NHS Ayrshire & Arran

Meeting:	**Ayrshire and Arran NHS Board**
Meeting date:	**Monday 25 May 2020**
Title:	**Performance Report**
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1. Purpose

This is presented to the Board for:

- Discussion

This paper relates to:

- Government policy/Directive

This aligns to the following NHS Scotland quality ambitions:

- Safe
- Effective
- Person Centred

2. Report summary

2.1 Situation

COVID-19 has impacted on how people seek healthcare and how health and social care is being delivered across NHS Ayrshire & Arran. This is being managed within Ayrshire and Arran on an integrated basis. NHS Ayrshire & Arran is working closely with East, North and South Ayrshire Health and Social Care Partnerships (HSCP). NHS Board members are asked to discuss the information provided in this report which provides assurance that systems and procedures are in place to monitor and manage the impact of COVID-19 on our provision of unscheduled and planned care for our citizens.

2.2 Background

Planning assumptions indicated that NHS Ayrshire & Arran, like other NHS Boards, were required to significantly increase the Intensive Care capacity to manage critically ill COVID-19 cases over the period of the outbreak. At both University Hospital Crosshouse (UHC) and University Hospital Ayr (UHA) the additional Intensive Care Unit (ICU) capacity was achieved through the cancellation of elective surgery, releasing the theatre recovery areas for conversion into ICU facilities. This also released Consultant Anaesthetists and theatre

nursing staff, who underwent some additional training to help support the staffing of the additional ICU beds.

Cancelling Non-urgent elective inpatient and daycase surgery also created additional bed capacity for both COVID-19 and non COVID-19 emergency admissions, and released medical, nursing and other clinical staff to assist with this emergency activity. NHS Ayrshire & Arran continued to, and will continue to, treat urgent and urgent cancer suspected patients throughout the outbreak, for as long as this remains practical and safe.

Outpatient activity was also scaled down to release key clinical staff to assist with emerging pressures, to allow adaptation of some Outpatient areas for other uses, and to reduce the public footfall in the hospital sites.

Mental Health Services (including Learning Disabilities and Addiction Services) within Ayrshire and Arran have continued to provide health and social care interventions based on contingency planning and RAG rating throughout the COVID-19 outbreak.

Contingency plans were also put in place across Musculoskeletal services.

In preparation for the anticipated demand of people being treated for COVID-19, our Acute hospitals, along with our HSCP, developed plans to create additional community bed capacity and adaptation of other services to enable patients who no longer required medical treatment, to be transferred to more suitable settings. This significantly reduced the occupancy levels within both Acute hospitals.

Despite an overall reduction in the number of patients attending our Emergency Departments (ED) in March 2020, NHS Ayrshire & Arran started to experience significant unscheduled care pressures with an increasing number of admitted patients requiring isolation. Red (COVID-19) and green (non-COVID-19) pathways were quickly established at both front doors at UHA and UHC. The Combined Assessment Unit (CAU) provides an environment to isolate those patients who require admission and are suspected of COVID-19 and awaiting test results. Acute Physicians and ED Consultants continue to work collaboratively to ensure that patients who can be assessed, treated and discharged at our front doors, have been. Pathways have been established on both sites to support safe transfer of patients who require a longer stay in hospital.

2.3 Assessment

This report provides an overview of Unscheduled Care (2.3.1) and Planned Care (2.3.2) performance to ensure that NHS Board members are sighted on the corresponding impact of COVID-19 across the system as a whole. Section 2.3.1 includes an infographic on unscheduled care in March 2020 (with March 2019 data provided for comparison).

Sections 2.3.2 provides assurance that systems and procedures are in place to monitor and manage the impact of COVID-19 on planned care. An infographic has not been provided within this section as current data on planned care is not comparable with performance prior to the COVID-19 pandemic.

2.3.1 Unscheduled Care

NHS Ayrshire & Arran – At a Glance

Unscheduled Care

Latest performance, with figures shown for same month of the previous year
Includes Scottish Government target (⊕) , where applicable.

Emergency Departments

UHA H A&E	2,303 Mar 2020	3,383 Mar 2019	attendances at UHA Emergency Department	
	76.4% Mar 2020	82.2% Mar 2019	ED attendees were treated, admitted or discharged within 4 hours of arrival	⊕ 95%
	124 Mar 2020	67 Mar 2019	ED attendees waited over 12 hours to be treated, admitted, or discharged	
UHC H A&E	4,612 Mar 2020	6,404 Mar 2019	attendances at UHC Emergency Department	
	91.9% Mar 2020	88.8% Mar 2019	ED attendees were treated, admitted or discharged within 4 hours of arrival	⊕ 95%
	67 Mar 2020	57 Mar 2019	ED attendees waited over 12 hours to be treated, admitted, or discharged	

Medical and Surgical Bed Occupancy

79.0% Mar 2020	95.1% Mar 2019	occupancy of acute medical and surgical beds at University Hospital Ayr
74.8% Mar 2020	95.1% Mar 2019	occupancy of acute medical and surgical beds at University Hospital Crosshouse

Combined Assessment Units

	1,197 Mar 2020	1,735 Mar 2019	1,205 Mar 2020	1,697 Mar 2019
	presentations to UHA CAU		presentations to UHC CAU	

Emergency Admissions

	640 Mar 2020	875 Mar 2019	1,069 Mar 2020	1,493 Mar 2019
	admissions to UHA via ED/CAU		admissions to UHC via ED/CAU	

Delayed Discharge

Numbers of patients whose discharge from hospital was delayed by 2 weeks or more for non-clinical reasons ⊕ 0	North Ayrshire HSCP		East Ayrshire HSCP		South Ayrshire HSCP	
	21 Mar 2020	26 Mar 2019	0 Mar 2020	0 Mar 2019	18 Mar 2020	32 Mar 2019

* Inpatient Admissions from the ED admitted directly into Medical or Surgical ward (excluding CAU) and Inpatient admissions from the CAU admitted to CAU (regardless of source) who are transferred to a medical or surgical ward (excluding discharges directly from the CAU)

Emergency Department

ED Attendances at both hospital sites have experienced a dramatic drop since the outbreak of COVID-19 when compared with the same period last year.

At UHA, there were 1,080 fewer ED attendances in March 2020 than in March 2019, representing a 31.9% decrease (Mar 2019: 3,383; Mar 2020: 2,303). The decrease is entirely in relation to Flow 1 (Minor Injury) and Flow 2 (Acute Assessment, inc Major Injury) attendances, with 389 fewer Flow 1 attendances in March 2020 than the previous year, a 31.9% decrease (Mar 2019: 1,218; Mar 2020: 829), and 697 fewer Flow 2 attendances, a 34.0% decrease (Mar 2019: 2,048; Mar 2020: 1,351).

Similarly at UHC, there were 1,792 fewer ED attendances in March 2020 than in March 2019, representing a decrease of 28.0% (Mar 2019: 6,404; Mar 2020: 4,612). Breaking this decrease down by patient flow category, there were 809 fewer Flow 1 (Minor Injury) attendances in March 2020 than the previous year, a decrease of 29.4% (Mar 2019: 2,753; Mar 2020: 1,944), 827 fewer Flow 2 (Acute Assessment, inc Major Injury) attendances, a decrease of 28.6% (Mar 2019: 2,891; Mar 2020: 2,064), 45 additional Flow 3 (Medical Admission) attendances, an increase of 30.2% (Mar 2019: 149; Mar 2020: 194), and 201 fewer Flow 4 (Surgical Admission) attendances, a decrease of 32.9% (Mar 2019: 611; Mar 2020: 410).

Prior to the outbreak, ED attendances at UHC had been gradually increasing in comparison with the previous year, whilst at UHA attendances had been marginally lower than the previous year.

Provisional data indicates that ED attendances have remained low in April 2020.

The **ED 4-Hour Wait** 95% target has not been achieved at NHS Board level since July 2018, although recent performance has improved. Compliance at UHA in March 2020 was 76.4%, a decrease of 5.8 percentage points when compared to the previous year (Mar 2019: 82.2%), however represents an improvement of 11.4 percentage points in comparison to the previous month (Feb 2020: 65.1%).

At UHC, compliance was 91.9% for March 2020, an increase of 3.1 percentage points from the previous year (Mar 2019: 88.8%), and an increase of 9.0 percentage points when compared to the previous month (Feb 2020: 82.9%).

Provisional data indicates that ED compliance continued to increase in April 2020.

12 hour breaches reduced significantly, having reached an all-time peak in January 2020 at both sites. There were 124 breaches at UHA in March 2020, a decrease of 97 from the previous month (Feb 2020: 221), although still double the number experienced in the same month last year (Mar 2019: 67). Meanwhile at UHC there were 67 breaches in March 2020, a decrease of 159 from the previous month (Feb 2020: 226), although an increase of 10 from the previous year (Mar 2019: 57).

Provisional data indicates that there were no 12 hour breaches in April 2020.

ED Attendances

The emergence of COVID-19 has had a significant impact on how people in Ayrshire seek care and also on how that care is being delivered.

The overall reduction in unscheduled care attendances could have a number of possible causes. Some reasons cited have been around reluctance or anxiety about using hospital services. Whilst urgent services remain open, the fear is that many people are staying away because they do not want to burden the NHS or are afraid of contracting the virus whilst in hospital. The nationwide lockdown restrictions have also led to decreased traffic on the roads and a reduction in workplace related injuries.

Calls to NHS 111 have significantly increased suggesting that the citizens of Ayrshire who might have previously attended ED could be seeking clinical advice elsewhere, and that NHS 111 is playing a critical role in advising people how to access the care they require. It would appear that the population of Ayrshire is following the official advice to avoid going to ED if there are suitable alternatives. Further work is required to better understand who is not attending ED, and whether unmet needs are being stored up for the future.

Around 170,000 adults in Scotland have been defined on medical grounds as clinically extremely vulnerable due to having an existing health condition. This places them at very high risk of severe illness from COVID-19. There is evidence to suggest that this group of individuals are being supported to remain at home wherever possible.

The ED 4-Hour Wait 95% standard

A reduction in front door attendances, along with lower bed occupancy on site, has resulted in an improvement in meeting the 95% access and treatment standard. Pre-COVID-19, the majority of breaches of the 4 hour standard on both Acute sites were ‘wait for beds’, as a result of exit block. At times, both Acute sites had in excess of 25% of their beds unavailable as patients were waiting to move onto the next stage of their health and social care journey.

Both South and North Ayrshire HSCPs had significant challenges in sourcing Homecare, lack of availability of Care Home placements, and ensuring that adequate funding was available to move patients onto these placements. This meant that many of our citizens remained in Acute care when their acute medical needs had been resolved. Increased Acute bed availability has meant that breaches due to ‘wait for beds’ have almost been eradicated. On a small number of occasions a wait for a single room has been an issue as a result of isolating patients awaiting test results.

12 hour breaches

Prior to the COVID-19 outbreak, NHS Ayrshire & Arran was an outlier in respect of 12 hour breaches. Although the overall number of breaches in March 2020 is higher at both sites than the previous year, the reduction in occupancy levels due to changes to planned care on both sites and the subsequent increased bed availability have improved flow from ED into the main hospital. This has meant that there have been no 12 hour breaches at UHA and UHC since 11 March 2020 until the end of

April 2020. Some waits have been longer than would normally be the case in ED as a result of staff donning Personal Protective Equipment (PPE) in specific cases. Furthermore there is anecdotal evidence that staff are spending longer treating people within ED to avoid hospital admission where possible.

Combined Assessment Units

CAU Presentations have experienced a similar level of reduction to ED attendances, with 538 fewer presentations at UHA in March 2020 compared to March 2019 (Mar 2019: 1,735; Mar 2020: 1,197), a decrease of 31.0%, whilst at UHC there were 492 fewer presentations in March 2020 than the previous year, a decrease of 29.0% (Mar 2019: 1,697; Mar 2020: 1,205).

In terms of sources of referral, this decrease is evident fairly uniformly across GP and ED referrals to both sites, although referrals from 'Other' sources at UHC CAU experienced an increase of 16 (Mar 2020: 83), representing a 23.9% increase.

Note: 'Other' referral sources include referrals from Outpatient clinics, Radiology patients requiring immediate assessment, and Cancer patients referred via the national cancer helpline, however do not include elective return patients, who are instead recorded separately as outpatient attendances at the Acute Clinic.

The CAU at UHC opened in April 2016 and at UHA in May 2017. Patients are referred by their GP or the ED. When comparing activity levels between the two sites, it should be noted that the CAU at UHA is configured to receive both Medical and Surgical admissions, whilst only Medical admissions are routed via CAU at UHC. Therefore, whilst UHA services a smaller catchment area and would be expected to have lower numbers of CAU presentations than UHC, the additional surgical admissions bring overall activity levels on a par with that at UHC.

Admissions and Occupancy

The numbers of **Medical and Surgical Inpatient Admissions from ED and CAU** have similarly experienced significant reduction since the outbreak of COVID-19, with 235 fewer admissions at UHA in March 2020 when compared to the previous year (Mar 2019: 875; Mar 2020: 640) and 424 fewer admissions at UHC (Mar 2019: 1,493; Mar 2020: 1,069).These figures represent general Acute admissions, and so do not include admissions to intensive care or high dependency wards, which may be reasonably expected to have experienced significant increase during the current crisis. Maternity and Paediatric admissions are also not included within this data.

Bed occupancy for Acute Medical and Surgical wards has also experienced a significant decrease following the outbreak, reducing to 79.0% at UHA and to 74.8% at UHC in March 2020, having previously been at a level consistently at or above 90% (Mar 2019: UHA – 95.1%, UHC – 95.1%).

Provisional data indicates that occupancy levels have started to increase towards the end of April 2020.

Combined Assessment Units/CAU Presentations

Red and green pathways have been established at both front doors at UHA and UHC. Acute Physicians and ED Consultants have worked collaboratively to ensure that patients who can be assessed, treated and discharged at our front doors have been. This has involved utilising existing spaces within both ED and CAU to create separate flows to ensure patient safety.

These red and green pathways will continue to exist as long as people suspected of COVID-19 continue to present at our hospitals. The CAU provides the ideal environment to isolate those patients who require admission and are suspected of COVID-19 and awaiting test results. Pathways have been established on both sites to support safe transfer of patients who require a longer stay in hospital.

Public Health Scotland analysis published on 6 May 2020 showed that planned admissions to hospital started to decrease on 16 March 2020 as hospitals across Scotland began to create capacity to cope with the anticipated pressure which was based on our modelling projections. GPs and Specialty Consultants have very quickly increased their use of digital solutions to advise and 'see' patients. The use of NearMe in Ayrshire has been rolled out to facilitate these virtual consultations. The number of GP referrals to both Acute sites in April 2020 have halved based on the number of GP referrals in January 2020. Surgical admissions have ceased with the exception of urgent and emergency cases.

There have been challenges in respect of rapid turnaround of test results within CAU, along with added infection control challenges. CAU requires to be prioritised in terms of testing as awaiting results can lead to bottlenecks within this part of our system.

Admissions and Occupancy

In preparation for the anticipated demand of people being treated for COVID-19, our Acute hospitals and our HSCPs developed plans to ensure that people who no longer required medical treatment, and were ready to move to the next stage of their journey, were transferred to more suitable settings. This had a significant effect on occupancy levels within both Acute hospitals with Acute beds being freed in a state of preparedness. Previous Day of Care surveys frequently highlighted that occupancy levels could be in excess of 100% on both sites.

Provisional data suggests that as demand and need increases, occupancy levels have started to increase towards the end of April 2020. This may be as a result of Scottish Government campaigns encouraging patients to continue to access services if they need them, despite the COVID-19 demands on hospital services.

At UHA, Station 16 (Stroke Rehabilitation) re-located over one weekend to Drummond Ward at Biggart Hospital to free 24 Acute beds to meet the anticipated demand.

GP referrals have halved which has led to a significant decrease in hospital admissions. Telehealth and other digital solutions have been utilised, where possible, to safely maintain people at home.

Red and green zones are being reviewed and revised as the number of COVID-positive patients change over time.

COVID-19 related staff absences have meant that some areas within the hospitals have had reduced staffing levels, especially between mid to late March, however the impact of this has been negated due to a reduced number of admissions to these areas.

Personal Protection Equipment (PPE) has been supported by the Bronze PPE Team to ensure all areas across the hospitals have adequate stocks, and that we are clear about our daily usage and anticipated demands with rising numbers of patients, more so at the beginning of the pandemic.

Both UHC and UHA have Extreme Teams in place with programmes of work focused on unscheduled care. A number of priority areas have been identified for improvement. The newly-appointed Site Directors at UHA and UHC are keen to re-establish work programmes to improve unscheduled care as non-COVID-19 presentations begin to increase, and to reconvene governance structures to support this work. Site Directors are working closely together to support a one single Acute system approach. The Recovery plan will embed learning around triaging patients more robustly, improved Multi-Disciplinary Team working, shared skills, and digital solutions which have all been used more effectively during the course of the pandemic.

Delayed Discharges

In preparation for the anticipated demand of people being treated for COVID-19, additional community bed capacity and adaptation of other services enabled patients who no longer required medical treatment, to be transferred to more suitable settings.

Delayed Discharges >2 Weeks (excluding complex code 9 delays) have fallen from a high of 84 in January 2020 to 39 by March 2020. There were 21 delays over 2 weeks for North Ayrshire HSCP residents at the end of March 2020, down by 17 from the previous month (Feb 2020: 38) and down by 5 from the previous year (Mar 2019: 26). Similarly for South Ayrshire HSCP residents there were 18 delays over 2 weeks at the end of March 2020, down by 14 from the previous month (Feb 2020: 32) and similarly for the previous year (Mar 2019: 32). Performance in East Ayrshire HSCP has continued to meet the target of zero delays over 2 weeks.

Delayed Discharge Occupied Bed Days (OBDs) for all delay reasons have experienced less of an impact, having reduced by 191 bed days in March 2020 compared to the previous month (Feb 2020: 4,830; Mar 2020: 4,639), however have increased by 792 when compared with the previous year (Mar 2019: 3,847). It should be noted however that 1,119 of these bed days (24%) were for complex code 9 reasons, whilst the previous month, only 16% of bed days were for code 9 reasons. This sharp increase indicates that whilst overall bed days occupied due to delayed discharges are decreasing following the COVID-19 outbreak, the numbers of these due to complex code 9 reasons are increasing.

In North Ayrshire, there were 91 fewer OBDs in March 2020 than the previous month (Feb 2020: 2,164; Mar 2020: 2,073), whilst in East Ayrshire, there were an additional 29 OBDs (Feb 2020: 447; Mar 2020: 476), and in South Ayrshire there were 129 fewer OBDs (Feb 2020: 2,219; Mar 2020: 2,090).

Provisional data indicates that delayed discharges continued to decrease in April 2020.

In **East Ayrshire HSCP**, actively managing 'delayed discharges' has been a key component in the Mobilisation Plan to create capacity for Acute service capacity and the critical care required by individuals with severe COVID-19 symptoms. The East Ayrshire HSCP Hospital Team has been allocating individuals immediately and planning with people at as early a stage as possible to ensure appropriate care and support is in place for those that no longer require hospital care and are ready for discharge to another setting. The number of standard 'delayed discharges' of any duration has reduced from the baseline for COVID-19 monitoring of 16 on 4 March 2020 to 0 as at 6 May 2020.

The role of step-up and step-down support in community hospitals has also been key in responding to the coronavirus pandemic, with for example East Ayrshire Community Hospital (EACH) managing seven individuals who transferred from Acute Services or were admitted from the community. A personal recovery story related to this was shared through a number of communication channels.

Community teams have played a central role in the response to COVID-19 with the Care at Home service in East Ayrshire having supported 29 people with suspected or confirmed COVID-19 and the District Nursing service providing care to 16 people who are confirmed or suspected COVID-19 as at 6 May 2020. Services have also supported a number of confirmed positive individuals at the end of their life.

At 4 March 2020 **North Ayrshire HSCP** had 78 individuals within hospital sites who were recorded as Delayed Discharges, for a variety of reasons. At 6 May 2020 the number of individuals delayed reduced to 9. North Ayrshire HSCP has been able to achieve a significant reduction in delays due to: deployment of additional staff to focus solely on delayed discharges on a temporary basis; the usual challenges of balanced budget versus demand and capacity being, temporarily, removed; extra capacity being created, temporarily, within care at home; and daily scrutiny and monitoring of performance. Due to the COVID-19 pandemic, the Scottish Government outlined to each HSCP a directive to reach zero delayed discharges and then maintain that status going forward. Scottish Government's further directive about Partnerships demonstrating, via mobilisation plans, the costs of achieving and maintaining zero delays has allowed the North Ayrshire HSCP to put in place these extra measures to achieve the current position. North Ayrshire HSCP are continuing to focus on delayed discharges and reaching the target of zero delays.

In **South Ayrshire HSCP**, delayed discharges (all delays) reduced significantly from 11 March 2020 to fewer than 30 by 23 April 2020. This initial improvement was achieved by increasing capacity in care homes and care at home. Unfortunately there has been little progress since mid-April with approximately 33% of delays due to difficulties accessing care homes (testing issues or complex behaviours making safe transfer challenging), 33% complex mental health delays (housing and placement challenges which have been exacerbated by COVID-19) and 33% guardianships where processes have been slowed and delayed due to COVID-19. The senior team are meeting twice per week to focus on unlocking some of the blocks to discharge with the aim of reducing delays to fewer than 15 by 22 May 2020.

2.3.2 Planned Care

Inpatient/Day Cases and New Outpatients

To effectively and safely manage the pressures of COVID-19, all routine inpatient/day case surgery ceased with planned care surgery restricted to emergency and cancer/very urgent cases only. Emergency surgery continues in all specialties, and in some specialties a small number of very urgent cases continue. This has in turn impacted on the number of patients waiting.

A comparison of the number of patients waiting as at 27 April 2020 is outlined below:

	Number waiting	As at 16 March 2020	As at 27 April 2020
Outpatients	> 12 weeks	3,870	7,949
Inpatients / Daycases	> 12 weeks	1,125	1,893

Patients whose inpatient surgery was cancelled, received a telephone call with an explanation as per normal practice. With regards to outpatients, a number of patients who were cancelled at short notice were cancelled by a phone call from the Referral Management service, or in a small number of cases by the clinic staff. This was done only for the cases for whom a letter by post was not expected to arrive in time. All other outpatients whose appointments were cancelled received notification by letter, explaining the reason.

COVID-19 has also consequently impacted on compliance against the National Waiting Times targets. Provisional data for April 2020 indicates that compliance has decreased to below levels of 60% across Inpatients/Daycases and Outpatients. This will be reported in full to NHS Board members in future papers once this information is validated.

Cancer

Cancer cases have continued on a selected and risk-assessed case by case basis in most specialties with the exception of colorectal and upper gastrointestinal cancer surgery, where the risks were deemed too high. Some urgent/urgent cancer suspected (UCS) outpatient activity continues using a combination of telephone, video and face to face consultations as deemed appropriate.

Planning is in process to take the first colorectal case and upper gastrointestinal case to theatre for the week commencing 11 May 2020, with subsequent cases to be re-introduced in a planned and phased manner once the process, pathway and outcomes of these initial patients have been reviewed.

When a patient has their surgery cancelled it is normal practice for the patient to receive a telephone call, normally from a medical secretary, with an explanation. More recently, cancer patients who are ready for surgery, but for whom a decision is taken to postpone surgery due to COVID-19, have a full telephone discussion with the consultant. These “paused” patients are noted by the Multi-disciplinary teams and are also being tracked on the cancer tracking databases.

Diagnostics

Like other services, routine diagnostic services including x-rays and scans were suspended from mid-March in order to create additional capacity to support the emerging COVID-19 demand; and also to reduce the public footfall in the hospitals with the associated risk of increased transmission of the infection. Urgent and UCS imaging investigations have continued throughout. This has resulted in an increased backlog of patients awaiting routine imaging investigations.

Endoscopy services have significantly been impacted during the COVID-19 outbreak. Following initial COVID-19 guidance issued by the British Society of Gastroenterologists (BSG) in March 2020, all routine, urgent and UCS endoscopy investigations were stopped due to the available evidence around heightened risk to staff. Only emergency endoscopy procedures have continued. Endoscopy at UHC has also been impacted by the expansion of ICU facilities which has extended into the Endoscopy recovery area. This has impacted both on the backlog of patients awaiting an endoscopy investigation, but has also impacted on the cancer pathway for both upper GI and colorectal cancer, since upper GI endoscopy and colonoscopy are key investigations in these pathways. Revised guidance from the BSG was published at the end of April 2020. The Endoscopy team are now reviewing this revised guidance and planning a staged re-starting of the endoscopy service, initially for those patients on a UCS pathway.

Looking ahead, Clinical teams are beginning to consider what a phased re-introduction of planned care activity would look like, and quantifying their most urgent surgical cases. Integral to this will be some modelling of expected ICU demand, and confirmation of the longer term ICU footprint/staffing requirement, as this will impact the capacity available for planned care.

An approval and governance process will be established to support any forthcoming proposals to re-introduce further planned care activity, beyond the currently agreed Urgent Cancer Suspicion and urgent category. It is important that the processes established, support the continued momentum, but balanced against appropriate whole-system consideration and governance. The scope of the (UCS)/very urgent surgery definition is being reviewed and selected colorectal and upper gastrointestinal surgery may re-start in the near future.

The Golden Jubilee National Hospital may also play a part in the recovery process. An initial discussion has taken place and a site visit arranged to explore how this could support general surgery/endoscopy.

Clinical teams are being asked to report back on new practices which have been introduced as part of the COVID-19 response, and particularly those practices which have worked well and should be continued, and built into business as usual. This feedback will be collated and used to inform the Recovery discussions

A decision will require to be taken about whether there is a need to extend the cancellation of appointments from June onwards (or replace with a new processes).

Mental Health

Mental Health Services (including Learning Disabilities and Addiction Services) within Ayrshire and Arran have continued to provide health and social care interventions based on contingency planning and RAG rating throughout the COVID-19 outbreak.

Some aspects of care requiring or requested to be put on hold include; day care, respite, support packages and group work. However, alternative support arrangements have been put in place to safeguard the individuals that this affected.

Other aspects of care required to be expedited in order to deliver the Scottish Government's directive to redirect individuals away from EDs and provide care locally and safely through the use of digital technologies.

Inpatient services have continued to be delivered throughout the COVID-19 outbreak albeit with an increased threshold for admission for only those most at risk and some realignment of services to afford specific isolated assessment provision and specific areas to support those confirmed positive for COVID-19.

A detailed Phase 2 mobilisation plan proposal has been developed to August 2020. The first steps as part of this Phase 2 include the following:

- Continue to determine the current risk or vulnerability to a patient based upon the most recent contact. Shielded patients will be prioritised for a weekly contact/check-in;
- Engagement with Staff –Side organisations and O&HR to understand any barriers or opportunities to maximise resources without increasing risk of transmission;
- Continued promotion of the wellbeing hubs and on-line resources for staff. A telephone contact centre will go live. Line Management supervision and clinical supervision arrangements will be maintained and positive reinforcement of well-being measures for staff working from home;
- Every service will guarantee that contact will be made with every patient - this may be considered to be appropriate by Phone, Video Conferencing, letter or face to face.
- Community Services will operate a tiered staffing shift system to maximise use of space whilst being mindful of social distancing guidance. Services shall deploy their staff as appropriate from base and home, dependent upon type and nature of activity. Use of digital technology such as Near Me, MS Teams will be optimised to support social distancing.
- An evaluation of available estate for administrative work and clinical work is required to be undertaken.
- Monitoring of access to public transport within our remote and rural communities and wider Ayrshire region is required to ensure that any change in service provision is accessible to the wider population.

Musculoskeletal

Performance against the MSK target of 90% of patients being seen within 4 weeks from referral to first clinical outpatient appointment at the end of March 2020 was 36.9%. But like other areas, Musculoskeletal (MSK) services have been impacted by the COVID-19 outbreak which will in turn affected the MSK 4 week performance target going forward.

Within **Orthotics,** outpatient activity has been significantly impacted by the COVID restrictions. However to help support patients, telephone clinics have been established and the option for NearMe consultations/digital consultations has been offered if required. The service is meeting the inpatient referral demand and delivering face to face appointments for those triaged as clinically urgent. The majority of cases will require an appointment review which will reduce capacity to see new referrals when services resume.

From 23 March to 11 May 2020, approximately 400 new **Podiatry** patients have been telephoned and offered advice, support, and signposted to various video links. Patients that staff were unable to make contact with have been sent an opt-in letter.

Approximately 150 patients on the existing podiatry caseload were telephoned and supported as above. Those patients identified as acute/complex are escalated and offered face to face consultations within new “Trauma Clinic” held at Ayrshire Central Hospital. Two sessions per week have been created and since its commencement at the beginning of May 2020, eight patients have attended. This NearMe/Attend Anywhere Podiatry MSK Service was actively progressed by an Advanced Podiatrist who lead its implementation and set up. Service user feedback has been positive.

Within MSK **Physiotherapy,** clinics started to be reduced on 9 March 2020 and clinicians phoned or sent letters to patients to give advice, sign post and cancel patient appointments with instruction to contact the MSK administration hub if clinical problems arose. Two MSK departments were moved out of Acute areas and three virtual MSK hubs were set up in peripheral sites.

Out of 56 MSK staff (45.45wte), 13 staff (10.31wte) stayed in MSK for telephone and NearMe consultations and have set up Standard Operating Procedures (SOPs) and evaluation processes for telephone and NearMe consultations. The residual 43 MSK staff (87.3%) were moved to acute and peripheral sites and downstream areas. This resulted in 2,900 MSK patient appointments being cancelled who are currently being contacted by the residual MSK team. In addition to this, approximately 2,300 patients are on the routine waiting list and a small amount of urgent referrals are still being received and being dealt with. There is no current capacity to deal with the routine waiting list.

There are two MSK sessions per week for face to face consultations. Escalation pathways to orthopaedic advanced practice physiotherapists are in place.

Within the **Occupational Therapy MSK Hands** service, urgent trauma patients have continued to been seen face-face within a designated area at UHC. These patients are planned and screened.

Around 160 existing review patients were cancelled within this service but all of these patients received telephone reviews where outcomes included: further review telephone call, review opt-in or discharge from the service.

There are currently 165 new patients on the case load list. Patients are vetted, reviewed and split into appointment types. Telephone clinics for this list have commenced and pathways planned for each clinical presentation. Other support includes splint provision, self-management advice, and signposting to various online links and information.

The Occupational Therapy MSK Hand service is now in a position of readiness to commence 'NearMe/Attend anywhere' with the service hoping to commence the week beginning of 18 may 2020. The service will evaluate patient experience/feedback of this new appointment type. The service will continue to evaluate new ways of working and permanently change pathways which have demonstrated improved patient outcomes and efficiency. Including; telephone consultation, NearMe, self- management pathways for identified conditions – eg. Ganglion, Carpal Tunnel Syndrome and Triger Finger.

2.3.3 Quality/patient care

Systems and procedures are in place to monitor and manage the impact of COVID-19 on our provision of unscheduled and planned care for our citizens and ensure high quality of care for patients.

2.3.4 Workforce

Sustainable workforce and recruitment levels are imperative to ensure appropriate levels of capacity are maintained to manage the demand of COVID-19 and non-COVID-19 patients across all services.

Workforce implications identified relate to COVID-19 related staff absences to ensure appropriate levels of capacity are maintained to manage demand.

2.3.5 Financial

The health and care system is ensuring appropriate levels of capacity are maintained to manage the demand of COVID-19 and non-COVID-19 patients.

The impact of COVID-19 on the delivery of key performance targets and trajectories are routinely being assessed and monitored.

2.3.6 Risk assessment/management

There is a significant risk to the organisation in failing to manage the impact of COVID-19 however detailed plans are in place to ensure that the safety of patient care is prioritised.

Risks remain that unforeseen circumstances, e.g. ward closures due to illness or staff absence, could adversely affect system flow. Staff and service leads have contingency plans in place where possible.

The impact of COVID-19 on the delivery of key performance targets and trajectories are routinely being assessed and monitored.

2.3.7 Equality and diversity, including health inequalities

An Impact Assessment has not been completed as this paper provides an update on performance levels during the COVID-19 outbreak.

2.3.8 Other impacts

Best value:
Successful management of waiting times requires leadership, and engagement with clinical staff. The HSCP have increasing influence on Delayed Discharge performance through patient flow. Local performance management information is used to provide as up to date a position as possible in this report. Some information may change when the data is quality assured by ISD in readiness for publication.

C**ompliance with Corporate Objectives**:
The achievement of the waiting times targets set out within this paper complies with a number of the corporate objectives: improving health; safety/outcomes; quality of experience; equality; transforming and patient flow; supply and demand.

Local outcomes improvement plans (LOIPs):
The achievement of the targets provides better access to healthcare services and should therefore have a positive effect on the health inequalities priority within local LOIPs.
The achievement of the patients awaiting discharge targets will have a positive contribution towards the Outcomes for Older People priority.

2.3.9 Communication, involvement, engagement and consultation

There is no legal duty for public involvement in relation to this paper. Any public engagement required for specific service improvement plans will be undertaken as required.

2.3.10 Route to the meeting

The content discussed in this paper has been considered by the Service Leads for each area. They have either supported the content, or their feedback has informed the development of the content presented in this report.

2.4 Recommendation

NHS Board members are asked to discuss the information provided in this report which provides assurance that systems and procedures are in place to monitor and manage the impact of COVID-19 on our provision of unscheduled and planned care for our citizens.