National Clinical Guidance for Nursing and AHP Community Health Staff during COVID-19 Pandemic

Version	Published	Summary of Changes
v.1.0	7 April 2020	
v.1.1	8 April 2020	Changes made to Section 6 re: PPE
v.1.2	9 April 2020	Addition made to section 6 – link to joint statement from SG, COSLA and SJC Unions agreeing that the 4-nations PPE guidance being the official and fully-comprehensive guidance on PPE use.
v.1.3	17 April 2020	Changes made to section 5.3 re: assessment and decision making Section 6 – Community Children's Nursing added Clarification added to Annex 4 relating to health visiting, school nursing and Community AHP services Disclaimer made regarding version control when the document is printed ACP link update at 10.7. Additional helpful links added in Annex 2

N.B. - This document is uncontrolled when printed. Before use, check the Scottish Government COVID-19 Guidance page to verify this is the current version

INDEX

This guidance is for ALL NHS staff working in community and Health and Social Care Partnerships (H&SCPs) during COVID-19. This guidance may also support planning and prioritisation of the workforce as part of the community and Primary Care resilience response.

This guidance will be updated regularly, so please ensure that you are checking this page for the most up to date version of this guidance. If you have any queries or comments about the guidance, please contact CNOD.Covid-19@gov.scot.

1. Purpose

1.1 Community clinical staff, namely Nurses, AHPs (referred here-in as the clinical team) alongside General Practice and Pharmacy colleagues are critical not only to maximise the community resilience response within this pandemic. They are also fundamental to enabling a whole system approach in reducing the impact on hospital acute services.

1.2 To support more care in the community it is essential to maximise the knowledge, skills and competencies of this group of staff, working in a fully integrated way. This guidance focusses primarily on the clinical team, within the context of integrated teams including social care services, such as care at home and care homes (Annex 2 contains useful links to other guidance).

1.3 To highlight the importance of integrated team work and effective communication among community and primary care teams, ensuring clinically coordinated delivery of care.

1.4 To support NHS Boards and Health and Social Care Partnerships (H&SCPs) in the planning and prioritisation of care within Children, Adult Community, Mental Health and Learning Disability services (please refer to Annex documents).

1.5 To ensure that NHS staff working in the community, including those working in H&SCPs have access information that informs and supports clinical practice at this time. This guidance will also ensure clinical leaders and service managers are equipped with the necessary information they require to inform resilience and decision making.

1.6 To support community and health care teams to prioritise care, support the most vulnerable and those identified as being at *risk* or *very high risk* groups who are self-isolating and being shielded. Information about these groups can be found on the NHS Inform website.

1.7 To recognise that the health and wellbeing of staff working in community settings is critical at this time, both in the immediate, short-term and the long-term, looking towards the future as we recover from this pandemic.

1.8 All of the above has the overarching aim of caring for people wherever possible and safe to do so within an integrated community context, alleviating pressure on acute services.

2. COVID-19 Presentation

2.1 Novel Coronavirus (COVID-19) is a new strain of coronavirus first identified in Wuhan, China. Clinical presentations may range from mild to moderate illness to pneumonia or severe acute respiratory infection.

2.2 The most common symptoms of the Coronavirus are fever, tiredness and a dry persistent cough. However some people also experience a sore throat, running or blocked nose, muscle aches, stomach upset and/or reduced taste or smell.

2.3 **Note**, for some older people living with frailty their presentation when unwell may be very different to younger people, they may present with declining function, for example falls and/or confusion.

2.4 If a child has symptoms or is unwell then parents/carers should be directed to NHS Inform COVID-19 pages. Parent Club also has helpful information for parents.

2.5 Where people are self-isolating due to risk of infection or potential infection external visitors should be reduced or stopped. Visits from health and social care staff that are deemed essential will need to be prioritised according to each individual's need and risk. These will be required to be risk assessed, prioritised and co-ordinated by the clinical team in a way to reduce footfall.

2.6 The following are sources of online advice for patients and clinicians relating to COVID-19:

- NHS Inform
- Health Protection Scotland (HPS)

There are a number of different sources of advice for patients and clinicians and they can be found in **Annex 2**.

NB Guidance on the use of PPE can be found on the HPS website.

3. Wellbeing Information for community healthcare staff

3.1 During COVID-19, information on self-isolation and shielding for health and social care staff in the at risk or high risk groups can be found on the NHS Inform website. Staff concerns should be discussed with their manager and occupational health.

3.2 We recognise that this is a very stressful time for staff and their families. Claire Haughey MSP, Minister for Mental Health wrote to NHS and Social Care staff

on 26 March 2020 about mental health and wellbeing support during the COVID-19 pandemic. Information and resources provided by her can be found in **Annex 3.**

4. Management and prioritisation of community essential clinical care during the COVID-19 Pandemic – key responsibilities

4.1 Senior clinical staff should lead and co-ordinate care ensuring liaison with General Practice, Social Work, Social Care management teams, and secondary care physicians as appropriate. This is applicable to both children and adult services to ensure a whole system response.

4.2 It is the responsibility of H&SCPs working with NHS Boards, Local Authorities and Primary Care to ensure a collective community response. This must include prioritisation of care in the community and appropriate mobilisation of staff to reduce the impact on acute services, together with co-ordinated support enabling effective and timely discharge from hospital.

4.3 **Annex 4** sets out the prioritisation of essential care in the community for professional groups covering children and adult services. Extensive work has been done to identify what should be stopped, continued and started during the pandemic. Community resilience plans will require to be frequently reviewed and risk assessed to maintain a proportionate response as the pandemic progresses.

4.4 The community response to this pandemic is likely to require individuals and teams to work flexibly, whilst ensuring appropriate use of skills and competencies. To meet the needs of all patients in community settings we expect H&SCPs in collaboration with NHS Boards, Local Authorities, and Primary Care to increase all staff to meet demands. Community workforce resilience plans should indicate how regulated staff (including returners and students), Health Care Support Workers, administrative staff and voluntary workers will be deployed to cover services 24/7.

4.5 Community nurses and AHPs work at senior practitioner and advanced practitioner level. These professionals are competent decision makers, many of whom have additional skills and training in **advanced clinical assessment, prescribing and confirmation of death**. This group of staff should work alongside general practice and secondary care e.g. hospital at home teams, virtual ward and psychiatry, to support more care in the community including **anticipatory care planning**, **urgent and end of life care**.

4.6 The community response must include the acceleration of anticipatory care planning for those within the **at *risk* or *very high risk*** groups with complex physical and mental health care needs across adult and children's services. This group of staff should be utilised to support the requirements for monitoring of long term conditions, supporting self-management and keeping people well at home. Information about the risk categories can be found on the NHS Inform website.

4.7 These plans must include how care at home staff and care home staff can quickly and effectively access the community clinical and Primary Care team as

necessary. These plans should also include mechanisms for supervision of home care staff by registered community practitioners should this be required.

4.8 Clinical teams should work with and support individuals, their relatives/paid and unpaid carers ensuring they continue to receive essential care and treatment that also incorporates positive mental health and wellbeing advice and support. Staff must continue to document decisions made, including how often they will be reviewed and the timescales for this, ensuring that contact information is available to relatives and carers should they have concerns.

4.9 To minimise the number of health and social care contacts to those most at risk, self-isolating or being shielded, local agreement and co-ordination across Health and Social Care teams is imperative. Families and carers may be required to take on additional roles previously undertaken by registered nurses, where it is appropriate to do. This will require appropriate delegation and staff acquiring new skills in order to maximise workforce impact and efficiency. Where care is delegated to families or others during this pandemic it is important that there are systems in place to ensure that any change to risk is monitored and documented. We are currently adapting the Northern Ireland delegation framework which we are adopting for use in Scotland.

4.10 Members of the clinical team, care home and care at home managers should work closely to ensure that teams are aligned, ensuring all essential care is provided. Processes for seeking assistance should be streamlined and seamless, adopting a 'one team approach' where possible. Good communication across teams is essential.

4.11 NHS Boards and H&SCPs should support teams to utilise digital solutions and technology such as telephone and various Apps, to enable the individual to maintain contact with family, friends and clinicians, minimising their isolation and unnecessary visiting and footfall. Increasing the use and availability of technology has the potential to increase workforce capacity and capability, whilst also improving communication.

4.12 **NHS Near Me** technology has been rolled out to all GP practices. Community teams and provision of care would also benefit from this technology, including access to seeking clinical opinion and remote monitoring.

4.13 At times both adult services and necessary children services (see **annex 4**) may be visiting a home: to reduce footfall in the home it is important that these are co-ordinated. Where possible care should be provided by **one** professional. Information about data sharing during the COVID-19 pandemic can be found on the Information Commissioner's Office website.

5. Children and Young People

5.1 Safety measures in relation to COVID-19 have restricted social mobility and therefore reduced the visibility of children and young people. Consequently, it is

imperative to carefully consider priority visits, contacts and assessments of children and young people across Scotland.

5.2 Staff and services should adopt a proportionate universal approach and further information to support practice within this is detailed with **Annex 4** of this guidance.

5.3 **Annex 4** also provides guidance in relation to interventions that can be stopped, undertaken in a different way, which will be based on professional assessment and decision making, and also those that should be continued at this time, wherever possible. Rapid innovation may be required to optimise any contact: this may involve undertaking other tasks whilst remaining within professional scope of practice, in order to minimise footfall.

5.4 Health Visitors and Family Nurses exercising the function of the named person on behalf of their Health Board/H&SCP will still be required to be available and responsive to parents to promote, support and safeguard the wellbeing of children and young people. This should be in the context of the family structure and dynamic, recognising that previously stable adult relationships may deteriorate unpredictably due to the need for all families to remain in close proximity. Supplementary national child protection guidance was published on 31 March 2020 and can be found on the Scottish Government website.

5.5 It is important everyone involved with children and family services remain vigilant to changes of service provision by partner agencies and the potential impact of this on children and their families, for example the recent closure of schools. Young carers (most often school age) will also benefit from ongoing contact, to ensure they receive any support they require and ensure their own health and wellbeing is prioritised.

5.6 As we know, women and unborn children can encounter increased risks during pregnancy, and midwives working within both acute and community settings are central to early identification of increased need and risk. At this time, maternity like other services may be stretched and therefore collaboration and support from other disciplines will be essential. A guidance document specifically for maternity services is being developed, and a link to it will be provided here once it is available.

5.7 It is important to highlight pregnant women may also be under significant additional stress following the guidance to self-isolate, this would be true for both first time mothers and those who already have children.

5.8 It is critical that health staff remain vigilant and supportive of potential need for support and/or increasing needs, particularly in relation to new born children, infant feeding, children and young people who may be Care Experienced, Looked After, have mental health issues, complex health needs or life limiting conditions. Further guidance is contained in **Annex 4**.

Infant feeding

5.9 During this pandemic it is essential to the health of mother and baby that Infant Feeding Services throughout NHS Boards continue to be delivered. These minimal standards of care will protect the establishment and maintenance of breastfeeding and safe formula feeding, ensuring optimal health outcomes. More detailed information about the Infant Feeding Pathway published on 31 March can be found on the Scottish Government website.

5.10 All mothers and babies, however they are feeding, should be enabled to stay together where possible, to have skin-to-skin contact, to feed their baby responsively and to have access to ongoing support when required. Sensitive conversations can facilitate understanding about the value of continuing breastfeeding during the COVID-19 outbreak. All mothers should be supported to maximise breastmilk intake and more information on how to achieve that can be found at UNICEF UK.

5.11 There is currently no clinical evidence to suggest that the virus can be transmitted through breastmilk. Infection can be spread to the baby in the same way as anyone in close contact. However, the benefits of breastfeeding outweigh any potential risks of transmission.

Care Experienced and Looked After Children

5.12 NHS Boards are Corporate Parents and have a responsibility to continue to assess and respond to the health needs of children and young people who are Looked After, given their greater risk of poorer health outcomes.

5.13 Due to COVID-19 social restriction there is likely to be increased stressors on families, including the families of Looked After Children and particularly those looked after at home/kinship placements.

5.14 During these unprecedented times all health professionals working with children and young people must continue to base their judgments on the best interests of the child or children that they have responsibilities toward.

5.15 Accepting the need for reduced or different methods of service delivery at this time, and in line with staff COVID-19 safety measures, CEL 16 assessments should still be undertaken. These are essential and have the advantage of incorporating an assessment of the individual's mental health. Other interventions deemed necessary should be based on professional assessment and judgement, prioritising needs and support and whether or not they require to be face to face or via telephone contact etc.

6. Community Children's Nursing and Allied Health Professional Services

There is recognition that children and young people are also vulnerable to Covid-19 due to long-term or chronic health needs. It is important to highlight that those with

complex health need must be shielded now. This is a priority group and more detailed guidance will follow.

7. Minimising the spread of COVID-19 (Infection Control and Prevention)

7.1 Many community health and care workers provide care to those in the at 'high' or 'very high risk' groups who require essential/necessary care. Information and guidance regarding caring for people within the community or residential settings and the use of PPE in this context can be found on the HPS website. This is applicable to all health and care staff.

7.2 The UK Government has issued 4-nation guidance around personal protection equipment (PPE) which should be worn by health and social care staff in the context of the current COVID-19 pandemic, which can be found on the Public Health England (PHE) website. This setting-based guidance has been updated to reflect the pandemic evolution and recognises ongoing transmission within the community and that some people may not always display recognised symptoms of COVID-19. The guidance also recognises high risk procedures in which the virus can become aerosolised called Aerosol Generating Procedures (AGPs). A list of AGPs can be found at Section 8 of the 4-nation guidance on the PHE website.

7.3 Additional considerations which are over and above the normal standard infection control and transmission based precautions based on sustained transmission of COVID-19 within the community ask that health and care staff who have direct contact patient/client and are not able to social distance (>2 m) should undertake a risk assessment around PPE. This risk assessment would be based on anticipated contact with splashes of blood or body fluids which poses a risk to themselves. Based on that risk assessment, a single use apron, gloves and fluid resistant surgical mask and eye protection would be worn on a sessional basis. Sessional use is described as a period of time where a health or care worker is undertaking duties in a specific care setting. The session ends when the health or care worker leaves that care setting e.g. a person's home. PPE should be disposed of prior to leaving the setting and hand hygiene performed. However, it is recognised that risk assessment is not always possible and therefore a fluid resistant surgical mask, eye protection and single-use apron and gloves can be worn.

7.4 Wherever possible, people receiving home visits or attending a community clinic should be asked to contact the services in advance, should they have developed any symptoms or there is any change in their condition. Patients should have a contact number to call to enable an assessment by a health professional prior to the visit.

7.5 Where a patient is suspected to have COVID-19 a telephone consultation or other technology (FaceTime, WhatsApp etc.) should be used to assess the patient. Where a face to face visit is assessed as being necessary, PPE should be worn as per HPS guidance.

7.6 CPR - The procedure of CPR , that is chest compressions and defibrillation, is not classed as an APG. However, where an airway is established (endotracheal intubation), then this would be classed as an AGP and a face filtering piece (FFP) mask must be worn. Those requiring FFP face fit testing in the community will be identified by the NHS Board. Information regarding this is available on the PHE website.

7.7 Aerosol General Procedures – The highest risk of transmission of respiratory viruses is during AGPs of the respiratory tract and the use of enhanced respiratory protective equipment is indicated for health and care works (see 6.6 above). Subject to a local risk assessment, the same precautions apply for all patients regardless of whether they are suspected or confirmed COVID-19. Where and AGP is a single procedure, all PPE should be single use. A list of AGPs can be found at Section 8 of the 4-nation guidance on the PHE website.

7.8 Self-isolation - This is undertaken by those people who either have symptoms of COVID-19 which include new continuous cough and/or high temperature of > 37.8^{o}C OR they are a household contact of someone who is displaying these symptoms. Someone who has symptoms should self-isolate for 7 days from the onset of symptoms. Household contacts should self-isolate for 14 days (from the day the first person in the household became ill). Information on this is available on the NHS Inform website.

7.9 Social Distancing: This measure reduces social interaction between people in order to reduce the transmission of the virus. It is intended for those situations where people are living in their own homes with or without additional support from friends, family or carers. Information on this is available on the NHS Inform website. Social distancing also applies to those people in higher risk groups such as people aged over 70 and pregnant women. Information about these groups can be found on the NHS Inform website.

7.10 Shielding: This is for people who are at extremely high risk of severe illness from COVID-19. Shielding measures must be used when an extremely vulnerable person is living in their own home, with or without additional support. The UK 4-nation PPE guidance give specific information on the appropriate PPE which must be worn by health and care staff who are caring for those individuals who are undergoing shielding. This PPE includes single use apron, gloves and surgical face mask. Information on which people are in this category and what to do are on the NHS Inform website.

7.11 Access to the UK 4-nations PPE guidance can be found via the HPS website. A joint statement from the Scottish Government, COSLA and the SJC Unions on PPE Guidance can be found on the Scottish Government website.

8. Community Pathway for managing COVID-19 in Scotland

8.1 In response to the growing number of COVID-19 cases a community pathway has been developed and implemented by all NHS Boards on the 23rd March. There

are two parts to the community pathway for COVID-19. Firstly, the COVID-19 triage Hubs (telephone triage via 111) then COVID-19 assessment centres (face to face assessment) will run 24/7.

8.2 The community pathway applies to all groups including children, pregnant women, older people and people with mental health and learning disability.

8.3 It is important that there are links with the community COVID-19 triage hubs to provide professional to professional advice for clinical staff caring for people with symptoms at home/care home.

8.4 It is also important that for those who have attended assessment centres and are able to be managed at home, community arrangements at the time of discharge must be in place for follow-up.

8.5 Those who are well enough to be discharged from hospital, having been treated for COVID-19, should be supported with a discharge plan outlining continued clinical care need.

8.6 The Community pathway for managing respiratory tract infection/possible COVID-19/definite COVID-19 can be found on the SHOW website. The Community pathway for managing COVID-19 in Scotland during delay phase can be found on the SHOW website. The letter issued to GPs following the announcement that we had entered the Delay phase for COVID-19 can be found on the SHOW website.

9. Provision of Holistic Care during COVID-19 Pandemic

9.1 Whether an individual has a physical health care condition and/or a mental illness, it is likely that their levels of anxiety and stress will increase during the pandemic. It is therefore essential that all health, social work and social care staff work together taking a holistic approach to each individual's care ensuring both their physical and mental health needs are met. This will require clinical community Mental Health and Learning Disability teams working alongside all community disciplines to meet the needs of their patients and vice versa.

10. Anticipatory Care Planning (ACP) during COVID-19 Pandemic

10.1 Older adults and those living with existing health conditions, such as diabetes, heart and lung disease, and frailty or are immunosuppressed are already at higher risk of dying from infections and other health problems and may be particularly vulnerable to becoming seriously unwell from COVID-19.

10.2 Healthcare professionals in Scotland should continue to find out what is important to people and their families, and should work with them to deliver personalised care. They should continue to listen to the people they care for, and make sure they have the opportunity to discuss their options and are fully involved in the decisions about their care and treatment.

10.3 This is an opportunity for members of the clinical team to have conversations with individuals, their carer's and loved ones about the type of care that they would like to receive should they become unwell. These conversations can be extremely difficult to begin; however, they are important and can be immensely helpful to patients and their families particularly at times such as this.

10.4 General Practice has recently been tasked with identifying all people registered with them who are in high or very high risk categories, including those who are being shielded. Some of these people will be receiving the majority of their care within Secondary Care. It is important that where possible, it is someone who knows the person who undertakes the ACP conversation.

10.5 Community and Secondary Care resilience plans should include how clinical staff are aligned to support the scale up of ACP implementation at this time. It is important that there is effective communication between teams.

10.6 Where individuals initiate conversations with carers or community team members, it is important that conversations are supported with a member of the clinical team who are confident and competent to do so, bearing in mind that this is skilled, challenging and ethically sensitive work. The person undertaking these discussions should have knowledge and understanding of all the implications of all the treatment options available for the individual.

10.7 Clinical team members will often have a lead role in supporting General Practice to identify and develop an electronic Key Information Summary (eKIS) and ACP. It is important that the clinical team establishes if a patient already has an eKIS and whether or not this requires to be updated/created. The eKIS is stored on the GP system, either EMIS or Vision, or in some Boards, may be on Trak-Care.

10.8 Healthcare Improvement Scotland have recently updated their ACP template. This should be used when completing an ACP. Once complete a copy should remain in the persons home/care home and a copy sent on a word document to the practice for updating information on eKIS around chosen place of care and place of death. The ACP information is stored on the notes section of the eKIS, this has limited word space therefore key information should be specific.

10.9 As part of the ACP, a frailty assessment and score, using the Frailty Tool on the iHub should be considered and undertaken where appropriate.

10.10 People for whom it is appropriate should have in place other documentation and provision such as 'Do Not Resuscitate' or Just-in-Case medication prescribed. You can find guidance on this on the Scottish Government website.

11. Recognition and Management of deteriorating patients at home or residential care home

11.1 If a patient with suspected COVID-19 condition is deteriorating families and carers should call 111 for advice.

11.2 It is imperative that staff have the right equipment in order to enable them to identify and diagnose individuals who may be deteriorating within community settings, at home or in a care home.

11.3 For those who have been discharged from the COVID-19 respiratory assessment centre to home, there should be clear guidance about the community arrangements in place for follow-up undertaken at the time of discharge. **Note,** further information will be available on clinical pathways and assessment criteria.

12. Palliative and End of Life Care Community Services during COVID-19 Pandemic

12.1 Where a patient who has an up-to-date ACP stating a preference to be cared for or die at home or in a care home becomes seriously unwell with COVID-19; then a plan of care should be agreed with the General Practitioner and/or the Palliative Care team, working alongside relevant social care teams and families, in line with local and national guidance that can be found on the Palliative Care Guidelines website.

12.2 Clinical and social care teams must be mindful that as a result of isolation measures, in some instances individuals may be on their own without family or friends. It is therefore imperative that staff caring for the person considers the individual, the family and their own emotional support at this time.

12.3 It is important that Health and Care staff providing palliative and/or end of life care within the community during COVID-19 pandemic have access to appropriate medication, equipment and PPE. This should be available 24/7.

12.4 To ensure continuity of care, it is important to check that all patients whose illness requires them to need palliative and/or end of life care during this period are also on the GP register for Palliative Care.

13. Public Protection and safeguarding during COVID-19 Pandemic

13.1 The COVID-19 pandemic and the introduction of safety measures such as social distancing, isolation and shielding may increase anxiety and pressure on individuals, families and communities. We know that some children and adults will continue to experience abuse and/or neglect and anticipate a likelihood of this increasing due to the pressures and constraints families and communities are currently facing.

13.2 While we must all continue to prioritise COVID-19 directives, it is vital to be aware that many individuals and families, particularly the very young and older people, are not as visible to staff during this time. With this in mind, it is essential that all health staff continue to discharge their duties in respect of Public Protection. This means continuing to work with and alongside partners to protect anyone who has additional need or may be at risk of harm, physical, emotional and financial. Boards must ensure these arrangements are maintained throughout the pandemic.

13.3 It is important to note that other family support services, particularly from third sector, will most likely have reduced access/capacity at this time, potentially increasing family and community stressors. Third sector organisations often provide significant support for some individuals, families and communities. It is therefore important to highlight that many, as a result of COVID-19, have reduced access and capacity to support.

13.4 Agencies and services are receiving advice and/or supplementary guidance on minimising footfall. A priority is to maximise the impact of community services and avoid hospital admissions wherever possible. However, health staff and their services must also continue to remain vigilant in their responses to Public Protection and safety and to promptly share any concerns with the statutory agencies, as per local and national guidance.

13.5 It is important that all staff remain aware of their Public Protection responsibilities and duty to raise concerns about children and vulnerable adults during this time.

14. Regulation and Delegation

14.1 It is recognised that staff may be deployed to work in areas out with their normal area of practice, and every member of staff should ensure that any role they are asked to undertake is within their sphere of competence. Temporary members of the workforce are being engaged to support continuation of services, such as senior students coming in as healthcare support workers and returners to the emergency register.

14.2 Registered staff are expected to provide adequate supervision and support to these team members who will be joining the service at a very stressful time. The professional regulatory bodies have issued a joint statement to reflect that we are all working in extraordinary times and the impact this will have for regulatory functions can be found on the Nursing and Midwifery Council (NMC) website for Nurses and the Health and Care Professions council (HCPC) website for AHPs.

14.3 Of particular importance to NMC registrants, has been the decision from the NMC that it will extend the deadline for revalidation by three months to your scheduled date for revalidation and this may be extended further. Updates are available on the NMC link above.

14.4 Nurses and AHPs will be expected to comply with their professional Codes and this includes safe delegation of care. Clinical team members must comply with the professional bodies/codes for safe delegation. There are a number of tools available to support this, for example the Northern Ireland delegation framework.

15. Supporting staff to be competent and confident (Education and Training) during COVID-19 Pandemic

15.1 We recognise that to manage the workforce flexibly and ensure all essential care is provided, staff will be required to work differently. Nevertheless, all staff must remain within their competence and scope of practice.

15.2 In order to support this there are a range of national training resources which have been made available by NHS Education for Scotland (NES), available to all health and care staff, including those working in the independent and voluntary sector. These resources should be utilised as part of NHS Board, H&SCP and Local Authority COVID-19 training plans. These resources can be accessed on the TURAS website.

15.3 An adapted induction programme has been developed to support those who are returning to practice from retirement, or students who have volunteered to join the NHS workforce. This will not be openly accessible to the aforementioned groups of staff, and will be permission only access linked to their employer.

ANNEX 1

Clinical Guidance For Community Mental Health And Learning Disability Services And COVID-19

1. Introduction

1.1 This guidance is targeted at providing clinical advice for adults and older people's Community Mental Health and Learning Disability Services. It is recognised that those utilising these services are often vulnerable or frail with complex needs and varying levels of dependence. Indeed a significant proportion of individuals with mental health issues and/or a Learning Disability have a number of co-morbidities resulting in life expectancy being 15 to 20 years shorter than the rest of the population illustrating the vulnerability of this group.

1.2 These Services are vital to the wider health and care system and it is essential that it continues to function in a safe and effective way as it provides a safe and appropriate alternative in some cases to acute settings such as hospital care. It is therefore imperative that Community Mental Health and Learning Disability Services continue to take referrals and admission into their case load were clinically indicated.

2. Measures To Prevent And Prepare For Infection In People Utilising Community Mental Health And Learning Disability Services.

2.1 It is recommended that individuals over 70 years of age, as well as those with underlying health problems be subject to **'social distancing'** to reduce the risk of infection with the aim of reducing the mortality.

3. Reducing Visitors To The Person's Home Apart From Essential Visits.

3.1 This should seek to reduce external visitors by 75%. Visits from health and social care staff are essential. However organisations should work in partnership with the individual and their relative/ carer to agree how their needs will be met during this period. This will ensure they are able to continue to receive essential care and treatment whilst reducing the frequency and duration of contacts. In essence reducing footfall into the person's home.

3.2 Technology such as telephone, FaceTime, Skype, NHS Near Me should be utilised where clinically appropriate, as an alternative to face to face consultation. In addition people using services should be encouraged to maintain contact with family and friends through the use of technology.

3.3 As with previous experiences it may be wise to exclude visits from children as potential carriers of infection.

3.4 Whilst it is necessary to reduce the foot fall into the individual's home it is also essential that we continue to ensure that vulnerable individuals have access to

relatives and carers which they may depend on for emotional support. This is just as crucial as managing their physical health requirements and will reduce morbidity by promoting wellbeing. Engagement with necessary therapies will enable individuals to continue to access the emotional support they need whilst recognising the fluidity of this dynamic situation and should be included in the individual's plan of care.

4. Self-Isolation.

4.1 People with mental health and learning disability issues often have limited networks of support. Mental Health and Learning Disability clinicians and social care professionals should work together to identify those at risk of poor levels of support proactively developing anticipatory plans. It is expected that this approach will provide an opportunity to strengthen their network of support during this period, reducing anxiety and improving concordance with national advice and guidance for COVID-19. As previously identified the use of technology should be considered to reduce social isolation.

5. Care And Treatment Of The Deteriorating Patient: People With Mental Health Or Learning Disability With Suspected / Diagnosis Of COVID-19.

5.1 Care and treatment of individuals in the community self-isolating for COVID-19 who become acutely mentally unwell and require to be detained under the Mental Health (Scotland) Act 2015 should have their care provided within Acute Mental Health Services where it is in the best interest of the person to do so. Input from Infection Prevention and Control personnel will be essential. Mental Health clinicians to include Mental Health Nurses, Allied Health Professions and Medical staff should undertake training relating to the deteriorating patient and respiratory care. In addition they should have access to a named individual for supervision and support, Personal Protective Equipment (PPE) and Oxygen during this period to enable this to safely occur.

5.2 The deciding factor is the extent and criticality of the individual's physical condition. This will require close monitoring to ensure the needs of the individual are met. Transfer to appropriate acute general health services should be timely and smoothly enabled if it becomes clinically necessary. NHS Boards and Health and Social Care Partners should identify an appropriate clinical area to enable a patient to be isolated from others preventing the spread of infection. In addition early conversations with patient transport and ambulance services are required.

6. Mitigating Factors To Consider While Caring For People At Home.

6.1 Implementing these measures including social distancing may have adverse effects that need to be considered. These may include:

- Increased immobility and higher falls risk for some individuals.
- Low mood from social isolation

- Boredom
- Loss of contact with families.
- Deterioration of Mental Illness

6.2 These factors may be more marked for people with dementia. Deploying measures to address and mitigate these factors will be important. This may be best addressed using volunteers or third sector charitable organisations to engage with individuals and to be seen as part of essential contacts. It is crucial that they are trained in the correct infection prevention and control precautions.

7. Care And Treatment Of The Deteriorating Patient: People With Mental Health Or Learning Disability With Suspected / Diagnosis Of COVID-19 Within Specialist Inpatient Services.

7.1 People within inpatient mental health or learning disabilities services infected with COVID-19 should be treated and cared for within an appropriate clinical environment which meets both their physical and mental health needs. In particular consideration should be given to the care of people accessing specialist services such as Forensic, Intensive Psychiatric Care, Specialist Learning Disability and Specialist Dementia Care Units. The deciding factor will be the extent of the individual's physical health condition. Where possible they should continue to be cared for within the specialist mental health services with input from Infection Prevention and Control. Mental health clinicians from all disciplines should undertake refresher / upskilling training in recognising the deteriorating patient and respiratory care. In addition they should have access to a named individual for supervision and support, Personal Protective Equipment (PPE) and Oxygen during this period to enable this to safely occur.

7.2 Close monitoring is essential to ensure the needs of the individual are met enabling transfer to appropriate acute general health services are smoothly and timely enabled where it is clinically necessary. NHS Boards and Health and Social Care Partners should identify an appropriate clinical area which would enable the individual to be isolated from others preventing the spread of infection.

7.3 A risk assessment approach should be utilised to limit the use of home pass during this period enabling social isolation to be enabled within the inpatient setting.

8. Restricted Patients.

8.1 Under the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") Scottish Ministers have statutory functions in respect of the management of restricted patients. This statutory role provides an additional layer of scrutiny as regards the protection and security of the public, and the delivery of appropriate care and treatment to the restricted patient.

8.2 The provisions in the UK Wide Coronavirus Act 2020 makes for certain modifications to sections of the 2003 Act and the Criminal Procedure (Scotland) Act 1995 during the emergency period. Further guidance has been issued. The guidance will be updated regularly, during what is a rapidly changing situation.

ANNEX 2

ADDITIONAL SOURCES OF INFORMATION

You may want to consider the following websites for information that is specific to certain professions and information for parents. Again, this list is not exhaustive, and information will be updated regularly.

- Scottish Government webpages
- Guidance for Nursing Home and Residential Care Residents
- COVID-19 - Medical, Nursing and Midwifery: Student Support Guidance
- Guidance on Care at Home, Housing Support and Sheltered Housing
- Joint NMC and RCN statement on decisions relating to CPR
- Health and Social Care COVID-19 Accelerated Recruitment Portal
- Royal College of Paediatrics and Child Health
- Royal College of Obstetricians & Gynaecologists
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Midwives
- Health and Care Professions Council
- Mental Welfare Commission for Scotland
- Joint letter from all CAHPOs
- The Queen's Nursing Institute Scotland
- Scottish Social Services Council
- Nursing & Midwifery Council
- NMC Guidance for Employers
- The Chartered Society of Physiotherapy
- Royal College of Speech and Language Therapists
- The Association of UK Dieticians
- Royal College of Occupational Therapists
- College of Paramedics
- The College of Podiatry
- The Society of Radiographers
- British and Irish Orthoptic Society
- The British Association of Prosthetists and Orthotists
- British Association for Music Therapy
- British Association of Art Therapists
- British Association of Drama Therapists
- Article about working within your level of competence
- Parent Club
- NHS Inform

ANNEX 3

Mental Health and Wellbeing: Key Messages for Staff

You are likely to be under increased pressure over this period and you will need appropriate support. It is going to be crucial that we are all able to talk openly and honestly about our mental health and wellbeing, and that we have access to the right help and support when we need it. Looking after our mental health is just as important as our physical health.

You Need Care Too

Here are some tips for staying safe and well:

Information and social media

- Get timely, accurate and factual information about COVID-19 from a reliable source no more than a couple of times a day.
- If you are feeling stressed or anxious, consider how you feel when you have constant exposure to media coverage and graphic news stories. Although it is important to stay informed, consider taking a break if you feel things are getting on top of you.

Looking after your basic needs

- Take care of your basic needs at work. Eat and drink regularly and healthily. **Always take regular breaks during shifts.**
- Allow time for sleep, rest and respite between shifts.
- Try and stay as connected to your friends and family as much as possible via technology.
- Maintain, where possible, your normal daily routine and a healthy diet, and get fresh air when you can. Avoid using unhelpful coping strategies that involve alcohol, tobacco or an unhealthy diet.
- Think about creating a consistent routine to ensure you get the amount of sleep you need, but also about ensuring your bedroom is quiet, dark and a relaxing environment to sleep in.

Looking after each other

- Speak to colleagues, line managers and professional leaders, building this into your team's daily huddles and handovers. They may be feeling the same way. It's good to talk. Peer and social support are often the best buffers against stress and adversity.
- Look out for each other and share small successes about what's gone well.
- Be kind to each other. This can have a profound impact on staff wellbeing.
- Use the Going Home checklist, where relevant, to leave work in work.
- It's good to talk, but not all of you will be 'talkers'. That's OK too but make sure you give yourself space to process the events of the day and deal with your feelings.

Additional information

- It is perfectly normal to feel worried during exceptional times such as these. However, if you are starting to feel overwhelmed, it's important to acknowledge your feelings and speak to someone you trust, whether that's a friend, a family member, or a colleague. A helpline such as NHS24 (short code 111) or Breathing Space (0800 83 85 87) may also help.

You may find the following websites of assistance:
NHS Education for Scotland
NHS Inform
Support in Mind Scotland
Breathing Space
Mental Health Foundation
The Queen's Nursing Institute Scotland

ANNEX 4

Prioritisation of Care in the Community – All Professional Groups covering Adult and Children's Services

This annex provides interim guidance in response to COVID-19 on children's community nursing including health visiting, school nursing, family nurse partnership and adult community services including district nursing.

Workforce
It is important to ensure that key aspects of service delivery continue to operate appropriately, however, it is reasonable to expect that staff will be required to work flexibly and modifications made to working practices which may include redeployment into different roles.

Prioritisation Key	
	Stop
	Adapt based on professional judgement
	Continue normal service provision
	Start – COVID-19 specific measures

1. Health Visiting

The following schedule of advice is based on the principles set out in the interim guidance and the Universal Health Visiting Pathway and **should be followed in conjunction with the information contained within the primary guidance.** There is an expectation that all contacts in the Pathway continue to be delivered, albeit in a different way, for example using Near Me. In all cases, **professional judgement** must be the driver for determining level of support required, to keep individual children and their families safe and well during this time.

#	Contact	Location	Plan during pandemic	Details
STOP				
1.	**Non-essential face to face visits**	**Stop**	**Stop**	
2.	**Antenatal contact**	**Stop**	Maternity services will advise if there are any other services involved with family in relation to vulnerability and also COVID-19 related. The discussion should establish existing engagement with services in order to coordinate and limit footfall.	The antenatal Health Visitor contact will cease. Discussion with Health Visitors and wider team should inform both Midwifery and Health Visiting if there are new or previous additional care needs. The wider team may be asked to support if midwifery services are unable to provide additional preventative care.

Adapt based on Professional Judgement				
1.	**Contacts:** • **3-5 week** • **3 month** • **4 month** • **8 month**	Phone/Near Me	Adapt to provide these contacts using the phone or Near Me wherever possible. A face to face contact may be delivered if HVs feel that is required to meet a family's needs, for example: Child protection or where additional risks/needs identified. Infant feeding assessment Weaning advice	Infant Feeding Assessment should be included where contact is made at 3-5 weeks. Further advice on infant feeding support can be found through your local Infant Feeding Advisor
2.	**Child Health Reviews:** • **13-15 month** • **27-30 month** • **4-5 year**	Phone/Near Me	Adapt to provide these reviews using the phone or Near Me wherever possible. A face to face review may be delivered if HVs feel that is required to meet a family's needs. Remote reviews should be completed as set out in the HV pathway as far as possible and documented on the relevant CHSP-PS form. The form should then be promptly returned to the local child health admin department for entry into the child's CHSP-PS electronic record. In case HVs do not currently have access to paper versions of the CHSP-PS forms, Word versions have been made available on the Public Health Scotland website. These can be downloaded and directly completed by	Contact and decision about the mode of contact (phone, face to face etc) should be documented in child clinical record. These reviews should explore key aspects of children's development and consider if additional support is needed including consideration of mental health and wellbeing/emotional and/or behavioural as described in the Pathway. Access to helplines for support advice and signposting for families where developmental concerns are raised should be made to Allied Health Professions using local helpline numbers

			HVs then securely emailed to local child health admin departments. If HVs feel they have been unable to complete a child's review at the initial remote contact, they can recall the child for a subsequent remote or face to face review as clinically appropriate. This second contact should be documented using a CHSP-PS recall form, which again should be returned to the child health admin department. The form should be marked 'Completion of 13-15m review' or similar as appropriate.	
Continue				
1.	**Pre-birth Antenatal letter**	Letter	Consider adjustment of the letter to incorporate national COVID-19 information on self-isolation for pregnant women	To link with maternity services and social work services to ensure child protection requirements are agreed and essential visits carried out.

2.	**11- 14 day contact**	Face to Face	We recommend this contact is undertaken in line with pathway guidance. Including prioritising: Infant feeding assessment for breastfeeding mothers: urine and stool output, positioning and attachment, condition of mothers' breast • Expected to have at least 6 heavy wet nappies in 24 hours • Expected to have at least 2 soft yellow stools in 24 hours Weight: at birth weight, indicative evidence of weight gain, indicative of further intervention required Continue to provide advice on safe formula feeding (the Parent Club has helpful information) This review should be documented on the relevant CHSP-PS form and promptly returned to the to the local child health admin department as usual.	Handover from maternity services should include information on current feeding challenges and interventions in place. If a mother asks for advice or raises a concern about breastfeeding, weight or her milk supply a breastfeeding assessment should be completed and a plan agreed with the mother and appropriate follow-up should be organised. Further advice on infant feeding support can be found at through your local Infant Feeding Advisor
3.	**6-8 week check (and review if separate)**	Face to Face	We recommend prioritising some key activity: • Infant feeding assessment – urine and stool output, positioning and attachment, condition of mothers' breast • Infant Observation – colour, tone, alertness, breathing, handling	Follow arrangements agreed locally in relation to the 8 week GP review. First point of contact should be paediatric dietician for suspected milk allergy to reduce GP contact. Check AHP pathway.

			• Weight – Stooling may change after the first 4 weeks in a breastfed baby • EPDS (protecting maternal mental health) This review should be documented on the relevant CHSP-PS form and promptly returned to the to the local child health admin department as usual.	
4.	**6 Months**	Phone/Near Me	The HPI should be reassessed around 6 months using appropriate Getting It Right For Every Child assessments as outlined in the Universal Health Visiting Pathway. Professional judgement should be used on whether to contact face to face or over the phone.	

2. Family Nurse Partnership

FNP provides an essential health service to the clients and children enrolled on the programme. The ReValuation Report demonstrated that families receiving the programme have very high levels of complex vulnerabilities and health needs including mental health challenges and domestic violence with 88% identified with socio economic disadvantage. Families will continue to need the support of FNP and, in fact, will likely need their connection to their FNP nurse more than ever.

FNP nurses to follow the guidance above relating to the delivery of the Universal Health Visiting Pathway alongside aspects in relation the FNP programme.

#	Contacts	Location	Plan during pandemic	Details
STOP				
1.	Non-essential face to face visits		**Stop**	
2.	FNP Education Programme		**Stop**	In agreement with Board wide protocols, all education and training has stopped unless it is COVID-19 specific or is for rapid upskilling of practitioners

3.	Case Presentation team meetings		**Stop**	
4.	Joint visits		**Stop**	Minimises footfall in family home
Adapt based on Professional Judgement				
1.	Engagement of new clients	Near Me/Attend Anywhere	**Except:** where potential client has additional needs	Clients to be engaged on to FNP programme via Near Me/Attend Anywhere. To link with maternity services and social work services to ensure child protection requirements are agreed and essential visits carried out.
2.	Pregnancy visits	Near Me/Attend Anywhere	**Except:** Essential home visits as agreed with multi-agency partners and professional judgement Child protection Families with additional needs	• Clients to have contact via Near Me/Attend Anywhere. • To link with maternity services and social work services to ensure child protection requirements are agreed and essential visits carried out. • Many clients will be impacted greatly by the reduction/closure of other services that support them in terms of their social and economic challenges.
3.	Infancy visits	Near Me/Attend Anywhere	**Except:** Essential home visits as agreed with multi-agency partners and professional judgement	Clients to have contact via Near Me/Attend Anywhere. Unless essential home visit required • Infant feeding/weaning support • Child protection risks for some families may increase due to isolation. • Emotional health and wellbeing /mental health support. • HV pathway • Economic impact e.g. food insecurity/access to welfare
4.	Toddler visits	Near Me/Attend Anywhere	**Except:** Essential home visits	Clients to have contact via Near Me/Attend Anywhere. Unless essential visit i.e. • HV pathway • Child protection risks for some families may increase due to isolation. • Emotional health and wellbeing /mental health support.

				• Economic impact. e.g. food insecurity/access to welfare
5.	Graduation of clients to universal Health Visiting Service	Near Me/Attend Anywhere	**Continue** – using professional judgement	Core families that do not require additional support should graduate from the service where possible. Negotiation with health visiting service and other multi-agency partners to identify which service best placed to provide continuing care.

3. School Nursing

In all cases, **professional judgement** must be the driver for determining level of support required to keep individual children and their families safe and well during this time. It is paramount that School Nurses in their targeted role, continue to work in partnership with education and local authorities to support school aged children and young people with potential increased health needs or risk.

#	Contacts	Location	Plan during pandemic	Details
Stop				
1.	**Non-essential contacts**		**Stop**	
2.	**P1 BMI measurement**		**Pause**	
Adapt based on Professional Judgement				
1.	Weight Management Services – Children & Young People	Near Me/Attend Anywhere	**Stop all face to face service delivery.** • Where possible, Boards should endeavour to continue support via telephone / digital platforms, with particular consideration given to high-risk patients. • Supported self-management tools to be used where possible.	Commissioned by NHS Boards.
Continue normal service provision				
1.	Engagement with Education	Near Me/Attend Anywhere	School nurses must remain accessible and responsive to requests and support required from the named person for school aged children (education).	Access to Allied Health Profession support via Attend Anywhere/Near Me Phone advice lines as needed.

			Review current caseload and use professional assessment to inform continuation with children and young people with additional need or risk – remotely where possible. Professional assessments will inform interventions.	

4. Children's Community AHP Services				
#	**Service**	**Location**	**Plan during pandemic**	**Details**
Stop				
1.	AHP CYP Community Services including Health Visiting referrals	Clinic Nursery and School Community and 3rd sector aligned projects	Professional decision making regarding individual cases for prioritisation on basis of clinical risk (see continue, below)	Some local provision for complex cases consultation to support families and meet individual needs via Near Me /Attend anywhere. Access to helplines for support advice and signposting for families where developmental concerns are raised should be made to Allied Health Professions using local helpline numbers. Parents signposted directly accessible in some Board AHP CYP services.
Continue normal service provision				
1.	Paediatric Dietetic	Clinics Acute	Prioritised high risk individual referrals and ongoing case support. Professional Decision making regarding clinical risk for prioritisation e.g. allergies, feeding issues high risk category CYP	Access to AHP for initial consultation where developmental concerns raised via HV/FNP/Family Support or Education should be directed to existing AHP helplines or identified lead practitioner

2.	Allied Health Professions Community /Local Authority Physiotherapy, Speech and Language Therapy, Dietetics and Occupational Therapy	NHS Boards Local Authorities and CAMHS Acute	Acute provision in Children's hospitals should be based on professional decision making regarding individual cases for prioritisation on basis of clinical risk. Work planning for Community CYP services to including AHPs Leads and ensure support for families and carers at home with CYP with complex needs.	Access to support and consultation should be available for families with core CYP expert practitioners available for consultation via Near Me /Attend Anywhere to prevent deterioration, reduce anxiety and prevent admissions. Concern that CYP Community Work planning required to enable helplines and existing virtual consultation to continue/expand.
Start – COVID-19 specific measures				
1.	Increase access to Attend Anywhere support for lead AHP CYP Practitioners for front line support of concerns from parents and HV/others	Identified locations		Increased access to Attend Anywhere for key AHPs in CYP practice to support concerns raised by existing CYP on caseload who are prioritised through professional decision making

5. District Nursing Services

District nursing services play a key role in supporting people with complex health and care needs to stay well at home or in a care home, anticipating changes in a person's condition enabling early intervention. They can provide urgent care when appropriate to do so in a community setting, enable supportive early discharge and are key to the provision of palliative and end of life care in the community. DN's have key leadership skills in the coordination of community clinical care and this should be drawn on when co-ordinating care at this time. Many DN's also have additional knowledge and skills in advance clinical assessment, prescribing and confirmation of death. It is important that the district nursing team at this time is fully utilised to ensure more care can be supported at home or in the community avoiding where possible the need for hospital admission and reducing footfall in the person's home. To achieve this it is important that a **'one team'** approach for Nursing (including specialist nurses), AHPs, social work and social care should be consider maximising the skills and knowledge of the whole team.

#	Service	Location	Plan during pandemic	Details
Stop				
1.	Stop all non-essential face to face visits.			Consider appropriate delegation
Adapt based on professional judgement				
1.	Routine visits		Clinically Prioritise urgent care needs and ensure dynamic case load management to free nursing capacity for more complex care needs. Defer visits where clinically appropriate to do so where a patient is self-isolating because they have suspected COVID-	Consider appropriate delegation of work that could be done by another professional (including AHP), a HCSW, a carer (paid/unpaid). Ensure systems in place to monitor care which has been delegated or deferred

			19 or they are living with someone who has confirmed or suspected COVID-19.	Actively coach patients/carers to self-administer Consider how the wider MDT can provide professional to professional support Consider how to support care homes more fully Increase the use of technology where appropriate to including access to NHS Near Me technology Co-ordinate care to reduce duplication and footfall
2.	Non-complex wound care			
3.	Continence/Bowel Care		Should be clinically prioritised to ensure that this does not become a cause for unnecessary admission to hospital Continence product assessment - Consider ceasing annual reviews unless due to decrease in care packages person needs higher absorbency, this needs to be managed for ordering.	Consider delegation to family or carers for the duration of the pandemic with support and clinical advice from the Clinical Team Consider use of specialist bowel nurses and continence nurses to support district nursing teams
4.	Lymphoedema Management		Continue to support where bandaging is required, consider potential to promote self-management as much as possible. Reduce number of bandaging changes on an individual risk assessment basis.	Consider lymphoedema specialist nurses working within community teams to support specialist needs requirements and to keep people safe at home
5.	Routine IM and Subcutaneous injections – including insulin and non - molecular weight heparin injections		Prioritise what must continue and consider alternative options for administration including oral which could be adapted Vit B12- If cannot be switched to oral, then consider ceasing administration of Vit B12 until post pandemic. If patients report neurological symptoms to GP/ team, then consider administration	
6.	Medication Prompts			Where appropriate to do so use technology or delegate to family/friends or carers
Continue normal service provision				
1.	All essential visits		**Continue but clinically prioritise urgent needs and ensure dynamic case load management. Reduce regular review work through appropriate risk assessment.**	Identify caseload workload to ensure that appropriate deployment of staff with the right skills and knowledge to enable care to be provided safely

2.	Monitor rising risk of deferred		Monitor rising risk of deferred work if disruption continues	Telehealth and telecare should be used to monitor all deferred appointments. Patients should have a central line to contact if they have had a deterioration in their conditions so an assessment can be undertaken prior to a face to face visit.
3.	Palliative and end of life care		Continue to support those in last days of life or high complexity palliative care at home or in a residential setting – syringe drivers and symptom management and any other identified clinical need Respond to increase needs for palliative care for people with complex co-morbidity	Co-ordinate care with other community specialist palliative care nurses and other speciality nurses who may be known to the patient where possible to reduce contact and maximise continuity
4.	Early supported discharge from hospital		Prioritise early supported discharge from acute hospitals who will have ongoing nursing care needs	Work with AHP teams and HCSW/social care workers to support early discharge from hospital Work with third and independent sectors
5.	Urgent Care		Prioritise Rapid Response teams response to rapidly deteriorating patients to facilitate admission avoidance.	Work with primary and secondary care teams to support more urgent care in the community where possible maximising the skills of the community nursing team in clinical assessment and prescribing where appropriate to do so
6.	Complex Wound Management		Complex wound care should continue Wound care where there are immediate concerns regarding the patient's condition e.g. infected wounds, heavily exuding wounds and compression bandaging that has been in situ for more than 7 days	
7.	Diabetic Foot Care		Needs continued	Consider podiatry doing this to release nursing time
8.	Urgent Catheter Care/Bowel Care		Needs continued - should be reviewed on a patient by patient basis	
Start – COVID-19 specific measures				
1.	Increase Anticipatory Care Planning		All patients who would benefit from an ACP should have this discussed with them and their families where appropriate.	

			In addition discussion and recording of eKIS and Ceiling of Care plus DNAR should be prioritised for people with long term and palliative conditions.	
2.	Palliative Care		Plan for increased demand	Ensure sufficient equipment Identify non-medical prescribers and deploy appropriately
3.	Urgent Care		Plan for increased demand	Ensure effective communication links with Primary and secondary care to reduce admissions to acute services where appropriate to do so
4.	24/7 Cover		Plan for 24/7 cover to support more care in the community to avoid admission to hospital and support community respiratory COVID-hub and assessment centres	Ensure increased activity is factored into NHS board mobilisation plans

6. General Practice Nursing

The General practice nurse case load are the practice population which includes adult and children they are highly skilled professionals with extensive skills in consultation which covers primary and secondary prevention as well as unscheduled care .

General Practices as individual small businesses will each have their own agreed Plan below are based on various information received it is not an exhaustive list .

#	Service	Location	Plan during pandemic	Details
Stop				
1.	**Service**	**Location**	**Plan during pandemic**	**Details**
2.	Routine LTC reviews	practice	Telephone scheduled patients revisit ACP eKIS	Individual practice plan
3.	Travel Health	practice		Not required /no travel COVID-19
4.	Routine CX smear *	practice		Individual practice plan
5.	Ear irrigation	practice	Determine patient has no pain/triage calls	Individual practice plan
6.	Social prescribing and other lifestyle consultations	practice	If patients are on a series of consultations please contact and reassure	Individual practice plan
7.	Non urgent face to face consultation	practice	This will be based on individual practice action plans	Practice Plan
Adapt based on professional judgement				

1.	Phlebotomy	practice	Only urgent bloods to be done	Practice protocol
2.	Routine OCP checks		Telephone consultation review prescription	Individual practice plan
3.	Wound management		Only urgent management, assist patient to self-manage where compression or complex wound continue	Seek advice from tissue viability nurses
4.	Asthma and COPD review		Use Telephone or video review ensure management plans are in place including eKIS review medication and prescription	Practice protocol
Continue normal service provision				
1.	Primary vaccinations	practice	Continue primary vaccinations	Liaise with community vaccination teams HV teams
2.	Post chemo vaccinations		Discuss with oncology	Individual practice plan
3.	INR management		Review of all patients prioritise management	Individual practice plan
4.	Pre chemo bloods		Arrangements for these should be agreed by oncologist	These patients are being shielded
5.	LAC depot injection		Discuss with patient alternative contraception	May need to continue existing contraception
6.	Other required injections		Zolodex, anti psychotic depot, Vit b12	Practices should be reviewing and liaison with other community team members
Start COVID-19 specific measures				
1.	Telephone triage of nurse appointments /other?	practice	Based on competence triage may be undertaken by GPN with skills	This already does happen in some practices but may be new to others
2.	Telephone consultations	practice	Ensure all patients adult and children have ACP/eKIS, work with all community colleagues to prevent duplication	See general practice letters regarding priority of eKIS and ACP
3.	Providing leadership around infection control	practice	Ensure the practice has a clinical lead with regards to equipment and PPE	Practice Action Plan
4.	Facilitate robust communication with community nursing colleagues is in place	practice	Establish contact numbers and engagement strategy to support integrated working	This may already be in place but there is variation across the Boards /HSCPs. All patients who would benefit from an ACP should have this discussed with them and their families where appropriate. In addition discussion and recording of eKIS and Ceiling of Care, plus DNAR should be prioritised for people with long term and palliative conditions.

7. Specialist Nurses

Specialist community nurses play a key role in supporting the community response to the COVID-19 pandemic in particular in supporting people in the 'most at risk groups' **and with long term conditions to remain well at home; support increased self- management for patient through remote access; ensure Anticipatory Care Plans are in place and up to date where appropriate and work with patients and families to alleviate concerns. Community Specialist Nurses should liaise with the wider community teams, primary and secondary care to ensure a co-ordinated approach to care reduce duplication and segmentation of care: Condition specific specialist nurses:** Palliative care, Heart failure, Continence/ Colostomy, Tissue Viability, TB, Parkinson's, Respiratory/ COPD, Stroke, cancer specialist nurses, neurological (MS,MND), MND, Falls, Lymphoedema, Diabetes, Cystic Fibrosis. This is not an exhaustive list.

#	Service	Location	Plan during pandemic	Details
Stop				
1.	Non-essential routine visits		Clinically prioritise urgent needs and reduce regular review work through appropriate risk assessment	Agree roles across health and social care to avoid duplication and segmentation of care
Adapt based on professional judgement				
1.	Monitoring patients with LTC Unstable respiratory patients		Continue to prioritise regular review and defer appropriately ensuring mechanisms for escalation of deterioration	Consider access to community teams for specialist advice. Increase use of technology to reduce face to face contact

2.	Assess existing case load		Prioritise case load with MDT discuss with consultant/GP ensure decisions are shared	Consider if AHP staff could provide this service for some people with LTC to free nurses to respond to increasing demands for nursing care
3.	Essential visits for high risk patients		Prioritise urgent needs patients who will need to stay on case load and people in the 'most at risk' groups	Use technology or NHS Near Me for consultations were appropriate to do so
4.	Anticipatory care planning		Update or develop anticipatory care plan for those who may not already have one	Ensure this is transferred to General Practice so eKIS can be completed /updated
Start COVID-19 specific measures				
1.	Palliative care		Plan for increased palliative and end of life care	Consider if specialist nurses could be redeployed to support palliative and end of life care in the community working alongside community nurses
2.	ACP		Plan to increase anticipatory care planning	Ensure shared with General Practice to eKIS
3.	Anxiety and distress management		Plan for increased anxiety and distress for patients in the at risk or most at risk categories	Have access to materials and communication
4.	Ensure prescribing pads/paper are in supply		Arrange the need for locality prescribing to ensure your skills can be fully utilised for all patients.	Ensure patients on caseload have access to their medicines that are prescribed

8. Learning Disability and Mental Health Nursing				
#	**Service**	**Location**	**Plan during pandemic**	**Details**
Stop				
	Service	**Location**	**Plan during pandemic**	**Details**
1.	Child And Adolescent Mental Health	NHS Boards / Health And	• New referrals that can be delayed with low level of risk or could be redirected to other support such as online self-care.	Consider use of technology where safe to do so

		Social Care Partnerships	• Routine non-essential contact. • Maintain review of whether care should be increased in the event of deterioration	
2.	Community Mental Health And Learning Disability Services	NHS Boards / Health And Social Care Partnerships	• New referrals that can be delayed with low level of risk or could be redirected to other support such as online self-care. • Routine non-essential contact. • Maintain review of whether care should be increased in the event of deterioration	Consider use of technology where safe to do so
Adapt based on professional judgement				
1.	Child And Adolescent Mental Health	NHS Boards / Health And Social Care Partnerships	• Based on risk assessment reduce frequency of mental health reviews were there is risk of harm of not continuing to provide services to the person.	Place based contact for vulnerable children Consider use of technology where safe to do so
2.	Community Mental Health And Learning Disability Services	NHS Boards / Health And Social Care Partnerships	• Based on risk assessment reduce frequency of mental health reviews were there is risk of harm of not continuing to provide services to the person.	Consider use of technology where safe to do so
Continue normal service provision				
1.	Child And Adolescent Mental Health	NHS Boards / Health And Social Care Partnerships	• Emergency Mental Health Care And Treatment • Urgent care and urgent referrals • In-patient Acute Care such as Mother and Baby Units and Child and Adolescent Acute Care	Place based contact for vulnerable children Consider use of technology where safe to do so.
2.	Community Mental Health And Learning Disability Services	NHS Boards / Health And Social Care Partnerships	• Emergency Mental Health Care And treatment • Urgent care of individuals open to the services as well as new referrals where there is risk of harm to an individual of not continuing or providing services. • Support care and treatment to Forensic patients. • Depot • Acute Mental Health and Learning Disability services across all specialties.	Consider use of technology where safe to do so.

Start COVID-19 specific measures				
1.	Mental Health And Learning Disability Services / Child And Adolescent Mental Health	NHS Boards / Health And Social Care Partnerships	• Establish Mental Health Assessment centres separate from Emergency Departments • Review Patients on waiting lists to ensure those requiring support receive appropriate care during this period	Use of technology assessed as not appropriate. The individual needs to attend a service.

9. Adults Community AHP Services				
#	**Service**	**Location**	**Plan during pandemic**	**Details**
Stop				
1.	Face to Face Group class work	Acute and Community Services	Redirect to self-management online group, Apps etc. where appropriate	
2.	Weight management and obesity services	Primary Care and Community Services	Redirect to self-management online group, Apps etc. where appropriate	
Adapt based on professional judgement				
1	Wheelchair, prosthetics and orthotics service	Across all areas	Prioritise urgent care needs	e.g. to support discharge from hospital; urgent repairs to maintain home living; pressure ulcer risks
2	Out Patient Clinics	Primary and Community Services	Prioritise and high risk, urgent needs	Consider digital options as 1st line
3.	Podiatry	Primary and Community Services	Continue high risk vascular/ diabetic e.g. Diabetic foot clinics cannot be stopped.	Consider digital options for check ins and pre home visit Consider team working with nursing for wound care to reduce footfall

4.	Neuro-rehabilitation	Community Services	Prioritise early supported discharge from acute settings and community neuro-rehabilitation	Consider which can be supported by "non-registered" staff with professional support via digital technology Consider follow up via digital technology Consider cross professional working with nursing
5.	Rehabilitation for Activities of Daily Living	Community Services	Prioritise admission avoidance and early supported discharge	Visits where options for self-management and/or alternative support have been exhausted consider use of the wider MDT with Professional support
6.	Respiratory Care	Community Services	Virtual Pulmonary Rehab	Consider links with other Respiratory services
7.	Weight Management and Obesity Services	Primary and Community Services	Prioritise where also providing management of associated high risk comorbidities (e.g. type 2 diabetes, obstructive sleep apnoea)	Consider digital options and close working with nursing colleagues
8.	Musculo-Skeletal Services	Acute and Community Services	Prioritise emergency and urgent referrals to prevent hospital admission Prioritise rehabilitation to support early discharge	Consider triage and follow up digital options
9.	Mental Health Services	Community Services	Prioritise to support admission avoidance and early supported discharge	Consider digital options e.g. NHS Near Me/Attend Anywhere Consider use of whole AHP MH team OT; Arts therapists; Physio etc. inc staff support
10.	Dementia Services	Community Services	Prioritise to support admission avoidance and early supported discharge	Consider digital options e.g. NHS Near Me/Attend Anywhere Consider use of whole AHP MH team OT; Arts therapists; Physio etc. inc for staff for support
11.	Learning Disability Services	Community Services	Prioritise to support admission avoidance and early supported discharge	Consider digital options e.g. NHS Near Me/Attend Anywhere Consider use of whole AHP MH team OT; Arts therapists; Physio etc. inc for staff support
Continue normal service provision				
1.	Respiratory Care	Acute and Community services	Prioritise acute and recovery respiratory care	Consider wider working as part of the acute resp team

2.	Rehabilitation	Acute and Community Services	Prioritise Admission avoidance and early supported discharge especially for those with frailty Fluid and nutritional priority areas including malnutrition to reduce frailty Swallowing assessment and advice	Consider AHP support with ACPs Consider digital options and close working with nursing colleagues
3.	Fluid and Nutritional support	Community services	Prioritise urgent care needs Prepare for increase in support for respiratory care inc. swallowing assessments to prevent aspiration	Consider digital options and close working with nursing colleagues
4.	Diagnostic Radiography	Acute Services	Prepare for increased demand for chest imaging Prioritise emergency and urgent work	
5.	Therapeutic Radiography	Acute Services	Prioritise and risk assessment for treatments	Consider digital options for pre and post conversations
6.	Scottish Ambulance	Community Services	Prepare for increased demand	
Start COVID-19 specific measures				
1.	Respiratory Care	Primary and Community Services	Consider deployment in respiratory Hubs Use of NHS Near Me/ Attend Anywhere to prevent admission	Link as part of the wider respiratory team
2.	Diagnostic Radiography	Acute Services	Providing skeletal reporting where staff are trained to do so	Consider chest reporting training
3.	Mental Health/LD and Dementia Services	Primary and Community Services	Consider providing digital support on coping strategies for those isolated and/or with increased anxieties	Link as part of the wider teams
4.	Hospital at Home	Community Services	As Hospital at Home services increase consider AHPs as part of the blended workforce team	Consider additional training for expanded roles AHP roles in ACPs

ANNEX 5

General Practice Nursing

COVID–19 Novel Coronavirus (COVID-19) is a new strain of coronavirus first identified in Wuhan, China. Clinical presentations may range from mild to moderate illness to pneumonia or severe acute respiratory infection. Because of this, patients with COVID-19 could present to primary care either via telephone or in person. Much work has taken place to mitigate patients freely walking into General Practice settings.
GP practices have a duty to protect and provide care to their patients, and a duty as employers to support and protect their staff. As independent contractors practices are proactive in managing this.

Infection Control

All infection control advice is from **Health Protection Scotland** and it is linked in the main document. Primary Guidance is available: it progresses frequently so always ensure you have the most current document/advice. **See** Health Protection Scotland (HPS).

Practice Action Plans

Practices will have their own action plans /protocols in place and there will be slight variation across Scotland.

Triage of Patients. Primary Care practices are advised to make every effort to triage patients by telephone to avoid the patient presenting at the practice unnecessarily and minimising any contact with patients with respiratory symptoms.

The practice should introduce processes to triage all **appointment requests** (on the day or in future). **This includes nursing appointments**. Each practice should identify the most appropriate members of the practice team to carry out this role and ensure that they have appropriate internal training, guidance and support to carry out this role. NES are currently providing Total Telephone Triage learning.

During this pandemic many GPNs will be working differently and using their skills in triage and ensuring ACP and eKIS are maintained or created for those patients deemed at higher clinical risk or who are vulnerable. They will also continue to deliver care to patients with agreed triaged appointments.

It is crucial during this pandemic that GPN's work closely with the wider care team to develop robust patient pathways and maximise community workforce potential. It is essential that good communication strategies between nurses in general practice and wider community teams are established. This will avoid duplication of work and ensure nursing capacity within the locality is utilised to full potential.

GPNs are part of the wider community nursing and multidisciplinary teams, individual practices will all operate with slight variation within their plans of operation during this time. The information in the main document will ensure you have the links to core vital information, and understand the guidance that all staff in the community has been given it is not possible to address all practice operational plans and individual nurse situations.