Joint Mobilisation Plan for Fife

May- July 2020

Second Draft
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NHS Fife

Fife Health & Social Care Partnership

Table of Contents

1 Introduction

This is the Joint Remobilisation Plan for health and care services delivered by NHS Fife and Fife Health and Social Care Partnership (HSCP) following the COVID-19 pandemic. Scotland and the UK is still in emergency planning measures, however, the framework published by the Scottish Government on 21 May 2020 provides a roadmap with 4 phases to restart society following the period of lockdown.

The purpose of this document is to set out the short term plan and will describe how clinical services will be restarted and the governance supporting the restart.

2 Background

In March 2020, Fife submitted a Joint Mobilisation Plan to Scottish Government Health & Social Care Directorates in response to the declared worldwide COVID-19 Pandemic. This Plan detailed the expansion of services to accommodate the expected increase in admissions of patients with COVID-19. A draft copy of this plan was shared with members of Fife NHS Board at the end of March.

On 24 April, the Interim Chief Executive of NHS Scotland confirmed that the Scottish Government was content in principle with the plans for acute services set out in the Fife Joint Mobilisation Plan and the activities undertaken to date. In parallel, the Cabinet Secretary for Health and Sport wrote to all Integration Authority Chief Officers on 9 April confirming support in principle for activities identified, on the basis that additional expenditure was clearly set out, understood and appropriate to deliver the plans.

Fife responded quickly to the emerging situation of COVID-19 in our population followed by the declaration of the emergency planning measures on Scotland and the UK.

The following actions took place as part of the COVID-19 Mobilisation Plan and are still in place:

- Pausing of all elective activity except the highest clinically prioritised urgent and cancer work including outpatients, diagnostic and inpatients and day case treatment and procedures being undertaken.
- Some staff were deployed to other clinical services within NHS Fife and Fife H&SCP
- All primary care referrals were deferred except urgent and suspicion of cancer. Referrals received were prioritised by clinicians and only seen if a high priority
- Limited services for CAMHS and Psychological Therapy services

The outcome of this resulted in

- a dip in performance for those patients waiting over 12 weeks for first outpatient appointment and procedure/treatment for inpatients and daycases.

- Waiting lists for outpatients and inpatients/daycases have remained broadly the same over the past 8 weeks as no patients have been added or removed.
- Improvement in Emergency Access Standard as few patients have presented to Emergency Departments.

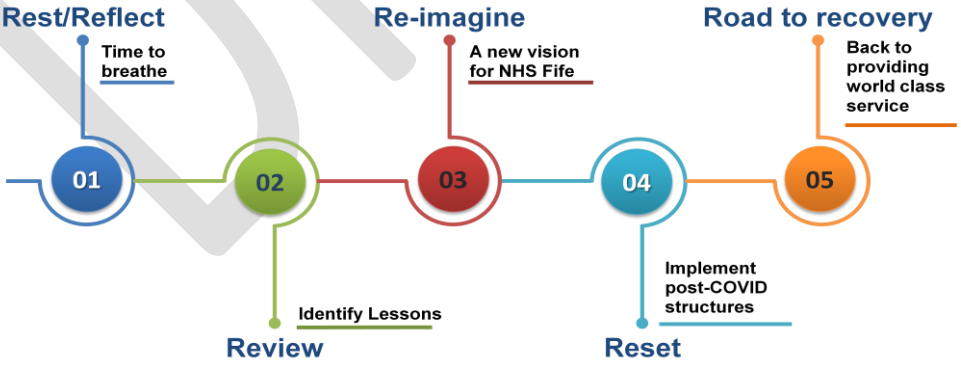
The development of the remobilisation plan is clearly aligned to principles and recommendations from Fife's Clinical Strategy, published in October 2016 and the Fife Health & Social Care Partnership Strategic Plan as well as an agreed set of remobilisation guiding principles.

3 Respond, Recover, Renew Methodology

In order to capture and make sustainable the changes that have taken place and to protect the new ways of working and prioritisation, a methodology was adopted to ensure NHS Fife and Fife HSCP provides safe and resilient services going forward and are aligned to the guiding principles which are:

- Whole System; safe and person centred care
- Clinical Prioritisation
- Agile, Flexible and Responsive
- Realistic Medicine/Care
- Protecting our workforce
- Digitally enabled
- Data enabled

The methodology that will be used is illustrated below and provided by Military Liaison Officers assigned to NHS Fife. It is acknowledged that staff and managers needed time to rest and reflect so a new future could be imagined using lessons learned over this time and implementing a new future in partnership with our staff.



An action plan was developed to accompany this model that will provide the basis of the short and longer term strategic planning for health and care services in Fife. The timeline for delivery of this work is dependent on the Scottish Government roadmap phases.

Agreed Actions from Methodology

Rest and Reflect	1. *A Gold Command workshop is set up to identify lessons learned, hold quality gains and understand losses and to agree how the team will work together to safeguard the future.* 2. *Managers and local teams will be encouraged to pause and reflect on what they have achieved and what they want to maintain going forward* 3. *A message will go out through Communications, possibly through Bright Ideas or StaffApp to gather lessons learned from all staff and managers*
Review	4. *A collation of all learning from COVID-19 experiences in a systematic and themed way. This will inform the Re-imagine phase.*
Re-imagine	5. *To establish a time limited Oversight Group to strategically oversee the plan based on living with COVID-19.*
Reset	6. *Develop a capacity and flow model to quantify non COVID-19 capacity that can be used to restart services. This will include emergency access, outpatients, diagnostics, theatre capacity and bed capacity in Acute and primary care emergency access, outpatients and bed capacity in Community.* 7. *Consideration must be given to formalising working from home with the development of a Working from Home policy written in partnership.*

3.1 Barriers to Change

For all plans, there are a number of barriers to change that need to be considered:

- **Bed Capacity and Physical Distancing**
  The state of emergency planning has forced a review of physical spacing in all hospitals and this has had a significant impact on bed capacity available especially in hospitals which are part of the older estate of NHS Fife. This will affect in particular Community and Mental Health Hospitals but with the impact of patient/client flow across all aspects of primary, community and secondary care.

  To adhere to the physical distancing guidance, work will be undertaken to improve the patient flow throughout the whole system across acute, community and Mental Health hospitals. To accommodate these changes, alternative models of care or managing the flow will have to be introduced. Delays and queues will have to be managed within hospital capacity if there is significantly reduced capacity (e.g. beds) to enable appropriate infection prevention and control measures to be put in place. For example, this will be achieved in the acute hospital by flexing the elective programme to create capacity.

- **Outpatient Capacity and Physical Distancing**
  Outpatient/Patient contact processes are being redesigned to take into account physical distancing and infection prevention and control measures. Alternative consultation and treatment models available include digital solutions like Near Me. The use of digital solutions has been embraced during this period of COVID-19 pandemic and plans must include embedding a progressive and innovative culture into the organisation.

- **Clinical Prioritisation**
  The reduced clinical capacity in all settings will mean that less activity will be able to be undertaken as pre-COVID-19. During COVID-19 lockdown, clinicians have prioritised care and treatments to accommodate only urgent patients and Urgent cancer patients. As we move through the different phases, this prioritisation will continue as capacity (which will be more limited than before for the reasons outlined above) is opened up. Clinical collaboration with primary and secondary care will be key to managing the demand across the system.
- **Testing**
  To ensure the safe restart of surgical procedures, all patients will be tested prior to surgery. As the number of procedures increase across Fife, we must ensure that we have enough capacity to test all patients prior to surgery in addition to other testing being undertaken.
- **Return to Old Ways of Working**
  The rapid mobilisation of clinical services to react to the COVID-19 pandemic showed that the organisation can redesign and remobilise staff and services in an agile and flexible manner and at pace but still with clear decision making and governance. There is a risk as we move back into 'normal' ways of working that this agile and flexible approach is not taken forward.

When considering solutions to these barriers, each service must consider and put measures in place to resolve any unintended consequences of a service change or redesign to other services and patients.

As previously described, clinical services available going forward will be different so a key piece of work going forward will be a communications plan that will engage with patients, staff and the public and manage expectations of everyone involved in healthcare from patients, clinicians, public and local and national politicians.

3.2 Timeline for Remobilisation Plan

The timeline for this methodology will be the next 6-12 months but there are shorter term arrangements in place to plan the restart of some services with caution due to the COVID-19 situation. The healthcare system must be flexible to react to an increase in COVID-19 in our population and scaling back up our COVID-19 response in our hospitals, community and social care settings.

As part of how Fife will work with staff to restart clinical services, in addition to good governance and partnership working, the following were agreed as the Fife ethos based on lessons learned through COVID-19 mobilisation.

- Empowerment
- Always thinking forward
- Speed of Action
- Good Enough

These along with being agile and flexible will be the way health and care services are developed and delivered in Fife in the future.

At the same time as this work is being undertaken, the Transformation and Change Team were tasked to analyse the impact of the changes implemented in response to COVID-19 across all clinical services in Fife. The table below outlines the high level categories of change that were implemented.

Category of Change	Brief description of changes
Screening	• National advice channelled people down the 111 advice route where people were advised to self-isolate rather than present at a primary or secondary care location. • Access to hospital sites was limited to designated access points at which a screening system was implemented to identify those with or suspected of having COVID-19 infection • Designation of RED and GREEN zones and pathways within the hospital site to effectively manage patient pathways and control risk of further infection • Dedicated COVID-19 Testing Hubs
Triage of lists, referrals and attendances	• A review of all Outpatient activity was conducted by Consultant clinicians whereby lists were re-triaged to identify Urgent and Urgent (suspicion of cancer) patients. All patients who did not fall into these categories were designated as routine and placed on a waiting list. • Defined pathways within departments to limit cross-infection of 'Red' and 'Green' patients • Urgent Care Assessment Area
Revised and Updated Pathways	• New pathways at the Front Door to increase patient and staff safety and ensure swifter flow for both COVID-19 and non-COVID patients. For example, some paediatric or suspected urology patients are being redirected directly to the specialist services themselves rather than waiting and being managed in ED.
Use of digital modes of delivery	• Introduction of MS Teams for staff • All GPs and Outpatient Consulting staff were given a laptop to enable them to work whilst self-isolating (if appropriate) • All clinicians were given NHS Near Me access for virtual consulting • All patient lists were clinically reviewed to identify patients appropriate for an NHS Near Me or Telephone consultation
Increased pace of decision making	• Hospital Control Teams and/or Control Rooms were set up as a vehicle for making quick yet still fully considered decisions, as well as decision support and barrier unblocking

Category of Change	Brief description of changes
Use of Alternatives to admission	• Hospital at Home Service and ICASS increase in capacity and activity • Urgent Care Service increase in capacity / activity, focus • Perception of reduction in people presenting at GP surgeries • Reduction in diagnostic capacity due to focus on COVID-19
Additional Support in community	• Support for individuals on Shielding Lists • The impact of having more people at home and having neighbours more available / willing to help has yet to be measured but is likely to have had an effect
Estates and Facilities (Redesign of hospital footprint)	• Redesign of front door to incorporate Red and Green zones within the medical assessment unit, medical and surgical joint assessment. • Services being moved to Queen Margaret Hospital (e.g. Diabetes Centre, Dermatology) to increase capacity at VHK for screening and inpatient demand.
Communication	• There has been a strong and consistent message coming from Scottish Government which has been reinforced locally and embedded consistently in operations across the system. • There has been a daily staff briefing which provides COVID-19 related workforce and staff wellbeing updates • NHS Fife has introduced a new Stafflink App

The purpose of this exercise was to collate the themes across acute and HSCP in terms of changes and to identify actions required to make these changes sustainable into the future. The themes collated in this exercise can be found in the review of COVID-19 and the remobilisation plans for each services.

Appendix 1 collates potential change ideas that have been collected from across all services and these have been identified according to sector and pathway to give a broad overview of the workplan for the Transformation and Change Team going forward.

4 Managing Restart of Clinical Services

There must be a clear and concise process for restarting of services which has been agreed by the Executive Directors Group that is based on the agreed guiding principles detailed in section 4 as well as patient safety, quality improvement and HAI compliant delivery of services.

As we move through Phase 1 of the Scottish Government framework for Decision Making, we recognise our plans must ensure we continue to keep capacity in

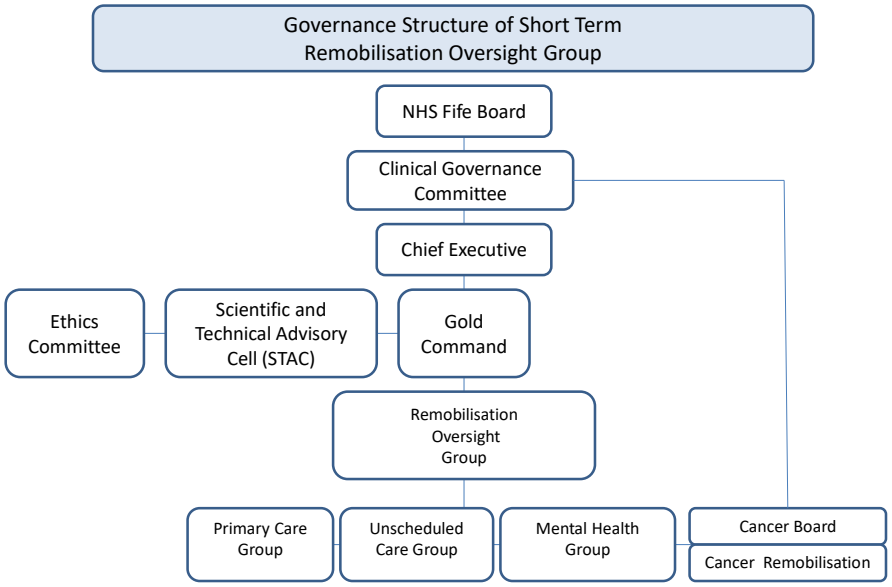
hospitals for COVID; and have a flexible approach to react to a second wave of COVID-19 as we release from lockdown.

Whilst the current COVID-19 situation is improving, there continues to be the separation of red and green areas and pathways in ambulatory and inpatient facilities. By doing so, all aspects of health and social care will continue to provide safe and effective care to patients whilst keeping staff safe.

Since the pandemic was declared, all elective activity has been stood down with only Category 1 patients, prioritised by clinicians, have been seen and treated. As previously mentioned, the flexible approach that will be taken to restart elective activity will see the re-introduction of some elective services based on clinical prioritisation, initially the Category 2 and 3 cancer activity.

A Remobilisation Oversight Group (ROG) has been established to oversee the restarting of health and care services in Fife during this phase. This governance group has a specific remit to remobilise clinical services paused since the start of the COVID-19 pandemic. This group may eventually be superseded by a strategic group overseeing the implementation and monitoring of the Annual Operational Plan (AOP) including population health and inequalities. The group will oversee the whole system in an integrated way to improve pathways from primary care, community, social care and secondary care adhering to our good governance arrangements with learning from our COVID-19 response.

The group is co-chaired by the Medical Director and Director of Nursing who will drive the reintroduction of clinical services in a safe, measured and COIVD-19 sensitive way with a wide representation of clinical leaders. The diagram below illustrates the governance structure of this group.



* Director of Health and Social Care will take the work of this group through the IJB

The following clinical priorities have been were identified and agreed:

1. Unscheduled Care
2. Critical Care
3. Cancer
4. Mental Health
5. Primary Care
6. Capacity and Flow

In parallel with the work of the Scottish Medical Directors group (SAMD) and Scottish Executive Nurse Directors group (SEND), we are taking cognisance of the following patient and system factors in our remobilisation of services:

Patient factors that require to be optimised before proceeding:

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

System factors that require to be optimised before proceeding:

- There is no compromise to flow and levels of occupancy are at a safe level, including in critical care.
- There are adequate resources- of workforce and supplies (including medicines and Personal Protective Equipment (PPE))
- The hospital and care home environment is as safe as it can be: there are no COVID-19 outbreaks suggesting in hospital transmission.

In addition to the work of SAMD and SEND, the Director of Pharmacy is providing leadership to ensure availability and appropriate allocation of medicines across the HBs.

Following the publication of *Re-mobilise, Recover, Re-design: The Framework for NHS Scotland,* NHS Fife will align our plans with the Scottish Government COVID-19 Routemap. The Remobilisation Plan will be adapted to re-start of clinical services in the 4 phases.

Appendix 3 is this mobilisation plan presented as the 4 phases in the COVID-19 Routemap. This is still being worked on and is in draft format. The detailed plans for each of these services are overseen by the Remobilisation Oversight Group and

delivered more operationally through the ROG sub groups. A template for the restart of every clinical services is completed in SBAR format including a risk assessment and confirmation of the involvement of clinical leadership, service management, staff side representation and HR and Finance Business Partners.

5 Population Health

5.1 Population Screening programmes

NSD has been planning for recommencement of screening programmes and has prepared a Screening Recovery Overarching Routemap. The recovery plans developed by Screening Programme Boards will consider participant and population safety; clinical prioritisation; whole screening pathway; standards assurance and capacity and control measures.

All of the cancer screening SBARs emphasise that it is critical that the screening programme recovery is included within NHS Board mobilisation plans and that the full screening pathway is available for screening to recommence, this is currently being considered locally. We have some local work to do on the detail of this to check capacity e.g. in colonoscopy, pathology and colposcopy and this will be considered locally through the Remobilisation Oversight Group.

Diabetes Retinopathy Screening (DRS) programme

The Diabetes Retinopathy Screening (DRS) programme is currently paused with staff being deployed across the organisation to support other clinical activities. In DRS, the main fixed site that is normally used is being used as a COVID-19 assessment centre and it is unclear when this will be available again.

A remobilisation plan is in development that considers key areas including sites, appointing, communications, prioritisation of patients as well as PPE and infection control.

The impact of withdrawing the DRS workforce from mobilisation is to be assessed. Service delivery would need adjusted to reflect infection prevention and control procedures. The restart of the service is being reviewed as part of the DRS remobilisation plan.

5.2 Test and Protect Service

Scotland's approach to maintaining low levels of community transmission of COVID-19 in Scotland is known as Test-Trace-Isolate-Support (TTIS). This is about to be rolled out across Scotland supported by a national public campaign. Local NHS Boards and Public Health Scotland have been asked to work together to deliver this programme. NHS Fife is one of three boards piloting the national training materials week commencing 18 May 2020 prior to a planned roll out on 28 May. Resources required to deliver the programme are being identified and costed at a local and national level, based on national modelling of the anticipated volume of activity.

There is no National Finance template available at this time and National funding and staffing arrangements have not yet been agreed. Initial projections indicate potential monthly pay expenditure £236k, one off IT equipment expenditure of £131k, monthly testing costs of £24k and capital investment for laboratory equipment (TBC).

It is assumed that testing will be undertaken by the UK testing programme increasing the number of mobile testing facilities available across Scotland to meet the needs of local areas. This is to be confirmed but is highly likely to be the case for the majority of testing of the general population (i.e. not hospitals, care homes or H&S staff). If this is not the case, we will need additional local laboratory testing capacity of 20-40 tests per day.

For the first three months it is anticipated that due to the staffing groups utilised, the majority of staff will be paid as part of their substantive post and will therefore be a sunk cost to NHS Fife and H&SCP. The costs will still be identified, however only costs in excess of their standard rota will attract a cost attributable to TTIS. Substantive staffing availability will be dependent on Scottish government policy around an extension to shielding and resuming hospital services, which would require staff to return to substantive posts. At that point a recruitment drive will source employees on temporary contracts and costs will start to materialise for the Community Testing Team.

We have been asked in the first instance to provide staffing and to completely run the Fife TTIS programme for 3 months. A decision will be taken in the next week or so when the national team will come on board, and what the local team requirements will be beyond 3 months. Support will also be required to increase Health Protection capacity for a two year duration to assist with the management of outbreaks and complex cases.

6 Whole system working

As part of our ongoing COVID-19 response we will maintain our links and involvement in the Local Resilience Partnership and the Care for People sub-group around recovery and social mitigation work to support people to access health and social care appropriately in the evolving local systems.

We are also restarting some of our partnership work through community planning with work streams emerging on recovery and social mitigation such as attention to the needs of vulnerable populations such as homeless, gypsy travellers, people with addictions, vulnerable children and families and those who are being shielded. We are also identifying our priorities for prevention activities to support population health improvement at this stage with a particular focus on reducing isolation, improving mental health and wellbeing and maintaining community engagement.

7 Restart of Clinical Services

The plan to restart clinical activity will be based on the capacity available in clinical facilities when physical distancing, HAI measures are applied taking into account red and green hospital areas. This will determine the level of outpatient and theatre activity that can be phased in.

A scenario model has been developed for Outpatients which calculates throughput and numbers of patient that can be seen in any outpatient department taking into account physical distancing in waiting rooms. Plans are in place to extend this method to front door flow (from primary care, community to acute hospital) as well as theatre and bed capacity.

Bed capacity is being realigned following the Scottish Government letter dated 20 May 2020 for COVID-19 and non COVID-19 general and ICU beds. Arrangement will be put in place for bed spaces to be flexible enough to increase or decrease depending on demand for COVID-19 beds. One of the planning assumptions for this work will be to keep hospital occupancy at around 85% for patient safety reasons and this will be achieved through managing hospital flow and the delivery of the elective programme.

The first stage of the process was to collate the current status of clinical services across Fife and the table below shows the summary of services in the operational directorates.

Directorate	On Hold <30% Service Delivery	Not on Hold <70% Service Delivery	No change	Total
Acute	8	14	7	29
H&SCP	5	2	12	19

This provides an overview of which services have remained working to the same level pre-COVID-19 and which services have reduced their service or deployed their staff and will have to plan remobilisation.

The impact on medicines supply was seen globally as demand increased. This was compounded by the requirement to use critical care medicines in theatre areas as ICU capacity was increased four-fold and further pressure resulted from the surge in use of the same in palliative care settings.

Granular intelligence on use of medicines is not presently available in Fife (plans are in place as part of national roll out).

The service was well placed during the initial phase to manage demand for medicines in ICU, due to the clear focus on that service. However, as services remobilise, there is a need to manage the interdependent medicines requirements to support surgery following diagnostic remobilisation, and greater resultant demand on

Green ICU. The need to maintain Red ICU capacity and medicine stock remains a key priority, and places demand on the same supply chains.

A data driven approach is planned in Fife, utilising long term trends in medication use and clinical activity, alongside current local intelligence to develop evidence based plans for remobilisation and assurance on ability to deliver. Continued close working between all partners in the system will remain critical to providing a robust service.

It will be vital that national agencies are aware of, and react to Board level plans for remobilisation, factoring in demand across services beyond ICU. Local managers will continue to react to intelligence provided by national agencies, which has been critical to delivery during COVID.

8 Unscheduled Care and Urgent Care

In line with the NHS Fife principles for the remobilisation of services, the Remobilisation Oversight Group identified Unscheduled Care to be an initial whole system priority. To progress this priority it was agreed a short life group would be established to clinically lead the remobilisation of unscheduled care services.

The group has been tasked with

- Reviewing and identifying lessons learned that will inform capacity and resilience across acute and community unscheduled care services, whilst COVID remains an active concern.
- Enabling a whole system reflection which will inform how unscheduled care can be re-imagined within Fife to support a sustainable unscheduled care response.
- Setting the priorities and developing the proposals engaging both clinical and operational support and demonstrating agile decision making within a framework of clinical, financial and staff governance.

This group has representatives from Acute, HSCP, Primary Care, Scottish Ambulance Service, NHS 24, SG Unscheduled Care Team and Staff Side.

As part of the COVID-19 recovery and renewal strands of work, the developing national strategic priority of Scheduling Unscheduled Care will be part of the work delivered by the local unscheduled care group.

8.1 Urgent Care

Urgent Care is essentially scheduled via clinical triage, dispositions and appointing. Urgent Care COVID Hub and COVID Assessment Centre are in place with Urgent Care for non-COVID related conditions being delivered via 2 centres in Fife.

The home visiting service has seen a steady increase in activity at weekends. There has also remained a dedicated Care Home response is in place.

There are strong professional to professional links with clear care pathways to palliative care and Hospital at Home.

Urgent Care is part of the Unscheduled Care Group that has been established to explore recovery in more detail as part of the Remobilisation Oversight Group.

Capacity in the COVID Hub and Assessment Centre is still required to maintain COVID response, although this is being reviewed. There is a staffing model in place but a leaner staffing model is planned for June but with ability to flex up should activity increase. Care Home activity remains low but is anticipated to increase.

There has been a reduction in hours of evening operation in 1 green centre as activity is low.

An integrated model of service delivery is to be explored at one site encompassing Minor injuries and urgent care – this is in line with transformation plans.

Service would be keen to see the return of Advanced Practice Paramedics to support home visiting. Discussions are underway with SAS.

9 Elective Care

Elective activity will be gradually increased under the guidance of the Remobilisation Oversight Group who will prioritise clinical services. The immediate increase in Clinical activity will focus on urgent and urgent cancer care and proposals are coming to the Oversight Group for approval.

All outpatients and diagnostic patients (new and review) whose appointments were cancelled have been re-triaged to identify those who need to be seen urgently. There has been a steady increase in urgent and urgent suspicious of cancer referrals over the last 4 weeks. Reduction in Clinic capacity to enable safe distancing will be a constraining factor for those patients for whom a digital solution is not appropriate. A template to aid in the clinical prioritisation of requests to increase activity has been developed and being used by the Remobilisation Oversight Group in decision making for the start up of services.

Approval has already been given to restart the following post-lockdown:

- **Limited Colonoscopy service** for those clinically triaged with a qfit>200. (c.45 patients per week)
- **Limited upper GI endoscopy** (ERCP and OGD) for those most clinically urgent (c. 25 patients per week)

Theatre capacity will be a rate limiting factor as our response to COVID-19 continues. Through the mobilisation plan, activity was consolidated on the Victoria Hospital, Kirkcaldy (VHK) site, closing theatre activity at Queen Margaret Hospital (QMH) to enable ICU scale up at VHK. To support the remobilisation approach, and

based on the latest available modelling data, ICU capacity has been reduced to triple our baseline levels, with the ability to flex back within 48hrs.

To facilitate an increase in elective activity, it is anticipated the following adjustments will take place over the coming weeks, in line with the phases in the SG route map:

- Reduce ICU capacity to double baseline by end May.
- Reduce Red theatres at VHK from 4 to 2 by 13th June.
- Reinstate 1 Orthopaedic elective theatre in Phase 2, VHK, for urgent patients from 29th June.
- Reopen QMH theatres from 13th July, initially starting with 1 cataract and 2 urgent day case theatres.
- External support from Spire and King's Park was due to cease at the end of June but this has been extended until the end of December 2020.

The timing of the above steps is indicative and will require to pass through the Remobilisation Oversight Group at each stage prior to service change.

Fife Response to Scottish Access Collaborative priority areas

Priority Area	NHS Fife Update
Near Me/ Telephone consultations	*Near Me and Telephone consultations have been rapidly been introduced across Fife. Going forward all requests to restart outpatient clinics will consider the use of Near Me and telephone as the first option* *Work needs to continue to embed the virtual environment into our process, systems and SOPs but learning from other boards and areas will assist in this.*
Active Clinical Referral Triage (ACRT)	*ACRT is in place across a few specialties and the experience from work to establish this in orthopaedics will help to embed this service wide.*
Patient Initiated Review (PIR)	*When lockdown started and outpatient clinics were cancelled there was a decision made that all review appointments should be triaged before re-appointment.* *The implementation of a formal PIR process for 2 specialties will begin on 1st June and rolled out service wide thereafter.* *As part of the restart of clinical services, PIR will be considered for all patients unless there is a clinical reason to bring them back to the hospital.*
Effective Quality Interventions Pathways (EQuIP)	*Implemented.*
Colon Capsule	*Work ongoing to fully embed through service.*

Priority Area	NHS Fife Update
Endoscopy (CCE)	
Scottish Access Collaborative commissioned Speciality Reports	*Work ongoing. Good opportunity to embed across all specialty groups as we move through the 5Rs approach and re-imagine our services.*
Waiting List Validation	*There has been a significant amount of time invested in re-triaging and clinically validating lists in Outpatients, Inpatient/Day case and Diagnostics This will continue to be an ongoing process*
Team Service Planning	*Remobilisation of activity based on a granular Demand/Capacity match, supporting the principles of Team Service Planning*
Accelerating the Development of Enhanced Practitioners (ADEPt)	*Implemented through a number of specialties, further dermatology practitioners to complete training in coming months. Opportunity in Radiology identified and being worked up.*
Enhanced Recovery After Surgery (ERAS)	*ERAS is already embedded in the delivery of inpatient services for Orthopaedics, Obstetrics and Urology.*

10 Maternity Services

Antenatal and Postnatal services are essential care. The following measures have been implemented in response to the pandemic to ensure the continuation of safe personalised care during pregnancy and in the initial postnatal period:

- Implementation of Near Me for selected appointments
- Pre-screening call for all women prior to appointments and postnatal appointments
- Social distancing measures implemented in antenatal waiting areas
- Implementation of red and green pathways for clinical areas across maternity
- Updated guidance for the optimal transfer home for postnatal women to ensure seamless transfer of care between hospital and community settings for women and babies
- Visiting restrictions implemented including women only to attend antenatal appointments and one birth partner who stays in hospital throughout only where possible to accommodate woman in a single room
- Interim guidance implemented for the following:
  - Glucose tolerance testing
  - Ultrasound and Fetal Medicine Guidelines- reducing scan appointments where appropriate
  - Health Pathway Referral Pathway
  - Perinatal Mental Health Pathway

11 Children's Services

To enable most effective delivery, Child Health practitioners have mitigated the impact of COVID-19, and have focused on 1) Support and prevention, 2) safeguarding and 3) protection of those who are most vulnerable.

The following provision of care has been provided since the outset of the COVID-19 outbreak:

- Health visiting home visits including essential universal pathway contacts.
- School nursing – virtual support to young people
- Community children's nursing
- Feeding Assessment (establish good feeding)
- Monitoring of growth (further advice on cleaning of equipment is being developed)
- Protecting maternal mental health through use of validated tools or professionally led discussions
- childhood immunisation schedules
- virtual occupational therapy advice and sign posting
- All child protection work

In the main, all children's services activity has resumed albeit using different delivery methods. This will continue well into the future. All staff who were initially mobilised are back in the service. There is no risk to quickly resume to pre-COVID-19 service delivery because of the limited impact that this pandemic has had on the service.

Plans are underway to put in place rotas to reduce footfall in office spaces. In 3 months, full service provision will be enabled utilising digital technology.

12 Primary Care

In Fife, General Practice has remained operational throughout the COVID-19 response.

It has embraced the use of telephone triage and Near Me consultations and all contacts are initially by this route and face to face consultations only occur currently either in practice or in the patient's home when it is clinically necessary to do so.

NHS Fife has supported this by timely role out of appropriate hardware and software and has supported robust connectivity.

The following plans are in place for Primary Care over the next few months:

1. A cautious restart of chronic disease management from June (over and above the urgent management of patients with chronic diseases that has continued to take place)

2. Local clusters within Fife working with Primary Care to ensure that locality priorities and health inequalities are considered as we carefully plan how we do this.

3. Increase phlebotomy provision within practices back towards pre-COVID-19 levels to support this anticipated increase in demand.

4. Bring treatment room nurses back into general practice to support the restart of chronic disease management.

5. Carry out a scoping exercise to ensure that we have sufficient staff to restart screening when it resumes.

6. Continue anticipatory care planning throughout this time and are looking at the best way to deliver care to those patients who are over 70 or are shielding in that home visiting may be the correct method of assessing these patients equally near me may be a very appropriate consultation method for others.

7. Develop a multidisciplinary approach to managing residents of care home with hospital at home, palliative care, district nursing, pharmacy and general practice all working together to ensure the person is seen by the right heath care professional to meet their need.

   The COVID part of this multidisciplinary response is being coordinated through the COVID triage hubs.

8. Staffing in the COVID-19 triage hub and assessment centre have been reduced but are monitoring activity very closely and have robust plans in place to step up staffing quickly if we require doing so.

9. The Urgent Care service which provides the OOH GP service in Fife has reconfigured to have non COVID-19 and COVID-19 responses and is well placed to adapt if demand increase.

10. Secondary and primary care interface is taking place to look at how we ensure we facilitate patients to navigate through the system in the best way depending on clinical priorities including health inequalities.

11. Preparations for delivering the next round of flu vaccinations and are exploring innovative solutions to how this may be achieved.

12. Planning GP practice sustainability at this time and how multidisciplinary teams within primary care work with the need for social distancing.

13. Primary Care response to an anticipated need to treat people with mild to moderate mental ill health

14. Physiotherapy provision is currently being looked at to ensure that the best model is used as this service increase.

These actions will be carried out over the next 2-3 months bearing in mind that services may need to be slowed again if there be an increase in COVID-19 activity.

13 Community Care

13.1 Community Hospitals

Community hospitals are currently recovering from COVID outbreaks with red and green zones are in place in the community hospitals. In the community hospitals there are 236 green beds, 17 red beds and 53 beds available for surge.

In response to COVID-19, red zones were established to support the ongoing care of patients with COVID-19. Currently there are 2 red wards across the community hospital estate with the ability to flex and increase COVID-19 capacity when required. Identified areas of surge capacity also remain in place for this reason.

Bed numbers are at funded levels as opposed to winter surge levels which also take into account HAI and IPC measures to support safe distancing between bed spaces.

Careful planning is required ahead of winter as the bed and social care model capacity being used to support COVID-19 is the same capacity used to manage winter pressure.

Work is ongoing to consider supporting more people at home through the Hospital at Home service.

Flow from acute settings to community hospitals is returning to previous levels which may not be sustainable due to physical distancing and Infection Prevention and Control (IPC) measures. Alternative pathways are being considered to ensure flow across the system by the sub groups of the Remobilisation Oversight Group.

At the moment demand for stroke rehab beds is high with capacity being flexed to support this.

Delivery of out-patient activity in community hospital settings needs to be closely monitored as there is a risk that clinics recommence without consideration of the function of the site in totality. However, the role of the Remobilisation Oversight Group should ensure outpatient clinics are started when clinically appropriate to do so taking into account unintended consequences.

13.2 Delayed Discharges

Delayed discharge performance has been at its best level ever but has increased over the past few weeks. This will continue to be monitored. Delays are being maintained at low levels and this is critical to maintaining capacity and flow.

13.3 Care Homes

Directors of Nursing are now accountable for the provision of nursing leadership, support and guidance within the care homes and care at home sector, within their given board area and provide assurance of standards in:

- Infection Prevention and Control Measures
- Documentation of care plans
- Fundamental care provision
- Communication

Other specific interventions as required where care homes have residents who test positive to COVID-19 or are COVID-19 positive.

There are 76 nursing and residential Care Homes in Fife, 50 of these are nursing homes and 26 are residential homes. The Care Homes are managed by local authorities, private companies or voluntary organisations.

Responding to the pandemic, NHS Fife and Fife Health and Social Care Partnership (HSCP) have put in place a range of measures to provide ongoing and practical support to Care Homes in Fife.

Work to date includes the community response to this pandemic requires flexible working, to meet the needs of all people in the community, including those in care home settings. This response includes, where appropriate and feasible, staffing from health-boards is provided by 'mutual-aid' to assist with the following:

- Deployment of sufficient staff to address care-home staffing shortages
- Bolstering senior and experienced nursing capacity, both registrant and non registrant, in care home settings.
- Promoting safe, effective infection prevention and control practices and supporting compliance with the extant guidance, through both nursing and public health teams.
- Support to district nursing and wrap-around care teams providing end-of-life care.

Fife HSCP working in collaboration with, Fife Council and Fife Primary Care and NHS Fife, will support care homes to mitigate any potential service delivery failure and harm to residents and staff including avoiding the potential need to transfer them to alternative care provision.

- To provide high quality safe, person-centred and effective care
- To ensure Staff are fully supported to work within a non NHS environment
- Have structures in place for clear communication and escalation channels.

To support this, a governance structure has been established incorporating assessment of risk, standard operating procedures, communication and escalation processes:

- Care/Nursing Homes having an induction process to prepare and support deployed HSCP staff.
- Identification of HSCP staff who have the appropriate skills and are willing to work in different locations. Placement is not compulsory under Fife HSCP, Fife Council and NHS terms and conditions.
- Vicarious liability maintained for individuals through working to their substantive employer terms and conditions as well as operating within their scope of practice, in accordance to their professional code or healthcare support worker standards.
- A process for support of staff e.g. key contact, mentor or buddy will be established.
- Review processes to assess the ongoing need for supplementary staffing with a time frame at least every 24-48 hours.
- A simple risk assessment tool and communication process for 24/7 escalation of staff concerns, providing support and advice for any concerns about any practice issues, including a line management structure.
- All deployed staff will continue to operate under NHS Fife policies and procedures.
- All registrants will continue to be governed by their registering body code of practice i.e. Nursing and Midwifery Council.

Care Homes in the region are managing COVID outbreaks. The impact of care home outbreaks on capacity and flow needs considered.

13.4 Hospices

Hospice admissions are very low and one hospice is closed at present with care being delivered at home. This will be reviewed as demand rises.

13.5 Hospital @ Home

Hospital at home has been bolstered to offer additional capacity and has supported the management of COVID positive patients in the community. This service will be reviewed in the coming months to ensure adequate capacity for demand.

13.6 Intermediate Care and Rehabilitation

Intermediate care has continued both bed based and delivered at home. Community Rehabilitation and intermediate care services will continue to be bolstered to support capacity and flow as well as early supported discharge and prevention of admission.

13.7 Patient Transport

Arrangements for the transfer of patients who have no access to their own transport are in place to support travel to Urgent Care Centres, the COVID Assessment Centre, as well as emergency community based Dental and Ophthalmology Centres.

A 9-seater mini-bus which is compliant with social distancing and ICP procedures is in place to take patients to centres. The existing transport procedure remains in place to support transportation to green centres. The short term plan is to keep minibus in place.

Scottish Ambulance Service support is in place 24/7 at the COVID Assessment Centre to support the conveyance of patients to acute care should it be required. Acute conveyance rates via SAS remain stable at approximately 5 per day and patient transport rates remain stable at approximately 2/3 per day.

The transport response for urgent care will depend upon levels of demand. There is an existing transport policy in place which will support return to service as usual. Review requirement for overnight patient transport as ad hoc requirements could be met by home visiting.

13.8 Dentistry

NHS dental services were retracted to providing an urgent dental care service on 26th March 2020. All General Dental Practices ceased seeing patients and operate a phone triage system, offering advice, analgesics and antibiotics and refer into the Urgent Dental Care Centres managed by the Public Dental Service (PDS). The Chief Dental Officer (CDO) issued a letter on 20 May detailing dental remobilisation:

Phase 1 (with immediate effect) expansion of urgent dental care centres, including the dental suite in Queen Margaret's Hospital, Dunfermline, Rosyth and Randolf Wemyss for urgent dental care (not outpatient appointments).

Phase 2A - opening independent dental practices by 31 July- very limited service- one surgery, urgent care, non aerosol generating procedures (AGP) – dependent on PPE. Possibility to have more than 1 surgery in agreement with NHS Board if premises, patient flow, PPE allow). Scottish Dental Clinical Effectiveness Programme (SDCEP) are publishing a Recovery Toolkit to support dental practices. Governance arrangements will be put in place to give assurance to NHS Fife that independent dental practices are safe to open (similar to the Combined Practice Inspection but self-assessment).

Phase 2B - practices open to routine care- assessment and treatment (non AGP)

Phase 2C - urgent dental care centres continue to carry out AGPs as required and PDS expand services for their patients which have been restricted.

Phase 3- practices doing AGPs (no timescale- dependent on evidence and PPE supplies). The Chief Dental Officer is rapidly reviewing the GDS contract with its major item of service element and remuneration. Concerns around financial viability of dental practices.

NHS Fife Hospital Orthodontic Services is triaging and seeing emergencies at present and is awaiting further guidance from the Chief Dental Officer on remobilisation of services but will have to work in combination with the wider acute services as to how to manage outpatient appointments.

14 Fife Mental Health and Learning Disability Services

In keeping with the National Clinical Strategy quality remains a primary concern with patient safety, clinical effectiveness and a person centred approach at the core. In addition, services now need to be COVID sensitive, with ICP practice at the fore and to meet the government's directions regarding social distancing.

Clinical and hospital services must continue to respond to people whose mental health and wellbeing are at particular risk and are in crisis during the pandemic. The Scottish Government has circulated principles for Mental Health services and these principles should underpin our remobilisation plans. Providing safe services through minimisation of infection risk is emphasised within the principles.

Full mobilisation plans for each Mental Health service have been produced and are available separately. A summary of the plans are included in this document.

Services should have a first line digital approach and where face to face assessment is required guidance on PPE must be adhered to. Inpatient transfers between wards and hospitals should be minimised and people should be assessed and treated in the community wherever possible.

There is increasing acknowledgement that the impact of COVID-19 is not just a medical phenomenon and is likely to have an additional significant impact on the mental health of the nation including the mental health of key workers. Demand on services is likely to increase as a consequence.

Work to date includes:

- ***Guidance*** **-** Clinical guidelines and contingency plans and guidelines for NHS Fife Mental Health and Learning Disability Services for both the initial and sustained transmission phase in the community were developed
- ***Staff wellbeing*** **-** Staff wellbeing was recognised as a priority area and staff hubs have been established on each inpatient site in addition to redeployment within psychology to provide ready access to psychological support where needed.
- ***Service reorganisation*** **-** ***S***ince the start of the emergency the services reorganised to be ready to operate with an anticipated absence within the workforce, adhere to social distancing and to ensure adequate staffing to provide

care to the most acutely unwell and high risk cases. The establishment of daily huddles has enabled a dynamic overview of these.

Priority areas that needed to be covered were identified as follows:

- Mental health inpatient wards
- Those presenting acutely to emergency services
- Those individuals already identified as being vulnerable in the community.
- Those requiring emergency Mental Health Act Assessments in hospital and the community
- Those already known to pose significant risk if not closely followed up by services in the community (for example Forensic patients)
- Those detained under the Mental Health Act and who require mandatory reviews
- Those recently discharged from hospital

Half the cohort of junior medical staff were redeployed to the acute hospital and rotas were rearranged to reflect this. A residential on call consultant rota was created.

The Services covered in the plan include

- ***Inpatient provision - t***he need to care for patients with COVID and mental health problems in addition to treating COVID within our mental health wards for existing patients was anticipated and provision arranged.

- ***Community Mental Health Teams (adult, older adult and learning disability services) - r***outine assessments within community teams were suspended. Provisions for digitally mediated interventions were enabled.

- ***Mental Health Emergency Services - a*** mental health emergency service was established and operates around the clock. In addition a patient access emergency phone line was set up.

- ***CAMHS services*** *(see separate CAMHS Remobilisation Plan)* **-** The CAMHS threshold was altered to responds to those with the most urgent and significant mental health issues with a degree of flexibility to ensure that children and young people with identified vulnerabilities are provided with appropriate support.

- ***Addictions Services*** *(see separate Addictions Plan)* **-** The addiction service reorganised to accommodate to social distancing requirements and developing a digital first response. Service provision was transformed from a clinic based model to an outreach model.

14.1 Current Priorities

The priorities identified for Fife Mental Health and Learning Disability Service established, with reference to the background information provided, can be considered under the following headers:

- **Treating and controlling infection** throughout the service
- **Having a safe and responsive service** - maintaining the existing reduced service and building on capacity to enable expansion required within second phase by:
- **Embed use of technology** - staff have been provided with lap tops and smart phones to facilitate agile working
- **Communication** - develop a communications plan to communicate with Mental Health and LD workforce and process for engagement with wider partners, service users and the public
- **Organisational development** - engage workforce in understanding of changes and need for forward thinking
- **Workforce** - readjust work boundaries to accommodate occupational health restrictions for some staff
- **CAMHS Specific priorities** (see separate plan)
- **Addictions specific priorities** (see separate plan)
- **Modelling likely future demand –** monitor and review activity based on redesign within each service

14.2 Priorities moving forward

In order to deliver on the priority areas we would recommend the following actions

1. **Treating and controlling infection throughout the service -** Rationalise admission sites and bed numbers to optimise infection control.
2. **Having a safe responsive service -** maintaining existing reduced service and building on capacity to enable expansion required within second phase by maintaining flow in hospital and community
3. **Embed use of technology - r**einstatement of the roll out of MORSE throughout the service and establishment of use of the immediate discharge summary
4. **Communication - a**cknowledge the central importance of the role of people using services and their carers.
5. **Workforce**

Full mobilisation plans have been submitted separately for Mental Health and Learning Disability Services.

14.3 Psychological Therapies

Current status of service provision

The Psychology service provision across the different clinical areas has been influenced by:

a) the status of multi disciplinary team (MDT) provision within that area

b) demands associated with redeployment to staff emergency/essential services
c) demands associated with setting up and running key elements of Fife's Staff Wellbeing and Support service.

During the pandemic, psychology input has remained the same to

- Oncology and palliative care services within clinical health speciality
- the psychology input to the IP wards within the physical rehabilitation service
- OP psychology services - adult services and the child and family service for outpatients deemed priority or urgent via telephone or video link
- primary care tier of the child and family service and the paediatric psychology service
- New referrals are being seen as part of the MH emergency services within AMH and CAMHS or for a small number of urgent cases via CMHTs (AMH, LD and Forensic services)
- Staff within Learning Disabilities have been able to continue some IP work (as they were redeployed to work on the wards).
- Consultancy work is being maintained within all clinical services, e.g via online MDT meetings and staff continue to meet online with colleagues in health, education and social work.

Suspended services include

- non-priority/urgent patients
- No psychology specialities are accepting new referrals for therapy
-

Alternative and new models of care and treatment include:

- The Child and Family psychology service has just established an Advice and Support Telephone line for Parents and Carers on who may be struggling with issues in the context of the COVID-19 restrictions
- The AMH Primary Care service is planning a similar self-referral telephone service via the Access Therapies Fife website.
- Staff in the Clinical Health, AMH and Learning Disabilities specialities continues to play a major role in Fife's Staff Support and Wellbeing service.

Reinstatement of clinical priority areas

The AMH service has the highest volume of referrals and largest number of patients waiting for treatment. In light of the continued SG focus on the LDP waiting times standard, AMH work across all service tiers is a priority.

AMH, Primary Care tier of service: This will re-open to urgent referrals by end of July. Clinicians are currently reviewing all open cases to assess the feasibility of resuming psychological therapy by Near Me or telephone.

AMH Secondary Care tier of service: The clinicians within this tier of service will continue to support the CMHTs, which have continued to accept urgent referrals throughout the emergency period.

Resource constraints mean that the Clinical Health Psychology service will continue to run as per current provision outlined above until staff are no longer required to provide input to the Staff Support and Wellbeing Hubs for acute medical and health and social care staff. They are also reviewing current caseload and waiting lists, with a view to completion of this by end of July.

Communication
In future, new referrals will be advised that assessments will be by Near Me or telephone and that interventions may be delivered partly or wholly by online means, potentially supplemented by Near Me or telephone.

Patients in treatment will be contacted (normally by the Psychologist they were previously working with) as described above.

Implementing virtual working
The following will be implemented going forward:

- Roll out of Near Me complete for all psychology specialities.
- Making information available online to general public and staff
- A range of newly developed resources via Department's MoodCafe website.
- A group of psychology clinicians is researching provision of group work online
- The Access Therapies Fife website will host a range of digital therapy options being made available via SG.

Specific resources to support staff wellbeing have been developed and accessible via staff intranets and via National Wellbeing Hub.

Modelling likely future demand
The demand for Psychology services will be informed by the audit of our current waiting lists and emerging research regarding the longer-term psychological effects of the pandemic (for the general population and also Fife H&SCP staff, who will be future users of our service).
It is anticipated that there will be increased demand on psychology services to support patients who have suffered psychological distress as a result of experiencing severe COVID-19.

Dependencies
Dependencies to remobilisation include:

- access to previously utilised clinical space.
- identification of suitable platforms for delivery of online group programmes
- staff support and wellbeing remains a priority

Staff support plans
Work is currently underway to scope resources required for delivery of staff support services across NHS, HSCP and Council. The older adult psychology service has

the skills and expertise to play a major role in addressing needs of staff within care homes. Clinical supervision for Psychology staff has continued where appropriate.

15 Pharmacy

15.1 Re-launch of pharmacy First

In Fife our 85 Community Pharmacies are well placed to provide Pharmacy First, all have kept doors open and maintained a face to face service during COVID-19, continuing to provide pharmaceutical care. Training for delivery of Pharmacy First is already complete; refresher training through NES webinars is available and will be promoted. Patient Group Directions are signed off within the Board and ready for circulation. A Pharmacy First Approved list of eligible medicines will be available for the launch date once nationally approved.

Private consultations within pharmacies have proved difficult to maintain during COVID-19 due to social distancing requirements which has resulted in more telephone triage. Moving forward Community Pharmacy would benefit from using Near Me to provide more personal face to face triage where necessary.

15.2 Serial dispensing and Medicines Control & Reconciliation (MC&R) in Fife

Prior to COVID-19 NHS Fife was actively targeting an increase in serial prescriptions which was steered through an established Serial Prescribing Group. Members include Practice Managers, Practice Administration staff, Practice Pharmacy Team members, Community Pharmacy representatives and eHealth support. An action plan is in place but coordinating work has taken a step back during COVID-19.

Activity on transferring patients on to serial prescribing has continued where possible. Before the end of July it is planned that the group will meet virtually and can focus on those areas of the action plan that can be implemented at this time. An official launch of MC&R was halted nationally to focus on the launch of Pharmacy First and so work continues within the Boards without a national communication strategy. The Serial Prescribing Group will hope to address this with targeted awareness work with both in-hours and out of hours partners, supporting re-mobilisation by ensuring that eligible patients can receive seamless pharmaceutical care from their chosen Community Pharmacy.

A key component of the wider strategy for Pharmacotherapy delivery in NHS Fife is to establish cluster level Pharmacy hubs, undertaking a range of work on behalf of GP Practices while maintaining a presence in each. As these hubs develop, there will be opportunities to address management of repeat prescribing, including serial dispensing. Recent developments in capability for remote IT access have improved the viability of this hub working model.

16 Personal Protective Equipment (PPE)

The PPE Single Point of Contact (SPOC) Group has worked over the past 2 months on a range of issues associated with the supply and demand for PPE. This group has been very effective and continues to operate as the executive leadership group for PPE across the Health Boards.

Key Activities

- Ensuring the stock of PPE supply continues to improve with individual areas remaining under close scrutiny.
- Positive progress on sustainable product solutions and local (Scottish) manufacturing capability coming on stream.
- Demand models developed and refined to match changes to guidance.
- Actual consumption is being monitored daily by National Procurement (NP). This remains at approximately 50% of the modelled demand.
- Whilst there have been issues with particular aspects of PPE, these are investigated and a support or improvement plan agreed with NP.
- Scotland moving towards sustainable self-sufficiency in many of the critical PPE lines generating employment and investment in our communities.
- NP are in the process of changing the way demand and supply is being reported, as we have reached a stage in the pandemic where recovery plans for elective care are being considered, and we move into a medium to long term view of PPE requirements.

National Procurement (NP) are modelling acute and social care demand based the most realistic curve of the pandemic, drawing on actual hospital admission rates.

There is a sustained and gradual decrease in COVID-19 patients in hospital and in ICU in particular, and the modelling is being update to take account of this. It should be noted that this could alter significantly based on how the pandemic progresses in the coming weeks. This is being monitored on a daily basis.

Modelling work is moving towards a staff based model for acute which will include the whole hospital, and take account of the demand for different types of PPE as elective work starts to scale back up.

Modelling work will continue to be reviewed to ensure all health and social care providers who receive stock from NP are included.

17 Staff Engagement and Partnership Working

In the creation of the remobilisation plan, and more importantly the setting of local priorities for service remobilisation we have engaged our staff, and staff side colleagues to inform and refresh the remobilisation of services in Fife. Staff feedback has and will continue to be sought on:

- what went well or could be improved upon from the response phase, as well as

- what changes to working practices in service delivery staff believe offer us a better way to meet patient expectation and/or provide better patient experience while maintaining staff safety and the safety of patients

We have engagement from staff side in our Remobilisation Oversight Group, and its sub-groups. These arrangements ensure detailed service lead remobilisation and an overarching system view to optimise remobilisation and avoid unintended consequences. This approach provides significant partnership working and involvement.

This is in addition to our existing partnership working infrastructure which continues virtually through our Area and Local Partnership Fora.

Further work is planned to ensure ongoing engagement and involvement of other key groups in the development of the Remobilisation Plan. In parallel with governance through the Fife NHS Board, we recognise the need to ensure plans are co-produced with our partners in the Fife Health & Social Care Partnership / Fife Integration Joint Board and Fife Council. The role of the Director of Health & Social Care in the Remobilisation Oversight Group is a key component in support of co-production.

18 Staff Health and Wellbeing Hubs

A number of new initiatives have been introduced to support the health and wellbeing of NHS Fife staff during the current pandemic. The provisions outlined below are in addition to the existing services and support to staff, including Occupational Health Services and Well @ Work initiatives.

The new and enhanced staff supports include an expanded Staff Listening Service, Staff Hubs and quiet spaces for staff with refreshments and resources at various sites, direct access to Psychological support, freshen up packs for staff and new dedicated online resources, also available in hard copy.

Communication with staff has been enhanced by the launch of the Stafflink, an app to enable staff to stay connected with the latest organisational news, information and guidance.

This activity is being overseen by a group representative of all areas of the Board, with partnership and Council input and is developing a plan for continued long term support.

19 Workforce Planning

The requirement of and for our workforce (employees, secondees, workers, contractors) will be central to our service redesign. We will establish workforce requirements from this remobilisation effort, and determine if our current workforce can meet the need and what else will we require to achieve that outcome. An

assessment will be made as to whether and how any gap in workforce resourcing would be filled. And if not possible the service restart will need to be phased or revised to manage the tension between what is required in terms of human resource and what is available.

Workforce planning and modelling with be essential to the optimisation of service delivery. We will take account of:

- **Capacity** (roles, numbers required) - The design of new, or redesigning existing roles to represent the changes made so far and that which has to be different for service delivery going forward. With what we know, how many of each role will be needed and when.

- **Capability** (knowledge, skills required). This goes hand in hand with capacity and assists in the (re)design of roles. In addition to this we will need to consider the skills. required to work 'with COVID-19' as a factor in our world/workplace. This would include:
  - Digital skills – to optimised the work done and springboard from there
  - Workplace arrangements – what needs to be practiced and learned to comply with social distancing or other guidance
  - Consolidating the knowledge and skills acquired during the rapid deployment of new /different service and ways of working
  - Orientation and Induction – what we need to include to reflect COVID revisions
  - Specialities – requirements for the way services will be delivered

- **Mobilisation of students** (e.g. Nurses, Doctors) – students have been deployed into Health Boards. We will progress from the rapid deployment and complete the employment journey into first role

- **New responsibilities** (e.g. Executive Nursing Directors role in Care Homes and Care at Home) – structures and accountabilities will need to reflect and embed changes to roles across health and social care.

19.1 Remobilisation of workforce services

In addition to the work to support the remobilising of service, we will be remobilising Workforce/HR Services. There are a number of services that will require to be restarted to support the remobilisation effort, for example:

- Job Evaluation
- Recruitment
- Learning and Development,
- Workforce Planning

And a range of other services normally delivered by Workforce Directorate that have to be remobilised

- Occupational Health
- Appraisal/performance Management
- Analytics and Reporting

20 Financial Planning

The financial plan supporting the initial COVID 19 Mobilisation response has been developing over the last 3 months with the latest version submitted on 18 May 2020. This will be updated again and resubmitted on 22 June 2020. This plan covers the projected costs in relation to Health Board and HSCP spend in 2019/21 and 2020/21. The projected costs at that point were £22m (NHS Fife) and £33.5m (HSCP) total of £55.5m.

The initial mobilisation forecast costs for 2020/21 are based on "worst case scenario – full year costs", this unprecedented level of cost nationally is being assessed by Scottish Government. A national benchmarking exercise is underway as is a review of the forecast costs against the revised Scottish Government impact modelling on the infection rates across Scotland. It is likely that this review and the local Board review of forecast spend (particularly in the context of the revised impact modelling) will confirm a reduction in costs in some areas.

At a recent meeting of the Health Board Directors of Finance it was agreed that more detailed service planning is required to reliably quantify costs to support remobilisation of services. This is particularly due to the requirement to continue physical distancing which will reduce activity and productivity in all care settings. Directors of Finance will however work towards producing revised financial plans for 2020/21 by July 2020. These plans will reflect the actual costs of mobilisation coming through in quarter 1 and will also a more detailed level of planning in relation to the cost impact of remobilisation.

As part of the revised financial plan we are reviewing the costs around maintaining the COVID Hub and Assessment centres, this will involve consideration of current activity and staffing levels and potentially links across to other emerging aspects of the remobilisation plan including supporting test and protect.

It is inevitable that 2020/21 will be a transitional year where we consider and embrace plans for the "new normal" and how that can be delivered in a sustainable and affordable way. Within NHS Fife, we will develop a 3-year financial plan which supports investment and disinvestment and which delivers prioritised and impact assessed financial arrangements. We will create financial models to present the tests of change already mobilised. This will take time and engagement to deliver robustly.

21 Regional and National Alignment

Regional Working

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

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

National Messaging

Some of the proposals in these initial and subsequent Plans, seek to build on the positive changes implemented over the last few months in delivering health and care services – changes in the way we manage access to urgent and unplanned care, directing patients to the most appropriate health professional, and reducing the need for face to face consultations in primary and secondary care. In the forthcoming weeks patients and public will need to adapt and comply with these changes and essential safety measures such as self-isolation and pre-admission testing, social distancing measures and reduced access to hospitals for visiting.

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

Across NHS Fife and Fife Health and Social Care Partnership, we are committed to doing this to the best of our abilities for the people of Fife.

22 Governance

The Remobilisation Oversight Group has the responsibility for the restart of clinical services across Fife by prioritising clinical services and functions. The responsibility for the remobilisation of healthcare services sits with the NHS Board through the Chief Executive and Board Governance Committees, in particular the Clinical Governance Committee.

Supporting this structure is Gold Command, STAC and the Ethics Committee.

A key component of our governance will be the financial assessment of our previous draft Annual Operational Plan, COVID Mobilisation decision tracker, and impact of specific remobilisation actions over the coming weeks and months. Whilst we recognise the emergency situation of the COVID pandemic, long term financial sustainability remains a priority.

23 Summary

This paper outlines the short term plan to restart clinical services in Fife over the coming weeks. Longer term planning is underway to reflect changes in services that have been since the COVID-19 pandemic was declared. The remobilisation will be agile with a whole system approach which is clinically led, COVID-19 sensitive, person centred and digitally enabled.

We note the likely imminent request from Scottish Government colleagues that we develop plans for the period to 31 March 2021, and in particular, take cognisance of the impact of winter on these plans to remobilise, recover and redesign health and care services in Fife.

APPENDIX 1: Change Ideas for Remobilisation

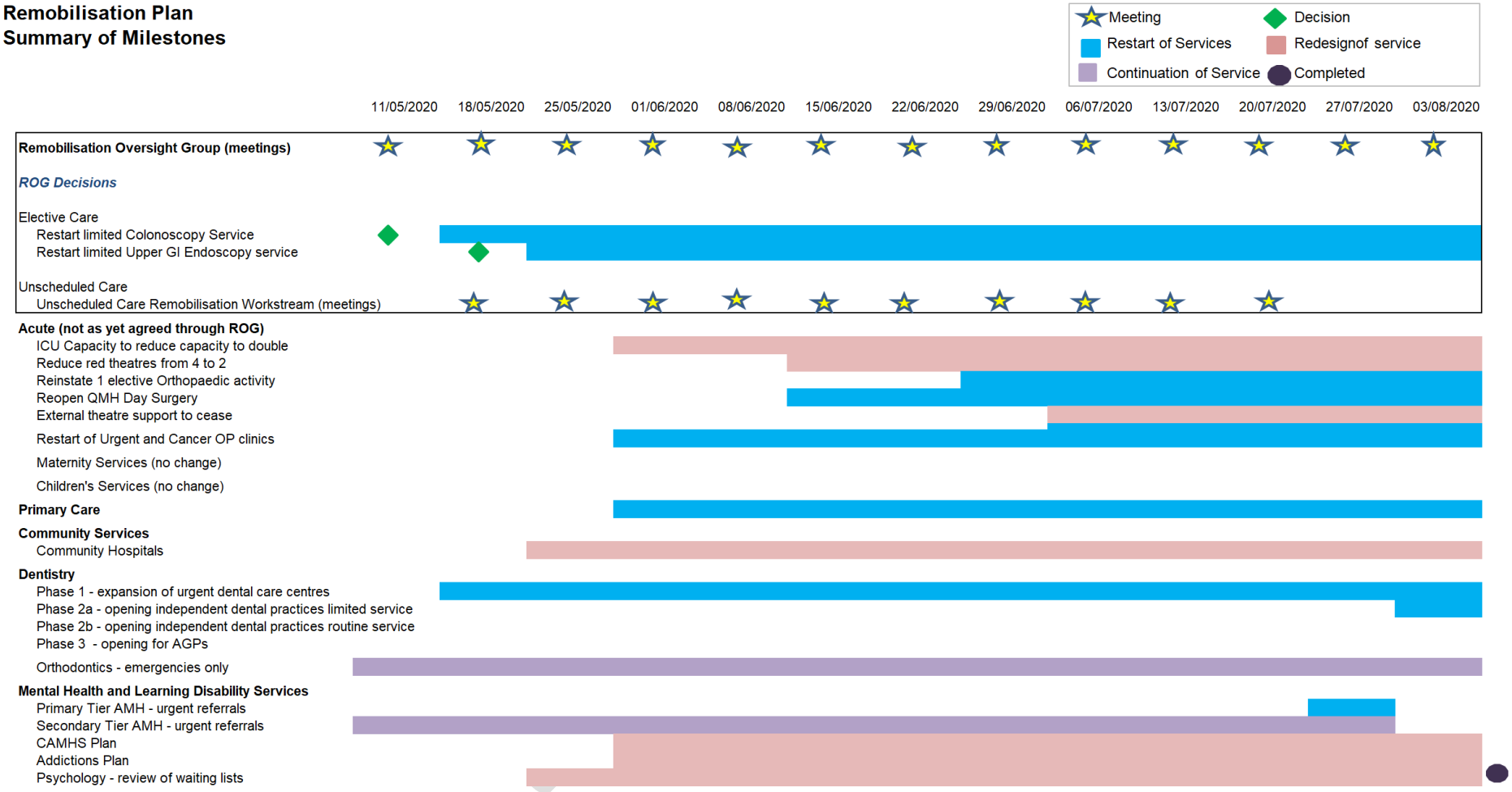
Remobilise, Recover, Redesign: Collated Cross-system Change Ideas

Innovation, Integration, Definition of Referral Pathways & embedding of Digital Working

Sector	Admission Avoidance	Referral / Triage / Initial Assessment	Diagnostics / Treatment	Discharge	Transfer of Care
Secondary Care	•Clinical Dialogue •GP & MAC Guidance •MAC Signposting to alternatives •Mental Health liaison with ED •SAS enhanced utilisation of Advanced Practitioners •SAS conveyance avoidance initiatives	•Clinical Dialogue •Acute Clinical Referral Triage •Extend use of NHS Near Me •Enhanced ECAS •Test use of NHS Near Me for Front Door Services	Scottish Govt. Identified potential for changes in the following areas: •Laboratory Diagnostics •Imaging •Pathology •Interventional Diagnostics	•Introduce a Transport Hub linked to Discharge Hub/Lounge for VHK •Transport Hub for QMH? •Rehabilitation delivered in homely setting - community based •Pharmacy (HEPMA) •Patient Initiated Return •Criteria Led Discharge (Acute beds)	•Explore further improvements around readmissions
Primary Care	•Clinical Dialogue •Ref Help Scale-up Action 15 deliverables for Mental Health Services	•Extend use of NHS Near Me after using 'NHS Near Me toolkit' to think about maximising use. •Urgent Care Assessment Centre /GP Hub		•Practice Workflow Optimisation	•Enhanced access to GP systems e.g. Pharmacy, Physio, Advanced Practitioners
Community Beds e.g. Community Hospitals, Care Homes, Hospital@Home	•Enhanced Clinical care within care homes. E.g. H@H, Palliative Care, etc.	•Identifying the role of Control Rooms post-COVID	•Hospice @ Home	•Criteria Led Discharge (Community beds) •Continue Pharmacy Transfer run late afternoon	•Step-up / Step-down bed capacity
Community Teams Inc. Social Care	•Pharmacy First? •Optometrist •ACP in place and support for people shielding and people >70 years •Signposting to 3rd Sector Services	•Extend use of MS Teams •Enhanced ICASS •Increased referral to 3rd Sector/ •Increased social prescribing	•Enhancing scope of Mental Health Unscheduled Care Team	•Remote Assessments for Therapy, Social Work, Discharge inc. Mental Health (13ZA) •Enhanced use of Blood Bikes	•Discharge to Assess •Discharge with No Package of Care in place via START •District Nurses extended hours / integration with Care Homes and Homecare
Self-Care	•111 / NHS24 •Ref Help - Patient facing •Signposting / Education / Re-directing Public •Self-management / Apps / Website		•Improve Uptake of national Screening programmes	•Education of patients around their condition and self-management to ensure appropriate PIR usage	

APPENDIX 2: Summary of Remobilisation Plan to July 2020

Remobilisation Plan
Summary of Milestones



APPENDIX 3: Revised Phased Approach to Remobilisation (in draft form)

Remobilisation of Clinical Services against National COVID-19 Phases

		Phase 1	Phase 2	Phase 3	Phase 4
Acute Services	Scheduled Care – TTG	Restart limited Colonoscopy service Restart limited Upper GI Endoscopy service	Reduce RED theatres from 4 to 2 Reinstate 1 elective Orthopaedic activity Reopen QMH Day Surgery	External theatre support to cease Expand to see all Routine Priority 2 patients	TBC
	Scheduled Care – OP	Restart of Urgent and Cancer OP clinics Restart of OP for patients requiring urgent assessment or review (digital first)	Expansion of OP to reduce backlog in urgent and USOC patients Start seeing Routine Priority 2 patients	Start seeing Routine Priority 3 patients	
	Unscheduled Care	ICU capacity to reduce to double original	TBC	TBC	TBC
Community & Primary Care	Primary Care	TBC	TBC	TBC	TBC
	Community Hospitals	Redesign of service	TBC	TBC	TBC
	Dentistry	Expansion of Urgent Dental Care Centres	TBC	Opening independent dental practices (limited service)	Opening independent dental practices (routine service) Opening for AGPs
Mental Health & Learning Disability	Psychology	Review of waiting lists	TBC	Primary tier AMH – urgent referrals	TBC
	CAMHS	TBC	TBC	TBC	TBC
	Addictions	TBC	TBC	TBC	TBC
Population Health	Immunisations	TBC	TBC	TBC	TBC
	Screening	TBC	TBC	TBC	TBC
		TBC	TBC	TBC	TBC