NHS Ayrshire & Arran

Meeting:	**NHS Board**
Meeting date:	**Monday 17 August 2020**
Title:	**Performance Report**
Responsible Director:	**Kirstin Dickson, Director for Transformation and Sustainability**
Report Author(s):	**Donna Mikolajczak (Performance Manager), Paul Dunlop (Senior Performance Officer), Steven Fowler (Senior Performance Officer)**

1. Purpose

This is presented to the NHS Board members 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

NHS Ayrshire & Arran has responded to the COVID-19 pandemic on an integrated basis, working with our East, North and South Ayrshire Health and Social Care Partnerships (HSCPs). As the health and social care system continues to respond to the challenges of COVID-19 there is also a requirement to move into the next phase of our re-mobilisation and recovery planning. This includes restarting services in a safe way but also positively learning from the new and innovative ways that have been employed to respond to the demands on services by COVID-19.

A Whole System Mobilisation Planning Group has been established to oversee the re-mobilisation and recovery plans. A high level summary of current plans, provided by the Senior Responsible Officers for each service area, have been included within this report.

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. Sections 2.3.1 and 2.3.2 includes infographics for data at June 2020, where possible, with June 2019 data provided for comparison. Some measures may relate to May 2020 and May 2019. Section 2.3.2 also

includes performance in February 2020 to provide comparisons with pre-COVID 19 performance.

NHS Board members are asked to discuss the information provided in this report which provides assurance that systems and procedures are in place to continue to monitor performance, including highlighting where the impact of COVID-19 has affected provision of unscheduled and planned care for our citizens.

2.2 Background

NHS Ayrshire & Arran, like other NHS Boards, were required to significantly increase our Intensive Care capacity to manage critically ill COVID-19 cases over the period of the outbreak. Additional Intensive Care Unit (ICU) capacity was achieved at both our Acute hospitals through the cancellation of non-urgent elective surgery, releasing the theatre recovery areas for conversion into ICU facilities, and releasing Consultant Anaesthetists and theatre nursing staff, 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 treat 'urgent' and 'urgent cancer suspected' patients throughout the outbreak, for as long as this was 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.

In preparation for the anticipated demand of people being treated for COVID-19, our Acute hospitals, along with our HSCPs, 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 University Hospital Ayr (UHA) and University Hospital Crosshouse (UHC). Red (COVID-19) and green (non-COVID-19) pathways were quickly established at both front doors at UHA and UHC. The Combined Assessment Units (CAUs) provided an environment to isolate those patients who required admission and who were suspected of COVID-19 and awaiting test results. Acute Physicians and Emergency Department (ED) Consultants continued to work collaboratively to ensure that patients who can be assessed, treated and discharged at our front doors, have been. Pathways were also established on both sites to support safe transfer of patients who required a longer stay in hospital.

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

Contingency plans were also put in place across Musculoskeletal (MSK) services.

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	2,470 Jun 2020	3,456 Jun 2019	attendances at UHA Emergency Department	
	95.4% Jun 2020	88.5% Jun 2019	ED attendees were treated, admitted or discharged within 4 hours of arrival	⊕ 95%
	0 Jun 2020	35 Jun 2019	ED attendees waited over 12 hours to be treated, admitted, or discharged	
UHC H A&E	5,247 Jun 2020	6,486 Jun 2019	attendances at UHC Emergency Department	
	96.9% Jun 2020	90.9% Jun 2019	ED attendees were treated, admitted or discharged within 4 hours of arrival	⊕ 95%
	0 Jun 2020	61 Jun 2019	ED attendees waited over 12 hours to be treated, admitted, or discharged	

Medical and Surgical Bed Occupancy

75.8% Jun 2020	94.2% Jun 2019	occupancy of acute medical and surgical beds at University Hospital Ayr
75.6% Jun 2020	93.4% Jun 2019	occupancy of acute medical and surgical beds at University Hospital Crosshouse

Combined Assessment Units

	1,222 Jun 2020	1,617 Jun 2019	1,589 Jun 2020	1,496 Jun 2019
	presentations to UHA CAU		presentations to UHC CAU	

Emergency Admissions *

	741 Jun 2020	843 Jun 2019	1,382 Jun 2020	1,597 Jun 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	
	2 May 2020	21 May 2019	0 May 2020	0 May 2019	7 May 2020	51 May 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 significant decrease since the outbreak of COVID-19 when compared with the same period last year. At UHA there were 986 fewer ED attendances in June 2020 than in June 2019, representing a 28.5% decrease. At UHC, there were 1,239 fewer ED attendances in June 2020 than in June 2019, representing a reduction of 22.4%. The decrease at UHA is predominantly in relation to Flow 1 (Minor Injury) and Flow 2 (Acute Assessment, including Major Injury) attendances. At UHC the reduction is mainly in relation to Flow 1 (Minor Injury).

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.

The **ED 4-Hour Wait** 95% target was achieved at NHS Board level in June 2020 for the third consecutive month, with overall compliance of 96.8%. Compliance at UHA in June 2020 was 95.4%, an increase of 6.9 percentage points when compared to the previous year. This is the first month that the 95% target has been achieved at UHA since June 2018. At UHC, compliance was 96.9% for June 2020, an increase of 6.0 percentage points from the previous year.

12 hour breaches have reduced significantly, with no 12 hour breaches reported at UHA and UHC in June 2020.

ED Attendances

Public concern around the possible exposure to COVID-19 in the hospital setting alongside repeated media messages to avoid ED if possible have led to reduced attendances at our Emergency Departments. Reduced outpatient clinics, the absence of routine surgical elective work and cancer screening programmes has also reduced the number of people presenting and being referred to specialist services in the hospital setting. The nationwide lockdown restrictions have also led to decreased traffic on the roads and a reduction in workplace related injuries.

The emergence of the pandemic has impacted significantly on how people in Ayrshire access health and social care services. NHS111 has played a critical role in advising people how to access the care they require which has resulted in people being redirected to more appropriate services.

The group of people who are shielding (estimated at approximately 170,000 in Scotland of which 16,444 reside in Ayrshire) are largely being supported at home wherever possible by primary care, community teams and voluntary organisations. This has led to reduced demand in emergency services during the height of the pandemic.

The Cabinet Secretary has established 11 national workstreams to support new ways of working in light of what has been learned during the pandemic. These include national messaging, pre-hospital triage, alternatives to admission, the further expansion and development of Community Resource Hubs, the value of virtual technology, and scheduling the unscheduled. All of these factors have been shown to have an effect on unscheduled care demand during the period of the pandemic.

The ED 4-Hour Wait 95% standard and 12 hour breaches

The emergence of COVID-19 led to reduced demand on emergency hospital services from March 2020. In turn, this resulted in improved performance in meeting the 4 hour access and treatment standard, and an improved experience for patients. Some waiting times within ED have been longer than we would have liked but these have been due to staff donning Personal Protective Equipment (PPE) at times when required. However, Senior leadership at both front doors of our EDs across 7 days has facilitated quicker decision-making and supported safer flow.

A reduction in occupancy levels and in the number of patients delayed for discharge has also meant that there have been no 12 hour breaches in June 2020.

Improvement work is ongoing to sustain reduced occupancy levels and delays to ensure the 4 hour standard continues to be met and that 12 hour breaches remain low. A dedicated workstream focused on reducing delays to discharge home will ensure that patients are not unnecessarily delayed within the acute setting allowing increased bed availability.

Combined Assessment Units

CAU Presentations at UHA have experienced a similar level of reduction to ED attendances, with 395 fewer presentations at UHA in June 2020 compared to June 2019, a decrease of 24.4%. However at UHC, there were 93 additional presentations in June 2020 compared to the previous year, an increase of 6.2%.

Admissions and Occupancy

Although the numbers of **Medical and Surgical Inpatient Admissions from ED and CAU** have experienced a reduction since the outbreak of COVID-19, with 102 fewer admissions at UHA in June 2020; and 215 fewer admissions at UHC compared to June 2019, the number of admissions have almost doubled between May 2020 and June 2020 at both UHA and UHC. 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 reduced to 75.8% at UHA and to 75.6% at UHC in June 2020, having previously been at a level consistently at or above 90%.

Combined Assessment Units/CAU Presentations

At the start of the COVID-19 response, the Combined Assessment Units were quickly established as a 'red' COVID-19 pathway and because the CAUs at both hospitals have single bedrooms, this has provided an environment to isolate those patients who required admission and who were suspected of COVID-19 and awaiting test results.

The surgical zone within the CAU at UHA was re-located due to the CAU being a red pathway – which would account for a proportion of the reduced presentations.

Patients who previously would have self-presented to ED, who were screened and then seen by ED doctors have been recorded in the Combined Assessment Figures. Any referrals from the COVID-19 Assessment Hub and other hospitals were also recorded in this way.

The rapid reconfiguration of ward areas to facilitate safe flow has been required frequently throughout the pandemic. Services and staff groups have mobilised quickly to accommodate this.

During the pandemic, innovative ways of working were employed. Primary care patients were triaged by telephone - this prevented patients attending General Practices (GPs) and subsequently being referred onto the CAUs. All appointment requests to GPs were also triaged. The COVID-19 Community Pathway Model has supported our citizens to access services through the single national NHS111 number - this has redirected many people and consequently reduced attendances to both front doors.

General Practitioners and Specialty Consultants have very rapidly increased their use of virtual technology to advise and 'see' patients. The use of Near Me in Ayrshire has been rolled out to facilitate these virtual consultations.

In capturing the learning from these last few months, the 11 national workstreams will drive new ways of working. 'Scheduling the unscheduled' has been shown to alleviate the pressure and ensure the demand is manageable. Locally, the Whole System Strategic Interface group is leading work around many of the priorities noted above. Work is already underway to test some of the concepts that worked well during the period of the pandemic. Short, medium and longer-term plans have been identified. In the short-term, reducing admissions with focus on zero day length of stay for rapid assessment and discharge and minimising length of stay for all specialty admissions (this is to ensure capacity and occupancy levels remain within reasonable levels) is a key priority.

Introduction of a pre-triage system is a medium-term goal, with redesign of high volume, complex pathways to ensure care is provided as close to home as possible, and is planned for the longer-term. All of this work will alleviate the demands on the CAUs. There are infection transmission risks related to the CAUs becoming overcrowded when the peak demand occurs.

Improvement work around scheduling GP referrals to smooth demand throughout the day; profiling all alternatives to hospital admission; and review of zero day length of stay patients to assess whether suitable community alternatives or acute planned options are available, are all underway.

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. As a result, occupancy levels within our Acute hospitals have been significantly lower than usual. Whilst cancer services have remained a priority throughout the pandemic, some procedures and routine surgeries were suspended which contributed to lower occupancy levels within the hospitals. Alongside reduced ED/CAU attendances and emergency admissions, these actions have supported reduced occupancy and increased bed availability.

Both Acute sites have managed the significant increases and the resultant demand between May 2020 and June 2020.

There has been renewed focus on Multi-Disciplinary Teams (MDTs) at daily Board Rounds in the wards. Due to the redeployment of Allied Health Professionals (AHPs) to the acute setting, this has allowed the opportunity to have good AHP representation at Board Rounds. Due to different working practices with senior medics increasing presence in the evening and working over weekends, the average weekend daily discharge rate has increased at both sites

In addition to the national priorities, workstreams focusing on improving the Frailty pathway and the Stroke pathway are being progressed. These will further improve patient experience and reduce the length of stay for these patients in an Acute setting.

Priority work to reduce ED/CAU attendances and avoid emergency admissions where possible, will support reduced front door/hospital demand ensuring hospital occupancy remains at a manageable level.

Both sites have worked collaboratively with our partners to ensure the number of patients delayed onsite remains low. At UHA, we have worked with Social Work teams working offsite to establish virtual long-stay reviews - reviewing patients with a length of stay 14 days and over to highlight and free obstacles which may be preventing discharge.

Recently, a shortened version of the Day of Care survey has been undertaken on both Acute sites to provide an overview of current delays and opportunities for improvement.

The 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. Draft plans, which capture the learning from innovative work during the pandemic, and align with the national unscheduled care priorities, have been developed. The Site Directors are working closely to support a one single Acute system approach with a Leadership Group spanning across both sites.

Two sessions at UHA and UHC (’Collective Wisdom’) captured learning from staff members which will also be taken into account in plans moving forward. 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 nine by May 2020. There were two delays over 2 weeks for North Ayrshire HSCP residents at the end of May 2020, down by three from the previous month and down by 19 from May the previous year. Similarly for South Ayrshire HSCP residents there were seven delays over 2 weeks at the end of May 2020, down by six from the previous month and by 44 from the previous year. 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 similarly experienced a significant reduction, down by 284 bed days in May 2020 compared to the previous month, and have decreased by 2,697 when compared with the previous year.

In North Ayrshire, there were 321 fewer OBDs in May 2020 than the previous month. In East Ayrshire, there were 83 fewer OBDs; and in South Ayrshire there were an additional 120 OBDs in May 2020 compared to April 2020.

In **East Ayrshire HSCP**, actively managing 'delayed discharges' has been a key component in the Mobilisation Plan to create capacity for Acute services 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 zero as at 6 May 2020.

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

Community teams have played a central role in the response to COVID-19, with the Care at Home and District Nursing services in East Ayrshire having supported a number of people with suspected or confirmed COVID-19, whilst also supporting confirmed positive individuals at the end of their life.

Within **North Ayrshire HSCP** there has been a continued focus on the reduction of delayed discharges. At 19 June 2020 the number of individuals delayed reduced to five. The HSCP have continued to see the benefits of the temporary deployment of staff to focus solely on delayed discharges; the temporary extra capacity within care at home and the daily scrutiny and monitoring of performance across the Service areas. However, the HSCP have also seen a rise, from acute sites, in the number of referrals for care at home provision and the requests for assessments of individuals' longer term needs during the month of June 2020 than in the previous three months. Therefore the daily scrutiny and performance monitoring

is key in ensuring that flow is maintained, that information on individual care needs are recorded appropriately and delays are managed accordingly.

In **South Ayrshire HSCP**, delayed discharges (all delays) reduced significantly between 11 March 2020 and 23 April 2020. This initial improvement was achieved by increasing capacity in care homes and care at home. South Ayrshire HSCP aims to reduce delays further. Approximately one third of current delays are due to difficulties accessing care homes (testing issues or complex behaviours making safe transfer challenging); one third of delays are also complex mental health delays (housing and placement challenges which have been exacerbated by COVID-19) and a further one third are guardianship delays where processes have been slowed and delayed due to COVID-19. The senior team within South Ayrshire have been meeting twice per week to focus on unlocking some of the blocks to discharge and have supported those who have waited longest to move. The Head of Community Health and Care Services and Director for University Hospital Ayr are commissioning an extreme team in July 2020 to focus on process improvement in pursuit of the aim to reduce delays.

2.3.2 Planned Care

NHS Ayrshire & Arran – At a Glance

Planned Care

Latest performance, compared with figures at February 2020 (pre COVID-19) as well as same month of the previous year
Includes Scottish Government target (◎) where applicable

Service Access

29.1% Jun 2020	**81.1%** Feb 2020	**81.5%** Jun 2019	waited fewer than 12 weeks for a New Outpatient appointment	◎ 95%
91.5% May 2020	**79.7%** Feb 2020	**80.1%** May 2019	waited fewer than 18 weeks from Referral to Treatment	◎ 90%
14.4% Jun 2020	**71.8%** Feb 2020	**80.1%** Jun 2019	waited fewer than 12 weeks for inpatient or day case treatment	◎ 100%

Child and Adolescent Mental Health

47.8% Jun 2020	**51.2%** Feb 2020	**82.2%** Jun 2019	◎ 90%

of children and young people started treatmentwithin18 weeks of initial referral to CAMH services

Psychological Therapies

74.0% Jun 2020	**74.9%** Feb 2020	**78.7%** Jun 2019	◎ 90%

of patients started treatment within 18 weeks of their initial referral for psychological therapy

MSK

16.5% Jun 2020	**53.1%** Feb 2020	**47.0%** Jun 2019	◎ 90%

of adult patients waiting fewer than 4 weeks for MSK services

Drug and Alcohol Treatment

99.2% Jun 2020	**98.6%** Feb 2020	**98.2%** Jun 2019	◎ 90%

of clients waited no longer than 3 weeks from referral to appropriate drug or alcohol treatment that supported their recovery

Cancer

98.4% May 2020	**100%** Feb 2020	**96.1%** May 2019	◎ 95%	**94.9%** May 2020	**89.6%** Feb 2020	**82.1%** May 2019	◎ 95%
started treatment within **31 days** following decision to treat				of patients with suspicion of cancer started treatment within **62 days**			

Diagnostics

15.1% May 2020	**63.8%** Feb 2020	**50.9%** May 2019	of patients waiting fewer than 6 weeks for Endoscopy	◎ 100%
26.3% May 2020	**73.0%** Feb 2020	**70.4%** May2019	of patients waiting fewer than 6 weeks for Imaging	◎ 100%

Inpatient/Daycases and New Outpatients

To effectively and safely manage the pressures of COVID-19, all routine Inpatient/Daycase surgery ceased with planned care surgery restricted to emergency and cancer/very urgent cases only. Emergency surgery continued in all specialties, and in some specialties a small number of very urgent cases continued. This in turn has impacted on the number of patients waiting and as a direct consequence affected compliance against the National Waiting Times targets. Data for June 2020 reports that compliance has decreased to levels below of 20% across Inpatients/Daycases; and 30% for Outpatients. Performance at February 2020 (prior to COVID-19) was 71.8% for Inpatients/Daycases and 81.8% for Outpatients.

A comparison of the number of patients waiting as at 29 June compared to 24 February is outlined below:

	Number waiting	As at 24 February 2020	As at 29 June 2020
Outpatients	> 12 weeks	3,924	16,412
Inpatients / Daycases	> 12 weeks	987	3,905

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.

Considerable progress has been made in re-starting planned care activity. An approval and governance process has been established, with all acute requests to re-start services being proposed via a complete risk assessment presented at the weekly Acute Mobilisation Steering group. This group has the oversight of all re-start activities and ensures that any wider impact on other services is considered before services are approved for re-start.

The Acute Mobilisation Steering Group is supported by several operational groups including a Theatre Re-start group at UHA and a Theatre Re-start group at UHC (with the same group Chair to ensure consistency of approach), and Outpatient Re-start Group and an Endoscopy Re-Start Group.

This process has already approved the re-start of 32 planned care re-start proposals.

With regards to outpatient services, a significant change in practice has been required through the COVID-19 Phase 1. Although significant numbers of face to face appointments have been cancelled, with only the most urgent face to face appointments continuing, there has been increasing use of telephone and NHS Near Me video consultations, and virtual review to support continued delivery of outpatient care in appropriate cases. This change in practice is being continued as part of the service re-mobilisation. Early experience has provided teams with a clearer view of what types of patients can be managed in this way, and what proportions of patients do require a face to face appointment. The requirement to continue to support physical distancing and avoid crowded waiting areas is key to the co-ordination of the service re-start process.

Elective surgery has also re-started taking a phased approach. Capacity is also reduced in the operating theatres due to ongoing use of some theatre facilities and staff to support the COVID-19 response. Elective surgery is being re-introduced based on clinical urgency. Initially this supported the re-start of colorectal and oesophageal resections which had been suspended in the COVID-19 Phase 1. Subsequently as increasing capacity has been confirmed there has been a steady expansion in the range and number of surgical procedures being undertaken.

18 Weeks Referral to Treatment

18 week Referral to Treatment (RTT) performance has exceeded the 90% target for the second month in a row, with an increase of 11.8 percentage points from the 79.7% recorded in February 2020 to 91.5% in May 2020. This is higher than the 80.1% recorded in May 2019. It should be noted that this increase in compliance has been affected by the measures put in place to effectively and safely manage the pressures of COVID-19. The 18 weeks RTT measurement is based on the patients who have completed their treatment stage. At the current time where we are prioritising the reduced treatment capacity for Urgent Cancer Suspected (UCS) and Urgent patients, and less urgent patients are not being treated, the 18 weeks RTT measurement cannot be meaningfully compared to performance prior to the COVID-19 outbreak.

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 Urgent Cancer Suspected imaging investigations have continued throughout. This has resulted in an increased backlog of patients awaiting routine imaging investigations.

Endoscopy services have been significantly 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 continued. Endoscopy at UHC has also been impacted by the expansion of ICU facilities which extended into the Endoscopy recovery area. This impacted both on the backlog of patients awaiting an endoscopy investigation, but also impacted on the cancer pathway for both upper gastrointestinal (GI) and colorectal cancer, since upper GI endoscopy and colonoscopy are key investigations in these pathways.

Within **Diagnostics**, compliance against the 6 week Access Target of 100% for **Endoscopy** is currently 15.1% in May 2020. Prior to the impact of COVID-19, performance at February 2020 was 63.8%. COVID-19 has impacted on the number of patients waiting over 6 weeks, which has increased from 735 as at the end of February 2020 to 2,118 as at the end of May 2020.

Imaging compliance has decreased to 26.3% in May 2020. Prior to the impact of COVID-19, performance at February 2020 was 73.0%. The number of patients waiting over 6 weeks has increased from 1,517 patients at the end of February 2020 to 3,893 patients at the end of May 2020.

Endoscopy services resumed at UHA on 15th June and at UHC on 29th June, initially prioritising only UCS patients. After an initial test of revised patient pathways and procedures, it is anticipated that patient throughput can be steadily increased through July and August. There is a plan to introduce colonoscopy for bowel screening patients at GJNH from 16th July. Revised guidance from the BSG was published at the end of April 2020.

The re-start of some routine scanning was approved in June. In addition, the Scottish Government has provided funding for a mobile MRI scanner, operating 7 days per week for 30 weeks to commence in July 2020.

Cancer

Cancer cases 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 continued using a combination of telephone, video and face to face consultations as deemed appropriate.

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 were ready for surgery, but for whom a decision is taken to postpone surgery due to COVID-19, had a full telephone discussion with the consultant. These “paused” patients were noted by the Multi-disciplinary teams and were also being tracked on the cancer tracking databases.

The **31 day Cancer target** of 95% has been met in May 2020, with performance of 98.4%. Compliance against the 95% **62 day Cancer target** was 94.9% in May 2020. Although prior to COVID-19, the 31 day Cancer Target was consistently met and the 62 day Cancer target was on an improving trajectory, it should be highlighted that although performance levels remain high, the number of patients being treated has reduced throughout COVID-19. Cancer performance may decrease over the coming months once newly diagnosed cancer patients require treatment.

Colorectal and upper GI cancer surgery were resumed on 11 May 2020, and prioritisation of theatre time to redress this priority area has meant that the colorectal and upper GI backlog has been redressed by the end of June.

Although some breast cancer surgery continued throughout Phase 1 of the COVID-19 pandemic, through usage of operating theatre capacity at Nuffield Hospital, there were a cohort of patients unsuitable for this, creating a backlog. This backlog is being steadily reduced following the re-start of this type of breast cancer surgery during June. Furthermore it is planned to start some breast cancer surgery at Golden Jubilee National Hospital (GJNH) from 12 August 2020.

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 included; 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.

Mental Health – Psychological Therapies

Psychological Therapies waiting times remain below the 90% compliance standard. Following an improvement in the waiting times during the COVID-response and a reduction in overall numbers of patients waiting, there was a reduction of 4 percentage points in compliance from 78% at May 2020 to 74% at June 2020. This is lower than the February

2020 position of 74.9% and is also lower when compared to the same time last year, when compliance was 78.7% in June 2019.

The Psychological Service provision of Psychological Therapies has been maintained, as close to business as usual, from the outset of the pandemic using remote delivery (telephone and Near Me). The infrastructure for Near Me was already in use within the Psychological Specialties of Adult Mental Health and Clinical Health and has since been rolled out across the wider Psychological Specialties.

At the outset of the pandemic, and in preparation for disruption to service delivery, RAG risk ratings were undertaken of open cases, the most vulnerable patients identified, and care plans developed. Patients waiting for assessment and treatment were contacted by letter or telephone. While some Psychological Service staff were refocused on supporting staff wellbeing resources (e.g. Acute Wellbeing Hub) and contributing to essential service provision in the teams they were embedded in, the majority of staff retained their usual work focus and moved to remote working.

Referral demand has reduced across all Psychological Specialties. This has enabled staff to work through existing cases and to start new patients. Where possible, new patients have been started in waiting time order. The exception is where remote delivery has not been an option. Waiting times must therefore be considered with some caution at present.

In the earlier phase of the COVID-19 response, there was reduced activity related to staff shifting from a clinic based face-to-face service to a home and remote working service, and to identifying those patients suitable for remote working. While the reduced referral demand has enabled overall waiting time compliance to hold up since February, there is variability across the Psychological Specialties. Some Specialties are experiencing improved waiting times while others are experiencing increased waiting times. The COVID-19 restrictions have had greatest impact on the waiting times for the Child Specialties of Child and Adolescent Mental Health Services (CAMHS) and Community Paediatrics.

New referrals have been accepted, assessed remotely and, where suitable for psychological input, placed on waiting lists. The majority of Adult patients have accepted remote delivery of treatment. Within the Psychological Specialties of CAMHS and Community Paediatrics, there has been low acceptance and suitability for remote working. This is in contrast to Medical Paediatrics which has a 95% acceptance of remote working. This relates to the predominance of neurodevelopmental and neuropsychological work within CAMHS and Community Paediatrics, and the limited evidence base and options to deliver these specialist assessments to children remotely.

The service provision which has been paused includes: face-to-face assessment and treatment; neuropsychological assessment in adults; neurodevelopmental and neuropsychological assessment in children, and: therapeutic groups. To reinstate this provision, service adaptations and developments have been progressed and reported on in our mobilisation plans. Further detail of the recovery plan from August 2020 until March 2021 has been outlined in the Remobilisation Plan.

In addition to this a further action has been taken to provide dedicated Psychology provision to support local staff wellbeing resources in the Acute and Community settings. Local staff can access first phase psychological first aid and brief intervention through the local Staff Care service for health and social care staff, the newly launched local Listening

Service which will expand its remit to the independent scare sector staff, and the national information and helpline resource of PRoMIS and NHS 24.

Stepped-up formal Psychological Therapy provision will continue to be provided from within existing Psychological Services resource. The demand for staff support and available capacity to meet this demand from within existing resource, without negatively impacting on patient waiting times, will be evaluated on an ongoing basis. A local proposal to sustain staff wellbeing supports, positively evaluated during the Covid-19 response, has been submitted. Local proposals and developments will be considered in the context of national developments and provision.

Mental Health – CAMHS

The Mental Health waiting time target of 90% for CAMHS has not been met, with a 20.1 percentage point decrease from 67.9% at May 2020 to 47.8% at June 2020. This is lower than the 82.2% recorded at June 2019 and is also its lowest recorded position.

Alongside the impact of COVID-19, due to a change in data recording guidance on what constitutes treatment, as of February 2020, a new Referral to Treatment data set has been used. Figures recorded in February 2020 cover the new way of recording with performance of 51.2%.

As the Service adapts to new clinical practices with the implementation of 'Near Me', access to CAMHS clinicians has been maintained. In June 2020, 115 children and young people started treatment, the third consecutive monthly increase. In line with access policies, 60 long waiters were allocated during June of which 27 had waited more than a year. This has reduced the RTT compliance as a consequence. In addition the waiting list has continued to reduce. Pre-COVID-19 the waiting list was reported at 1,266 in February 2020. As at 30 June, this has reduced by 40% to 760. At the same time, the CAMHS Service saw a 40% increase in total referrals received between May and June. The service continues to support those in treatment, with 872 return contacts, an increase of 38% on the previous month.

Despite some improvements made during the lockdown period, the service is anticipating an increase in demand with the exam result release in August and the subsequent opening of Schools and General Practices.

A key development as a result of the COVID-19 pandemic is the development of a co-produced medication and health monitoring pathway for young people with Attention Deficit Hyperactivity Disorder (ADHD), for those who are already diagnosed with the condition. A ‘test of change’ is being developed and it is hoped that this will comprise of 30 young people currently risk rated as amber due to their monitoring needs to engage in the programme.

Agreement has been reached to fund two Non-medical prescribing/Nurse prescriber posts to develop a Pan-Ayrshire pathway for ADHD. It is hoped with required approval that these will be advertised & recruited to for October. In the meantime funding for monitoring equipment is being identified. The introduction of this model will release a significant amount of Consultant Psychiatrist time and therefore have a positive impact upon associated waiting lists and times for diagnosis.

Centralisation of referral pathways as a Pan-Ayrshire service remains a priority for CAMHS. A single point of virtual access for referrals via Scottish Care Information (SCI) Gateway and an MDT screening group will allow for consistency in triage, allocation and prioritising of work. TrakCare & SCI Store will be augmented accordingly to allow what is currently three locality CAMHS Teams to receive referrals as one Pan-Ayrshire Service. Changes in the systems are now actively being pursued. It will take time to 'migrate' cases currently open over to the new Centre of Care on Care Partner but the service are confident that this can be done before the end of this calendar year. It is perceived that the net benefit will be quicker access to routine assessment with a greater emphasis upon Tier 3 work (as outlined in the National Specification for CAMHS 2020) being commenced sooner.

A review of Psychotherapy has been started and one vacant post from this discipline group will become a 'Therapist Post' more in line with the CBT (Cognitive Behavioural Therapy) model. It is hoped that this new post will be able to actively reduce the number of children and young people currently waiting over a year for access to Psychotherapy.

Work has begun to develop of 'unscheduled care pathway' for children & young people in conjunction with adult unscheduled care services. Finalising the pathways for young people presenting at ED is key to this, whilst understanding those pathways for supporting young people experiencing distress as opposed to mental ill-health. It is envisaged that this will help differentiate between those requiring follow up by CAMHS and those who can be sign-posted elsewhere or supported in a less formal way than by a Tier 3 service. Offering initial assessment to those young people or children should help to build a narrative that may prove useful if presentation via unscheduled care continues.

Initial plans to understand the benefits of seven day working for CAMHS are being reviewed. With the current challenges around clinic space and the age range of the patient population of CAMHS, it may be viable that weekend working for all forms of intervention is possible.

In anticipation of the schools returning in August, the Pan-Ayrshire service will be split into two distinct staff groups by the end of July. This will essentially be one group of staff at work undertaking triage, assessment & allocation of referrals with the other team working from home engaging via Attend Anywhere and telephone. Clinic rooms will be staggered with 30 minute gaps in each base to ensure that we can offer 24 appointments a day as opposed to the 3 appointments a day that we are offering now. These appointments will be a mixture of nursing, Occupational Therapy (OT), Psychology, SALT (Speech and Language Therapy) and Psychiatry. Caseloads have been reviewed and patients who are on the waiting list, who at the moment are having telephone contact and Near Me appointments, will be offered face to face appointments where they have indicated that they would prefer to wait rather than use Near Me.

Mental Health – Drug and Alcohol Treatment

Drug and Alcohol Treatment continues to meet and exceed the target of 90% with performance of 99.2% in June 2020.

Addiction Services have continued to provide safe, essential alcohol and drug related support throughout the period of the COVID-19 pandemic.

- Each client's situation has been risk assessed to determine their level of support and contact;
- Services continue to accept all new referrals with initial screening taking place via telephone. Individual face to face contacts are by appointment and are offered based on risk assessment and identified need;
- The service has identified additional 'Priority' groups for face to face contact - those risk assessed as the most vulnerable and most in need of protection which includes, but not be limited to - prison release clients, clients requiring Injecting Equipment Provision (IEP) intervention, mental health interventions and statutory interventions (child & adult protection);
- IEP continues with staff ensuring all safety precautions are adhered to;
- Ward 5 initially refocused its service provision to all essential hospital based detoxification support. However, the residential rehabilitation programme has been recommenced with the easing of COVID-19 related restrictions.

COVID-19 has placed a lot of pressure on health and social care services and GP surgeries. Community pharmacies were put under significant pressure early on, and together with the specialist addiction service, implemented changes to the prescribing, dispensing and supervision of Opiate Replacement Therapy medications. The highest risk assessed clients continued to be prescribed daily and be supervised. All other clients received their medication either twice a weekly or a week at a time (with no supervision provided).

Addiction Services staff worked with local pharmacies and clients who are self-isolating to ensure that their essential medications was delivered to their home. Naloxone supplies continued to be prioritised with different ways of getting kits to more people implemented e.g. home and postal delivery. Our drug and alcohol services are now focussed on implementing measures to increase face to face contact whilst continuing to increase the use of digital technology (including Near Me) for communication with clients. All actions will be detailed within the Remobilisation Plan (Phase 2).

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 February 2020 was 53.1%. But like other areas, MSK services have been impacted by the COVID-19 outbreak which has in turn affected the MSK 4 week performance target. 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 June 2020 was 16.5%.

In March 2020, MSK staff were placed in other areas to help support with the COVID-19 pandemic. This created a back log of long waiting lists (5,958 patients) and current caseloads. These current caseloads have now been cleared and two streams of work are being planned to target: new ways of managing referrals (Active Clinical Referral Triage) and reducing waiting times.

Within MSK, outpatient activity has been significantly impacted by the COVID-19 restrictions. Very few MSK face to face consultations have continued for Category A and B patients with telephone and Near Me consultations being introduced in to the service.

Escalation pathways to orthopaedic Advanced Practice Physiotherapists are in place for patient safety.
For the return of C and D services, the new norm will be virtual consultations, with face to face consultations guided by strict guidelines. Outpatient areas have been risk assessed to re-start face to face consultations albeit on a reduced capacity due to infection prevention and control measures which will be continually assessed.

Digital, Social media and the public facing web page have been increased significantly to provide self-management and exercise advice. Enhanced self-management information is being integrated in to the clinical pathways which are currently being re-vamped to include virtual consultations and digital for the whole patient pathway across whole systems.

Qualitative feedback has been sought for telephone and Near Me consultations with very positive feedback from patients and staff. The service will continue to evaluate new ways of working and continually develop pathways which have already demonstrated improved patient satisfaction.

Many MSK staff have been re-patriated to MSK services after working in the acute sector to help with the COVID-19 pandemic. These staff are now trained to return to the acute sector if required.

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.

Compliance 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.