Throughout, services have sought opportunities to maximise capacity whilst providing a service which is safe for staff and patients.

The below outlines service level plans for service provision in the pre-vaccine phase of the epidemic. It should be noted that these plans are continuously evolving as events develop, and a key aspect of the response will be the ongoing ability of services to adapt to changing circumstances in an organised and safe way.

All plans are in keeping with wider organisation principles outline elsewhere within this document.

18.2.1 Key Themes

18.2.1.1 Partnership & Inter Agency Working

All services will continue to review caseloads taking account of client contact with partner agencies, including third sector organisations.

In order to minimise risk to staff and to ensure maximum utilisation of limited resources steps have been taken to minimise duplication of effort across the various agencies which are involved in the care of children and families across Lothian. Where possible joint visits will continue to be avoided, and measures put in place to support communications between professionals from multiple organisations.

Teams will ensure that they are aware of changes to service provision from other agencies and make assessments of changes in need or service demand arising from this.

18.2.1.2 Patient Screening

Services have developed standardised approaches to screening of patients prior to any patient contact. These will be maintained for the foreseeable future to ensure the safety of staff and patients.

18.2.1.3 Activity Rationalisation

The Scottish Government have issued extensive guidance to services with regards to minimum service provision. All services have ensured compliance with this guidance throughout, and will continue to align resources with the requirements set out within guidance documents.

Services will continue to make assessments of resources available, and where necessary will take steps to redeploy available staff to essential services. At all times the health and wellbeing of children and families, as well as the safety of staff will be prioritised.

18.2.1.4 Facilities

Work is underway to assess the suitability of all clinical and non-clinical facilities across all four HSCPs. This work will focus on required changes to clinical and non-clinical working spaces to facilitate physical distancing, taking account of changes to working practices, and the utilisation of telehealth and IT solutions to allow for remote consultations and working.

18.2.1.5 TeleHealth

Face to face consultations will not be undertaken unless the risk associated with this is deemed to be less than the risk of converting the consultation to an alternative medium.

Services have actively engaged with NHS Lothian and Scottish Government 'Near Me' implementation teams and have adapted pathways to take account of the increased number of virtual consultations. These changes will continue throughout the course of the pandemic, with many being maintained permanently.

It is anticipated that significant investment in technology will be required to enable teams and facilities to deal with high volumes of remote consultations. Furthermore, investment will be required to enable clinical and non-clinical staff to carry out administrative tasks away from healthcare settings where at all possible. Many teams have made significant steps towards these changes in working practices, with further progress anticipated in the coming period. This will link closely with the aforementioned work to assess accommodation needs for all services.

18.2.2 Service Areas

18.2.2.1 Medical Abortion

Medical abortion provision remains an essential service to be provided to all suitable patients as required. In order to minimise patient attendances on acute hospital sites and direct contact with staff, measures regarding the administering of medical abortion treatment have been put in place.

Patients under 12 weeks gestation will no longer be required to attend in person to be prescribed mifepristone. This means that those patients who meet criteria contained within Scottish Abortion Care Providers Guidance will receive a telemedicine consultation with a qualified medical professional before being issued with Early Medical Abortion at Home package.

18.2.2.2 Infant Feeding

Infant feeding has been designated as an essential service by the Scottish Government and as such all efforts will be made to ensure ongoing support is provided to parents and carers throughout the course of the pandemic.

Community midwifery teams will continue to carry out infant feeding assessments at the first postnatal visit. Where mothers require additional support a feeding plan will be made with mothers given appropriate support and advice. Community midwifery staff will liaise with specialist infant feeding advisors as required.

Group drop in sessions will be replaced with online resources with work underway to provide online classes.

18.2.2.3 Community AHP

All non-essential face to face intervention and visits will stop and be replaced with telehealth consultations as directed national clinical guidance.

Clinical decisions regarding requirement for face to face intervention and visits in urgent cases will be taken on a child by child basis. Help lines have been setup to enable parents, carers and anyone needing support to contact AHP services directly.

18.2.2.4 School Nursing

In line with Scottish Government guidance all P1 height and weight checks have been paused for the time being.

Staff will continue to support those patients referred to Weight Management services via 'Near Me' or telephone consultations where required. No face to face visits will take place.

School nursing staff will continue to work in partnership with named persons to ensure appropriate care and/or interventions are available for children with particular needs or who are deemed to be at risk.

18.2.2.5 LAC Nursing

Teams will continue to respond to new requests for service, making assessments of need based on the details of the case and progressing appropriate care plans. Caseloads will be reviewed with assessments made as to ongoing care needs of children and young people.

Initial Health Assessments following notification of a child becoming looked after will continue. Looked after children's nurses will communicate with social workers and other health & social care professionals as required to progress and inform assessment and to confirm consent prior to contacting child/young person/carer and undertaking initial health assessment.

19. Care Homes

In light of the most recent Scottish Government Coronavirus (COVID 19): enhanced professional clinical and care oversight of care homes guidance, issued on the 18th May; amendment to the Coronavirus Bill, together with a Variation Order on the role of the Executive Nurse Director has provided a clear statement on the expectations of Executive Nurse Directors, Medical Directors, and Directors of Public Health to provide enhanced clinical and professional oversight of care homes during Covid-19.

Within Lothian, there is an existing, good working relationship between the Health and Social Care Partnerships and care homes within their locality, with support frameworks already in place. Three of the four H&SCP in Lothian had long established Care Home Support Teams and the 4th offered a comprehensive in reach from the District Nursing Service.

In response to the Covid 19 pandemic NHS Lothian had established through the Nurse Director (Primary Care):

- A daily Care Home call across the Health and Social Care Partnerships on 07/05/20
- A weekly Tactical Level meeting, co chaired by the Nurse Director (Primary Care) and a representative Chief Officer which first met on 12/05/20

All 4 H&SCP are now delivering a 7 day per week Home Care Support service and in reach to Care Homes. Each H&SCP has its own local oversight arrangements for care homes in place as part of their incident management and resilience arrangements, feeding into both their respective Local Authorities and NHS Lothian, as well as the pan-Lothian arrangements set out above.

These arrangements offer a sound foundation for the governance structures required to support the Scottish Government requirements. The accountability of the Executive Nurse Director will be delivered through a programme management approach to this governance arrangement which is being developed currently. The programme of work will support a number of work streams, those underway are:

- Testing Tracing and Isolation
- Data Measures & Reporting / Excellence in Care national measures
- Clinical Education and Training
- Workforce Planning Nurse / HSCW Staffing Supply
- Supportive Framework (including a framework for the supportive review / visits)

- Joint Care Inspectorate / HIS inspections
- Care Home Staff Wellbeing
- Integrated Pharmacy
- GP engagement
- Scenario planning

20. Finance

In May 2020, the NHS Lothian Local Mobilisation Plan (LMP) forecast additional costs of £149.8m associated with the COVID-19 response across the Board and four HSCPs. Of this, £71m is anticipated in the four months to the end of July.

This is a developing picture across all services. Through the Management and Governance groups described in sections 3 and 4, NHS Lothian will continue to:

- refine estimates of additional expenditure from the LMP, including offsets from reduced expenditure;
- update for analysis of actual expenditure, to understand how this begins to confirm or clarify assumptions;
- forecast when and how additional expenditure may be switched off, through the remobilisation plan;
- understand the timing and impact of key initiatives on NHS Lothian services, such as Community Hubs; roll out of digital infrastructure; test and trace;
- highlight requirements for capital investment through equipment or property, or impact on support services to deliver proposed changes.

A fully integrated model, working with IJBs, HSCPs and Council partners, is fundamental to NHS Lothian's remobilisation plan. Governance structures as well as operational processes remain under review to ensure they support effective and transparent decision making, as well as robust forecasting of expenditure.

Consistent with previous discussions with Scottish Government, the output of this process is anticipated as part of the Quarter One Review. However analysis on specific areas may be accelerated as required.

Appendix 1 – SBARs considered by SMG Gold during coronavirus period

This list is of the SBARs submitted and considered by the SMG during the period. Each is submitted in writing and assessed with full clinical input. Not all SBARs are agreed first time, with several having been taken back for further discussion. All are focussed on clinical safety.

SBARs – 20/03/2020

- SBAR - cancelling monitoring clinics at Lauriston
- SBAR - cease booking diabetes appointments from May 2020
- Ritson (substance misuse service) SBAR

SBARs – 23/03/2020

- LEAP (abstinence service) SBAR

SBARs – 27/03/2020

- DRAFT IJB SBAR

SBARs 30/03/2020

- SBAR Theatre activity reduction plan 26 3 2020 update
- SBAR Near Me 26.03.2020.

SBARs 06/04/2020

- SBAR ECC SACT (systematic chemotherapy)Provision During Covid_Final_01 04 20- v2

SBARs 10/04/2020

- SBAR Manufacturing and quality control visors v1.0.
- SBAR Spire Cancer Contract 090420.

SBARS 13/04/2020

- SBAR Flow Centre Discharge Navigators.

SBARs 17/04/2020

- 2020 PPE supply chain SBAR v2

- Children's Ward (SJH) potential to Decant SBAR April 2020.
- Discussion of SBAR to Reduce Surgical Risk 150420tg.
- SBAR COVID Costs - 17th April 2020.
- SBAR Covid-19 Recovery 17 04 20.
- SBAR Care Homes v3 (002) (3).

SBARs 24/04/2020

- SBAR_RT_COVID testing and treatment_final 070420 v2
- SBAR allo SCT Final with IDs redacted.
- SBAR auto SCT - Final (003).
- SBAR ECC SACT Provision During Covid_Haem 06 04 2020 Final.
- SBAR Cancer Regional Mutual Aid.
- SBAR_RT_COVID testing and treatment_final 070420 v2.
- SBAR COVID Financial Costs - 23rd April 2020.

SBARs 27/04/2020

- SBAR Facilities COVID costs 23-4-20.
- GOWNS SBAR LOTHIAN SMG 230420 v12.

SBARs 01/05/2020

- SBAR - 28th April 2020 - Department of Orthopaedic & Trauma Surgery.
- SBAR - Cardiology, Cardiothoracic & Respiratory Medicine Directorate-CTR.
- SBAR - Providing an interim Fertility Preservation service for patients from Greater Glasgow and Clyde.
- SBAR - RIE OPD 1 - 28-04-2020 - Trima.
- SBAR Requesting Approval for One Stop Process for Non Melanoma Skin Cancers and Extension.
- SBAR - Covid Community Pathway Updated version 20200430.
- SBAR - Lothian COVID staff testing and outreach service.
- SBAR 2020 COVID Costs [FINANCE] - 30th April 2020.

SBARs 08/05/2020

- SBAR - NHSL Endoscopy Services.
- SBAR Breast Cancer High Risk Patient Surveillance - Post Op & Genetic Populations 2020-04-30 inc process map.

- 2 SBAR Use of ward 220 RIE as clean area for scheduled urgent surgery 060520.
- SBAR urgent Vasc CV19[1].
- SBAR Briefing paper on restarting newborn hearing screening.
- SBAR Shielding patients and contact with health care services.
- 2020 SBAR COVID Costs - 7th May 2020.

SBARs 11/05/2020

- Discharge to Care Homes Guidance.
- SBAR temperature screening v0.1.

SBARS 15/05/2020

- SBAR Ritson - Phased Service.
- SBAR - Dermatology BCC.
- SBAR COVID Costs - 14th May 2020.

SBARs 18/05/2020

- SBAR - Women's Services - Edinburgh Fertility Centre COVID-19 Planning.

SBARs 22/05/2020

- SBAR - Restarting Planned Surgery at RHSC.
- SBAR Bronchs SJH - 140520.
- SBAR - SJH Lung Ca Clinics 140520.
- SBAR - NHSL Endoscopy USoC upper endoscopy
- SBAR urgent Vasc V3 210520.
- SBAR COVID Costs - 21st May 2020.
- SBAR - SACT Management Recovery May 2020 Final.
- SBAR - Homebirth.
- SBAR Use of ward 220 as clean area for scheduled urgent surgery 060520
- SBAR Renal Transplant Services Restart.
- SBAR v2 2 Coronavirus enhanced professional clinical and care oversight of care homes 210520.

Appendix 2 - Clinical priorities for the next three months for remobilisation

1. This paper builds on SAMD and SEND discussions to inform the clinical prioritisation bullet point in CE paper, presented on 05 May 2020 on remobilisation, recognising all the principles within that paper:
 - **Clinical prioritisation** - addressing the needs of the population across physical and mental health through a clear clinical prioritisation process; developing a phased approach to the re-introduction of services and care based on need; aligning the available capacity recognising the preconditions of the different clinical specialties and the need for social distancing measures within hospitals; the need for infection prevention and control to be at the forefront of clinical prioritisation; high volume care as close to home as possible; complex low volume work concentrated in a small number of locations at regional and national levels, aligning clinical needs to the available capacity across Scotland.

Discussions have identified the following areas of clinical priority and ways of working. Some ideas and proposals would extend far beyond the three months, which has sensibly been set as the next horizon for planning remobilisation.

2. Board led increase in their volume of Planned work in acute hospital systems

All boards are maintaining some level of urgent cancer and clinically urgent work in outpatients, diagnostics and inpatients and are seeking to extend this as they are able. The work that boards are undertaking currently and plan to expand in the next three months under this heading, is led by the principles orientated around the patient and their needs, and the local system. These are in line with the Framework for Recovery of Cancer Surgery produced by Scottish Government and with recent letter jointly published by the Kings Fund, Nuffield Trust and Health Foundation, indicating it will take some considerable time to return to routine work.

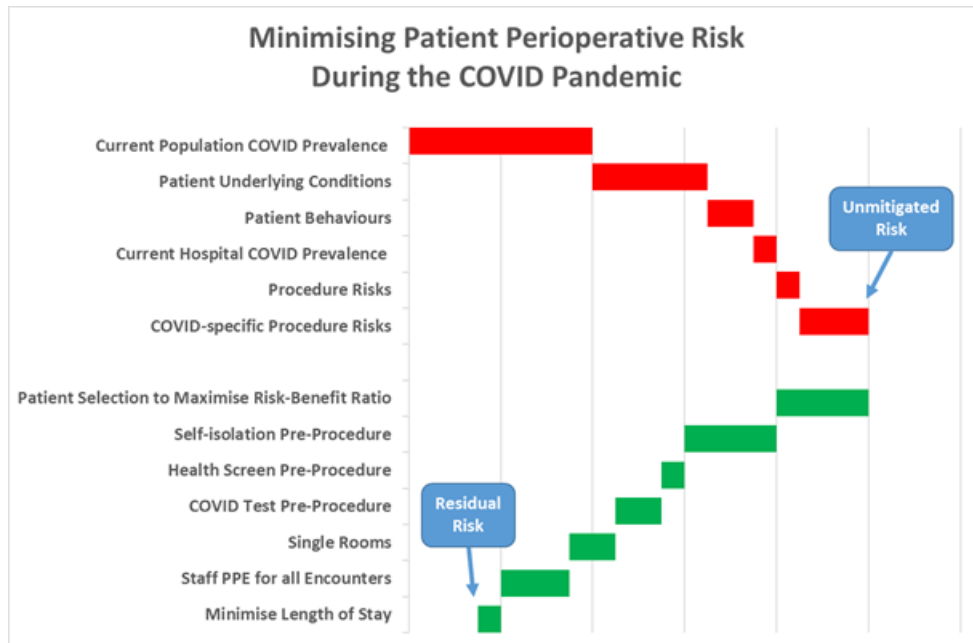
Patient factors that require to be optimised before proceeding:

- Agreement that the risk of procedure is less than the intended benefit
- That the level of urgency of the procedure supports proceeding at this time
- There has been explicit consideration and documentation of risk as part of the consent process and patient chooses to proceed. The impact of that choice on TTG status needs to be clarified so that the same adjustments and communications are applied across Scotland

System factors that require to be optimised before proceeding:

- There is no compromise to flow and levels of occupancy are at a safe level, including in critical care.
- There are adequate resources- of workforce and supplies (including medicines and PPE)

- The hospital environment is as safe as it can be: there are no hospital outbreaks suggesting in hospital transmission.



This visualisation of the components of risk (with thanks to MMacG from GJNH) is a useful way to bring these factors together to support patient discussions. There is opportunity for common language and demonstration of risk stratification.

The phrase “clinically urgent” may reflect the circumstances of the individual patient as well as the condition and extends beyond cancer based procedures. All agree this is a priority for the use of non Covid capacity within individual health systems and will be need to be balanced with additional demands in unscheduled work. Within an outpatient setting, telephone and virtual consultations have been tried extensively and demonstrated to be acceptable and effective, so should be maintained as the first approach to the patient. Evaluation of patient experience and outcomes need to be undertaken to inform their more deliberate use and to ensure that the consultation through this method functions as a replacement to a face to face consultation rather than an additional step.

There are constraints that require explicit consideration:

- Diagnostics are recognised as a constraint within both scheduled and unscheduled work- due to both an increased requirement for diagnostic tests to support increasing volume of urgent work and the reduced throughput consequent on the changed way of working from Covid restrictions of social distancing and PPE.
- Most boards are cautious and concerned about moving to more routine work too quickly, particularly with PPE requirements still being very high for all clinical and interventional work including endoscopy.

Particular consideration should be given to the opportunities to resume the provision of services for children more rapidly, given the lifelong disadvantages they may face over poorer clinical outcomes

that occur through further delay, and that these services are often geographically separated from other areas.

- 3. Unscheduled care** – converting unplanned attendance or assessment to one that is in a planned appointed clinical system is the most important priority for Medical and Nurse Directors and which should link clearly to the clinical priorities described in the remobilisation plans. There is strong support for not reverting to old ways of delivering unscheduled care but using what has been learnt across the whole system to maintain and expand the new ways of working. Most boards wish to continue to use the models established in Covid hubs as a way of supporting more self-management and avoiding overcrowding and unnecessary face to face contact. The potential safety gains of a more controlled approach to unscheduled care attendance to any healthcare setting will be significant and may play an important factor in mitigating or reducing winter pressures generally and any additional Covid pressures that emerge in the future.

The NHS 24 model of triage into Covid hubs has been well received by patients and professionals and delivered safe, consistent care. It has also supported more self-management and self-care, and links clearly to the wider primary care resources of Community Pharmacy and optometry. SAS have identified opportunities to join up parts of the service and consider they can play an important part in the move to the greater scheduling of unscheduled care (the Danish model). These changes would need implemented across the whole system rather than on a piecemeal basis for maximum impact.

Consistency and effective use of skilled resources has been demonstrated by the GP led Covid hubs and the maintenance of the principles of these for unscheduled care and the gains they have given has the strong support of Medical and Nurse Directors. A similar approach to urgent mental health assessments would provide a better patient experience in a safer and more timely way. In short, we should prioritise the development and expectation of clinical contact and conversation virtually before any attendance a necessary step and one that with appropriate localised clinical decision support benefits the patient and the system as a whole.

- 4. Prioritisation around Mental Health services** –changes introduced for urgent access and managing unscheduled demand have been effective and MH services are using new digital consultation approaches in unscheduled and scheduled settings well. Opportunities for more interventions to be delivered on line and with a focus, where appropriate, on self-management have been a feature of work in the last three months and there is strong support to continue these.

Rising levels of distress in individuals are noted and given these frequently result in urgent or unscheduled presentations, rapid access to appropriate assessment and support is recognised as a clinical priority. SAS have noted a rising number of mental health calls under the 999 category and without clear routes for onward support, these have the potential to result in additional unscheduled hospital attendances.

There are specific concerns about children and young people in CAMHS for whom social isolation and loss of regular contact through education has had significant impact.

- 5. Primary Care services:** our clinical priorities would be to support the opportunities to join up previously segmented areas of service in primary care to make things more straightforward for patients and staff and to reduce duplication. These include accelerating aspects such as the digitalisation of optometry and e prescribing. General Dental Practice work is emerging as a public concern around access and has particular issues about PPE and social distancing.

Self-care and self-management have been widely used and become more acceptable to the public and there are opportunities to provide good quality resources once across Scotland through NHS Inform and to link these to the individual's postcode for the available options in their area with DHI input.

Maintaining or developing services in primary care that enable care to be delivered remotely, or which avoid the need for hospital attendance requires infrastructure and resources in ways that are consistent. Undertaking more tests in the community would avoid travel, inconvenience and risk for patients and will be necessary for the monitoring of shielded patients for their bloods, ECGs and other physiological parameters. Current models around local determination of such services at an individual HSCP level reduces the opportunities for successful interface working with secondary and tertiary care who may span multiple HSCPs. There are also opportunities for national boards to be part of this, and it would have a positive impact on health care in prisons and the State Hospital. Office 365 rollout will support better working across diverse teams.

Support for the ongoing vaccination of children needs to be well articulated and supported by public messages.

6. Population health and prevention: Screening

Following discussion, Medical Directors would not see reintroduction of screening services as a priority until the whole pathway from diagnosis to treatment for each individual patient can be supported.

Screening programmes are designed to identify patients whose detected disease is at an earlier stage and these individuals would not take priority over a patient presenting through an urgent pathway with more overt disease.

Reintroduction may miss an opportunity to consider whether any modernisation of screening pathways would be beneficial and whether there could be any alignment between USOC pathways and screening in a way that allows better risk stratification.

7. Managing Expectations

Nurse and Medical Directors recognise the need for consistent messaging and management of expectations and that some of these may be difficult to achieve with the flexible, urgent based, service provision which will be necessary in the next phase. These include managing the expectations of:

- patients: who expect that care will be safe and risks minimised, and that their choices about risk will be carefully discussed and that any decision to defer will not disadvantage them in the future
- carers and families- that care will be safe and they will have adequate opportunities to be involved
- the wider public- that care in one region matches another in terms of access and standards and who need to adjust to virtual contact proceeding or replacing face to face contact, except in the most urgent of circumstances.
- professionals that the principles of realistic medicine will be followed in managing interventions, choice and risk.
- the broader health and social care workforce in the use of technology as part of everyday clinical work, with consequent implications for its availability for all groups of staff, the expertise and skills to use it and its functionality in supporting the delivery of care in all sectors.
- Non Executive Directors and MSPs and others where the understanding of the impact of Covid on productivity and ways of working may be less well understood, including the need for there to be sufficient time for staff to recover and for patients to feel safe in health care settings
- managers: safety will be strongly linked to levels of occupancy in all healthcare settings and we need to maintain lower levels of occupancy than previously tolerated or might seem efficient, particularly with all the complexities of red and green areas.

Using more real time data with defined trigger points to inform decisions about the need to flex capacity, pressures on supplies (e.g. PPE distribution) and early warning systems about pockets of Covid activity would allow boards to proceed at the correct pace for local need but demonstrate that decisions are being made according to standard criteria, following the same principles, even if different boards are in different waves of Covid activity.

8. **A stronger clinical voice** to provide leadership and pace- we recognise that previous attempts at service reform have been hampered by individual views and preferences rather than what's best overall. Medical and Nurse Directors want to contribute more to seeing some work through, by bringing discussions about diverse clinical views to a conclusion and in being seen as a more direct resource for Chief Executives in accelerating whole scale adoption.

Appendix 3: Enhanced outbreak response for closed settings

This appendix is included as a separate document due to size.

Appendix 4 – Workforce information

Covid Rapid Recruitment & NES Returners (NB Numbers of candidates not wte)

Numbers of Staff Recruited / Pending and Source	Local Rapid Recruitment			NES Portal		
	Fixed Term	Bank Contract	Outstanding	Fixed Term	Bank Contract	Oustanding
Registered Nurse	10	39	14 (pending interview)	2	-	44 (pending pre empl checks) + 98 (under review) + further cohort expected
Registered Midwife	1	10		0	0	
Student Nurses Band 4	-	-	-	422		
Student Nurses Band 3	-	-	-	297		
Non Registered Nurse	78	288	40 (pending interview)	0	-	19 (pending pre empl checks)
AHP	8	25				162 (under review) + further cohort expected
Pharmacists	-	2		1	7	
Pharmacy Technicians	-	1	-	-	-	
Pharmacy Support Workers	28	20	-	-		8 (pending pre empl checks)
Facilities	226	223	193	-	-	

