Our System-Wide Remobilisation Plan – 2020

Working together to protect the health and wellbeing of our patients and staff

Contents

Foreword

On the 17th March 2020 Jeane Freeman, the Cabinet Secretary for Health and Sport, announced that NHS Scotland would be placed on an emergency footing to help free up capacity and respond to the Covid-19 pandemic. Our response to this emergency was swift and, in collaboration with our staff and partners and we increased our capacity not only in our hospitals but also in our communities, working closely with our two local Health & Social Care Partnerships, three local councils and public sector colleagues. We ensured our staff were resourced and supported to provide care and treatment for patients with Covid-19. We did all of these things in a matter of weeks and, despite the many concerns and challenges we faced at the start of the pandemic, we were able to support a level of change and service reconfiguration that was quite remarkable.

We have also made huge inroads using technology to support virtual consultations including the widespread use of Near Me to help deliver outpatient appointments. We have also extended the use of real time virtual assessments to help assess and treat patients with emergency and urgent eye conditions and rolled out the use of an app developed by local dermatologists which allows patients to self-manage their skin conditions. Our ability to innovate and work differently continues to be evident in our everyday practice across a wide range of clinical and support services. For example, we have responded to the Chief Scientist's call for healthcare challenges that need innovative solutions using remote spirometry to monitor people with respiratory problems and our Ageing and Health Consultants have shifted their location from hospital to the community to support local care teams, helping them to assess and manage older people in their own homes, in care homes and the wider community. Our integrated approach to supporting care homes has been outstanding helped by our HR team who have through a new staff deployment hub helped ensure staff and resources were deployed to where they were needed most. We have also put in place a wide range of services and resources to support the health and wellbeing of staff across the organisation and our psychology team and staff side colleagues have been instrumental in supporting our approach.

Going forward, the Cabinet Secretary for Health and Sport launched the 'Re-mobilise, Recover, Re-design: The Framework for NHS Scotland. This Plan sets out how we will safely and incrementally start to resume services over the next 100 days whilst being vigilant and able to continue to respond to ongoing challenges of Covid-19. I thank everyone from across our local health and social care services for everything you have done and continue to do to respond to the many challenges posed by this pandemic.

Cathie Cowan

Chief Executive

Executive Summary – Second Phase Response Highlight Plan (Key Actions)

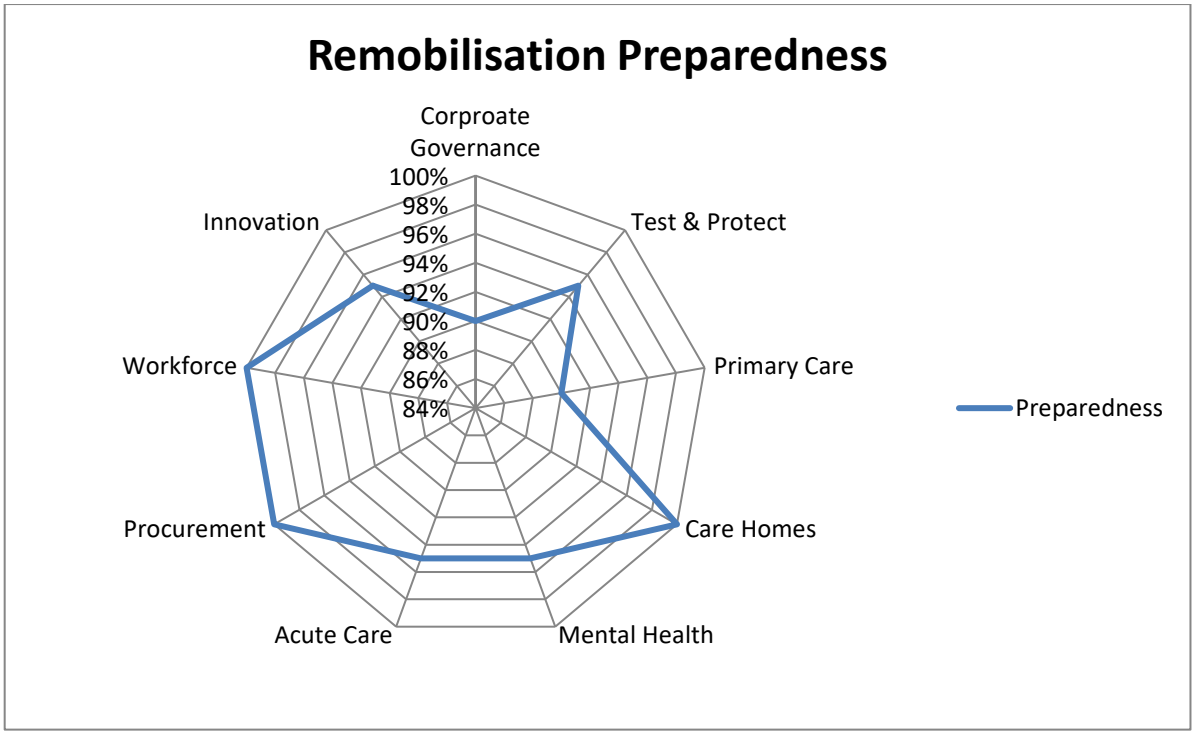
Category	Action	Target Date	Comp. Date	% Completed	Owner	RAG Rating and/or comments
Corporate Governance	Delivering the Blueprint Functions and discharging our governance responsibilities including collaborations and **engagement of stakeholders** notably HSCPs, ACF, and APF colleagues	25 June		80	C Cowan	Seminar to inform initial Plan took place on 22 May – GP sub, APF and ACF were represented. Further engagement seminar planned for late June
Corporate Governance	Maintain COVID-19 Daily Balanced Scorecard (key measures to include e.g. PPE, Critical Medications) and COVID-19 Risk Register	10 April	10 April	100	C Cowan	Daily Balanced Scorecard (BS) issued, weekly BS issued to NHS Board Non Executive Members. COVID-19 Risk Register approved by NHS Board in May
Corporate Governance	Recovery and Renewal Programme e.g. 'lock in' beneficial changes capture baseline data	18 May	18 May	100	C Cowan/A Murray	Internal Audit supporting this work, baseline data complete
Corporate Comms'	Communication Plan to support remobilisation	1 June	Ongoing	-	E Campbell	
Public Health - Test & Protect	Saving Lives - in line with national guidance	29 April	29 April	100	G Foster	System live with no issues
Public Health - Test & Protect	Key Workers - symptomatic H&S Care workers, symptomatic household members of staff and other symptomatic key workers	23 March	23 March	100	G Foster	System live with no issues
Public Health - Test & Protect	Index cases	1 June		100	C Goodall/O Harding	Contact Tracing Hub established – operational 7 days per week
Public Health - Enhanced Outbreak testing	Testing residents and staff in care homes with a confirmed case of COVID-19 case, in linked homes where staff work between homes run by same operator	12 June		95	J Champion/H Prempeh	Care Home providers with linked homes - testing of staff and residents will be complete - end of w/b 8 6.20
Public Health - Test & Protect	Surveillance – 8% sampling in care homes where there are no cases	25 April		100	J Champion/H Prempeh	System live with no issues
Public Health - Test & Protect	Asymptomatic staff 50% of non COVID-19 care homes Asymptomatic staff 100% of non COVID-19 care homes	8 June		100	J Champion/H Prempeh	Asymptomatic staff in Non-COVID Homes – to be tested through the portal - allocation of places is sufficient to cover homes not tested by NHS FV

Category	Action	Target Date	Comp. Date	% Completed	Owner	RAG Rating and/or comments
Primary Care	Remobilisation Planning - preparedness including the continuation of Community Hub and Assessment Centres operating at Stirling Community Hospital and Forth Valley Royal Hospital with strong interface (primary/secondary care) in place	25 May	25 May	100	S Williams/K O'Neill/C Copeland/ Partnerships	Evidence of good partnership and interface working – e.g. care homes, 'hospital at home' and SCI Gateway Advice line
Primary Care	Planning for future Primary Care OOH service	29 June		75	C Mair	Work part of wider OD review in response to Internal Audit recommendation
Primary Care	FV Primary Care Improvement Plan - third iteration includes immunisation planning	23 June		90	S Cumming	Work progressing, Forth Valley Programme Board to be reconvened
Community Care - Dental	Remobilisation Planning – 3 phases now agreed			100	J Rogers	Set out in this document
Community Care - Pharmacy	Remobilisation Planning, includes reference to repeat prescriptions and NHS Pharmacy First Scotland service	N/A	Ongoing	-	S Mitchell	Set out in this document
Community Care – Optometry	NHS Forth Valley has delivered an EETC model through three Emergency Eyecare Treatment Centres	N/A	Ongoing	-	C Ward	Set out in this document
Care Homes	Implement Enhanced Care Home Assurance System including outbreak management and oversight arrangements with Chief Officers and H&SCPs	18 May	1 June	100	J Champion/H Pempreh	Daily Care Home Strategy Group established since 23/4, new oversight arrangements in place as from 05/06
Mental Health	Remobilisation Planning – set out in Appendix to this document	25 May	25 May	90	J Crabb/K O'Neill	MH and LD services remobilisation plan includes CAMHS to July appended to this document
Acute Care	Remobilisation Planning includes unscheduled and scheduled care preparedness – set out in this document	25 May	25 May	90	A Fyfe	
Acute Care	COVID-19 second wave capacity	25 May	25 May	100	A Fyfe	Ability to flex up COVID-19 response (e.g. second wave), co-ordination and capacity
Procurement	Remobilisation Planning – e.g. PPE availability as we step up services. Stock levels – monitoring in place and NPD links in place to manage the supply chain	1 June	1 June	100	J Procter/ D Logie	Critical supply chain reliant on NP supplies. Forecasting information via Deloites fed into national plans

Category	Action	Target Date	Comp. Date	% Completed	Owner	RAG Rating and/or comments
Critical Medicines	Remobilisation Planning - stock levels – monitoring in place	1 June	1 June	100	S Mitchell	Set out in this document
Workforce	Overarching Workforce plan to support remobilisation plans, maintaining deployment hub and Skills Register	23 March	23 March	100	L Donaldson	Ongoing work to support NHS, Care Homes and Louisa Jordan
Workforce	Staff Health & Wellbeing Resources	17 April	27 April	100	L Donaldson	Regular updates to APF (meeting fortnightly) and Health Board
Digital	Support Public Health with the Introduction of the Test & Protect digital solutions and enablement	w/c 1st June		100	J Procter/ R Paton	Training and "on boarding" progressed as planned
Digital	Accelerate roll out of digital enablers: Near Me; Remote Monitoring of Patients	N/A	Ongoing	-	J Procter/S Bishop	Ongoing development to support new ways of working
Digital & eHealth	Purchase of hardware and software to deliver enablers and step up remote access arrangements – Promote utilisation of Office 365 tools (e.g. MS Teams)	N/A	Ongoing	-	J Procter/S Bishop	As above
Digital & eHealth	Remobilisation Planning - agree priority scale up	N/A	Ongoing	-	J Procter/S Jaffrey	As above
Facilities & Infrastructure	Remobilisation Planning - review of Service/Partnership Remobilisation Plans – consider/agree reconfiguration and provide infrastructure support/management to address physical distancing etc	N/A	Ongoing	-	J Procter / M Farqhuar	Ability to reconfigure space to support physical distancing parameters

In summary:

Figure 1: Escalation Preparedness/Performance in key priority areas, diagram set out our level of preparedness



SECTION 1: ABOUT THIS PLAN

DOCUMENT CONTROL

Date	Version	Revision/Amendment Details & Reason	Author
25/05/2020	**1.0**	**Original Version**	**Cathie Cowan Kerry Mackenzie**
05/06/2020	**1.1**	**Redrafting includes 27 May Scottish Government feedback and 1 June System Leadership Team consideration. Refresh (4 June) of Service/Partnership Next Phase of NHS Response Plans**	**Cathie Cowan Kerry Mackenzie**

1.1 PLAN PURPOSE

The First Minister launched Scotland's route map through and out of the crisis[1]. The Route Map describes a number of phases by which the Government aims to ease lockdown following the 28 May end of cycle review of Covid-19 regulations. The Cabinet Secretary for Health and Sport on the 31 May then launched the 'Re-mobilise, Recover, Re-design: The Framework for NHS Scotland[2]. In response to this Framework our Remobilisation Plan sets out how we will safely and incrementally start to resume services over the next 100 days whilst taking account of how we:

- retain and build on the many positive transformative changes inspired by staff who have come together to work differently during this Pandemic
- remaining vigilant and able to respond to potential increases in future Covid-19 cases
- safely and incrementally informed by clinical prioritisation resume elective services including surgery, therapies, treatments and outpatient appointments
- adjust to a new normal and continuing to adapt to any new or going challenges whilst living alongside this virus as we prepare for winter

[1] https://www.gov.scot/publications/coronavirus-covid-19-framework-decsion-making-scotalnd-route-map-through-out-crisis/pages/4/

[2] https://www.gov.scot/publications/re-mobilse-recover-re-design-framework-nhs-scotland/

In this regard NHS Forth Valley will continue to:

- instil and maintain the trust and confidence of our staff, public and partners by ensuring that they are involved and well informed in our plans
- look after the health and wellbeing of our staff
- work in partnership with our staff side and clinical advisory colleagues
- embed innovations and digital approaches into our everyday business
- plan and adapt our remobilisation and recovery work alongside our H&SCPs and in partnership with our wider partners and communities with a focus on reducing health inequalities
- avoid unnecessary disruption or adverse economic impacts and in this regard connect to the Renewal work led by Scottish Government

1.2 PLAN REMIT

Following mobilisation of the COVID-19 Response, NHS Forth Valley through its recovery work had begun a dialogue within the Health Board and System Leadership Team to plan for resuming services, this dialogue includes regular engagement with clinical and staff side colleagues. This Plan takes account of the different ways in which we have been working during our COVID-19 response and considers the ongoing impact of this virus as we seek to move forward. This continues to be a living document which will be adapted and modified as we build our plans to resume our services. We have a follow up dedicated session in June to further inform the scaling up of activity using a risk based approach which takes account of other capacity notably in the Region.

1.3 PLANNING ASSUMPTIONS

NHS Forth Valley as reported to the Health Board temporarily suspended non urgent services including elective and routine care from 23 March 2020 whilst continuing to deliver emergency and urgent primary and community care, maternity, mental health and acute hospital services. For those people whose operations have been postponed they remain on a waiting list until it is clinically appropriate for elective care to recommence. It is recognised that any delay in tests or treatment can be distressing for patients and their families and we are therefore keen to restart services as soon as it is safe and possible to do so. To guide the resuming of our services we have made a number of planning assumptions, notably:

- Shielding arrangements remain unchanged
- Sufficient public health and health system capacity is in place to implement the ‘test and protect’ strategy
- Community COVID-19 pathway through NHS24 to our community triage and assessment will continue for the foreseeable future
- Interfaces with primary and secondary care are maintained
- Adoption of Royal Colleges - clinical guide to clinical/surgical prioritisation

- Physical capacity may be reduced to maintain physical distancing measures
- Access to separate bed based COVID-19 of c. 60 acute beds and 7 level 3 ITU beds
- Outbreaks are minimised and managed in care homes
- PPE supplies and access to critical medicines continue
- Robust IP&C measures are maintained
- Workforce (health and social care) availability continues
- Access to transport continues
- New ways of working established during this Pandemic continue
- Ongoing financial support from the Scottish Government will remain in place

Alongside these assumptions are opportunities to rethink and to reshape how we deliver both scheduled and unscheduled care services as we live alongside COVID-19 and adhere to ongoing physical distancing and travel restrictions. Our current unscheduled care system can be sometimes be complicated to negotiate and there is now a real opportunity to build on our investment in community triage and assessment. Partnership working will continue to guide how we optimise enhanced community care in our localities. How we use Community Hospitals and Care Homes in the future also needs to play a more prominent role as we look to strengthen the interfaces and relationships that have emerged during this pandemic across primary and secondary care.

1.4 GOVERNANCE ARRANGEMENTS

NHS Forth Valley in response to COVID-19 reviewed its governance arrangements and introduced new arrangements. These interim arrangements were set out in a paper to our March Health Board and aimed to:

- enable the Board to effectively discharge its governance responsibilities during this Pandemic and in particular deal with any necessary legislative or regulatory aspects of business
- provide assurance that plans were being developed in line with national direction and that resources were being deployed effectively
- maximise the time available for management and operational staff to respond to COVID-19
- minimise the need for people to physically attend meetings
- seek assurance through the fortnightly Chair, Vice Chair and Assurance Committee Chairs meetings

Since this time we have reduced our daily COVID-19 System Leadership Team daily Huddle to two days per week and our Pandemic Incident Management Team from weekly to fortnightly. We have re-established our System Leadership Team weekly meetings from 4 May 2020 as we look to support effective mobilisation and work with the ‘new norm’.

1.5 LINKS TO OTHER PLANS

- NHS Forth Valley Interim Pandemic COVID-19 Response Framework
- NHS Forth Valley Directorate/Partnership Remobilisation Plans
- NHS Forth Service Level Business Continuity Plans
- NHS Forth Valley Major Incident Plan
- Forth Valley Local Resilience Partnership COVID-19 Framework
- Health Protection Scotland COVID 19 Guidance (various)
- Scottish Government, Health and Social Care Guidance (various)

SECTION 2: PLAN ACTIVATION – REMOBILISATION

2.1 OVERVIEW

Our Mobilisation Plan was developed in partnership and adopted a whole system approach to support our mobilisation response. This whole system approach is reflected in our work to resume services which will be achieved in stages. Infection Prevention & Control will inform how we resume services and the throughput of these services whilst physical distancing requirements remain in place. It is assumed these measures will be required for some time; this has implications for how we use space, staff and equipment. The continued use of working from home where possible and appropriate will continue to be maximised. Overcoming capacity, workforce, logistics (PPE, drugs and other equipment), space/facilities, and transport challenges are all being considered to support a scale up of services aligned to Regional and National Plans.

Contact tracing, in conjunction with other measures will form an integral part of the roll out of 'Test & Protect'. The work led by Public Health is well underway with assistance from Local Authority Environmental Health Officers and good internal systems including local laboratory capacity to support the agreed testing pathways.

Our preparation to support safe and effective remobilisation is detailed in our planning assumptions set out above (page 10).

2.2 Enabling Activity

2.2.1 Digital & ehealth & Information Management Services

Since the beginning of March 2020 our ehealth department postponed all non-essential services to enable staff working within this area of work to:

- accelerate roll out of 'Near Me'
- initiate Microsoft Teams roll out to support meetings and communications
- identify and introduce messaging solutions for clinical and operational teams
- increase wifi access for key staff at Forth Valley Royal Hospital
- establish remote access arrangements for staff bringing access up to c. 50% coverage for primary care
- procure additional laptops and mobile devices to support more agile and home working
- strengthen cyber security (Advanced Threat Protection (ATP) roll out)
- review and refresh ICT business continuity plans including OOH support
- support operational arrangements for key IM reports to be generated to inform SITREP reporting externally and internally and to support decision making
- provide IT and Communication support for Hub & Assessment Centres e.g. Adastra and TRAK functionality along with telecoms

- roll out of ipads to support Critical Care and community hospital visiting
- enhancements to the Patient Management System to monitor and record COVID-19 activity (via TRAK)
- enhanced 'Portal to Portal' and SCI Store links to share patient information across Health Boards boundaries
- roll out of access to Emergency Care Summaries (ECS) to Dental, Pharmacy and Optometrists in the community
- enhanced 'paper-lite' working in ICU

2.2.2 Managing Quality & Safety

We continue to prioritise clinical governance and have implemented a rapid response to registering changes and developing, assessing and signing off COVID-19 guidelines and procedures. In addition we continue to oversee information about changes to every service and have collated as a baseline data collection, recording services and care that have been temporarily postponed. This will guide our remobilisation efforts.

We have maintained many of our safety programme interventions, for example falls prevention and clinicians are planning to build on our Best in Class knee problem programme. We have already tested out restarting our Value Management Collaborative.

We plan to begin to systematically adopt specific Scottish Access Collaborative interventions in the outpatient remobilisation plan. This has already included waiting list validation and will include extending Active Clinical Referral Triage and Patient Initiated Review. We have also had a meeting with the national team to discuss 'colon, capsule endoscopy' and are submitting estimated numbers from now to the end of March 2021. We have plans to support implementation and have allocated an Improvement Advisor to support this development if it approved by Scottish Government.

2.2.3 Emphasis on innovation and transformation

NHS Forth Valley's most innovative clinicians and support services have responded to COVID-19 by working closely with other teams, NHS Boards and Scottish Government to realise the potential benefits from existing and new projects.

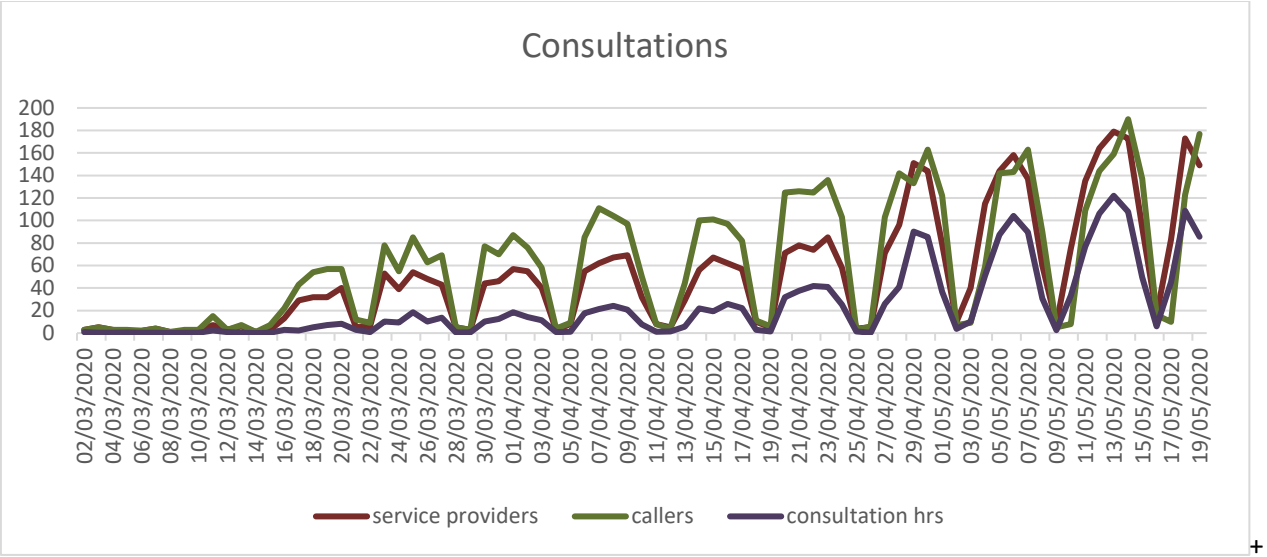
The tele-ophthalmology real time virtual assessment of emergency and urgent eye conditions has been extended to community-based optometrists and formed the basis of national Emergency Eyecare Treatment Centre. Fewer patients have to travel; physical distancing is maintained for patients and healthcare providers and in some cases treatment, including medicines and emergency surgery, has been accessed more quickly than before. In the next two months we plan to increase the types of eye conditions that can be assessed remotely and have started working with the Chief Scientist and interested NHS Boards to develop an Eyecare Small Business Research Initiative.

The Virtual Asynchronous Consultation (VAC) platform and app developed by our dermatologists and Storm ID has been put into routine use for a proportion of appointments, supporting people to self manage and helping to diagnose benign skin lesions. We will continue to work with NHS Grampian and NHS Greater Glasgow and Clyde, on behalf of NHSScotland with the Scottish Government Access Team to integrate the

technology and process into Trakcare our patient information system. The information about use has been shared in a MS Teams meeting with other NHS Boards to increase engagement in adopting VAC.

We contributed to the Chief Scientist Office's call for information about healthcare challenges that need innovative solutions, submitting a challenge to remotely monitor and respond to people with chronic respiratory problems requiring spirometry.

In response to the COVID-19 outbreak, a team has been supporting the rapid scale up of Near Me across NHS Forth Valley to GP practices, primary and secondary care services. This report presents the growth and activity of Near Me on a daily basis from the 2nd March 2020.



Reach extends to

- 54 GP practices
- 26 acute areas
- 4 COVID-19 centres
- 23 Mental Health services
- 17 Women & Children Services

- 25 Community Services
- 1 Oncology
- 1 Community Pharmacy

We will continue to systematically embed Near Me into Trakcare as part of our outpatient remobilisation and recovery planning. Our mental health services rapidly increased use of Near Me at the start of COVID-19 and are embedding it within their remobilisation plan. We have taken full advantage of Healthcare Improvement Scotland and Scottish Government's offer of support to work with priority outpatient specialties and GP Practices to share best practice through webinars and identify barriers to use. Both our number of clinicians using Near Me and number of consultations has increased.

Our Ageing and Health Consultants shifted their location from hospital to community to support the Enhanced Care Team to assess and manage older people. We are exploring what further changes would be needed to build on the successfulness of this change.

2.2.4 Workforce

Our HR Director has been instrumental in developing a redeployment hub with input from AHP, medical including DME and nursing senior decision makers in line with clinical priorities and in response to staff absence as it presents across NHS Forth Valley. This measure along with a comprehensive skills register enabled us to reassign staff to temporary roles to support new services and ways of working as we resume services this will become even more important.

2.2.5 Financial Sustainability

As we move towards this new phase of the plan it is important that financial sustainability and value remain key factors which influence the development of our service and workforce plans. The principles of Value Based Healthcare and Realistic Medicine be applied across the plan to maximise the opportunities to improve costs and patient outcomes. The financial impact of our Covid-19 remobilisation response will be reviewed and refreshed as part of the next iteration of the finance templates which are expected to be submitted in mid June. This will include any additional workforce impact beyond that already identified across all our Health and Care services, plus any equipment or capital priorities to support innovation and digital priorities. There will be a full review of wider NHS Board financial planning assumptions for 2020/21 following quarter 1 to assess the position in respect of cost trends, savings programme, and an updated assessment of financial risk.

- ✓ Additional supporting information in relation to Recovery, Innovation and Advancing Integration is included here.

SECTION 3: SAFE AND EFFECTIVE REMOBILISATION

Over the forthcoming 100 days, there will be a safe and gradual resuming of NHS services. Section 3 of this Remobilisation Plan provides a summary of actions being taken to resume services. The summaries set out have been informed by Service/Partnership Remobilisation Plans embedded within this document.

3.1 Test & Protect

Outcome
Suppress the transmission of the virus and prevent/control nosocomial related infections and care home outbreaks

NHS Forth Valley will:

- ✓ continue to support the 'test and protect' pathways including surveillance in hospitals, care homes and for key workers and their households
- ✓ provide a 7 day per week contact tracing service
- ✓ maintain robust IP&C measures within all its NHS sites/services
- ✓ sustain the enhanced assurance system to support care homes (i.e. daily tele-call) including establishing a Forth Valley oversight/assurance group

Summary

NHS Forth Valley has implemented all of the Test & Protect Pathways (see Executive Summary Highlight Plan – Key Actions).

There continues to be a marked reduction in the overall positive rate from all testing (down from approx. 30% in recent weeks to 1-2% positive week ending 5 June). The cumulative number of all key worker tests carried out within Forth Valley is 3253 (up to 31st May). Locally validated figures for the last 10 weeks find that for NHS staff testing, of 1378 staff and household contacts tested 183 (13%) have been positive. Of the 1750 social care staff and household contacts tested and with available results, 227 (13%) were positive. Other public sector staff testing numbers are smaller by comparison but of 126 people tested 22 (18%) were positive for COVID-19. Up until the 31st May, of the approx 1000 tests on admitted inpatients over 70 years without symptoms there have been only 7 positives. Test and Protect contact tracing has started with relatively small numbers so far.

As of 9th June we have completed testing for 1934 residents (86.1%) in care homes of which 224 have been positive. Of the 2246 (70.8%) care home staff tested over this period 113 have tested positive. We continue to remain committed to testing both staff and residents in care homes.

Risk and Mitigation

The is a risk NHS Forth Valley will be unable to suppress the virus and spread of nosocomial related infections and/or care home outbreaks

NHS Forth Valley has taken steps to

- ✓ resource the Test & Protect programme and pathways
- ✓ resource a contact tracing service 7 days per week
- ✓ heighten IP&C awareness and monitoring across all of its NHS sites/services
- ✓ resource an enhanced care home system and response to maintain non-COVID are homes and/or promptly manage care home outbreaks with key partners
- ✓ maintain vaccination programmes and prepare for winter and the roll out of the flu programme
- ✓ Prepare for winter

3.2 Building Resilience

Outcome

Maintain and enhance our preparedness and responsiveness to future potential COVID-19 waves

NHS Forth Valley will:

- ✓ support the roll out of 'Test & Protect' pathways
- ✓ continue to maintain community hub and assessment centre capacity
- ✓ maintain dedicated COVID-19 acute and ICU level 3 beds
- ✓ sustain SCI Gateway advice line and established primary/secondary care interfaces
- ✓ retain HR deployment hub to ensure access to workforce
- ✓ provide professional support and advice to care homes to maintain safe service delivery
- ✓ maintain robust IP&C measures
- ✓ encourage ongoing innovation

Summary

There has been no update to the modelling since last reported when actual Forth Valley positive numbers were at the low end of the range of predictions. It's assumed that there will be a delay to the next modelling summary to include variations of the easing of the lockdown. It is anticipated that new confirmed cases will continue to decrease in number as will hospital admissions over the next fortnight.

The total number of confirmed cases has been on a steady decline and ICU occupancy remains in low single figures and stable. There is now a daily report on the number of hospital admissions with shielding alerts. Average in the last week is between 12-13 people, the majority of which do not have COVID-19 alerts and the small number of deaths (1 per day) has been due to underlying causes.

Deaths of COVID-19 confirmed hospitalised patients continue to very slowly increase in number, with one additional death since the update last week. As of 4th June there were 60 COVID related deaths reported within Forth Valley Royal Hospital (FVRH) and 2 at other community hospital sites. NRS data for week 22 (25th - 31st May) report falling deaths from all causes to 50 which is the lowest number this year and lower than the normal minimum level for week 22. There were 3 COVID-19 related deaths reported by NRS which is 6% of all deaths in FV. The equivalent Scottish figure is 12%. Since the start of the outbreak there have been 219 NRS COVID related deaths in FV. COVID Death Rate per 10,000 populations in FV (7.1%) is slightly lower than the Scottish average (7.2%).

The cumulative number of confirmed COVID-19 inpatients that have been discharged has now reached 176.

Risk and Mitigation

There is a risk that NHS Forth Valley is unable to respond a future COVID-19 recurrence

NHS Forth Valley has taken steps to ensure it will have capacity and reserve to in the event of a COVID-19 second wave, these include:

- ✓ timely access to appropriate PPE
- ✓ ongoing robust IP&C measures including physical distancing requirements
- ✓ community hub and assessment centre – primary care capacity
- ✓ c. 60 acute COVID-19 beds and 7 ITU level 3 beds to support segregation and cohorting of patients
- ✓ supporting the roll out of 'Test & Protect'
- ✓ access Louisa Jordan capacity

3.3 Non COVID-19 urgent care

Outcome
Commit to supporting the National Screening Recovery Plan - Cervical, Bowel, Breast, Triple AAA, Diabetic Retinopathy

NHS Forth Valley will:

- ✓ continue to support the Screening Recovery Plan and play into supporting modelling of demand and capacity work and readiness to support our internal local planning – i.e. numbers screened, requiring further investigation and referred for treatment
- ✓ contribute to national and local messaging

Summary

Of those patients in our screening programme:

- Bowel screening – all patients have received their pre-assessments and are waiting a colonoscopy, colonoscopies have resumed and the waiting list is gradually being reduced. The colonoscopy lists are also being used to reduce the number of urgent suspected colorectal patients who are also awaiting a colonoscopy. The number of Bowel Screening Patients waiting for a colonoscopy is 43.
- Breast screening – our screening patients receive their diagnostics at the screening centres in Glasgow and Edinburgh, if cancer is detected patients can be referred back to NHS Forth Valley for treatment. We have not received any referrals for the past month.
- Cervical screening – currently we have no screening patient referrals waiting for colposcopy.

NHS Forth Valley will engage in the national AAA and DRS screening programmes and will be guided by NHS NSS and NSD.

Risk and Mitigation
There is a risk that NHS Forth Valley will be unable to support the Screening Programme NHS Forth Valley will take steps to: ✓ work with the NSD to inform prioritisation of high risk screening participants ✓ continue to inform risk mitigation national discussions – i.e. to ensure access to local treatment capacity and ongoing capacity going into winter

3.4 Re-establish Primary Care Services

Outcome
Resume services based on 3 principles, namely: safety, clinical prioritisation and population need

NHS Forth Valley will:

- ✓ establish a local recovery management team led by the Deputy Primary Care Medical Director to include acute interface representatives
- ✓ review how we use our community hub and assessment centre model
- ✓ continue to update documentation – ACPs, KIS and ReSPECT
- ✓ support those patients in the shielding group
- ✓ reconfigure services within primary care to segregate COVID-19 and non COVID-19 flow
- ✓ expand remote consultation using telephone triage and Near Me
- ✓ support care homes
- ✓ develop the Hospital at Home model of care at scale
- ✓ roll out of NHS Pharmacy First Scotland
- ✓ implement for those patients who receive a repeat prescription a shift towards serial prescriptions (aim to see 20% moved to serial prescription per GP practice)
- ✓ continue to support EETC through three Emergency Eyecare Treatment Centres
- ✓ support a phased approach to resuming dental services
- ✓ increase access to treatment room and phlebotomy services
- ✓ prepare flu vaccination plan in preparation for winter

Summary

As we move into the next phase of COVID-19, with small numbers of patients going through the triage hubs and assessment centres, it is clear we need to start increasing activity throughout the system. While Primary Care have had to reduce the number of services they provide, there has still been a lot of activity in non-COVID areas, as well as the more directly COVID-19 related work streams.

All Practices have maintained assessment and management of undifferentiated presentations to primary care, and services have been maintained albeit at a reduced level in Community Nursing, Health Visiting, Community Pharmacy and Optometry. It should be noted also that primary care have provided the majority of resource to cover the triage hub, in close association with the OOH service, the Community Assessment Centres (CAC) and the Care Home Assessment and Response Team (CHART).

Services that have been temporarily postponed include:

- some screening programmes as per national direction
- routine chronic disease recalls
- joint injections, minor surgery, LARC, pessary fitting
- near patient testing regimes have been reduced as per specialist guidance

There has been a significant switch from face to face to telephone or Near Me consultations but Practices have also maintained the ability to bring in patients as dictated by clinical need.

There has been a significant increase in the numbers of specialties offering advice through the SCI gateway and there has been increasing use, especially as the responses have been turned around very quickly often within 24-48 hours.

Clusters have been meeting remotely, with more regular meetings, often weekly in some areas, providing peer support and sharing ideas for new ways of working. They have developed escalation plans on a cluster as well as Practice basis.

As we plan the start of recovery we need to keep in mind that:

i) The COVID-19 pathway for symptomatic patients will continue.
ii) That asymptomatic patients are assumed to be COVID-19 +ve
iii) Some practices may experience reduced capacity due to team members self-isolating.
iv) Some practices may have reduced capacity to assess and treat problems due to the challenges of face to face assessments and reduced availability of investigations, out-patients etc.

3.4.1 General Practice

With that in mind the GP Sub Committee has adapted a guide to practices to help steer the course back to a more usual way of working, taking into account the restrictions enforced by physical distancing and shielding.

Increasing the number of pre-arranged **patient contacts**, via telephone or near-me where possible, but allowing for more face to face consultations where appropriate has already begun in many GP Practices. Physical distancing within the waiting rooms will have an impact on patient flow within practices. One of the limiting factors currently is the lack of availability of suitable equipment to support Near Me consultations from Practices. While all practices are now set up to provide near me consultations there is a number lack the equipment and network access required to support this.

While **referrals** have reduced, that is mainly due to reduced attendances at Practices. GPs are still referring, where appropriate, and the referrals have been 'held' within the system in secondary care.

Anticipatory Care Planning has increased because of the care home work and shielding, and will continue to be a priority. The safety of shielding patients remains a priority and an appropriate risk assessment is made before deciding on the most suitable place for a shielded patient to be seen.

Workforce **resilience** is being supported by the provision of psychological and wellbeing tools that can be accessed by all staff. Access to rapid testing allows for minimal time off if staff or members of their household have symptoms.

3.4.2 COVID-19 Workstream

The ongoing maintenance of the separate COVID-19 pathway via the triage hubs and CAC has also given some reassurance to those working in the non-COVID pathways, although they are ever mindful of the potential for asymptomatic COVID-19 patients. With the current primary care estate, especially in older premises, there are likely to be difficulties for some Practices to identify appropriate areas or flow to allow for adequate separation of Red and Green zones within the Practice, maintaining a separate COVID-19 pathway will help these Practices recover services more quickly and efficiently. If there continues to be low levels of COVID-19 in the system, there is an option to further reduce the staff deployed there, by closer integration of the CAC and CHART, while keeping in place an escalation plan to re-open centres are required. The next stage of this is to merge the CAC and CHART into one response team, whilst being still flexible enough to respond to daily fluctuations in workload but smaller to allow more staff to return to core work in preparation for recovery. Work has started to explore how a central triage hub could be used.

While this work is progressing in primary care it is important that we continue to develop this in **partnership** with colleagues in secondary care and social services. If not then we risk creating new barriers to the patient journey. Simple guidance on where our shared priorities lie, with an agreed schedule for increasing or re-starting services and good communication between the services should help keep the path clear.

3.4.3 Care Homes

Practices undertook to review their care home patients to ensure appropriate Anticipatory Care Plans (ACP). Key Information Summaries (KIS) and Adults with Incapacity (AWI) documentation was in place. This was supported by the Care Home Liaison Nurses (CHLN). The Enhanced Community Team (ECT), augmented by the addition of three Geriatricians, are now providing clinical support for GPs and the CHLNs with a dedicated phone number and also providing a COVID-19 response for the frail in the community while continuing its core function of keeping unwell frail adults at home. To increase the response to care homes for dealing with COVID-19 symptoms, the Care Home Assessment & Response Team (CHART) was created. This has a clinical compliment of GPs and ANPs, and colleagues form social care working collaboratively with AHPs, the palliative care team, CHLNs, ECT, community nursing and public health to help monitor the situation with care homes and provide support where required, either clinically to specific patients or a wider response to support care homes including staffing

issues, training infection prevention and control measures and leadership support. There is direct access to the team via a dedicated number, and the team are also proactive in contacting care homes to offer support. A number of education sessions have also been organised and made available to clinicians and care home staff.

Close working with each of the Health & Social Care Partnerships has helped develop new pathways including step-up facilities and COVID-19 assessments. These developments are also informing a larger Hospital at Home model.

As well as the Forth Valley wide Medical Leadership Forum, there has been representation from primary care at many of the recovery meetings for acute services. Reciprocally, secondary care has engaged well with the Primary Care Incident Management Team. Recent developments have included a community phlebotomy hub, staffed by colleagues from acute services and providing access to investigation investigations for both primary and secondary care.

To help deliver this then it is important that we continue to develop the Forth Valley Primary Care Improvement Plan, in line with the direction of travel previously agreed. We have strong tri-partite engagement, ensuring that the program of development continues at pace. We have increasingly well developed services in various clusters across Forth Valley, with the plan to deliver the contract in full by April 2021. This should support sustainability of the Practices across Forth Valley, and allow GPs to spend more time with patients at most need. It must be noted however that there are 2 areas that may impact on the deliverability of this:

- the recurrent funding shortfall that needs to be addressed to be able to fully support practices going forward
- the current lack of Primary Care IT infrastructure to fully support Near Me, remote working for GPs and Hub working to deliver cluster and board wide services

3.4.4 Optometry Services

NHS Forth Valley has delivered an EETC model through three Emergency Eyecare Treatment Centres and Community Optometry continues to manage a large number of patients within the community through telephone or video consultation, advice and treatment including clear pathways for onward referral to Independent Prescriber optometrists and a designated community pharmacy pathway. This model has been very successful in providing rapid access to advice or assessment for those with urgent, sight threatening conditions while keeping the number of face-to-face appointments required to a minimum.

Patients from Rapid Access Clinic (RAC) have also been seen by the EETCs along with some essential patients from Hospital Eye Service. Having access to tele-ophthalmology at each EETC has been an essential component of patient management in the community and for minimum onward referral to hospital eye departments. Further planning is under way for post lockdown/EETCs, to establish how eye care can best be provided for patients for a range of conditions and to support appropriate management in the community wherever possible. This would include shared care (non-GOS) for both acute patients seen in the RAC and for chronic conditions, building on the excellent models during

EETCs, where patients could be seen in the community setting. Continued secondary care tele-ophthalmology support would be vital and inter-board cover could be utilised. This shared care modelling would require suitable PPE, funding and Open Eyes (Electronic Patient Record).

A range of eHealth initiatives have been implemented to assist with eye care and these would need to be continued over the next few months e.g. Open Eyes, Emergency Care Summary, Near Me/Attend Anywhere and vCreate. The roll out of CAT20 is being supported across all practices to improve speed and connectivity of community optometry and NHS systems.

3.4.5 Dental Services

Dentists have remained open to phone calls, but due to the nature of their work and the fact that their procedures are aerosol generating, they have been unable to see patients in the community. Urgent dentistry is still carried out by the Public Dental Service from 3 hubs.
The following phased plan is proposed.

Phase 1: Increasing Capacity of Urgent Dental Care Centres (UDCCs) During phase 1 dental practices will remain closed to face-to-face patient consultation. Dental practices will now work to prepare for the practice receiving patients under phase 2(a) (for further details see below).

NHS Forth Valley has expanded capacity in the Urgent Dental Care Centres to increase the scope of treatments available to patients. UDCCs will move as soon as possible towards providing an expanded list of treatment for acute and essential care.

Phase 2: Restarting Dental Practices During phase 2 the Senior Dental Management Team will work with primary care towards restarting NHS dental services in practice. There are two identifiable steps within this phase:

- Phase 2(a): All dental practices to open for face-to-face consultation for patients in need of urgent care that can be provided using non-aerosol generating procedures;
- Phase 2(b): Face-to-face consultation to be expanded for patients that can be seen for routine care, including examination, and treatment that can also be provided using non-aerosol generating procedures.

UDCCs will continue to see patients on referral for treatments involving aerosol generating procedures.

Phase 3: Introducing AGPs to Dental Practices Phase 3 envisages a limited introduction of AGPs to dental practices; this will be dependent on evidence of risk and possible mitigation. The main focus at present is on a staged recovery and phases 2(a) and 2(b) – see attached plan.

3.4.6 Community Pharmacy

Movement of Repeat Prescription from GP Practice to Community Pharmacy

An ePharmacy Serial Prescribing Group has been convened to progress increasing the number of serial prescriptions managed by community pharmacies. The membership of this group includes representation from eHealth, Community Pharmacy Development, Community Pharmacy Forth Valley and Primary Care. Within Forth Valley there are areas where both GP Practices and Community Pharmacies already have experience of serial prescribing. A Roll out of Serial Prescription Approach has been agreed by the Pharmacotherapy Implementation Group and a cluster identified where serial prescriptions are already in place for a small number of patients. The group has agreed an aim of 20% of those who receive a repeat prescription to be moved to serial prescription per GP practice.

North West Stirling is the first identified cluster and within that cluster Doune GP Practice and Woodside Pharmacy will be the first site to progress towards 20% of repeat patients with a serial prescription. An initial increase of 10% is aimed to be completed by August 2020 once refresher training for GP practice staff and the pharmacotherapy team has taken place. A Shared Care Agreement (SCA) will also be agreed between the GP practice, Community Pharmacy and Pharmacotherapy Team.

Work is underway to agree a process for submitting Treatment Summary Reports to ensure information included is beneficial to the GP Practice and achievable for the Community Pharmacy. A planned roll out will then commence to additional sites within the North West Stirling cluster where there is experience of serial prescriptions and further clusters have also been identified for future roll out. While the roll out within the identified clusters progresses it is recognised that some GP Practices and Community Pharmacies out with these clusters may start to progress the implementation of serial prescriptions. In these circumstances Pharmacy Champion resource would be utilised to support this process where eHealth support is unavailable and we would aim to use the same SCA across Forth Valley for consistency and ease of staff working across clusters.

NHS Pharmacy First Scotland Service

The Community Pharmacy Development Team and Pharmacy Champions will support the national roll out of the NHS Pharmacy First Scotland services in Forth Valley. The following actions have already been undertaken:

- Production of supporting documentation/checklist to aid pharmacy champion visits to brief Community Pharmacy Teams on service requirements
- Pharmacy champions briefed on new service and aware of requirements
- Scenarios prepared to aid training

The aim is to ensure Forth Valley community pharmacies are in a state of readiness when the service launches and are aware of the requirements of the service. Our aim is for Community Pharmacies to start making changes to their daily practice prior to the service launch so new processes become embedded in daily practice for example recording activity. Where pharmacy champion visits are not possible due to social distancing the Community Pharmacy Development Team will explore alternative solutions including video conferencing, online meetings and utilising email communications. The local Community Pharmacy website will be updated to include all local resources and to signpost to the NES webinar and Community Pharmacy Scotland website for additional support materials.

3.4.7 Flu Vaccine Campaign

This is an area where there is a need to develop new model of delivery. Physical distancing and shielding mean the traditional model of mass immunisation clinics is not possible. The Vaccine Transformation Group, with clinical input and leadership from General Practice have begun looking at alternative models for this to ensure safe delivery of flu vaccine to the population of Forth Valley.

3.4.8 Treatment Rooms and Phlebotomy

Some treatment room services and phlebotomy have been retained through this but there are plans to increase the capacity to provide more phlebotomy and B12 injections to support recovery in primary care (see attached Plan).

Risk and Mitigation

There is a risk that NHS Forth Valley will be unable to meet a resurgence in primary care demand

NHS Forth Valley will:

- ✓ work alongside primary care colleagues at a Practice and Cluster level to ensure we have capacity to meet demand
- ✓ support ongoing interface (primary/secondary care) ways of working to improve referral management
- ✓ promote a realistic medicine approach to support patient choice
- ✓ look to support social prescribing to help people self manage long term conditions
- ✓ continue to support the implementation of the Primary Care Improvement Plan and the MOU/GMS contract negotiations

- ✓ Additional supporting information in relation to Primary Care is included here.

3.5 Re-establishing Elective (Hospital) Care Services

Outcome
Resume services based on 3 principles, namely: safety, clinical prioritisation and population need

NHS Forth Valley will:

- ✓ establish a local recovery management team led by the Deputy Medical Director
- ✓ develop/agree clear clinical prioritisation protocols to reflect local and national needs
- ✓ assess surgical workload to include deferred/backlog cases pre COVID-19 and new referrals since lockdown
- ✓ review all waiting lists including diagnostics adopting a realistic medicine approach to inform patient choice
- ✓ prepare patient and local communication letters/briefings
- ✓ revisit job planning approach
- ✓ reconfigure services on acute site to segregate COVID-19 and non COVID-19 admissions
- ✓ expand remote consultation across all acute specialties using telephone triage and Near Me
- ✓ utilise digital and treatment innovations
- ✓ work with regional colleagues in the West Region to inform our local and regional cancer remobilisation plans

Summary

NHS Forth Valley remains committed to addressing the cases that have built up since pre-COVID-19 as set out in Table 1, however this needs to be safely managed using a clinically led risk based prioritisation approach. The numbers on our waiting list as anticipated remain fairly static however our long waits have increased significantly, addressing our long waits is a priority. We have begun to systematically adopt specific Scottish Access Collaborative interventions in our remobilisation plan. This has already included waiting list validation and will include extending Active Clinical Referral Triage, Patient Initiated Reviews and Effective Quality Interventions Pathways. Working with the Independent Sector and Golden Jubilee National Hospital to increase our capacity will help address our waiting times challenges. We have also held discussions with the national team and have shared estimated numbers to support this service being implemented if supported.

Table 1

Summary Table

	18-Mar-20	03-Jun-20
IP/DC Total waiting	2,950	3,104
IP/DC > 12 weeks	968	2,380
OP Total Waiting	12,696	12,456
OP > 12 weeks	2,424	8,038

3.5.1 Hospital Services

Elective surgery being suspended was seen as a logical and necessary response to COVID-19 however The Royal Colleges have highlighted a decline in hospital presentations/admissions, ITU occupancy during the pandemic and all NHS Boards are now considering how best to resume acute including surgical activity, in line with national guidance. The Acute Services Directorate plans to resume surgical activity whilst being thoughtful about available 'space, staff, systems and stuff' (equipment).

Work to resume services is well underway informed by good levels of clinical engagement. At the outset access to separate bed based COVID-19 capacity c. 60 acute beds and 7 level 3 ITU beds has been assumed. Bed occupancy to accommodate physical distancing requirements has been set at 75% supported by community triage and assessment and ageing and health enhanced community support. Clinical guide to surgical prioritisation during the Pandemic informed clinical interventions and treatment with levels 1a (emergency - operation needed within 24 hours) and 1b (urgent – operation needed within 72 hours) and Ic (surgery can be deferred for up to 4 weeks) all being supported. Access to the independent sector and Golden Jubilee provided cancer treatments for people undergoing e.g. skin, breast surgery. Ongoing use of the Golden Jubilee, Independent Sector and if required the Louisa Jordan hospital will influence our ongoing local remobilisation planning. The Acute Services Directorate has set out a number of essential priorities during mobilisation are to:

- Maintain emergency care services for both COVID +/- patients together with care for priority patients. For example: Urgent suspected cancer and conditions requiring urgent treatment or intervention; and
- Develop plans for delivering a range of risk stratified acute services for patients who fall out with emergency/urgent categories. The focus of this plan centres around the key principles of: Respond, Recover and Renew and allows:

1. The flexing of Intensive Care Unit (ICU) and acute bed capacity for COVID and non-COVID presentations.

2. Agility for elective inpatient, day case, diagnostics and outpatient activity through innovative approaches, whilst maintaining urgent and suspected cancer services.
3. Dynamic unscheduled care delivery with the ability to flex and be responsive to changing demands and continue to build on new ways of working and innovations.
4. Provide actionable plans to assist partners in the delivery of reduced delayed discharges and interfaces with primary care and community services.
5. A whole system approach to COVID-19 responsiveness.
6. A governed approach to recovery with evidence-based prioritisation of services.

3.5.2 Cancer Services

Whilst on an 'emergency footing' NHS Forth Valley clinicians have clinically reviewed all their patients and continue to treat patients with life threatening conditions. Where it was safe to do so, a number of surgical treatments were put on hold. Over this period a number of pre-assessment and diagnostic tests have continued to be delivered with changes to the number of procedures and lists taking place to comply with restrictions. Work is ongoing to review and prioritise any patients whose procedures were postponed and this will be discussed in our routine weekly recovery meeting.

We have robust monitoring in place and are tracking those additions to our 31 day and 62 cancer pathways.

3.5.3 Diagnostics

Imaging and endoscopy services have been significantly reduced as a result of the COVID-19 pandemic.

Endoscopy Pre & Post-Covid-19

Endoscopy services were significantly reduced during March. This was in line with British Society Gastroenterology (BSG) guidance, resulting in only clinically essential procedures being undertaken. Actions have been taken to help mitigate the impact of this service reduction and include telephone consultation where clinically appropriate.

Colonoscopies have been recommenced adhering to strict guidelines with 34 procedures being undertaken per week.

Imaging Pre & Post-COVID-19

Work to resume 'normal' and safe working practice is impacted by the need to maintain appropriate physical distancing throughout the department acknowledging all PPE requirements and the need for additional cleaning of imaging equipment and waiting areas.

CT/MRI capacity to help address these capacity constraints is being assessed to optimise use.

3.5.4 Outpatients

Over the lockdown period the number of outpatients waiting over 12 weeks has increased from 2,424 on 18 March to 8,038 on 3 June 2020. One positive factor to report is that the waiting list, the main determinant of waiting times, has reduced from 12,696 in March to 12,456. This is a result of the reduced referrals and ability of the team to perform virtual clinics.

3.5.5 Inpatients and daycases

Over the lockdown period the number inpatients/daycases waiting over 12 weeks has increased from 968 on 18 March to 2380 on 3 June 2020.

3.5.6 Inpatient Surge Capacity and overall responsiveness

There are 401 beds available on site for acute care. In addition to this there are 54 Acute Receiving beds, 16 medical and 10 surgical assessments spaces. A robust model is in place to maintain inpatient ward capacity for both COVID and non-COVID admissions. It allows flexibility in line with the actual levels of COVID positive patient admissions plus an immediate 50% increase in capacity if/when required. The key trigger is when acuity and bed occupancy reach levels that impact whole system capacity and flow. In addition, the model allows for phased increase of high-risk capacity as required.

Plans are in place to accommodate the changing landscape of arrangements for testing and isolating patients with confirmed or suspected COVID-19, in addition to meeting the requirements to protect patients identified as high-risk and shielding, patients over aged 70 who require regular screening. The system will remain flexible to be able to meet any further additional requirements, around screening, testing and safe placement of patients.

3.5.7 Resuming Priority Services

The Acute Services Directorate is implementing a robust delivery plan for the resumption of priority services. This implementation plan encompasses both strategic and operational intelligence on the benefits realisation of resuming priority services. Baseline strategic service intelligence data has been captured and synthesised into clear operational recovery plans at a service level. These recovery and resumption plans, in conjunction with the clinical prioritisation framework will allow clinical services to expand their remit from their maintenance of urgent care pathways to the inclusion of more routine pathways. The recommencement of national screening programmes has not been factored into the Acute Services Remobilisation Plan; however collaboration with NSS will guide the reinstatement of these Programmes.

This model will be supported by analytical data that allows for both capacity and demand to be modelled in line with new measures on social distancing and governmental guidance. In addition to this a clinical prioritisation approach based on the guidance from the relevant Royal Colleges and professional bodies that presents the potential opportunity to encompass the principles of realistic medicine, following a person centred approach to clinical treatment, treating those cases first that are most urgent and ensuring that activity levels are aligned with available **space, systems, staff and stuff** (PPE, medicines, equipment, and consumables).

3.5.8 Emergency Care

The number of attendances at Forth Valley Royal Hospital has fallen compared to the period before the outbreak began. Our unscheduled care pathway can sometimes be complex for patients to negotiate and this is therefore an ideal time to develop a more scheduled care approach for those 'non life threatening' presentations. A Once for Scotland approach should be adopted to inform the future of emergency care. In the meantime we will look to develop a more scheduled approach for people presenting to ED with a non-life threatening injury or illness. This approach including redirecting all minor presentations to the Stirling Minor Injury Unit has worked well during COVID-19 – these arrangements need to continue as we learn to live alongside this virus for the foreseeable future. Physical distancing cannot be achieved in our current waiting room/facilities.

3.5.9 Acute Services Directorate Prioritisation Action Plan

0-2 Weeks	2-4 Weeks
Maintain current refined Emergency, Urgent care and Cancer service delivery	Reconfiguration of bed base work stream finalised. Plan for incremental change established
Commence reconfiguration of bed base model based on new ways of working	Finalise Consultant flexible receiving model
Agree clinical prioritisation framework and transpose to non-surgical planning	Develop infrastructure strategy that supports new ways of working. E.g. remote working strategy, Near me virtual consultation framework

Establish capacity of current footfall in all Board Estate for OPD, theatre, Ass Units and ED, to allow more accurate calculations of deliverables	Begin implementation of physical modifications to support new ways of working across FVRH estate
Work with partners to understand model of unscheduled care delivery for phased recovery (assessment and triage hubs)	Support key capital developments across acute site. To include: ✓ Re-configuration of critical care footprint to deliver 100% single side room accommodation and Emergency department resus reconfiguration to created segregated AGP bays.
Continue development of workforce strategy that aligns with service reconfiguration and delivery	Review capacity to deliver 24hr/7day week model to support waiting times delivery and identify any associated resource required.
Development of risk stratified approach to resuming priority services that aligns with co dependencies.	
Redesign of geography to facilitate IP&C requirements and optimise flow	

- ✓ Additional supporting information in relation to Acute Services is included here and planning document here.

Risk and Mitigation

There is a risk that NHS Forth Valley will be unable to address the pre COVID-19 backlog and new elective demand post COVID-19

NHS Forth Valley will:

- ✓ access Golden Jubilee National Hospital capacity
- ✓ work alongside the independent sector (IS) to maximise internal and IS capacity to address long waits based on Royal College surgical prioritisation criteria
- ✓ expand hospital capacity to include scheduling modifications (e.g. working day/7 day working)
- ✓ access Louisa Jordan capacity if required
- ✓ maintain a scheduled approach to urgent care presentations

3.6 Re-establishing Community Care

Outcome
Resume services based on 3 principles, namely: safety, clinical prioritisation and population need

3.6.1 Mental Health

Mental Health Leads (managers and clinicians) have been working collaboratively with colleagues noting the interdependency between primary and secondary (acute hospital) care services. Inpatient services have seen an increase in demand and high levels of detention under the Mental Act and a need to isolate COVID-19 cases.

Community referrals decreased during March and April although from April to May referrals have increased by 23% and it is predicted that this increase will continue. By the end of July the services will be receiving a higher level of referrals than was the case pre-COVID-19 should this trend continue. If the increase in demand for admission beds translates to the same level of increased demand for community provision then a demand in the region of an additional 30% may be seen across the service.

During COVID-19 the service developed a Psychological First Aid process which reached out to all new routine referrals and provided a time-limited intervention. This has, based on early data, been successful and we will be working to build this into our normal processes as we recover. In addition, the service will develop condition-specific pathways, make use of online resources and continue with a focus on tele-health and video-conferencing.

At the onset of the pandemic the Mental Health Services examined caseloads and identified cases where it was safe to pause treatment and devised person-specific plans for keeping in touch. As we prepare to re-establish some of the services which were scaled down the service will be guided by clinical priorities in re-establishing parts of the service. These will focus on recommencing treatment for those paused, and beginning to re-open to new routine assessments. Although, the latter requires robust pathways and new processes to support demand capacity.

Managing the demand on the inpatient admission beds will be a key area of work. As community services return to full provision we will face the challenge of balancing the demand for services in and out of hospital with multiple co-dependencies between these two areas.

As with other service mental health and learning disability services will require a consistent supply of PPE (which will increase as the service expands), access to moveable media ICT and reliable clinical virtual platforms supported by building and infrastructure adaptations. A platform to support group work is yet to be identified and in its absence, this will impact on the capacity to deliver group therapy. In addition, the teams

across the service will continue to make alterations to hours of working and deploy staff differently to achieve phyiscal distancing. There is an opportunity to enhance and maximise the benefits of integration, specifically in the joint commissioning of third sector services. A renewed focus on realistic medicine with evidence based, time limited interventions will be essential in the service recovery.

- ✓ A separate and more detailed Mental Health Response is appended to this Plan at Appendix 1.
- ✓ Additional supporting information in relation to Health & Social Care Partnerships is included here.

3.6.2 Health & Social Care Partnerships

NHS Forth Valley continues to work with its two Partnerships and three Local Authorities as part of local resilience partnership arrangements to support our most vulnerable people and communities and to enhance and maximise the benefits of integration. Public Protection has remained high on all our agendas and we have established a Forth Valley Chief Officers Group in line with our Chief Officers responsibilities. In regard to health and social care services work is advanced in both of our Partnerships to respond to:

- anticipated ongoing significant increases in demand and complexity of care in the community (at home and for people rehabilitating from COVID-19) and community intermediate care and community hospital facilities and in this regard Partnership colleagues are:
  - ✓ increasing Homefirst team capacity across our acute and community sites
  - ✓ securing access to more AHP resources
  - ✓ increasing resources in MECS overnight support to continue to support Rapid Response Teams
  - ✓ developing at pace Hospital at Home services and increasing the enhanced care in the community team capacity
  - ✓ refreshing pathways to support Home Care, Enhanced Care and ReACH services
  - ✓ accessing community nursing support to continue to support people at home, including vulnerable older people
  - ✓ working with Third Sector Providers to maintain resilience and build ongoing additional community capacity
- delayed discharges within our health system and work to discharge all acute delayed discharges and at least 95% of people currently delayed in our community and or mental health beds continues
- Care Home Support and implementing the enhanced care home assurance system including the enhanced clinical and professional care oversight of care homes is well established in Forth Valley and a number of innovate ways of working across primary and secondary care supported by public health have emerged and are being supported

3.6.3 Falkirk H&SCP

Falkirk HSCP continued to provide the main core services including: care at home, community care team, community nursing and mental health officers, care homes and MECS. Day services were suspended in line with national lockdown requirements however the service maintained regular contact and support for service users and their carers. The partnership will remobilise and recover key services aligned to the COVID-19 route map, where it can safely do so with social distancing and IPC requirements, taking the opportunity to review and redesign services for post COVID-19 delivery. As part of Phase 1 the respite facility at Thornton Gardens reopened on 3 June.

On initial review the main priority areas in the current HSCP delivery plan still apply, however there may be opportunities to accelerate delivery.

The HSCP will prioritise where we can:

- accelerate integration
- sustain new models of care where they have proved effective
- review how we can accelerate the shift in the balance of care to extend community based support for people to stay at home longer
- continue to develop support and assurance model for Care Homes
- progress the review of community bed-based care and care at home

3.6.4 Clackmannanshire & Stirling H&SCP

Clackmannanshire and Stirling HSCP continued to provide the main core services including: working closely with providers across Clackmannanshire and Stirling care at home and independent sector care homes, community adults social care services, community nursing and mental health officers, and Mobile Emergency Care Services (MECS). Day services were temporarily postponed in line with national lockdown requirements however the service maintained regular contact and support for service users and their carers. Carers Centres undertook emergency plans with carers in the community. The focus for the HSCP was to effectively manage individuals who were delayed unnecessarily in hospital. The HSCP had no one delayed in hospital at the start of the pandemic however additional community bed capacity was created with services being brought back into service within Beech Gardens and Allan Lodge care homes. These homes were created to provide 'safe haven care' for people unable to go straight home from a hospital setting.
The HSCP has prepared a mind map to remobilise and recover key services aligned to the COVID-19 route map, where it can safely do so with social distancing and IPC requirements, taking the opportunity to review and redesign services for post COVID-19 delivery.

On initial review the main priority areas in the current HSCP mobilisation plan still apply, however there may be opportunities to accelerate delivery.

The HSCP will prioritise where we can:

- accelerate integration of services within the community
- sustain new models of care where they have proved effective
- review how we can accelerate the shift in the balance of care to extend community based support for people to stay at home longer
- continue to develop support and assurance model for Care Homes
- progress the review of community bed-based care and care at home
- develop a collaborative and multi-disciplinary Care Home assurance team
- review social care assessment community beds to consider different models (step up/step down)
- admission assessment to prepare for discharge – Home First approach
- develop integrated discharge pathways in collaboration with Falkirk HSCP and Acute
- development of a Hospital at Home model
- consider the development of care closer to home
- Primary Care Hub - Explore single point of contact
- review Hospital Discharge process, model and recording systems – map and streamline

✓ Additional supporting information in relation to Health & Social Care Partnerships is included here and here.

3.6.5 Allied Health Professions

- ✓ Additional supporting information in relation to Allied Health Professions is included here.

3.6.6 Women & Children Services

All acute inpatient services have continued to offer treatment to those presenting urgently or meeting the criteria for urgent care pathways e.g. cancer, paediatrics, maternity and CAMHS. Services can be resumed for non urgent deferred services although some of these services are require support from other Health Boards and/or visiting consultants.

Following the active referral triage, Outpatient services can resume for those people presenting with non urgent and life affecting conditions in both paediatrics and obstetrics and gynaecology.

Community services have continued for patients identified as high risk or presenting as urgent and requiring enhanced contact. Following the active referral triage, Outpatient services can resume for those people presenting with non urgent and/or those people identified as vulnerable.

Maternity services operate at both community and acute levels therefore a distinct approach was taken and the Directorate implemented the nationally agreed minimum standards set out for Maternity Services. Assessments of pregnant women in the community and maternity settings continued to be offered and emergency care pathways were adjusted and maintained. Home confinements were recommenced and support to vulnerable women continues. Maternity Services will continue to offer a (near) business and usual model of working.

CAMHS prioritised and focused care and treatment to those presenting as urgent or as an emergency. Risk assessments were completed on every child open to the service. Priority interventions continued to be provided to those identified as Red and Amber and spare capacity was directed to those categorised as green. Active triage of children open to the service (without case holders) aimed to completing treatment of those children, TAC and multiagency involvement was supported remotely, as was professional consultation across children's services. On going forward there is a need to adapting service provision to complete NDD assessments due to the need to link with other agencies – see Mental Health Plan.

- ✓ Additional supporting information in relation to Women and Children's Services is included here.

Risk and Mitigation

There is a risk that NHS Forth Valley will be unable to re-establish community services in response to population need

NHS Forth Valley will:

- ✓ focus on improved population health and wellbeing
- ✓ work with partners to address health inequalities
- ✓ continue to invest in prevention and community based support and interventions
- ✓ recognise and support early intervention in response to mental illness
- ✓ pay attention to non COVID-19 related harm and in particular public protection issues such as child and adult protection and domestic abuse
- ✓ strengthen relationship-based approaches
- ✓ develop and co-produce with staff, partners and the public new ways of working that are routed in National Performance Framework outcomes
- ✓ continue to promote and accelerate innovation and reform that deliver better outcomes for the people of Forth Valley

SECTION 4: WORKING TOGETHER TO REMOBILISE, RECOVER AND REBUILD A BETTER HEALTH & CARE SYSTEM

Health and Social Care systems need to be thoughtful about how they play a bigger role as part of a community planning response that integrates economic, social, physical and environmental ambitions whilst using technology to help us do things very differently as we live alongside this virus for the foreseeable future. We acknowledge there is no blueprint we can turn to for answers and we also know the status quo is neither realistic nor viable. Public services that are robust and sustainable with an eye to the National Performance Framework (NPF) outcomes will be a key requisite for socio-economic recovery locally, regionally and nationally. NHS Forth Valley is keen to play a key role in: driving transformation with partners to address health inequalities, addressing the backlog in our system and preparing for a winter that is likely to be challenging.

This Plan has begun a conversation with our staff as we look to ensure that their health and wellbeing is protected as we look to resume services safely. The complexity of how we bring all of this together using our Programme Management Office will help to shape the next iteration of our Plan as look beyond 100 days and what the COVID-19 modelling tells us with a regard to easing lockdown restrictions.

Appendix 1

Recover, Redesign & Renew

Outline Communication Plan

Background

As the rates of Covid-19 continue to fall across the country the focus is now shifting from how we respond to the virus to how we recover from the widespread impact it has had on health, education and the economy. The Scottish Government's Coronavirus framework for decision making provides a route map which sets out the order in which the current restrictions will be lifted and provides details of the gradual changes in four main phases.

The Cabinet Secretary for Health & Sport launched a new framework Re-mobilise, Recover, Re-design – The Framework for NHS Scotland on 31st May 2020. This sets out how NHS Boards across the country will follow national and local clinical advice to safely and gradually prioritise the resumption of paused health services while maintaining capacity and the new arrangements which have been put in place to deal with current and potential future cases of Covid-19. The priority is to address the backlog of cases which have build up over the last few months while continuing to manage ongoing demand, maintain capacity to deal with existing and potential future waves of Covid-19 infection, embed and build on the learning, innovation and new ways of working which have been put in place in response to the pandemic and prepare for winter.

All NHS Boards have developed local remobilisation plans which set out local plans and priorities to restart a range of hospital and community based health services. It is important that these plans are communicated effectively to ensure that local people are aware of the timing of any changes, understand how to access them (taking into account some of the new arrangements for Covid-19 which will remain in place for some time) and that the expectations of patients and the public are managed. This is not only important for patients whose operation, scans or appointments were postponed due to the pandemic but also patients who have and will continue to be referred for treatment over the coming months. There is also an opportunity to not only focus on **recovery** but also to maintain many of the innovative new ways of working and use some of the recent learning, experiences and feedback to **redesign** the way we deliver services and **renew** our existing healthcare strategy which is due to be revised and updated over the next year.

Timescales

The Cabinet Secretary for Health & Sport has confirmed that the NHS in Scotland will remain on an emergency footing for 100 days until the end of July 2020 with remobilisation plans being implemented in phase 2. An announcement on phase 2 and what this means for NHS services was issued on 19th June 2020. National communication plans and resources for remobilisation are also being developed and the local messages, strap lines and actions outlined below will require to reviewed and updated to take account of these to ensure a consistent approach.

Key aims

- Raise awareness of the plans to restart health services while reminding people of the many services which have continued to be delivered throughout the pandemic
- Ensure local people and patients are aware of how to access these services including any new arrangements which will continue to be in place for some time
- Manage public expectations while providing assurance that everything possible is being done to treat patients whose operations or appointments have been delayed although this will take some time
- Remind people that coronavirus hasn't gone away and that measures to control it will impact on our capacity and ways of working
- Reinforce the importance of continuing to follow the national guidance to reduce transmission and prevent a second wave

Key Messages

- A wide range of health services continued to be delivered across Forth Valley throughout the pandemic
- Services will restart on phased basis to ensure they are delivered as safely as possible
- Priority will be given to patients with the most serious and urgent health needs and this will be based on clinical assessment
- It will take time to work through the build up of cases and continue to meet ongoing demand as we won't be able to return to previous activity and capacity levels due to the need for physical distancing and enhanced infection control measures
- The latest advice and information can be found on NHS Forth Valley's website including advice for people attending hospital appointments and alternative ways to access health advice and treatment
- Although cases are falling coronavirus remains a serious threat and people need to follow national guidance to help protect themselves and others and help avoid a second wave

Target Audiences

- Patients
- Local residents
- Local & national media
- NHS Forth Valley & Serco Staff (including Patient Relations & Switchboard staff)
- Independent contractors & their staff (GPs, Dentists, Opticians, Pharmacies)
- Community representatives (including local councillors, MSPs, and MPs)

Channels of Communication

The plan is to work with partners to reach as wide an audience as possible. This will include the use of:

- NHS Forth Valley website (and links with council websites)
- NHS Forth Valley intranet, Staff Brief & Staff News
- NHS Forth Valley social media channels (and those of partner organisations)
- Local media briefings, news releases, quotes and interviews with relevant service and clinical leads
- Patient information - letters, texts and digital information screens at FVRH and MIU

Outline Action Plan

Action	Leads	Timescale	Comments/Progress
Issue initial media release setting out local plans and priorities for remobilisation across hospital and community services	Communications	w/c 22nd June	Scottish Government national release issued on Friday 19th June setting out plans for restarting NHS services in phase 2 Ensure local release reflects and is consistent with national messages
Provide overview of plans at local media briefing		Wed 24th June	High level overview provided by Medical Director and Director of Public Health
Arrange follow up media briefings and social media to highlight plans for specific services along with key messages, advice for patients and public. Update information on NHS Forth Valley website and ensure this is prominent and easy to access Update information on digital screens at FVRH & MIU Highlight on staff intranet to ensure staff are aware and able to advise/signpost patients to correct information	Communications and Local Professional Leads • Dental Services • GP services • Mental Health & Psychological Therapies • Maternity Services • Pharmacy Services	Ongoing	Dental Services reopened for urgent treatment on 22nd June and some routine services will be introduced from 13th July 2020 Localised media release issued on Monday 22nd June to highlight dental changes Optician services to reopen for urgent eye problems on 29th June Signpost to other sources of information and support (e.g. online resources for mental health, voluntary services, NHS Inform etc) Share details with Serco staff and ensure switchboard staff at FVRH are kept updated

Explore opportunities with national media and health correspondents to highlight local services restarting and remind public of ongoing need to follow national advice	Clinical Leads/Communications	Ongoing Initial feature arranged for Wed Ist July 2020	Interview arranged with Dr Mark Spears, Respiratory Consultant for Stirling Observer feature article on the impact of Covid-19 and experiences of front-line staff to highlight that coronavirus remains a serious risk and people should not become complacent.
Provide regular updates on social media and work with partners to ensure information is shared and reaches as many local people as possible Monitor and review feedback (from services and online) and adapt messages, as required – consider the use of promoted posts to highlight key messages to address any ongoing issues or concerns		Ongoing	NHS Forth Valley Social Media Total Followers – 36.1k • Facebook 19.1k • Twitter 13.7k • Instagram 3.3k (new and growing steadily) Facebook Reach (1 March -18 June) 3.9m Facebook Average daily reach (1 March - 18 June) 29K Our three local councils have a combined total of 100k followers
Work with relevant leads to review and update information in patient letters and texts		End June	Include key messages and signpost to website for more information Covid-19 section of the website updated with key information on for people attending hospital appointments to reflect new guidance on face masks, use of hand gel and measures to maintain physical distancing
Organise short online		July	

questionnaire for local staff to capture feedback, learning and ideas to inform short and long-term planning			
Develop plans to capture feedback from public, patients and community to inform future strategy		August onwards	Explore opportunities to tap into existing public, patient and community engagement networks

Appendix 2

Mental Health and Learning Disability Services Mobilisation Plan to July 2020

Contents

1. Scope of Mobilisation Plan

Forth Valley's Mental Health and Learning Disability Services are comprised of several distinct clinical specialties. These include:

- inpatient psychiatric units (general adult, IPCU, older people's, dementia, learning disabilities)
- acute hospital based mental health services (liaison, clinical health psychology)
- community specialist services (eating disorders, perinatal)
- community forensic services
- crisis services
- community older people's mental health services
- community alcohol and drugs services
- community mental health teams
- psychological services
- community learning disability teams
- child and adolescent mental health services (CAMHS)

This Mobilisation Plan covers all of the above services, and where specific services have specific issues, these are highlighted.

While CAMHS are included within this plan, if more detail is required about this service it can be found within NHS Forth Valley's Women's & Children's Mobilisation Plan.

2. Current Position/Baseline

The Mental Health, Learning Disability and Prison Healthcare Services have devised a tiered response to COVID-19 to help provide clarity for staff operating within the system.

Tier 1 – Normal service delivery whilst preparations for disruption are underway.

Tier 2 – Minimising face to face contact. Rapid increase in the use of tele-health, but clinics, outpatient work etc continues as normal. Groups are suspended with patient specific plans for contact until COVID-19 is past.

Tier 3 - Significant service disruption with community activity continuing only in essential cases to deploy staff to:

- maintain acute and inpatient services across Mental Health, Learning Disability and Prison Healthcare services.
- provide COVID-19 specific support to primary care and the population of Forth Valley.
- provide staff support across Forth Valley, including staff from the NHS, HSCPs and care homes.

Tier 3 Augmented – Temporary augmentation of Tier 3 in response to the duration and pattern of onset of the Pandemic.

Tier 4 – At this stage the workforce will be deployed centrally, including to clinical areas out-with the mental health, learning disability and prison healthcare estate. At this stage only emergency work will be undertaken in the community, inpatient work will include supporting those who are physically sick on the mental health and learning disability wards, as well as in prisons.

Presently the services are operating at **Tier 3 Augmented** and have not required to progress to Tier 4 of the plan.

2.1 Community Services

Routine assessments and routine therapeutic interventions are suspended, including all therapeutic groups. Current clinical work consists of seeing patients who are:

- Referred by primary care who require urgent assessment (within 5 working days)
- Requiring emergency Mental Health Act Assessments in the community
- Already known to the service, and known to be at significant risk of harm to themselves or others if not assertively outreached
- Open to the service and identified as high risk or vulnerable
- On the children protection register
- Detained under the Mental Health Act and who require mandatory reviews
- Recently discharged from hospital e.g. 7 day follow up
- Requiring depot administration
- Attending Clozapine Clinics
- Subject to the Mental Health Act
- Complex, where early signs of destabilisation are becoming apparent though not yet at a crisis point
- Waiting for assessment in the first instance

Virtual CPAs/MDTs for complex patients who have multi-agency involvement have also been prioritised.

Telephone contact or contact via Near Me is being used instead of face to face with patients as far as possible. If face to face contact is required patients are being telephoned before contact and asked if they are experiencing symptoms of COVID 19.

Teams have phone contact at least weekly with patients they have assessed as being especially vulnerable, and use their clinical judgement to decide if more frequent contact is required.

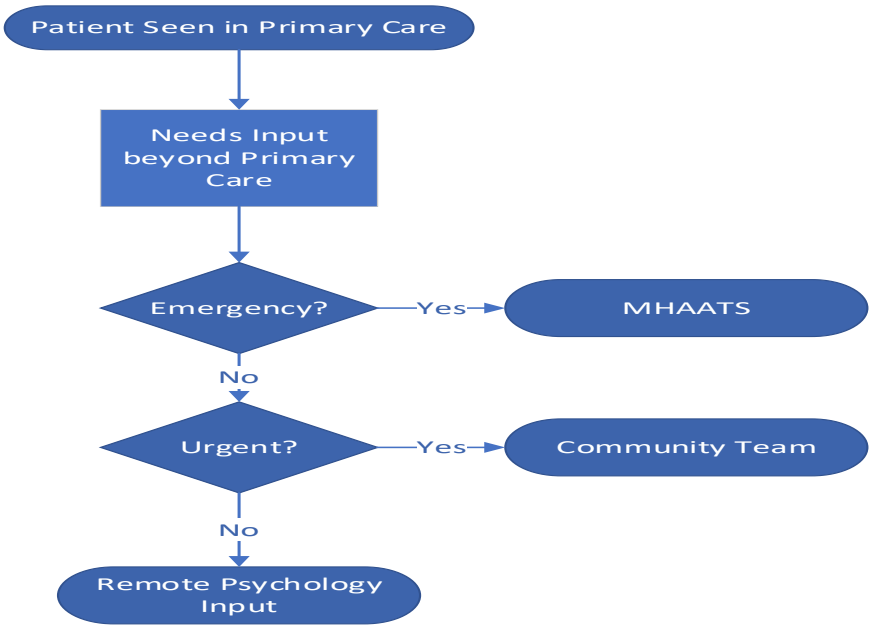
If vulnerable patients cannot be contacted directly clinicians contact their next of kin for an update on their welfare, and part of the initial COVID-19 planning included ensuring that up to date next of kin details were held for all patients. If the patient's next of kin cannot be contacted, this is escalated to senior professionals in the team and consideration given to visiting the individual at home with appropriate PPE.

Community Mental Health Teams have a daily huddle (virtually if possible) with the Acute Mental Health Unit. This meeting identifies vulnerable patients who need to be assertively

outreached and organises safe staffing levels, to maximise the flow through the acute system, minimise hospital bed use and deploy staff from the community where required.

All other patients known to secondary care mental health services have been sent a letter informing them that their contact with our service has been suspended. The letter also contained advice to contact the service should their difficulties worsen, the contact details of the relevant part of the service and details of alternative sources of support, including online resources.

All referrals into the service are screened by a clinician. Only urgent referrals are being assessed and routine assessments are suspended. However all patients referred to the service are contacted by letter with the same information as given to current patients. Referrals are being managed as below with Psychology deployed to support non-urgent, non-emergent cases. During Tier 3, access to Consultant Psychiatrists will continue.



2.2 Psychological Services

Psychological Services are currently operating in line with the Tier 3 Augmented Community Service provision outlined above. The service also continues to provide clinical input to inpatient settings (both mental health and physical health) and to the three Forth Valley prisons. In addition, Psychological Services staff are currently providing:

- a Primary Care Support Service, to which all GPs and Primary Care Mental Health Nurses can refer and which provides rapid access (within 7 days) for patients to up to 3 sessions of Psychological First Aid

- a comprehensive suite of staff wellbeing and support, open to staff from the NHS, HSCPs and care homes (see Appendix 3)
- a Psychological Therapies Hub, where patients who are either open to the service or on the waiting list can speak to a clinician either on the phone or via Near Me

2.3 Addictions Services

In line with the Scottish Government Directive, Forth Valley Addiction Services have not suspended non-urgent services in the same way as other parts of the Mental Health & Learning Disability Service and have instead maintained their activities as far as possible. This has been achieved in partnership with Change Grow Live (CGL) and community pharmacy. Specifically, the following have been maintained:

- Dispensing of opiate substitution therapy (OST) for existing patients (including delivery where patients are shielding and do not have a family member/friend available to support this)
- Initiation of OST to new patients, with priority given to those identified as high risk i.e pregnancy, acute presentation of mental health, sucidality, high risk injecting behaviour
- Assessment of new referrals for both drug and alcohol issues, again with priority given to patients identified as high risk
- Transfer of cases of prison liberations
- Acute presentation of mental health and sucidality which require a full psychiatric assessment and medical review.
- Child Protection and Risk Management meetings via teleconferencing.
- Psychological support and advice for staff and for high risk/unstable patients.
- Phone/Near Me contact with existing patients
- Face-to-face contact with high risk patients (including home visits) where this is required e.g. patients with ARBI
- Injecting Equipment Provision (IEP) clinic delivered daily from Falkirk, Stirling and Alloa office bases

Although the Scottish Government advised that Addictions Services should be maintained at or above pre-COVID-19 levels, some adjustments have had to be made to the service to ensure the safe delivery of care, to protect both staff and patients. The following elements of the service have been suspended to ensure compliance with national social distancing guidance:

- Routine appointments face to face (instead delivered via phone/Near Me)
- Outreach clinics
- Keep well assessments
- Some physical tests e.g. BBV, breathalyser
- Group work
- Drop-in access/clinics

Addictions Services are currently putting additional measures in place to support the safe delivery of services:

- additional community premises have been sourced in three locations to allow the provision of socially-distanced clinics
- a joint protocol with CGL to ensure safe oral fluid testing

- an evening clinic is being set up to offer more appointments for routine patients
- joint clinics with CGL are being introduced to review and transfer patients between services to optimise capacity
- online platforms are being explored to allow the delivery of groups
- Near Me has been set up in clinics as many patients do not have access to appropriate technology at home

2.4 Emergency and Inpatient Services

Inpatient Services have continued, although the ward configuration has been adapted to enable isolation and cohorting of patients with COVID-19.

Non-emergent cases have not been to the psychiatric unit since the service began mobilisation in response to the pandemic. However, where an elective admission has been necessary to preserve life or prevent an emergency admission in the immediate future, admission has been facilitated.

The Mental Health Acute Assessment and Treatment Service (MHAATS) provides emergency mental health assessment 24 hours a day. This service has been enhanced during the response to COVID-19 to support direct access for patients presenting to the Emergency Department (ED), without patients having to either be admitted to ED or triaged there.

MHAATS has also maintained Intensive Home Treatment as an alternative to hospital admission. This has been done through successful implementation of Near Me and telephone contact.

Within Learning Disabilities (LD) Services, the Additional Support Team (AST) maintained a daytime service but worked flexibly where required to ensure crisis home visits. The AST also provides advice and support to MHAATS concerning LD patients, support at ED for LD patients who present in distress and support for discharge plans from Forth Valley's Learning Disability Inpatient Unit (Loch View).

3. Continuing Focus on Urgent and Emergency Services

The provision of emergency services will continue as above as the service expands its remit back into normal working. It is likely that to enable this, with a predicted higher demand (see section 9) there may be some changes to skill-mix and hours of work for the staff within the service.
Urgent services have continued undisrupted during the response to COVID-19 and will continue to be delivered in this way going forward.

4. Resuming Scheduled Services

4.1 Non-Urgent CAMHS

CAMHS now have a waiting list of close to 1000 children and young people as well as a small internal waiting list due to staff moving on from the service. Rather than resume scheduled services, instead CAMHS intends to take the opportunity to redesign and develop the Service by undertaking small, focused tests of change. This work has built on

learning in responding to the current pandemic but also improvement work completed prior to March. FV CAMHS intends to:

- Complete a Waiting list validation, prioritising and triaging those waiting the longest. As the current waiting list is lengthy, this will be a significant piece of work
- Offer Near Me/telephone assessments to new non-urgent patients following this triage process
- Offer Near Me/telephone treatment to these new patients, following appropriate prioritisation
- Resume and complete the assessment of children referred for ASD, ADHD and LD and complete their care journeys
- Review and resume pathway for new titrations of medications for non-urgent patients following appropriate risk assessment to support face to face contact, with the aim of supporting struggling families. This is dependent on other services to support physical health monitoring.
- Review and enhance the CAMHS website and identify self help resources for children and families, including signposting families to evidenced based digi-health services
- Link with children's services with a view to resuming the discussions and support in the development of children's mental wellbeing services.

4.2 Psychological Therapies

As for CAMHS, the Psychological Therapies Service has a sizeable pre-COVID-19 waiting list, and is therefore beginning a similar waiting list validation exercise. Due to the size of the waiting list, this is a significant task.

In addition, individual treatment for current non-urgent/non-vulnerable patients who have had their treatment suspended will begin to be resumed where this is possible remotely. Capacity for this will be created by a predicted reduction in demand for the Psychological Therapies Hub as staff begin to resume work with their existing caseloads and contact people on the waiting list. This will take some time to fully implement due to capacity restrictions, and is unlikely to be complete by the end of July.

There are also several potential limitations to the provision of remote therapy:

- Some types of psychological treatment are not appropriate for remote delivery with some patients e.g. EMDR
- Some patients do not have access to a 'safe space' at home to participate in remote therapy
- Some patients do not wish to continue therapy remotely
- Some patients do not have reliable access to a phone/computer to enable remote therapy

Solutions to these issues will continue to be sought throughout the period of the mobilisation plan, although are likely to be dependent on variables such as access to clinic space, availability of public transport and social distancing measures.

The Primary Care Pathway developed with Psychological Therapies has been a real success in providing ready access to support for people referred from GP, and is being

considered as part of a redesigned process to manage the flow of referrals and demand for secondary care mental health services more broadly. However if this is maintained by Psychology staff then this will limit the capacity of this department to return to normal service provision, and will contribute to prolonged waits. The MHLD Service is therefore exploring options to maintain the pathway without limiting the capacity of Psychological Therapies.

Likewise, the Staff Wellbeing & Support currently provide by Psychological Therapy staff has been an essential part of the Board-wide response to COVID-19. As there is a requirement to maintain a level of support for staff, this will continue as part of the current Mobilisation Plan. However this will inevitably limit the capacity of the Clinical Health Psychology Team, who are providing most of the staff support from this service, to pick up more routine clinical work. A proposal around the medium term resourcing of the Staff Wellbeing & Support Service is currently in preparation, which will aid planning as the service moves into the next phase of planning.

4.3 Non-urgent CMHT and CLDT appointments

Community teams will commence a waiting list validation exercise, whereby all patients awaiting a first appointment will be contacted by phone/Near Me to ascertain their current needs.

Since service disruption started, the management of routine referrals has been directed through the process detailed in Section2.1. Moving forward the recommencing of routine referrals for the community services is being considered as part of a wider pathway and redesign process. One of the main successes of this period of work has been the appropriate and safe redirection of non-urgent work and moving forward, with a predicted increase in demand, ensuring our services are targeted and operate in an efficient way is essential. A key task for this period is therefore designing and consulting on a revised pathway for all referrals into mental health services. This will include significantly improved access for patients to online resources and a more consistent approach to referral triage. This will also include a focus on ensuring the delivery of time-limited evidence-based interventions.

LD psychiatry have been able to pick up non urgent and routine contacts using Near Me and telephone. There have been many advantages to this, as although not able to see patients face to face it has been found that many patients have benefitted more from more regular but shorter telephone consultations than from less frequent face to face consultations (ie weekly rather than monthly). This frequency of contact with patients and their carers is thought to have been instrumental in preventing deterioration or crisis. The LD Additional Support Team and other community nursing teams have had the same experience.

It is intended to continue with remote appointments where appropriate across MH&LD Services both throughout and beyond the period of this Mobilisation Plan.

4.4 Group Therapies

Prior to COVID-19, therapeutic group interventions were an increasingly important part of the treatments delivered by Forth Valley Mental Health & Learning Disability Services. While it is not felt to be possible to safely re-start physical groups currently, the use of online platforms to remotely deliver group interventions is being actively explored. As this is dependent on the availability of a reliable and secure online platform, it is not possible to

definitely state that online groups will be in place before the end of July. However the Service is linking with national developments in this area, and once a suitable secure platform is available the intention is to adapt existing group protocols and commence online delivery as soon as possible.

4.5 Decider Skills Online

Over the past year, an important component of Forth Valley's service model has been the roll-out of Decider Skills training for multi-professional, multi-agency staff. This is an approach designed to equip staff at all levels across all agencies with the skills to teach others how to tolerate distress and manager their emotions.

The Decider Skills company have developed an online training package, together with a self-help book, which is aimed at patients themselves (see: https://www.thedecider.org.uk/who-we-help/individuals/). NHS Forth Valley is in the process of purchasing access to this for three months. This will allow patients to learn the skills themselves online, following an assessment from a clinician. The patient will also receive a follow-up session remotely from a member of the clinical team. The online training will also be made available to current patients who have already been taught the skills but who would benefit from them being refreshed.

So far it has been identified that the following areas would benefit from access to the online Decider Skills course:

- CMHTs / Resource Centres
- CADS (some patients)
- MHAATS
- Community Older Adult Teams
- Primary Care Mental Health Nurses

Consideration is being given to the feasibility of providing access to Forth Valley's prisons. The capacity of Decider-trained staff to provide the required post-training support for patients is in the process of being explored, as there are some limitations on this caused by staff deployment to support the mental health wards. However the intention is to progress this over the life of this Mobilisation Plan.

4.6 Other Online Interventions

Beating the Blues is well established within Forth Valley, with all GPs and Primary Care Mental Health Nurses able to refer patients. As of 25 May, this has been expanded to include the additional digital packages provided by Silvercloud. These target health anxiety, social anxiety, depression and anxiety associated with several long-term conditions, and COVID-19 specific depression and anxiety. In addition to direct access for primary care, the intention is to include these packages as part of the stepped care pathway in development.

Forth Valley is also part of the national roll-out of online CBT provided by IESO, and regular meetings are taking place with the NHS24 Mental Health digital lead to progress this. While the implementation schedule is partly determined by developments at a national level, it is hoped to have this in place over the course of the current Mobilisation Plan.

5. Communicating with Patients

NHS Forth Valley has developed clear and consistent letter templates for use across the MHLD Services. This consistent approach will be maintained, as far as possible, with the reopening of services in order to minimise confusion and ensure a collective response across the system. In learning disabilities, information was offered in an easy read and social story format in relation to letters and information regarding Covid-19, use of PPE, testing etc.

5.1 Those Referred

New referrals to the community teams will be offered an appointment via NearMe or telephone in line with the patient's preference to discuss their current situation and identify potential pathways.

5.2 Those on Waiting Lists

NHS Forth Valley has already communicated with everyone on our waiting lists in line with the previous directions from the Scottish Government. The practicalities of beginning to work through the waiting lists across our services will require further consideration in terms of process and this will be communicated to patients.

5.3 Those Receiving Care and Treatment

Patients who are currently under the care of our services have either had contact maintained during this time, or have been contacted and received an explanation as to why there has been a pause in treatment. Treatment pauses have been made only when it has been clinically appropriate and this has been reviewed in cases where the patient's presentation has changed.

A number of children within CAMHS have had their care journey's suspended, therefore priority is being given to completing treatment and assessments for those already known to us and in receipt of treatment. There remains a significant proportion of children who are being assessed for potential Neuro Developmental Disorders (e.g. Autistic Spectrum Disorder, Attention Deficit Hyperactivity Disorder and Intellecutal or Learning Disability). The completion of assessment requires a multi agency response and for example, the need to see the children in different settings. Whilst this remains a priority for resuming services, it is highly dependent on other services and the availability and willingness of the family. Therefore this will be actioned on a case by case basis.

6. Arrangements for COVID-19 in Inpatients

We have three inpatient areas:

- The Acute Mental Health Unit (MHU) at Forth Valley Royal Hospital (FVRH)
- The Bellsdyke Hospital Site
- Loch View Hospital

Each of these areas has been reorganised and infrastructure work undertaken to provide separate isolation areas for patients who are admitted with or who develop symptoms of COVID-19. The details of this are contained within Appendix 1.

7. Moving Patients through the System

In response to COVID 19 NHS Forth Valley as a whole saw a 60% reduction in the number of delayed discharges. This was replicated across MHLD services where a significant number of beds were freed up through expedited discharge processes. Working with colleagues across the Health and Social Care Partnerships (HSCP) we will work to maintain this.

Internally we are adopting an electronic referral system and working to streamline the process of referrals for movement through the service. This includes transitions across the hospital sites to maximise the flow of patients.

8. Virtual Team Working

NHS Forth Valley has made use of Microsoft Teams to minimise the need for travel and meeting in person. This has been largely successful in replacing the traditional working methods.

There are however challenges in working with those employed in the third sector and by other statutory organisations that do not have access to Microsoft Teams. This is especially challenging for our most complex cases where multi-agency working is essential to support people in the community and avoid prolonged admission to hospital.

9. Online Support and Information

The expansion in available online interventions is described above in Sections 4.5 and 4.6.

The Mental Health & Learning Disability Service is also working with the Communications Department and Health Promotions to develop a local online resource for the public. This will collate links to appropriate self-help information, sources of support and information on local services for people with mental health issues.

There is also a significant amount of online support and information available for staff to support their mental health and wellbeing. This can be accessed either via NHS Forth Valley's intranet or the National Wellbeing Hub (see Appendix 3 for details of local staff support).

10. Modelling Future Demand

There is a growing body of evidence which identifies the predicted increase in demand for mental health services as a consequence of COVID-19 and some key examples of this are included in Appendix 2.

10.1 Current Demand

Referrals into community teams reduced in March and April. However these are not thought to be a reliable indicator of demand, due to the impact of COVID-19 both on the main referring services and on the help-seeking behaviours of the general public. Based on referrals to date (22 May), referral demand has increased by more than 20% between April and May and is highly likely to increase again in June and July.

There has been an increase in admissions of approximately 30% to NHS Forth Valley's mental health wards compared to a similar period last year. These cases have not been known to secondary care services. Nearly all have presented with first episode psychosis, have been significantly unwell by the time they came into contact with services and have required detention under the Mental Health Act. Most first episodes of psychosis develop into either schizophrenia, bipolar affective disorder or a related long term condition. In general in any population around the world 1% would be expected to develop schizophrenia and 1% bipolar affective disorder during the course of their lifetimes. Individuals inherit a genetic pre-disposition for developing these conditions, however the time when these conditions actually take hold is thought to depend on a variety of psychological and social factors (with a significant life event, or stress being associated in at least 50% of cases). There are concerns that the psychological impact of the COVID-19 pandemic could lead to an increase in presentations, admission rates and detentions under the Mental Health Act for those predisposed to psychosis.

If correct, this could significantly increase the demand placed on secondary care mental health services. Recovery from a first episode of psychosis usually takes months, and after this the evidence based guidelines (such as the NICE guidelines for Schizophrenia / psychosis) recommend a comprehensive package of monitoring, illness education and psychological interventions be offered over at least 2 years. Follow up studies have also shown that individuals who experience psychosis / schizophrenia also tend to follow the 'rule of thirds'. A third of patients will make a full recovery after 2 years and will never experience another episode. A third of patients will go on to experience fluctuating episodes of illness throughout the rest of their lives whilst a further third will, sadly, not be able to make a full functional recovery after their first illness. This would then suggest that at best, it would only be possible to discharge 1/3 of any 'additional' presentations seen recently after 2 years of intensive intervention. The other 2/3 will likely require long term contact with mental health services.

The above are very provisional estimates, as there is a lack of evidence and studies with which to compare the current situation. Indeed, the scale and effects of the COVID-19 pandemic are a unique event in modern times and the overall impact may not be fully understood for many years. However current estimates would suggest that secondary care mental health services are likely to experience two vsignificant additional demands. Firstly, through an increased number of patients presenting with very serious mental illness such as psychosis and who will require intensive long term follow up, and secondly due to patients who may present with anxiety spectrum disorders (such as PTSD). For this reason it is especially important that robust, time limited pathways are developed so that secondary care services can focus what resources are available on the most unwell patients and process all other presentations as efficiently as possible.

10.2 Future Demand/Capacity

While it is extremely difficult to accurately model future service demand, an estimated increase of around 30% would seem reasonable. This is informed by the percentage increase in admissions described above, and by the population prevalence/incidence data available in the, admittedly limited, evidence base.

At the same time, it is predicted that in the short to medium term service capacity will be decreased in the region of 20-30%. This is informed by the current absence rates, and by the limitations placed on service delivery by COVID-19 outlined below in Section 11.

Taken together, an increase in demand and a reduction in capacity is likely to lead to a gap between the two and therefore significant pressure on MHLD Services. This is exacerbated in parts of the service where there is a pre-existing waiting list e.g. Psychological Therapies.

10.3 Strategic Approach

While the potential for a significant discrepancy between demand and capacity is clearly concerning, MHLD Services have begun to consider strategies to address this. Further modelling work will be undertaken with the support of the Information Services team, to develop a more detailed and more robust understanding of likely future demand and capacity. In addition over the coming weeks the service will develop:

- Improved processes for the appropriate signposting and redirecting of referrals
- Robust stepped care pathways
- Enhanced access to online resources and interventions
- Sustainable remote working capability

11. Dependencies

11.1 PPE

The availability of PPE is assumed as being undisrupted. This is will be essential for all services where patient-facing activities are essential. Examples of these would include:

- Inpatient services
- Depot administration
- Health maintenance (weight, venepuncture, BP etc)
- Addictions Services testing for use of substances
- Detentions
- Neuropsychiatric/neuropsychological assessments

11.2 Digital Infrastructure

There has been a surge in demand for Moveable Media Devices (MMDs) and specifically for web cameras. The MHLD service adopted a prioritisation process for those who were identified as requiring this equipment, and this proved an effective means of managing supply and demand. However some equipment is on loan between services, and a sustainable longer-term solution requires to be developed over the coming months.

The development of a reliable and secure digital platform for the delivery of groups is also central to the provision of a sustainable service model moving forward.

11.3 Accommodation

Physical distancing within existing premises presents a significant challenge for both patients and staff. Many patient waiting areas and clinic rooms are too small to allow adequate physical distancing, and many staff currently work in close proximity within shared offices spaces. It is not possible to fit our workforce into the office spaces in the same configuration as before, and it is not possible to run outpatient clinics in the same way.

Consequently the MHLD service has maximised the number of staff working remotely and is in the process of working through the logistics of staff deployment and working spaces. The service is also exploring the use of extended opening hours and different shift patterns to reduce the number of staff and patients in buildings at any one time.

11.4 Workforce

Currently the absence rate across the organisation attributable to COVID-19 is around 5%. This is in addition to the usual absence rate attributable to other causes.

The workforce capacity is also affected the need to maintain essential inpatient service, and the deployment of some staff to these areas from the community. The ongoing high level of demand in inpatient settings raises some difficulties in returning these staff to their core roles, and this will have to be carefully managed in a phased and flexible way.

In common with all NHS and HSCP staff, the Mental Health & Learning Disability workforce have been working under considerable pressure in recent weeks. It is essential that they are supported to take regular leave, which will have a further impact on capacity.

11.5 National Guidance

Forthcoming national guidance around the relaxation of 'lockdown' has the potential to influence service delivery over this period:

- the availability of public transport will impact on staff's ability to travel to their place of work, and patient's ability to travel to appointments where face-to-face contact is essential
- school and childcare provision will impact on staff's availability for work and patient's availability for appointments
- workplace guidelines will impact on the capacity of clinical and administrative spaces
- there is the potential for relaxation of physical distancing to lead to increase in transmission, and subsequent impact on a) other areas of the health and social care system which may require support and b) workforce availablity

12. Neuropsychiatric/Neuropsychological Assessments

Neuropsychiatric/neuropsychological evaluations require patients to complete standardised measures which cannot be undertaken via video-conferencing. While professional groups are exploring clinical solutions, these have not yet been developed. As these type of assessments are rarely clinically urgent within MH&LD Services, patients awaiting them not currently being seen.

This is beginning to create a build up of patients requiring assessment. It is a particular difficulty within old age psychiatry, where the majority of people referred for this will fall into the shielding or vulnerable groups category. Therefore even as the service begins to resume non-urgent work, there would be considerable risk in seeing these patients as it would require to be done in a face-to-face setting.

There is ongoing local and national dialogue regarding this patient group, and it is hoped that a clinically effective and safe process will ultimately be developed.

13. Vulnerable and Minority Groups

The emerging evidence indicates that those living in poverty and those from ethnic minority groups are more severely affected by the COVID-19 virus than the general population. It is not yet clear how this translates into psychiatric outcomes.

However it is apparent that those living in poverty face particular challenges regarding access to the equipment necessary for remote appointments, and the service needs to ensure that this group are not further disadvantaged by this. People living in poverty are also likely to be affected by access to public transport, which again must be considered when reviewing and recommencing services.

In addition, while online and remote service delivery works extremely well for some people, it is important not to disadvantage those with limited technological literacy.

The focus of the MHLD Services will be to redesign services in line with the princples of the 2010 Equality Act to ensure that we take account of the differences in our population. MHLD Service leads are working closely with HSCP colleagues to ensure that people are supported across the system. The restart from COVID-19 provides an opportunity to enhance the commissioning process of third sector services to respond to the changed needs of the local population.

Appendix 1 – Inpatient Isolation

Isolating Patients

Throughout the inpatient services there will be patients who present with symptoms, or a confirmed as COVID-19. These patients will need to be isolated from patients who are not COVID-19 Positive.

The doctors and nurses looking after these patients will have a number of options for how best to isolate the patients. These decisions should be based on the following principles:

- A person-centred approach must be adopted
- Where patients can be safely managed, and are able to isolate within their own ward, this should be considered.
- Minimising the number of wards caring for patients with COVID-19

The following guidelines are designed to support safe management and Infection Prevention. Deviation from these plans should be based on the above principles with an assessment of risk and person-specific plans.

Provision for Isolating in Wards 1, 2 and 3 FVRH

We have developed a 4-bedded area using bedrooms 1 to 5 of Ward 2, re-provisioning the gym and the Charge Nurse Office to provide an isolation area for those with suspected or confirmed COVID within the general adult inpatient population.

This ward will be used for anyone with symptoms either already on Wards 1, 2 or 3, or being admitted from the community.

The ward is called “Ward 2- IPCU” (formerly used as an IPCU) and the details are as follows:

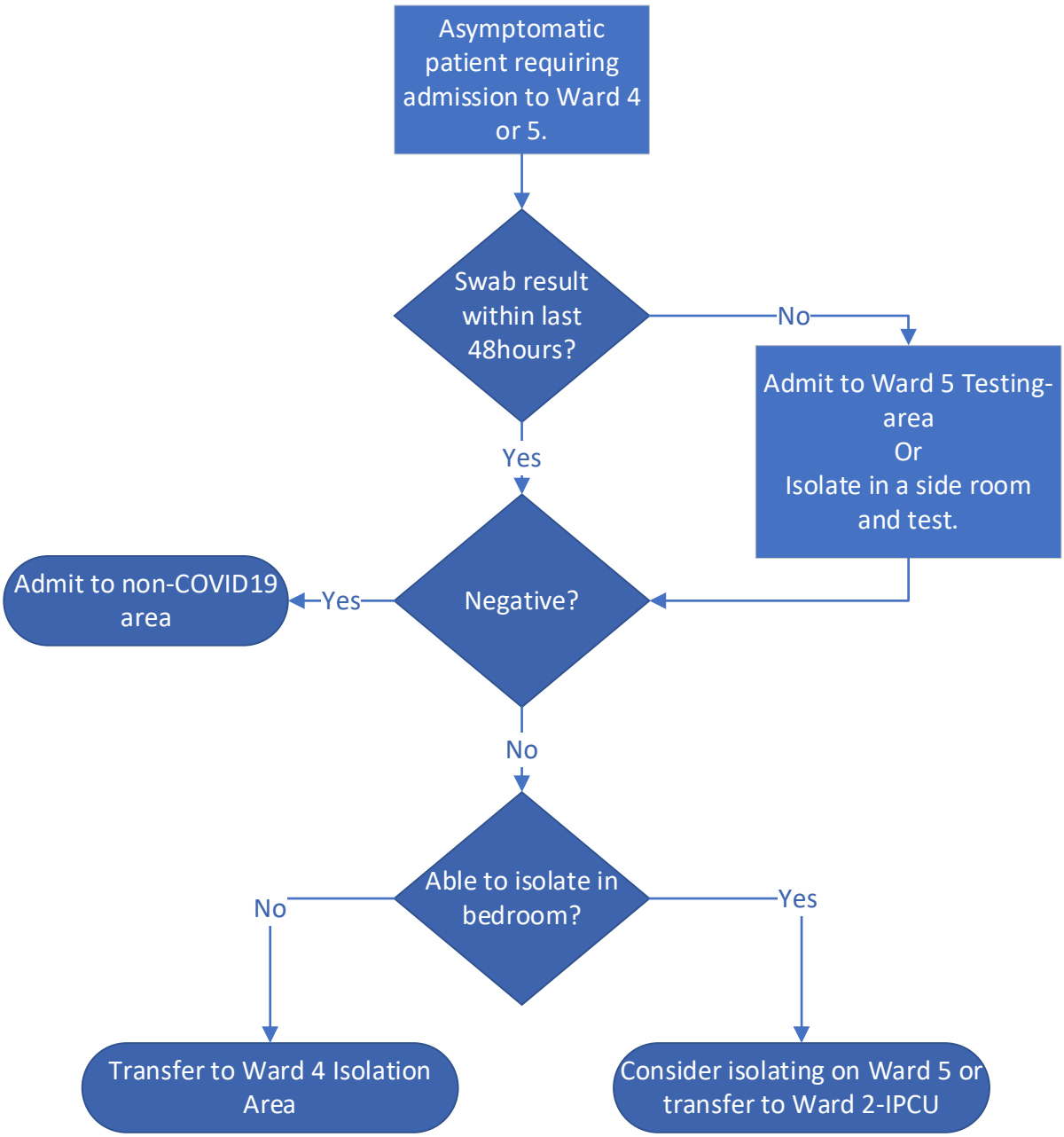
- Telephone: 567613
- HePMA Name: MH Ward2-IPCU
- TrakCare: Ward 2-IPCU

Provision for Isolating in Wards 4 and 5 FVRH

All patients being admitted to ward 4 or ward 5 will be isolated and tested, unless a negative swab has been reported within the last 48hours.

In cases where a negative result is returned for COVID-19 the patient will be moved to another ward, appropriate to their needs.

Return to contents



Those patients who have tested negative will be tested every four days throughout their inpatient stay, or immediately if they develop symptoms.

Bedrooms 17 to 20 in Ward 4 have been transferred to Ward 5. These four bedrooms are now the testing area, making Ward 4 a 16-bedded ward and Ward 5 a 24 bedded ward.

Bellsdyke Hospital & Patients with COVID-19

It is intended that, in the first instance, all patients on the Bellsdyke Hospital Site who present with symptoms indicative of COVID-19, or have a confirmed diagnosis, are cared for on the Bellsdyke Hospital Site. The rationale for this is to:

- Minimise the distress and upheaval for the patients
- Minimise the risk of multiple, unfamiliar staff being involved with highly complex cases
- Reduce the demand on services to transport patients

Any patient who presents with a continuous cough, pyrexia or flu-like symptoms will be immediately isolated as follows:

- **Trystpark** – Patients will be isolated in team 3, Trystpark**
- **Hope House** - Patients will isolate on an individual basis, according to their patient summary & care plan. There is 1 room in Hope House identified for isolation. Other patients have been identified as potential for community/Bellsdyke flat use, isolated in bedroom in Hope House or Transfer to isolation team 3, Trystpark. **
- **Russell Park** – Patients will remain on Russell Park and be nursed in isolation
- **Trystview** – Patients will be transferred to team 3, Trystpark**

** The Clinical Nurse Manager and Consultant will required to be involved in decision about Hope House patients or other site patients where isolation is dependent on mental state. **

Staff must wear PPE in all interactions with the patient and during transfer. Where the patient is walking through other clinical areas, they should be asked to wear a facemask. The patient must tested for COVID-19.

Loch View

It is intended that, in the first instance, all patients in Loch View who present with symptoms indicative of COVID-19, or have a confirmed diagnosis, are cared for within Loch View. House 4 at Loch View has been made available and is now set up to transfer patients who have tested positive, or are being investigated for COVID-19.

The rationale for this is that this will:

- Minimise the distress and upheaval for the patients, many of whom would not manage, nor understand the need for transfer
- Minimise the risk of multiple, unfamiliar staff being involved with highly complex cases
- Reduce the demand on services to transport patients

Any patient presenting with symptoms will require isolation and barrier nursing with staff wearing PPE. As all rooms within Loch View are en-suite this can be achieved within the patient's own house, or transfer to House 4.

In many cases within Loch View the patients will not be able to tolerate barrier nursing within their rooms and care risk assessment will be required to determine whether attempting to limit the movements of the patient may actually increase the risk of cross-infection by

provoking incidents of aggression. If this is the case then transfer to House 4 should be arranged. House 4 will only be used for patients testing positive or being investigated for COVIS-19, providing a safe space where patients can be nursed and have freedom to use a communal area without the risk of cross infection to other patients who are not symptomatic.

Person specific plans for each of the inpatients on Loch View have been developed.

The patients on House 1 would be unable to tolerate moving to another clinical area and will find being nursed in their bedroom intolerable. Therefore where a patient is suspected of having COVID-19 they should have their movements around the house and contact with other patients minimised. This may include managing a cohort of patients in one area of the ward, or transferring to House 4.

As a consequence of being unable to eliminate the mixing of patients within House 1, all patients should be treated as though they are COVID-19 positive. This means that staff will wear PPE for all patient interactions. Staff rotation to other areas will be minimised as far as possible.

Within house 2, there is an area which can be locked off to provide care for one acutely behaviourally disturbed person. This will support the prevention of infection in this case. The other resident in House 2 can be managed within their bedroom without difficulty.

The remaining vacant bedrooms will be used to isolate patients from House 3 who would not tolerate staying within their own bedroom continuously.

For all patients in House 3 who will tolerate being looked after within their own bedroom, this is sufficiently isolating provided the door is closed and staff use barrier nursing precautions.

Return to contents

Appendix 2 – Literature Review

Expected psychological impact of Covid-19 and recommendations

Studies carried out during Covid-19

The Covid-19 pandemic is expected to lead to a rise in demand for mental health support. Three studies have been conducted on the prevalence of psychological distress in China during the Covid-19 pandemic:

Cross-sectional study of Zhongshan in China from 15th – 29th of February 2020 (Zhang et al., 2020)

- 205 participants completed questionnaires – The Chinese version 9-item General Health Questionnaire (GHQ-9), and the 7-item Generalised Anxiety Disorder questionnaire (GAD-7).
- Administered to identify prevalence and severity of psychological distress of patients newly recovered from Covid-19 (n = 57), individuals in quarantine (n = 50), and the general public n = 98)
- **Prevalence of depression** - 29.2% in patients who experienced Covid-19, 34.7% in the general public and 9.8% in those in quarantine
- **Prevalence of anxiety** – 20.8% in patients who experienced Covid-19, 19.6% in the general public, and 10.2% in those in quarantine
- **Prevalence of co-morbid anxiety and depression** – 21.1% in patients who experienced Covid-19, 22.4% in the general public, and 8% in those in quarantine
- **Severity of depressive symptoms** – Severe depressive symptoms found in 19.3% in patients who experienced Covid-19, 14.3% in the general public, and 4% in those in quarantine
- Those who experienced Covid-19 and the general public were **more likely to demonstrate depressed mood and somatic symptoms**, compared to those in quarantine.
- Becoming **easily annoyed or irritable** (measured by the GAD-7) was **more common in the general public.**
- Authors suggest vulnerability to psychological distress during the Covid-19 pandemic could be variable by gender, social support, length of isolation, amount of exposure to the media, and specific experience with Covid-10.

Nationwide survey of psychological distress in Chinese people from 31st January – 10th February 2020 (Qui et al., 2020)

- Self-report questionnaire administered and made openly accessible to the general public.
- Questionnaire designed to measure peritrauamtic stress.
  - Measure used called **Covid-19 Peritraumatic Distress Index (CPDI)**
  - Measures frequency of anxiety, depression, specific phobias, cognitive change, avoidance and compulsive behaviours, loss of social functioning and physical symptoms in the last week.
  - Scores ranged from 0 to 100. Score **between 28 – 51 indicated mild to moderate distress**. Scores **over 52 indicate severe distress**.

  - Questionnaire incorporated relevant diagnostic guidelines for stress disorders and specific phobias (ICD-10)
- **52730 responses from 36 provinces – 35 % male and 65% female**.
- Mean CPDI score was 23.65.
- **Almost 35% of respondents experiences psychological distress** (29.3% of scores between 28=51, and 5.1% were over 52)
- Further analysis showed that an individual's CPDI score was associated and impacted by gender, age, education, occupation and region.
  - **Gender: Female respondents** had **significantly higher psychological distress than males** – this is in line with other evidence that **females are more vulnerable to stress** and have a **higher likelihood of developing PTSD** (Sareen et al., 2013)
  - **Age:** Those **under 18** years had **the lowest psychological distress**. Those between **18-30 and those over 60 had the highest psychological distress**. The low distress in juveniles could be explained by **relatively low morbidity rate** and **limited exposure to the epidemic** due to home quarantine. For those between 18-30 it confirms finding that **young people get large amounts of information from social media that can trigger stress** (Cheng, Juin & Liang, 2014). The highest mortality rate occurs in the elderly so higher levels of psychological impact are expected.
  - **Education:** those with **higher education** tended to have **higher psychological distress**, possibly due to more self-awareness of health (Roberts et al., 2018).
- **Author's recommendations:** More attention needed towards vulnerable groups such as the young, elderly, and women. Nationwide strategic planning needed for delivering psychological first aid during major disasters, potentially through telemedicine.

Factors Associated With Mental Health Outcomes among Health Care Workers (Lai et al., 2020)

- Cross-sectional survey based study of 1257 health care workers from January 29th – February 3rd 2020 in China – **76.7% were women** and **64.7% aged between 26-40**. **60.8% were nurses**, and **39.2% were physicians**.
- Measures used - The Chinese version 9-item General Health Questionnaire (GHQ-9), and the 7-item Generalised Anxiety Disorder questionnaire (GAD-7) and 7-item insomnia severity index, and the 22-item impact of events scale revised.
- **50.4% reported depression**, **44.6% reported anxiety**, **34% reported insomnia**, and **71.5% reported distress.**
- Nurses, women and frontline health care workers reported more severe degrees on all measurements of mental health symptoms.

Historical evidence of mental health impact

The COVID-19 Global Pandemic: Implications for People With Schizophrenia and Related Disorders (Kozloff et al., 2020)

- Previous outbreaks of SARS (2003) **significantly elevated rates of psychiatric disorders** and psychological distress (Mak et al., 2009)
- **Stress of Covid-19** is already impacting general public so this would be expected to further impact those with mental health problems, in particular schizophrenic patients.

- Those with **schizophrenia have on average smaller and pooper quality social networks** than the general population so may be **less likely to tolerate social distancing**.
- **Social support associated with better recovery** in schizophrenic patients so removing this could have adverse outcomes. **Social isolation may also increase risk of suicide** and **stress** in **schizophrenic patients has been associated with aggressive behaviour.**
- Developing ways to **maintains social support** with this group is crucial i.e. video conferencing apps. One study found **high levels of satisfaction** over an 18 month period **using video conferencing with those with severe mental illness** (Hulsbosh et al., 2017)

Effects on mental health in previous pandemic/community disasters

- Boston Marathon Bombings – 3.4 fold increase in **incidence of functional neurological symptom disorder** reported after city-wide lockdown following Boston Marathon Bombings (Guerriero et al., 2014).
    - Korean MERS-CoV (2015) – Care providers should **be aware of functional neurological symptom disorders** following stressful community events **especially in those with prior psychiatric diagnosis** (Jeong et al., 2016)
- **Family members** of those with **severe illness/hospitalisation in ICU** during SARS 2003 reported **higher levels of stress and depression and higher needs of psychological support** (Elizarraras-Rivas et al., 2010).

Effects on mental health of Health Care providers in previous pandemic/community disasters

During Covid-19 health care staff have been working under high stress with risk of infection, overwork, inadequate protection, discrimination, isolation, frustration, lack of contact with families, exhaustion etc. (Kang et al., 2020)

- During SARS-CoV outbreak in Singapore, **27% of health care workers** reported **psychiatric symptoms** (Lee et al., 2018)
- After the Korean MERS-CoV outbreak in 2015, **medical staff showed post-traumatic stress disorder symptoms**. The rate of these symptoms **increased even following isolation** or home quarantine (Shantanu & Kearsley, 2020)
- During the 2015 Korean MERS-CoV outbreak, the **influences of stigma and hardiness** had a **direct impact** on **mental health** of health personnel working on public hospitals (Shigemura et al., 2020).
- During the Ebola outbreak in Sierra Leone in 2014, **medical staff reported high levels of anxiety** and felt a **large impact of stigma** being individuals in **direct contact with infected patients** (Park et al., 2018)
- During SARS-CoV outbreak in Taiwan, **majority of staff in the emergency department and the psychiatric ward developed PTSD.** The emergency department staff developed this more severely than psychiatric staff (Lee et al., 2018)
- **Psychological adaptation** was found in health workers who had access to a **well-equipped** and **structured environment** (Lee at al., 2018)

Mental Health Response: Recommendations from research

- Covid-19 has increased the prevalence of anxiety, depression, PTSD, and insomnia in the population and contributed to fatigue and decreased performance in health care workers (Torales et al., 2020)
- **Mental health support** and follow-up should be provided **up to 6 months after release from isolation**, especially for those with **prior vulnerable mental health** (Torales et al., 2020)
- There is a **need for community-based and brief psycho-social interventions**. Research has shown as much as **weekly telephonic sessions** can **reduce anxiety during a pandemic**. The sessions should be **brief and solution-focused** (Yang et al., 2020)
- Due to the psychological impact of loneliness on an individual as a result of self-isolation and quarantine, it is important **to maintain digital communication** and **encourage others to maintain this with loved ones** (Banerjee & Rai, 2020)

The Covid-19 Five-a-day: A proactive approach to protecting your mental health during the pandemic (Online Article from 21st March 2020)

Ideas and perspectives from psychological theory to reduce impact of Covid-19 on mental health.

- **Limiting direct interaction** between people is **psychologically stressful and even traumatic**. **Research on resilience** shows **interpersonal relationships** and **social connects** are key for **well-being**, this includes **social touch**. Asking people to isolate is asking people to **forgo social interactions** that can **actually reduce stress** (Burleson & Davis, 2014)
- Studies on people who had to isolate during SARS and MRSA outbreaks illustrated the higher likelihood of **irritability, fear, loneliness, boredom, disruption of usual routines, feeling stigmatise, and a loss of control** (Hussain, Sultana, & Purohit, 2020).
    - Research also found **1/3 of people in isolation** had poor mental health status with particularly high rates of anxiety, and **60% of people had increased irritability**
    - **Health care workers** also experienced **higher rates of stress and exhaustion, anxiety, depression and insomnia**
    - This should be expected following prolonged periods of isolation during Covid-19.
- Psychological crisis intervention developed in china so far in 2020 to deal with anxiety and distress in healthcare workers and the general public.
    - Service model of West China Hospital (Zhang et al., 2020) took into consideration the publics knowledge of infectious disease, coping skills, psychological self-awareness and health behaviour.
    - Online resources were developed that included mental health self evaluations, public health information, a telephone helpline and an app to provide information screening and an online platform for social support. A psychological rescue team was also created for crisis intervention.
- Research into how people cope with isolation found that a period of adaptation to new circumstances is needed to adjust and periods of boredom, accompanied by low mood and lack of motivation are to be expected. Finding ways to keep busy are important.

- Researchers applied positive psychology to sea ship workers who had to endure similar long periods of confined quarters and interactions with similar people. Techniques applied were:
    - Thinking about the good things in your life, develop a sense of self-efficacy, hope and optimism, practice mindfulness, write about goals, identify strengths then use these in new ways, cultivate humour and laughter. These are all thought to have developed resilience and improve mental health.
- **The covid-19 five-a-day suggested by research**
    1. **Have some fun** – play and laugh
    2. **Be positive** – find opportunities to grow daily life and access accurate information
    3. Interact with others – make time for positive interactions with others and maintain relationships
    4. **Take time for yourself** – maintain personal space and allow others to do that too
    5. **Cultivate compassion** –be kind to yourself and others – show tolerance.

https://helpwithmentalhealth.net/2020/03/21/the-covid-19-five-a-day-a-proactive-approach-to-protecting-your-mental-health-during-the-pandemic/

Good read >>>> Sritharan, J., & Sritharan, A. (2020). Emerging Mental Health Issues from the Novel Coronavirus (COVID-19) Pandemic. *Journal of Health and Medical Sciences*, *3*(2).

References

Banerjee, D., & Rai, M. (2020). Social isolation in Covid-19: The impact of loneliness.

Burleson, M. , & Davis, M. (2014). Social touch and resilience. In: Kent, M., Davis, M., & Reich, J. (Eds). *The resilience handbook*. New York: Routledge, Chapter 10 pp131-143

Cheng, C., Jun, H., & Liang, B. (2014). Psychological health diathesis assessment system: a nationwide survey of resilient trait scale for Chinese adults. *Stud Psychol Behav*, *12*, 735-42.

Guerriero, R. M., Pier, D. B., Gusmão, C. M., de Bernson-Leung, M. E., Maski, K. P., Urion, D. K., & Waugh, J. L. (2014). Increased pediatric functional neurological symptom disorders after the Boston marathon bombings: A case series. *Pediatric Neurology*, *51*, 619–623.

Hulsbosch, A. M., Nugter, M. A., Tamis, P., & Kroon, H. (2017). Videoconferencing in a mental health service in the Netherlands: a randomized controlled trial on patient satisfaction and clinical outcomes for outpatients with severe mental illness. *Journal of telemedicine and telecare*, *23*(5), 513-520.

Jeong, H., Yim, H. W., Song, Y.-J., Ki, M., Min, J.-A., Cho, J., & Chae, J.-H. (2016). Mental health status of people isolated due to Middle East Respiratory Syndrome. *Epidemiology and Health*, *38*, e2016048.

Kozloff, N., Mulsant, B. H., Stergiopoulos, V., & Voineskos, A. N. (2020). The COVID-19 Global Pandemic: Implications for People With Schizophrenia and Related Disorders. *Schizophrenia Bulletin*.

Lee, S. M., Kang, W. S., Cho, A.-R., Kim, T., & Park, J. K. (2018). Psychological impact of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients.*Comprehensive Psychiatry*, *87*, 123–127.

Mak, I. W. C., Chu, C. M., Pan, P. C., Yiu, M. G. C., & Chan, V. L. (2009). Long-term psychiatric morbidities among SARS survivors. *General hospital psychiatry*, *31*(4), 318-326.

Park, J.-S., Lee, E.-H., Park, N.-R., & Choi, Y. H. (2018). Mental health of nurses working at a government-designated hospital during a MERS-CoV outbreak: A cross-sectional study. *Archives of Psychiatric Nursing*, *32*, 2–6.

Roberts, T., Esponda, G. M., Krupchanka, D., Shidhaye, R., Patel, V., & Rathod, S. (2018). Factors associated with health service utilisation for common mental disorders: a systematic review. *BMC psychiatry*, *18*(1), 262.

Sareen, J., Erickson, J., Medved, M. I., Asmundson, G. J., Enns, M. W., Stein, M., ... & Logsetty, S. (2013). Risk factors for post-injury mental health problems. *Depression and anxiety*, *30*(4), 321-327.

Shantanu, S., & Kearsley, S. (2020). How should clinicians integrate mental health into epidemic responses? *AMA Journal of Ethics*, *22*, E10–E15.

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *International Journal of Social Psychiatry*, 0020764020915212.

Appendix 3 – Staff Support & Wellbeing

NHS FV Staff Support and Wellbeing during Covid-19 v6 21.05.20

In recognition of the potential emotional impact of Covid-19 on staff various services across NHS FV are offering different types of staff support which is available for health and social care staff. The work is delivered under the auspices of NHS FV Staff Support and Wellbeing Group chaired by Linda Donaldson, HR Director and NHS FV lead for staff support during Covid-19.

TYPE OF SUPPORT	DESCRIPTION AND EXAMPLES OF SUPPORT	CURRENT STATUS	ACTION PLAN
Psychologically based information for all staff	Self-care information and wellbeing resources for all staff Information for managers regarding how to build resilience, and promote wellbeing in staff. Developed by Psychology Services from recognised resources.	Info now on Staff Wellbeing section of staff intranet/Forth Valley internet Info sent to all GP practices. Packs for care homes and carers centres prepared	Organise and update information as indicated. Care home packs to be distributed wk beg 25.05.20
Other staff support info	Trickle online wellbeing support	All NHS FV staff emailed an invitation to join Trickle. Note Trickle content is not governed.	
Drop-in	Support staff available in staff wellbeing areas / sanctuaries to provide quiet spaces and ad hoc support for staff	FVRH library area M-F 9-5 (psychologists), and M and Th 5-6pm (psychiatrists) FVRH Spiritual Care Centre M-F 9-5 (spiritual care staff)	Continue to monitor use and scope for development of drop-in/sanctuary areas Ongoing evaluation

		FVRH Mental Health Unit (psychology, psychiatry) Prisons and forensic inpatient areas (psychology) FCH Reach FV Tues (psychology) SCH Hub gp rm Th (psychology) LD inpatients Livilands Resource Centre	Continued advertising via managers, intranet and posters in key areas.
Structured support sessions	Psychology and psychiatry led brief relaxation or self-care sessions. Medical peer support Virtual staff rooms led by Strathcarron Hospice staff. To be available evenings.	Psychiatry led relaxation FVRH library M and Th 5-6pm FCH Reach FV Tues at 12 and 4.30 (psychology) SCH Hub gp rm Thurs at 12 and 4.30 (psychology) Existing networks in place Investigating technology, and management of presentations of risk.	Ongoing monitoring, evaluation and change as indicated Respond to need expressed during psychology drop-ins.
Staff training	Psychological First Aid sessions Communication training – eg having difficult conversations with relatives of dying patients	Psychologically informed training materials provided to consultant anaesthetist in ICU for delivering sessions on resilience. Hospital palliative care staff / psychiatry/psychology delivering training to ED, ICU staff, mental health unit.	Continued liaison with colleagues to identify need and deliver appropriate training.

		Psychology led wellbeing training for FIY2s	
	Bespoke staff support topics considered on request	Several sessions delivered in various areas across FVRH, SCH, FCH.	Summary of specific sessions available to be sent by Susie Porteous to Staff Wellbeing and Support Group for consideration by managers.
	Hot and cold debriefs for theatre staff (doc led)		
1:1 support	Psychological First Aid (internationally recognised appropriate support for staff at this stage in emergency response). Delivered via phone, video call, or face to face by trained Psychology Services staff member.	Psychology Services staff (Clinical Health Psychology team and Adult Psychological Therapies counsellors) redeployed to provide staff support. Contact number advertised on Covid-19 pages of staff intranet. Agreed pathway for onward referral to MHAATS if imminent risk. Agreed documentation and reporting structures with Occ Health.	Continued collaboration amongst services offering 1:1. Aim of ensuring understanding of different types of support to enable appropriate signposting amongst services.
	Spiritual Care offering a Listening Ear.	Advertised on intranet / via posters. To finalise pathway for managing risk.	
	OD coaches and Keep Well life coaches also available for 1:1 support.	To be advertised.	
Psychological consultancy for managing difficult	Psychologists already embedded with cancer, diabetes, Reach, pain, mental health, LD, prisons FCMHS and Bellsdyke,SMS, older adults service, paediatrics provide	Ongoing access as per usual practice for teams where psychology is embedded (incl care planning and risk	Advertise to other managers and team leads via staff intranet, posters, leaflets

scenarios	psychological consultancy for staff managing challenging scenarios. Consultancy to be offered to managers / team leads in FVRH Challenging scenarios may include: Managing distressed /angry patients /relatives, breaking bad news, looking out for more vulnerable staff, discussing death and dying, applying tools such as decision navigation aids	assessment) Delivered by phone, face:face sessions in different areas across FVRH.	
Support to Covid-19 Ethics Group	Chaired by psychiatry, with contribution from clinical health psychology	Clinical health psychology working with group to identify support needs for staff and for the group	
FACTORS TO CONSIDER ACROSS EACH TYPE OF SUPPORT	Be mindful of: All staff professions Raising awareness in different ways to increase accessibility- some staff will be looking for support from home Wellbeing of staff providing the support. Covid-19 frontline staff, + staff in other essential services impacted by Covid-19 Staff support needs to be responsive to changing needs over time as expected according to the literature Monitoring update and effectiveness Ensuring representation from key staff groups	Circulate as widely as possible to managers to ensure a co-ordinated approach across the organisation. Psychology Services staff have buddy systems, supervision and staff are aware of Spiritual Care 1:1 service. Planning with reference to Paijmans & Guy 2020 All support services documenting uptake (mindful of confidentiality) Frequent meetings of staff support	If external support is required external psychologists are available via staff bank. Staff support and wellbeing group are developing a brief, anonymous evaluation survey. Monitor gaps in representation and

	and service areas. Ensuring staff support offered in NHS FV fits with the Scottish Government's directives on the provision of staff support.	and wellbeing group All information and support offered has been checked (14.04.20) to ensure it complies with directives set out by Scottish Government.	invite collaboration accordingly. Keep abreast of Scottish Govt and NHSFV directives related to staff support during Covid-19, and plan accordingly.