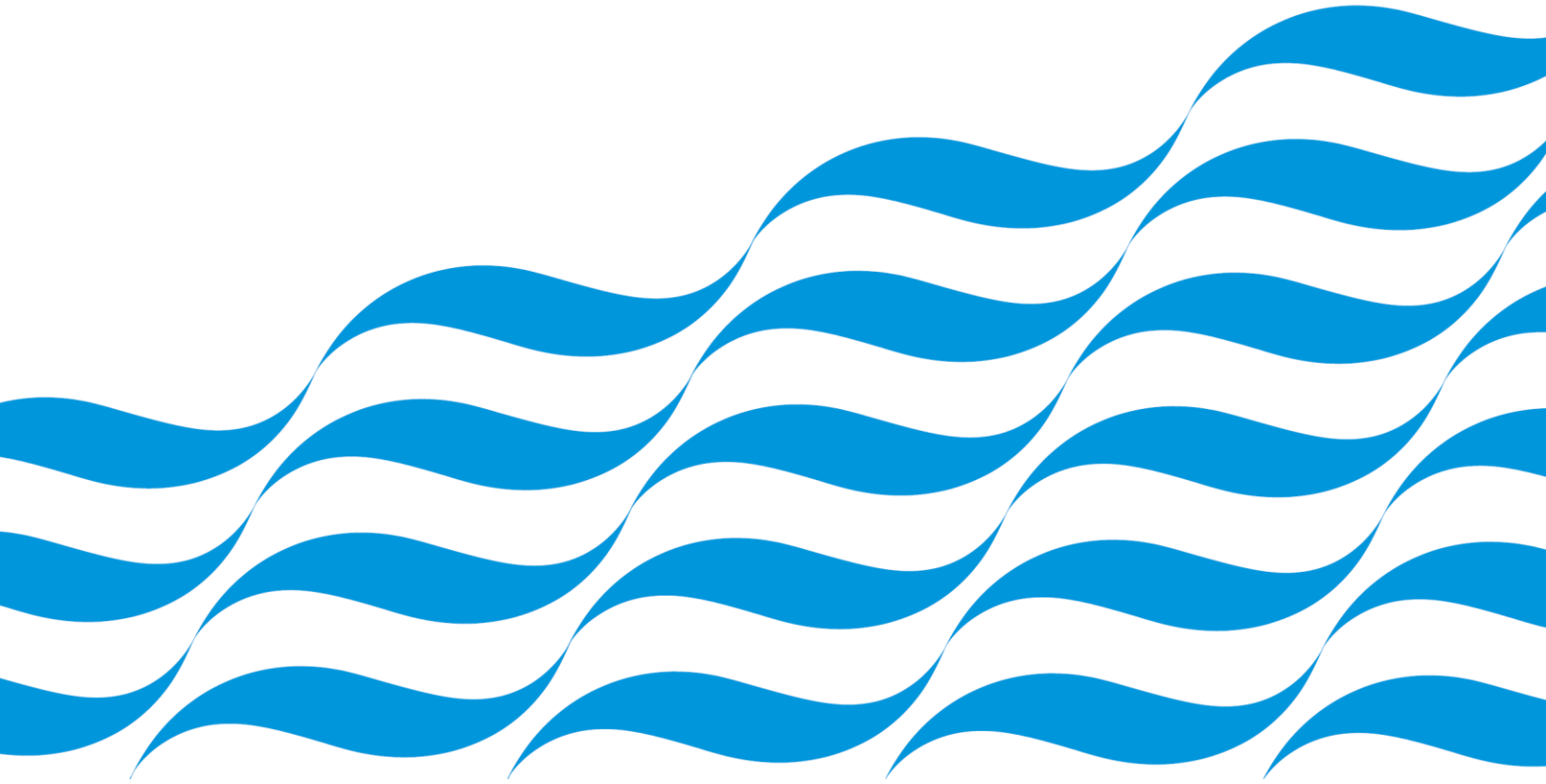
NHS Fife Winter Plan

2020/21



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1 Introduction

Health and Social Care providers have a key responsibility to undertake effective planning of capacity to ensure that the needs of vulnerable and ill people are met in a timely and effective manner despite increases in demand on services or a mismatch between demand and supply of services. This can happen at any time of the year but commonly in winter activity rises, there is increased risk of infection (Norovirus in particular), the weather conditions can be adverse and influenza is more likely than at other times of the year.

Winter 2020/21 will come with additional challenges relating to COVID-19 including possible subsequent waves and impact on scheduled care services as well as planning for a possible COVID-19 vaccination programme.

NHS Fife, Fife Council and the Fife Health and Social Care Partnership (HSCP) share the challenges of managing service delivery in the context of demographic change across primary, secondary and social care. The organisations are collectively responsible for managing the local health and social care system. This includes managing information and intelligence; assessing needs and working with community partners to ensure that services are fit for purpose; they meet the needs of patients; and are cost effective despite the pressures described above. The purpose of this document is to describe the arrangements put in place by NHS Fife, Fife Council, Fife HSCP and partner organisations throughout the year, but particularly over the winter (including the Christmas and New Year holiday).

This plan is supported by:

- Joint Fife Remobilisation Plan
- NHS Fife Pandemic Flu Plan
- NHS Fife Major Incident Plan
- NHS Fife Business Continuity Plan
- H&SCP Response and Recovery Plan

NHS Fife, Fife Council and Fife HSCP have completed the self assessment checklist which helps to measure our readiness for winter across several domains. The checklist will be utilised as a local guide to assess the quality of winter preparations. A detailed review of plans in these areas will apply a Red, Amber, or Green status. The self assessment checklist will be reviewed over winter to ensure that plans are in place to cope with system pressures and ensure continued delivery of care.

2 Key Deliverables

The Fife Integrated Winter Plan takes on a whole system approach, to offer seamless transition between the Acute Hospital, Outpatient Services, Community Hospital and Community Social Care Services throughout Fife.

The Winter Plan aims to:

- Describe the arrangements in place to cope with increased demand on services over the winter period and subsequent COVID-19 waves
- Describe a shared responsibility to undertake joint effective planning of capacity
- Ensure that the needs of vulnerable and ill people are met in a timely and effective manner, despite increases in demand, and in accordance with national standards. (e.g. 4-hour emergency access target)
- Support a discharge model that has performance measures, a risk matrix and an escalation process
- Ensure staff and patients are well informed about arrangements for winter and COVID-19 through a robust communications plan
- Build on existing strong partnership working to deliver the plan that will be tested at times of real pressure

Our approach to planning for winter recognises:

- Our workforce are key to the successful delivery of the winter plan
- Engagement with staff across key stakeholders is essential and this took place through winter plan workshops
- Multiple threats are present, beyond those seen in previous years, including - but not exclusively - seasonal flu, ongoing presence of COVID-19, possible severe weather, norovirus and EU Exit; however resilience plans are continually revisited and are in place

We have completed the Scottish Government's self assessment checklist (attached at Appendix 8) which indicates that arrangements are in progress to support the delivery of the winter plan.

3 Planning Priorities Winter 2020/21

A different approach was taken in preparation for Winter 2020/21, due to the continuation of emergency measures to manage the COVID-19 pandemic through to March 2021 at the earliest.

Firstly, a short questionnaire was sent to the Winter Planning stakeholders by email with the following questions:

- What do you anticipate the key challenge for this winter will be?
- What learning from COVID-19, could be utilised for this winter?
- What new changes should be considered for this winter?

The results were then analysed and the following key actions were agreed for 2020/21 including the introduction of a number of new models of care that will change how care is delivered over the winter period or during subsequent Covid-19 surges.

1. Point of Care Testing (POCT) in Paediatrics, A&E and Admissions Unit
   POCT used within acute assessment and admission areas throughout winter flu season. Anticipated this year this will expand to provide expedited COVID-19 testing to ensure appropriate clinical placement and pathway management.

2. Restructure of medical assessment and admissions
   Review of clinical pathways from GP referrals to accommodate anticipated need for red and green pathways in winter months to allow for increased presentations in line with normal seasonal flux. Scope need for medical short stay and care model that this could deliver.

3. Scheduling of Unscheduled Care
   Work with guidance for Urgent Care Model to dovetail processes and smooth demand through the clinical day. Expand use of the ECAS and supporting services for this pathway to ensure maximized use of outpatient care models and reduce unnecessary admissions.

4. AHPs continue 7 day working from COVID
   AHP support to continue over 7 days with a view to supporting criteria led discharges and preventing de-conditioning which could prolong length of stay.

5. Process re the use of Near Me for Unscheduled Care
   Full evaluation of all previous face to face services prior to remobilization thereby reducing footfall into the hospital and efficiently utilizing clinical time. Work with services to shift to Patient Initiated Review for appropriate patient groups.

6. Home First Model
   Additional capacity in intermediate care teams will be retained to support a Home First model to avoid admissions.

7. Scale up direct entry to STAR units from community MDT's
   Scoping work is required to explore the use of care home beds to prevent avoidable hospital admission. This would include a blended model of care with Hospital at Home to support individuals with medical needs.

8. Whole System Pathway Modelling
   Work is underway to develop a capacity and flow tool to support whole system planning and commissioning.

9. Effective Test and Protect service
   Ensure increase capacity of test and protect team in order to support reduced transmission of Covid-19 in the Fife population.

Secondly, a Winter Review and Planning Workshop was held on 18 August 2020 on MS Teams with key stakeholders. The Workshop was well attended with a wide range of stakeholders from across all agencies although numbers were limited as the event was held online. Additional actions were identified including:

- Embed Daily Dynamic discharge and EDD in all wards
- OPAT expansion
- Explore flexible staffing models to utilise resources accordingly
- Staff support to continue through Winter period

Some of these actions will be progressed through other groups and some actions will not be progressed as they are cost prohibitive.

Additions to the Winter Plan for 2020/21

As 2020/21 is different from previous years, focus has been on redesigning the plans for winter taking into account our Covid-19 sensitive environment. Additional work has taken place on surge capacity, COVID-19 subsequent waves, development of a care capacity tool, revision of escalation plan and participation in the nationally led, locally delivered redesign of urgent care.

Surge capacity plans
Surge capacity has always been a challenge during the winter period and 2020/21 will be particularly challenging due to HAI restrictions impacting on bed spacing and COVID-19 hospital pathways. We are approaching surge capacity differently this year by focusing on patient flow through the health and social care system and making sure we have capacity in community and social care by stepping up and stepping down care for patients and avoiding hospital admissions.

COVID-19 pathway plans
As winter approaches, COVID-19 pathways are in place in each of Fife's hospitals. This is in place to protect emergency admissions into the hospital as well as the green pathways for the elective programme. At the time of writing, these pathways are established but a further plan details how the organisation of the hospital will change if the number of COVID-19 admissions increase including increased admissions to ICU.

Care Capacity tool
Although during winter, there are weekly meetings to review activity and capacity and to plan ahead, key information about future capacity in community and social care is not available. This year, a care flow tool is being developed to support service planning and commissioning to

meet demand ensuring that people receive the right care, in the right place and by the right person.

Tool effectively translates demand to commissioning in a timely, proactive way. Work is still ongoing developing this tool but is planned to be in place by October 2020.

Escalation plan
A revised escalation plan has been developed to take into account changes to surge capacity and COVID-19 plans. The trigger points for acute and community are being revised to ensure escalation to different levels are appropriate. These triggers will cover all health and social care metrics and will include the Care Capacity Tool metrics.

Redesign of Urgent Care
The national led, locally delivered redesign of urgent care will change how patients flow through urgent care to emergency care pathways. This should impact how patients access urgent and emergency care to more appropriate pathways but also continue to maintain physically distancing in departments and waiting rooms.

The first milestone for this programme is the establishment of an Urgent Care Flow and Navigation Centre by the beginning of December 2020, in line with the national programme of work. Any lessons learned from the pilot in NHS Ayrshire and Arran, and shared with other NHS Boards, will be reflected in our planning during November.

The planning priorities identified for 2020/21 align with a range of transformation programmes across Acute Services and Health and Social Care. However, although transformation continues to happen during this period of COVID-19 through programmes like Redesign of Urgent Care and Near Me, the formal Transformation Board has been suspended until the emergency planning measures cease (currently end of March).

The Executive Nurse Director has been identified as the Executive Lead for Winter. Whole system working will be supported by the operational leads through the Director of Health and Social Care and Director of Acute Services. A Silver Command Group for Winter is being established which will support both escalation, monitoring and agility of decision making at a senior level over the winter months. The Winter Planning Group is now the Bronze Operational Group and there will be a Bronze Workforce Group established.

4 Winter Planning Process

4.1 Clear alignment between hospital, primary and social care

a) Winter Review 2019/20 – Actions and successes continued to 2020/21

- Ensure adequate Community Hospital capacity is available supported by community hospital and intermediate care redesign
- Review capacity planning ICASS, Homecare and Social Care resources throughout winter
- Focus on prevention of admission with further developments into High Health Gain, locality huddles to look at alternatives to GP admissions
- Reduce length of stay as a winter planning group and being progressed through BAU
- Test of Change for use of the community hub during Winter
- Test of Change to reconfigure STAR bed pathway
- Urgent Care ED enhanced direction model
- Implementation of model for discharge lounge through tests of change
- Weekly senior winter monitoring meeting to review winter planning metrics and take corrective action

b) Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Scheduling of Unscheduled Care – creation of an integrated flow and navigation centre to triage, assess and manage unscheduled care	November 2020	DOA DOHSC		DCOO GM EC	DGM West			
2	Implement Home First Model - more timely discharges & realistic home based assessments	November 2020	DOHSC			DGM West			
3	Scale up direct entry to STAR units from community MDT's	November 2020	DOHSC			DGM West			
4	Restructure of medical assessment and admissions	November 2020	DOA		GM EC				
5	Process re the use of Near Me for Unscheduled Care	November 2020	DOA		DCOO				
6	Right Care – Right Place campaign to increase awareness of alternatives to the Emergency Department for minor, non-urgent illnesses and injuries and encourage local people to make use of local services	October 2020	DON	Comms					
7	Ensure national winter campaigns, key messages and services (including NHS 24 and NHS Inform) are promoted effectively across Fife and supported by relevant local information and advice	November 2020	DON	Comms					
8	New model of care for Respiratory Pathway	November 2020	DOA DOHSC		GM EC	DGM West			

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
9	Ensure adequate Community Hospital capacity is available supported by community hospital and intermediate care redesign	October 2020	DOHSC			DGM West			
10	Review capacity planning ICASS, Homecare and Social Care resources throughout winter including 7-day access to H@H	October 2020	DOHSC			DGM West			
11	Focus on prevention of admission with further developments into High Health Gain, locality huddles to look at alternatives to GP admissions	October 2020	DOHSC			DGM West			
12	Continue to Test change to reconfigure STAR bed pathway	November 2020	DOHSC			DGM West			
13	Weekly senior winter monitoring meeting to review winter planning metrics and take corrective action	October 2020	DOA DOHSC	AD P&P	DCOO GMs	DGM West			

4.2 Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods

a) Winter Review 2019/20 – Actions and successes continued to 2020/21

- Secure Social Work staffing in the Discharge Hub and community hospitals over the festive period
- Integrated services to support discharges will run throughout all public holidays – this includes social work, homecare, community therapy staff and district nurses. Communication will be supported through daily huddles across services
- Test of change of a rota of senior decision making capacity in OOH/weekends to promote 7 day discharges
- Agree Urgent Care workforce levels and secure staffing as early as possible. All rotas in place to ensure public can access OOH across the winter period
- Public facing information across social media platforms developed to communicate access to OOH including public holiday access
- Enhance Clinical Co-ordinator role within the Urgent Care service
- Enhanced linkage with Hospital Ambulance Liaison Officer (HALO) role to further plan and arrange efficient discharges
- Enhance weekend discharge planning with further development of the weekend discharge team
- Explore augmenting IAT/MSK resource at front door with a view to reducing admission rate
- Proactive recruitment and a joined up workforce plan to utilise staff intelligently across the year as well as winter
- Implementation of 7-day pharmacy service in place within Acute on substantive basis

b) Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Implementation of a sustainable 7-day OT and PT service for acute being progressed through the Integrated Capacity and Flow Group- invest to save to support effective patient flow and address de-conditioning.	December 2020	DOA		GM WCCS			1.6 Band 6 PT 1.8 Band 4 HCSW 1.0 Band 5 OT 1 Band 4 HCSW	£72.5k
2	Paediatric nurse staff levels currently being reviewed. The increased activity associated with winter combined with the requirement for managing Covid-19 pathways will require additional staff to ensure safe staffing levels	October 2020	DOA		GM WCCS			13.3 band 5 3 band 3	
3	Implement flexible staffing models to utilise resources accordingly – managed by tactical workforce group, chaired by Associate Director of Nursing	November 2020	DON		DCOO	DGM West			

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
4	Ensure NHS Fife staff are kept informed about preparations for winter including arrangements for staff flu vaccinations, local service arrangements and advice for patients	November 2020	DON	Comms					
5	Occupational Health medical and nursing support was increased temporarily to support the pandemic efforts, funding has been secured to recruit to these posts on a substantive basis	November 2020	DOW	Workforce					
6	Staff health and wellbeing signposting resources were provided from April 2020 and an expanded Staff Listening Service, (accessible to Health, H&SC Partnership, and care home staff), available from April 2020 to 31 March 2021	November 2020	DOW / DON	Workforce /Nursing					
7	Mental Health Occupational Health nursing input in place for staff support from August 2020	August 2020	DOW	Workforce					
8	Agree Flow & Navigation Care workforce levels and secure staffing as early as possible. All rotas in place to ensure public can access OOH across the winter period	October 2020	DOHSC			DGM West			
9	Create and enact a workforce plan to staff surge capacity taking into account Fife Council Christmas shut down	October 2020	DOHSC		DCOO GMs	DGM West			

4.3 Local systems to have detailed demand and capacity projections to inform their planning assumptions

a) Winter Review 2019/20 – Actions and successes continued to 2020/21

- Proactive and dynamic planning that follows predicted problems with use of system watch and better use of data including Urgent Care in collaboration with NHS 24
- Performance measures will be in place and scrutinised
- Estimated Discharge Date process to be further developed and clear instructions in place
- Full review of how and when surge capacity is used against the escalation plan
- Banish boarding event to take place to reduce pressure in hospital with patients boarding in non patient wards.
- Comprehensive review of board and ward round process across Acute inpatient wards to identify and implement consistent best practice
- Location and staffing plan for surge capacity in place

b) Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Whole System Pathway Modelling – development & implementation of capacity tool	November 2020	DOA		GM EC	DGM West			
2	Daily Dynamic discharge and EDD to be embedded in all wards	November 2020	DOA		GM EC	DGM West			
3	Plan for Surge Capacity (including Community Hospitals, Care Home, Home care ICASS & H@H)	October 2020	DOA DOHSC		DCOO	DGM West		See App2	Acute HSC

4.4 Maximise elective activity over winter – including protecting same day surgery capacity

a) Winter Review 2019/20 – Actions and successes continued to 2020/21

- Produce a winter surgical program plan that includes use of the short stay surgical unit, and distribute the surgical programme, taking into account the periods of higher demand from emergency patients
- Review the ambulatory model for surgical and medical patients and implement any enhancements
- Review theatre requirements for SHDU cases to smooth activity over the week

b) Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Implementation of rapid diagnostic outpatient appointments for inpatients to ensure that no inpatient discharges are delayed whilst waiting on diagnostics	October 2020	DOA		GM WCCS				
2	OPAT expansion to release bed capacity	October 2020	DOA		GM EC		Not progressing this year		
3	Configure SSSU as amber Unit to support peaks in Orthopaedic Trauma demand	September 2020	DOA		GM PC				
4	In line with SG guidance, configure green elective areas and pathways within DIU, Ward 52 and Day Unit (within QMH) to maintain elective activity over winter	September 2020	DOA		GM PC				
5	Set-up weekly theatre meetings to review theatres lists 3 weeks in advance, including full review of patients waiting by clinical priority to determine list allocation to be escalated to Clinical Prioritisation Group	September 2020	DOA		GM PC				

4.5 Escalation plans tested with partners

a) Winter Review 2019/20 – Actions and successes continued to 2020/21

- A review of the integrated escalation plan with action cards including training and testing, and agreement of the surge capacity model over winter, including opening and closing of surge beds
- Review and improve business continuity plans for services
- Tabletop exercise arranged to test Major Incident plans
- Multi Agency meeting to discuss winter arrangements across Fife
- Update Corporate Business Continuity Plan and Response and Recovery Plan
- Ensure that community services have access to 4x4 vehicles in the event of severe weather and that staff have received an appropriate level of training to drive such vehicles
- Review the full capacity protocol

b) Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Corporate Business Continuity Plan has been reviewed by the NHS Fife Resilience Forum	August 2020	DPH	Business Continuity					
2	Corporate Business Continuity Policy has been reviewed by the NHS Fife Resilience Forum	August 2020	DPH	Business Continuity					
3	Business Continuity templates to be updated, re-issued to all departments and returned	October 2020	DPH	Business Continuity	DCOO	DGM West			

4	Ensure severe weather communications plan is in place and provided to NHS Fife Resilience Forum and EDG	October 2020	DON	Comms					
5	Local Resilience Partnership to hold a workshop to look at how Fife would manage events/incidents over winter including Covid-19, season flu, winter weather and EU-exit	November 2020	DPH	Public Health					

4.6 Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings

a) *Winter Review 2019/20 – Actions and successes continued to 2020/21*

- Point of Care Testing (POCT) for flu will be implemented early this year in preparation for the challenges expected from increased numbers of patients presenting with flu
- Weekly Winter Planning Meetings to continue to monitor hospital position

b) Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Point of Care Testing (POCT) in A&E and Admissions Unit	November 2020	DOA		DCOO		Funded separately		
2	Define and agree paediatric COVID pathways to stratify patient flow based on clinical urgency and IPC measures	December 2020	DOA		GM WCCS				
3	Package of education/training to support best practice in IPC in NHS Fife acute & community settings	October 2020		IPCT					

4.7 Delivering seasonal flu vaccination to public and staff

a) Winter Review 2019/20 – Actions and successes continued to 2020/21

- Deliver the staff vaccination programme to NHS and Fife HSCP staff through drop-in clinics and peer vaccinator programme in order to achieve 60% national target and 65% local target for uptake among healthcare workers
- Monthly review of progress against seasonal flu action plan
- Deliver staff communications campaign across Acute & HSCP
- Develop & distribute Information pack to independent care sector in Fife, covering staff vaccination, winter preparedness and outbreak control measures
- Redesign consent form and data collection methods to enable more detailed & timely monitoring of staff vaccination against targets
- Insert flu vaccination messaging for at-risk groups in out-patient letter template

b) Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Deliver the staff vaccination programme to health and frontline social care staff (NHS, Fife HSCP, independent and third sector) through peer vaccinator programme, occupational health clinics, care-home based and pharmacy delivery in order to achieve 60% national target and 65% local target for uptake	December 2020	DOHSC			DGM West			
2	Implement actions required for staff and community seasonal flu vaccination delivery under the Joint Fife HSCP & NHS Fife Flu Silver Group	December 2020	DOHSC			DGM West			
3	Ensure data collection methods enable weekly monitoring of flu vaccination uptake	October 2020	DOHSC			DGM West			

4	Raise awareness of the flu campaign and encourage health and care staff and key workers in the public sector to take up the offer of a free flu vaccination and lead by example	February 2021	DOHSC	Comms					

4.8 Covid-19 Mobilisation and delivering the COVID-19 Immunisation Programme

Winter Planning 2020/21 – Actions we are going to take this year

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
1	Produce plan for possible second Covid-19 wave in Acute and H&SC	October 2020	DOA DOHSC		DCOO	DGM West			
2	Refer to Business Continuity plans in event of resurgence in Covid-19 cases	October 2020	DOA DOHSC		DCOO	DGM West			
3	Engage in regular review of care homes in collaboration with the HSCP	October 2020	DPH	Public Health					
4	Support weekly asymptomatic staff Covid-19 testing in care homes	October 2020	DPH	Public Health					
5	Support symptomatic residents Covid-19 testing in care homes, and flu testing where there is a suspected outbreak	October 2020	DPH	Public Health					
6	Carry out resident Covid-19 surveillance testing on a care homes in Fife	October 2020	DPH	Public Health					
7	Increase capacity and skills with Health Protection Team for outbreak management for care homes in Fife	November 2020	DPH	Public Health			Funded Separately		
8	Increase and sustain capacity to undertake all contact tracing requirements for Fife residents as part of the National Contact Tracing Test and Protect Programme.	November 2020	DPH	Public Health					
9	Maintain surge capacity to manage abrupt changes in incidence of Fife Covid-19 positive cases throughout the winter months	October 2020	DPH	Public Health					

Ref	Action	Timescales	SRO	Lead/s			Status	Workforce	Finance
				Corp	Acute	H&SC			
10	Develop action plans for outbreak prevention and management of high-vulnerability settings and events. The aim of identifying these settings is to minimise the outbreak risks.	October 2020	DPH	Public Health					
11	Promote local and national messages associated with COVID-19 and Test and Protect	November 2020	DPH	Comms					
12	Review of outbreak management guidance in line with latest national guidance	October 2020	DON	IPCT					
13	Local delivery framework for COVID-19 immunisation to be developed and implemented using outputs of national work	December 2020	DOP	Pharmacy		DGM West			
14	PMO to be established for COVID-19 immunisation programme and required workforce to be recruited for the next 12 months which encompasses the different delivery models required at each stage of the plan	December 2020	DOP	Pharmacy		DGM West			

5 Summary

The Winter Plan for 2020/21 describes the arrangements in place to cope with increased demand on services over the winter period and possible subsequent COVID-19 waves. This has been carried out in partnership with NHS Fife, Fife Council and Fife HSCP who have a shared responsibility to undertake effective planning of capacity. Partnership working is essential in order to deliver the plan and will be tested at times of real pressure.

The priority is to ensure that the needs of vulnerable and ill people are met in a timely and effective manner despite increases in demand. Our workforce are key to the successful delivery of the winter plan. Pandemic, resilience, severe weather, norovirus and flu plans have been re-visited and are in place.

The plan is supported by a discharge model, performance measures, a risk matrix and an escalation process.

Winter communications planning is well under way and will include COVID-19 communications. The communication planned is both staff and public facing using recognised communications mechanisms (including social media).

The financial plan (detailed in Appendix 5) outlines our required resource in order to deliver upon the expectations of Fife outlined in Director General Health & Social Care and Chief Executive NHS Scotland's letter, Preparing for Winter 2020/21 dated 22 October 2020. This is based on a worst case scenario with all levels of surge capacity and associated actions being required. If this were to come to fruition, there would be a cost pressure which carries financial risk for both NHS Fife and Fife Health and Social Care Partnership as Scottish Government funding for winter will not cover the indicated cost required to enact this plan. The costs shown are only for the surge capacity and the working assumption is that all other actions detailed in the Winter Plan (section 4) are manageable within existing budgets, or via other funding streams such as Test & Protect.

The workforce requirements for surge capacity are detailed in Appendix 2, with the financial consequences set out in Appendix 5 (as described above). Staffing and financial implications of the Test and Protect, Seasonal Flu, and Covid19 Vaccine Programmes are not included in this plan.

Appendices

Appendix 1: Fife Integrated Escalation Plan

Appendix 2: Fife Winter Surge Bed Plan

Appendix 3: Fife Additional Wave ICU Response Plan

Appendix 4: Fife H&SC Additional Wave Response Plan

Appendix 5: Winter Plan Financial Table

Appendix 6: Weekly Winter Monitoring Report

Appendix 7: HSCP Provisional Winter Placement Tracker

Appendix 8: Preparing for Winter 2020-21 Supplementary Checklist

Appendix 9: COVID Surge Bed Capacity

Appendix 1: Fife Integrated Escalation Plan

Fife Integrated Escalation Plan Winter 2020/21 v0.4

Escalation at:	Acute Services Actions		H&SC Actions	Total Capacity
	Emergency Care	Planned Care		
	NHS Fife and Fife Council CEO to agree actions			
Extreme Pressure Hospital Occupancy: >=100% >10 patients awaiting admission in A&E/AU1au/AU2au for admission No critical care capacity available H&SC: >100% Occupancy >30 patients clinically fit for next stage of care from VHK	Instigate Full Capacity Protocol as follows: • All acute beds available for any patient • Organisational business continuity plans invoked • Move all delayed patients to other locations in Fife • Surgery proceeds on the premise that Ward 52 cannot receive Amber patients without impacting on the green status of the ward • In the event of surgery cancellation redirect available theatre staff to support inpatient activity. • 11 intermediate beds • Commission up to a maximum of 35 external nursing home placements • Increase QMH W8a by 5 beds • Open Cameron Balfour dependent on medical cover and staffing plan – 16 beds			Hosp / Tot / Core / Surg All 739 691 48 CC 36 36 - AS 437 417 20 HSC 266 238 28 **H@H** - 51 admissions **ICASS** - 100 Beds **Intermediate beds** - 11 **Increase in care packages** - 25 **Nursing home placements** - 35
	COO and Director of H&SCP to agree sequence of actions DAILY *Review requirement for delivery of non-critical services with a view to deploy staff into clinical areas* *Critical review of planned activities across all staff groups to focus on patient care and flow*			
Severe Pressure Hospital Occupancy: >=95% >5 patients awaiting admission in A&E/AU1au/AU2au without allocated beds Intensive care capacity available H&SC: >100% Occupancy >20 patients clinically fit for next stage of care from VHK	Open W6 – 12 beds Increase AU1 Red occupancy to 3 patients per bay Cancel outpatient clinics where medical staffing can support inpatient management based on specialty requirement	Maximise use of SSSU so that inpatient surgery has no impact on hospital capacity Surgical consultants are contacted by the PC management team to support with timely discharges and creation of flow Re-evaluate AU2 capacity split across medical/surgical beds	Increase flow to homecare and care homes – scale up resource in line with winter surge plan, up to 25 care packages and 25 care home placements Utilise 11 intermediate beds Increase ICASS capacity – additional 20 beds Increase H@H – additional 6 admissions Increase QMH W8 – additional 7 beds	Hosp / Tot / Core / Surg All 714 691 23 CC 36 36 - AS 433 417 16 HSC 245 238 7 **H@H** - 51 admissions **ICASS** - 100 Beds **Intermediate beds** - 11 **Increase in care packages** - 25
	Deputy COO and DGM West to agree sequence of actions DAILY			
Moderate Pressure Hospital Occupancy: >85% < 5 patients awaiting admission in A&E/AU1au/AU2au without allocated beds Critical care capacity available H&SC: >90% Occupancy >10 patients clinically fit for next stage of care from VHK	Every patient to be reviewed by a consultant Expedite medically fit for discharge patients Early Supported Discharge to H@H All wards to identify at least 1 patient for discharge pre 10:30am Assess AHP caseload and implement staffing moves as required. Specialty ward rounds to take place every day	Identification of amber surgical patients in surgical wards and in AU2 who are near discharge and suitable for a move to SSSU, appropriate patients would be approved by the respective on call Planned Care Consultant. Urology patients admitted to the surgical assessment unit (AU2) are redirected to UDTC Specialty ward rounds to take place every day	Increase flow to homecare and care homes – scale up resource in line with winter surge plan Prioritise ICASS discharges from VHK & QMH - Prioritise discharges from VHK to STAR/ Assessment beds/home with homecare above normal commissioning levels	Hosp / Core All 691 CC 36 AS 417 HSC 238 **H@H** - 45 admissions **ICASS** - 80 Beds
Planned Operation Working Hospital Occupancy: <85% No patients awaiting admission in A&E/AU1au/AU2au Critical care capacity available H&SC: <90%% Occupancy <10 patients clinically fit for next stage of care from VHK	Management plan put in place • Huddle discussion and predictor indicates that hospital is able to accommodate both elective and emergency patients for the day • There are no patients in A&E or Admission Units awaiting admission without allocated beds		The normal flow to H&SC services is expected (10/12 patients to exit each day)	Hosp / Core All 691 CC 36 AS 417 HSC 238 **H@H** - 45 admissions **ICASS** - 80 Beds

Appendix 2: Fife Winter Surge Bed Plan

Fife Winter Surge Plan 2020/21 v1.2					
Health & Social Care | Homely Setting and Care Homes					
Order of opening	**AREA**	**BED CAPACITY AVAILABLE**	**RISKS/ISSUES**	**BENEFITS**	**FINANCIAL IMPLICATIONS**
1	Maximise Home Care Capacity	300 hrs internal 300 hrs external contracted	• Additional resource if contracting out to private providers – either spot purchasing or book advanced hours/runs	• Home First principles • Low cost • Creates capacity for all inpatient areas	**Total £274,050** **Internal: £157,500** **External: £116,550** (unit costs £18.50/£25 00 per hour)
2	ICASS	20 Core 80 **100 beds**	• Dependent on recruitment - will dictate increased capacity • Additional investment required for Band 3 Rehab Support workers to increase daily capacity – (90K 6 months)	• Home First principles • Continues rehabilitation at home and reduces demand for homecare • Low cost • Creates capacity for all inpatient areas	**£90,000** 5 WTE band 3 (unit cost £17 per hr)
3	H@H	6 Core 45 **51 admissions**	• Recruitment will dictate increased capacity in particular as skill set required for H@H is highly specialist at NP level	• 7 day access to for admission's from GP OOH urgent care • Step down from AU1 to prevent Acute admission • Increased capacity for GP admissions to prevent admission to acute hospital • Less likely to close the service • Creates capacity and supports prevention of admission • Supports Fife wide model	**Total £187,083** **Pharmacy** £67,950 for 7-day cover for 5 months comprised of: 1.1 WTE clinical pharmacist B8a £32,675 1.3 WTE pharmacy technician B5 £23,140 1.0 wte pharmacy support worker B3 £12,135 **Nursing/Medical** Nursing Band 6 NP 2.4 - £71,250 Medical staff for weekend shifts - £47,500 - Total request = £118,750 Cost per day per patient £168.00
4	Intermediate Care beds	11 Dedicated intermediate care beds to enable step down Emergency respite provision would be ring fenced across the system.	• GP registration would be required for patients who did not live locally • Community Nursing may be required • Patients must be medically well to step down • Pre-assessment required • New model of care • Cost needs to be worked up • COVID testing pre-admission • Public perception of care homes • Additional care transition • LOS average 56 days	• Homely setting • Promote individuals to be independent • Releases in-patient capacity • Number of patients in delay reduces • Location – supports flow in West Fife which can be a challenge	**Total £75,000** Transfer of respite to accommodate step down beds £740 per week *20 weeks* 5 beds - £74,000 Registration Fee - £1,000
5	Additional nursing care home placements (private providers)	Commission interim Nursing Home placements depending on pressures across the VHK and community hospitals	• GP registration would be required for patients who did not live locally to the care home • Community Nursing may be required • Patients must be medically well to step down • Pre-assessment required • COVID testing pre-admission • Public perception of care homes • Financial implications • Additional care transition • District Nursing may need to support • LOS average 41 weeks	• Homely setting • Promote individuals to be independent • Releases in-patient capacity • Number of patients in delay reduces	Care home beds have been calculated on a sliding scale based on usage and also calculated on risk therefore additional beds could be commissioned as follows: • **25 beds would cost £210K** • **35 beds would cost £296K**

Inpatient Hospital Areas							
Order of opening	AREA	SURGE BED CAPACITY	CORE BEDS	CORE STAFF	RISKS/ISSUES	BENEFITS	FINANCIAL IMPLICATIONS
6	QMH Ward 8/8a	12 7/5	0	22 WTE (nursing, 1 AHP, 1 RMO cover)	• AHP cover required • Medical cover required • Sexual health would require remobilisation	• LOS average 40 days	**Total - £454,363** Additional Nursing: W8 - £169,624 W8a - £117,739 1 AHP £25,000 RMO £142,000 (only if W8a opens, will also cover W3 and Balfour)
7	VHK Ward 6	12	0	0	• Currently being used as Diabetes Centre due to service displacement • Environment is sub-optimal • Unable to use hoists • Limited patient cohort can be admitted to area • Securing the workforce required • Medical staff buy in to provide RMO cover • Pressure on AHPs to provide rehabilitation • High cost • May not be sustainable	• Within acute setting • Ward area already partly prepared • Could be used to support those approaching discharge and waiting on care packages • Could be used to deliver ambulatory model	**Total - £587,779** Nursing (19.96 WTE) - £360,027 AHP (2 WTE)- £38,754 Medical (2 WTE) – £188,998
8	Cameron Hospital Balfour Ward	18 Assuming 4 bedded bays	0	20 WTE	• Securing the workforce required staff being re deployed to imms/test & trace • Medical staff would need to secure RMO cover which is not available in the HSCP and also need to secure junior medical or ANP cover as existing locum junior medical cover on Cameron site unlikely to be able to provide this without increased secure staffing. • Pressure on AHPs to provide rehabilitation • High cost • May not be sustainable • Accommodation required for AHP staff if Balfour ward opened as this was the rehab area and office space	• Ward area already prepared as a result of COVID • Some staff may be available following Wellesley closure • LOS average 40 days	**Total - £482,000** 80, 000 per month Nursing - £400,000 Junior Doctor - £57,000 1 AHP - £25,000
9	QMH Ward 3	Up to 22 beds	0	22WTE 13 WTE registrants 8 WTE 2 1 WTE 7 3 x Medical Sessions	• Securing the workforce required – staff being re deployed to imms/test & trace • Medical staff buy in to provide RMO cover • Pressure on AHPs to provide rehabilitation • High cost • May not be sustainable • Isolated area within QMH	• Ward area already prepared as a result of COVID up to 18 beds • Could be used to cohort patients awaiting guardianship – trend is increasing • LOS average 40 days ≥ if guardianship cases	**Total £498,750** £94,750 per month nursing - £473,750 Consultant costs covered in £170,000 for ward 8 and ward8a 1 AHP - £25,000
10	HSCP and Acute Hospital Areas Revert to pre-covid bed spacing - 6 bedded bays	HSCP 31 Acute 20 (dependent on bed spacing)	248	480	• Additional staffing may be required • Risk of staff burnout • Pressure on AHPs • Infection control risks of providing care within environment's with <1m bed spacing with no physical screens • Provision would be beyond the funded bed base	• Areas already up and running functioning with MDT staffing in place	Unclear if this will be within IPCT guidance - assumed a medium level of costs

Appendix 3: Fife Additional Wave ICU Response Plan

NHS Fife COVID-19 Additional Wave Response Plan – Acute Services v1.1

NHS Fife has immediate equipment stock to enable ventilation of 35 patients. Any additional requirement can be facilitated through use of theatre ventilator stock
Previously deployed staff are engaged in a programme of Keeping in Touch (KiT) days in order to maintain critical care competencies. Identified ratios in accordance with guidance issued 26/03/20 from CNO

Escalation at:	Acute Services Actions		Staff Impacts Critical Care	CC Capacity
	Critical Care Actions	Enabling Actions		
	Gold command to agree sequence of actions DAILY			
Stage 4 **Scale up 48-72hrs** **14 COVID +ve patients in ICU**	3rd Red ICU opened – critical care floor becomes full level 3 support Amber ICU remains in Recovery 2 Green SHDU remains Ward 52 Amber SHDU into Recovery 1 Amber medical level 2 care into CCU Red medical level 2 care remains in Ward 43	Surgical programme reduced to P1 activity only	1:6 critical care nurse / patient ratio PLUS 4 deployed RNs PLUS 4 deployed nRNs Nursing staff deployed from surgical specialty ward areas Prioritise support from anaesthetic team into critical care 15 WTE physiotherapists allocated to critical care	CC T R A G All 54 32 18 4 L3 38 28 10 S L2 8 4 4 M L2 8 4 4
	Silver command to agree sequence of actions DAILY – Gold command briefed DAILY			
Stage 3 **Scale up 24-48hrs** **7 COVID +ve patients in ICU**	2nd Red ICU opened in SHDU area Amber level 2/3 move from SHDU to Recovery 2 Red medical level 2 care into Ward 43	Surgical program reduced to P1&2 only Reduce QMH theatre programme to support reallocation of staff. F2F Outpatient activity suspended – focus on inpatient care	Move to 1:4 critical care nurse / patient ratio PLUS 3 deployed RNs PLUS 4 deployed nRNs Nursing staff with transferrable skills deployed from Theatres and Recovery Reduction in theatre program critical to releasing anaesthetic support 9.0 WTE physiotherapists allocated to critical care	CC T R A G All 42 24 14 4 L3 26 20 6 S L2 8 4 4 M L2 8 4 4
	Silver command to agree sequence of actions BI-WEEKLY – Gold command briefed WEEKLY			
Stage 2 **Scale up within 24hrs** **3 COVID +ve patients in ICU** **2 COVID +ve patients in MHDU side rooms**	ICU becomes red ward Amber level 2/3 created in SHDU SHDU (surgical level 2 care) move to Ward 52 (4 green in 52 – 4 Amber in SHDU) **Should ICU be accommodating COVID +ve patients on main floor – potential to accommodate level 2 medical patients to prevent MHDU expansion. Situation dependent.*	Elective program reduced to P1-3 only Review QMH theatre programme. Review nursing staffing across Division to identify supporting staff from critical care trained pool	Move to 1:2 critical care nurse/patient ratio PLUS 2-3 deployed appropriately trained RNs Increased medical support from Anaesthetic staff Prepare to remobilise respiratory physiotherapist	CC T R A G All 32 10 18 4 L3 16 10 6 S L2 8 4 4 M L2 8 8
Stage 1	4 x ICU side rooms (2x -ve pressure) 2 x MHDU side rooms and Bay 1 Available for use for COVID or other query-infectious patients	Full surgical program in operation. Maintain availability of negative pressure rooms in Wd 51 for COVID patients requiring NIV	No impact on nurse / medical staffing. 1:1 critical care nurse /patient ratio No impact on physiotherapy	CC Total All 25 L3 9 S L2 8 M L2 8

Appendix 4: Fife H&SC Additional Wave Response Plan

Fife H&SC COVID-19 Additional Wave Response Plan – Community Services v1.1			
Escalation at:	**Community Hospital Actions**	**Enabling Actions**	**Workforce**
Stage 4 **Scale up 48-72hrs** **14 COVID +ve patients in ICU** **Ward 53 24 +ve** **Ward 51 5 +ve**	**Gold command to agree sequence of actions DAILY**		
	QMH Ward 3 / Cameron Balfour opened	Redeploy nursing resource to support additional wards Additional medical staffing required (RMO and ward Dr)	AHP model of care targeted to the most complex individuals
Stage 3 **Scale up 24-48hrs** **14 COVID +ve patients in ICU** **Ward 53 20 +ve patients** **Ward 51 open**	**Silver command to agree sequence of actions DAILY – Gold command briefed DAILY**		
	QMH Ward 8a opened with 5 beds	Review nursing resource to support Ward 8a from deployed areas QMH Ward 3 / Cameron Balfour plan to open	AHP's to be deployed to in patient areas - cardiac and pulmonary rehab physio staff may need to be deployed to Acute
Stage 2 **Scale up within 24hrs** **7 COVID +ve patients in ICU** **Ward 53 10 +ve patients** **Ward 51 plan to open**	**Silver command to agree sequence of actions BI-WEEKLY – Gold command briefed WEEKLY**		
	QMH Ward 8a plan to open	Review nursing staffing across HSCP to identify supporting staff who could support in patient areas Transfer service delivery for sexual health operating within QMH Ward 8a	Plan for critical service delivery as identified within business continuity plans
Stage 1	231 beds 79 side rooms available for use for ward based COVID outbreaks or other infectious patients	Normal transfers from VHK to community hospitals	No impact on nurse / medical staffing No impact on AHP's

Appendix 5: Winter Plan Financial Table

Winter Plan 2020/21 Financial Impact *Cost based on 6-month winter period*					
Ref	**Description**		**Area**	**Timescale**	**Cost (CYE)**
4.2.1	Implementation of a sustainable 7-day OT and PT service for acute		Acute	Nov-20 to Mar-21	£72,500
4.3.3	Costs in relation to Surge Plan (see Appendix 2)	Provide additional homecare capacity to support timely discharges from and prevent admissions to hospital	H&SC	Nov-20 to Mar-21	£274,000
4.3.3		Provide additional ICASS capacity to support timely discharges from and prevent admissions to hospital	H&SC	Oct-20 to Mar-21	£90,000
4.3.3		Provide additional H@H capacity to support timely discharges from and prevent admissions to hospital	H&SC	Nov-20 to Mar-21	£187,083
4.3.3		Provide additional Intermediate Care placements to meet demand	H&SC	Nov-20 to Mar-21	£75,000
4.3.3		Commission 25 additional Nursing Home placements to meet demand and support hospital discharges	H&SC	Oct-20 to Mar-21	£210,000
4.3.3		Surge Capacity – Ward 8/8A QMH	H&SC	Nov-20 to Mar-21	£454,363
4.3.3		Surge Capacity – Ward 6 VHK	Acute	Nov-20 to Mar-21	£587,779
4.3.3		Surge Capacity – Balfour Ward, Cameron	H&SC	Nov-20 to Mar-21	£482,000
4.3.3		Surge Capacity – Ward 3, QMH	H&SC	Nov-20 to Mar-21	£469,000

Total Potential Cost (Worst Case Scenario)	£2,901,725
SG Winter Funding	£661,000
Potential Cost Pressure	£2,240,725

Appendix 6: Weekly Winter Monitoring Report

Area	Indicator	Trend	03-May	10-May	17-May	24-May	31-May	07-Jun	14-Jun	21-Jun	28-Jun	05-Jul	12-Jul	19-Jul	26-Jul	02-Aug	09-Aug	16-Aug	23-Aug	30-Aug	06-Sep	13-Sep	20-Sep	27-Sep	04-Oct	11-Oct	18-Oct	25-Oct
OOH Urgent Care	Contacts		2143	1876	1978	2006	1927	1890	1818	1804	1995	1903	1897	1902	1816	1852	1899	1915	2176	2380	2225	2065	1910	1836	1895	2294	1691	1779
	OoT Home Visits		31	21	48	19	37	22	15	24	31	22	29	37	13	24	31	16	20	29	30	22	21	19	42	20	20	31
	% ref to 2ndary Care		3.83%	2.61%	3.24%	3.54%	4.20%	4.23%	4.24%	4.77%	5.41%	4.68%	5.06%	4.78%	5.84%	4.91%	5.63%	5.54%	4.69%	3.78%	3.91%	5.42%	4.76%	4.74%	4.91%	4.18%	5.09%	4.95%
	COVID Ax Centre		177	137	151	135	123	118	117	96	137	108	98	123	102	115	106	118	181	217	175	142	142	106	139	110	111	106
	COVID Advice Calls		349	336	272	289	218	255	220	193	201	196	172	157	162	165	165	190	308	477	377	305	193	176	207	212	155	166
Emergency Department	Attendances		723	763	805	910	1022	941	981	1055	1102	991	1050	1166	1123	1089	1177	1145	1228	1148	1172	1157	1136	1154	1061	1094	976	1051
	Performance		96.8%	95.4%	96.1%	94.3%	95.7%	94.9%	96.1%	96.2%	95.7%	96.5%	95.9%	95.9%	90.7%	95.9%	94.5%	94.8%	93.0%	93.8%	93.2%	94.2%	95.4%	96.8%	94.4%	93.7%	93.9%	93.7%
VHK	Admissions		520	494	552	595	564	590	588	641	643	642	647	675	714	681	702	678	678	672	708	714	646	657	672	638	695	662
	Emergency		487	459	517	554	533	555	554	600	595	586	578	604	638	602	636	605	594	601	630	626	566	587	592	554	612	581
	Discharges		444	508	513	548	569	599	524	620	627	639	671	638	662	692	694	667	652	667	714	694	638	641	640	657	670	684
	% B4 Noon		15.0%	15.4%	16.1%	12.9%	15.5%	10.4%	20.3%	18.6%	15.8%	12.3%	14.3%	12.0%	16.0%	16.7%	14.4%	15.8%	13.6%	14.7%	13.3%	11.9%	13.0%	13.8%	13.5%	13.0%	14.6%	14.5%
Theatre Activity	Scheduled		21	32	26	30	34	25	48	61	45	88	85	150	178	182	150	192	216	205	243	231	251	265	245	272	229	239
	Cancelled		0	4	0	0	1	0	4	6	0	10	2	5	6	4	3	7	12	9	18	8	8	12	14	18	3	12
	Hospital Cancelled		0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	1	1	0	2	1	0	0	0	0
VHK Bed Utilisation	Occupancy		64%	67%	68%	73%	79%	77%	75%	81%	83%	79%	78%	77%	85%	82%	80%	80%	81%	84%	85%	79%	81%	84%	85%	87%	83%	82%
	COVID Bed Days											143	113	106	129	84	97	109	78	63	87	91	106	110	121	104	184	251
	Boarding Bed Days		148	170	178	181	239	219	204	205	207	217	224	192	252	250	176	166	222	237	214	240	287	247	309	363	301	316
	DD Bed Days		10	12	16	14	17	19	46	53	60	38	22	25	38	19	27	31	13	23	34	20	7	23	16	13	22	23
Community Hospital	Admissions		37	37	35	41	39	35	26	29	36	27	38	33	30	48	43	37	49	45	41	38	35	41	34	38	43	46
	Discharges		35	38	35	41	40	34	26	28	36	27	38	33	29	48	44	37	49	44	40	37	35	41	34	37	43	45
	Occupancy		61%	59%	64%	66%	65%	67%	67%	68%	69%	84%	85%	87%	91%	93%	91%	92%	93%	89%	89%	92%	92%	91%	92%	94%	94%	94%
	COVID Bed Days											7	11	4	10	4	0	2	2	2	6	1	4	2	1	3	3	0
	DD Bed Days		233	208	188	194	218	228	201	238	248	258	293	297	332	348	318	385	421	341	325	302	329	352	342	344	300	254
	DD Standard		109	98	82	86	108	106	81	127	143	153	185	183	218	235	215	293	333	245	211	188	216	230	215	211	158	122
	DD Code 9		124	110	106	108	110	122	120	111	105	105	108	114	114	113	103	92	88	96	114	114	113	122	127	133	142	132

Appendix 7: HSCP Winter Placement Tracker

	Downstream Beds (DSB)	Social Care Discharge Models						Other Discharge Routes				
	Placed / Moved within Community Hospital	Predicted Demand for HSC placements	Long Term Care	Homecare	START	Assessment & Intermediate Care Beds	STAR	Predicted Demand for Placements	Re-Start Care Packages	High Health Gains	Hospital @ Home	ICASS
Nov-20	165	149	34	8	77	18	12	169	75	10	20	64
Dec-20	157	152	37	8	77	18	12	169	75	10	20	64
Jan-21	178	159	36	12	81	18	12	177	75	10	20	72
Feb-21	157	157	34	12	81	18	12	177	75	10	20	72
Mar-21	146	157	34	12	81	18	12	177	75	10	20	72
	803	774	175	52	397	90	60	869	375	50	100	344

Appendix 8: Preparing for Winter 2020-21 Supplementary Checklist

Preparing for Winter 2020/21:
Supplementary Checklist of Winter Preparedness: Self-Assessment

Priorities **1. Resilience** **2. Unscheduled / Elective Care** **3. Out of Hours** **4. Norovirus** **5. Covid -19, Seasonal Flu, Staff Protection & Outbreak Resourcing** **6. Respiratory Pathway** **7. Integration of Key Partners / Services**	These checklists supplement the Preparing for Winter 2020/21 Guidance and support the strategic priorities for improvement identified by local systems from their review of last winter's pressures and performance. For the avoidance of doubt, your winter preparedness assessment should cover systems, processes and plans to mitigate risks arising from a resurgence in covid-19, severe weather, winter flu and other winters respiratory issues, and a no deal Brexit – either individually or concurrently. The checklists also include other areas of relevance but are not exhaustive. Local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery. NHS Special Boards should support local health and social care systems to develop their winter plans as appropriate

Winter Preparedness: Self-Assessment Guidance

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

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

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

1	Resilience Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1.1	The NHS Board and Health and Social Care Partnerships (HSCPs) have robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather, EU Exit and Covid-19 resurgence. These arrangements have built on the lessons learned from previous events, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The Preparing for Emergencies Guidance sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☒ ☒		NHS Fife and HSCP have established and robust Business Continuity Plans in place. Each ward, department and service have responsibility to review and update their plans at least once each year. This is supported by the Business Continuity Manager. The Business Continuity Manager and Emergency Planning Officer are involved in all aspects of contingency planning.
1.2	Business continuity (BC) plans take account of the critical activities of the NHS Board and HSCPs; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios, including Covid-19 reasonable worst case scenarios. Risk assessments take into account staff absences including those likely to be caused by a range of scenarios including seasonal flu and/or Covid-19 as outlined in section 5 and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.	☒ ☒		All NHS Fife and HSCP Business Continuity Plans consist of a Business Impact Analysis; Risk Assessment; and Continuity Plan. New templates all include these elements.

	The Health Board and HSC partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.			
1.3	The NHS Board and HSCPs have appropriate policies in place should winter risks arise. These cover: • what staff should do in the event of severe weather or other issues hindering access to work, and • how the appropriate travel and other advice will be communicated to staff and patients • how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*	☒		HR18 - Disruption of Staff Travel Arrangements Policy is in place and staff will be directed accordingly as required. NHS Fife has a Severe Weather Response Plan, which includes H&SCP. This Plan includes the Command & Control structure, staff reporting arrangements, 4x4 responses and access to voluntary agencies.
1.4	The NHS Board's and HSCPs websites will be used to advise on changes to access arrangements during Covid-19, travel to appointments during severe weather and prospective cancellation of clinics.	☒		Advice and information are issued on NHS Fife website, Blink, Twitter and Facebook pages. Links and information from East of Scotland Local and Regional Resilience Partnership, Fife Council, Travel Scotland and the Met Office will also be distributed.
1.5	The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☒		The current core capacity across NHS Fife is 72 at VHK. Joint working continues with Fife Council and Funeral Directors to ensure contingency plans would increase throughput across local crematoriums and cemeteries. Multi-faith arrangements around mutual aid support are ongoing.

1.6	The NHS Board and HSCPs have considered the additional impacts that a 'no deal' EU withdrawal on 1 January 2021 might have on service delivery across the winter period.	☒		Multi-agency exercises continue on a regular basis which, although not specifically around winter and builds on existing arrangements. A silver command Brexit Group will meet WB 02/11/20. A Fife Multi-Agency Winter Preparedness Review is being planned where key members from all partner organisations will be present.

2	**Unscheduled / Elective Care Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
2.1	**Clinically Focussed and Empowered Management**			
2.1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity. *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☒		A winter review event of last winter was held August 2020 via Teams. This event involved representative from all areas of NHS Fife and HSCP. The outcomes were developed and learning used for the winter plan. Hospital Control Room established within Acute during COVID, now part of core Site Management process and will remain in place through winter. Integrated Capacity tool is in the final stages of testing, this will be used each day to look at capacity across acute and the HCSP. Inprovement actions will be identified and progressed with escalation to Silver Command as necessary.
2.1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as	☒		There is a daily acute and HSCP multi-disciplinary daily safety huddle via Teams to support decision-making in the very early part of the day. The HSCP contributes to VHK huddle to ensure a whole system approach is taken. This

	they occur departmental and whole system escalation procedures are invoked.			is supported by a mid morning capacity review with Director involvement. Weekly operational planning meetings continue to look at operational plans for a week ahead and agree a weekend plan for the site. The balance of accommodating elective and emergency admissions is part of this process and informs the decision to open additional capacity if necessary
2.1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.* *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*	☒		A full review of our current escalation plan has been undertaken. Escalation plan in place as part of Winter Plan, with enabling actions across Acute and HSCP. Supported by ICU escalation plan in response to COVID-19.
2.1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☒		As above – Escalation plans link to staffing requirement. Additional capacity costed under financial plan.
2.2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID activity (both short and medium-term) based on forecast emergencyand elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective	☒		System watch is used routinely to predict on a daily basis current demand and activity is planned (this will include urgent elective care) around these numbers. There a

	provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Weekly projections for Coved demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity.* *Plans in place for the delivery of safe and segregated COVID care at all times.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*			robust escalation plan which includes surge beds also being implemented. This has however been impacted with Covid with fluctuations being seen and taken account of. Daily discussion in Acute of predict admissions and discharges (using EDD) and projection of profile on weekly basis.
2.2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter / COVID surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are*	☒		A full escalation plan with actions re emergency and elective work has been put together and is now in place to avoid unnecessary disruption.

	cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution. *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.* *Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical prioritisation and planning assumptions*			
2.3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.**			
2.3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☒		Plans in place – being finalised with clinical teams and adjusted to account for increasing COVID activity. A tactical workforce group has been established to support workforce planning and deployment due to competing priorities.
2.3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services.	☒		Plans in place – being finalised with clinical teams. Workforce planning is ongoing and will be supported by tactical group.

2.3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☒		NHS Fife is a core member of Fife LRP (Local Resilience Partnership) and is fully engaged in all multi agency arrangements
2.3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☒		All rotas in place to ensure public can access OOH across the winter period and public holidays.
	Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of healthcare associated infection and crowded Emergency Departments. **Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.**			
	To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS	☒		Cabinet Secretary announcing UC Redesign programme on 27/10/20, await National Strategy and can commence Public Local Communication plan and public engagement following this. Go live date confirmed as 1/12/20 FNH test event planned 7 – 10 days prior to launch to allow rigorous review of clinical and digital pathways to identify any issues / further risks to be managed. Workforce Modelling is progressing within ED / MIU to support the virtual FNH.

	• A range of other community healthcare professionals. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide visible appointments / timeslots at A&E services. The impact on health-inequalities and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.			Training needs analysis is being completed with RAG status being reviewed. Algorithm has been reviewed by UCSF clinical colleagues awaiting ED sign off. Existing Clinical Pathways mapped and pathway Subgroups are progressing work to enhance existing models. Readiness assessment discussed with Scot. Gov 23/10/20 Phased implementation plan in development Digital Delivery pathways for ED/MIU have been created, meeting to be held early w/c 26/10 for approval by ED clinicians before build is undertaken. Adastra hosting solution has been investigated, approved by Board awaiting sign off ongoing cost before Digital process map has been developed and awaiting sign off from ED colleagues. This will then allow the build and training plan to be commenced. Kit was ordered and requires sign off. Band 3 dispatcher role is seen as key to affect service delivery within FNH. Workforce modelling has commenced and is expected to be completed with decision from Finance to be presented to UC Redesign Group on 3/11/20.
	Professional to professional advice and onward referral services should be optimised where required Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission.	☒		Existing Professional to Professional pathways have been mapped and aligned to clinical pathways Existing clinical Pathways mapped and pathway Subgroups are progressing work to enhance existing models

				Multi disciplinary engagement to develop whole system pathways in collaboration with partner agencies eg. SAS and NHS24
2.4	**Optimise patient flow by proactively managing Discharge Process utilising 6EA – Daily Dynamic Discharge to shift the discharge curve to the left and ensure same rates of discharge over the weekend and public holiday as weekday.**			
2.4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☒		Within the Acute hospital, the Discharge Hub facilitates the discharge of those who require ongoing support from health and social care following an in-patient stay. This service offers a multi-agency, integrated, person centred approach to the assessment of an individual's needs as they approach discharge. The hub has a key role in community and whole system flow. Close working relationship with SAS to ensure sufficient patient transport support, utilising the HALO to link between teams.
2.4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate.	☒		Ongoing. Review of all ward and board practices taken place across the Acute hospital. Ongoing support from Unscheduled Care team against 6EAs to improve practices prior to peak Winter. Rolling programme in place for ward level review of discharge activity led by Associate Medical Director, Associate Director of Nursing and Deputy Chief

	Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.			Operating Officer with individual ward MDTs. Programme supported by data from Unscheduled Care team.
2.4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☒		Discharge lounge not currently in operation. Has routinely been part of our core discharge processes, but has been suspended in response to COVID. Previous discharge lounge area unsuitable due to physical distancing requirements and appropriate clinical space currently utilised.
2.4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*	☒		The H&SC Discharge Model is based on demand for services from last year. Weekly monitoring reporting and escalation plan are in place where provision of services is reviewed and increased if necessary.
2.5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			

2.5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.* *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☒		There is a plan incorporating predicted demand into planning for Social Work packages of care.
2.5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.* *All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible*	☒		As above
2.5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☒		Patients identified as part of HHG recorded on Trak to ensure joint working and communication across teams including discharge HUB and OOH

2.5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.*	☒		ACP's completed for all HHG patients as part of intervention and monitored using RAG data base. This is reviewed daily for all patients.
2.5.5	Covid-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November. Turnaround times for processing tests results within 24/48 hours.			Additional lab platforms to be delivered late October and in operation by mid-November to support increased capacity requirement. Local lab turnaround times within 24 hrs.
2.6	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
2.6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☒		This is addressed during the morning safety huddles and weekly winter meetings between NHS Fife and HSCP General Managers. Established link with SAS through Hospital Ambulance Liaison Officer (HALO).
2.6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around*	☒		Ongoing communication through multiple mediums (website, social media, press) regarding winter preparedness and COVID-19 response. Enhanced communication will be in place to cover service provision over key holiday periods.

	direction to the appropriate service are effectively communicated to the public. *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*			

3	**Out of Hours Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
3.1	The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays. *This should include an agreed escalation process.* *Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?*	☒		The OOH plan covers the full winter period and pays particular attention to the festive period and covers pre-prioritised calls from NHS24. There is an agreed escalation process in place to ensure Senior Management within the H&SCP are aware of any current or potential service delivery challenges real time. In consultation with NHS 24, partner assistance with pre-prioritised calls will be provided by Urgent Care Service Fife (UCSF) on agreed public holidays, covering predicted peak time call volumes. Further consideration to providing triage can only be given once all UCSF sessions are filled.

				Close consultation with NHS 24 continues and plans will be flexed over the winter period in response to demand.
3.2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☒		This year, as in the previous festive periods, UCSF has reviewed the Business Continuity plan to ensure our contingency plans remain robust, current and flexible to be able to deal effectively with all technical and operational issues or demands placed upon the service taking account of the Public Holidays and weekends prior, during and after the festive period. UCSF has referred to previous years and the predicted festive information supplied by NHS24 through as a baseline for formulate festive planning. Updated data will be available from NHS24 closer to Christmas giving Boards the chance to revisit requirements and amend accordingly. Activity rates are reviewed weekly in conjunction with data received from public health and Scottish Government regarding activity. Additional recruitment and training has taken place for both admin and clinical staff to ensure as flexible a workforce as possible is in place to meet the requirements of the service Bank staff are also available organised through the respiratory nurse service for H@H only.
3.3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☒		UCSF plans to increase staffing levels over the winter period on Saturday and Sundays to supplement the home visiting capacity as this has previously been identified as critical to the delivery of care. Activity is closely monitored during the winter months and reviewed along with guidance from HPS and SGHD. New ways of working are now established as part of Urgent Care Transformation, including Clinical HUB Supervision, UCP Home Visiting. Evaluation evidences safe,

				appropriate and effective care. UCPs work within specific clinical criteria, releasing time to care for GPs to manage more complex clinical presentations.
3.4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☒		Direct referrals are encouraged between UCSF and MIU and A & E. Fife Urgent Care Practitioners can directly refer to other specialties, including tertiary services such as ENT, without the need for a GP to be involved. Direct referrals ensure that the patient journey is not added to by an unnecessary reassessment in A&E. Specialist Paramedics can now directly refer to AU1 and other services, removing the need for a further clinical consultation and ensuring an appropriate patient journey and effective use of resources.
3.5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☒		UCSF employ Adastra for all documentation and all clinicians are trained in the use of this. Regular reviews of documentation are undertaken and fed back to clinical staff to ensure good, clear, accurate record keeping in line with professional codes is achieved.
3.6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☒		The use of the professional to professional line is encouraged at all times and is routinely used by Pharmacists; District Nurses, Labs and SAS. Calls come directly into Fife's Dispatcher and details are entered into Adastra for a clinician to clinically manage. Pharmacists have repeat prescribing PGDs which have further reduced calls to NHS24 and UCSF. . Community pharmacies within the health board area can manage minor illness through the Pharmacy First service. Each centre and the hub will have a copy of all Pharmacy opening times across NHS Fife. This includes a list of designated palliative care pharmacies. Dispatch and the Centres will utilise the flowchart – "Accessing medicines OOH" which was devised by

				Pharmacy. Oxygen concentrators are now available in all centres. A robust system for Controlled drug supply is in place and all GPs are aware of the ordering procedure. Drugs are checked at the start of each shift and a regular audit is carried out by NHS Fife Pharmacy staff. No major drug issues have been noted. Prior to the festive period all drug levels are assessed, and additional stocks are agreed, for commonly used medications such as, antibiotics, inhalers, steroids, analgesia and emergency contraception. This includes those used in the Centres by GP's and UCP's and those in the mobile bags
3.7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☒		Direct referral to the Unscheduled Care Mental Health team is available. The team is available during the out-of-hours period and will make arrangements to see the patient. Unscheduled Care Assessment Team (UCAT) telephone screening service is available for individuals who have contacted NHS 24, aged between the ages of 18 to 65 with concerns regarding mental health issues or self ham ideation expressed. If the patient's life is in immediate risk or they are actively self harming, it would not be appropriate referral to UCAT and Police / SAS should be considered as the safe and appropriate outcome. GPs will attend patients at home if it is considered that due to their clinical condition they may require an emergency detention, this is a necessary step due to current legislation.
3.8	Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres	☒		Provision of dental services is organised through NHS24 as the single point of contact and this has been well established for several years and is robust in its arrangements

	This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.			
3.9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☒		**Call Handling /Dispatch staff**: Double staffing required during peak times. Staff will be expected to attend shift as planned. **Nursing staff**: Nursing staff rotas will reflect activity, available accommodation and profiling of peak demands from previous years **GPs:** Extra GPs will be recruited for all centres during peak periods. A review of peak demands on the service has allowed UCSF to predict staffing requirements and plan to meet potential demand. **Short Notice GP Directory** of those willing to come in and work additional shifts/part shifts throughout festive period will be available.
3.10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☒		NHS Fife will be working with the communication department to ensure effective plans are in place to communicate how services should be accessed over the winter period. NHS24 Winter Campaign messages support the delivery of the out of hours service and routine local communication will signpost to where services are available as well as the need to order repeat prescriptions well in advance. Communication strategy will be implemented reflecting previous public holiday arrangements. Primary Care Department will request all practices advertise their opening hours and encourage them to use the facility on all prescriptions to remind patients to order repeat prescriptions early. Advertisements in local papers will be placed.
3.11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along	☒		There is enhanced partnership working with the Scottish Ambulance Service (SAS). Arrangements with SAS remain in place as in previous years.

	with examples of innovation involving the use of ambulance services.			
3.12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☒		NHS Fife UCSF and NHS24 have worked very closely. This will continue with regular meetings between the services to plan and review service delivery to the population of Fife and Kinross. Pre-prioritised calls are received directly into the hub where the GP/UCP's will be based. This allows liaison between the staff groups for those patients who require face to face consultation and equity in service provision. UCSF are working with NHS 24 using previous year's data from both organisations to continue to develop plans. Festive arrangements will be shared in detail with NHS24 and vice versa to enable the two organisations to work in close partnership.
3.13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☒		Planning is shared with colleagues from the Acute Sector, in particular, the Emergency Care Directorate.
3.14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☒		UCSF can refer directly to emergency Social Work if necessary. Public Protection referral polices available to support effective referral in the urgent care period.

3.15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic flu and other emergency plans, including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☒		Previously NHS24 escalation plans would be tested with all Health Board areas prior to the festive period and UCSF would participate in the planned teleconferencing meetings to discuss any issues/pressures that have been identified and agree the trigger points for moving towards escalation if required. Pandemic Plan has been reviewed for 2020/2021 winter period.

4	**Prepare for & Implement Norovirus Outbreak Control Measures** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
4.1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☒		
4.2	Infection Prevention and Control Teams (IPCTs) will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which nursing and care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*	☒		
4.3	PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards and that frontline staff are aware of their responsibilities with regards prevention of infection.	☒		Control measures described in NHS Fife Infection Control Manual (on Blink) with Links to NICM Outbreak folders including guidance on Norovirus have been provided to all inpatient wards

4.4	NHS Board communications regarding bed pressures, ward closures, etc are optimal and everyone will be kept up to date in real time. *Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☒		Daily safety huddle, attended by Senior Management and IPCT. Use of Boards at entrances to provide information about ward closures. Use of social media.
4.5	Debriefs will be provided following individual outbreaks or at the end of season to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☒		
4.6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker.	☒		Reported via ICC and CGC reports
4.7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.	☒		
4.8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*	☒		Microbiologists provide 24 / 7 cover. 2 IPCNs on call/onsite each day over public holidays.
4.9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☒		

4.10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *HPT/IPCT and hospital management colleagues should ensure that the they are all aware of their internal processes and that they are still current.*	☒		
4.11	The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus.	☒		including use of social media via comms team
4.12	Boards should consider how their Communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of Covid-19.	☐		Communications plan: including use of social media via comms team

5	Covid-19, Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
5.1	Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMO's seasonal flu vaccination letter published on 07 Aug 20 https://www.sehd.scot.nhs.uk/cmo/CMO(2020)19.pdf *This will be evidenced through end of season vaccine uptake submitted to PHS by each NHS board. Local trajectories have been agreed and put in place to support and track progress.*	☒		Peer vaccination in all areas.
5.2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.* *Vaccine uptake will be monitored weekly by performance & delivery division.*	☒		Peer vaccination being delivered within teams. No drop in clinics are available, but strong pool of peer vaccinators. HSCP colleagues are being supported to have flu immunisations through local pharmacy settings.
5.3	Workforce in place to deliver expanded programme and cope with higher demand, including staff to deliver vaccines, and resource phone lines and booking appointment systems.	☒		Increased capacity has been developed within the immunisation team to ensure a safe and effective delivery of the flu programme.

5.4	Delivery model(s) in place which: • Has capacity and capability to deal with increased demand for the seasonal flu vaccine generated by the expansion of eligibility as well as public awareness being increased around infectious disease as a result of the Covid-19 pandemic. • Is Covid-safe, preventing the spread of Covid-19 as far as possible with social distancing and hygiene measures. • Have been assessed in terms of equality and accessibility impacts *There should be a detailed communications plan for engaging with patients, both in terms of call and recall and communicating if there are any changes to the delivery plan.*	☒		Increased capacity has been developed within the immunisation team to ensure a safe and effective delivery of the flu programme. Social Distancing is in place across all services
5.5	The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)*	☒		Near patient testing in AAU and ED will take place. Test turnaround time reduced to half hour, which assists in bed management decisions
5.6	PHS weekly updates, showing the current epidemiological picture on Covid-19 and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *PHS and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.*	☒		Weekly distribution of information to key staff

5.7	NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows: • Adults aged over 65 • Those under 65 at risk • Healthcare workers • Unpaid and young carers • Pregnant women (no additional risk factors) • Pregnant women (additional risk factors) • Children aged 2-5 • Primary School aged children • Frontline social care workers • 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household • Eligible shielding households The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This will include regular reporting that will commence from the end of week commencing 12th October. We will adopt a the Public Health Scotland model, which is a pre-existing manual return mechanism that has been used in previous seasons with NHS Boards to collate Flu vaccine uptake data when vaccination is out with GP practices.	☒		
5.8	Adequate resources are in place to manage potential outbreaks of Covid-19 and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☒		Winter plan and escalation plan in place

5.9	Tested appointment booking system in place which has capacity and capability to deal with increased demand generated by the expansion of eligibility and increased demand expected due to public awareness around infectious disease as a result of the Covid-19 pandemic.	☒		Planning in progress to make sustainable
5.10	NHS Boards must ensure that all staff have access to and are adhering to the national COVID-19 IPC and PPE guidance and have received up to date training in the use of appropriate PPE for the safe management of patients. Aerosol Generating Procedures (AGPs) In addition to this above, Boards must ensure that staff working in areas where Aerosol Generating Procedures (AGPs) are likely to be undertaken - such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) - are fully aware of all IPC policies and guidance relating to AGPs; are FFP3 fit-tested; are trained in the use of this PPE for the safe management of suspected Covid-19 and flu cases; and that this training is up-to-date. ***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013). https://www.hse.gov.uk/pUbns/priced/hsg53.pdf***	☒		Covid-19 PPE Guidance shared and adhered to across all areas. Aeroborne precautions are being followed in areas with AGP's

5.11	NHS Boards must ensure that the additional IPC measures set out in the CNO letter on 29 June staff have been implemented. This includes but is not limited to: • Adherence to the updated extended of use of face mask guidance issued on 18 September and available here. • Testing during an incident or outbreak investigation at ward level when unexpected cases are identified (see point 9). • Routine weekly testing of certain groups of healthcare workers in line with national healthcare worker testing guidance available here (see point 9). • Testing on admission of patients aged 70 and over. Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster. • Implementation of COVID-19 pathways (high, medium and low risk) in line with national IPC guidance. • Additional cleaning of areas of high volume of patients or areas that are frequently touched. • Adherence to physical distancing requirements as per CNO letter of 29 June and 22 September. • Consideration given to staff movement and rostering to minimise staff to staff transmission and staff to patient transmission. • Management and testing of the built environment (e.g. water systems) that have had reduced activity or no activity since service reduction / lockdown – in line with extant guidance.	☒		• Adherence with CNO letter of 29th June and updated letter of 18th September. Reminders of practice given at safety huddle by IPCT. • Testing completed at ward level for all suspected outbreaks. • Routine weekly testing as per National testing guidance – oncology, haematology and mental health staff • Over 70's serial testing stopped within Fife. Testing on admission for all patients continues and all inter health board transfers • Covd pathways implemented • Cleaning regimes adhered to and compliance monitored via cleaning sheet and walk arounds. Updated on safety briefs. • Physical distance being adhered to as per CNO letters of 29 June and 22 September • Staff rosta's reflective of covid pathways • Estates montoring all areas

5.12	Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf In addition to this, key healthcare workers in the following specialities should be tested on a weekly basis: oncology and haemato-oncology in wards and day patient areas including radiotherapy; staff in wards caring for people over 65 years of age where the length of stay for the area is over three months; and wards within mental health services where the anticipated length of stay is also over three months. *Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-covid-19-healthcare-worker-testing/*	☒		Robust Staff testing in place and protocols updated to ensure rapid access. Drive-through facility available for staff and mobile testing in place for staff who cannot drive.
5.13	The PHS COVID-19 checklist must be used in the event of a COVID-19 incident or outbreak in a healthcare setting. The checklist is available here: https://www.hps.scot.nhs.uk/web-resources-container/covid-19-outbreak-checklist/ The checklist can be used within a COVID ward or when there is an individual case or multiple cases in non-COVID wards.	☒		Checklist used which would inform local PAG's led by Microbiology for all ward outbreaks
5.14	Ensure continued support for routine weekly Care home staff testing This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results.	☒		Covid Care Home HUB in Place to support staff testing with care homes.

6	Respiratory Pathway *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
6.1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
6.1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☒		The demand for Respiratory Services remain high and a Consultant Nurse post has been developed to focus on treatments that can be supported through our ECAS service or supported at home.
6.1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☒		Part of Community Discharge Model
6.1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☒		Developed a targeted integrated preventative model called High Health Gains, which improves community focussed health and wellbeing outcomes and reduces hospital emergency admissions. This model was trialled within 3 GP practice localities and worked well
6.1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☒		
6.2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			

6.2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*	☒		The Emergency Care Assessment Suite within the Victoria Hospital continues to extend the number and types of patient that can be assessed and treated there. This includes an enhanced range of interventions including DVT, IV Antibiotics/Infusions, Lumbar Puncture and Blood Transfusion.
6.2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☒		
6.3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
6.3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☒		These patients are part of High Health Gain patient group.
6.4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			
6.4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860)	☒ ☒ ☒		

	Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☒		
6.5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
6.5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☒		

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service	☒		
	Nursing / Medical Consultants	☒		
	Consultants in Dental Public Health	☒		
	AHP Leads	☒		
	Infection Control Managers	☒		
	Managers Responsible for Capacity & Flow	☒		
	Pharmacy Leads	☒		
	Mental Health Leads	☒		
	Business Continuity / Resilience Leads, Emergency Planning Managers	☒		

	OOH Service Managers	☒		
	GP's	☒		
	NHS 24	☒		
	SAS	☒		
	Other Territorial NHS Boards, eg mutual aid	☒		
	Independent Sector	☒		
	Local Authorities, incLRPs & RRPs	☒		
	Integration Joint Boards	☒		
	Strategic Co-ordination Group	☒		
	Third Sector	☒		
	SG Health & Social Care Directorate	☒		

Appendix 9: COVID Surge Bed Capacity

Covid Surge Bed Capacity Template

		Baseline ICU Capacity	Double Capacity and Commitment to deliver in one week	'Triple plus' Capacity Commitment to deliver in two weeks	ICU Max Surge Beds	Y - Correct / N Incorrect with comment	Please list assumptions & consequences to other service provision to meeting these requirements
PART A: ICU	Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out	9	20	36	36	**N**- Incorrect. Triple capacity is 26 not 36.	Severely reduced surgical programme – P1-2 with some P3 cancer activity. Elective activity step down required to support staffing (assuming unscheduled Amber demand remains at present levels)

PART B: CPAP	Please set out the maximum number of COVID patients (at any one time) that could be provided CPAP in your NHS Board, should it be required	40	In line with current IPC guidance, CPAP is considered an AGP. Within NHS Fife, AGPs are only conducted either within Critical Care, Theatres, or Ward 51 (LIDU with 10 x -ve pressure rooms). Currently NIV is only conducted in Ward 51. Physically hold a total stock of 40 CPAP capable machines, so could conceivably have up to 40 patients on CPAP if Respiratory (Ward 43) became an AGP area.
PART C: Acute	Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID patients (share of 3,000 nationally), should it be required	322	Excludes critical care. This would be based on all medical wards red, surge capacity open in Wd 6, Wd 10, DIU. ENT, Wd 10, Wd 44, SSSU all convert to COVID from surgical along with all medical wards. Maintenance of surgical capacity for P1 and urgent cancer activity ONLY (AU2 & Wds 52,54,31,33). All other elective surgical activity suspended. All OP activity suspended, all elective endoscopy/DIU suspended. All clinical teams focussed on inpatient care.