NHS Ayrshire & Arran

Meeting:	**NHS Board**
Meeting date:	**Monday 5 October 2020**
Title:	**Performance Report**
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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

The health and social care system as a whole across NHS Ayrshire & Arran continues to work collectively to effectively manage and safely respond to the ongoing challenges of COVID-19. NHS Ayrshire & Arran has moved into the next phase of our re-mobilisation and recovery planning to restart as many of its normal services as possible, as safely as possible; ensuring we have the capacity that is necessary to deal with the continuing presence of COVID-19; and preparing the health and care services for the winter season. We are also continuing to learn positively from the new and innovative ways of working that were employed to respond to the demands on services by COVID-19.

The Whole System Mobilisation Planning Group oversees the re-mobilisation and recovery plans and where relevant, high level summaries 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.

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

To manage critically ill COVID-19 cases over the period of the outbreak, NHS Ayrshire & Arran were required to significantly increase our Intensive Care capacity 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.

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.

Along with our Health and Social Care Partnerships (HSCPs), the Acute Sites 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. 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 and 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 Performance

Sections 2.3.1 and 2.3.2 include infographics for data at July 2020, with July 2019 data provided for comparison. Some measures may relate to August 2020 and August 2019. A separate **Appendix** includes trends in performance.

2.3.1 Unscheduled Care Performance

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	2,673 Jul 2020	3,579 Jul 2019	attendances at UHA Emergency Department	
	93.6% Jul 2020	82.0% Jul 2019	ED attendees were treated, admitted or discharged within 4 hours of arrival	⊕ 95%
	2 Jul 2020	71 Jul 2019	ED attendees waited over 12 hours to be treated, admitted, or discharged	
UHC	5,724 Jul 2020	6,311 Jul 2019	attendances at UHC Emergency Department	
	96.2% Jul 2020	91.5% Jul 2019	ED attendees were treated, admitted or discharged within 4 hours of arrival	⊕ 95%
	0 Jul 2020	69 Jul 2019	ED attendees waited over 12 hours to be treated, admitted, or discharged	

Medical and Surgical Bed Occupancy

83.6% Jul 2020	94.9% Jul 2019	occupancy of acute medical and surgical beds at University Hospital Ayr
82.0% Jul 2020	92.8% Jul 2019	occupancy of acute medical and surgical beds at University Hospital Crosshouse

Combined Assessment Units

1,502 Jul 2020	1,633 Jul 2019	presentations to UHA CAU		
1,663 Jul 2020	1,585 Jul 2019	presentations to UHC CAU		

Emergency Admissions*

789 Jul 2020	849 Jul 2019	admissions to UHA via ED/CAU		
1,509 Jul 2020	1,549 Jul 2019	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	
	0 Jul 2020	44 Jul 2019	0 Jul 2020	0 Jul 2019	8 Jul 2020	51 Jul 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)

ED Attendances

ED Attendances at both hospital sites experienced a significant decrease during the outbreak of COVID-19, dropping to their lowest levels in April 2020. The decrease at UHA was predominantly in relation to Flow 1 (Minor Injury) and Flow 2 (Acute Assessment, including Major Injury) attendances. At UHC the reduction was mainly in relation to Flow 1 (Minor Injury).

Despite numbers being lower in July 2020 than in July 2019 (at UHA there were 906 fewer ED attendances in July 2020 than in July 2019, representing a 25.3% decrease; at UHC, there were 587 fewer ED attendances in July 2020 than in July 2019, representing a reduction of 9.3%), ED attendances have been increasing month on month since April 2020. ED attendances at both UHA and UHC are now at the same levels as they were in January 2020.

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 latest national published data for ED attendances for June 2020 highlights that ED attendances across Scotland fell during the COVID-19 outbreak in a similar way to Ayrshire & Arran. Rates for May 2020 were 19.84 per 1,000 in Ayrshire & Arran, increasing to 21.21 per 1,000 in June 2020. The figure for June 2019 was 27.61 per 1,000.

ED Attendances

As the COVID-19 pandemic emerged, attendances at our Emergency Departments began to fall. This was driven partly by concern around the possible exposure to COVID-19, repeated media messages to avoid ED and by people not wanting to be a burden on an NHS that could become overwhelmed.

As lockdown restrictions have eased, attendances to ED have risen since April 2020. As restrictions on citizens shielding have been lifted as of 31 July 2020, this has also impacted on emergency demand on our services.

Learning from the pandemic has led to the establishment of a National programme Redesigning Urgent Care which is utilising key factors such as National messaging, pre-hospital triage; and the use of virtual technology in ‘scheduling the unscheduled’. A key strand is to optimise digital health within clinical consultations in urgent care. Over the past six months, Near Me has been widely enabled across NHS Scotland. NHS Ayrshire & Arran is now taking part in National workstream 3 to better understand how Near Me can be used in urgent care services.

We are also learning from the experience in NHS Lothian around using virtual consultations for treatment of minor injuries. Both UHA and UHC are keen to embed this practice, and to prevent attendance at ED where possible, mitigating the risk of overcrowding at the front door.

Pre-hospital triage during the most affected time of the pandemic resulted in redirecting patients to a more suitable service which resulted in fewer presentations at our acute hospital sites.

In preparation for scheduling ED attendances, some exploratory work has been undertaken to better understand those who have accessed NHS24 and presented at ED following this consultation. Understanding patient behaviour in more detail will help inform where we need to focus our efforts.

ED 4 HR Compliance and 12 hour breaches

The **ED 4-Hour Wait** 95% target was achieved at NHS Board level in July 2020 for the fourth consecutive month, with overall compliance of 95.4%. Compliance at UHA in July 2020 was 93.6%, an increase of 11.6 percentage points when compared to the previous year. At UHC, compliance was 96.2% for July 2020, an increase of 4.7 percentage points from the previous year.

The latest national published data is for June 2020 with ED compliance levels of 96.3% across NHS Ayrshire & Arran. This compares to 95.6% for Scotland.

12-hour breaches have reduced significantly, with only two 12-hour breaches reported at UHA and 0 breaches at UHC in July 2020.

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

Despite recent increases in attendances and emergency admissions, the 4-hour Wait ED standard across NHS Ayrshire & Arran has improved when compared with July 2019, and exceeded the performance Nationally in July 2020.

There were two instances of 12-hour breaches during July at UHA. One of these was awaiting a suitable bed, and the other was for clinical reasons. At times, patients must be stabilised in ED before safely moving to the next stage of their journey.

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.

Medical and Surgical Bed Occupancy

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 60 fewer admissions at UHA in July 2020; and 40 fewer admissions at UHC compared to July 2019, the number of admissions 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 reduced to 83.6% at UHA and to 82.0% at UHC in July 2020, having previously been at a level consistently at or above 90%. Occupancy levels have generally been increasing since a low in April 2020.

Admissions and Occupancy

High levels of occupancy are an important indicator of a system under pressure. A lack of available beds has widespread consequences within the system.

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 were significantly lower than usual. However, despite low numbers of delayed discharges, occupancy levels have been increasing at both UHA and UHC since April 2020 as emergency demand on the system has increased.

Over the course of July 2020 the occupancy level at UHC increased significantly which resulted in boarding a higher number of medical patients in surgical wards. This pattern of increased activity is similar to that experienced with the Ayrshire Urgent Care Service. With ED attendances having risen again, this has been challenging with red and green pathways in place at the front door. A high number of suspected patients (on the red pathway) in the CAUs awaiting results can cause a bottleneck. Awaiting test results means that patients remain in the CAUs in single rooms until confirmation of their COVID-19 status is known, before they can be moved to a ward if required.

It is expected that with any resurgence of COVID-19, capacity within the acute hospital settings will be extremely challenged. Surge capacity has been built in to the COVID-19 mobilisation plans which will be supported by an Escalation Policy describing trigger points and expected action. The Acute Services mobilisation group and the theatre group have approved the restart of surgical services in line with clinical prioritisation. This is having an impact on overall bed capacity and requires risk assessments for services to restart safely.

The Whole System Strategic Interface Group has been established to guide and support the recovery and mobilisation of services across Primary, Community and Acute care and will ensure that a whole system approach is adopted. This group is commissioning specific pieces of work to build on the learning from COVID-19 to reduce demand on acute front door services by providing alternatives best suited for the patient's clinical condition. The Interface Group will lead on the establishment of a National Single Point of Access through NHS24/111 for urgent care, and the development of a Flow Hub across both acute hospitals offering rapid access to a senior decision-maker.

Changes were made at pace by all services during COVID-19. These were necessitated by the emergence of the pandemic. All services are now reforming and adjusting to these changed parameters. The same focus will be kept on unscheduled care and the importance of patients not remaining in acute care once their medical needs are met.

A shortened version of the Day of Care survey highlighted wards with the highest number of delays - this, in turn, helped us to target specific wards for input and collaborative

working with our HSCP colleagues in relation to reducing those delays. Both sites have worked with our partners to ensure the number of patients delayed onsite remains low.

At UHA, an extreme team has been established, commissioned by the Site Director and Head of Service within South Ayrshire HSCP to explore and deliver a whole system response to quality urgent care, including frailty, within South Ayrshire HSCP and UHA ensuring delivery of urgent care only happens in a hospital setting where absolutely necessary. When patients' stays exceed 7 days there will be active appraisal of their care to assess whether this can be delivered in a more homely setting.

At UHC, weekly review of patients with stays exceeding 14 days has been undertaken since early August 2020. This has been led by a senior clinician with support from HSCP colleagues, Allied Health Professions (AHPs) and Quality Improvement teams.

Combined Assessment Units

CAU Presentations experienced a month on month reduction between January and April 2020 at UHA; and a month on month reduction between January and March 2020 at UHC. Since April 2020 at UHA, and March 2020 at UHC, numbers have been increasing but there were still 131 fewer presentations at UHA in July 2020 compared to July 2019, a decrease of 8.0%. However at UHC, there were 78 additional presentations in July 2020 compared to the previous year, an increase of 4.9%.

Combined Assessment Units/CAU Presentations

During the pandemic, new ways of working resulted in fewer presentations at our CAUs. Primary care patients were triaged by telephone which prevented patients attending their practice and subsequently being referred to CAU. All appointment requests to GPs were also triaged. The COVID-19 Community Pathway Model supported Ayrshire & Arran citizens to access services through the single national NHS111 number, redirecting many people and consequently reducing attendances to both front doors.

Rapid Assessment and Treatment (RAT) - a model normally used in ED - was implemented in the CAU at UHC during the pandemic. This involved the early assessment of patients by a senior clinician, with the initiation of investigations and/or treatments. This was supported by Advanced Nurse Practitioners (ANPs), and was successful in discharging 25% of patients at this early stage.

Following the success of these new pathways for COVID-19 patients, there are opportunities to learn from this and undertake pre-hospital triage by working collaboratively with GPs and other services.

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 peak demand occurs.

In addition to this, there are opportunities to 'schedule the unscheduled' at CAU. When a GP referral is received at CAU, there may be instances where the individual does not have

to be seen/assessed that day. Ensuring there are a range of suitable options will allow care to be delivered in a planned way for some.

Utilising all available capacity in our Medical Daycase Unit is one option currently being explored. Being able to access resources within the unit will allow call handlers in Initial Assessment to offer alternatives to admission and/or a planned admission where appropriate. All of this information/data gathering will support the establishment of an Ayrshire-wide Flow Hub.

Improvement work around scheduling GP referrals to smooth demand throughout the day at CAU at UHA has resulted in reduced waiting times for patients and an improved experience.

We know that the peak demand in CAU occurs late morning and then mid-late afternoon. A recent test of change focused on scheduling people who travel independently to CAU once referred by their GP. Referrers are given an appointment time and asked that the person attends at that specific time for assessment.

Feedback from GP colleagues in South Ayrshire has been positive. We know that referrer practice will take time to change but, as it does, and referrers consider alternative options to admission, this will have a positive impact on the 4 hour access and treatment standard. A local Flow Hub will be established by 31st October 2020 and staff within the centre will re-direct accordingly, and offer alternatives to admission where possible.

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.

The latest National published data for **Delayed Discharges >2 Weeks (excluding complex code 9 delays**) has fallen from a high of 84 in January 2020 to 8 by July 2020. There were no delays over 2 weeks for North Ayrshire HSCP residents at the end of July 2020, down by one from the previous month and down by 44 from July the previous year. This was the first month that North Ayrshire HSCP has achieved the 0 delays over 2 weeks target since June 2016. For South Ayrshire HSCP residents there were eight (8) delays over 2 weeks at the end of July 2020, up by 2 from the previous month but down by 43 from the previous year. Performance in East Ayrshire HSCP has continued to meet the target of zero delays over 2 weeks.

In regards to the monthly **Occupied Bed Days associated with Delayed Discharges**, numbers have reduced significantly. Across North and East HSCP areas in particular there has been substantial reduction in the numbers of occupied bed days associated with code 9 delayed discharges (i.e. patients with incapacity issues, or who require a specialist facility where no suitable facility exists).

Delayed Discharges

In **East Ayrshire HSCP**, actively managing delayed discharges has been a key component in the Mobilisation Plan. 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 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.

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.

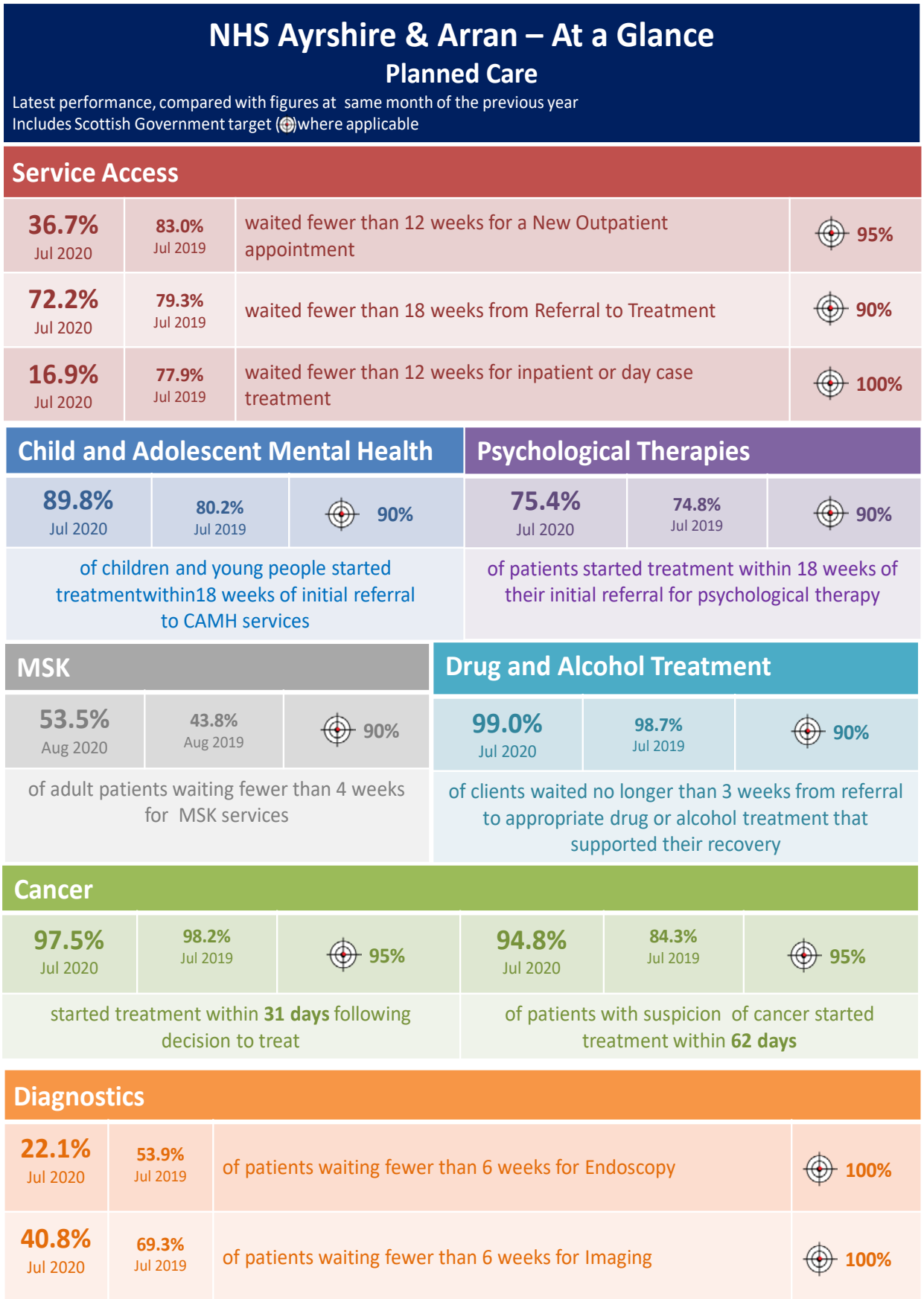
North Ayrshire HSCP continues to actively manage the number of referrals received from all hospital sites with a focus on, as early as possible, discussions with the individuals about planning their care needs post hospital discharge. The HSCP continues to see a rise in the number of referrals, from acute sites, for care at home provision and requests for assessments of individuals' longer term care needs. The daily scrutiny and performance monitoring continues to be key in ensuring that flow is maintained. On 1 July 2020, North Ayrshire HSCP recorded its lowest number of delays across all hospital sites with 4 delays. This is the lowest daily number of delays recorded and reported to Scottish Government since daily reporting began in March 2020.

In **South Ayrshire HSCP**, there has been a continued focus on delayed discharges. The senior team within South Ayrshire have been meeting weekly to focus on supporting those who have waited longest to move and to identify areas for improvement across the system. This has resulted in a reduction in the average time waited for a care home place but there remain approximately 15 people waiting long periods due to guardianship processes. The management team have implemented improved processes to manage the application arrangements for Guardianship Orders.

The Head of Community Health and Care Services and Director for University Hospital Ayr have commissioned an "extreme team" to focus on process improvement in pursuit of the aim to reduce delays. Six workstreams have been identified and small tests of improvement have been initiated.

Despite this work, in recent weeks referral numbers for care at home have increased significantly at a time when additional care at home capacity has become fully utilised. This has resulted in rising numbers of delayed discharges. Care packages are being reviewed to ensure that care is allocated appropriately with the aim of eliminating waits for care at home.

2.3.2 Planned Care



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.

The target for Inpatient/Daycase compliance is 100% and local management information indicates that compliance has increased by 2.5 percentage points, from 14.4% in June 2020 to 16.9% at July 2020. Prior to the impact of COVID-19, performance at February 2020 was 71.8%.

For New Outpatient compliance, the target is 95% and local management information indicates that compliance has increased by 7.6 percentage points, from 29.1% in June 2020 to 36.7% at July 2020. Prior to the impact of COVID-19, performance at February 2020 was 81.1%.

The Remobilisation process is prioritising planned care patient activity on the basis of clinical urgency rather than length of wait, therefore Inpatient/Daycase and New Outpatient compliance is expected to remain at a lower level, although services are being restarted safely and are being prioritised for the patients most at need.

A comparison of the number of patients waiting as at 31 July compared to 29 February is outlined below:

	Number waiting	As at 29 February 2020	As at 31 July 2020
Outpatients	> 12 weeks	3,965	15,838
Inpatients / Daycases	> 12 weeks	1,051	3,736

New Outpatients

A significant change in practice within outpatient services 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.

Face to face appointments are starting in a safe and controlled way with patient and staff safety being a priority. The requirement to continue to support physical distancing and avoid crowded waiting areas is also key to the co-ordination of the service re-start process. However this has reduced both capacity and productivity. There are also plans in place for initiation of clinics at the Louisa Jordan Hospital.

Inpatients/Daycases

Considerable progress has been made in re-starting planned care activity. Elective surgery has resumed across all specialties with clinically urgent patients being prioritised. However there are still opportunities available to use resources to re-start some routine surgery (for example, theatre lists with no anaesthetists can be used for routine local anaesthetic cases and cataracts).

Capacity to support Inpatient/Daycase surgery is still reduced due to a combination of infection control measures, impact of the ICU expansion on reduced theatre recovery capacity, elective inpatient bed capacity impacted by unscheduled care demand, and anaesthetist capacity.

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.

18 Weeks Referral to Treatment

The target for 18 week Referral to Treatment (RTT) compliance is 90% and local management information indicates that compliance has decreased by 6.1 percentage points, from 78.3% in June 2020 to 72.2% at July 2020. Prior to the impact of COVID-19, performance at February 2020 was 79.7% and had been showing an improving trend.

It should be noted that this decrease in compliance has been affected by the measures put in place to effectively and safely manage the pressures of COVID-19, which resulted in higher than expected compliance being recorded in April and May 2020.

18 Weeks Referral to Treatment

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 and as a direct consequence affected compliance against the National Waiting Times targets.

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** local management information indicates that compliance against the 6 weeks Access Target of 100% for **Endoscopy** has increased by 3 percentage points, from 19.1% at June 2020 to 22.1% at July 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 2,491 as at the end of July 2020.

Imaging compliance against the 6 weeks Access Target of 100% has increased by 6.7 percentage points, from 34.1% at June 2020 to 40.8% at July 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 3,881 patients at the end of July 2020, although there has been a 9% decrease from 4,272 patients at the end of June 2020.

The Remobilisation process is prioritising planned care patient activity on the basis of clinical urgency rather than length of wait, therefore Endoscopy and Imaging compliance is expected to remain at a lower level.

Endoscopy

Endoscopy services resumed at UHA on 15 June 2020 and at UHC on 29 June 2020, and are prioritising UCS and bowel screening patients. Capacity still remains reduced due to infection control measures and reduction in recovery capacity which has been impacted by the ICU expansion.

Endoscopy procedures for two days per week has started at the Golden Jubilee National Hospital (GJNH). NHS Ayrshire & Arran are also introducing qFit to help stratify patient urgency, and reduce demand by the end of August 2020. There are also plans to introduce Colon Capsule Endoscopy as an alternative for some colonoscopy patients as part of the 2nd phase of national roll out with an approximate timescale of October 2020. We are also planning to introduce cytosponge as an alternative for some upper GI patients; the timescale for this is dependent on national roll out.

Imaging

Imaging Services have restarted after the suspension of all elective work. NHS Ayrshire & Arran are prioritising inpatient scans for UCS / Urgent patients. Demand has returned to pre-COVID-19 levels and the projected growth in waiting list is therefore quite large.

The Scottish Government has provided funding for a mobile MRI scanner, operating 7 days per week for 30 weeks from July 2020 which will deliver 2,200 scans. Plans are in

place for staffing some additional CT / MRI & Ultrasound sessions using locums. Plans are also being developed to access additional CT capacity via CT pods at the Louisa Jordan Hospital.

Cancer

Throughout the COVID-19 outbreak, 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.

Local management information indicates that the **31 day Cancer target** of 95% continues to be met in July 2020, with performance of 97.5%. Compliance against the 95% **62 day Cancer target** was 94.8% in July 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.

Cancer

The backlog of cancer surgery has been cleared, however the main ongoing challenge is endoscopy capacity to diagnose colorectal/ upper GI cancer. The GJNH is also being used to supplement operating capacity for breast surgery to support the re-start of the breast cancer screening programme

The referral rate for most cancer pathways is returning to pre-COVID-19 levels, except for Lung Cancer, for which referral rate is still very low. We are seeing an impact of this on unscheduled care as a higher number of lung cancers are being diagnosed from Emergency Admissions, rather than GP referrals.

Mental Health

Mental Health Services (including Learning Disabilities and Addiction Services) within Ayrshire and Arran 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 were 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 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.

Mental Health – Psychological Therapies

The target for Psychological Therapies compliance is 90% and local management information indicates that compliance has increased by 1.4 percentage points, from 74.0% in June 2020 to 75.4% at July 2020. Prior to the impact of COVID-19, performance at February 2020 was 74.9%.

Psychological Therapies

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, Red, Amber, Green (RAG) 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. Waiting times have been maintained at pre-COVID-19 levels.

While the reduced referral demand has enabled overall waiting time compliance to remain stable since February 2020, 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 negative impact on the waiting times for the Child Specialties of Child and Adolescent Mental Health Services (CAMHS) and Community Paediatrics. Meanwhile, the waiting times for Clinical Health and Neuropsychology have reduced to within the 90% compliance, and redesign and new systems/processes are aimed at maintaining this improvement.

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, for example, 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 the re-mobilisation plan August 2020 until March 2021. Actions include:

- Continue remote delivery of psychological assessment and treatment where this is appropriate (e.g. dependent on individual circumstances, risk assessment and management, therapeutic modality).

- Expand access to an increased range of SG supported SilverCloud Computerised Cognitive Behavioural Therapy (cCBT) digital options.

- Assess the requirement for, and implement the recently available SG supported Internet-Enabled (IESO) digital option, as part of a tiered model of service delivery.

- Development of local guidelines, based on recent national and international evidence base and guidance, on remote delivery of neuropsychological and neurodevelopmental assessments.

- Re-instate face-to-face clinical contact that had been paused. Local guidelines have been co-produced, with Infection Control, to inform staff of the necessary safety measures and Personal Protective Equipment (PPE) to resume face-to-face assessment, at domiciliary visits and at outpatient clinics. Psychological Service staff are now receiving notification of their access to clinics and are planning a return to face-to-face work in September. Access is reduced from pre-COVID-19 levels but will enable targeting of patients waiting for face-to-face appointments.

- Reinstate face-to-face therapy using a blended approach with remote therapy when the benefits of doing so off-set risks (e.g. using remote delivery initially to engage a new patient who is anxious about attending a clinic setting, or to review a patient who otherwise could not attend their appointment due to financial costs), therefore removing barriers to accessing psychological therapy.

- Development of a remote trans-diagnostic group therapy for Adults presenting with distress and emotional regulation problems. It is estimated that this therapeutic group will be suitable for the majority of the patients waiting for Psychological input, removing or reducing the need for additional individual input.

- Through the developments of further expansion of remote and digital working, and re-instatement of face-to-face activity, increase activity levels across the Psychological Service to pre-COVID-19 levels by September 2020. In April 2019, 335 new patients were seen. In April 2020, a reduced number of 209 new patients were seen, related to COVID-19 restrictions.

- Re-instate clinical supervision, reflective practice sessions, and consultation to the wider clinical team who are delivering psychological interventions, including clinicians training in psychological treatments (e.g. Diploma in CBT, Masters and Doctorate Trainees). This activity will be expanded as the wider clinical staff group are released and given protected time for psychological therapies work.

- Continue to adapt provision of teaching, training and clinical placements to support Trainees in formal professional Psychology training courses as key to increasing capacity and access to psychological therapies.

- Reinstate training in psychological therapies for the wider staff team to increase capacity for delivery of psychological work.

Local health and social care staff can access first phase psychological first aid and brief intervention through the local Staff Care service, the recently launched local Listening Service which will expand its remit to the independent scare sector staff, the national information and helpline resource of PRoMIS and NHS 24, and the Acute and Community Wellbeing Hubs.

Mental Health – CAMHS

The target for CAMHS compliance is 90%, and local management information indicates that compliance has decreased by 3.5 percentage points, from a positon of 93.3% in June 2020 to 89.8% at July 2020. Although compliance in July 2020 is higher than the 80.2% reported in July 2019, it is the first time that compliance has fallen below 90% since October 2019. Prior to the impact of COVID-19, performance at February 2020 was 94.6%.

Note: Up until February 2020, the waiting clock was stopped at the point of First Treatment for CAMHS which included assessment as informed by skilled and knowledgeable Nurses and Allied Health Professionals (AHPs) who delivered an intense generic assessment which resulted in a clinical treatment plan and elements of treatment such as guided self-help and anxiety management. As of February 2020, there was a change in data recording guidance and the waiting clock was stopped only at the point of a First Treatment appointment with an assigned Clinician, irrespective of supports offered prior to that. 'Internal' referrals for CAMHS Clinician to CAMHS Clinician were also to be included. Internal referrals are for children/young people which have been open to the Service for some time, often years, who are requiring a short term intervention by another clinician as part of the over treatment programme.

Following discussions with Public Health Scotland and the Scottish Government in early September 2020, Internal Referrals are to be excluded for the Referral to Treatment standard in line with the defined standard but will be monitored locally; in addition to this, NHS Ayrshire & Arran were asked to revert back to the original definition used prior to February 2020.

The compliance figures reported within this report are based on the original definition so will differ to figures reported in previous NHS Board Reports.

CAMHS

As the Service adapts to new clinical practices with the implementation of Near Me, access to CAMHS clinicians has been maintained. 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.

We are working with our Intensive Support Team to develop care pathways for young people who have experienced significant self-harm or poisoning post discharge from Acute hospital. To this end a pilot with North Ayrshire HSCP Service Access Social Work has been established. This pilot will allow for a more responsive approach to joint assessment of a young person without the immediate need for a formal referral.

The 'duty' service for the whole of Ayrshire is now delivered from Lister Street at Crosshouse Hospital, as working relationships with Liaison and Crisis Resolution Team (CRT) are further developed in anticipation of closer working in an unscheduled way.

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.

Mental Health – Drug and Alcohol Treatment

Drug and Alcohol Treatment continues to meet and exceed the target of 90% with performance of 99.0% in July 2020. Prior to the impact of COVID-19, performance at February 2020 was 98.6%.

Addiction Services have continued to provide safe, essential alcohol and drug related support throughout the period of the COVID-19 pandemic. Staff have continued to offer all interventions during the last 3 months with more face to face appointments/visits being offered in addition to increased telephone contact. Staff have also been trialling out the use of Virtual Technology (Near Me). As part of the re-mobilisation plan, there will be increased face to face contacts for all new and existing clients.

Musculoskeletal

Local management information indicates that compliance against the MSK target of 90% of patients being seen within 4 weeks from referral to first clinical outpatient appointment has increased by 19.7 percentage points, from 33.8% at July 2020 to 53.5% at August 2020. Prior to the impact of COVID-19, performance at February 2020 was 53.1%.

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.

Escalation pathways to orthopaedic Advanced Practice Physiotherapists are in place for patient safety. As we resume, the new norm will be virtual consultations, with face to face consultations guided by strict guidelines. Outpatient areas have been risk assessed and face to face consultations re-started, 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 access 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 are currently developing pathways for a whole systems approach.

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

As we move to re-mobilising our services, systems and procedures continue to be 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

A sustainable workforce and recruitment levels are imperative across all services as we move to restart our services and prepare for any potential future outbreaks of COVID-19.

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 restart services but also to manage the demand in the event of any future COVID-19 outbreaks.

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 and post the initial 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 Public Health Scotland 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 Senior Responsible Officer 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

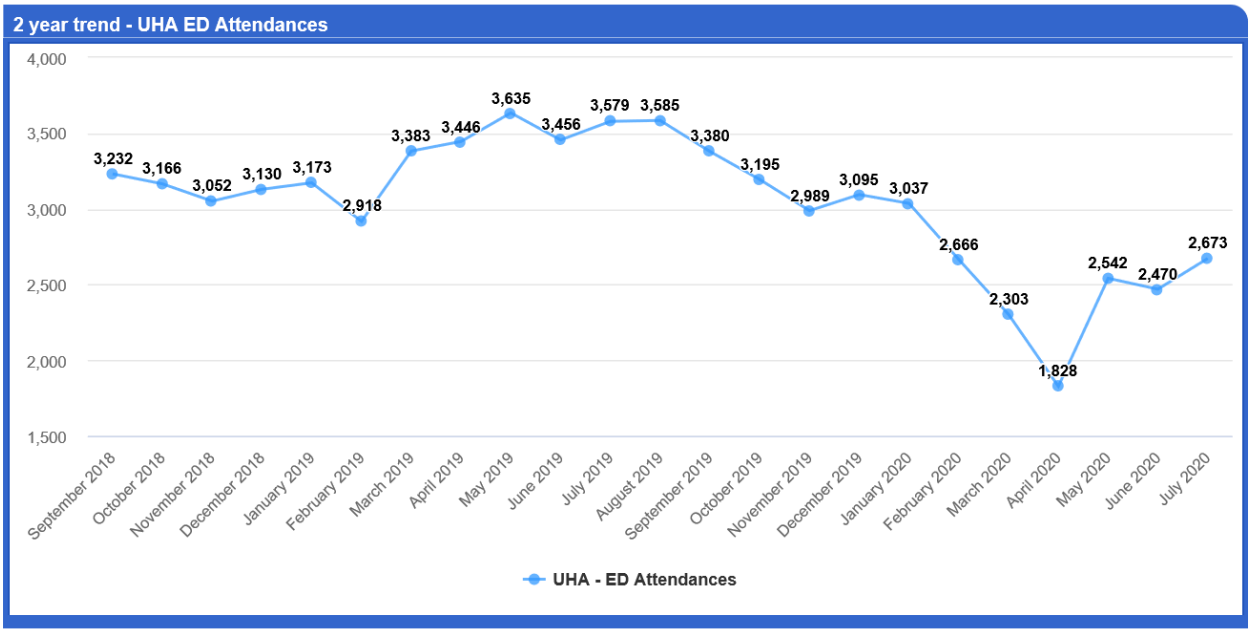
NHS Board members are asked to discuss the information provided in this report which provides assurance that systems and procedures are in place to monitor and manage the impact of COVID-19 on our provision of unscheduled and planned care for our citizens.

3. List of appendices

There is one Appendix to support this report which provides detailed trend charts for elements of the planned and unscheduled care performance as described within those sections in this paper.

Appendix

Unscheduled Care



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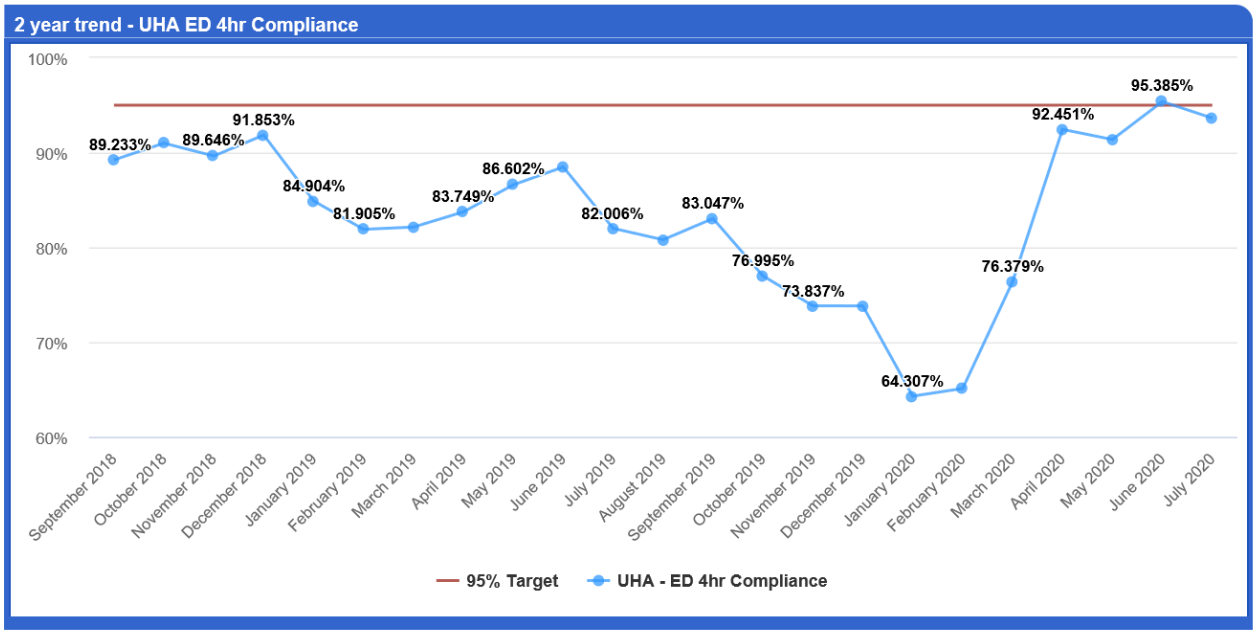

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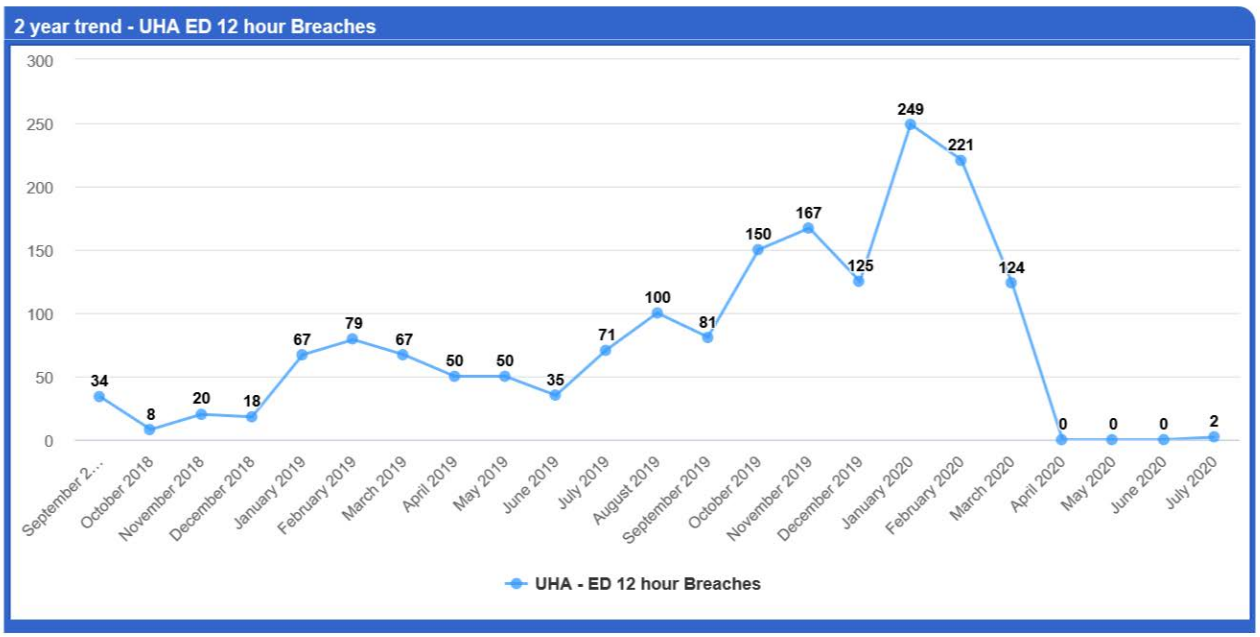

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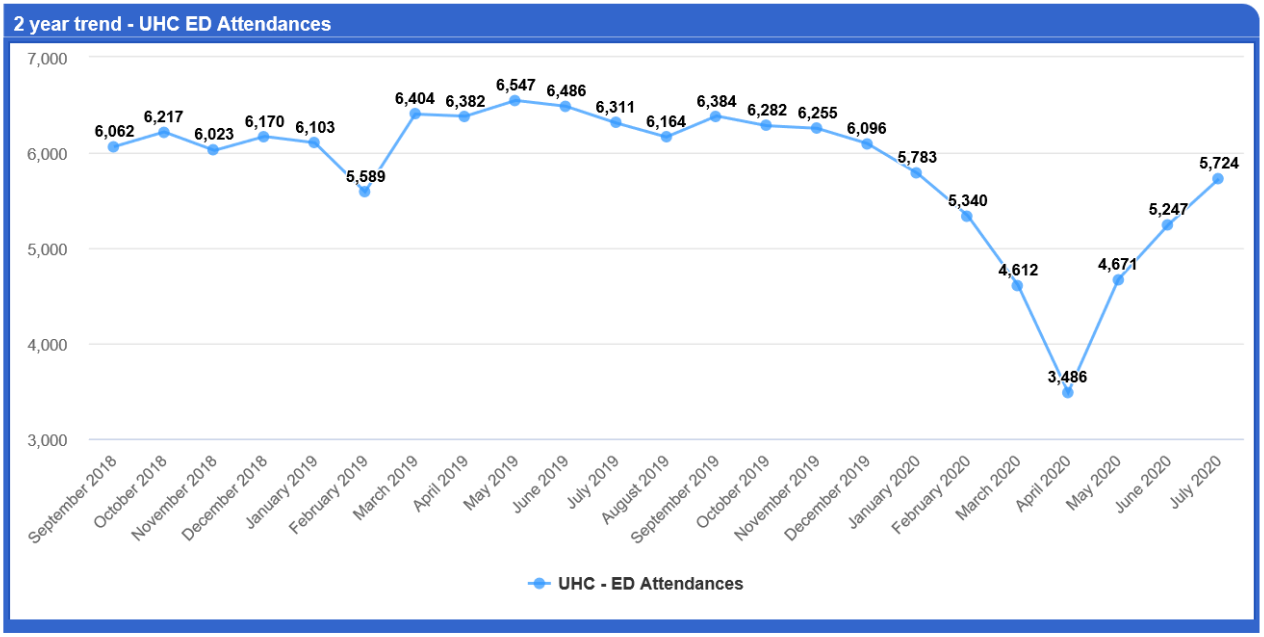

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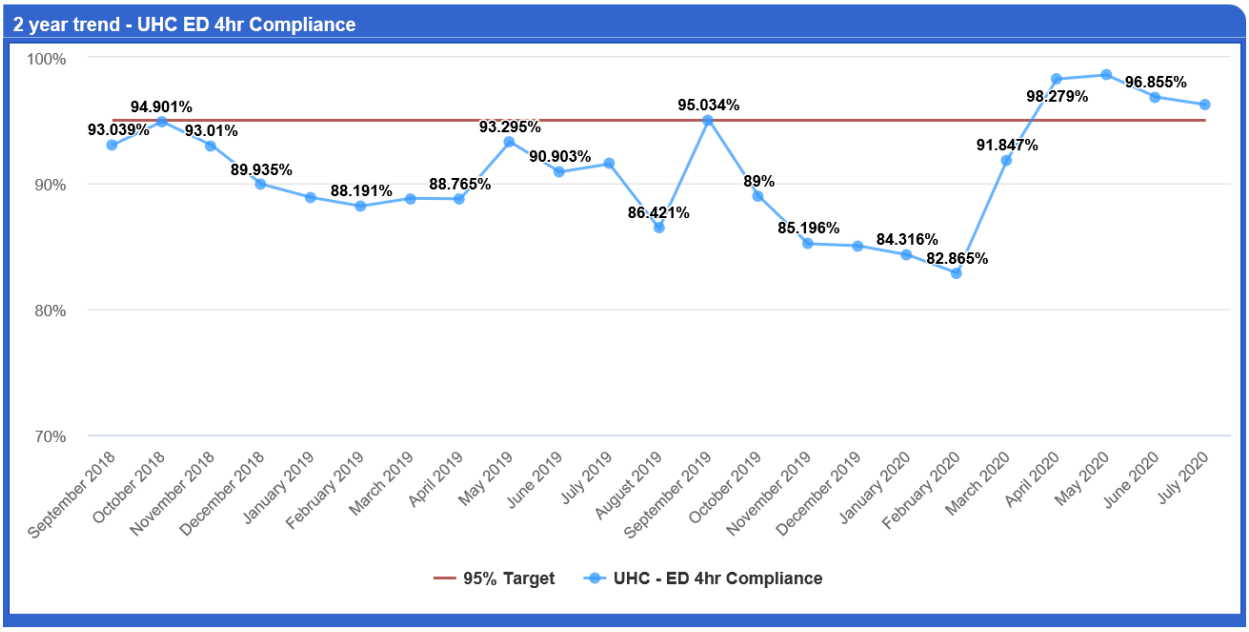

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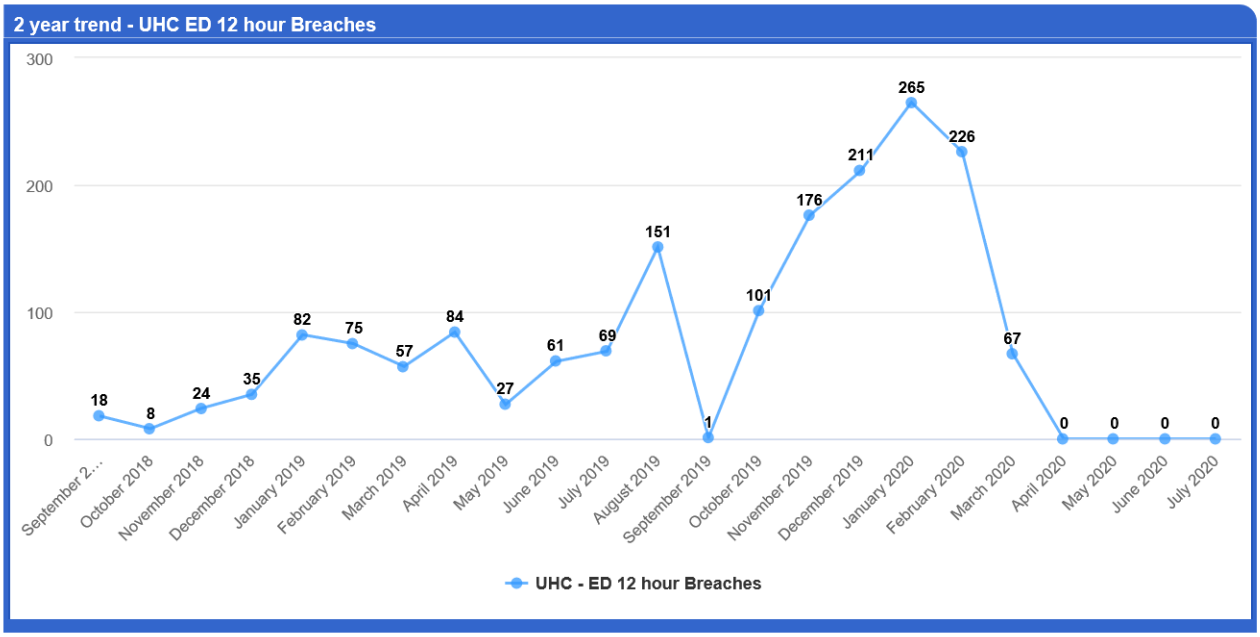

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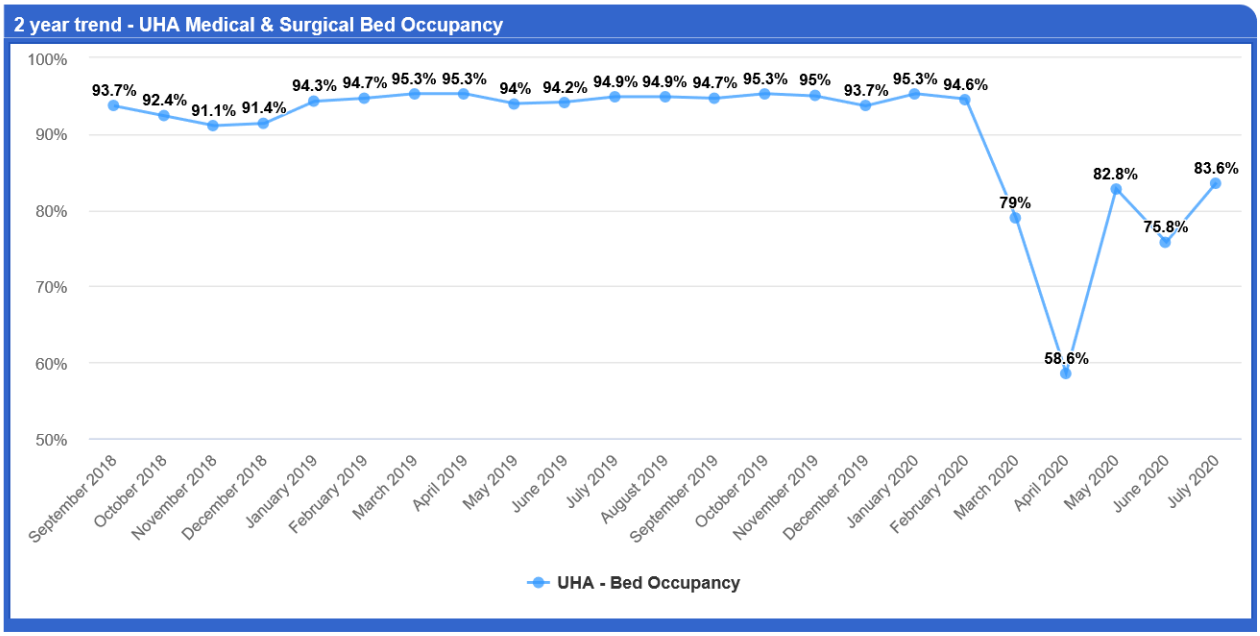

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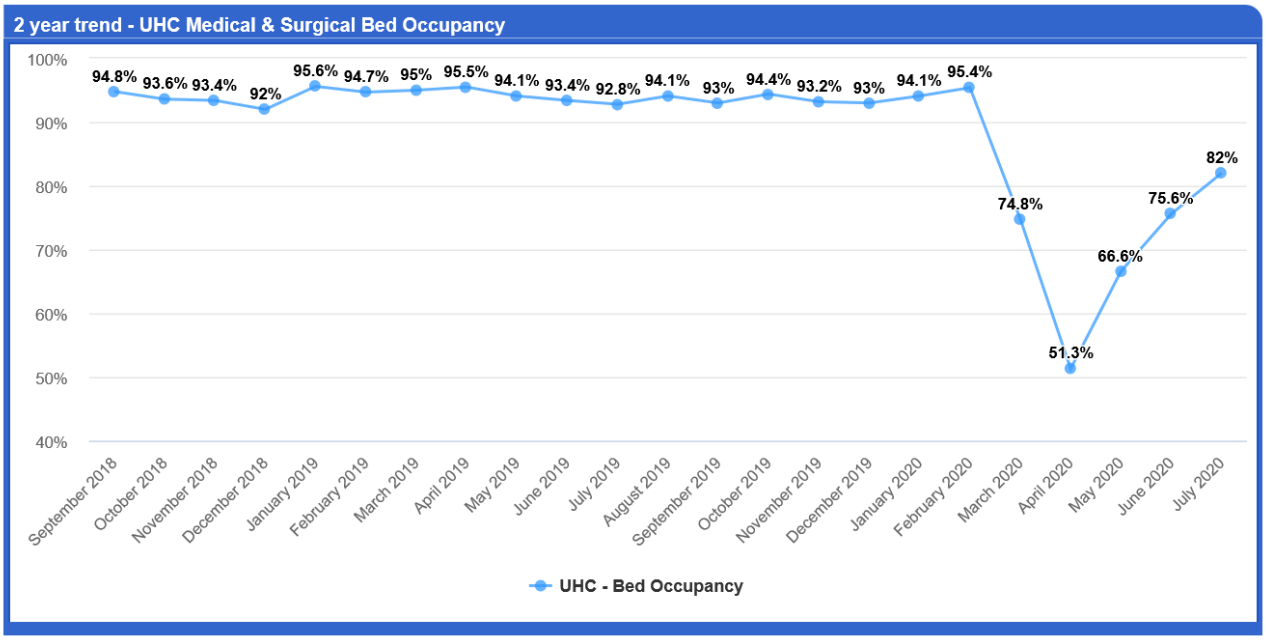

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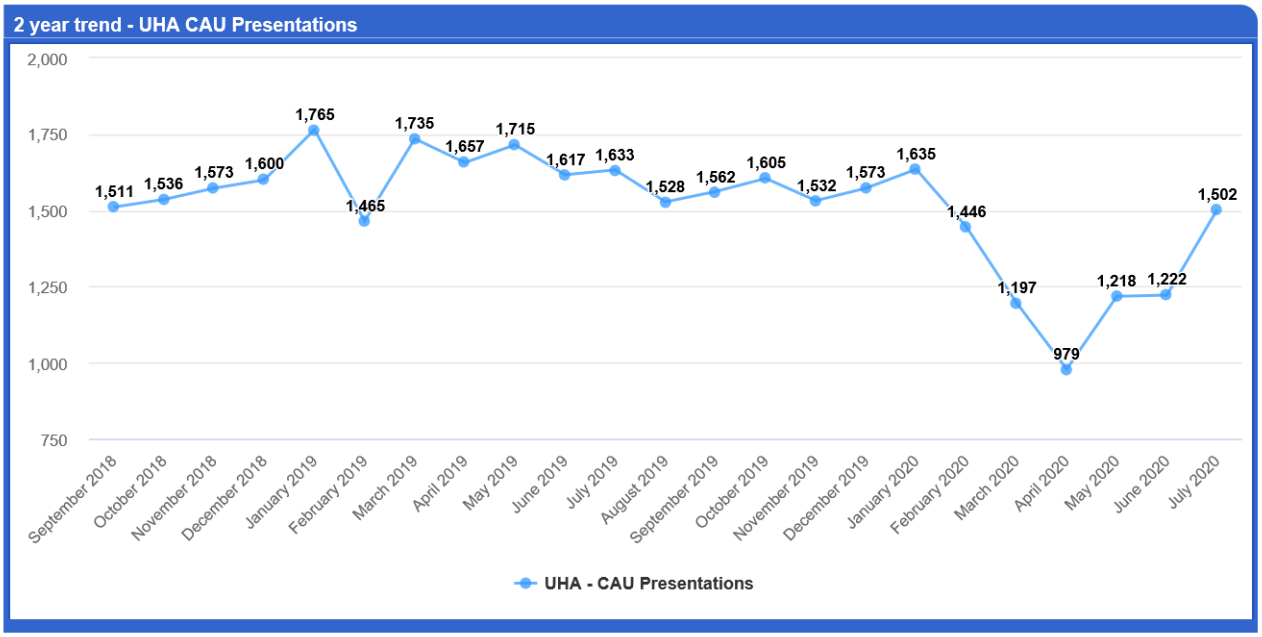

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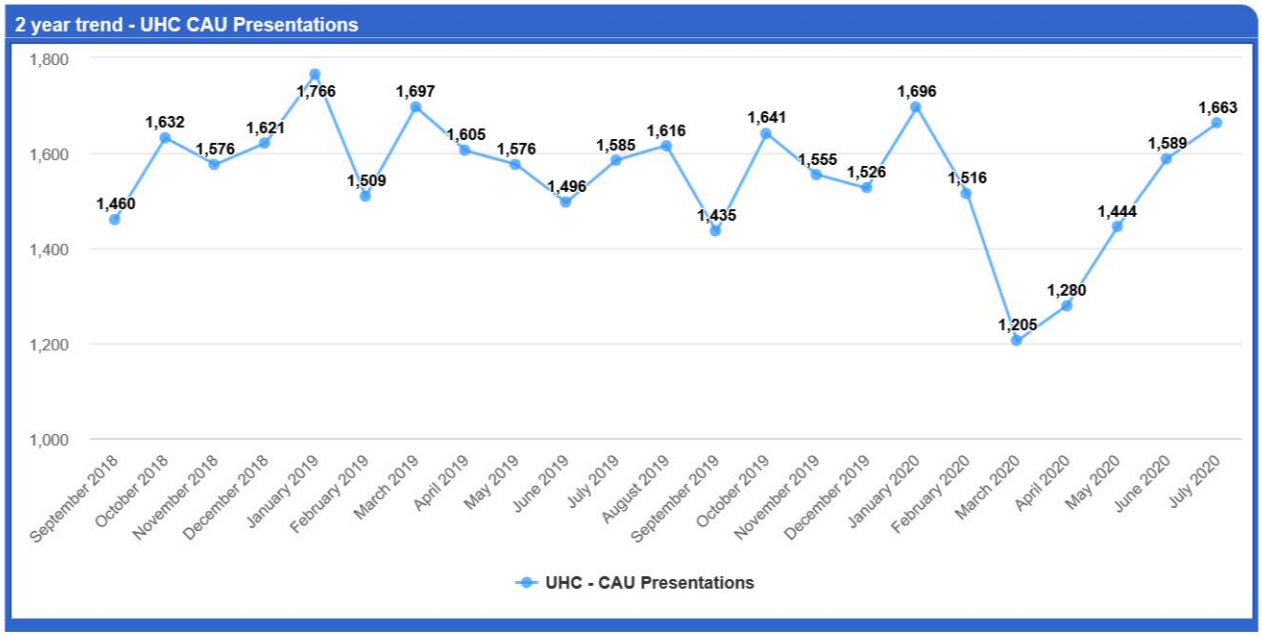

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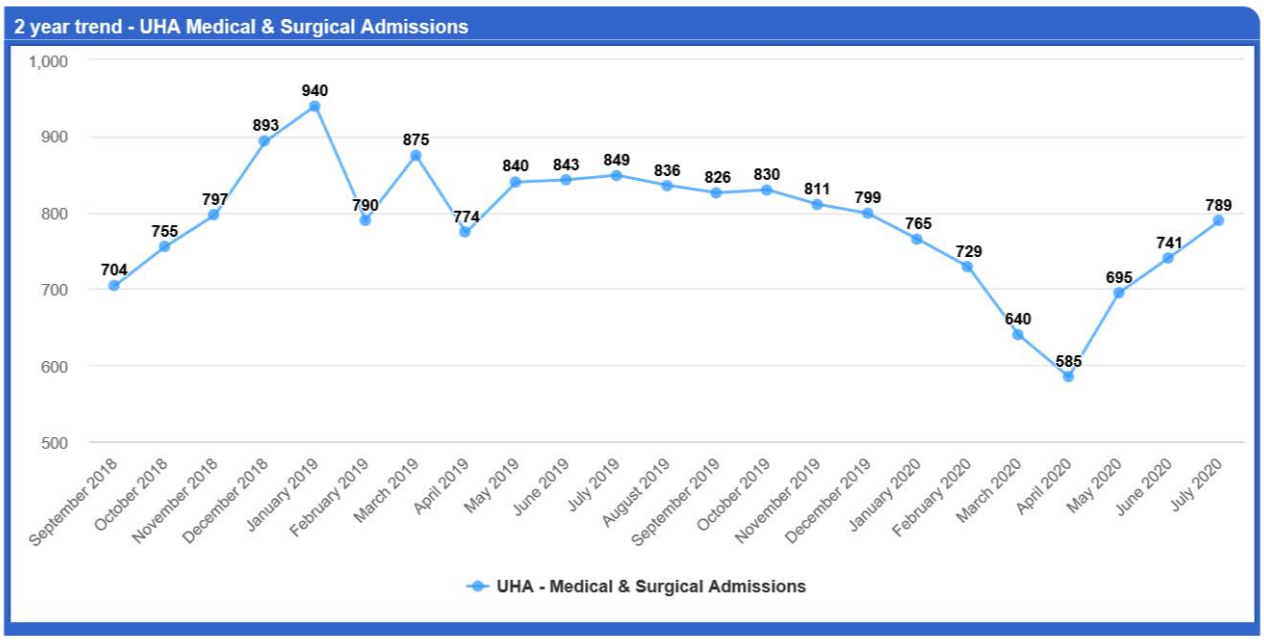

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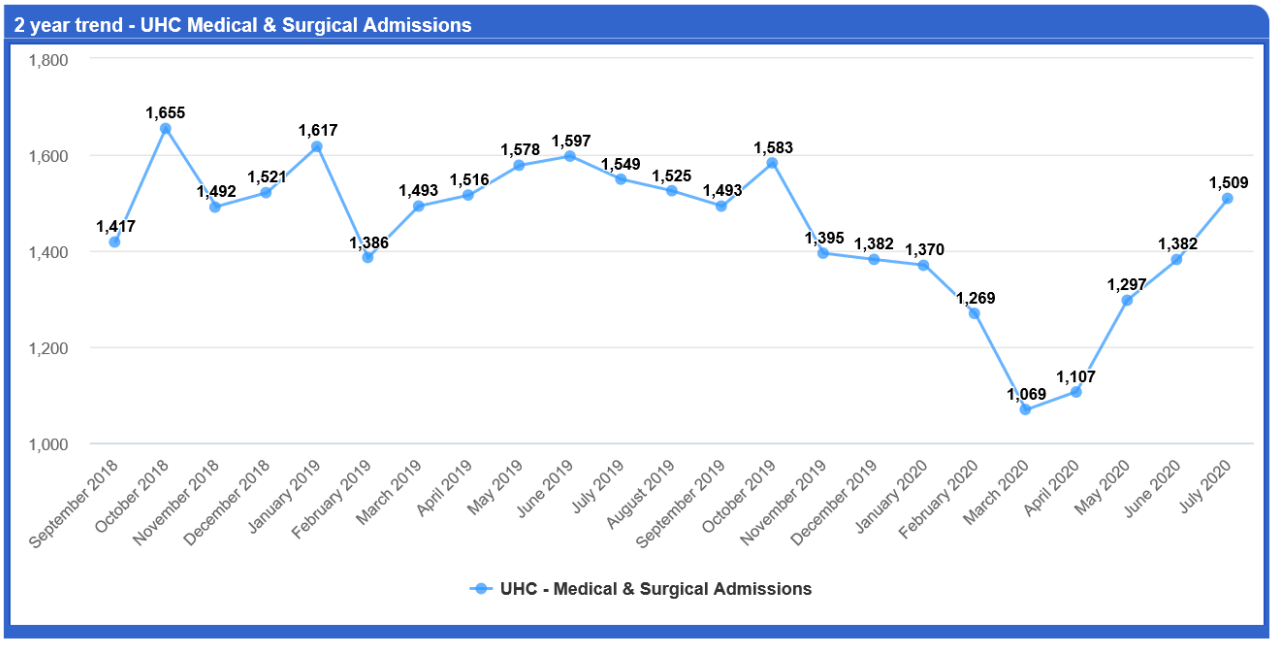

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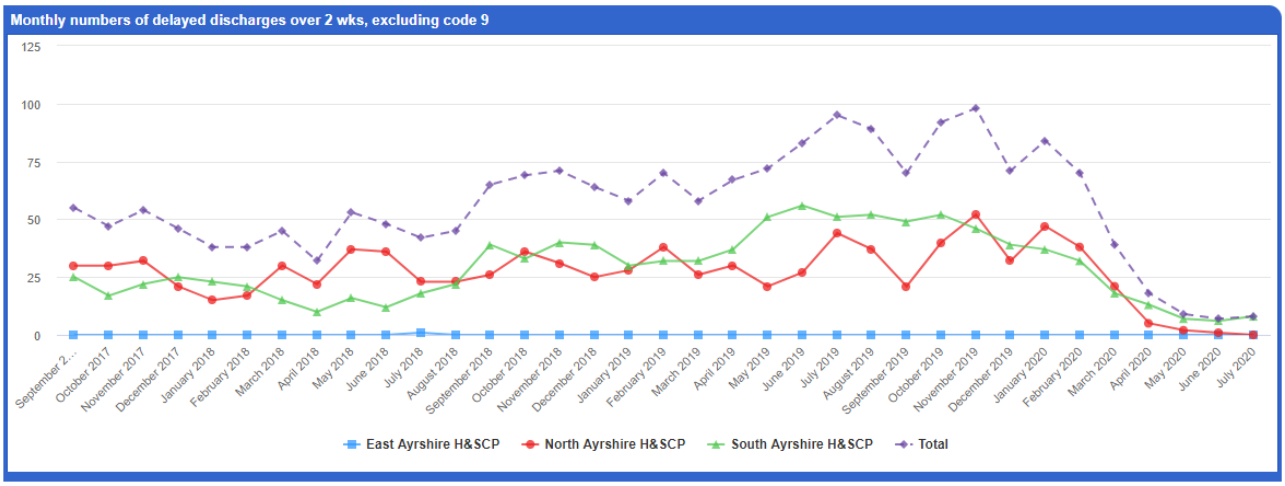
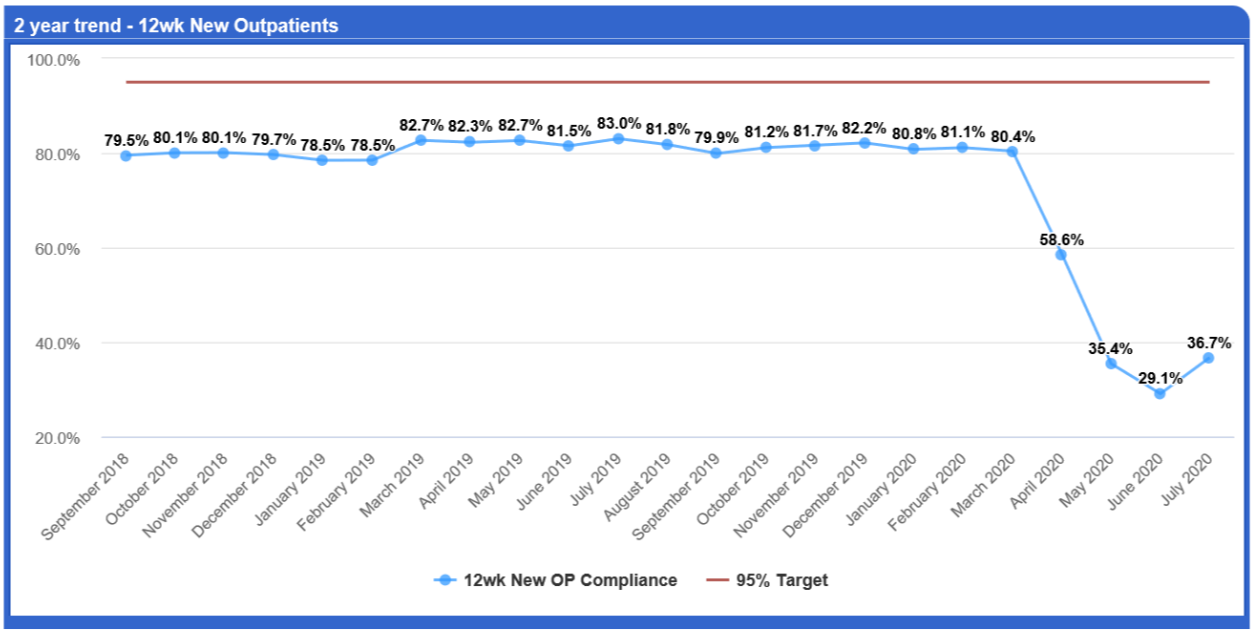


Source: Public Health Scotland Publication

Planned Care



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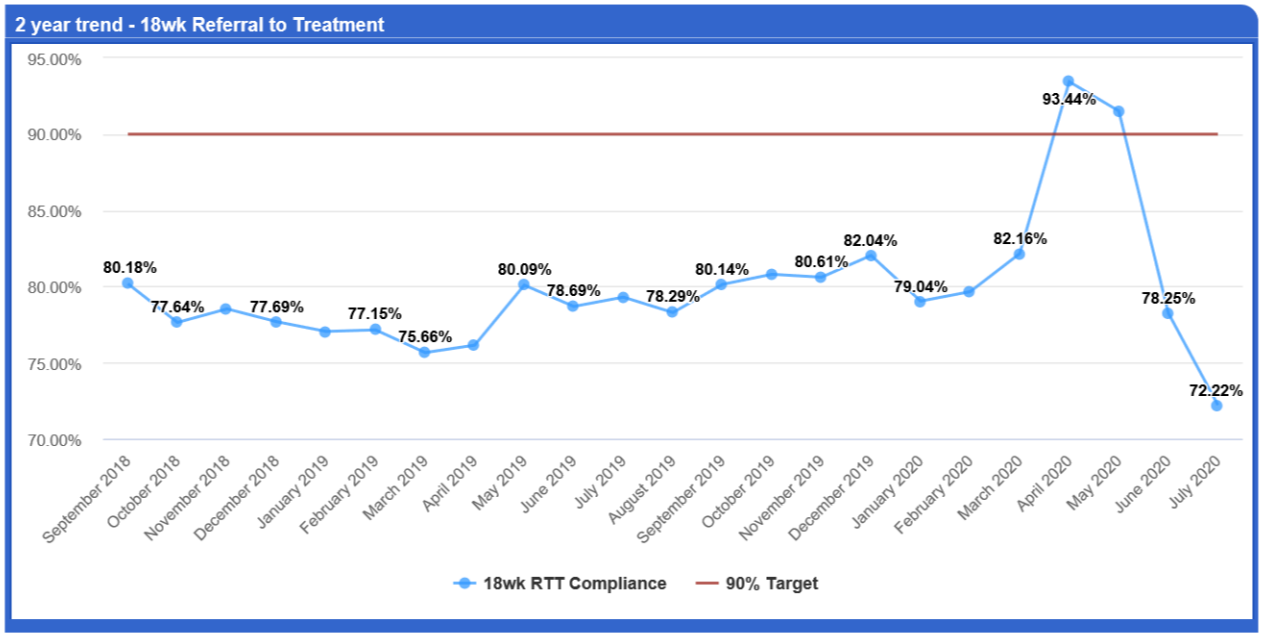

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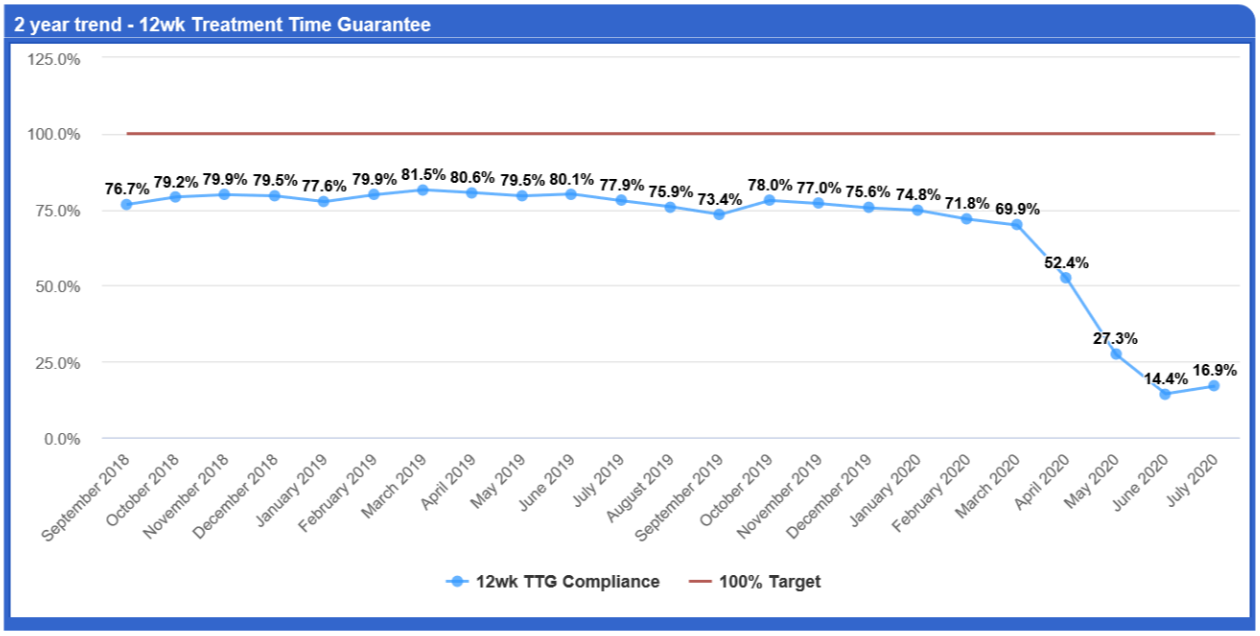

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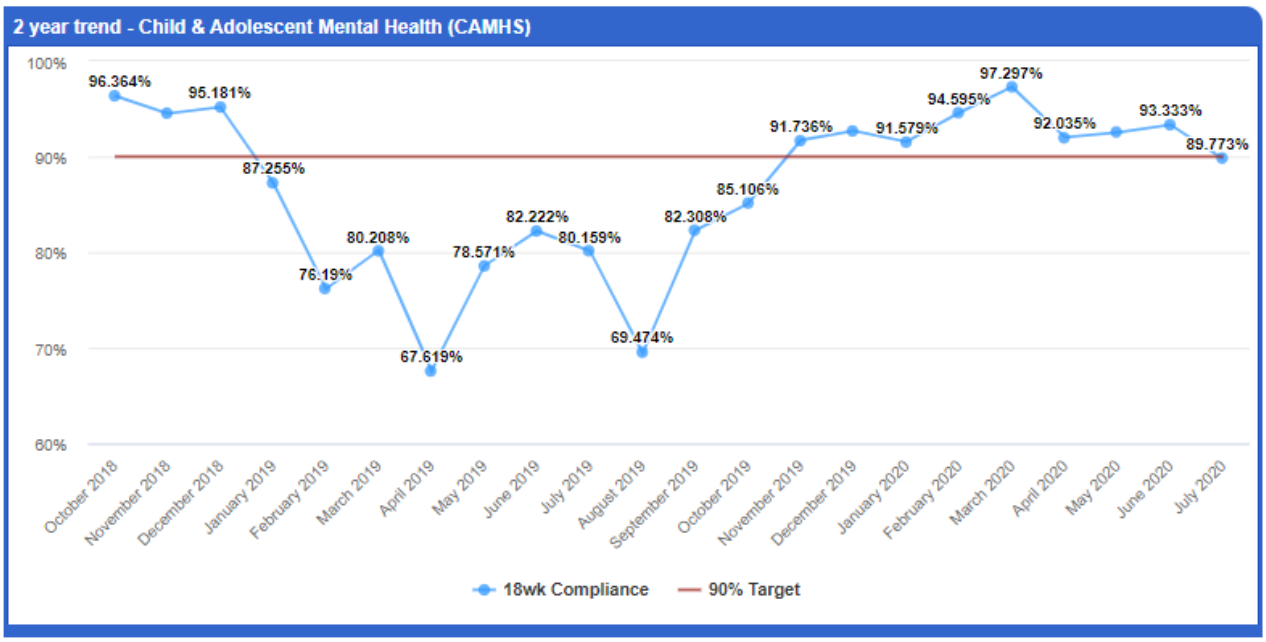

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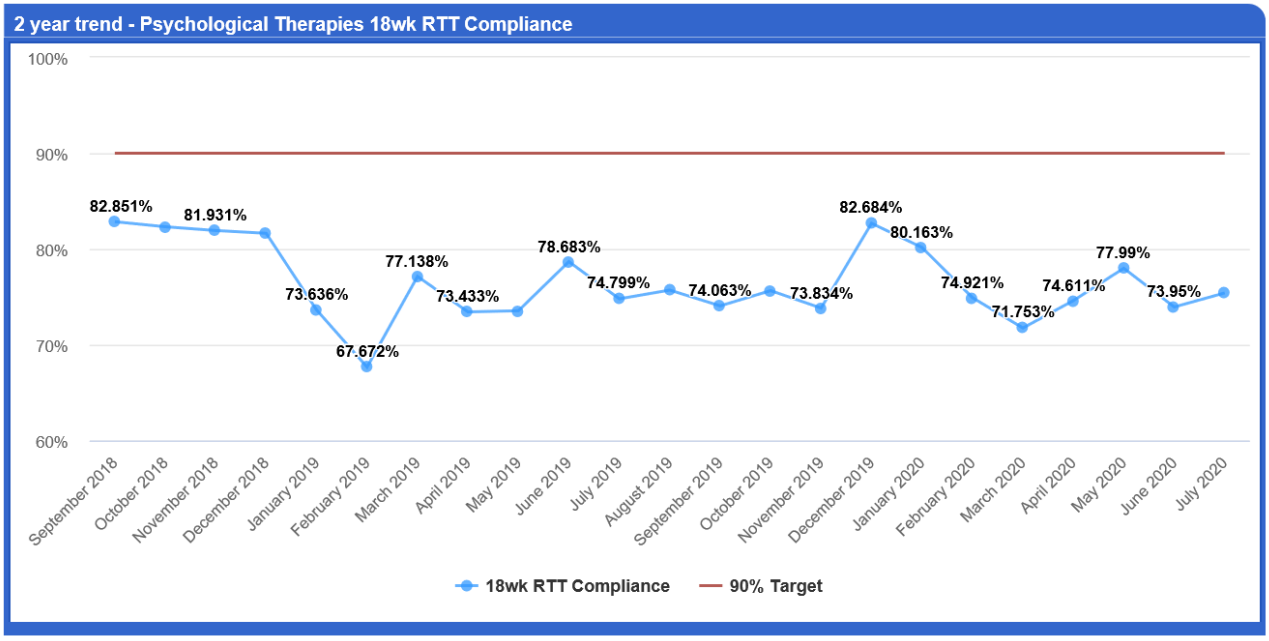

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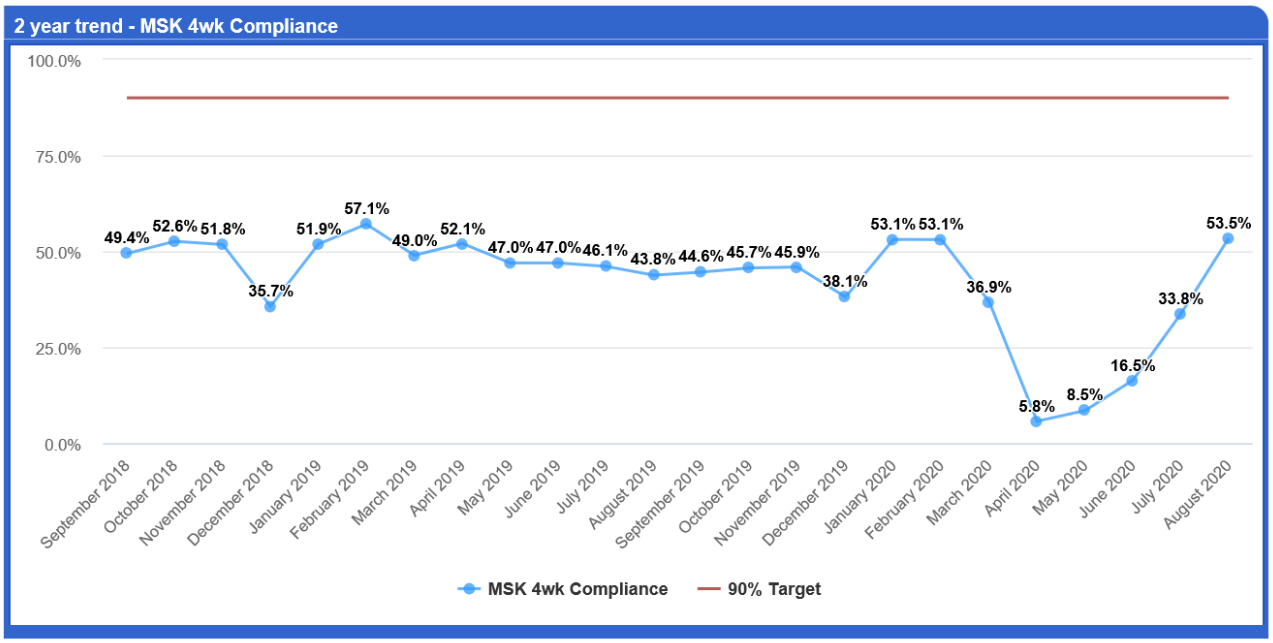

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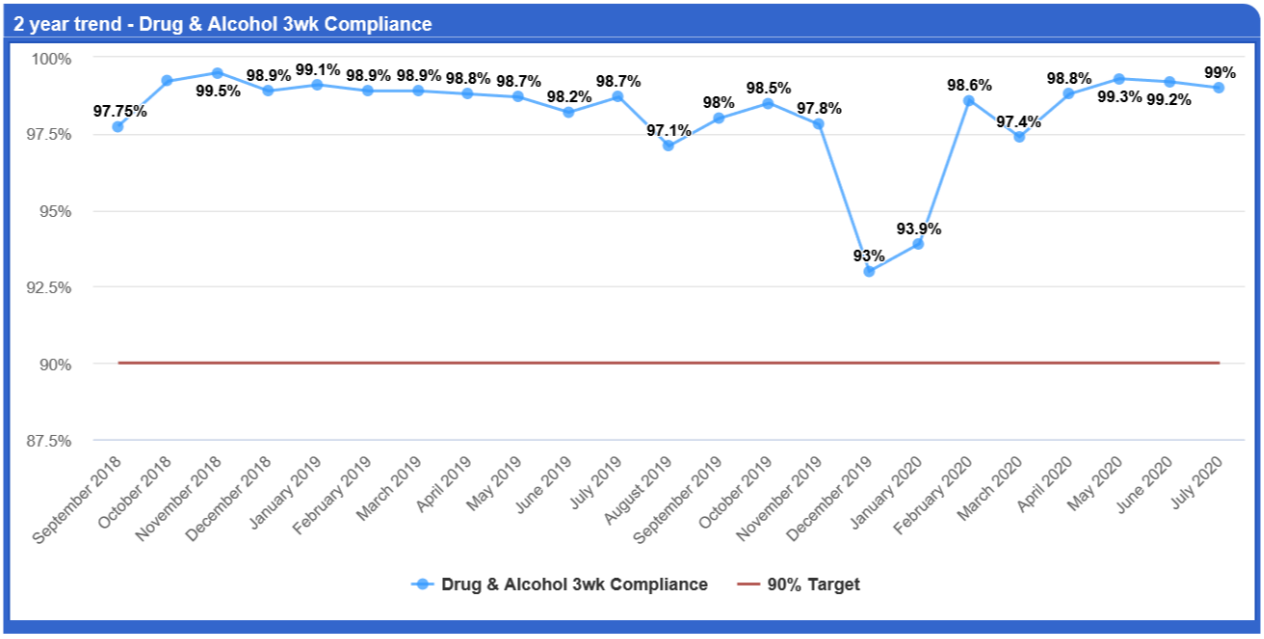

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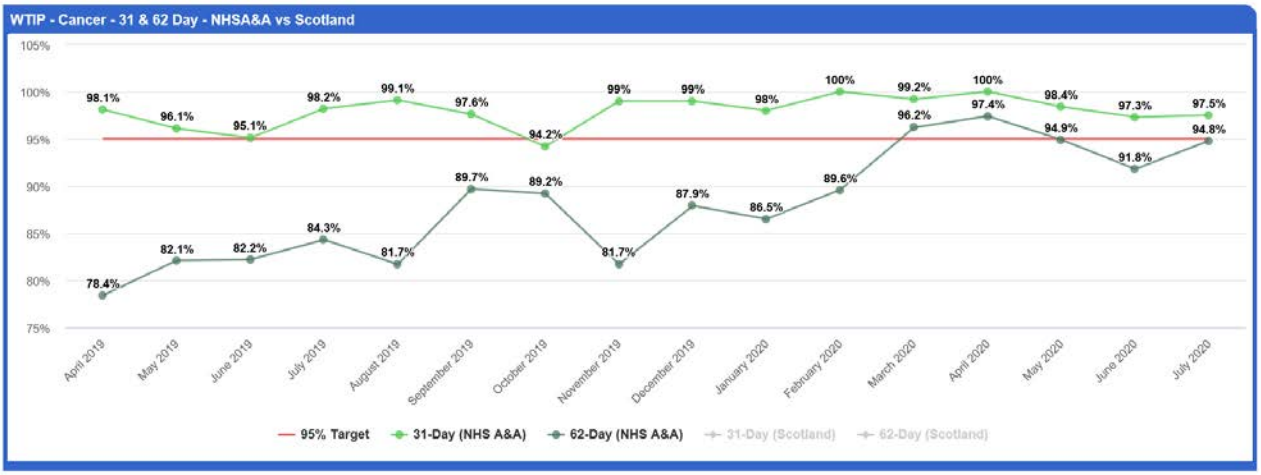

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