DUMFRIES AND GALLOWAY

HEALTH AND SOCIAL CARE
MOBILISATION PLAN

NHS Dumfries & Galloway

DUMFRIES AND GALLOWAY Health and Social Care

Mobilisation Plan for Dumfries and Galloway

DRAFT 2.0

Contents

Introduction

This mobilisation plan sets out the preparedness of the Health and Social Care Partnership in Dumfries and Galloway to achieve our overall **strategic intent of 'minimising excess deaths from COVID-19' within our community.**

Dumfries and Galloway Health and Social Care Partnership has, from the outset of planning for this epidemic, worked operationally as a whole system across Primary, Secondary and Social Care to identify our key risks and challenges and to develop an appropriate response.

At a Tactical and Strategic level, a multi-agency approach has been undertaken across the Health Board, Local Authority, Health and Social Care Partnership, Police Scotland, Scottish Ambulance Service (SAS) and Scottish Fire and Rescue Service, alongside our partners in the Third and Independent Sector to agree plans and priority actions in relation to COVID-19.

This mobilisation plan therefore represents a whole system approach to this unprecedented situation and will continue to evolve as more information/data becomes available to our local system.

At the request of Scottish Government the detailed financial data has been extracted from this narrative and is reported to Health Finance on the prescribed template and will be submitted under separate cover.

1. Intensive Care Unit (ITU) Scale Up

Plans are in place to scale up our Critical Care Capacity. We are currently staffed for 4 level 3 ICU beds. This plan represents a phased approach to providing care to a maximum of 19 ventilated patients through use of a surge area in Stage 1 Recovery area of our Theatres complex.

In summary, our Critical Care Unit (CCU) capacity plans are set out below:

Current	Phase 1	Phase 2 (currently moving into Phase2)	Phase 3
17 ICU / Medical High Dependency / Surgical High Dependency beds; **4 staffed for Level 3 critical care (flex)**	**Provide 4 x additional ventilators in CCU siderooms to support up to 8 x Level 3 patients (could be positive / negative, dependant on workload elsewhere in the unit)** **Trigger point** **In the event of > 4 Level 3 patients, move to Phase 2.**	**In the event of > 4 Level 3 Covid-19 patients in CCU, restrict admissions to Unit ie "closed" ward Model.** **Then open "Recovery – ICU" (in Theatre Stage 1 recovery), running up to 7 anaesthetic machines (supporting between 4-8 Level 3 Covid-19 patients dependent on staffing).** **Trigger point to move to Phase 3 is 8 patients in "Recovery – ICU" and 8 Level 3 patients in CCU.**	**Consider further increase in patient nos in "Recovery – ICU".** **Likely up to 19 ventilated via endotracheal tube and up to 4 ventilated by tracheostomy.** **(7 ventilators; 7 anaesthetic machines; 5 transfer machines)**

The key challenge in delivering such an increased ventilation capacity is availability of a skilled, critical care workforce. Plans are in place to augment critical care trained nursing teams with other registered nurse provision.

Discussion are ongoing around the provision of an additional 10 ventilators for Dumfries and Galloway via Scot Gov procurement which could increase capacity beyond the levels indicated in the current plan. These are potentially available by the end April 2020. This would present significant challenges re staffing.

2. General Bed Capacity Scale Up

Significant progress has been made on the development of the bed surge plan since the submission of the original mobilisation plan on the 18 March 2020.

A five stage surge plan has been developed which expands capacity on a phased basis dependent upon demand levels, with trigger points to ensure preparedness for the next stage, with a detailed implementation plan sitting behind each phase.

Details of phases 1- 3 are described in **Appendix 1**, setting out how we would achieve the bed capacity surges. Dumfries and Galloway Royal Infirmary opened in December 2017 with 100% single rooms. These large rooms give us the opportunity to potentially double the capacity in our general wards. The plan also identifies further surge capacity elsewhere within the DGH.

Whilst this plan has developed significantly over the last two weeks further work is ongoing to review phases 4 and 5, but as a system we are already working towards implementation of phase 2. Phases 4 and 5 are very much theoretical at this point and their requirement as local capacity is very much contingent upon updating the latest epidemiology modelling based on the assumptions around the impact of social distancing which gives rise to significant variability on the bed capacity required.

There are a number of risks and critical vulnerabilities which are summarised below.

Beds

- **Current available additional beds = 66 (26 hired, 20 Estates, 20 from a mothballed service)**
- **100 beds on order; potential delivery date W/C 20 Apr 20**
- **Critical Vulnerability as this enables us only to provide sufficient beds for a proportion of Phase 2 of the plan (B2 and C5 only)**
- **Potential uplift of 107 from other sources**
- **494 extra beds required to achieve Phase 5**

Ventilators

- **Max capacity = 19 at Phase 3**
- **Staffing risks and subsequent quality risks once 16 or more are in use**
- **Current modelling suggests Critical Vulnerability early in Phase 2**

Oxygen

- **Critical Vulnerability for Cottage Hospitals escalating from Ph 2 to Ph 3**
- **Detailed planning for the new hospital which opened in 2017 means that there is currently sufficient oxygen capacity to quadruple the number of ventilators (up to a maximum of 19) and provide oxygen therapy to 600 patients.**

Mortuary

- **Further modelling required based on social distancing impact. Proposals made to SG re further capacity requirements.**

Workforce

- **We have introduced a Deployment Hub across our Health and Social Care Partnership to identify staff in non-Covid19 essential roles who can be redeployed to support front line teams.**

3. Cottage Hospital Utilisation Plan

Introduction:

This plan covers the use of Newton Stewart, Castle Douglas, Kirkcudbright, Thornhill, Annan, Moffat and Thomas Hope Cottage Hospitals. In addition it covers the temporary use of Cresswell (the previous Maternity Hospital based at Mountainhall Treatment Centre) as a COVID Hospital for Nithsdale Locality and the addition of Treastaigh in Annan as a non COVID unit. The full plan is included in **Appendix 2.**

Lochmaben Cottage Hospital will be solely for the admission and transfer of people requiring intensive rehabilitation.

Business Continuity Plans (BCPs) in respect of COVID-19 have been developed individually for each cottage hospital, these focus on maintaining service during the outbreak and give advice and information re hospital layout and infection control precautions and measures. The BCPs were prepared with the expectation to deal with both COVID and non COVID patients in all Cottage Hospitals.

Following discussion with Silver Command it was agreed that the Cottage Hospitals will be designated as either exclusively for COVID-19 patients or exclusively NON-COVID-19 as follows:

COVID-19 COTTAGE HOSPITALS	**NON COVID-19 COTTAGE HOSPITALS**
Moffat Annan Kirkcudbright Newton Stewart Cresswell	Castle Douglas Thomas Hope Thornhill Treastaigh Temporary Hospital Lochmaben (Rehab only)

Escalation:

SUMMARY OF PHASED BED SURGE:

PHASE	COVID	NON-COVID
Phase 1	64	44
Phase 2	92	60
Phase 3	92	69

PHASE 1: IMMEDIATE PLAN

Increase would be 10 beds all COVID at Newton Stewart and Moffat: Commence now, implementation by latest 6/4/2020

COVID 19 COTTAGE HOSPITALS			
WEST		EAST	
Newton Stewart Hospital	22	Annan Hospital	18
Kirkcudbright Hospital	12	Moffat Hospital	12
Total	34	Total	30

NON-COVID 19 COTTAGE HOSPITALS			
WEST		EAST	
Castle Douglas	19	Thornhill Hospital	13
		Thomas Hope Hospital	12
Total	19	Total	25

PHASE 2: AS ABOVE +

Increase would be for 28 COVID19 beds at Cresswell and 16 Non-COVID at Castle Douglas and Treastaigh: we aim for the additional resources to be available during the week commencing 13th April.

COVID 19 COTTAGE HOSPITALS			
WEST		EAST	
Newton Stewart Hospital	22	Annan Hospital	18
Kirkcudbright Hospital	12	Moffat Hospital	12
		Cresswell	28
Total	34	Total	58

NON-COVID 19 COTTAGE HOSPITALS			
WEST		EAST	
Castle Douglas	19+6	Thornhill Hospital	13
		Thomas Hope Hospital	12
		Treastaigh Temporary Hospital	10
Total	25	Total	35

PHASE 3: AS ABOVE ++ (MAXIMUM)

Increase would be another 9 Non-COVID between Castle Douglas and Thornhill and we would aim for this resource to be available during the week commencing 20th April

COVID 19 COTTAGE HOSPITALS			
WEST		EAST	
Newton Stewart Hospital	22	Annan Hospital	18
Kirkcudbright Hospital	12	Moffat Hospital	12
		Cresswell	28
Total	34	Total	58

NON-COVID 19 COTTAGE HOSPITALS			
WEST		EAST	
Castle Douglas	25+5	Thornhill Hospital	13+4
		Thomas Hope Hospital	12
		Treastaigh Temporary Hospital	10
Total	30	Total	39

4. Reducing Delayed Discharges and Enhancing Social Care

Achieving a sustainable reduction in delayed discharges remains a key focus of the Health and Social Care Partnership (HSCP). Significant investment totalling more than £1m has been made prior to the COVID 19 response period to address the challenges associated with addressing the ongoing delays. This investment has resulted in a 15% increase in capacity of our in-house care at home service (CASS) resulting in an additional 22,000 hours of care at home provision in the coming year. In addition, the HSCP has funded a 25% increase in capacity within our reablement service (STARS) resulting in an additional 250 individuals being supported through our 6 week reablement programme. We have also been working closely with our independent sector providers to introduce block contract arrangements where appropriate to increase capacity.

We review delayed discharge cases on a daily basis at both an acute and community level.

The Flow Management Team focuses on discharging or moving the delays to create capacity across the system. This team is made up of staff across the partnership including the independent sector. The action plan from this team is being progressed. Work being undertaken across the Partnership will aim to deliver a reduction in delays from 43 to 18 by end March 2020 and to 5 delays (complex AWI delays) by end April 2020.

Care Home placements – We have suspended the local 30 mile criteria within the choice guidance for care home placements to enable us to discharge people from a hospital setting by maximising the use of all current vacancies across the region. Two of our Care Home providers are recently out of a moratorium status; this is where most of our vacancies are. To enable us to utilise these vacancies we will admit carefully and with caution, with risk factors at the forefront, ensuring that we have additional support for the provider to allow them to do this; this support will come from the partnership in various ways e.g. exploration of non-essential staff and retired health and social care staff, extra support from community nursing teams. Work is well advanced to ensure that all delays awaiting a care home placement are in the process of moving or have been moved into placements. We have increased placements by 30 at a cost of £566k per annum. We propose to pay our Care Home providers an additional administration fee to support the additional movement and placement of individuals across the region at a cost of £19k over the next 12 months.

New individuals who come into hospital and require assessment for long term care will be moved to a care home environment and assessed by a social worker within 72 hours of the move.

Care at Home – It is recognised that this is an unprecedented time and acknowledging the operational crisis a reconfiguration of existing care packages is being undertaken to release capacity within our social care service to be able to respond to situations where there is no alternative. These changes will only be implemented following a robust assessment of risk for each individual care package. This will ensure that finite capacity is directed at supporting individuals most at risk and enable the Partnership to focus released capacity on those individuals affected by Covid19.

Support will continue to be provided to those needing personal care but will be at a reduced level to keep people safe. This will only be following a assessment of risk. The provision of additional support elements will be available as required to enhance the personal care elements of individual care packages.

The impact of Covid-19 is already significantly affecting our social care staff with staff absence across our care at home provision currently sitting at 17.15% collectively and 30% for in house home care services (**5,485** hours lost for w/c 30/3/20).

We have already increased our in-house care team to cover losses of staff availability due to self-isolation by 279 hours at a cost of £340k over the COVID 19 period.

We have undertaken significant work to increase volunteer capacity which has been focussed through the arrangements to support non personal care, such as filling the support roles, delivery of required groceries, medicines, and hot meals, with the priority for complex care provided in people's homes from our existing care teams. We are acutely aware that we have high number of citizens willing to volunteer, however, we need to be mindful of what we are asking and requiring them to become involved with. Personal Care is one area which a significant number of volunteers have indicated they are unable or unwilling to be part of.

Whilst we can never eliminate risk, we are confident that the decisions we have taken as described above minimises the risk and allows us to make professional judgments on the best way to meet the complexity of the delivery of care at home and continue to deliver reconfigured care packages to our most vulnerable which will continue to meet their needs and keep them safe.

We are working closely with our independent providers and our own in-house service. We are collating data and mapping where people in receipt of care and those delayed awaiting care are in the region to assist with the range of responses being prepared to meet the needs of the most vulnerable during this period.

We are continuing to pay providers when an individual is admitted to hospital in order that the care can be redistributed and made available for discharges. This will cost an additional £113k over the COVID response period. We have increased care in the community from hospital and community hospital settings by 120 hours at a cost of £81k over the COVID 19 period.

We are working with all partners to consider ways in which staff resource can be shared across the region for Care Homes and Care at home providers. We have asked all staff within the Partnership to provide details of their skills and experience (including those not working in front line roles) and have initially asked for expressions of interest from staff to be redeployed into social care roles. Non-essential staff will be deployed to do other types of work. This work has commenced this week.

Work is being undertaken with the third sector and a separate sub group has been formed and chaired by a Commissioning Manager. This work will feed into what the third sector can do to support people being discharged from hospital and in the community. It will also link with groups of individuals who are setting up volunteer groups on social media as well as link to the Community Cohesion Cell within the council which is co-ordinating activity across the region.

We introduced a Home for Assessment model on 23rd March 2020 to manage new patients in hospital or coming into hospital. Only assessments for very frail or palliative patients will be assessed in hospital. For this model to be sustained there will be an additional cost of £435k for recruiting health and social care support workers over the COVID 19 period.

In addition, a review of our admission/transfer criteria to cottage hospitals is being undertaken. Only individuals who are requiring rehabilitation that cannot be delivered at home would move to an identified cottage hospital. This will also include palliative individuals whose needs cannot be met at home. This currently would not include guardianship cases. All possible measures are being taken locally to address the challenges in relation to delays of individuals with incapacity (AWI). Section 3 of this mobilisation plan details the proposed use of all of our cottage hospitals during this pandemic.

We have instigated a public engagement programme with our community to keep them informed of changes to social care provision as a result of COVID-19. This engagement programme has been well received.

We are suspending the use of CM2000 during this epidemic for payment purposes. This will, in effect, lead to the Partnership paying for 'committed care' rather than 'actual care delivered' and will lead to flexibility in use of capacity from Providers. This will cost an additional £754k over the COVID 19 period. We will utilise the real time monitoring information the system provides to ensure our cared for people continue to receive care that keeps them safe.

We are also working closely with our local Carers Centre to ensure plans are in place to support unpaid carers across our Partnership and that they have access into the resources within the Community Cohesion cell to ensure delivery of essential supplies.

We have suspended non-residential community care charges as there is likely to be disruption in delivery of non-personal care. This will cost £1,178k over the COVID 19 period in addition to the risk around delivery of savings assessed at £1,015k.

These proposals are fully supported by the both the NHS and Local Authority Chief Executives and the Chief Social Work Officer.

5. Community Assessment Hub

Guidance from Scottish Government directed the establishment of a community assessment hub to provide a pathway for those experiencing moderate to severe symptoms associated with Covid-19, particularly those with underlying conditions, are likely to need rapid access to acute care.

It is therefore vital that a dedicated pathway is designed, developed and delivered to enable those with mild to moderate symptoms to safely manage at home, with appropriate access to advice and support.

Guidance from Scottish Government has clarified that this pathway should begin with patients being directed to NHS 24 for initial triage and that those who cannot self-manage at home will be passed on to a local hub and assessment centre.

The hub runs 24/7 and handles all calls from NHS 24, with the Senior Clinical Decision Maker providing secondary triage, further advice on self-management and scheduling of face-to-face assessment where the presenting symptoms meet the specified criteria.

Two assessment centres and a home visiting service will also run 24/7, offering the capacity necessary to provide face-to-face physical assessment of patients based on an agreed protocol.

The hub will also provide targeted, telephone follow-up to those who have been assessed by telephone or in the assessment centre and where it has been determined that their condition is likely to worsen.

The creation of this pathway will support individuals with mild to moderate symptoms, who would otherwise self-present to the Emergency Department or General Practice, to access dedicated advice, support, assessment and treatment planning.

Without such a sustainable pathway being in place prior to the predicted increases in Covid-19 activity, there is a real risk that demand for assessment and treatment planning will default to individual GP Practices and the Emergency Department and that these services will quickly struggle to cope with the anticipated increased activity.

The hub was operational on w/c 23 March 2020 and in the first week of operation triaged over 200 calls with 99.5% of cases managed within the community. The costs are reflected in the financial framework with the detailed pathway set out in **Appendix 3.**

Skillmix for the East Assessment Centre

It is anticipated that the East Assessment Centre will see around 1 patient per hour through until the end of April 2020, with activity estimated to increase on site to up to 7 patients per hour towards the end of May and the likely peak in mid-June 2020. The demand profile is then expected to reverse along a similar trajectory through until early August 2020.

A full clinical assessment will is expected to take approximately 20 minutes, inclusive of time to put on and take off PPE and to write up notes. There will also be a need for down-time during each six-hour shift. On that basis, and recognising the need for some down-time for staff during their working period, each member of the assessment team will be able to see a maximum of 3 patients per hour, which would equate to between 10 and 16 patients per shift, depending on shift length.

This assumption will need to be tested during the initial days and weeks of operation and if it holds true, then the following staffing model proposed by Scottish Government would be likely to meet the demand in Dumfries and Galloway up to and including 20 April 2020:

- 1 administrator
- 1 non-clinical call handler
- 1 chaperone
- 2 drivers
- 1 domestic
- 3 Clinical Assessors (Nurses – Band 5 or above, or other trained Healthcare Professionals)
- 1 senior decision maker (General Practitioner, Consultant or Advanced Nurse Practitioner)

Plans may need to be developed between now and the middle of April 2020 to increase staff capacity, in line with learning from the initial weeks and revised demand projections.

The guidance from Scottish Government confirms that the senior clinical decision-making role can be undertaken by the following professionals:

- Respiratory clinicians
- Respiratory CNSs (Primary and Secondary Care)
- TB nurses
- Emergency Department Band 6+ nurses
- Acute medical / Emergency Department doctors
- GPs
- Advanced Nurse Practitioners
- Paediatric assessor

West Covid-19 Assessment Centre

Further, work is underway to create an assessment centre co-located with the Out of Hours Service and Emergency Department at the Galloway Community Hospital. This site will also operate 24/7.

Dedicated space for the Assessment Centre will be created within a self-contained section of the out-patients area. This will offer three consulting rooms designated for sole use by the West Covid-19 Assessment Centre team, served by a dedicated entrance to maintain entirely separate patient flows.

6. Whole System Responses

Dumfries and Galloway has a long history of working in a multi-agency way to address challenges we face, particularly in times of crisis. Planning for COVID-19 has taken place at an operational level across the entirety of the Health and Social Care System (incuding Acute Services, Primary Care, Community Health and Social Care and Mental Health). At a tactical and strategic level, a multi-agency approach has been adopted with involvement of Health, HSCP, Local Authority, Police Scotland, Scottish Fire and Rescue Service alongside our third and Independent sector partners.

Our major incident plan has fully activated with appropriate arrangements in place at bronze, silver and gold command levels. The activation of our plan is intended to deliver our strategic intent of **minimising excess deaths from COVID-19 within our community.**

The command and control structure is set out in **Appendix 4.** This is currently under review as we move into the response phase of the pandemic.

The Health and Social Care Partnership has devised an action plan which provides the full detail of our mobilisation, this includes current action being taken in relation to:

- Communications
- Public Health including testing arrangements
- Infection Control
- Emergency Care Centre
- Critical Care
- Diagnostics, Mortuary and Imaging
- Downstream beds
- Elective care
- Support services
- Day Care
- Care at Home/Care Homes
- Cottage Hospitals
- Primary Care
- Out of Hours
- Mental Health
- Women and Children's Services
- E Health
- Facilities
- Pharmacy

The Tactical Local Resilience Partnership (chaired by the HSCP Chief Officer) has membership from Health, Local Authority, Police, Fire, SAS, Third and Independent Sector and has established 5 cells focused on priority areas of work. These include:

- Excess Deaths cell
- Workforce cell
- Estates and Infrastructure cell
- Community cohesion cell
- Communications cell

The HSCP Chief Officer is the NHS Board Exec Lead for Shielding. Shielding plans are being lead through the Tactical LRP with arrangements in place for patient identification, communication, triage, assessment and fulfilment of needs.

The Strategic Local Resilience Partnership is chaired by the NHS Board Chief Executive.

In addition, the public sector bodies locally are working to streamline committees and change Board and governance arrangements to ensure professionals are focused appropriately on COVID-19.

We have reviewed business continuity plans and introduced Standing Financial Instructions (SFIs) waivers to streamline purchasing.

7. Appendices

Appendix 1 – Bed Surge Capacity

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Appendix 2 – Cottage Hospitals Utilisation Plan

CHSC COVID-19 Community Hospital U

Appendix 3 – Community Hub Assessment Centre

Community Hub Assessment Centre.d

Appendix 4 – Command and Control Governance Structure

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Appendix 5 – Social Care mobilisation template

Appendix 5 - Social Care Mobilisation Ten