Phase 2
Mobilisation Plans

EAST AYRSHIRE Health & Social Care Partnership

south ayrshire health & social care partnership

NHS Ayrshire & Arran

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Completion of the following signature blocks signifies the approver has read, understands, and agrees with the content of this document.

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1. Recovery

This document responds to the requirement for NHS Ayrshire & Arran to develop a Phase 2 Mobilisation plan, presenting the next step in an iterative and evolving approach to planning that builds on actions set out in the Mobilisation Plan submitted on 23 March 2020. This document is intended to provide Scottish Government with assurance that we are planning on a whole system basis with our IJB and Council colleagues, in collaboration with our staff side representatives, and developing our plans through strong clinical and professional leadership, co-produced across community, primary and secondary health and care teams.

Our planning, risk assessments and associated decision making are being undertaken in the context of the Four Country UK PHE Guidance continuing to indicate at this time that the country is in 'sustained transmission' status, with no time frame of when that status will be reviewed.

Underpinning our decision making is a focus on the health and safety hierarchy of control:

- Elimination of risk;
- Substitution of risk;
- Engineering controls (environmental changes);
- Administration controls (work practice changes); and
- PPE to protect staff if all above controls are not possible.

NHS Ayrshire and Arran is an active partner in each of the local authority Public Protection Chief Officer Groups. These have continued to meet virtually during this time and all recognise that there is significant potential for an increase in Child Protection, Adult Support & Protection and Gender Based Violence activity as lockdown eases.

Our teams have continued to work closely on an interagency basis with social work and police colleagues during this time and are sighted on the anticipated increase in activity.

In line with the 'COVID-19 Framework for Decision Making,' health and care services across Ayrshire and Arran mobilised to respond to the Coronavirus Pandemic in March 2020. Measures included:

- Increasing capacity within Acute services including increasing ICU beds;
- Creation of a COVID-19 community clinical assessment centre;
- Reduce levels of delayed discharges in hospital through creation of additional community capacity;
- Creation of a central staff hub for COVID-19 related staff absence;
- Establishment of a COVID-19 Workforce Planning & Deployment Group and employment of additional staff ;
- Procurement of additional equipment for acute and community including PPE; and
- Investment in digital solutions e.g. Near Me as well as in providing the digital infrastructure to support more staff to work from home.

Throughout this time we swiftly reconfigured our primary, secondary and community care services to support our population during the COVID-19 pandemic.

Phase 2 Mobilisation Planning focusses on the ask to detail what can be delivered over the coming months through to the end of July 2020. We have developed our plan in a way that is future focused, putting us on a path to deliver the reform we know we need to make to ensure Ayrshire and Arran has a health and care system that safely and effectively manages sustainable services for a pathway of care for COVID-19 patients and for patients following other pathways of care. We have structured our plan to deliberately focus firstly on Primary & Community Services, recognising our strategic priorities in 'Caring for Ayrshire' to provide care in our citizen's homes and communities where possible.

Added to our established Emergency Management Team, Gold, Silver and Bronze structures is the Whole System Mobilisation Planning Group, bringing together colleagues from across the Health and Care system, community, primary and secondary care services from clinical and professional leadership roles.

As we emerge from the first wave of the spread of the virus, though still in sustained transmission, where we have seen the R(t) gradually start to fall in Ayrshire, and where we are seeing a continual downward trend in bed utilisation within our ICUs, we recognise we must do three things. We must plan for recovery to manage health and care capacity to meet our population needs. Secondly, we must consider how we retain and build on positive changes we've made in how the health and care system operates in Ayrshire and Arran. Lastly, we must continue to be prepared for a potential resurgence of COVID-19, as and when lockdown is eased across Scotland.

These first two priorities are in part more familiar to us: we plan and manage our capacity in health and care as part of our normal planning approaches. However, our context is new and within this new context we must continue to seek the best health and care possible for the people of Ayrshire and Arran. Therefore our recovery phase will be:

- preventive: staying focussed on ensuring evidence based health protection and infection prevention and control advice to aid the prevention of transmission;
- responsive: safely and incrementally restoring our services to meet need, informed by infection prevention and control advice;
- adaptive; closely monitoring our R(t) number, making use of data, information and modelling to align services in a planned way to keep ahead of the curve, taking advice from Public Health; and
- transformative; seeking to build on the many areas of positive change and innovative practice which have emerged during this Pandemic.

Crucial in our planning is the recognition that we will have to balance maintaining a level of resource to provide care for COVID-19 patients alongside the need to support patients requiring access to other services. This phase of planning looks to ensure that we can adequately resource and safely provide a level of emergency and urgent care activity in primary, secondary and mental health services, and in maternity and paediatric services. The provision of service will be on the basis of clinical prioritisation on need informed by the work of the Scottish Association of Medical Directors and Scottish Executive Nurse Directors and the National Cancer Treatment Response Group in relation to cancer services.

We recognise that the foundations of our Health and Care system in Scotland have not changed. Nor has our strategic intent described under the banner of 'Caring for Ayrshire'. Our clinical priorities remain as does our commitment to digital transformation and emergence of new ways of working that deliver services in the right place at the right time and our underlying commitment to quality and patient safety as laid out in our NHS Ayrshire & Arran Quality Strategy has even more weight in these times.

2. Primary & Community Services

Previous engagement in relation to Caring for Ayrshire and the Primary Care Improvement Plan provides a sound foundation to ensure that Our mobilisation and recovery plan in Community and Primary Services is developed in an environment of positive partnership working across NHSAA, the 3 HSCPs and our partners in the Area Clinical Forum including GP sub committee.

In Primary Care our PCIP and response to COVID19 have been developed jointly with GP sub and has seen an enhanced level of engagement across all our GPs both in hours and out of hours.

Through our HSCPs and Community Planning arrangements this partnership working is extended further into wider Council services of Housing, Education, Leisure, the third sector and commissioned services including care homes.

As we look towards recovery and new ways of working these partnership arrangements are vital in ensuring our Health and Care services are increasingly community based accessible to our citizens close to their home and embrace engagement of health and care through new technology. Pathways to access Acute hospital services should be informed by progress made in response to COVID-19.

Activity

The Primary Care De-escalation Committee will oversee the recovery plans of practices towards full delivery of the GMS contract including Enhanced Serviced. The Committee will set out measures to support GP Practices in hours and GP out of hours, to support practices through the de-escalation process and for practices to deliver services and manage increased demand. The work of the De-escalation Committee will be considered in relation to the overall NHS Ayrshire and Arran plan with activity monitored and reviewed initially on the short to medium term basis.

General Practice are feeling the positive benefit to workload by not requiring to work through large volumes of correspondence due to many services currently not seeing patients. There is also the associated workload with chronic disease management that is currently not being undertaken. GP feedback is that they are actually ‘getting all the day work done on the day’. It has also been fed back that this is replicated across acute services and something we must try hold onto.

As part of COVID-19 reporting each practice is assessed daily against an escalation scale. As of 22nd May 2020 24 practices are at level 1 (suspension of non core activities) and 28 practices are at level 2 (managed suspension of services).

As part of Recovery we will work with all practices to return to full operation.

It is recognised, as services start operating again, this workload will increase and GP Practices will have to redesign accordingly to manage this. Although this will not all be possible in the current circumstances, there is a desire that the ways in which patient groups and chronic disease is managed is included as part of the review of the wider recovery plan.

A survey has been sent to practices for completion to understand how they are caring for patients within the various shielded groups. This will be important to understand the totality of work associated with supporting this patient group differently should they require it. Once the workload associated with this is known, this can be factored into the support required for general practice and community.

In summary we require to consider;

- Urgent Care;
- Chronic Disease Management;
- Resumption of activity as a consequence of planned care and
- Implications of Shielding.

It is anticipated that delivery of General Medical Services in an environment where both COVID-19 and non COVID-19 patients will result in resource challenges, with environmental issues in practice premises, time issues in relation to PPE and complexity of care.

Primary Care Improvement Plan

The new 2018 Scottish General Medical Services (GMS) Contract came into effect from 1 April 2018. The overall aim of the Contract is to ensure patients access the right person, at the right place, at the right time. The Contract facilitates a refocusing of the GP role as Expert Medical Generalist.

In 2018, under ‘Caring for Ayrshire’ Ayrshire and Arran set out an ambitious and forward looking Primary Care Improvement Plan (PCIP) to implement a Once for Ayrshire programme transformation plan to deliver the new General Medical Services contract.

The PCIP was revised in December 2019 for years 2020-22 with clear actions and timelines for delivery by 2022. Progression of the PCIP is being reviewed alongside the learning from the COVID-19 response and the development of this Mobilisation Plan Phase 2, all in pursuit of strategic aims of Caring for Ayrshire.

Delivering the community treatment and care (CTAC) service as part of PCIP potential models was scoped in conjunction with key stakeholders during 2019 to support chronic disease management, screening and flu preparation. Approximately 90 wte staff were committed within PCIP 2020-22 to provide full service delivery across Ayrshire and Arran. This projected workforce model incorporated a mix of Band 3 Healthcare Support Workers and Band 5 Registered Nurses. Discussions had commenced with current practice staff and recruitment was anticipated to commence in May 2020 for staff to be in place by September 2020. This is now paused whilst we await further clarity on Primary Care Improvement Funding (PCIF). This group of staff were also going to support delivery of flu clinics based on current practice models where possible using additional workforce and bank staff.

There is currently the opportunity to recruit to approximately 40 newly qualified nurses who will be registered from September 2020 who are currently working in primary care and community as Band 4 nurses. Funding required via PCIF is essential to secure these roles.

We continue to work with GP Practices and HSCPs to agree principles and progress with development of a primary care/community nursing model. Using ANPs to support COVID-19 and urgent care presentations working alongside Primary Care nurses has demonstrated an effective model for delivery and should be explored through new ways of working.

We are exploring the delivery of flu vaccines as part of the primary care nursing model in place in response to COVID-19 assessment centres to support GP Practices and the most vulnerable group who are shielding.

We see the continuation of the PCIP delivery as an important part of the COVID-19 response as it would support a strengthened community and primary care service to deliver care in homes.

Over the coming weeks the Primary Care Transformation team will review current progress against the Memorandum of Understanding (MoU) and reflect the current position whilst we await further guidance on the new contract nationally. It is anticipated there are still many areas that can be progressed in line with the PCIP timelines and recovery plan. However, clarity on funding for 20/21 is required to support this work.

Care at home

A foundation of Health and Care services is social care provided to people in their own home. People with complex health needs and cognitive impairment are enabled to remain living at home through the provision of personal care including help with eating, dressing, toileting, bathing and medication.

COVID-19 has required social care workers to adopt significantly enhanced use of PPE. This has resulted in resource pressures in relation to:

- Longer visit times
- Cost of PPE
- Distribution network for PPE

As part of initial mobilisation plans, resources were invested across all 3 HSCPs to increase social care capacity to address service pressures arising from complexity of care and provide service resilience when higher than normal levels of staff are unable to work due to sickness, self isolation or shielding.

In the foreseeable future community social care will require to work in an environment of providing close personal care to people with COVID-19 and those who do not. Working practices that encompass where possible social distancing and infection control will be required and present an ongoing resource pressure.

In the immediate future the implications of Test Trace Isolate for care staff remains unclear, with a planning assumption that at any time there may be a number of staff excluded from work isolating.

Service pressures on care at home social care has implications across the full health and care system, effectively supporting people at home meets the aspiration of many of our older people and also supports a system where admission to hospital is for when this specialist resource is required and return home is timely.

It is anticipated that there will be significant resource implications to meet the challenges in care at home services.

Community Nursing

All our community nursing teams have continued to provide services throughout Phase 1. A small number of practitioners with expert skills were redeployed, for example, into ITU or the Clinical Assessment Hubs, and consideration is being given to how to safely return these staff as appropriate. We are also exploring and modelling whether these services need to be augmented in Phase 2 of our plan in order to meet the potential demand in communities, and also to support care homes if required.

Health Visiting

Health visiting teams have continued to provide services during this time and only a minimal amount of service needs to be stepped back up when safe to do so.

Health Visitors, school nurses, Family Nurse Practitioners and Looked After Children teams have developed Continuity Plans for engagement and support of families and children during Phase 1. They have planned care with Education and Social Work partners, using technology and home visits through risk assessments to maintain contact and review of families. There has been a particular focus on those families who are most vulnerable and known to caseloads and the continued support that is needed.

All vulnerable children in Health Visitor and School teams have continued to be visited/or contacted through use of technology. All children within Child Protection, Vulnerable or Additional Categories are supported through contingency planning and working with multiagency colleagues.

All critical and essential visits are supported have been supported at home with staff making contact prior to visit. This includes: 1st visits, 6-8 weeks, 3-4 month review and any shielding patients have been supported.

The following have been paused - if not risk assessed as essential contact: 12-13 month, 27-30 month and 4-5 years visits. Each HSCP is now considering how and when it will be safe and appropriate to recommence these contacts, taking into account any further national guidance when issued.

AHP Workforce

NHS Ayrshire & Arran is currently working on quantifying the resource required to meet predicted demand on AHP services.

AHP services across Ayrshire and Arran are working together to scope out what demand on Rehabilitation is likely to look like at this stage in our response.. This will include the use of available basic workforce tools and professional judgement/published evidence and recommendations with predictions on increased demand from the non-COVID/ COVID +ve population. Public Health data will be used to project the impact of the rehabilitative demands COVID +ve patients in Ayrshire and Arran.

We recognise that there will be a funding and personnel challenge with regard to any increase in resource required for AHPs both locally and across Scotland. The national Transforming Roles agenda for AHPs will be a vehicle to aid working differently to meet the needs of the population of Ayrshire and Arran in Phase 2 and beyond however this is not a quick fix and requires to be planned.

We are currently moving AHP staff back to their substantive roles in a planned way to begin redesigning how we provide AHP services for people while following guidance on limiting contact for face to face consultations and social distancing guidance. We will continue our use of technology and other new ways of working to support this as part of our new way of working in Phase 2.

Services are exploring different shift patterns and splitting into discreet teams which work at different times or in other bases to limit contact; this is in case the Trace and Protect system asks staff to self-isolate for 14 days in order to maintain essential service provision. This will be part of our scoping exercise for how Rehabilitation Services will respond to the next phase of this crisis with the caveat that if we see a second peak we may have to move staff back into their original mobilised roles to support demand.

Day Services

For many people with health and care needs social isolation is a key issue. To mitigate isolation group activities are commissioned, including Day Services for older people and Adults particularly those with Learning Disabilities. These services provide not only benefit to the individual but are also often a key element of support to family carers, providing a valuable contribution to maintaining care at home.

In response to COVID-19 most if not all day services have been suspended replaced on a temporary basis during lock down with family arrangements or bespoke care at home services.

In recovery to maintain social distancing existing models of Day Services will not be viable. Transport arrangements particularly in rural communities will need revision to ensure cohorts of people are not in close proximity for extended periods.

Similar to arrangements for schools numbers of people within any facility will require limiting. This will have staffing implications for both the care facilities and replacement services for those not able to attend as frequently.

Where care is provided within 2 metres the use of PPE will be required and this will be a challenge for communication with people with cognitive impairment or learning disabilities.

It is anticipated that there will be significant resource implications to meet the challenges outlined above in day services.

Community Resilience

A positive aspect of the COVID-19 pandemic has been the response of communities. The willingness of people to come together, volunteer their time, effort and talents to support both individuals in need and also wider communities.

Our ambition in Caring for Ayrshire has been about inclusion in local communities, focusing on person centred care and the priorities that matter to individuals. In so doing we anticipate improvement in wellbeing and reducing the need for some traditional care services particularly in relation to mental health. It will be a missed opportunity if we do not maintain and build on this community resilience.
Partnership arrangements with community and voluntary services are well established through Councils and HSCPs.

The role of the Third Sector and community organisations in delivering an effective response to COVID-19 should not be underestimated. From commissioned services like Red Cross Home from Hospital to food distribution, financial advice, emotional wellbeing through social contact to formal support of independent advocacy, all have played important roles. In many instances short term funding, or full funding whilst operating at lower capacity has sustained these organisations. The models of future service delivery need to be considered and resourced to provide sustainability to the sector.

To achieve our ambitions of Caring for Ayrshire and wider Healthier Scotland ambitions, as a cornerstone of our PCIPs, Health Improvement and Community Planning we need to support and resource wellbeing and community resilience.

Rehabilitation Services

As we move towards plans for Phase 2 of the response to the COVID-19 mobilisation in Ayrshire and Arran an area of particular focus and concern is Rehabilitation Services. The early published evidence describes a picture of significant risk that the need for rehabilitation services may rapidly overwhelm current resource.

This anticipated increased demand on services is predicted on a backdrop of waiting times and significant staffing risks already identified in specific areas of AHP staffing e.g. Adult Speech and Language Therapy.

The recommendations for staffing of the Louisa Jordan demonstrate the gap between recommended staffing levels for level 0/1 inpatient rehabilitation (step down from requiring acute care but not appropriate to return to home or homely setting) and our current establishment of AHP staff in these areas. The table below outlines the current modelling for Louisa Jordon dependent on the number of beds opened. This modelling can be used to highlight gaps within own services across professions as part of triangulated approach. E.g The adult SLT team operates a 'single system' model with 5.9 wte to deliver across all inpatient UHA Biggart and Girvan and community settings in South Ayrshire.

Role	40 Beds WTE	120 Beds WTE Additional Ask	300 Beds WTE Additional Ask	Total Ask
AHP Clinical Lead	1.00	0.00	0.00	1.00
Physiotherapy	5.10	9.90	26.00	41.00
OT	3.40	8.60	18.00	30.00
S&LT	1.00	2.00	3.00	6.00
Dietetics	1.00	2.00	3.00	6.00
AHP HCSW	7.20	13.80	39.20	60.20
AHP Total	**18.70**	**36.30**	**89.20**	**144.20**

Pressure on Rehabilitation Services is a complex picture and is likely to be increased due to a number of complex factors;

- The mobilisation of AHP staff to support category A and B services and the pausing of all other services resulting in increased waiting lists and patient who may have deteriorated and have increased rehabilitative needs.
- The return of mobilised staff to their substantive positions will be equally complex, as increased demand is anticipated to continue within the Cat A and B areas, whilst staff will also be required to return to restart the paused activity as described.
- The significant rehabilitation needs of COVID-19 patients who have been discharged home from hospital or have remained in a community setting including rehabilitation of respiratory function, fatigue, sarcopenia, anxiety and deconditioning.
- The impact of lockdown and social distancing measures on the general population e.g. physical deconditioning, increased anxiety, social isolation, increased smoking or consumption of alcohol and unemployment increasing the demand for rehabilitation services.
- Patients who did not present to the NHS during this time who may now have sub-optimal outcomes due to omission of care.
- Potential increase demand from the Care Home sector.
- Additionally, as other services and agencies begin to restart routine activity, anticipated increased referrals to AHP services.

Taking the above into consideration, in the context of **local intelligence** and **published evidence** around AHP staffing levels and existing or waiting demand, the areas of particular concern for the AHP Senior Management Team are;

- Mental Health and Learning Disability Rehabilitation Services. Philips et al (2020), Holmes et al (2020) and Mahase (2020) all discuss concerns regarding the direct and indirect psychological and social effects of the COVID-19 pandemic which are pervasive and could affect mental health now and in the future. They report this pandemic is occurring against the backdrop of increased prevalence of mental health issues in the UK in recent years in some groups.
- Children and Young People Rehabilitation Services. (The Royal College of Paediatrics and Child Health has compiled a research resource outlining the impacts of COVID-19 and the complexity of this situation for children and young people and service provision)
- Inpatient Rehabilitation Services in downstream wards – maintaining system flow and optimal individual outcomes (Boldrini et al 2020 describe increasing pressure from acute services to transfer patients to inpatient rehabilitation units, so as to facilitate new admissions of

COVID-19 cases, as well as to ensure the care of patients affected by other medical conditions whose admission cannot be postponed).

- AHP Services across primary care including primary care dietetics and MSK Services (Hellas et al 2020 discuss the need to focus on food, fluid and nutrition as a means of limiting the impact of the complications of immobility and reduced intake as a means of improving outcomes and reducing the risk of longer-term disability)
- Neurological and Stroke Rehabilitation Services (There have been multiple reports of evidence of increased incidence of these conditions post COVID published (Varatharaj et al 2020)
- Reconfiguration of Acute Service delivery for Rehabilitation *(*Brugliera et al 2020 discuss the need for adapting how our healthcare system functions with a particular focus on Rehabilitation to reduce the impact of the significant complications experienced by some COVID patients post critical care but also for those patients not affected by COVID to ensure they do not receive sub-optimal input)
- Adult Community Rehabilitation Services (Boldrini et al 2020 report significant pressures in this area due to lockdown restrictions imposed to prevent the spreading of the infection. This situation is expected to have a significant negative impact in the short term, mainly for those patients at higher risk of deterioration of their functional abilities and already suffering from important limitations in participation).

The statement from the 4 nation's Chief Allied Health Profession's Officers describing Allied Health Professionals' role in rehabilitation during and after COVID-19 describes the same concerns about complexity and affirms "The rehabilitation needs of these at-risk groups are vitally important and need to be met as we collectively support people to recover, regain health and wellbeing, and reach their potential, and ultimately ensure we flourish as a nation."

Rehabilitation Services will work to continue using new solutions to meet demand in phase 2 to provide safe and responsive services including the use of digital solutions such as Attend Anywhere. Learning from the developments to ways of working and service provision during this crisis must not be overlooked. Systematic reviews on tele rehabilitation interventions post stroke have demonstrated either better or equal salutary effects on motor, higher cortical, and mood disorders compared with conventional face-to-face therapy (Koh and Hoenig 2020). There is also work underway to refresh the public facing AHP page on Ayrshire and Arran's website.

There has also been real progress in the use of social media to promote self-management and anticipatory care from AHP services with a drive to spread this across appropriate services. The continued roll out of agile devices to teams will be critical in supporting ongoing advancement and application of digital care. Koh and Hoenig 2020 discuss a variety of considerations when trying to plan for the recovery phase of rehabilitation during this pandemic. They describe potential for the effects for patients undergoing rehabilitation who need to be quarantined (eg, from contact with a positive case) or if they became unwell due to COVID-19, including deconditioning and providing effective rehabilitation while protecting health care staff as major concerns. They include practical advice on continuation of home exercises last prescribed, and continued attendance at rehabilitation centres if possible and well but with stepped-up infection control measures such as patient screening for fever and flu symptoms at the entrance.

Services have been working hard wherever possible in anticipation of this demand, active monitoring of existing vulnerable caseloads, promotion of self-management/ signposting to other services have all been key pieces of ongoing work. Efforts were also made to reduce active caseloads at point of enacting the Workforce Mobilisation Plans in order to reduce the impact of pausing services wherever possible. Additional AHP staff have applied locally and via NES portal routes. The teams are keen to welcome these new temporary team members and use their skills wherever possible whilst providing support and local induction. This crisis has demonstrated real staff willingness, engagement and leadership in working flexibly across traditional boundaries to support best use of resource available.

Writing in the Health Service Journal Murray et al (2020) state “At present there are insufficient resources in terms of beds and facilities for those requiring longer rehabilitation. Community services are already overstretched and overloaded and will have a limited ability to track post-covid patients after discharge.” They discuss that using the NHS discharge to assess model (COVID -19 Hospital Discharge Service requirements 19 March 2020);

- Fifty percent of people will require no input from health and social care,
- Forty five percent will need support from health and social care
- Four percent will require rehabilitation in a bedded setting
- One percent for whom discharge from the acute sector is not an option.

In the coming weeks AHP services across Ayrshire and Arran will be working together to scope out what the local picture of demand on Rehabilitation is likely to present as in Phase 2 of this crisis. This will include the use of available basic workforce tools and professional judgement/published evidence and recommendations with predictions on increased demand from the non-COVID/ COVID +ve population. Public Health data will be used to project the impact of the rehabilitative demands COVID +ve patients in Ayrshire and Arran.

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To meet expected demands on rehabilitation services a significant increase in resource will be required in order to meet this demand and reduce the impact of COVID-19 and lockdown measures on the population's physical and mental health.

2.1 Clinical Assessment Hubs and Ayrshire Urgent Care Service (AUCS)

As part of the national response to COVID-19 the Scottish Government asked that all Boards in Scotland set up community clinical hubs and assessment centres to support citizens with COVID-19 related queries, providing a comprehensive front line community response to enable rapid pathways for those affected by COVID-19.

Over the last eight weeks the Clinical Hub, GP Practices and AUCS have all worked using a clinical triage model providing timely telephone or video consultations to patients, ensuring these are followed with a face to face consultation if required. This has ensured:

- a planned approach to any patient contact protecting the patients and workforce from unnecessary exposure to COVID-19;
- streamlined referrals to the CAU or ED when necessary;
- Better access for patients; and
- Better work life balance for staff.

We have continuously developed to ensure best use of resources, GPs continue to work flexibly across the hub/assessment sites to support activity. In the Out Of Hours (OOH) period this also includes supporting the OOH GPs with general telephone consultations and seeing patients. This way of working has ensured flexibility of the role with telephone consultations, face to face consultations and home visits with clinical leadership of the team all evident.

Recovery

With recent modelling confirming that COVID-19 is likely to be in our communities for some time it is important for primary care and community services to be configured and commissioned appropriately to look after patients, both those who have the virus and those who do not, as close to home as possible. Recognising that these dual pathways will mean working differently across the whole system.

In achieving this it is essential that we capture learning from our experience of rapid change over recent weeks and apply this towards our strategic aims and ambitions in terms of Caring for Ayrshire.

National discussions with Scottish Government colleagues and COVID-19 Clinical Hub Leads have indicated that Clinical Hubs will require to stay in operation for the foreseeable future providing a 24 hour response to COVID-19 under the same consistent pathway.

Board areas have been asked to staff these safely and ensure appropriate links with general practice, care homes, OOH services, Scottish Ambulance Service and secondary care.

We have sound foundations that enable this to continue to be achieved locally with the model and pathways in place, and also offer opportunities to test out embedding and spreading learning as part of recovery.

The sections below are the initial areas scoped to identify best value and specific interfaces to work towards a whole system recovery.

This will only be possible with ongoing support and investment in digital alternatives for remote working and consultations.

Unscheduled Care in the Community

Unscheduled / Urgent Care is a significant driver of activity in both Primary and Acute Services. Within Caring for Ayrshire it is identified as a key shared responsibility across the system.

As the demand from patients seeking urgent care about their physical, mental health and wellbeing increases, this will be stressful and complex to navigate, as well as putting additional workload on to GP Practices and the wider system.

General Practice and OOH services are seeing rising activity associated with urgent care presentations to be seen at the practice or in an OOH centre. Practices advise that contacts are now at pre COVID-19 levels.

As we work towards recovery social distancing rules will require all urgent care sites, including GP Practices, Clinical Hub, OOH Centres, ED and CAU to be designed to see patients safely in a timely manner.

It is recognised that to have this operating in as much a planned way as possible will maximise the opportunity to allow social distancing in all these settings.

At a NHSAA level The clinical hub triage model, in response to specifically COVID-19, has allowed delivery of a truly integrated model for delivering urgent care over a 24 hour period using a whole system approach involving a range of multi-disciplinary team members to provide consistent medical advice, triage and treatment.

At the same time General Practice and other services have developed telephone triage and support models that have changed the shape of delivery of non COVID-19 work.

Due to reduction in attendance numbers at the hospital front door, opportunities have been taken across CAU / ED to deploy senior clinicians in a way that has seen where appropriate patients receive early assessment and treatment and return home rather than admission.

Delayed Transfers of Care

When people are admitted to hospital the majority return home to the care of families and universal services with no delay. For some people additional support is required to facilitate a safe transfer from hospital and involves a multi-disciplinary team approach to ensure the patient gets the right care in the right place.

For a variety of reasons these transfers of care can be delayed, resulting in:

- poorer outcomes for the person;
- service implications of capacity and flow that result in poorer outcomes for other patients; and
- a perverse financial situation where it costs more to keep the person in a care setting that does not meet needs.

In response to COVID-19 many of the system blockages that prevented people receiving care in an optimum setting have been removed. We need to ensure these improvements are maintained and built upon as services resume.

Discussions between Primary Care and Acute colleagues have identified there are many opportunities to move forward and do things differently as a whole system to improve unscheduled care pathways. There is a joint view that the patient journey can't go back to what it was from urgent care presentations through to being referred to a specialty service. A common theme throughout discussions was the impact on the patient journey and associated workload for all through the 'queues' we create in our system.

The areas that were highlighted as an immediate joint areas of focus and benefit included:

- Chronic disease management
- Caring for shielded groups
- Utilising the Clinical Hub for urgent care

- Using the time we have now to improve health behaviours – reinforce to the public the difference current behaviours has made to the system and access
- Simplify access
- Learn from referrals being actioned/seen quickly
- Can we approach secondary care referrals in a different way

To achieve the whole system transformation clinical and management leadership is essential across the interface.

At a national level with the infrastructure remaining in place from NHS24 building on the principles and demonstrable effectiveness of the COVID-19 community hubs pathway undoubtedly offers an opportunity to streamline access and clinical pathways across urgent and unscheduled care. The success of this model has been consistent. The evidence shows that effective clinical triage and access through NHS 24, supported by local clinical consultation with local knowledge, is a strong model. This model has worked because the outcomes have been simplified, the pathway has been implemented consistently 24/7 in all Boards, and the access route for patients has been unambiguous. These underlying principles could be applied across other clinical pathways to support a real and sustained shift in managing the flow of unscheduled care across our system.

NHS 24 could be configured to be the triage gateway 24/7 rather than solely out of hours. Embedding the development of the local hub model brings to life the policy and direction set out in 'Pulling Together', the 2015 review of urgent care conducted under the leadership of Professor Sir Lewis Ritchie. Next steps would include the development of consistent pathways in line with agreed clinical priorities. NHS 24 would support access through clinical triage to primary and secondary urgent / /unscheduled care, helping to manage ED attendances and helping patients to access the right care. There are benefits for in-hours primary care if we get this right, freeing up capacity there to manage complex, long-term care and build on the success of Near Me and a different approach to delivery of primary and community care.

Near Me is currently in use across Ayrshire and Arran GP practices. Other digital triage solutions such as Ask My GP and e-Consult have also been established and Medlink which supports remote Chronic Disease Management of patients is in place.

Patients have accepted this approach in recent weeks. Now is the time for us to acknowledge that much of the system's pre-COVID-19 configuration reflected a 'failure' on our part, in that patients were required to navigate an overly complex and confusing set of arrangements. In this context, building on what we have learned during the pandemic becomes an imperative.

Across General Practice and OOH, face to face consultations reduced significantly throughout March and April due to the triage models put in place and telephone consultations replacing patient footfall. Call volume reduced within General Practice in the early weeks of the clinical hub being established, but this has been back to normal levels in recent weeks.

The OOH service call volume has on average remained consistent throughout the pandemic with telephone consultations replacing centre visits. Home visit activity has remained largely consistent.

Clinicians across General Practice and AUCS have advised that this way of working has been preferred and allowed them to assess patients over the phone either providing self-care advice or providing a prescription without the need for a face to face consultation that would have previously just been booked straight in for an appointment either within the practice or from NHS 24 triage.

We have commissioned a strategic team to progress modelling and implementation of this Urgent / Unscheduled activity across NHSAA and the 3 HSCPs.

In scope is General Practice, OOH, community services and acute services to work towards an integrated unscheduled care pathway for urgent care presentations. Working in this way would allow Ayrshire and Arran to fully test the vision set out in 'Transforming Urgent Care for the People of Scotland' report by Sir Lewis Ritchie in 2015.

As part of the national response to COVID-19 the Scottish Government asked that all Boards in Scotland set up community clinical hubs and assessment centres to support citizens with COVID-19 related queries, providing a comprehensive front line community response to enable rapid pathways for those affected by COVID-19.

Over the last eight weeks the Clinical Hub, GP Practices and AUCS have all worked using a clinical triage model providing timely telephone or video consultations to patients, ensuring these are followed with a face to face consultation if required. This has ensured:

- a planned approach to any patient contact protecting the patients and workforce from unnecessary exposure to COVID-19;
- streamlined referrals to the CAU or ED when necessary;
- Better access for patients; and
- Better work life balance for staff.

We have continuously developed to ensure best use of resources, GPs continue to work flexibly across the hub/assessment sites to support

activity. In the Out Of Hours (OOH) period this also includes supporting the OOH GPs with general telephone consultations and seeing patients. This way of working has ensured flexibility of the role with telephone consultations, face to face consultations and home visits with clinical leadership of the team all evident.

Recovery

With recent modelling confirming that COVID-19 is likely to be in our communities for some time it is important for primary care and community services to be configured and commissioned appropriately to look after patients, both those who have the virus and those who do not, as close to home as possible. Recognising that these dual pathways will mean working differently across the whole system.

In achieving this it is essential that we capture learning from our experience of rapid change over recent weeks and apply this towards our strategic aims and ambitions in terms of Caring for Ayrshire.

Hospital at Home

Hospital at Home is a short term, targeted intervention that provides a level of acute care in an individual's own home, that is equivalent to that provided within a hospital. This provides comprehensive geriatric assessment from a multi-disciplinary team of health and care professionals, in a more person centred care experience. Evidence would support around 40% to 60% of ED attendances are from the over 75 age group, with this group having the higher conversion to admission, longest waits in ED, for a frail population, will affect these patient outcomes. We know the frail elderly population can have adverse consequences of hospital admission, causing increase risk in delirium, de conditioning and higher risk of infection. This hospital at home model provides an alternative to traditional hospital admission. Evidence from around Scotland suggest this model can maintain at home 80% of frail elderly population referred by their GP for hospital admission, with an average length of stay on the hospital at home pathway of 4 -6 days, and high level of patient and family satisfaction.

In Ayrshire and Arran we are seeking to develop our Enhanced Intermediate Care Team (EICT) model to support a Hospital at Home delivery. The EICT is a 7 day model, based on a MDT approach which enables skills development in managing acute and deteriorating presentations including frailty. The model supports seamless pathways across Acute sites, community hospitals and people's homes. There is a single point of contact via a hub model, ensuring right person, first time, with a treatment focus on discharge support and alternatives to admission.

EICT is an integrated model of care including social care, AHP fast and slow stream rehabilitation and Advanced Nurse Practitioners (ANPs) are a core element of the model. There are established links across the service with acute wards and close alignment with Advanced Care of the Elderly (ACE) practitioners. In addition the service works with GPs, District Nurses and other primary care services to identify and triage complex cases at risk of admission. Scottish Ambulance Service (SAS) are an integral partner to the EICT with the aim of admission prevention. A particular challenge is capacity for a medical model for Hospital at Home. There has been development of GPs with Extended Roles (GPwER), specifically in older people's care and end of life, and developing the links with Care of The Elderly and emergency medicine consultants and outreach models.

Health Improvement Scotland has developed a guiding principles document to assist boards in implementing Hospital at Home model of care and we will seek to utilise this to progress in Ayrshire and Arran.

2.2 Care to Over 70's and Shielding Groups

On 17 March 2020, the First Minister announced: "*The third and final step is to shield the most vulnerable – by which I mean specifically people with compromised immune systems. GPs and other healthcare workers will be contacting these patients to ensure they are fully supported"*

A Pan Ayrshire Shielding group has been established led by the NHS Board Executive lead. This is supported by groups at each Council/HSCP level and Local Resilience Partnership arrangements where progress of this work is reported weekly at Chief Officer level.

Effective from end of March 2020 The Primary Care Contracting and Support team working with GP practices, Secondary Care and, Local Authorities embarked on a programme of work to identify those patient across Ayrshire and Arran that required shielding.

Process and systems were agreed and implemented in terms of sharing the data timeously and securely and this has continued to be refined over the last 7 weeks. From our local process Public Health Scotland (PHS) are advised daily of an update to their master patient list. This allows PHS to letter those shielded individuals explaining why they need to shield.

On receipt of the patient data from Primary Care the 3 Local Authorities/Health and Social Care Partnerships are able to offer:

- emergency and weekly deliveries of food,
- medication collections
- community-based support for social isolation and mental health,
- financial advice

Many of those identified with community support needs were previously not in contact with formal support services. It is anticipated that these community supports will continue beyond shielding.

To understand the current arrangements that GP practices have put in place to manage their shielded patient's health care needs a survey was distributed to all practices. The analysis of this information will be used to identify current practise unmet demand or workforce/capacity issues that need addressed. This analysis will also further support the Guiding Principles document that is being developed in partnership with our local GP Sub Committee.

As service demand increases It is anticipated that continued support arrangements to shielding patients will present additional but as yet unquantified demands on practices.

In relation to Anticipatory Care Plans all GP practices and Hospital clinicians were written to by the CMO about the plans for supporting those patients, in addition to those identified centrally for shielding, as being at the highest risk of mortality and severe morbidity from COVID-19. This piece of work is progressive in relation to identifying patients at high risk from Coronavirus. GP Practices, members of the wider MDT and secondary care were encouraged to have anticipatory care plan discussions with their patients.

Throughout the pandemic face to face consultations have reduced significantly in general practice due to the triage models put in place and telephone consultations replacing patient footfall. Many routine services haven't been in operation in general practice, with the additional Multi-disciplinary Team (MDT) members (Pharmacists, ANPs, MSK Physios, Mental Health Practitioners, and nursing team) providing remote support where possible as well as assisting general practice where they can if face to face consultations haven't been an option.

The aim throughout the Primary Care Improvement Plan (PCIP) implementation developing MDT teams in general practice/primary care has always been to develop a consistent pathway/model for patients to access, but further understanding is required as to how each HSCP are supporting their citizens aligned with wider HSCP recovery plans. Agreement to be reached on current service delivery model in collaboration with GP Practices of immediate/medium term aligned to recovery arrangements. Consideration also being given to other MDT members being able to deliver home visits and/or on the day presentations. The plan is to further progress through informed through consultation with practices.

ACPs are mainly being completed by ANP /District Nursing teams at this point in time, but recognise that this needs widened to other groups of staff within the wider MDT.

The ACPs are being progressed to an electronic format using EMIS, which will improve the communication of the plan to all community services also using this system. The District Nursing Service currently also enter the ACP within the GP system and a printed copy is left with the service user as a patient held record.

This agenda is also being progressed through frailty pathways and our geriatrician colleagues.

We are working to ensure this information flows to unscheduled care and social care, and begin to build on the teams completing/updating ACP. This Work will run in parallel to ACP completion in response to COVID presentations.

Inclusion of mental health service approaches support the primary care team developing a standard SOP and scrutiny via the locality MDTs , ensuring what matters to you conversations and asset approaches , keeping individuals and families at the centre.

Emergency Care Summaries and Key Information Summaries (KIS) are actively being updated as the shielding programme of work evolves. As of 18th May 91% of those people identified for shielding have had their KIS updated through GP practices.

The ability to share this information across the Health and Care system has been beneficial and is something that would benefit from being developed further.

It is anticipated there may be a small number of occasions when the Local Authority is unable to contact a shielded person by telephone however systems and processes have been developed in collaboration to deal with these cases accordingly should this occur.

2.3 Wider Community Services

Community Optometry

Work is progressing across Primary Care and Secondary Care Eyecare Integration Group to shift more care from acute ophthalmology into community optometry. This group have advised that they are currently developing their recovery plans with regard to reinstating limited elective procedures and they have advised revised referral protocols for community optometrists were being developed for consultation and are to be in place for Phase 2 of the recovery plan.

Following on from the establishment of our Emergency Eye care Treatment Centres (EETC) within University Hospital, Ayr which is staffed with a compliment of hospital staff and Independent Prescribing Optometrists we are now exploring the possibility of expanding this provision to three local EETC's in the community to accommodate the management of both emergency and essential eye condition referrals.

In order to comply with Scottish Government Guidelines around the phased re-opening of community optometry practices and re-instatement of the provision of face to face General Ophthalmic Services. Access to the Emergency Care Summaries has already been provided to all Independent Prescribing Optometrists and this will continue to be rolled out to all optometrists on an ongoing basis. Near Me has been offered to all Optometry practices in Ayrshire and Arran, with many having already confirmed uptake. As Optometry practices move into Phase 1 of their recovery plan use of Near me will be included within those recovery plans for all practices. This will allow for remote face to face consultations to take place. As outlined above the availability of Emergency Care Summary to the wider Health and Care system has been invaluable in these supports.

Primary Care Contracting and Support Team will work closely with Public Health around the resumption of the Diabetic Retinopathy Screening Programme which is provided by accredited Community Optometry practices ensuring that this service can be provided in a way that is safe for patients, Community Optometrists and their staff.

Progress is being made with for all optometry practices to use secure clinical mailboxes. Digital colleagues continue to supporting this work.

There is some concern about the financial viability of Community Optometry Practices due to social distancing and previous reliance on retail sales for income. We have been in contact with Scottish Enterprise to seek business advice.

General Dental Services and the Public Dental Service

Across Ayrshire and Arran plans are well established to increase the number of available appointments at the Urgent Care Centres (UCC) The Public Dental Service currently has 2 operational UCCs on the mainland and a further centre on Arran. Due to increasing demand a third mainland UCC will open week beginning 25th May, with the opening of this centre there will be an UCC in each local authority area. The current centres are operating well within capacity and there is a contingency plan in place to meet both demand spikes and longer term increases in service demand.

Secondary Care are starting to offer some General Anaesthetic clinics for dental patients and the Public Dental Service is prioritising the cases to be seen.

The Dental Management Team have already had discussions with colleagues from other Health Boards, the Area Dental Professional Committee and NES on how practices could potentially re-open to provide non AGP treatments to their patients. We are awaiting the guidance from the Chief Dental Officer for Scotland and SDCEP, to allow us to devise and implement an action plan.

All General Dental practices (GDP) remain closed but are continuing to triage patients, issuing prescriptions and dealing with emergencies in collaboration with the Public Dental Service. (PDS) whilst supporting the PDS within the dental hubs.
The PDS service is currently scoping the potential use of Near Me and how this can be used across the service. MS teams are also being used across the service.

There is some concern about the financial viability of General Dental Practices due to social distancing and previous reliance on non NHS work for income. We have been in contact with Scottish Enterprise to seek business advice.

Pharmacy

Prior to COVID-19 as part of the Pharmacotherapy Service element of the new GP contract, a project plan was developed to introduce Serial Prescribing (SRx) in all 53 GP practices and to maximise patient numbers receiving a SRx by March 2021. Although this has stalled over the past few months we have recently restarted the plan, utilising remote technology to support GP practice and community pharmacy involvement. 34 of the 53 GP practices have issued SRx with some making significant increases on patient numbers over the last few weeks. Increasing the patient numbers will have a positive effect on workload within GP practices by decreasing contact and footfall relating to repeat prescriptions. At the community pharmacy end, increased numbers allows planning of workload and footfall. Given the huge increase in prescription numbers in the initial weeks of the outbreak, higher patient numbers at that time would have meant a much smaller negative impact on both services. It is important to stress that the success of SRx requires full involvement of both GP practices and pharmacy teams.

We hope to take maximum advantage of the introduction of Pharmacy First and its expanded availability to all patients in Scotland. The Patient Group Direction (PGD) for Trimethoprim for UTIs and Fusidic Acid for impetigo have been established for a number of years and are frequently used. We also have two local PGDs for Flucloxacillin for skin infections and Aciclovir for shingles supported by the Primary Care Improvement Fund that are also well utilised. We are currently assessing other common clinical conditions which may be suitable for PGDs. The challenge for the service will be the current and future rules around social distancing and access to community pharmacies. This may have an impact on patient's ability to access the new service when launched. We are currently discussing the use of NHS Near Me and are watching national developments in community pharmacy in relation to remote support for Pharmacy First.

Community Pharmacy is a key partner in support of people who have alcohol or drug dependency and are often the main point of access in relation to substitute prescribing.

We are working with Specialist Addiction Services, local community pharmacy contractors and the Specialist Pharmacists in Substance Misuse group to plan for a safe and responsible recovery programme from the practice changes imposed by the COVID-19 pandemic in the care of people with substance dependence. This planning addresses the safe provision of treatment during the reintroduction of supervision and instalment dispensing in line with pharmacy and service capacity over the following months while maximising interventions to promote safety, wellbeing and prevention of harm to those in need during the transitional period. In the current COVID-19 environment we have negotiated for provision for safe injecting equipment through community pharmacy. **This additional service has been funded on a temporary basis and we anticipate will look to be continued at recurring additional cost**

There have been a number of positive developments related to COVID-19. Community pharmacists now have access to Emergency Care Summary (ECS) and that access has allowed them to support patients with medication issues. We have created a record of pharmacy staff working in NHS Ayrshire & Arran who would be able to provide cover within community pharmacies should they be affect by COVID-19. We have established a daily update to keep community pharmacies informed of the current situation and a dedicated email address for all COVID-19 related queries. We have also been able to establish a weekly MS Teams meeting with Community Pharmacy Ayrshire & Arran to allow discussion of the main issues, including those covered, above. We will continue to work closely with them as the outbreak progresses.

Community Pharmacy Advisors continue to support those pharmacies experiencing demands of the service. Pharmacies continue to practice safe service provision such as social distancing by remaining outside of the pharmacy and scripts being provided to them. The Health board, Local authorities, GP practices and pharmacies continue to work together to ensure prescriptions are being collected and dispensed with as little disruption as possible

3. Acute Services

3.1 Management Approach

The Phase 2 mobilisation response will aim to continue the momentum which was established in the Phase 1 response, based on ownership, expertise and delegated authority. At all times infection prevention and control advice will inform and shape our decision making, recognising that at this time the UK continues to be in 'sustained transmission' status and the associated risk mitigation required across a wide range of settings and services.

It is however recognised that the Phase 2 mobilisation will require a greater degree of whole system co-ordination. This will include phasing and prioritisation of resources including staffing, facilities, testing and PPE. In order to do that a management and governance structure has been established (Appendix 1).

The Acute Mobilisation Phase 2 Steering Group will meet weekly, chaired by the Director of Acute Services. The Acute Group will be directed by the Scottish Government, NHS Ayrshire & Arran Emergency Management Team (EMT) and the NHS Ayrshire & Arran Whole System Mobilisation Planning Group (WSMPG) and will interpret and define the appropriate level of mobilisation, for example in line with the phased relaxation of lockdown. The Acute Group will also be responsible for ensuring that the acute mobilisation response takes a whole system view, and that any issues relevant for other parts of the health and care system, such as community services or the Health and Social Care Partnerships are raised accordingly through the WSMPG.

The Acute Group will set the parameters within which the operational groups will work at each stage. Operational groups will then be empowered to plan the prioritisation and allocation of resources. These operational plans will be communicated back to the Acute Group, along with feedback on progress and relevant issues.

The ongoing mobilisation phase 2 progress within acute services will be reported to the WSMPG and EMT as required.

The Phase 2 Mobilisation Plan for Acute Services will take a dual approach, ensuring ongoing planning and provision for the management of COVID-19 related illness at the same time as maintaining the delivery of non-COVID-19 emergency, urgent and maternity care and the safe and incremental restoration of elective services.

The reform work undertaken across Acute Services has developed alternative ways of working to support clinical prioritisation of patients during phase 1. For Phase 2, Acute Services will continue with the innovation and transformation of services, this includes working with Health and Social Care partners to support urgent care as evidenced with the community hubs, increased use of telephone and near me consultations, agile workforce to enable clinical services to upscale where required and flexible infrastructure to respond to this phase of mobilisation.

For unscheduled care there will be focused work in the forthcoming weeks to develop as many “planned” unscheduled care pathways. This interface group has been commissioned jointly by East Ayrshire Health and Social Care Director and the Director of Acute Services. This is referenced in the Primary Care chapter. This commission sets out the ambition to capture the success of the community hubs alongside the revised front door pathways to develop an unscheduled care approach that provides high quality and safe services. For example, the hot clinics for unscheduled care patients to be appointed to through an enhanced triage process.

In Ayrshire and Arran we recognise that we can best serve our citizens by offering a cohesive health and care system that is integrated from the perspective of the person accessing services. We take a whole system approach to strategic planning, service design and, whenever appropriate, service delivery.

As we build towards recovery, on a dual pathway managing COVID and non COVID services, it is recognised that there are interfaces in our system where the resumption of services will present both opportunities and risks specifically;

In response we have commissioned a Strategic Interface Group to coordinate Clinical and Strategic leadership across the system. It is not intended that this group assume responsibility for existing work streams but provide coordination and commission work where gaps are identified.

Specifically:

- Managing Unscheduled Care in the Recovery Phase and beyond to include impact of dual pathways, winter and physical distancing requirements
- Exploring opportunities in respect of whole system Urgent Care including Community Hub and aligning as much urgent care to planned care where possible within acute, primary and community care and extend out to encompass services in acute and community.

- Coordination of service resumption in secondary care and de-escalation in Primary Care. This includes the mobilisation of Surgery and the mobilisation of Out-Patient Services where there are strategic interface issues to be progressed.
- Capitalise on the learning and new processes developed during the pandemic to further develop end to end patient pathways and better communication that encompasses the principle of doing the work of the day on the day.

NHS Ayrshire and Arran supports 2 acute hospital sites, both of which will continue to provide Emergency Departments and to receive unscheduled care admissions to hospital. As such, it is not planned to establish completely separate ‘red’ (COVID-19) and ‘green’ (non-COVID-19) hospitals, however some changes in practice will be introduced to move towards the use of University Hospital Ayr (UHA) as a predominantly ‘green’ site, with University Hospital Crosshouse (UHC) as the acute hospital where a greater proportion of COVID-19 patients will be cared for.

This approach will be delivered by :

- Centralisation of ‘red’ ICU on the UHC site
- Continued use of the Community Assessment Hubs to direct suspected COVID-19 patients who require hospital assessment to UHC

3.2 Intensive Care

NHS Ayrshire & Arran as part of its Acute Directorate Improvement and Reform Plan (2020-2022) recognised the need to invest in Critical Care provision. Our Mobilisation Plan in response to COVID-19 increased our Intensive Care Unit (ICU) capacity across both sites treating both COVID-19 and non-COVID-19 cases on each site.

In line with guidance and our most up to date bed modelling NHS Ayrshire & Arran will move to create a split facility in terms of our ICU provision whilst retaining our ability to flex should we require to open further surge beds. University Hospital Crosshouse (UHC) will become the COVID-19 site providing 12 beds in ICU.

University Hospital Ayr (UHA) will provide 4 non-COVID-19 beds with a further 4 provided at UHC.

However it is planned to further harness the remarkable planning, adaptability and resilience of our critical care staff in setting the parameters for mobilisation to the period when services will co-exist with COVID-19. We must remain sighted on the wellbeing of our staff in that they have delivered amazing care over prolonged periods under difficult conditions. Their recovery is of paramount importance and, as clinicians, they will support other strands of recovery including the restarting of surgery.

Regional planning assumptions have been drawn from modelling that estimates the requirement for ITU to run at 150%-200% baseline capacity in the region. Collating this with the regional Critical Care Network view and advice from local teams, this figure has been agreed locally. 20 beds represents a doubling of normal ICU capacity. However, in phase 1 mobilisation, we were asked to plan for quadruple capacity which required cancellation of the majority of elective activity. If this was required in phase 2, a similar level of cancellation would be implemented.

Consideration needs to be taken of the relatively small baseline footprint, in that a small rise in numbers from case clusters could rapidly increase the proportional bed occupancy compared with larger units. Local clinical advice was to provide this increased capacity from the UHC site in a model whereby there was a COVID-19 predominant site and a COVID-19 lighter sight. This would facilitate logistics such as rota planning for ITU capacity on one site and a greater focus on surgical restart on the UHA site. Equity of access is crucial for all the citizens of Ayrshire to all services in this model. Flexibility of approach is required in this planning for ITU additional capacity in that consideration should be given to other key services, particularly surgery, in view of co-adjacencies.

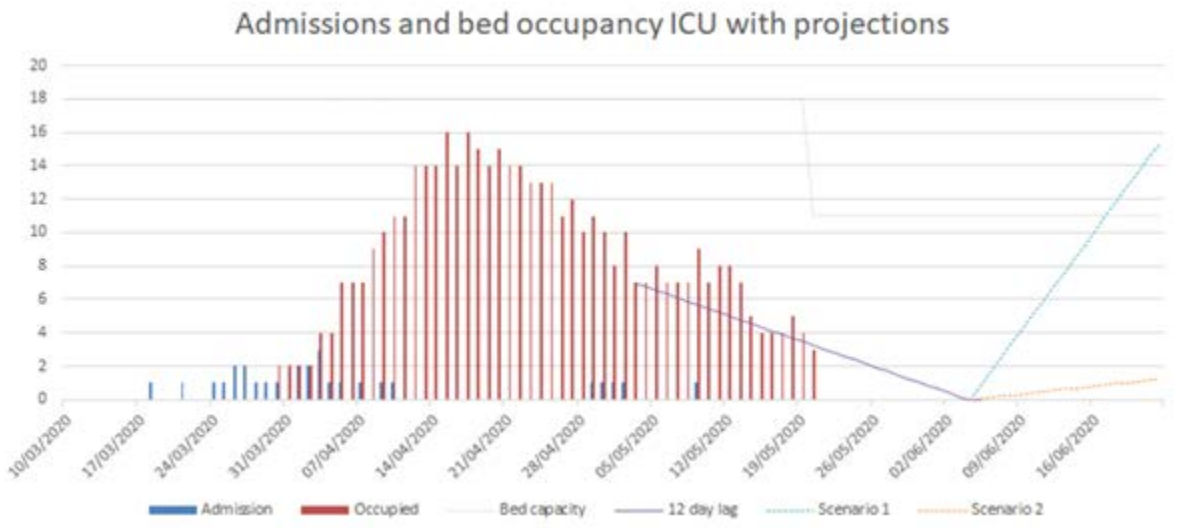
The principles of safe patient, safe staff and safe services apply to this planning. Unused additional ITU areas need to be balanced with the need to restart the services that depend on the same areas. The ability to scale up ITU capacity quickly also needs to be factored in. Surgical patient pathways, co-adjacencies and the requirement to separate surgical flows from COVID-19 activity are also critical.

In order to deliver this increased capacity there will require to be investment in the Capital Plan which supports this ethos of predominantly COVID-19 beds on one site.

This is greater than the requirement outlined in the SG letter dated 20th May but is a reflection of local modelling and clinical judgement.

Figure ** NHSAA Public Health ICU Forecasting (20/05/20)

Scenario	Description	Breach 11 beds	Breach 18 beds
1	Complete relaxation	24 days	33 days
2	Controlled relaxation	173 days	•



3.3 General Hospital Beds

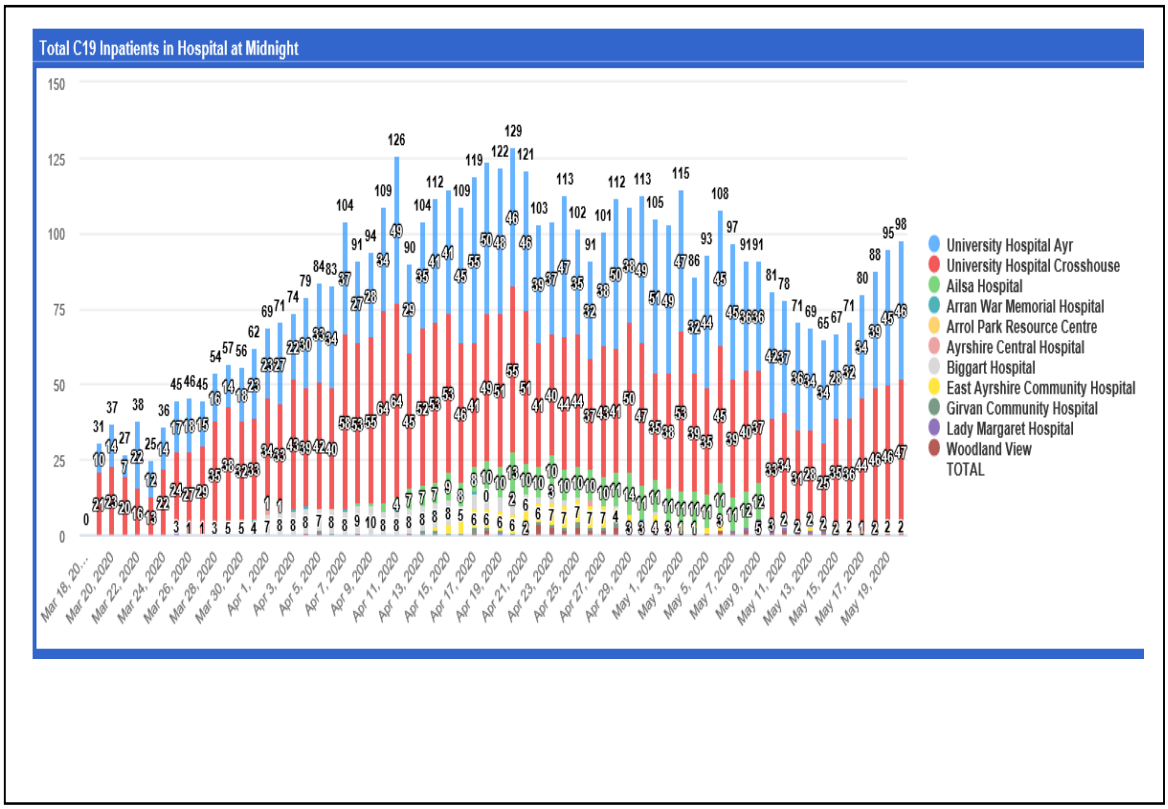
The Phase 1 Mobilisation Plan set out the maximum acute bed COVID-19 surge capacity which could be made available. This set out the capability to make available a total of 200 additional acute hospital beds to deal with emerging COVID-19 pressures. These 200 beds were made up of :

- 132 additional beds created by staffing up new areas
- 68 beds made available by cancelling non-urgent surgery

In this mobilisation plan we have set a maximum of 189 acute COVID-19 beds which could be delivered in the event of a COVID-19 peak.

Phase 1 of the COVID-19 pandemic however did not require the full extent of this identified capacity. Social distancing measures introduced by the Scottish Government successfully reduced the transmission of the COVID-19 virus, and so the admission of patients for hospital care was less than anticipated.

Within NHS Ayrshire & Arran at the peak of hospital admissions for COVID-19, there were 129 confirmed and suspected patients in Ayrshire hospitals, of which 101 were within the two acute hospitals, UHA and UHC.



** Note that the increase in numbers between 17 and 20 May is caused by a technical issue with the COVID-19 testing platform which resulted in a delay in confirming test results and so an increased number of suspected cases.*

Moving into Phase 2 of the pandemic, we will require to maintain a green pathway for non COVID-19 activity and a separate red pathway for COVID-19 suspected and confirmed. It is anticipated that the requirement for COVID-19 hospital beds will fluctuate as transmission of the virus varies at different stages in the relaxation of population lockdown. Modelling of the predicted demand over the next 3 months, and beyond remains work in progress, both nationally and at a local level.

Bed modelling for Phase 2 of the COVID-19 pandemic takes into account the Scottish Government guidance, and includes a 50% flex up based on current COVID-19 demand and the requirement to also make bed allowance for suspected COVID-19 patients until a test result is returned.

With the inclusion of suspected cases as part of the COVID-19 bed requirements, we will maintain 79 COVID-19 red beds. In order to maintain the red and green pathway separation we will require to utilise 33 beds that will require additional funding.

In terms of immediate surge, we will have available capacity to open an additional 48 COVID-19 red beds which will require to be funded if used.

To provide the bed capacity of 189 within 7 days, we have identified a further 62 beds that could be opened but will require funding.

Should all of the additional beds be required for surge capacity this will impact on this mobilisation plan.

We believe the above is adequate capacity taking into consideration the following:

- Increased COVID-19 admission following the relaxation of population lockdown;
- Increased length of stay should there be any delays in analysing test results; and
- Increased length of stay should there be any delays associated with delayed transfer to care homes.

Furthermore, a risk assessment on distancing within clinical and non-clinical areas is underway. It is anticipated that this will require inpatient beds to be more distanced in the acute hospital wards, and will lead to a reduced bed availability. This has not been factored in to current bed numbers as the risk assessment is not complete.

If a strategy for socially distanced beds requires to be implemented further additional investment would be required to staff additional wards. Initially, we have considered ward areas on the Ailsa campus as potential step down for patients from the University Hospital Ayr. The additional bed capacity with the application of social distancing would be 36 step down beds.

3.4 Re-starting Planned Care Activities

It is now recognised that the COVID-19 virus is likely to remain present within the community over the next 12 to 18 months, or until a vaccine is produced and rolled out across the population. While it was possible to suspend the majority of non-emergency activities, this is not advisable over the longer term and there is wide recognition of the longer term impact on health.

Access Collaborative Principles and Learning from Phase 1

The Phase 1 mobilisation response moved at pace, with some significant changes to how planned care services are delivered. In many cases this accelerated the development and/or extension of the initiatives endorsed through the Scottish Access Collaborative Groups.

In early May, Clinical Teams were surveyed through the clinical leads for all acute services. This demonstrated an overwhelming commitment to new ways of working and a clinical intention to continue and further develop these changes. In particular, there has been a significant shift to the use of enhanced vetting, telephone appointments, NHS near me and patient initiated review. Clinical Teams are recognising that these new ways of working now need to be incorporated into the 'new norm' and that approaches such as team based rostering will need to form part of the upcoming planning processes.

Prioritisation Principles

Through Phase 1 of the pandemic, emergency and some of the cancer surgery and most urgent non-cancer surgery continued in small volumes. Most non-urgent surgery was suspended in order to release space and workforce capacity to support the COVID-19 response, for example around increasing the ICU capacity. In addition, some specific urgent and cancer surgeries and diagnostic procedures were also suspended due to the increased risk to the patient and/or staff.

The Phase 2 Mobilisation and resumption of these activities will be managed on a phased and incremental basis, and will follow clinical prioritisation. Planned Care activities will be categorised, based on guidance from the Royal College of Surgeons which has been adapted for local use.

	Surgery	**Outpatients / Diagnostics**
Priority 1a	**Emergency in 24hrs**	**Urgent Cancer Suspected (UCS) in 2 weeks**
Priority 1b	**Emergency in 72hrs**	
Priority 2	**Urgent in 4 weeks**	**Urgent in 4-6 weeks**
Priority 3	**Semi Urgent in 12 weeks**	
Priority 4	**Routine**	**Routine**

The Phase 1 response supported continuation of Priority 1a/1b cases, and some Priority 2 cases.

The Phase 2 response from June to August will start by prioritising Priority 2 cases, and will progress to include Priority 3 and then Priority 4 cases, in line with the incremental relaxation of lockdown, and influenced by capacity.

3.4.1 Outpatients

In line with clinical priorities and throughout the pandemic telephone consultations have been undertaken across the majority of acute out-patient services for Urgent Cancer Suspected (UCS)/Urgent and some routine patients.

Selected services including Paediatrics, Midwifery, Orthodontics, Oral Maxillofacial Services (OMFS) and Musculoskeletal Services (MSK) have been using NHS Attend Near Me for a proportion of their workload.

Whilst some services have been deferred until investigative services are operating enhanced vetting and telephone triage has been utilised along with recommended guidelines and clinical risk assessments.

For example, Cardiology and Respiratory services have been using enhanced vetting to good effect for a considerable time. Work is progressing in Trauma and Orthopaedics supported by our Extended Scope Physiotherapists (ESP's) to utilise patient telephone consultation and Active Clinical Referral Triage (ACRT) to work through the longest waiting new patients.

For Phase 2 mobilisation individual services have had discussions about how they intend to work going forward, appreciating that the volume face to face consultations will be limited and thus require to be prioritised alongside the implementation of new ways or working.

Discussions with individual specialties has included:

- Arrangements for New referrals and any changes to vetting arrangements enhanced vetting, use of advice etc
- New Telephone consultations - many specialties have been undertaking for UCS and Urgent and this will be extended to a proportion of routine news – schedules will be set as Generic at specialty level so the service agree week to week how they staff with consultant grade staff
- Review Telephone Consultations – are being set up at Named Consultant level unless the specialty agree to work on a generic basis e.g. Urology and Renal have already adopted this methodology
- Checking in on where services are with the case review of return patients who were cancelled down for period 23 March till 31 May
- Use of NHS Near me where applicable
- Use of eforms to record clinical consultations

Plans are currently being developed across all specialty teams to facilitate new ways of working including Straight to Test and Patient Initiated Review (PIR) pathways.

3.4.2 Diagnostics

Imaging Investigations

Similar to other outpatient services, all routine outpatient imaging investigations were suspended as part of Phase 1. Investigations associated with UCS and Urgent patient care, as well as emergency and inpatient scans have continued.

Imaging capacity is impacted by the need to increase scan time to allow disinfection of scanners and equipment between patients, doffing and donning of PPE and has also been impacted by staff availability due to shielding and absence.

The Phase 2 mobilisation for Imaging (Appendix 2) includes increasing capacity in each imaging modality, focussed on continued support for inpatient and urgent work. It is also anticipated that towards the end of July, and assuming a steady relaxation of lockdown rules, some re-introduction of non-urgent scanning will re-start.
Specific actions to support Phase 2 will include :
1. Opening additional scanning rooms at either UHA/UHC or in some cases in community hospitals, for general ultrasound and plain film x-ray;
2. Introduction of elective CT and MRI scanning at weekends where possible;
3. Re-contracting the previously used mobile MRI van if available.

There is the potential through the use of the radiology home working solution additional reporting capacity can be generated by radiologists and reporting radiographers working from home.

Endoscopy

At the start of the COVID-19 pandemic, the British Society of Gastroenterologists (BSG) published guidance which recommended that only emergency endoscopy procedures should be undertaken, due to the elevated risk to staff. As a result, during Phase 1 no UCS, Urgent or routine endoscopy investigations have been undertaken.

Restarting endoscopy procedures is a high priority in the Phase 2 mobilisation, particularly given the key role that endoscopy procedures play in the colorectal and upper GI cancer pathways.

Revised BSG Guidance has informed discussions about the re-starting of endoscopy procedures during Phase 2. There are some notable implications which will result in significantly lower endoscopy capacity and throughput compared to pre-COVID-19. This includes the need for increased distancing between patients, down time between patients for infection control purposes, PPE (particularly for upper GI endoscopy procedures) deployment of some endoscopy staff to support COVID-19 related activities and the reduced availability of endoscopy facilities on the UHC site due to the expansion of ICU.

The Endoscopy Phase 2 re-start incorporates a number of aspects :

1. The prioritisation of Urgent Cancer Suspected patients (UCS) as first priority, and patients referred by the bowel screening service as the second priority;
2. An Ayrshire-wide approach to prioritisation of patients based solely on clinical need;
3. The introduction of qFiT testing for patients awaiting colonoscopy, with support from NHS Lanarkshire for the laboratory testing element of this. This will support prioritisation of patients, and may identify some patients for whom a colonoscopy is not in fact required;
4. The introduction of COVID-19 testing and a period of patient self-isolation as part of a pre-endoscopy assessment;
5. A planned incremental resumption of endoscopy at UHA from 15 June 2020. Initial numbers of patients will be low based on the above constraints, and re-introduction of one elective endoscopy room providing capacity for 20 patients per week;
6. A planned incremental resumption of endoscopy at UHC. Facility restrictions at UHC have meant that no firm date can yet be confirmed, but the intention would be by early July 2020. It is also likely that UHC will only reach around 35-40% of its previous throughput due to mostly likely only 2 of 4 endoscopy rooms being available and reduced patient throughput;
7. An approach has been made to Golden Jubilee National Hospital to provide 30 UCS / bowel cancer screening colonoscopy and upper GI procedures

We are aware of some national discussions taking place following the recent trialling of Colon Capsule Endoscopy in NHS Highland and NHS Grampian. Colon Capsule Endoscopy has been discussed amongst clinical colleagues however there is currently no clinical agreement to implement this within NHSAA, with implementation of qFiT testing being unanimously agreed as the priority for implementation in Phase 2. However, during Phase 2 discussions on Colon Capsule Endoscopy will be progressed with a view to preparation of a Business Case.

3.4.3 Surgery

In phase 1 of the COVID-19 pandemic, operating theatre provision was significantly reduced. This was the result of re-deployment of anaesthetic and theatre nursing staff to support the expanded ICU facility which was required. In addition the operating theatre recovery areas were used to create physical space for expanded ICU, and elective inpatient beds were freed up to support additional COVID-19 admissions.

Phase 1 operating theatre capacity was limited to the provision of emergency, cancer and other very urgent surgery.

Moving into Phase 2, there continues to be significant limitation on operating theatre capacity :

- Consultant anaesthetists continue to work 12 hour shifts to support ICU, resulting in limited availability to support operating theatre lists;
- Theatre nursing staff continue to be deployed to support other aspects of the COVID-19 response;
- At UHC the requirement to maintain a red ICU will result in continued use of the Day Surgery recovery area, and endoscopy recovery area; and
- Risk assessment of ward beds, and the expectation that there will require to be a reduced number of beds in each ward in order to maintain social distancing is expected to significantly limit the number of beds available to support elective operating activity.

This needs to be considered in the context of the current rate limiting factor with regard to PPE – in particular the availability of sterile surgical gowns; at the current time these are modelled to run out at current usage levels in mid-June. A&A has undertaken a clinician led risk assessment process, identified a number of mitigation actions and asked for opinion from our local Ethical Advice Group with regard to the prioritisation process for use of sterile gowns as essential services resume in case of a scenario where national supply cannot meet demand across the country.

A second rate limiting factor is the deployment of theatre and DSU nurses and anaesthetists to support increased ITU capacity. This will need to be carefully modelled to maintain the skills and competencies required for an agile and flexible ITU expansion plan, alongside the phased recovery of surgical activity. From a nursing perspective the employment of all current Y3 student nurses will support our ability to mitigate this factor.

On this basis, planned use of operating theatres in Phase 2 is expected to be as follows :

Number of Operating Theatres

Hospital	Normal (pre-COVID)	COVID-19 Phase 1	COVID-19 Phase 2
UHA	1 Emergency/trauma theatre 5 Elective main theatres 2 DSU theatres	1 Emergency/trauma theatre 1 Elective main theatre 1 DSU theatre (3 days/wk)	1 Emergency/trauma theatre 2 Elective main Theatres 1 DSU theatre
UHC	2 Emergency/trauma theatres 6 Elective main theatres 3 DSU theatres	2 Emergency/trauma theatres 1 Elective main theatre	2 Emergency/trauma theatres 2 Elective main theatres

This provides a small increase in operating theatre capacity. Given the continued limitation, this capacity will continue to be prioritised based on clinical need, as described in section 3.4.

In general terms this will allow Phase 2 to support the re-starting of surgical cases which fall into the Royal College of Surgeons Categories 2 and 3 :

	Surgery
Priority 1a	Emergency in 24hrs
Priority 1b	Emergency in 72hrs
Priority 2	Urgent in 4 weeks
Priority 3	Semi Urgent in 12 weeks
Priority 4	Routine

It has been recognised that there are some areas where specialties may be able to re-start certain types of surgery which fall into Priority 4: routine. These would be cases where there is minimal impact on other services or staffing, which have no requirement for inpatient beds and where it is possible to use an operating theatre resource that is not in demand for other specialties with greater clinical urgency. Once these service proposals have been properly risk assessed, there is an intent to re-phase some of this activity in from late July.

Surgical Specialty	Phase 2 Elective Operating Plan
Breast Surgery	Continue some Breast Surgery at Nuffield Hospital as per Phase 1 Restart some breast Surgery within NHS Ayrshire & Arran
Cardiology	Re-start time sensitive procedures such as pacemaker battery replacements
Community Dental	Re-start small number of urgent cases which are at risk of becoming emergency presentations to hospital maxillofacial service
ENT	Continue Cancer surgery as per Phase1 Re-start time-sensitive cochlear implants in the youngest children where delay will have significant outcome on speech development
General Surgery	Re-start colorectal and upper GI Cancer Surgery
Gynaecology	Continue Cancer surgery as per Phase 1 Re-start small number of urgent non-cancer cases
Maxillofacial Surgery	Re-start small number of urgent cases
Ophthalmology	Continue urgent sight threatening procedures as per Phase 1 Re-start routine cataract surgery July as minimal impact on other services
Orthopaedics	Continue small number of very urgent cases as per Phase 1 Intent to re-start small number of routine elective procedures once risk assessed towards end July in line with clinical priorities. This will be delivered at UHA on an Ayrshire-wide basis. At this time our activity trajectory for orthopaedics remains as per the template. However this is a dynamic situation and detailed planning is underway to establish capacity for elective orthopaedics at UHA which will require resource contribution from UHC (without impacting on trauma activity). It is anticipated that this could bring forward the date for starting orthopaedic elective work and increase activity. This will be monitored weekly by the acute mobilisation steering group in line with our clinical priorities.
Plastic Surgery	Continue cancer surgery as per Phase 1
Urology	Continue Cancer and urgent surgery as per Phase 1 Re-start small number if urgent day cases in July
Vascular Surgery	Continue urgent surgery as per Phase 1

A detailed breakdown of planned activity is shown in Appendix 3.
It should be noted that this is based on current expectations, but that plans continue to evolve as individual service risk assessments are completed, and as plans for bed capacity, COVID-19 testing capacity and other relevant factors evolve.

	June (4 weeks)				July (5 weeks)			
	Urgent		Routine		Urgent		Routine	
	Inpatient	Daycase	Inpatient	Daycase	Inpatient	Daycase	Inpatient	Daycase
UHA								
Cardiology	0	48	0	0	0	60	0	0
General Surgery	8	0	0	0	25	0	0	0
Ophthalmology	16	0	0	0	20	0	0	100
Plastic Surgery	0	12	0	0	0	15	0	0
Trauma and Orthopaedics	4	0	0	0	10	0	4	0
Urology	32	0	0	0	40	25	0	0
Vascular Surgery	8	0	0	0	10	0	0	0
UHC								
Community Dental	0	12	0	0	0	15	0	0
Ear, Nose & Throat	8	0	0	0	10	0	0	0
General Surgery	16	0	0	0	20	0	0	0
Gynaecology	8	0	0	0	10	0	0	0
Maxillo Facial	4	0	0	0	5	0	0	0
Trauma and Orthopaedics	0	0	0	0	0	0	0	0

Enhanced Recovery After Surgery (ERAS) is in place for Colorectal, Orthopaedics and Obstetrics Services across NHS Ayrshire & Arran.

3.4.4 Cancer

Cancer services have remained a priority throughout the pandemic, and as far as possible, cancer services have continued. Notable exceptions have been endoscopy and colonoscopy procedures, and colorectal and upper GI surgery where the risk was deemed too high.

Introduction of innovative approaches to patient management including consultant-led enhanced vetting, telephone appointments and virtual review have been instrumental in mitigating the risks and impact during Phase 1, and will continue to be used in Phase 2.

Urgent Cancer Suspected (UCS) referrals reduced significantly in Phase 1 of the pandemic, to around 50% of the normal volume. It is therefore anticipated that a significant volume of delayed demand will become apparent as we progress through Phase 2. We have started to see an increase in UCS referrals to 75% of normal volumes as at end May 2020, probably the result of the recent Scottish Government “The NHS is Open” public campaign.

A backlog in cancer assessment, diagnosis and treatment has developed, particularly in endoscopy investigations, colorectal and upper GI surgery. Redressing these backlogs is a main priority in Phase 2.

Key priorities for cancer services in Phase 2 will be:

- Re-starting UCS and bowel screening colonoscopy and upper GI Endoscopy (see Section 3.4.2) to address the backlog of 239 UCS endoscopy/colonoscopy procedures and 228 bowel screening colonoscopy procedures which were too risky to undertake in Phase 1;
- Re-starting colorectal and upper GI cancer surgery to treat the 31 patients whose surgery was too risky in Phase 1 (see Section 3.4.3);
- Re-starting breast cancer surgery in NHS Ayrshire & Arran for the 45 patients whose surgery could be safely delayed in Phase 1 through other interim treatment. It is anticipated that some breast surgery will continue to be undertaken by our surgeons at Nuffield Hospital in Phase 2, but that additional provision will have to be made in NHS Ayrshire & Arran for some patients.

3.4.5 Trauma and Orthopaedics

In keeping with the Implementation of the National Major Trauma Network and the local delivery of Trauma and Orthopaedic services, NHS Ayrshire & Arran had set out its ambition to deliver all trauma services from UHC with all inpatient elective activity delivered at UHA with an implementation date of August 2020. In order to achieve this, there is agreement that Vascular Services will be transferred to NHS Lanarkshire. As a result of NHS Boards Phase 1 Mobilisation Plans, this date has been delayed and this transfer of services is not expected to take place until early 2021.

However a planned incremental approach will enable the movement of some inpatient elective cases to be provided in UHA. In line with Scotland's Route Map through and out of the crisis (2020) it is planned to commence routine elective Orthopaedic Surgery at UHA week commencing 20 July with 2 elective cases planned per week in the first instance. Although this represents a very limited volume of elective orthopaedic activity this needs to be considered within the context of the limited overall operating theatre capacity. As described earlier, the operating theatre capacity at UHA in Phase 2 will be half of the normal capacity, and this will be prioritised based on clinical need. The majority of elective orthopaedic surgery is routine is nature and so it is anticipated that there will be very little operating capacity available for orthopaedics once the UCS and urgent cases for other specialties have been accommodated. It is also valid to consider that elective orthopaedic surgery very often involves more elderly patients and so re-starting this type of surgery needs to be in an appropriate timescale.

Waiting List validation process

The majority of patients waiting on surgery were listed prior to the COVID-19 pandemic. It is recognised that some patients' intentions regarding their upcoming surgery may now have changed in light of the current situation. A waiting list validation will be undertaken during Phase 2. Patients who are listed for surgery will receive a letter asking them to advise of their intentions against 3 options :

- Still wish to proceed with surgery;
- Wish to delay surgery until after COVID-19 pandemic has passed; or
- No longer wish to have surgery and wish to be removed from the waiting list.

Further advice is expected from Scottish Government colleagues on how to administratively manage the patient who advise that they wish to delay surgery until after the COVID-19 pandemic has passed.

With regards to Outpatient Waiting List validation, individual clinicians have been provided with listings of review patients whose routine follow-up appointments were cancelled from 23 March to date. These clinicians are currently reviewing the clinical records of each case and advising of the next steps including discharge, patient initiated review, telephone consult, written advice/treatment plan or the scheduling of face-face consultation.

In some particular specialties, further validation of new outpatient waiting lists will also be undertaken. This includes in Orthopaedics, where introduction of the Active Clinical Referral Triage process will be adapted and introduced.

3.5 Emergency, Urgent and Maternity Care

3.5.1 Emergency Services

Enhanced Out Of Hour (OOH) Consultant Cover has been provided to augment service provision across ED and CAU including increased 7 day working.

The Advanced Nurse Practitioner (ANP) teams together with the Acute Care of the Elderly (ACE) Practitioners have been working closely with colleagues across the HSCPs to prevent unnecessary admissions and ensure that all patients were referred directly to the most appropriate services to meet their care needs.

In addition, Orthopaedic/Surgical Assessment Units have been developed ensuring fast track referral to Orthopaedic/Surgical Services.

Working collaboratively with our HSCPs facilitated a reduction in the number of patients delayed within both acute hospitals. This reduction has ensured that safe system flow has been achieved allowing for the development of COVID-19/non COVID-19 pathways across both ED and CAU.

Community Clinical Assessment Hubs have ensured that the right patient is cared for in the right place at the right time.

Following on from the work established to support the COVID-19 mobilisation plans, we are progressing with a model to establish 7 day senior leadership at both front doors to deliver safe patient flow. This will be established through:

1. Recruitment to both ED's as a combined Ayrshire service to ensure consistent staffing. 5 posts are in the process of being advertised;
2. Single service clinical leadership through the appointment of a single CD for Ayrshire and site based clinical leads. This will support consistency, strategic direction and single service governance; and
3. Maximisation of Direct Clinical Care (DCC) delivery through transparent e-job planning (Allocate system).

We will continue to work with our partners to further develop the Community Clinical Assessment Hub Model and continue to embed across all HSCPs the Discharge to Assess model.

As we progress into phase 2 mobilisation we will continue our approach to caring for our frail patients.

NHS Ayrshire & Arran are part of the HIS frailty collaborative, and have initiated the rockwood screening in both ED, and CAU, and have plans to test out a frailty unit. This could potentially link with the enhancement of the Community Clinical Assessment Hubs.

A clinically led multidisciplinary virtual Frailty/Rehab/EOL network has been established and is leading key pieces of work spanning primary and community care, acute care and supporting care homes.

3.5.2 Respiratory Pathways

The Respiratory Managed Clinical Network in Ayrshire & Arran leads exemplary work across the area, and has various programmes of work within the Network - Primary Prevention/Public Health; Self-management; Prescribing; Primary Care; Respiratory Rapid Response; Use of technology/digital; Unscheduled /SAS COPD Pathway; and work alongside voluntary organisations.

- As a result of savings in respiratory prescribing, it was possible to reinvest in the Pulmonary Rehabilitation (PR) service last year. There is now increased capacity within the PR service in East and South Ayrshire. It is hoped that further investment will be made soon to increase capacity further, this will include North Ayrshire.
- As well as core programmes, locality-based programmes are now available to make it easier for more people to access PR. Home PR is also available to people who cannot participate in a traditional group programme.
- Technical innovations have led to a range of options for improved self-management for people living with COPD. The Ayrshire & Arran COPD app was launched in March 2019 and information shared widely to encourage uptake.
- Using Near Me, 3 virtual clinics have been established (Ayr Respiratory Specialist Nurses (RSN), Crosshouse Respiratory Specialist Nurses, Respiratory Specialist Physiotherapist) and protocols developed.
- Whilst Home & Mobile Health Monitoring is currently only available in South Ayrshire (via Intermediate Care Team (ICT)), North and East ICTs making plans to have this in place.
- The Florence protocol for Newly Diagnosed COPD has been finalised and launched via GP Practices. COPD and Asthma templates are being developed to guide Practice staff carrying out patient reviews.

Medicine in Reserve - plans are underway to revise documentation and relaunch in General Practices. From survey monkey results we know provision of antibiotics and steroids to COPD patients is variable and patchy. Provision of medication, along with education, is known to help patients manage COPD exacerbations and prevent attendance/admission to hospital.

3.5.3 Falls

We are already connected into our colleagues from the Scottish Ambulance Service (SAS) with a specific focus on falls. Working with SAS through the Model of Care to explore alternatives to admission by referrals to ICT falls and other work. Previously, a case review identified cultural issues as main barrier, similar to the rest of Scotland.

- Non conveyance uptake low - Models of Care clinical pathways group linking with Dr Rowan Wallace will look at a pan-Ayrshire frailty pathway which will include falls.
- Evidence from models elsewhere – would support a more integrated approach with social care Single Point of Contact with a more responsive falls team to ensure confidence

3.5.4 Maternity Services

The majority of maternity services have continued throughout the pandemic, and new ways of working including telephone consultations and Near Me clinics have been implemented to enable this to take place

In addition online antenatal and breastfeeding support classes have been provided, homebirths have recently been reinstated, and as part of the national programme remote blood pressure monitoring is being funded and supported for use locally. These new ways of working will continue to be progressed.

This has been in the context of continuing to keep Best Start as the guiding principle for delivering our maternity services, in particular with the concept of continuity of carer supporting women and families at this time.

3.6 Regional Approach Mutual Aid

The Director of Acute Services will represent NHS Ayrshire & Arran in the Acute Care Network for the West of Scotland (WACN) (NHS Greater Glasgow & Clyde, Lanarkshire, Ayrshire & Arran, Forth Valley and Dumfries & Galloway).

The aim is to establish a regular call between the Boards to allow the coordination and planning of acute care services across the region during the COVID-19 pandemic when it is necessary. This will be linked to the West of Scotland Critical Care Network and will be supported by the Regional Planning Team.

The network call will be attended by the Acute Directors or their representative who will be responsible for providing the essential information in relation to their Board to allow an understanding of the position across the region to be gathered to support where possible patients get access to the most appropriate level of care.

The call will cover an agreed set of questions/data collection and will use the information currently required nationally to collate a regional picture for consideration thus avoiding duplication of effort. This includes the information from the daily update position including the assessment of status, by site, on ability to maintain services over next 24-72 hours across key questions to assess ability to:

- maintain business critical services;
- maintain emergency care pathway;
- support major incidence response; and
- have sufficient workforce

Through daily monitoring and the Health Board (HB) assessment of ability to maintain services over the next 24 and 72 hours the Regional Acute Care Network will have an oversight of emerging pressures across the system identifying any hotspots on a site, HB and Regional basis. This will be supported by an agreed data set pulled from the national monitoring returns and for NHS Ayrshire and Arran will be available on the Pentana portal. The need for mutual aid will initially be agreed through the Regional Acute Care Network.

3.6.1 Working with NHS Louisa Jordan

To support the response to the COVID-19 pandemic within the West of Scotland the Acute Care Network will provide a link between the Boards in relation to acute hospital care and NHS Louisa Jordan (NHSLJ).

In support of the mutual aid model NHS Ayrshire and Arran has identified staff from Nursing, AHP and Medical staff groups to support the NHS Scotland facility.

We will continue to support workforce identification to support the 120 and 300 bed model by identifying substantive staff who can provide mutual aid should this be required.

This will become increasingly more challenging as services resume and our workforce requirements locally increase.

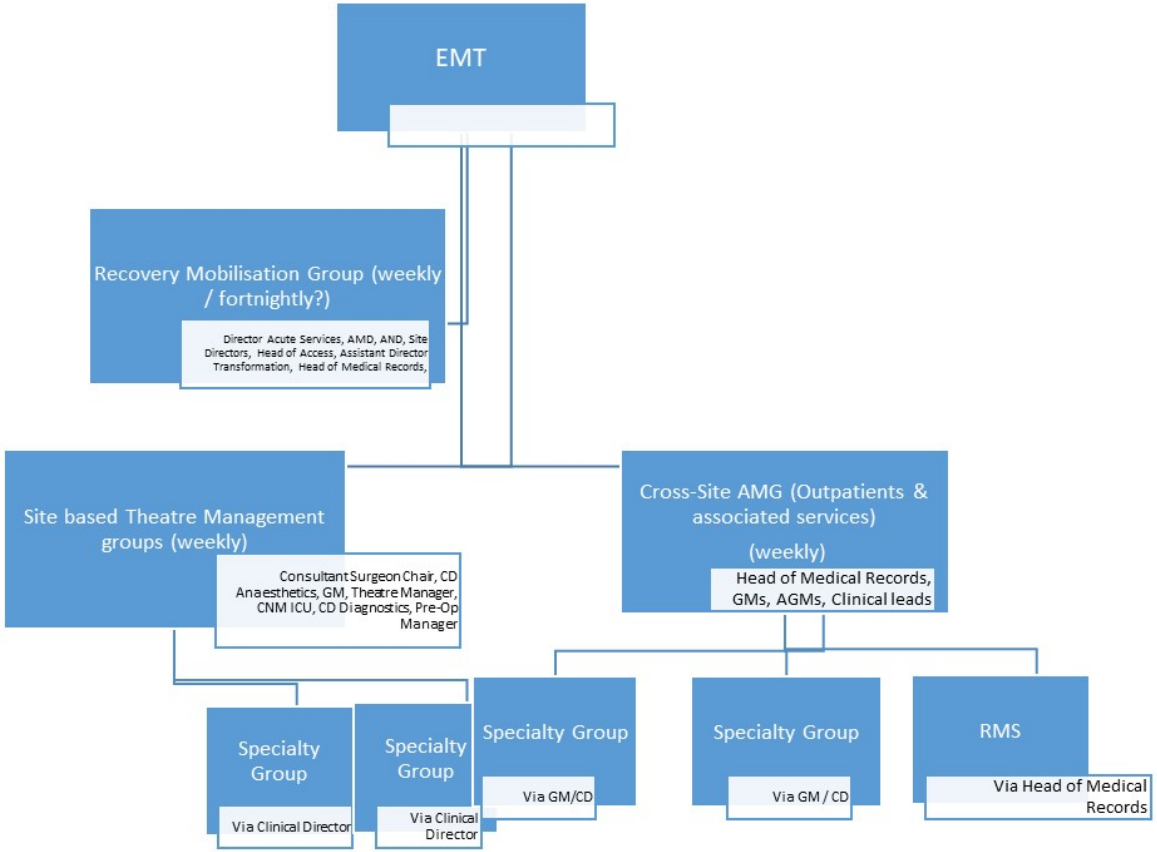
3.6.2 Golden Jubilee National Hospital

NHS Ayrshire & Arran undertook a site visit to GJNH in early May.
It is proposed that GJNH would provide capacity for some endoscopy procedures. This is a particular priority for us in Phase 2 as a result of the significant loss of endoscopy capacity, but the critical role that these procedures play in the colorectal and upper GI cancer pathways.

An initial request for 30 procedures in Phase 2 has been made to GJNH, but has not yet been confirmed.

Further general surgical capacity for 20 non-cancer day cases has been requested. This would be for procedures which are less urgent than the cancer cases which will be undertaken in NHS Ayrshire & Arran and for whom there is a significant impact on quality of life such as laparoscopic cholecystectomy. There will not be capacity for this type of surgery locally in NHS Ayrshire & Arran and the use of a protected ‘green’ facility for this type of patient for whom the risk balance is different would be beneficial.

Acute Services - Appendix 1



Acute Services Appendix 2 – Imaging Services Mobilisation

COVID-19 Phase 1	COVID-19 Phase 2	Continued Suspend / Pause	Enhanced vetting (by radiologist doing relevant MDT)
Capacity CT : 78/wk MR : 50/wk General US :251 /wk General x-ray : 600 /wk	Capacity CT : 112 / wk MR : 70 / wk General US :341 / wk General x-ray : 800 / wk		
1. All cancer staging. 2. Interim scans (on chemo therapy) 3. Scans for patients who are being assessed for response/relapse 4. CT Urograms- marked as urgent (if not sure please send for enhanced vetting) 5. Lung nodule follow up 6. MR spines 7. MR pancreas follow ups 8. MR spines (preference for myeloma, CES and cord compression history) 9. MR Brain (aneurysm and ?SOL) 10. MR MSK acute injuries with a plan for surgical intervention (if in doubt ask relevant clinician)	1. Annual follow up of known resected malignancies 2. MR brain in MS follow ups	CT 1. CT Colons 2. CT KUB 3. CT Brain in dementia 4. HRCT 5. CT Urogram MR 6. MR enteroclysis 7. Barium swallow 8. MR fistulas 9. MR IAM's and tinnitus 10. MR Sinusitis 11. MRCP 12. MR knees 13. MR hips 14. MS follow up 15. MR arthrograms 16. MR prostates Flouro/x-ray 17. Cystogram 18. HSG NM 19. All nuclear medicine scanning apart from V/Q in pregnancy US 20. US MSK(hernias, lumps and bumps) 21. US –Aorta	1. UCS 2. ? malignancy in wt loss 3. Non-cancer thyroid 4. MR Gynae 5. MR liver 6. MR neck 7. US Testis

11. Antenatal scans 12. U/S paediatric hips 13. US kidneys in microhaematuria 14. Cirrhosis- HCC screening		22. US -?gallstones 23. US pelvis apart from PMB 24. Follow scan	

4. Support to Care Homes

Care homes provide an environment where many people particularly older people with 24 hour care needs can live safely with access to social and nursing care to meet their needs.

As a response to COVID-19 Enhanced support and assurance arrangements are in place with oversight to:

- Chief Officer
- Executive Nurse Director
- Executive Medical Director
- Chief Social Work Officer
- Director of Public Health

A letter to each care home from the local Chief Officer explaining the process was issued 25/5 and Consolidated Ayrshire and Arran Guidance for Care Homes issued 29th May.

The arrangements include on an individual care home basis, daily telephone contact and a series of planned and prioritised visits to all care homes jointly by senior nursing and social work managers. On a daily basis at HSCP level there is an assurance meeting to consider the individual contacts with the homes and immediate actions taken to provide support / improvement when necessary. 4 times weekly assurance is then provided at an NHS Board level to the Strategic EMT.

In addition, at a HSCP level there are weekly care home manager meetings where open conversations are had about guidance, support and emerging issues.

Director of Public Health also on a consolidated basis holds a weekly meeting with relevant NHS leads, HSCP leads, Scottish Care and Care Inspectorate.

In Ayrshire & Arran we have good relationships with the sector and Scottish Care as the representative body. They are represented through our strategic planning integration arrangements and have participated actively in initiatives including, My Home Life leadership programme, CAPA (Care about Physical Activity) and Anticipatory Care Planning. In many areas Care Homes and early years / schools have partnership arrangements that are mutually beneficial.

The COVID-19 pandemic has been traumatic for the sector, continuing to provide care for all residents whilst providing enhanced support for those residents infected with COVID-19 and where required end of life care. At the same time when there is an outbreak often staff are infected and require to isolate at home between residents and their loved ones.

As part of the COVID-19 response all but essential visiting to care homes has stopped and this brings further pressure with anxieties of both residents and families. Care homes have been facilitating telephone and social media contact.

Social distancing within care homes, particularly for residents with dementia who often purposefully wander, can be confusing and isolating. The staff are working hard to find new ways to keep people safe and active.

In Care Homes where there have been multiple deaths, this has been traumatic for all involved. Through the care services, at a local and pan Ayrshire level, staff care has been offered to provide psychological support.

The COVID-19 Clinical Hub and Out of Hours service has a single point of contact number for all care homes to allow staff direct access to clinical advice and support without having to go through NHS 24 allowing more time to focus on caring for residents. Care Homes are accessing this regularly over the 24 hour period.

In support of the sector, regular contact is maintained both through the HSCPs and Public Health. For instance in East Ayrshire this includes a daily social media group and weekly group phone call with Care Home managers led by senior management and where the IJB Chief Officer and the Council Chief executive regularly participate.

The Health Protection Team within Public Health has maintained daily supportive telephone contact with those care homes who have COVID-19 symptomatic and positive patients. This includes all care homes with active outbreaks and a number of care homes being supported and monitored whilst test results from symptomatic residents and/or staff are awaited.

4.1 Care Home Professional Oversight Group

From 18 May 2020, there is a requirement to ensure appropriate clinical and care professionals take direct responsibility for the professional support required for each care home, it is recognised that care homes may require more clinical input to manage residents' needs at this time. NHS Ayrshire & Arran and the three Health and Social Care Partnership are working closely together to ensure those needs are met.

Following a variation letter from Scottish Government, the NHS Board Nurse Director is accountable for the provision of nursing leadership, support and guidance within the care home and care at home sector.

Specifically to:

- Identify where specific nursing support may be required and to develop and impellent solutions where required. This will include clinical input to ensure that there are effective community nursing arrangements in place to support increasingly complex nursing care requirements
- Identify where specific infection prevention and control support may be required; this will include recommendations and review with regard to cleaning to prevent transmission and appropriate use of PPE
- Support the development and implementation of testing approaches for care home and care at home settings
- Identify and support sourcing of staffing as required by the care home and are at home setting as defined by the requirements set out in DL (20200 10 and DL (2020) 13

In response to the letter of 17 May from the Cabinet Secretary, each of our Health and Social Care Partnerships (HSCPs) has established a Care Home Oversight Group (CH-OG), with delegated membership from the following:

- Nurse Director
- Medical Director
- HSPC Director
- Director of Public Health
- Chief Social Work Officer

these Care Home Oversight Groups will:

- meet daily to discuss safety huddle information from the care homes in their area and identify any support required;
- prioritise and co-ordinate nursing and social work professional support visits to every care home in their area and consider the outputs from these support visits;
- get assurance with regard to progress of the planned COVID-19 testing programme underway;
- co-ordinate and facilitate any staffing requirements that the care homes are not able to meet from their own workforce. This will need to be either proactive and planned, or rapid and responsive depending on the need identified;
- escalate any immediate issues of concern to the HSCP Director and/or Nurse Director depending on the issue;
- provide a 3 minute Sit Rep report to every EMT meeting detailing support activity undertaken and any resulting actions or escalations;
- specifically the Associate Nurse Directors will provide professional assurance to the Nurse Director with regard to the support enacted if required; and
- any care home which persistently refuses to allow a professional supportive visit to take place will be escalated to the Care Inspectorate as the sector regulator.

The COVID-19 Community Primary Care Group and an Enhanced Care Home Learning and Improvement Group (including membership from Care Inspectorate and Scottish Care) meet weekly and report into the Emergency Management Team. The weekly RAG report produced by the DPH for Scottish Government is discussed each week by the COVID-19 Community and Primary Care Group. East, North and South Ayrshire all have local care home groups and these are well connected to the Enhanced Care Home Learning and Improvement Group which is chaired by one of the Joint Interim DPHs.

NHS Ayrshire & Arran have appointed an Interim Associate Nurse Director for Care Home Support and Assurance who will report directly to the Nurse Director and provide additional senior professional whole Ayrshire leadership.

The Associate Nurse Director for Care Home Support and Assurance will:

- establish, develop and Chair an Expert Advice Group*
- undertake a review of the support resources already available to Care Homes in order to build and strengthen these as required
- lead an education / training needs analysis based on the information gathered form the support visits and safety huddle data.
- develop the professional reporting mechanism for the resulting activity to the Nurse Director
- work in close collaboration with HSCP-AND colleagues

*Expert Advice Group: Dementia Nurse Consultant, CHEF, ASP co-ordinator, QI Advisor for EOL Care, IPC Senior Nurse and access to TV and nutrition advice.

4.2 Infection Control

Thus far all care homes which are identified as requiring support have been followed up by the health protection team via the telephone to ensure that staff are aware of current infection control guidance and resources. The discussion includes understanding of PPE, ensuring or establishing if there may be any issues in the availability of PPE. The Health Protection Team (HPT) also take this opportunity to ensure the care home is aware of local arrangements to access PPE if they have been unable to source sufficient through their usual routes. This is arranged through the HSCPs.

As part of the new enhanced professional oversight arrangements described above each care home in Ayrshire and Arran will receive a joint support visit from a nurse and social worker to establish a baseline understanding of any support requirements, including any need for further support on appropriate use of PPE. We have a senior nurse from acute services specifically aligned to the Infection Control Team to provide support and guidance with regard to use of PPE. This senior nurse will also support care homes.

4.3 Testing

There are clear arrangements in place for testing of residents and staff in Care Homes in line with Scottish Government policy. There is robust governance and oversight in place via Bronze, Silver and Emergency Management Team (Gold) structures.

This is being led by one of the Joint Interim DPHs and a Testing Strategy has been agreed by EMT.

4.4 Staffing

There is an expectation that each care home will have a resilience plan in place for any staffing requirements.

In addition to this there are local arrangements in place in for each HSCP to provide oversight and support for any staffing issues through local recruitment portals. If the care homes have exhausted their usual way of accessing staff during a shortage, they have a single point of contact (SPC) in each of the HSCP who will support the home to access staff.

Each care home across Ayrshire and Arran has also been offered the opportunity to join the NHS Allocate Nurse Bank system to access staff.

Now that the additional oversight arrangements are in place any staffing needs will be flagged on the daily discussion and actions agreed to meet these.

There is a recognition locally that staffing requires to be considered from two perspectives:

- proactive and planned in response to potential positive COVID-19 testing – these potential staff will require to be tested and COVID-19 negative before deployment
- reactive / rapid in response to an immediate care risk – staff who require to be deployed in this urgent scenario may not have been tested and this risk will be managed by ensuring they provide care using PPE at all times until such time as the urgent risk has passed and staff can be deployed who are confirmed as COVID-19 negative.

The impact of COVID-19 has also impacted on the financial stability of the sector. Costs of increased staffing, lower admissions, and enhanced costs for PPE are all impacting. Arrangements agreed by CoSLA are in place through IJB commissioning arrangements to provide support but this remains a concern.

There will be ongoing financial pressures to sustain the viability of the care home sector.

5. Mental Health

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

Some aspects of care requiring or requested to be put on hold include:

- day care*;
- respite;
- support packages; and
- group work.

*Some aspects of day care have continued, these included socially distancing walks, essential shopping and more recently sessional attendance at day centre sites.

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 emergency departments 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.

In terms of our mobilisation plan phase 2, the following is proposed:

Stage 1 Mid-May to Mid-June

We will 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 colleagues to understand any barriers or opportunities to maximise use of our staffing resource without increasing risk of transmission.

Wellbeing hubs for staff have opened and on-line resources are available. This has been promoted across services. The telephone contact centre will go live. Line Management supervision and clinical supervision arrangements should 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 irrespective of the following RAG status articulated below; this may be considered to be appropriate by phone, video conferencing, letter or face to face.

- Red = For those who are most vulnerable, isolated or with multi-morbidities, with limited to no protective factors or social support – being mindful of lockdown in this phase. Services will determine frequency of contact.
- Amber = For those who have a known level of vulnerability but have adequate support, supervision or risk mitigation clearly documented within their risk and care plans. Services will determine frequency of contact.
- Green = For those who have no known immediate risk and clear provision of support and a history of self-management/ regulation. Services will determine frequency of contact.

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.

Joint transitions planning continues between children's and adult services to ensure that the delivery of alternative service options are developed in alignment with identified need – this includes the planning for alternative provision to day service and respite provision where these have been reduced or suspended.

Engagement

There has been a significant amount of engagement to develop mobilisation plans and ensure safe service continuity during this period. There are a number of examples of this identified below.

- Development of Community Hubs in partnership with Mental Health Practitioners. This collaborative work has ensured early identification of mental health concerns at the first point of contact into the community hubs during telephone contact ensuring a timely response and signposting to appropriate services.
- Development of Wellbeing Hub in Acute Hospital and Community Services. Stakeholder engagement with partners across the whole health and social care system to develop a listening service.
- Development of a combined duty system and ED diversion pathway in collaboration with acute inpatient ambulance and police services.
- Workforce planning in collaboration with Universities and partner agencies through the whole health and social care system to enable responses and immediate mobilisation of workforce when required.
- Multi-Agency Partnership working with Children's services and third and independent sector to develop wellbeing in response to rising demand.
- Engagement with Pharmacy provision and Addiction Services to ensure safe and effective provision for vulnerable groups.
- Participatory Budgeting work to enable implementation of projects to prevent drug related deaths.
- Wide scale engagement via social media including the development of an addictions app and mental health app. Addictions app and mental health app with a CAMHS app and Autism Strategy app in development.
- Continued engagement to ensure implementation of Autism Strategy recommendations.
- Partnership working with NHS 24 in the development of risk management approaches utilising the Ayrshire Risk Assessment Framework.
- Multi-agency distressed you person pathway work to ensure rapid and seamless response for young people in distress.

Distress Brief Intervention (DBI)

Building on the strong foundation, spirit of collaboration and shared objectives between NHS Ayrshire & Arran, North, South and East HSCPs, Primary Care, Police Scotland and the Scottish Ambulance Service, a Distress Brief Intervention (DBI) programme has been planned to develop, test and incrementally upscale a direct referral pathway from NHS Emergency Departments, Primary Care, Police Scotland and Scottish Ambulance Service to DBI level 2 support. It is proposed to commission a third sector provider to deliver this level 2 support across Ayrshire (£150k per year over next 2 years with a maximum spend of £500k).

Due to the promising results from existing test sites and the challenges posed by the actions required in response to the current pandemic, Scottish Government were keen to provide a specific DBI response related to increased levels of distress connected to COVID-19. This has resulted in an additional £1m investment across Scotland to widen access to DBI. Under the COVID-19 arrangements DBI Level 1 will be provided by colleagues working in the NHS24 Mental Health Hub. Level 2 care will be provided by existing level 2 DBI providers who are associates to current national programme. These experienced providers will receive additional investment to accommodate this increase in activity.

For Ayrshire, this COVID-19 response means that contacts received via NHS24,111, exhibiting levels of distress related to COVID-19 will be triaged via the mental health hub and will be offered DBI level 2 support, in line with the existing approach. This should be in place by early June 2020. Given the existing positive relationship with North Ayrshire and their skills in supporting the needs of younger people, Penumbra has been identified as the lead provider.

Stage 2 Mid-June to July

As guidance from the Scottish Government is developed, the second phase will be to reconsider historical approaches to screening/ referral meetings with structured strategies focusing upon IT solutions such as Microsoft Teams.

Delivery of traditional clinics for assessment and follow up will be considered in light of availability of clinic space and location. Where there is no necessity to see the patient face to face this will be delivered via Near Me and telephone contact. Where monitoring requires physical intervention at outpatient appointments this will either be delivered at home or self-management protocols considered. Consideration will continue to be given to use of PPE.

Continue to adapt shift patterns and tolerable levels of staffing in line with guidance from Government.

Staff Well-being measures to be reviewed for frequency of use and accessibility to all staff groups.

The requirement for rises in demand for MH services which is anticipated against previous years is being modelled in liaison and with input from Public Health & Health Improvement Scotland. Linking with GP and unscheduled care services such as NHS24, there are key programmes of Pan Ayrshire multi-agency work to address this already established including; suicide prevention, distressed young person's pathway development, health and homelessness and drug death prevention forums linked to ADP's.

Review home visit arrangements and use of PPE in line with Government guidance.

Revision may be required if indication to schools nurseries or day services resuming in any shape. Sessional day attendance has resumed in a limited way in East Ayrshire.

Consider whether inpatient realignment of services and threshold for admission can be reviewed in context of COVID-19 prevalence.

Digital Developments to support services

Digital Developments to support the mobilisation plan for Mental Health Services and detailed below.

App Development

Mental health services have engaged with our technology enabled care team to develop a set of apps to support our mental health services as they re-mobilise services.
These include an app to support nursing staff returning to clinical practice and making them aware of the policies and procedures to support the coronavirus. (850 Downloads)
An app for mental health services to support patient well-being and the provision of information about our services. (550 downloads)

An app to support our addiction services engage with patients across Ayrshire. (600 downloads)

We are currently starting the development of two new apps to support post diagnostic dementia care and CAMHS services. These will be developed and implemented in the next 3 months.

NHS Near Me

Mental Health services have used the guidance in the NHS Near me Mental Health guidance to assess the type of technology (Telephone or Video) or a specific clinical need for FACE to FACE contacts. They have widely adopted the use of NHS Near Me to support the following:

- Clinical care on a one to one appointment basis
- Small group work basis of 4/5 people. NHS Near me can only accommodate a maximum of 5 people at a time.
- Facilitation of multidisciplinary team discussions in both wards and community environments which include engagement with both patients and their carers.

There is currently a technology gap in a solution to provide digital interventions with larger groups of patients. We believe that there is a current evaluation of products available to make a recommendation on the tools that can be used to facilitate these larger groups.

As we move back to managing caseloads we will continue to assess where Telephone and Video consultations can be best used to manage patient care and where direct contacts are required. We have asked for specific service and professional specific data to analyse the uptake and we understand this is being worked on nationally with the development of a dashboard.

Microsoft Teams

Management and clinical staff have widely adopted Microsoft teams to support communications between staff who are both in their working environment and working from home. (NHS Ayrshire and Arran have approx. 1000 staff working from home on a daily basis).

Staff are using the product to discuss aspects of patient care and seek clinical advice as well as using it as a tool to support clinical supervision.

Patient Administration Systems

Mental Health Services are currently engaged in implementing Trakcare across our MDT Teams in Mental health. It is currently used in CAMHS and by our Medical Staff. This will be implemented over the next 3 or 4 months and will be in line with service redesign to support the integration of primary care and CMHT staff. This will allow us to have access to better scheduling tolls and associated data to manage demand on services.

In Health Care Self-Management and Remote Monitoring

This new toolkit has been procured by the National TEC team and has been available in NHS Ayrshire and Arran for 4 weeks now in order to support us

in the remobilisation of services. The services are currently exploring a number of use cases to identify how we can implement the system. Early use cases include the management of medication for ADHD patients, measuring clinical outcomes for patients in Primary Care Mental Health and managing the physical health care of patients with long term mental health problems. These will be developed and implemented over the next 3 months alongside the TEC team.

Computerised CBT and Silver Cloud online resources

We continue to develop and integrate the computerised CBT programmes in to our clinical pathways to support the management of mild to moderate Depression and Anxiety. Since it started we have seen over 4000 referrals to the programme and this has had an impact on waiting times for our Primary care Mental health Services. We will continue to implement this as part of our Mobilisation Plans.

The timescales are embedded within the wider digital plans for health and social care.

Stage 3 July to August

Review caseloads and RAG status for individual patients and frequency of required contact.

Continue to promote the use of prevention approaches by working with stakeholders such as GP's, pharmacies and schools.

Consider re-opening of Day Services and respite care to support individuals living in the community with long term care needs and to support their families who will have had little additional support during the COVID-19 outbreak. As detailed above, some aspects of day care have continued, these included socially distancing walks, essential shopping and more recently sessional attendance at day centre sites.

The above high level plan is predicated upon the trajectory and transmission of COVID-19 being downward. Any indication of increase in transmission rates or Acute Hospital admissions as a result of confirmed or suspected cases will result in service engaging revised contingency plans.

Mental Health Service Modelling of Demand & Finance Planning

Covid 19 is impacting on people's mental health and wellbeing. As time passes it is expected that there will be significant need and demand for support in this area. There is an expectation that services, agencies, partnerships and our local communities will require to work together to support our staff, our patients and the wider community.

However, it is also acknowledged that statutory Mental Health services had significant challenges meeting the needs of individuals experiencing mental illness pre-Covid and has limited abilities to meet the needs of this new and emerging group of individuals and communities affected by COVID19. There is already information, signposting, and an increased availability of resources developed to support people experiencing distress in response to COVID19. It is important to recognize that much of this distress is a natural and normal response to overwhelming and abnormal events associated with the pandemic. A broad based, multi-faceted approach to support the emotional wellbeing and resilience of our population will be required.

The mobilisation plan is underpinned by a continuous programme of modelling of future demands in collaboration with public health and all agencies across the health and social care system. The baseline data provided in the report will be further developed, monitored and updated on a weekly basis to inform this programme of work and assist in informing the shape of future service delivery.

The total Mental health financial spend across Ayrshire and Arran whole system is approximately £94m including funding for health and social care provision across. A programme of transformation has been underway since 2015 from which through service transformation, re-design, development and investment significant improvements have been made across the health and social care system. This programme of transformation is aligned to the national mental health strategy and the '*Ayrshire Mental Health conversation, Priorities and Outcomes 2019-2027'.* In 2019/20 there had been a 41% increase in demand for Mental health services locally. The National Records of Scotland (NRS) in a context prior to the current Covid 19 pandemic had also predicted that the number of people with mental health problems will increase by up to 4% per year. In 2019/20 the Scottish Government acknowledged rising demand with a requirement for a real terms increase of 1.8% on mental health budgets before the application of any additional funding.

In Ayrshire and Arran the ongoing programme of Transformation has identified in the pre-Covid context a number of gaps in service provision with investment required across the whole pathway for wellbeing and mental health. This includes investment in workforce capacity noted in the mobilisation plan and investment in the spectrum of provision from universal services all the way through to acute and critical care delivery. The investment required is estimated to be approximately £5m and at least a 5% recurring increase in Mental health spend/investment compared to existing budgets. This estimate is a whole system one and based not only on the specialist mental health services but including prevention and early intervention via the third sector, community groups and through education. This is the scale of investment in real terms required prior to Covid 19.

Some more specific examples of where additional costs are likely to arise have been highlighted in the CAMHS and Learning Disability sections of the plan.

The potential for increased demand post-COVID further emphasises the need to ensure that current provision across the health and social care system is as robust in capacity and resilience as possible to be able to effectively respond. Modelling of demand and effective financial planning will continue to be undertaken to inform the shape of future service delivery and ensure that there are local solutions and maximisation of capacity pending future investment potential.

Mental Health Services Baseline Data and Comparison

CAMHS waiting list reduced following intensive telephone contact exercise. This not only provided assurance to those waiting that they mattered but also allowed teams to provide guidance/advice/assurance over the phone. It also allowed any child/young person whose mental health may have been deteriorating to be risk assessed.

- Waiting list March was 1182
- Waiting List April was 904

The data also provides an assurance that those who need help/support are receiving appropriate support.

We were only into the 2nd week of lock down and there was a lot of assertive action to adapt services including the roll out of IT/Digital Support.

This allowed 'virtual appointments' to take place. Despite challenges of service delivery in this period

CAMHS assessed 129 children and young people (first appointments) and 81 CYP commenced treatment.

Psychological Therapies, treatment started for 199 (adults/CYP) during April, again during of the reconfiguration of services.

In Adult primary care, over 150 referrals have been received and vetted, this work has taken place despite the closure of some GP Practices. As GP services begin to re-establish more fully, we will utilise the GP-based Mental Health Practitioners to build these numbers back up.

Consultants have increased their activity significantly adapting to the virtual clinics. At the start of the lockdown, Consultant activity was just under 300 appointments per week. During May this has exceeded 400+ appointments per week.

It should be noted, that some individuals have deferred treatment for personal reasons.

Particular attention will be paid to the number of referrals being received by Alcohol Liaison, the numbers are increasing albeit slight and recent media highlighting alcohol intake is on the increase through boredom. People who would not normally be classed as having an issue with alcohol may well do so after restrictions lifted.

Monthly Comparison - April 2018, 2019, 2020

	Apr-18	Apr-19	Apr-20
Emergency Department * 8 - 17 yrs	30	49	21
Emdergency department - 18 yrs plus	283	347	204
CAMHS Referrals Total	171	145	57
CAMHS Referrals Accepted	143	110	35
CAMHS Seen (first contact)	111	120	129
Psychological Therapies Accepted Referrals		377	98
Psychological Therapies Waiting List		1230	971
Seen - 1st treatment		335	199
Crisi Team Referrals Recieved	90	190	123
Adult Admissions (W8 -11)	48	45	26
North PCMHT Referrals Received	254	243	48
North PCMHT Referrals Accepted	133	153	28
1st Treatment Appointments			
East PCMHT Referrals Received	231	205	68
East PCMHT Referrals Accepted	174	127	29
1st Treatment Appointments			
South PCMHT Referrals Received	254	274	50
South PCMHT Referrals Accepted	168	125	25
1st Treatment Appointments			

5.1 Urgent Care Services

To support the delivery of Urgent Care Services a number of strategies are being utilised –

- Continuing to extend use of digital technologies to support contact between professionals via MS Teams and Near Me for direct patient contact
- Use of MS Teams to facilitate Discharge Liaison Groups to review persons with complex needs to facilitate timeous discharge and ensure throughput
- Reintroduction of Crisis Team to proactively engage with inpatient teams to proactively identify persons for 'early' discharge
- Emergency Department redirection will continue with individuals in mental health crisis being seem at settings out-with Emergency Departments after initial triage assessment where required
- Continuation of focussed 96 hour assessment provision for adult acute inpatients to determine if ongoing inpatient care is required or recovery can continue in community with support
- Use of CMS video conferencing to support Care Programme Approach reviews
- Developing contingency plan to expand Adult Mental Health inpatient services temporarily to cope with expected surge in demand.

Contingency plans are being further reviewed to support the ongoing provision of services during expected higher level of demand as the public are likely to seek more support from services due to the perception that it is now safe to do so and the effects of social isolation.

Out of Hours/Crisis

Redirections from Emergency Departments have been implemented as per Minister for Mental Health's directive. Police pathway in place already to reduce unrequired attendances, with open contact to crisis team 24/7. No routine work has been cancelled. All referrals are risk assessed and responded to as appropriate. There are no waiting lists for these services. Current caseload remains consistent as to other times, if not busier.

Mental Health inpatient setting
Operational Practices to Minimise Risk of Introduction and Spread

Part of the UK Government's 'containment' strategy has been to avoid spread of the virus by encouraging social distancing; particularly that people should avoid being within 2 metres of each other to minimise person-to-person spread. Further measures were put in place in 'locking down' the country to minimise the risk of spread, closing places where people may gather, travel only for key activities – essential shopping, work considered as 'key' and not able to be undertaken from home etc.

This requirement of social distancing to avoid spread is equally true within the mental health inpatient setting but in the nature of providing physical care and mental health support to individuals there will frequently be occasions where the care team have to be within 2 metres of patients and each other.

Personal Protective Equipment (PPE) is available to staff and guidance in its use and nature has progressively changed as Coronavirus spread through the population and better information has become available.

As of 16/04/20 official confirmation was given that Scotland and Ayrshire and Arran are in a 'sustained transmission' phase in respect of Coronavirus. A number of strategies have already been introduced to try and reduce risk of introducing Coronavirus into our inpatient environments – increasing threshold for admission to those absolutely necessary, cessation of visiting, activity out-with the hospital setting being minimised, increased awareness/vigilance amongst staff if they or anyone in their household may be symptomatic not to come to work and contact the Staff Hub for advice and latterly the introduction of a 96 hour isolation approach for admissions to monitor for symptoms and creation of specific areas to manage/support individuals confirmed as being positive for COVID-19.

It is recognised that individuals within the mental health setting may lack capacity or have reduced cognitive capacity to understand or ‘comply’ with the social distancing and effective hand hygiene practices therefore we should take all possible measures in how we deliver services to minimise risk to exposure/cross contamination for the protection of those in our care and those delivering services.

Nursing staff should also assess their clinical area and implement measures to support social distancing such as ‘capping’ the maximum number of staff in the duty room, stagger patient meals and/or offer some patients to eat in their room, consider marking 2m zone where meds are dispensed/at nurses stations, in courtyards etc to assist in readily sustaining social distancing.

Although not exhaustive the measures overleaf are suggested to assist in the avoidance of the introduction of and spread Coronavirus within mental health inpatient services.

1. •Highest possible threshold for admission to reduce numbers of persons in wards and new persons brought into wards
2. •All admissions will be asked to self-isolate for the first 96 hours following admission, as a minimum strict social distancing will be adhered to within Ward 11.
3. •Where a patient is unable/unwilling to 'comply' urgent consideration should be given to enforced isolation and barrier nursing, use of MHA should be discussed to support or is discharge appropriate
4. •Consideration should be made for any/every procedure that requires staff to come within 2 metres of a patient - routine bloods, physical examination, frequency of NEWS (after initial 96 hour monitoring period) - **is it absolutely necessary?**
5. •Regular NEWS to be taken during this 96 hour period - if concerns re pyrexia, cough, breathlesness take urgent advice from medical/MHANP staff, then Infection Control/Microbiology re testing
6. •Symptomatic persons should be barrier nursed within their bedroom and kept isolated from their peers until test results are known (see Step 3 also)
7. •All unneccessary footfall should be avoided - only persons essential to delivery of services entering wards. Where possible nursing staff within ward should undertake venepuncture etc
8. •Entry to wards should be governed by nursing staff to ensure each person entering is essential to come in to the ward and aware of required restrictions re distancing and use of PPE where required
9. •Use of technologies to minimise avoidable person to person contact should be promoted - telephone, 'Near Me' function, Microsoft Teams
10. •All avoidable movement of all staff between wards on shift should be avoided - only if crucial in terms of safe staffing levels or in response to a Guardian Assistance or 2222 situation (7C, Jura or Ward 3/4 redzone staff will not respond to a Guardian or 2222 situation)
11. •Staff should be mindful of maintaining social distancing between themselves, esp minimise staff in duty room at one time, when on breaks - wearing sessional PPE where close proximity is unavoidable
12. •Where 'external' staff require to come in to ward and be within 2m of patients then they should not go straight in to another ward unless able to change their uniform/PPE - use of gowns/scrubs should be promoted for this purpose (see point 10 re unavoidable inpatient staff moves)
13. •Charge nurses should be mindful of staffing levels and avoid having more staff on than is strictly necessary to deliver services to maximise ability to support social distancing amongst staff
14. •Where there are changing facilities staff should change before leaving the hospital premises. If unable to change uniform then staff should travel straight to/from work and launder their uniform immediately on returning home. Uniform/scrubs will be available to temporary staff if required.
15. •Regular hand hygiene is of paramount importance and hard surfaces such as door handles, desk tops, keyboards, mouses etc should be cleaned regularly

5.1.1 Out of Hours & Crisis Response Services

Accessing Our Services

We worked with Liaison/CRT services to develop Emergency Department Diversion service, wherever possible assessing person out with ED.

All referrals to this service have been screened and triaged prior to RAG assessment. Where possible digital technologies have been utilised, however, where necessary face to face assessments and interventions have been carried out with infection control measures in place.

Adapting Our Services

- Use of digital technologies being explored re MS Teams for professional to professional contact and possible use of Near Me for direct patient contact.
- MS Teams option for meetings so that we can ensure that we can have as many people at meetings as possible.
- ED redirections to continue and be enhanced.

Referrals

Within Ayrshire & Arran we have an Unscheduled care Mental Health Service, encompassing community crisis teams and psychiatric liaison teams within our acute and district hospitals. All teams have continued to provide a 7 day service.

5.2 Planned Care Services

The sections below provide detail on Planned Care Services

5.3 Child & Adolescent Mental Health Services

Access is predicated upon Risk which is determined for known patients on Risk Assessment & by contacting families/ children when Urgent referral

CAMHS has continued to undertake 'urgent' work throughout the pandemic. More often than not this has taken place by telephone or video conferencing.

CAMHS have continued to undertake face to face contact when necessary. Where available this will be delivered within a locality base or building and only when risk or urgency are clinically evident.

Such contact will take place by domiciliary visits if there is urgent risk and requesting a child or a young person to go to a locality base or building is not in the best interest of the child or young person.

Waiting List and Referral Management

The time is being used to revise waiting lists, every person on a waiting list has been contacted as has every child or young person in active care/ treatment.

Referrals are routinely received via GP and schools which have not been accessed as frequently due to the COVID-19 emergency.
Early intervention approaches have routinely been delivered by teachers in schools – however this is now challenging as the schools are closed. Neuro development , ADHD, ASD referrals are identified in nurseries and first year at primary school so now may be undetected and there will be a significant increase in referrals when school open.

Some telephone assessments require a face to face assessment before moving onto treatment waiting list which may impact on waiting times.

Referral to Treatment from the onset of COVID-19 is seen below:

- 13.04.2020 -19 = 57%
- 20.04.2020 = 26 = 60%
- 27.04.2020 - 03 = 43%
- 04.05.2020 - 10 = 67%
- 11.05.2020 - 17 = 83%

This is across all disciplines and is prone to variation based upon staff availability due to sickness and shielding. A dip in meeting the Target is anticipated due to sickness in mid May as well as changes in management for referrals internally as waiting lists are audited for accuracy.

CAMHS are undertaking a full review of caseloads and waiting lists to ensure that there is accurate reporting and governance.

The service is presently innovating and mapping the service to the New National Specification.

As test of change we are developing a co-produced medication and health monitoring pathway for young people with diagnosed ADHD as a result of the pandemic.

Whilst CAMHS will monitor developments with relation to guidance, at this time we will foresee the return to schools by children re-instigated GP clinics as a key indicator of a review of the above.

Whilst there is an expectation that services will not return to 'normal', CAHMS are committed to working flexibly to meet the needs of children and young people.

Adapting our Service

Centralising all referrals through one point rather than three locality Teams has been an innovation for CAMHS.

Use of Near Me for routine work and by SLT for Neuro work has been a new introduction also.

The CAMHS MDT are now exploring the use of Near Me to facilitate groups for young people, this development is a positive and an innovation that we would wish to continue.

CAMHS are developing an App to offer a digital platform to engage young people. This is being co-produced and once again an innovation that will continue beyond the pandemic.

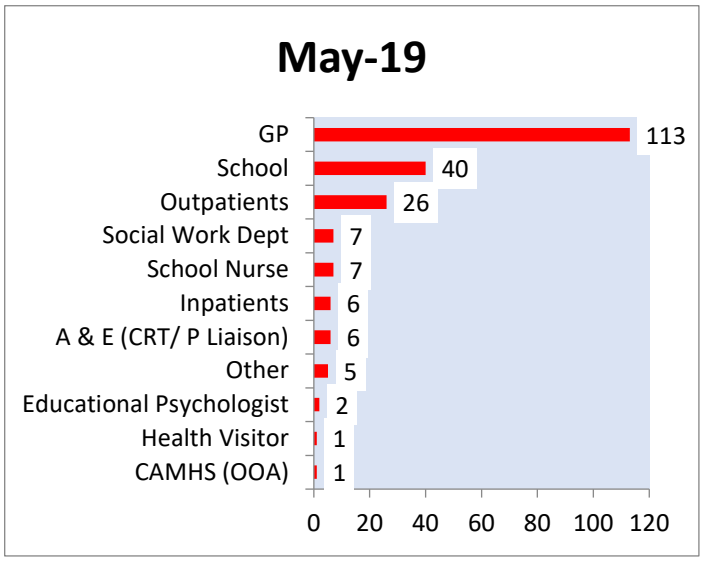
With this in mind there is an aspiration to develop a clear unscheduled care pathway in collaboration with Liaison & Crisis Services. This development is in its infancy but plans are progressing through the appropriate governance structures.

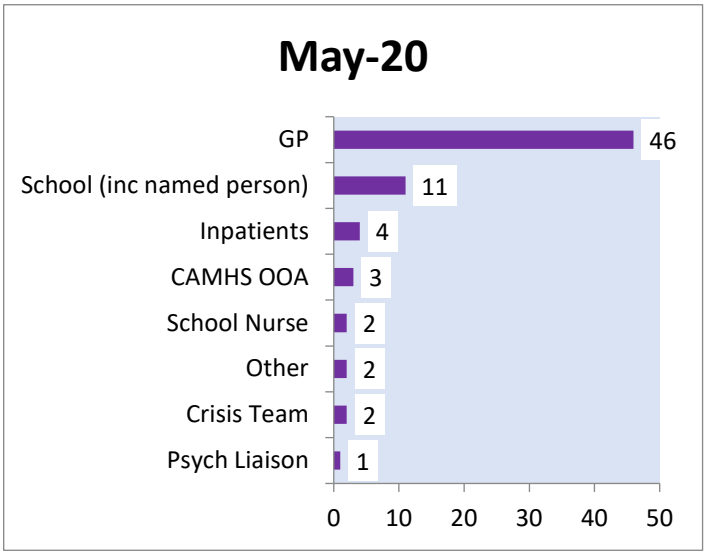
CAMHS are also developing non-medical prescribing pathways which it is hoped will reduce wait times for access to medical assessment whilst generate greater capacity in the management of Neuro care pathways

Referrals

CAMHS

There has been a marked reduction in referrals from all referral sources when considering a 'year-on-year' comparison. This is illustrated in the tables below. The overall result is a reduction in referrals of 67% in the month of May.





The reduction in referrals has been as a result of reduced GP activity and the closure of schools. These are the two areas that traditionally generate the largest source of referrals for CAMHS.

On-set of Covid19 Pandemic:

All of the staff team were requested to contact their caseloads at the start of lockdown and complete a risk assessment with them over the phone using ARAF to identify any vulnerable young people, all of the young people on caseloads have had regular ongoing contact from the clinician involved, any young person, who identified as either amber or red on the ARAF were also added to a priority contact list that the duty team accessed and provided support where required this is reviewed weekly and people added or removed as risk levels changed.

Throughout the pandemic, CAMHS have continued to see young people and children on a face-to-face basis when there is urgency or risk. Efforts have also been made to continue treatment and therapy for young people and children considered to be 'Amber' within our RAG rating which is based upon risk and progressing of treatment, these are mainly reflected in the 'Returns' column.

The way we triage referrals at the moment is being trialled as a 'test of change'. We are aware that we are receiving a vastly reduced level of referrals and we are working with our social services partners to develop a way forward to ensure that young people are able to access the service when they require it. To this end developments with Trak Care and SCI Gateway are progressing which will see the service be a single Pan-Ayrshire service as opposed to its current make up of three Locality Teams.

All young people and families being referred into the service now are being phoned on the day of receiving the referral and their concerns discussed before being offered a telephone/ near me assessment within 5 working days.

Dependencies

Prior to COVID-19, significant investment in neurodevelopmental assessment staffing was made by the Partnership, and the process of rapidly reducing back-log was underway from February 2020. CAMHS initially stopped all neurodevelopmental assessments due to restrictions on face-to-face work (this being reserved for urgent cases only). However we were able to complete developmental histories over the telephone. The service is seeking to identify means by which assessments can be conducted remotely (including contacts with other Boards to find common solutions). We are about to trial the use of a streamlined ADOS, which may allow us to assess, for autism, young people who are at the older age of the

CAMHS age range. This will allow us to understand what more might be offered until more face-to-face contact can be undertaken.
Moving forward it is anticipated that CAMHS may be able to provide a 'staggered' appointment system. We shall await the Risk Assessment for the buildings being completed to inform any decisions relating to this. The significant feature however is that this will considerably impact our ability to meet targets relating to Referral to Treatment for those disciplines whose work is routinely clinic based and where Near Me or telephone appointments are not the preferred option for young people, or where a clinicians believes that a face-to-face appointment is necessary for clinical care reasons.

Whilst there may be a need to develop clinic space and build capacity within caseloads for any anticipated increase in demand, the availability of whole time equivalent staff to do so will pose a significant challenge in the short to medium term. There are innovations planned re Non-Medical Prescribing which will have a significant impact upon medical out-patient clinics with regards to monitoring of ADHD medication. It is envisaged that two Nurse Prescriber posts will go to advert in mid to late June.

Whilst non-medical prescribing is developed in the first instance to complement the management of ADHD care pathways, there is also consideration around the need which will arise through unscheduled care routes. Young people presenting to ED's is an area that has been of significant focus for CAMHS during 'lockdown' as a specific unscheduled pathway is developed for young people.

Below is a snapshot of presentations to ED by young people from mid-March to mid-May.

56 attendances for 41 individuals

- 1 x 7 presentations – young person with significant psychiatric history
- 9 x 2 presentations
- 31 x 1 presentations

2 out of every 3 presentations involved an overdose and poisoning event

It is anticipated that in order to provide a seven day service the following whole time equivalents would be required.

- 2 x Band 7 ANP offering return clinics for assessment of young people and children presenting in distress and crisis with thoughts of suicide or self harm
- 2 x Band 6 Charge Nurse to engage in outreach work, including Child Protection and vulnerable children follow up, remaining engaged for up to 12 weeks post incident as well as assisting in assessment clinics.
- 4 x Band 4 Staff Nurse supporting outreach and care planning, child protection
- Projected costs including unsocial hours payments £340,000.00

The benefit of the introduction of this service will bring on line a seven day service accessible to young people and children form 8am until 8pm. These young people will benefit from an intensive period of support if required with the anticipation that there will be a reduction in need for young people to require on ward referral to CAMHS.

By managing unscheduled work in this way it is envisaged that capacity will be increased within CAMHS to focus upon Neuro-developmental work, treatment and assessment as well as develop care and treatment pathways for psychiatric disorders such as psychosis, depression, delusional and phobic disorders.

There is also the capability to expand the unscheduled care team to work with children and young people who might otherwise require hospital admission into adult services or when agreeing early discharge to shorten in-patient stays, reducing the need for children to be away from home and possibly ‘out of area’.

With an anticipated return of schools to a reconfigured structure on the 11th of August CAMHS aspire to return to seeing those children and young people who are considered to be RAG rated as ‘Green’. The development of an Unscheduled Care Team would allow for the capacity to make this happen as we progress into the normal pressures of school and social life by offering brief interventions and harm reduction.

5.4 Psychological Therapies

Managing Referrals

Psychological Service staff have been able to retain a focus on their core business. New referrals have been accepted, assessed remotely and, where suitable for specialist psychological input, placed on the waiting list.

The majority of patients have accepted remote delivery of treatment. Where the patient and clinician have agreed that a wait for face-to-face treatment is the preferred option, they have been placed on the waiting list and provided with suitable resources while they wait. The Service has received no complaints during this baseline period.

Staff have maintained their existing caseloads and taken on new assessment and treatment cases as remote appointments become available, in line with usual service priority criteria.

To resume delivery to those services paused, innovations and adaptations are now being progressed, as described as part of the wider re-modelling of the Service team (e.g. CAMHS mobilisation plan for neurodevelopmental assessment).

Referral demand has reduced across all Services (GP, Consultant out-patient and intra-team).

Adapting Our Services

To facilitate remote neuropsychology assessments (including intellectual and dementia assessments) for the Adult, Older Adult and LD patient groups, the Psychological Service has produced local guidelines for remote delivery of neuropsychological assessments, based on recent international and national evidence base and guidance. The necessary additional laptops and test materials have been ordered.

Elements of the specialist assessment are being undertaken remotely. There is communication with other HB specialist Psychological Services to identify best practice within current constraints.

Face-to-face - local guidelines have been co-produced, with Infection Control, to inform staff of the necessary safety measures and PPE to resume face-to-face assessment.

Therapeutic Groups – development of a remote 8/9 session trans-diagnostic therapeutic group for adults presenting with distress and emotional regulation problems. Will use video and pdf/audio clips, materials accessible for patients through the NHS Ayrshire & Arran MHS APP. Planned to be operational in around eight weeks. This group has application to staff presenting with COVID-19 related distress.

cCBT – there was a considerable decrease in referrals for cCBT (around 70% reduction) in the initial phase of the COVID-19 response, coinciding with the restriction in General Practitioner access. To increase access to this remote digital option, referral access has been widened to AMH Community Teams. As part of the national development of digital resources, cCBT product has been upgraded and, once embedded into local infrastructure, has application to a wider patient group, including long-term conditions. The latter will provide a remote and tiered therapeutic option to patients presenting to the Clinical Health and Neuropsychology services.

Staff Wellbeing - during the first phase of the COVID-19 response, dedicated Psychology resource was identified to develop and deliver psychological/ wellbeing support to staff in the Acute and MH/Community services, including the Neonatal and Maternity Units. An evaluation of the Psychology provision, to date, is now being undertaken.

The need for stepped-up Psychology provision through the recovery phase is currently being assessed, both locally and nationally (linking in with HOPS, the national Heads of Psychology group), and options for delivery at local, regional and national level considered.

A telephone listening service for all health, social care, and third sector/care home staff is due to be operational in June.

The following increases in activity are estimated through June and July/August as the services implement their adaptations of remote and face-to-face delivery to additional therapeutic work, including an evaluation of group work, and to neurodevelopmental and neuropsychological assessments (including intellectual and dementia). There remain limitations in remote neurodevelopmental assessment for children but clinical assessment can be commenced as schools re-open. Formal assessment will then progress quickly when face-to-face is resumed. Also, we have staff resource tied up in the staff wellbeing resources that will continue through to July. Need for longer term Psychology resource provision to staff wellbeing considered at local and national level.

CAMHS Psychology current activity approx. 65%. Projected 15% increase.

Community Paediatric Psychology current activity approx. 65%. Projected 10% increase.

Learning Disability Psychology current activity approx. 70%. Projected 10% increase.

AMH Psychology current activity approx. 70%. Projected 15% increase.

Older Adult Psychology current activity close to maximum activity. Projected additional 10% increase if new post recruited to.

Clinical Health Psychology current activity approx. 85%. Projected 10% increase.

Medical Paediatric Psychology current activity approx. 90%. Minimal projected increase through June – July while retaining a focus on staff wellbeing and to Maternity and Neonatal and limitations in resuming face-to-face neurodevelopmental assessment in Neonatal.

Neuropsychology staff resource focused its activity on functional assessment. Dedicated resource provided to Acute staff wellbeing. Projected 10% increase.

There are no waiting time breaches in **Addictions and Forensic/Low Secure**, and they are continuing with existing caseload remotely. The wider MDTs are managing referrals and no new referrals to Psychology at present.

So, approximate 10% projected increase in activity for PT over the next Covid phase.

5.5 Community Mental Health Teams

Prioritising Services

Services have been prioritised on a RAG system. All clients had contact to agree in partnership their current level of need and risk, and follow up care was planned accordingly. Wherever possible digital technologies have been utilised for those able to do so, however where face to face treatment/ interventions have been required these have been carried out with appropriate infection control precautions taken.

Pausing Our Services

Put on hold due to COVID-19

- MHO pilot,
- well being and liaison post,
- recovery college, tendering process for the recovery college,
- evaluation of recovery college not fully undertaken,
- Care pathways introduction
- Royal College of psychiatry Community Mental Health Services accreditation scheme,
- Going live with integrated service.

Adapting Our Services

Developments since COVID-19

- MS Teams option for meetings so that we can ensure that we can have as many people at meetings as possible whilst reducing the need to travel,
- Development of clinical mailbox, being able to email service users as this would ensure more rapid access to treatment,
- Re-consideration of how we carry out depot administration and cloazpine monitoring within the community,
- Near me and other digital platforms for clinics and groups.

Vulnerable patients who are known to mental health services and who are shielding have been identified and are being contacted weekly. Ensuring these individuals and their carers, where appropriate, are accessing available support through the Local Authority Community Hubs.

Mental Health Practitioners in GP Practice

The MHPs have been supported with laptops to facilitate home working and access to case files. Assessments are undertaken by telephone. There has been an increase in referrals to MHPs

In East Ayrshire alone, the MHP's since December have had input with 1,561 patients and these numbers have steadily increased since COVID and lockdown. Staff report there are able to triage more via telephone as opposed to being in surgeries however they are able to quickly access the GP's if needed.

This data is attributed to the delivery of service via 3 Mental Health Practitioners based in North Ayrshire and the high level of engagement reflected with the newly established community hubs in response to Covid.

Total Contacts 23.03 –02.06	Referrals to CMHT	Referrals to PCMHT	Referrals to CRT
602	14	1	3

5.6 Adult Community Mental Health Service (Social work)

Access to services

New referrals continue to be accepted including ASP and Vulnerable adult concerns.

Ongoing cases have been supported by telephone where possible and where required home visits have taken place.

Staff have continued to liaise with care at home providers and have supplemented gaps in provision where risks have been identified. MHOs within the team have continued to deliver statutory service

Adapting our Services

There has been a stop to groupwork that has had an impact within the MH Social work team. There is a focus to have these groups running again as soon as possible.

There has been an impact in terms of:

- Integration and social contact.
- Ability to signpost referrals.
- soft inputs around benefits, general welfare and so on that were frequently dealt with at these spaces.

In this area the reduction in the availability of social care for social integration and contact has been a challenge. Even with an increase in availability of such support, communities in general will need to open up again for there to be activities for people to be involved in.

In other teams, Group work/ Therapeutic groups have been cancelled:
Decider skills training (initially planned to be group based- requirement to explore other methods of delivery)
Cognitive Stimulation Groups – very positive feedback from carers and attendees who identify them as an important, integral part of their structured week.

Baseline Data & Monthly Comparison – April 19/20

MHO Stats Comparison

March – June 2019 against March – June 2020

2019			2020		
Week Commencing	**Sect 36.**	**Sect 44.**	**Week Commencing**	**Sect 36.**	**Sect 44.**
04/03/2019	2	2	02/03/2020	1	1
11/03/2019	0	1	09/03/2020	2	4
18/03/2019	3	1	16/03/2020	2	1
25/03/2019	1	0	23/03/2020	2	1
01/04/2019	0	1	30/03/2020	0	3
08/04/2019	2	4	06/04/2020	2	1
15/04/2019	0	0	13/04/2020	2	3
22/04/2019	1	0	20/04/2020	0	2
29/04/2019	0	2	27/04/2020	0	1
06/05/2019	0	2	04/05/2020	1	0
13/05/2019	2	0	11/05/2020	0	2
20/05/2019	3	2	18/05/2020	3	6
27/05/2019	1	2	25/05/2020	3	4
03/06/2019	1	3	01/06/2020	0 so far	2
Totals	**16**	**20**	**Totals**	**18**	**31**

5.7 Community Drug and Alcohol Services

Prioritising our services

RAG criteria – similar across Ayrshire and Arran
RAG for interventions

Red:

- Currently requires face to face contact daily, weekly to fortnightly basis (regardless of discipline), and depending intervention.
- Prescribed medications which require a level of monitoring in initial stages of drug or alcohol detox process
- Has a known underlying condition which is complicated by medication treatment or management when commenced on a new medication.
- Is currently rated high risk in relation to suicide or harm to self or others (factors must be identified on up-to-date ARAF)
- Has no other service actively involved in their care and treatment and has identified as high risk on ARAF (where other services are involved it must be confirmed that there is a shared understanding of contact so as to avoid duplication of resource)
- Where there are noted levels of vulnerability or isolation which could contribute to the decline of an individual's mental health
- Has known symptoms of anxiety, delusion or paranoia that are being exacerbated by a health crisis such as pandemic flu (telephone contact may be increased as required)
- Is subject to legislative measures associated with MH Act, AWI/ ASP / CP (where other services are involved it must be confirmed that there is a shared understanding of contact so as to avoid duplication of resource)
- Where alcohol / drug use and risk behaviours have been assessed as chaotic level that requires increased monitoring as identified within the ARAF.

Amber

- Currently requires face to face (or telephone contact if deemed appropriate) –
- contact on a monthly basis moving to 6 week basis (regardless of discipline).
- Prescribed medications which require a level of medication monitoring.
- Completed initial intervention but still requires a degree of monitoring. E.g post detox and ongoing medication.
- Currently rated moderate risk in relation to suicide/ self harm or harm to others (factors must be identified on up-to-date ARAF)
- Has limited social support or other services available to them

- Where there has been historical vulnerability or isolation when unwell or relapsing
- Has in the past experienced health related anxieties in conjunction with other current relevant amber risks identified in ARAF
- Has recently been deregistered /signed off from legislative measures associated with MH Act, AWI/ASP/CP
- Where alcohol and poly drug use is prevalent in conjunction with associated moderate risk behaviours as identified within the ARAF.

Green:

- Is open and has active care and treatment plan underway (regardless of discipline) currently requires contact as a minimum 3 monthly moving to 4 monthly with interim telephone contact if required.
- Is prescribed medications but requires minimal monitoring or dispensing.
- Is currently rated low risk in relation to suicide/ self harm / self harm or harm to others (factors must be identified on up-to-date ARAF)
- Has known social support or other regular contact with other services
- Has no significant health related anxieties
- Is not subject to legislative measures associated with MH Act or AWI/ ASP/
- Where alcohol and poly drug use is not prevalent or associated with risky behaviours as identified within the ARAF.

Pausing our services

Pan Ayrshire:
All services remain open to all referrals. Most vulnerable clients prioritised for face to face support. Increased use of telephone contact. Near Me option being scoped.

Referral Management

Open referral system is triaged regularly throughout each day. Most vulnerable clients prioritised for face to face contact (e.g. immediate prison release clients). There is no waiting list or backlog.

Access to Services

Referrals: Continue to offer an 'Open' Referral process e.g. anyone can refer, including self, and can refer in any way (letter, clinical email, referral form, phone call, in person etc). This has not changed. There has however been a reduction in the number of referrals to statutory services.

Each referral is screened immediately using the RAG status – however, for every new referral, over 90% of clients commence treatment appropriate to their recovery within 3 weeks of receipt of referral and 100% commence treatment within 6 weeks. This has been maintained during the covid situation.

Seen/not seen and method of contact – face to face contacts have continued e.g. clients being released from prison, clients attending our IEP specialist sites, clients who have increased vulnerability in relation to mental health or adult or child protection.

RAG status – every client classed as most vulnerable (Red RAG status) has been receiving a weekly contact/check in. This includes all shielding clients. This level of contact has been achieved 100%. Staff have attempted to contact every other client within the Amber and Green RAG status groups. For the clients whom they have not been able to contact – processes have been implemented to engage with these clients.

Method of contact – this has changed from the majority of contacts being delivered face to face with the vast majority of contacts now being conducted via the telephone.

Prison release clinics have continued to take place within out-patient department at Ailsa Hospital. These clinics have been re-organised to offer joint assessments with a prescriber to reduce the amount of appointments/DNA.

Addiction services staff are offering Home delivery/Outreach clinics for Injecting Equipment Provision (IEP). In addition, they are now able to offer a Postal service for Naloxone/IEP.

New Ways of Working

Community Services

All interventions continue to be available but with increased support provided not via face to face meetings but through the use of the telephone.

Group work (for lower level support) was stopped via face to face meetings. Clients have been supported on a 1 to 1 basis, mainly by phone contact.

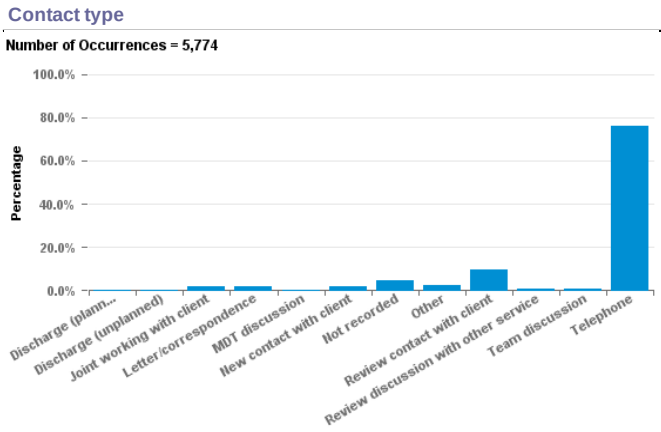
Service has been setting up the processes required to use Near Me technology. Use of Near Me has now commenced for identified groups. Partner agencies (3rd sector services, recovery groups etc) has moved from face to face contact to making greater use of telephone contact and online and social media and virtual group meeting (via Zoom etc)

Ward 5 – Hospital based support

Day attendance programme was stopped – with clients being supported by the community teams.

Hospital based detoxification was prioritised (the main difference is that EVERY client has to remain in their room, socially distancing, for the initial 96 hours, supported by staff utilising appropriate PPE). Residential rehabilitation support was stopped in Ward 5 due to pressure on beds and to support the implementation of the wider Woodland View Continuity Plan.

Below is the activity data for community drugs and alcohol services.



Action	Person CHI	Percentage
Discharge (planned) with client	14	
Discharge (unplanned)	6	
Joint working with client	119	
Letter/correspondence	92	
MDT discussion	5	
New contact with client	96	
Not recorded	279	
Other	143	
Review contact with client	540	
Review discussion with other servic	59	
Team discussion	32	
Telephone	4389	7
Total:	*5774*	*10*

5.8 Community Older People's Mental Health Services

Access to Services

Existing caseloads prioritised by clinicians. New referrals screened by nurse team leader and consultant if required for priority. Routine work on hold being placed on waiting lists.

Referral Management

All referrals are being screened for urgency. All patients referred are contacted to be placed on waiting list or consultations taking place via phone or face to face as assessed.

Waiting list for the North team is approx. 130 have been placed into priorities high medium and low.

Between the 27th March and 22nd May we have completed approximately 500 telephone contacts and 60 face to face contacts. New referrals have totalled 76.

Assessment and review/treatment contacts via telephone for all disciplines is taking place. Face to Face assessments and home visits are still being offered when clinically required/critical and no other safer option identified.

Home visits for administering depot injection medication and the taking of bloods is taking place in people's homes unless a particular risk is identified.

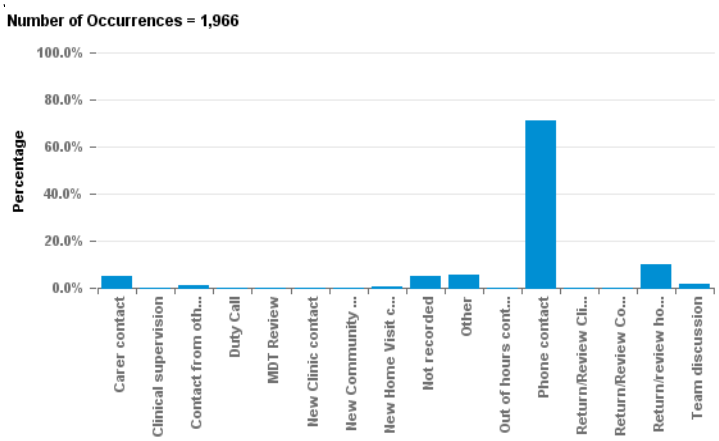
There has been noted benefit of seeing patients in their own home, making connections with family but also being able to better identify social circumstances and vulnerabilities.

Urgent assessments, including detentions and hospital admissions, continue to be delivered recognizing that coordination of such interventions require more planning than usual due to additional measures e.g. PPE.

Active Patients between 01/04/2020 and 30/04/2020

Centre: ALL

Nature of contact



Action	Person CHI	Percentage
Carer contact	98	5.0%
Clinical supervision	2	0.1%
Contact from other agencies	23	1.2%
Duty Call	2	0.1%
MDT Review	1	0.1%
New Clinic contact	1	0.1%
New Community Resource contact	2	0.1%
New Home Visit contact	11	0.6%
Not recorded	97	4.9%
Other	103	5.2%
Out of hours contact	1	0.1%
Phone contact	1395	71.0%
Return/Review Clinic contact	3	0.2%
Return/Review Community Resourc	3	0.2%
Return/review home visit contact	191	9.7%
Team discussion	33	1.7%
Total:	***1966***	***100.0%***

5.9 Community Forensic

Access to Services

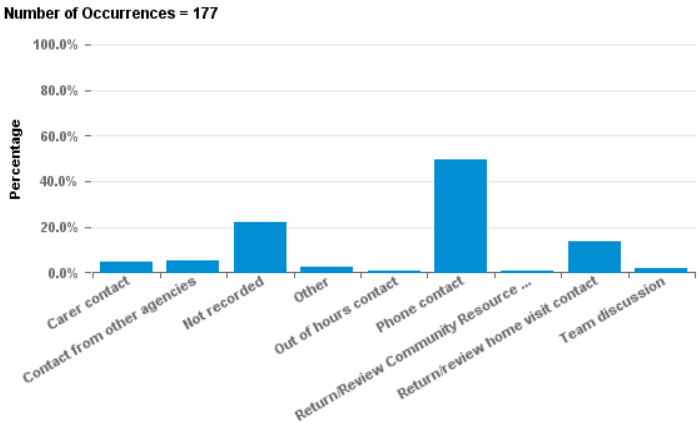
Access to services has been prioritised based on a RAG rating. Currently there are:
Red = 8 and face to face appointments sustained.
Amber = 16 and telephone contact maintained.
Green = 12, confirmed contact would be maintained by other agencies, inpatients.

Court Liaison has been sustained throughout. The service has seen a lower level of referrals compared to 'normal' (March = 19, April = 6).

Active Patients between 01/04/2020 and 30/04/2020

Centre: ALL

Nature of contact



Action	Person CHI	Pe
Carer contact	8	
Contact from other agencies	9	
Not recorded	39	
Other	4	
Out of hours contact	1	
Phone contact	88	
Return/Review Community Resourc	1	
Return/review home visit contact	24	
Team discussion	3	
Total:	***177***	

Referral Management

Referrals have been screened as normal and there is no backlog.

Direct re-engagement with Amber group will be progressed via Near Me or meeting in outside public areas so social distancing can be maintained.

Adapting Our Services

Recognising the ongoing need to think differently about how we deliver services we are:

- Use of MS Teams for professional meetings/contacts.
- Developing use of Near Me.
- Working from home will be continued to support social distancing.
- Use of CMS for CPA processes.

5.10 Community Specialist Provision Services, Perinatal and Trauma

Access to service is predicated upon risk, caseload is RAG rated and monitored. Full service access is available to patients by phone, by video conferencing and where necessary using appropriate levels of PPE and social distancing, in person. Utilisation of Near Me and telephone calls has increased in order to deliver both routine and urgent work, face to face contact has continued where necessary.

Perinatal/trauma Referrals

Perinatal

	East	North	South	Total
13.04.2020 - 19.04.2020			2	2
20.04.2020 - 26.04.2020	3		2	5
27.04.2020- 03.05.2020	3	2	1	6
04.05.2020 - 10.05.2020	3	1	1	5
11.05.2020 - 17.05.2020	1		5	6
	10	3	11	24

Trauma Related

	East	North	South	
13.04.2020 - 19.04.2020		1		1
20.04.2020 - 26.04.2020	1	3		4
27.04.2020- 03.05.2020	1			1
04.05.2020 - 10.05.2020	1			1
11.05.2020 - 17.05.2020	1	2		3
	4	6		10

Trauma may not be identifiable at referral (10 mins consultation time with GP) or may be underlying with a presentation of low mood, anxiety, self-harm etc but should identified at assessment. If order to quantify there are trauma specific ICD10 codes that could be utilised. Perinatal data excludes Psychiatry session. As an indicator the Perinatal Psychiatry clinical expected 20 referrals in April 2020 and 15 in May 2020.

5.11 Inpatient Psychiatric Units

Accessing Our Service

IPCU & Low Secure provision has been unaffected.

Our specialist addiction facility within Ward 5, in light of national guidance, has refocussed its service provision to prioritising hospital based detoxification support to those individuals assessed as the most vulnerable by our community teams as requiring this specialist intervention.

Bed Occupancy

% Occupancy	March	April	To 17/05
EMH Admissions	76%	80%	88.3%
EMH HBCC	88.6%	86.7%	84.6%
AMH Admissions	60%	69.2%	82.2%

No waiting lists.

Creation of 96 hour assessment unit to screen all AMH admissions for COVID-19 and to determine if ongoing inpatient care required.

Move to sector consultant approach to minimise footfall and reduce number of MDT reviews.

Delivering Our Services

Rehabilitation service currently full as one ward vacated to be COVID-19 red zone if required.

Can readily be re-instated when confident risk has been reduced.

Referral Management

Threshold for admission raised to ensure only those with highest need/risk admitted.

Outreach support from remaining rehabilitation ward to AMH assessment wards to start rehab process/work for persons who otherwise would have been referred.

Adapting Our Services

- Specific ward for focused 96 hour assessment period will be continued to ascertain if leads to reduced length of stay – focused input from Crisis Team.
- Use of MS Teams for professionals' contacts and MDT reviews.
- Developing use of Near Me.
- Use of CMS for CPA processes.
- Staff Well Being Hub created within Training Centre ACH and enhanced rest areas at Ailsa x 2 and Woodland View x 2 as well as 'calm zone' in Spiritual Care Area.
- Wellbeing area being created at Ailsa Site.

Demand & Activity

Rehabilitation Beds were reduced by 10 from 17th April 2020 to allow for realignment of services and 10 AMH Acute Assessment beds were also removed to allow for creation of admission 'amber' zone to screen for AMH admissions a red zone ward to support COVID-19 positive cases.

Weekly trend data for activity:

Weekly Acute Mental Health Activity Report

Admissions

	Wk 23/3	Wk 30/3	Wk 06/3	Wk 13/3	Wk 20/3	Wk 27/3	Wk 04/05	Wk 11/5	Wk 18/5	Wk 25/05	Change last week
Elderly MH admissions ward 3 -4	1	3	2	0	3	1	3	1	5	2	↓
East Ayrshire		*1*			*1*		*1*			*1*	
North Ayrshire	*1*					*1*	*1*	*1*	*3*		
South Ayrshire		*2*	*1*		*2*		*1*		*2*	*1*	
Acute MH admissions wards 8 - 11	5	9	5	5	6	7	7	11	15	6	↓
East Ayrshire	*2*	*2*	*2*	*2*	*0*	*4*	*3*	*6*	*8*	*3*	
North Ayrshire	*3*	*3*	*3*	*2*	*4*	*1*	*1*	*2*	*4*	*2*	
South Ayrshire	*1*	*4*	*0*	*1*	*2*	*2*	*3*	*2*	*2*	*1*	
Total	6	12	7	5	9	8	10	12	20	8	↓

Emergency Department Attendances

	Wk 23/3	Wk 30/3	Wk 06/3	Wk 13/3	Wk 20/3	Wk 27/3	Wk 04/05	Wk 11/5	Wk 18/5	wk 25/5	Change last week
8 - 17 yrs old	4	11	2	5	3	6	9	9	7	11	↑
East Ayrshire	*3*	*3*	*1*	*3*	*1*	*2*	*4*	*1*	*4*	*3*	
North Ayrshire	*1*	*3*	*1*	*2*	*1*	*3*	*5*	*4*	*2*	*3*	
South Ayrshire		*5*			*1*	*1*		*4*	*1*	*5*	
18-64 yrs old	36	25	49	41	50	48	50	51	62	68	↑
East Ayrshire	*13*	*6*	*11*	*15*	*17*	*13*	*15*	*14*	*19*	*21*	
North Ayrshire	*10*	*8*	*14*	*15*	*14*	*13*	*14*	*21*	*20*	*24*	
South Ayrshire	*13*	*10*	*23*	*11*	*18*	*21*	*19*	*16*	*22*	*23*	
65 years plus	3	2	1	5	1	4	0	3	5	4	↓
East Ayrshire	*2*		*1*	*2*		*2*					
North Ayrshire	*1*			*1*				*3*	*3*	*2*	
South Ayrshire		*2*		*2*	*1*	*2*			*1*	*2*	
	43	38	52	51	54	58	59	63	74	83	↑

Mental Health Act (data subject to change)

	Wk 23/3	Wk 30/3	Wk 06/3	Wk 13/3	Wk 20/3	Wk 27/3	Wk 04/05	Wk 11/05	Wk 18/5	Wk 25/5	Change last week
Assessment Order					1						
Compulsion Order						1					
Compulsory Treatment Order (inc interim)	4	4	4	1			3	3	2	1	↓
Emergency Detention	2	1	5	4	1		4	2	5	2	↓
Short Term Detention	1	5	2	7	3	3	2	4	9	3	↓
Treatment Order								1			
	7	10	11	12	5	4	9	10	16	6	↓

Crisis Team Referrals

	Wk 23/3	Wk 30/3	Wk 06/3	Wk 13/3	Wk 20/3	Wk 27/3	Wk 04/05	Wk 11/05	Wk 18/5	Wk 25/5	Change on last week
East	3	7	13	8	7	17	10	15	19	22	↑
North	9	8	10	14	13	19	13	17	22	11	↓
South	8	5	5	4	13	7	7	9	13	15	↑
Total	20	20	28	26	33	43	30	41	54	48	↓
Sub set of Total - Police Referral	*9*	*8*	*14*	*14*	*18*	*22*	*11*	*19*	*20*	*23*	
	45%	*40%*	*50%*	*54%*	*55%*	*51%*	*37%*	*46%*	*37%*	*48%*	

Author: Elaine McClure, Portfolio Programme Manager

5.12 Priority Groups - Learning Disabilities

The draft plan outlined below reflects the 3 phases of the local Mobilisation Plan but has in the first instance been framed around the recent correspondence from Scottish Government regarding their expectations of the NHS in the next phase of mobilisation.

Recovery in the context of Scottish Government Correspondence

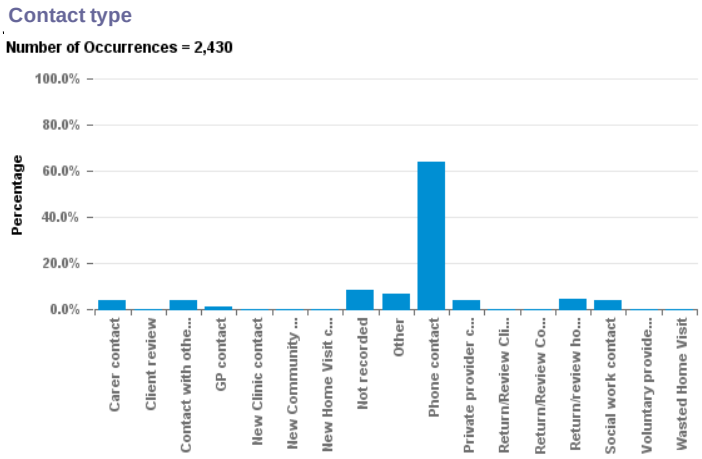
Baseline service Provision

The Learning Disability Team continues to link with clients on a prioritised basis, using telephone contact and Near Me. In support of the latter, team members have developed easy-read guidance for clients regarding the use of Near Me. Near Me is not a universal solution, with some clients opting for phone calls instead. As always, the team is acting in line with the wishes of clients as far as possible at the current time. Face to face contact is being managed where essential in line with existing guidance, with home visits being conducted where needed. All contact is undertaken in line with the principles for Mental Health Services shared by the Scottish Government. The pan-Ayrshire Assessment and Treatment (A & T) facility, now based in ward 7a at Woodland View, continues to function.

With regard to service elements that have ceased due to COVID-19, the key ones are:

- Day opportunities (continued in a limited way in East Ayrshire)
- Respite services
- Completion of tenancy moves into Trindlemoss
- Group work supported by the Integrated Team
- Planned opening of Complex Needs Unit

The current activity for Community Learning Disability Teams - Ayrshire wide is shown below.



Action	Person CHI	Pe
Carer contact	89	
Client review	3	
Contact with other agencies	95	
GP contact	25	
New Clinic contact	2	
New Community Resource contact	1	
New Home Visit contact	1	
Not recorded	195	
Other	166	
Phone contact	1552	
Private provider contact	92	
Return/Review Clinic contact	4	
Return/Review Community Resourc	1	
Return/review home visit contact	111	
Social work contact	91	
Voluntary provider contact	1	
Wasted Home Visit	1	
Total:	*2430*	

Access to Services

New referrals to the team are being processed in line with guidance shared previously by Scottish Government to Mental Health Services. New referrals are discussed within NHS team meetings and prioritised on the basis of information provided; in the first instance, new referrals are contacted by telephone and offered where appropriate an appointment via video link over Attend Anywhere, with physical home visits taking place where needed. Existing caseloads are being managed as required using available technology, and prioritised using Red/Amber/Green categorisations on the basis of need (e.g. level of existing support, health status, identified risks) which dictate frequency and nature of contact. This prioritisation is done by team members already involved with the individual.

Different Ways of Working

With the exception of some Day Provision for younger adults in East Ayrshire, Day Opportunity and Respite Services ceased completely in response to the pandemic. Over time aspects of Day Opportunities contact have been recommenced e.g. using Skype, and it is anticipated that this will continue to be a feature of the service going forward. Currently, Day Opportunities provision is planned to recommence week commencing June 15th. This will probably look like 1 day per week in much smaller groups, with maximum capacity of around 28/29 customers per day supported by approx. 12 staff. Over time it is hoped to supplement this provision with support nearer home. Work has been undertaken to develop a prioritisation list of clients/families most in need of respite, 40 individuals have been identified. Risk assessments for these individuals are already in place regarding respite use, and it is anticipated that provision will most likely comprise a reduced number of individuals (4) being on site for a 7-day block (to reduce crossover)

Neighbourhood Networks were to be piloted in the Garnock Valley. Currently, the service is supporting 4 individuals referred to them by Community Link Workers, prior to the lockdown commencing. This support is primarily over the telephone, but the organisation has also developed a broad range of online activities. It currently has capacity to take additional referrals, which may be of particular importance at the moment in terms of rebuilding connections and support networks for individuals.

Between now and the end of July, and in line with Phase 2 of the local mobilisation plan, the LD service will:

- Continue to promote the use of Near Me;
- Review existing staffing provision (shift system) in line with the available space;
- Consolidate plans as regards limited provision of respite and day opportunities, including collaboration with external partners
- Explore phased reintroduction of group work (including through virtual means)
- Progress planning and support in relation to the move of individuals into Trindlemoss tenancies

Communicating with those referred, on waiting lists and those receiving care and treatment

The integrated team have already sent out information to all active clients earlier in the pandemic and will follow this up with second blanket communication.

- A standard letter will be sent to all active clients across the integrated team (using a contact spreadsheet developed for this purpose which pulls together info from Care Partner, Care First, and Trindlemoss attendance registers). This will explain the current situation of the service and outline a provisional timetable for developments over the coming weeks. Subsequent contact will be made by an involved team member to clarify the nature and frequency of ongoing contact as required. As noted above, Near Me is already in use within the team, and will continue to be. Where direct contact is required, this will be carried out in line with existing infection control guidance RE. COVID-19. (Appendix A.). A similar standard letter will be sent out to all those newly referred to the team who are still awaiting allocation.

- In the interests of establishing a fresh baseline which accurately reflects the current situation and allows us to evidence possible changes in demand (e.g. linked to anticipated rises in mental health issues, as referenced in recent Scottish Government correspondence), contact with clients following the blanket correspondence will employ as standard a brief set of questions, intended to broadly capture changes in status e.g. regarding general wellbeing and support needs, and any changes as regards carers and other aspects of pre-existing support networks. Crucially, this will also be used as an opportunity to briefly capture something of people's experiences over recent months, but also of their ideas and observations regarding the way forward. Co-production was meant to be a defining feature of services prior to the pandemic, and while the current situation demands a service led response for many reasons, it will become increasingly important to build in further opportunities for listening and responding to the concerns of clients and carers and working with them to address these.

- Where this contact identifies a need for more in-depth review or assessment, this will be prioritised in line with the RAG categorisation outlined within the local mobilisation plan.

Establishing arrangements for COVID-19 positive inpatient settings, and non COVID- 19 inpatient settings, and ensuring safe and effective inpatient care

The LD A&T unit presently has 5 patients in it, one of whom is being shielded due to age and other comorbid health conditions. There are no visitors to the ward and no home visits at this time until the restrictions are lifted. However, iPods have been used successfully to enable video calls with family members. Due to the needs of patients, maintenance of social distancing is not possible, therefore staff are using PPE as per recent guidance. Should the need for a new admission arise, they would require to be isolated for a period of time to reduce risk to other patients. There is facility in the ward to create a red zone if there were any suspected or positive COVID-19 cases, which would be staffed by an identified team. There is also a COVID-19 ward which could be used if necessary. As restrictions ease it is hoped to allow for some family contacts, and to increase the available opportunities outwith the ward, to assist in recovery.

The Learning Disability Service is moving forward with the opening of a new complex needs unit within Trindlemoss. Currently this is scheduled for the 8th of June, with 4 individuals identified for initial occupancy, and a fifth due to move in following preparation of the environment. PPE and restricted visiting are key to the current support of these individuals and will continue to be. The environment to be moved to will lend itself better to isolating potential COVID-19 cases, as each individual will have their own flat within which they could be isolated. As part of this containment, the staff supporting any isolated individual would be restricted to a small group as far as possible. Use of iPads to enable video calls is also being considered for this group of individuals. It should be noted that the emergence of any COVID-19 cases (suspected or confirmed) within the existing complex needs unit could potentially result in the move occurring later than planned.

Helping to move patients quickly through the system in line with the above clinical priorities

The nature of support to people with a learning disability entails delivery at a pace which recognises their needs and abilities. The team will continue to work in this manner, while also seeking to manage existing and incoming demand through effective collaboration with all grades and professions across the integrated team. This will be done with full attention to the stated plans of individual professions as regards continuing to deliver a service over the coming weeks (e.g. see Appendix B. re. Physiotherapy position; Appendix C. re. Speech and Language Therapy, Appendix D. re. Dietetics position).

Implementing virtual team working and clinical service delivery arrangements during the next phase and beyond, where clinically appropriate to do so

NHS and social work colleagues within the integrated team have already been employing Near Me, while also using Microsoft Teams for profession specific and other meetings. Teams has also been used to enable the pan-Ayrshire Clinical and Care Governance Meeting to take place, as well as local management meetings. A next step for the use of Teams will be its use to facilitate discussion across the broader Integrated Team, including Social Work. While Team Managers will have an obvious and essential role to play within these discussions, the use of Teams may also create opportunity for senior managers to be involved in a way which had not previously been possible due to time pressures.

Making online mental health wellbeing information, advice and support available to staff and the local population

Online staff wellbeing resources are regularly shared across the service as they are promoted or made available within the Partnership or NHS Ayrshire and Arran. Wellbeing resources for clients and families are being gathered and promoted via a range of national organisations, including the Scottish Commission for Learning Disability and the National Autistic Society. The Ayrshire Autism One Stop Shop has also recently promoted online social groups, while SCLD have been facilitating a successful Facebook group to enable contact and discussion, since early on in the pandemic. The LD Service now has a tile within the Mental Health section of the NHS Ayrshire and Arran app, within which links are provided to a wide range of online resources. Availability of the app will be promoted to clients and families over the course of Phase 2 and beyond.

As with many aspects of service delivery, the service's use of online resources has the potential to capitalise on their necessary use during the current time. While promoting a broad range and type of resources has always been standard within the service, there is scope for online resources use in particular to further developed. Potentially, this could include considering the necessity for an app better tailored to the information needs of people with a learning disability (and potentially others).

The service has also been directing people to the Community Hubs for advice and support, and will continue to do so as long as they are operational. Their role in the provision of food and medication delivery to those shielding has proven to be of particular value.

Modelling likely future demand for mental health services

While the LD Service has a strong history of evaluation and evidence generation, there has been a recognition in recent years of the need to develop better means of describing and reporting on the population it works with. Work outlined above to reconcile the client lists of the integrated community team (Care Partner and Care First) with that of Day Opportunities could potentially serve as the starting point for a new database designed from the outset to facilitate ease of reporting on the nature and level of service demand, should capacity be available at the current time to enable this. Even developed in a minimal manner, it could serve a useful function in tracking and projecting demand.

Alongside this, the implementation of a simple question template as part of re-establishing contact with individuals, with the potential for its repetition at a future point, would provide additional detail with regards to demands and the efficacy of support measures put in place. While the extraordinary demands on staff, individuals, and those supporting them are undeniable, it is essential that some effort is made to understand the impact of the ongoing changes. This is true for the whole population, but particularly so for a traditionally marginalised one such as people with a learning disability.

Required dependencies e.g. digital services infrastructure, accommodation, PPE, staff support arrangements and staff and patient travel arrangements

All of the above are critical with regard to moving forward with service recovery, with digital infrastructure being key to easing dependence on some of the others (PPE and travel).

- With regards to digital infrastructure, it is worth noting that the extent of access to and use of technology by people with learning disabilities has in recent years been described as falling far short of that within the broader population. For example, research conducted for Ofcom found that fewer people with a learning disability had access to the Internet than the non-disabled population, and that the access to a PC, laptop or smartphone was significantly lower[1]. Given how critical effective communication will be over the coming weeks and months, it would be relevant to explore the extent and nature of the client-side digital infrastructure: how many people (either them or someone in their immediate support network) are already accessing technology which could allow for remote video

[1] Ofcom (2015). Briefing Sheet: Consumers with Learning Disabilities. https://www.ofcom.org.uk/__data/assets/pdf_file/0028/81586/disabled_consumers_use_of_communications_services.pdf

sessions and other electronic communication? And if they are not, could it somehow be encouraged or facilitated?

- That the new TEC platform helps with digital inequality. A telephone can be used as a method of access to the service now

- The stated dependency regarding PPE is another where carers may potentially have been experiencing issues. Both this and the above areas are ones which could be explored within the brief question template suggested above.

- Availability of PPE is a critical component of safely engaging with many individuals supported by the service. The service is following the guidance outlined in Appendix A. as regards the conditions for use of PPE.

- Transport is a particularly critical issue when considered in the context of re-establishing day opportunities at Trindlemoss. Discussion with colleagues in transport has been initiated, and it is hoped to have day opportunities available in some form in line with Phase 3 of the local mobilisation timetable. It may be that the current time presents a natural opportunity to explore, where appropriate, alternative transport options for individuals. Further information regarding the re-establishment of day opportunities is provided in the relevant section below.

Re-establishing Day Opportunities

Day Opportunities offers a range of meaningful activities designed alongside the people we support to enable them to achieve their personal outcomes. During the COVID-19 outbreak the service has been closed to all individuals with staff team members being re-deployed to other service areas. Some staff have also been supporting individuals and their carers who have been experiencing particular difficulties as a result of service suspensions.

In order to establish what the ‘new normal’ might be when it is determined that some level of service can be offered there are a number of suggestions / considerations. Day services have continued in East Ayrshire in a limited way.

Reduced group working

Within the Day Opportunities building work has begun to map out how many people could safely use a space within the building (adhering to social distancing rules – as far as is practicable). Some of the smaller spaces will only be able to accommodate 2 – 3 people plus a team member.
In establishing what the groups might be consideration should be given to small groups of people who can be safely supported by team members whilst in the building. Areas of the building can be zoned and designated for particular groups. Alternative entrances / exits can be used to stagger the foot fall through the building.

Staffing levels were stretched pre COVID-19 with groups often having 10-15 attendees with 1-3 team members. This reflected in part a necessary transition phase towards a greater focus on moving individuals on to other opportunities, to a greater extent than had been realised previously. Consideration should be given to each individual's level of service and look at the possibility of reducing days, and staggering the times that people attend.
Matching team members to particular groups could also be explored, to avoid working across a large number of people. This would be informed by individual needs, but also existing relationships and shared interests.

Social opportunities in our communities will likely be reduced for some time to come. This will impact on community-based opportunities. Consideration must be given to how we can support people in their own areas. This could again involve small groups of people who live close by and who would enjoy some time in the company of others.

Social distancing will be challenging and some of the people supported may have a limited understanding of what this and/or who to implement it. PPE supplies will be essential to keep staff safe and to reduce the risk to them and the people we support. Protocols for PPE use in relation to activities including medication administration and personal care will be essential to reduce risk and assure staff.

Activities on offer

Some of what we can offer can only be established when we know fully what community resources will be on offer.

In terms of building based activities we can plan/consider the following:

- Outdoor activities – art, gardening – social distancing will be easier to achieve.
- Indoor activities – art and crafting activities, sensory based activities, music and sporting activities.

All activities will need to be re-planned and will be designed around the people who intend to participate.

We can consider how we continue to support people digitally. During the COVID-19 outbreak we have been using Skype to contact a couple of the people we support (including delivery of Wellness Recovery Action Planning), and this has proved very beneficial. There is scope to develop this further and offer group support for some activities via video group call. Consideration will need to be given to transport and how people will get to and from the building. This is a much-needed service that families rely on. The likelihood will be much reduced numbers on transport and this will impact on how many people can attend.

All aspects of an individual's support needs will be considered prior to any return. As part of this engagement with individuals and families, the opportunity will be taken to reaffirm the purpose of Trindlemoss, as a place of transition and preparation for other opportunities. We will have a complex challenge in meeting individual needs and adhering to workplace guidance.

Re-establishing Respite

Respite services provide an essential source of support for individuals and families which it has not been possible to offer over the past months. Taigh Mor is the main respite facility in North Ayrshire, with capacity for 8 individuals under normal circumstances. As part of a phased re-establishment of respite it would be proposed that capacity is created in the first instance for 4 people to be supported on site. Core to this will be identifying the cohort for whom respite is a priority in order to maintain their wellbeing and that of their carers'.

- Identify all those scheduled for respite over next (2-3) months, as well as those who have not accessed respite over the period of lockdown

- Potentially, involve existing respite staff (if not reallocated) in contacting those families (as coherent part of review process outlined above) to explore existing need

- Combine above with existing respite allocation assessments/dialogue with care managers and others to inform initial allocation

- Explore potential for other forms of respite during period of limited provision (in line with prevailing COVID-19 guidance)

Completing Tenancy Moves

The movement of people into tenancies at Trindlemoss was making good progress prior to the pandemic. As of the current time, 12 individuals are being supported within their tenancies at Trindlemoss, in line with current guidance, with a further 5 tenancies allocated but still to complete (linked in part to closure of courts and necessary legal powers not being in place). The need to safely complete these moves will be addressed as part of the planned contact outlined previously:

- Contact with these individuals by Care Managers will explore any changes in their situation, while also addressing any concerns they or their family may have regarding moving under the current conditions. Actual moves would not take place until Phase 3 of the local mobilisation plan (July to August).

- Along with communication with the individuals due to move, communication will be ongoing with provider and home care staff regarding the potential timeline for moves.

- For those who have been residing within Trindlemoss over the course of the pandemic, there will be much to learn from the experiences of supporting them over the past months. The question template suggested as forming part of the renewed contact with all clients will form part of this, but a brief set of supplementary questions could be used to capture the experiences of care staff

LD Psychology Update

The Adult Learning Disability Psychology Service is a pan-Ayrshire service providing psychological assessment and intervention for people with a learning disability living in Ayrshire & Arran. The service is embedded within each of the CLDTs in Ayrshire and also the LDS Assessment & Treatment Service based at Ward 7A Woodlands View.

The Service continued to operate during the COVID-19 pandemic using Attend Anywhere/telephone contact for all existing community referrals and working as part of the multi-disciplinary team. Throughout the COVID-19 period, the Service has continued to provide involvement 'as usual' to the LDS Assessment and Treatment Service. At the outset of Scottish Government restrictions, priority was placed upon risk assessment (using ARAF and RAG ratings, as with other A&A MH Services) and care planning in order to identify individuals at significant risk and ensure that other members of Psychology and the wider CLDT were aware of the needs of clients on Psychology caseloads in case of sickness absence or redeployment of Psychology staff.

Any individuals on waiting-lists or new referrals were contacted, as per Scottish Government principles, to identify those who required a prioritised assessment (in line with our referral criteria) or to facilitate signposting and self-help, optimising the full range of Digital Services available. Referrers were informed of outcomes. Opening cases of clients identified as 'routine' referrals was paused during the acute phase response to COVID-19.

The Psychology Service has developed detailed guidelines on how it will operate under Phase 2 of the Scottish Government Mobilisation Plans, including the on-going use of Attend Anywhere/ telephone appointments and guidelines to minimise infection risk for face-to-face assessments when these are required. Waiting-list work for routine referrals has re-commenced, albeit with the limitations on neuropsychological and neurodevelopmental assessment, as outlined within the section on ASD within this document.

ASD Updates

Pan-Ayrshire Autism Strategy

Active work on the Pan-Ayrshire Autism Strategy has continued through our Autism Co-ordinator, although some limitations on the scope of this have resulted from the pandemic. Many of the people involved in progressing the vision of the ASD strategy were required to reprioritise their workload to cope with planning demands of the COVID 19 crisis, and working practices for these individuals changed with the introduction of lockdown and social distancing. Nonetheless, although the whole Pan-Ayrshire Strategy steering group was unable to meet during the pandemic, we have made use of video-conferencing to progress the following areas:

- Work on developing an Ayrshire neurodevelopmental information app.
- Conversations on developing online neurodevelopmental support information for children, families and adults.
- Development of visual pathways describing diagnostic procedures in Ayrshire.
- Involvement in development of resources to support children with ASD and their families when children return to school after lockdown restrictions are lifted.
- Involvement with an Education work stream to introduce a pilot scheme across Ayrshire to introduce “Circle of Friends” as an inclusion/additional support tool for children with ASD.
- Development of a framework for outcomes-based support for people with ASD living in Partnership/NHS supported accommodation.

To bring to completion the above work there will be engagement with adults and children with autism and their families and carers. For the foreseeable future we will not be able to do this work face-to-face. However, we will use online alternatives to face to face interactions. We understand from colleagues working in 3rd Sector organisations for people with ASD, that on-line support has been positively received by individuals that access their services, so we hope that engagement by distance will be a positive, rather than negative, outcome from pandemic restrictions.

Assessment for ASD

Assessment for ASD is undertaken across several clinical services (CAMHS, Community Paediatrics, LD, AMH). Work in this area has been paused across services due to restrictions on face-to-face work (this being reserved for urgent cases only, and requirements for PPE if close working required, which interfere with social interaction and adversely impact validity of assessments). During the course of the pandemic restrictions, routine neurodevelopmental assessment work was paused, with new assessments not being undertaken (unless significant priorities identified), and only those aspects of existing assessments that can be done at distance (e.g., developmental history) being completed. Services are actively seeking means to operate assessments at distance via contacts at Heads of Learning Disability Psychology, Heads of Child Psychology and Child Lead Clinicians groups. Re-starting of some waiting-list cases is now beginning, but this will be restricted to situations where face-to-face assessments can be conducted without the use of high levels of PPE, which would impact on the validity of assessments.

People with Down syndrome (DS) are at significantly higher risk of dementia, particularly Alzheimer's disease, than those without DS. A baseline cognitive and functional assessment for everyone with DS, at the age of 30, is recommended by the British Psychological Society and Royal College of Psychiatrists. This provides a 'baseline' against which future changes can be measured, and reduces delays in time to diagnosis.

The Community Learning Disability Teams within Ayrshire & Arran have implemented a screening programme for dementia for people with DS. Cognition and functioning in individuals with DS are assessed, and findings summarised, by a multi-disciplinary team. Outcomes of assessments are provided to families by the Clinical Psychologist in the Team. If no concerns are identified in assessment, the individual is discharged from the screening pathway; they will be reassessed if concerns about their cognition and functional skills arise in future. If results from the baseline assessment are inconclusive then the assessment is repeated in six months, to clarify any concerns. Service evaluation, including client and carer consultation, is on-going in order to guide future development of the screening service.

Recovery Aligned to Local Mobilisation Plan Phases

	Client Contact	Team Processes	Trindlemoss Tenancies	Respite	Day Services
Phase 1 (May to June)	Mailshot to all clients explaining current status, and provisional plans for coming months. Clients prioritised for contact as per RAG scheme Contact as prioritised by team members, to include use of brief 'feedback' template (to extend as necessary into Phase 2)	Implementation of Near Me, accompanied by accessible guidance. Microsoft Teams used for profession and team meetings (NHS staff) Shift system reducing number of staff in base at any one time	As part of overarching contact plan, establish current needs of those moving to Trindlemoss. Work with individuals, families, care teams, to develop timeline for move, address barriers for this, and resolve outstanding issues (to extend as necessary into Phase 2).	Over course of Phase 1 and 2: Identify those who should have received respite over period to closure. Reflecting ongoing contact by community team, identify all those for whom respite provision is a priority. Work with provider to establish initial safe allocation and staffing framework	Over course of Phase 1 and 2: Work with Trindlemoss staff and others to develop potential delivery program. Build on contact by Community team members to identify individuals to prioritise for attendance. Explore possible transport solutions with Transport and individuals prioritised. Linked to continuing engagement via Community Team, explore allocation of days for all attending Trindlemoss, with a view to facilitating gradual progression towards fair provision for all as possible.
Phase 2 (June to July)	Explore re-introduction of group work, facilitated by technology initially (in partnership with Day Services) Continue promotion and use of Near Me, NHS Ayrshire and Arran app, and other resources	Explore Teams use across the entire integrated team, including Day Opportunities, for referral/allocation. Review and revise shift system with a view to maximising use of available venues, including non-traditional ones.	Work with Trindlemoss Care team to review provision to existing tenants. Use this info to further inform planning regarding pending moves.		

	Client Contact	Team Processes	Trindlemoss Tenancies	Respite	Day Services
Phase 3 (July to August)	Limited re-introduction of physical group sessions with individuals and in spaces that will accommodate prevailing guidance. Analyse and report on data collected using template. Communication to all active clients regarding service status, future delivery, using electronic means to the extent identified via info gathering in Phase 1.	Progress manageable mechanisms for capturing and reporting on service activity, in the interests of tracking demand/impact.	Where possible, implement moves to new tenancies.	Open respite to limited provision, reflecting allocation and staffing exercise.	Open Day Opportunities for to initially allocated clients. Continue to refine allocation in line with developing situation. Continue to work with staff and clients develop programme of activities in line with possible use of space and available community opportunities.

Appendix A. Guidance on Client Contact

New & Return Appointments

- All patients who have been allocated to a clinician will be contacted by telephone in the first instance to offer an initial assessment appointment using Near Me, or if unable to use this, via telephone.
- Where possible all patient appointments will continue to be offered through Near Me or phone contact.
- Contact with family or paid carers will also be offered via Near Me or telephone.
- If a patient is self isolating or categorised as shielding then an alternative date for the assessment will be offered once self isolation and/or shielding period has passed.
- Patients will be called on the morning of the appointment by admin (or the clinician) to check whether the patient or a member of their household is presenting that day, or in previous days with symptoms of COVID-19. If this is the case, the appointment will be delayed in line with Scottish Government guidance on isolation periods.
- If a patient arrives and COVID-19 is suspected, the appointment will be terminated immediately and patient advised to return home and seek medical advice
- Staff also need to be aware of their own physical health status – if any symptoms of COVID-19 are suspected the appointment will be cancelled immediately and the clinician will follow NHS A&A COVID-19 reporting advice & procedures.

General Appointment discussion:

- Appointments can take place in any location across Ayrshire as long as relevant control measures can be implemented
- Asking patients to travel could put them at greater risk of exposure in the community / public transport
- Where possible, have a room within the clinic area / department designated for these appointments.
- Maintain social distancing within waiting areas and clinic rooms
- A time gap is required between face-to-face appointments in order to allow social distancing and cleaning of equipment
- No current requirement to check patient temperature, unless clinically indicated.

PPE

- Only required within 2 metres of the patient
- Staff to wear gloves, apron and Type 11R fluid resistant surgical face mask

- Eye protection only required if risk of splashing or spraying of bodily fluids
- Where a time gap is in place between appointments, all PPE should be single use
- If clinics become busier and the time between appointments is reduced, masks can be sessional use.
- PPE will be available in the clinic areas. Link with Senior Charge Nurses / Practice Managers to ensure appropriate supplies

Clothing

- No additional need to change clothing between patients (only if contaminated)
- Normal guidance applies to uniforms e.g. travelling, laundry, bare below the elbow

Hand Hygiene

- As per world health organisation 5 moments
- Alcohol hand rub appropriate (except where hands are visibly soiled or following contact with bodily fluids)

Cleaning of Environment / Equipment

- Routine cleaning with general purpose detergent between patients
- If a symptomatic patient attends the area or there is body fluid contamination – decontaminate with chlorine releasing agent at 1,000ppm concentration (1 tablet per 1 litre of water), unless otherwise instructed by the manufacturer
- Ensure only essential items are kept in the room
- Writing assessments – encourage the patient to clean their hands before the task, file notes as normal, staff can decontaminate their hands after handling the notes

Appendix B. Physiotherapy Provision during the COVID-19 Crisis

Community Learning Disability Physiotherapy Service COVID-19 update 17/04/20

The Community Learning Disability Physiotherapy Service will adapt as required over the coming weeks and months, in response to staffing, re-deployment and clinical demand.

Current service is detailed below, however will be subject to change as necessary.

Current caseload:

- Where appropriate/required a telephone review with relevant advice provided.
- Remote consultation utilising Near Me appointment as appropriate.
- Provision of relevant advice sheets and home exercise programme.
- Use of Giraffe exercise platform as appropriate.
- Face to face home visit appointment considered if deemed absolutely essential and all above options have been considered or tried.

New referrals and those on current waiting list:

- Telephone contact made with individual or care provider/family.
- Remote consultation utilising Near Me appointment as appropriate.
- Provision of relevant advice sheets and home exercise programme.
- Face to face home visit appointment considered if deemed absolutely essential and all above options have been considered or tried.

Appendix C. Speech and Language Therapy Provision during the COVID-19 Crisis

Speech and Language Therapy Service Update – Adult Services

Due to the outbreak of the Coronavirus (COVID-19) and in line with national policy, we are required to prioritise our services to support the wider organisation of NHS Ayrshire & Arran.

This has led to the temporary reconfiguration of our services to ensure support for the most unwell across Ayrshire and Arran.

We are continuing to offer a service to support clients who:

- Have high risk, new or increased severity, and unmanaged dysphagia,
- Require dysphagia and communication support to facilitate management within patient environment
- Require community support to stabilise discharge or avoid admission
- Require communication support in decision making discussions in relation to discharge and potentially life changing decisions

We will post regular updates via our Twitter pages:

- @NHSaaaAdultSLT
- @weepeoplechat

We will provide information via these pages when our normal SLT services resume.

Appendix D. Dietetics Provision during the COVID-19 Crisis

Community Learning Disability Dietetic Service

The dietetic staff continue to provide a service to the Community Learning Disability Teams during this period of sustained transmission of COVID-19 Current service is detailed below, however will be subject to change as necessary.

Current Caseload:

- Where appropriate telephone reviews are made with advice provided
- Remote consultation via Near Me is offered where appropriate
- Provision of relevant written dietary information/ Signposting to relevant websites/Apps
- Liaison with Nutrition Nurse Specialist and Fresenius Homecare to support home enteral feeding. Dietetics continue to order and supply plastics as and when required for internally fed patients (North Team only). Plastics continue to be supplied by District Nursing teams in the South.
- The Wheelchair weight clinics led by Dietetics at both Douglas Grant Rehab Centre, Irvine and Arrol Park, Ayr are currently suspended until further notice.

New referrals:

- We continue to accept new referrals through the teams as normal
- Initial contact will be made via telephone
- Remote consultation via Near Me as appropriate
- Provision of relevant written dietary information/signposting to relevant websites/Apps
- A face-to-face appointment would be considered on an individual basis, if deemed absolutely essential. This would adhere to current Government Guidelines with the use of required PPE.
- Dietetics can be reached on **01294 323234 (North Team) and 01292 614931 (South Team)** and a voicemail can be left on our answering machine if no one is available. This will be checked at regular intervals.
- We also have a clinical mailbox: clinicaldieteticsmh@aapct.scot.nhs.uk
- There is currently no LD Dietetic cover on Mondays. Urgent Dietetic enquiries are directed to the Team Lead (01294 279 222) or by emailing the clinical mailbox.

Workforce

Allied Health Professions in Mental Health Services

Section 2.3 details the current and anticipated pressures on Allied Health Profession (AHP) services across Ayrshire and Arran, in terms of need for physical and mental health recovery and rehabilitation.
With specific regard to mental health, the Allied Health Professions play a critical role in supporting service delivery and personal outcomes. Previous exercises to benchmark the AHP workforce against comparable services elsewhere, and evidence, guidelines and best practice, highlighted deficit in the AHP workforce, including that in mental health services, pre COVID-19.

AHP Input to In patient Mental Health Services

From an inpatient mental health perspective, access to the AHPs – Dietetics, Occupational Therapy, Physiotherapy, Podiatry, Speech and Language Therapy, continues. New referrals are triaged, with high risk cases being supported as appropriate. Routine group work, therapeutic activity, new inductions to the inpatient gym facilities are currently paused. These will resume within the limitations of social distancing measures, in line with recovery plans, and as staffing levels return to usual.

AHP Input to Community Mental Health Services

For community mental health services, Occupational Therapy is a core component of the interdisciplinary teams. As such, generic tasks have been supported within the teams during the pandemic, in line with high category activity as detailed above by each service area. Specific, routine occupational therapy interventions have been paused at this time. The limited scale of occupational therapy, with teams sensitive to the impact of unplanned leave, has historically resulted in waiting times around and beyond 18 weeks - within adult community mental health services in particular. Increased referrals to occupational therapy are anticipated across mental health services as a result of the direct and indirect impacts of COVID-19.

For the other AHP services in mental health, which are generally accessed via onward referral, triage continues to support high risk new referrals, with vulnerable existing caseloads receiving regular contact and support as required.

Community referrals to the physiotherapy mental health team have reduced during the pandemic period, but with anticipation of rising demand as lockdown measures relax and the impact of social isolation and inactivity are realised. Again, baseline capacity within the team is limited. Across the

elderly and adult community mental health teams, for example, the total establishment for physiotherapy is less than 1WTE per HSCP area.

Demand for the Dietetic mental health team has remained relatively static during this time, again with high risk new cases and vulnerable current cases being supported through predominantly digital methods. Previous initiatives have highlighted the limited provision of speech and language therapy across mental health services, and the challenge in quantifying unknown, unmet need.

Some specific treatment options – for example, rebound therapy, hydrotherapy, group therapeutic activities – and routine review appointments have all been paused during this time, largely to support redeployment of staff to high category activity, and reduce unnecessary footfall on hospital sites.

Workforce and Interdependencies

Additional AHP staff have been secured via the NES Portal, and are now starting to commence fixed term posts. Those AHP staff previously redeployed to acute areas in the early stages of the pandemic are now beginning to return to substantive posts, in readiness of resuming previously paused activities. This repatriation requires sensitive balance so as not to compromise continued need within acute areas whilst beginning to restart previously paused activities and will therefore take some time.

In addition to the aforementioned workforce challenges faced prior to COVID, social distancing measures will impact upon working patterns, clinical capacity and treatment options. Shielding, and the continued variation to education provision will also likely impact on availability of AHP staff during usual working hours, with the need for greater flexibility. A continued pace will be required around the roll out of digital devices in support of agile working practices to facilitate this. The wellbeing of staff will continue to be of paramount importance during these times of change.

Physiotherapy

- Adult mental health wait time now 28 weeks, demand has dropped by 80% during lockdown period
- Elderly Mental health wait time now 14 weeks, demand has dropped by 50 % during lockdown period

Podiatry

- The pan-Ayrshire Podiatry 'Enablement' pathway has a current existing Care Home and Domiciliary 'adult and elderly mental health' caseload of approximately 1750 patients category 'C' that have been placed on hold. As we move into the next phase, the Podiatry Service envisage this as an area of pressure on top of pan-Ayrshire existing podiatry clinic patients of approximately 4500 pts that have also been placed on hold during Covid-19.

Additional AHP resource for Mental Health

An exercise is underway to use workforce tools and professional judgement to quantify the additional capacity required to meet anticipated increased demand across AHP services, including those in mental health. Meantime, a crude estimate has been made, based on areas of pressure prior to COVID, and anticipated increased demand based on evidence and learning from elsewhere.

Based on the above, and prioritising the estimated additional resource required for AHPs in mental health services across Ayrshire is as follows, with the priority for any additional resource being within adult and elderly community mental health services :

	B5	B6	TOTAL
Dietetics		2WTE	88K
Occupational Therapy	2WTE	3WTE	204K
Speech and Language Therapy		1.5WTE	66K
Physiotherapy		3.0WTE	132K
Podiatry	1.5WTE		54K
TOTAL	**4.5WTE**	**8.5WTE**	**544K**

Nursing Mobilisation

In meeting the requirements of phase 2 of the mobilisation plan, nursing will play a pivotal part in the proactive and continued development to ensure best use of resources. Within in-patient services the re-alignment of services to offer specific indicated assessment area has released numerous staff to assist and support areas of shortfall and this has proved absolutely essential in moving forward. In addition all of the year 2 and year 3 pre-registered mental health students have been employed into band 3 and 4 posts within the in-patient areas, proving to be very effective along with a very unique learning experience. As we move onto the next phase, it is recognised that community workload will increase, and with this some of the pre-registered students will move back to their community base placement and continue to be an invaluable resource.

Community services have already set out a plan for offering extra hours and overtime as required within their own teams, however and crucially so with the competency and skill set of our nursing teams, movement of resources to meet demand is in place. This will allow a potential pan Ayrshire provision across services and will include in-patient areas as required.

To further bolster increased demand and mobilisation, the Nurse Bank are currently interviewing an additional 30 plus Registered Staff over the next few weeks, with a further advert for Registered Staff going out soon. They are holding a mass recruitment of Nursing Assistants over June and July which will provide more availability of Nursing Assistants to Acute and Partnerships, also Nursing Homes if required. With Nursing Homes and following testing of staff we are proposing a shadow roster system to cover any shortfall if any large number of staff need to isolate at any one time.

6. Digital Support

Use of digital technology

The use of digital technology has been a significant enabler during the current COVID-19 emergency. It has facilitated the continuation of essential health care across Ayrshire and Arran. Our increased use of new ways of working and technology during this period has highlighted the many opportunities for change.

During the pandemic digital services have delivered a number of significant benefits and will continue to do so. This will include agile working, and remote access allowing to work from anywhere at any time securely. The successful and rapid deployment of teams has had a direct benefit to patient care by allowing clinicians to collaborate across the traditional boundaries.

Specifically, to support the Boards activities to date Digital Services have delivered solutions that have provided significant benefit including:

- Remote working for the majority of staff
- Increased capacity for clinical portal
- Deployment of ECS to independent contractors
- Rapid deployment of MS teams to assist with collaboration, cross boundary
- Virtual visiting devices for patients without any communication methods
- Deployment of NHS Near Me
- Increased capacity and coverage of public Wi-Fi
- Increased capacity of links to several community sites
- Procured and commenced implementation of two additional TEC solutions
- Development of a radiology home working solution

We will look to build on this as we move into phase 2 mobilisation and beyond into the future. Technology Enabled Care will play an integral part in providing pathways to help us delivery high quality health care services in a modern and inclusive way and ultimately improve health and wellbeing across Ayrshire and Arran.

The use of digital services and associated technology with a particular focus on TEC to support long term conditions from primary care to acute services combined with effective use of NHS Near Me will ensure that the significant majority of outpatient/GP appointments can be carried out safely, remotely. Through effective engagement with clinicians we will ensure that we both lead on and fully support remote health monitoring from a patients residence.

Immediate areas of focus will include continuation and expansion of remote appointments, remote monitoring programmes, improving our use of data, wider deployment of the clinical portal across our entire system and maximising our use of office 365 to increase collaboration to improve organisational efficiency and patient care.

With reference to the remote monitoring letter from Caroline Lamb dated 21st May our assigned programme manager will work alongside the senior clinical lead to deliver appropriate TEC solutions to support care at home across all disease groups and for all health and social care services. We will deploy the most appropriate solution for the patient cohort utilising our existing TEC team supplemented by additional Digital Services resource as appropriate. Wherever possible we will integrate the data from these TEC solutions in to our clinical portal ensuring a consistent view across Ayrshire and Arran.

7. Testing and Test & Protect

7.1 Testing for COVID-19

A large part of the response to the COVID-19 pandemic is effective testing. Both the UK Government and the Scottish Government have laid out their testing strategy including the requirements from Health Boards.

Societal responses to COVID-19 have changed markedly over the course of the pandemic, and there have been seismic changes even within days. We have moved from no testing to a mass roll out of testing to support a wide range of functions. These continue to change, largely by Public Health Scotland and clinical judgment but at times due to political strategy. With this in mind, we require to be flexible with our response and be able to flex to suit the needs.

The purpose of testing is:

- Identification of positive cases;
- Prioritisation and determination of appropriate clinical treatment;
- Early identification of outbreaks and to enable appropriate infection control arrangements to be established;
- Appropriate isolation arrangements to be put in place to slow the spread of transmission;
- Identification of negative key staff members and/or their family, allowing them to return to work; and
- Supporting enhanced surveillance.

To develop the strategic approach to manage the dynamic and wide ranging demands on COVID-19 PCR testing resources with the aim of maximizing and optimizing use of COVID-19 PCR tests whilst controlling demand to mitigate impact of COVID-19 by.

Strategic Objectives

- Maximising testing capacity;
- Understanding clinical demand;
- Use of prioritisation when required (demand exceeds capacity, temporary or longer term);
- Steam lining and utilizing data; and
- Keeping R <1 in combination with other measures

The eligible groups for testing are wide ranging. These include:

- care home residents and staff who are living and working in a care home where there is an active outbreak of COVID-19;
- care home staff and a proportion of residents who are living and working within a care home where there is no active outbreak of COVID-19;
- all those aged over 70 years of age admitted to hospital after the 29th April 2020 (tests repeated every 4 days);
- patients who have been diagnosed with COVID-19 returning to their care home;
- all residents with no diagnosis of COVID-19 returning to their care home after a hospital stay;
- older people within the community wishing to move into a care home;
- symptomatic key workers or their symptomatic household contacts;
- anyone over the age of five years of age who have symptoms of COVID-19;
- Clinicians within secondary and primary care can also test symptomatic or asymptomatic individuals as a necessary part of their clinical diagnosis;
- as primary care and secondary care services return to full capacity following the pandemic there will be a requirement to test more asymptomatic individuals prior to surgery, treatment or procedures.

NB testing policy is rapidly changing: more groups are likely to become eligible for testing as laboratory capacity increases.

We plan to increase our testing capacity to ensure we meet the needs of the citizens of Ayrshire. This will include utilising our local laboratory, the Lighthouse Facility and additional regional laboratory services to meet projected demand. We are planning for our in-house and additional regional laboratory testing to support the analysis requirements over the next 3 months. Please see summary below:

Testing Cohorts	Projected average numbers of tests per week based on current activity
Staff and Household Contacts	200
Acute wards and ICU symptomatic testing and asymptomatic over 70s testing	250
Community Outbreaks	150
Discharged Patients	130
Pre-Op Testing	150
Care Home Testing Outbreaks (staff & residents)	700
Care Home Testing No Outbreaks (staff & residents)	300
Enhanced Surveillance	80

We plan to utilise the Lighthouse Testing Facility in Ayrshire to test those identified as contacts via Test and Protect contact tracing programme, community testing for the over 5 years symptomatic population along with all key workers.

Testing for COVID-19 on this scale requires significant resource to perform the tests, analyse, disseminate results and provide specific information to those who test positive in order to support them to self-isolate, establish close contacts and determine which other individuals require to be tested and self-isolate. These are predominantly manual processes which at this time being completed by staff who have been released from normal duties during the COVID-19 pandemic. As services return to normal many of these staff will be required to return to their substantive posts therefore additional permanent staff will be required to support this new service, this could be up to 20 WTE staff in total.

7.2 Test & Protect

National COVID-19 contact tracing is due to commence in May 2020, and could be in place for up to two years. Contact tracing may have a significant impact on business continuity. From May 25th 2020, Health Boards will be required to conduct contact tracing of all individuals diagnosed with COVID-19. NHS Ayrshire & Arran are rapidly progressing our local approach building on our existing experience of supporting individuals with positive results and managing outbreak situations in the community. We have 34 staff in place by 1st June and will have a further 77 staff on board by 1st July. Digital support and remote working will be essential for these staff and we are progressing this work. We will draw on our wider workforce in the early stage of the process blending expertise from across the organisation.

Individuals diagnosed positive for COVID-19 will require to, not only isolate for 7 days from the onset of symptoms, they will be asked to provide a full list of their contacts to the NHS contact tracing team, to include from 48 hours before symptom onset to 7 days after. Contacts will be divided into those for 'Active' follow-up and 'Passive' follow-up. Those assigned to Active follow-up will require self-isolating for 14 days from the date of the case's positive test. Those assigned to Passive follow-up will only require self-isolating if they develop symptoms. If contacts develop symptoms, they must self-isolate for 7 days.

Both testing of individuals along with the associated analysis, dissemination of results plus the additional resource heavy contact tracing and the potential of advising cohorts of staff to self-isolate will affect NHS Ayrshire and Arran's overarching mobilisation plans. With flu season only 4 months away, the upcoming winter pressures along with the ongoing opportunity costs associated with the new normal and necessary focus on COVID-19 over the next 2 years each element of the Health and Social Care system will be dependent on the outcomes of testing and contact tracing.

8. National Programmes

8.1 Bowel Cancer Screening Programme

NHSAA participates in the bowel screening programme, receiving referrals from the Scottish Bowel Screening Centre for citizens who have returned a home bowel screening test and for whom the results suggest that there may be an abnormality. Once referred to NHSAA these patients undergo a colonoscopy procedure.

In Phase 1 of the pandemic the colonoscopy service was suspended on the advice of the British Society of Gastroenterologists (BSG) due to evidence around the level of risk. This has lead to a backlog of 228 bowel screening patients awaiting colonoscopy, in addition to 239 patients awaiting colonoscopy following GP referral.

In Phase 2, colonoscopy services will be re-started in line with revised guidance from the BSG. However the capacity to undertake these procedures will be significantly reduced as outlined in section 3.4.2. It is currently estimated that once resumed, the colonoscopy capacity will be limited to about 40-50% of the previous capacity. On this basis it is anticipated that it will take around 5 – 6 months to clear this backlog and it is recommended that the National Bowel Cancer Screening programme does not resume until this backlog has been cleared.

8.2 Breast Screening Programme

The south west Scotland Breast Screening service is based at Ayrshire Central Hospital, supported by a mobile screening van. During Phase 1 of the pandemic, breast screening services across Scotland were suspended.

For patients whom had already been referred to the breast service in NHSAA with symptoms or abnormal mammogram, the breast service in NHSAA continued. Some adjustments were made, moving the breast clinics normally held at UHC to the Breast screening unit at Ayrshire Central Hospital in order to allow continuation of the face to face consultant and nurse-led clinics where this was necessary.

Some breast surgery was able to continue through Phase 1, undertaken at Nuffield Hospital, however a proportion of patients who could be managed in a different way, and whose surgery was less time critical have had their surgery deferred for a few months.

Moving into Phase 2 there are 45 patients whose breast surgery was deferred, but who now require their surgery. Current plans are that this will be undertaken in NHSAA for these patients. Most of these patients require procedures which can't be undertaken at Nuffield Hospital due to the equipment required, however during phase 2 we will continue to use of Nuffield Hospital for appropriate cases for as long as access there can be continued.

It is expected that this backlog of breast surgery will take 4-6 months to recover, and it is recommended that the breast screening programme should remained suspended until the autumn 2020.

8.3 Abdominal Aortic Aneurism Screening (AAA)

NHSAA participates in the AAA screening programme to detect Abdominal Aortic Aneurysm in men aged 65. The AAA screening programme uses the Community Health Index as a register of men aged 65 in Scotland. The gentleman who are eligible for screening are offered an ultrasound scan. Where an aneurysm is detected the patient will be managed depending on the size of the aneurysm, Outcomes include, discharge, quarterly surveillance, annual surveillance or immediate referral to vascular services if aneurysm measures over 5.5cm. The British Vascular society has recently advised it is now not safe to operate on any person with an aneurysm measuring less than 7cm.

In Phase 1 of the pandemic the ultrasound scanning was suspended initially until the end of May and then extended until the end of June in line with Scottish Government guidance that screening programmes should pause. As a result of suspension of this programme there are now 890 men aged 65 or over who have not as yet been offered a scan. There are 29 men who were due to have their quarterly surveillance scan and who have not as yet received this and there are 26 men who were due to have their annual surveillance scan who are still waiting for this. There is therefore a total backlog as at end June 2020 of 945.

In Phase 2, discussions are still taking place as to what might be possible to reinstate. The capacity to undertake any ultrasound scans is dependent on the sonography and technical assistants being available to run sessions. The capacity to undertake the scanning will be reduced by approx. 50% meaning we will see patients at 30 minutes intervals to allow for appropriate cleaning and changing of PPE at all 3 screening locations, Ayrshire Central, North West Centre and University Hospital Ayr will all be suitable to ensure appropriate social distancing and safe patient flow can be in place. On this basis it is anticipated that the service will commence by offering scans to those patients in the 3 month surveillance group before commencing a service to the new patients.

There has been no confirmed start date, this is being reviewed on a daily/weekly basis.

8.4 Cervical Screening Programme

NHSAA participates in the cervical screening programme with the majority of cervical screening being performed in Primary Care. If an abnormality is found then the patient is referred to the Gynaecology service and is seen in the Colposcopy service.

In Phase 1 of the pandemic all cervical screening was paused. The Gynaecology service continued to review patients that were vetted to Colposcopy as Urgent Suspicion of Cancer. There was minimal disruption to this service during phase one.

In Phase 2, the Gynaecology service plan to continue to review Urgent Suspicion of Cancer vetted to colposcopy. The gynaecology service would be able to support re-instatement of the cervical screening programme from early July.

8.5 National Cochlear Implant Programme

The national Cochlear Implant Programme is run from UHC. This is a surgical service which fits a device for individuals with moderate to profound hearing loss which is then specially programmed to provide the individual with sound.
During Phase 1 of the pandemic, the cochlear Implant programme was suspended as a non-emergency service.

During Phase 2, cochlear implant surgery and programming will be re-started but only for the highest priority patients. These will be younger children for whom the timing of cochlear implantation is critical in their development of speech and language, and ultimately their future

integration into society. This subset of patients are considered as Category 3 in the Royal College of Surgeon matrix. The remaining cochlear implant patients are considered in Category 4, and so the re-start of this subset will be later in the pandemic process.

9. Infection, Prevention & Control

9.1 Infection Prevention & Control – Support & Advice

During Phase 1 and our emergency response to COVID-19 there have been a number of phases of activity for the IPCT in managing the emerging pandemic. These can be described as:

- Awareness Raising
- Review of Pandemic Plans
- Admission of Suspected Cases for Testing
- Emergence of Confirmed cases
- Peak Pandemic Activity
- Increasing Green Pathway Activity

These phases are not strictly marked in time and overlapped however they do describe the pandemic progress.

As it became evident nationally that the virus was spreading there was a significant increase in preparations across the organisation for management of suspected and confirmed cases across the organisation. The demands for support from the IPCT escalated rapidly. As a result much of the routine IPCT activity which had been declining since the emergence of the novel coronavirus now ceased. This included:

- Standard Infection Control Precautions (SICPs) and Environment Audit Programme
- All non-COVID-19 education and training
- Support for HAI SCRIBE and Build Work
- Non-COVID-19 committee and group work, e.g. Decontamination Committee
- Policy, guideline and SOP review programme
- General IPCT presence in clinical areas

Non-COVID activity was primarily restricted to:

- Alert organism surveillance
- Non-COVID-19 outbreak and incident management
- Water safety – continue to assess high risk areas for signs of Pseudomonas infection with potential links to water system.

At this time the CNO issued guidance with regard to cessation on a temporary basis of the national routine infection surveillance programmes.

As the organisation moves into Phase 2 and plans to resume services, advice and guidance from the IPCT will be crucial in order to manage and mitigate the associated risks as we maintain COVID-19 and non-COVID-19 patient pathways.

In addition the ICM and ICD, in close collaboration with the Nurse Director as HAI Exec Lead have begun to consider the prioritisation of routine IPC activity and how to phase the resumption of key elements of this important work.

The Control of Infection Committee has resumed its business meetings in May 2020 and will report into the Healthcare Governance Committee when it meets in June 2020.

The resource requirements for ICP activity, support and advice going forward need to be modelled and reviewed to ensure that we can meet:

- continued COVID-19 / non-COVID-19 advice needs, including outbreak management
- plan and prioritise the resumption of routine IPC activity and also
- plan to provide increased IPC support and advice to care homes as this is a significant additional requirement and current IPC resource requires to be augmented to meet this need.

9.2 PPE

Phase 1 and our emergency management phase was characterised by emerging issues with supply of personal protective equipment including FFP3 masks, full face visors and gowns. For example, at one point early in the COVID-19 scenario and in order to ensure continued provision of full face visors for ICU staff, the IPCT had to risk assess and sanction the re-use of single use face visors and provide a protocol for their decontamination. Since that time our Max Fax lab has been producing both single use and re-usable visors and out supply is now satisfactory.

NHS Ayrshire and Arran recognised the importance of PPE to effectively managing the virus and keeping our staff and patients safe and established a Bronze PPE Team to model and understand our PPE usage and demand, and map out daily stock requirements. An increase in Fit Testers was also undertaken at this time to increase testing capacity. This Bronze Team reports into the Emergency Management Team and developed a PPE Escalation Plan. It meets daily and has a member of the team ‘on call’ over the weekend to address any emergent PPE issues if required.

The Bronze Team identified that in Acute Service there was a need to support staff with understanding PPE guidance and appropriate use. To

this end a senior nurse has been released and appointed to work closely aligned to the ICPT and provide this support – which is now being done across all settings and not limited to Acute Services.

The need to identify and train volunteer peer PPE safety officers was put forward by the Bronze Team and supported by the EMT. A training programme was swiftly developed and a group of 20 trained to support colleagues across Acute Services in the first instance. As part of our Phase 2 plans training of these peer PPE safety officers is being rolled out.

NHSAA has a nominated Single Point of Contact (SPOC) and deputy responsible for coordinating the supply of Personal Protective Equipment (PPE). The Board SPOC is an Assistant Director who provides a daily status report on PPE availability to the PPE Gold Command Group (Emergency Management Team chaired by the Chief Executive). The status report links directly via a PPE product availability RAG to the agreed PPE Escalation Process that triggers replenishment and conservation actions. The actions are specific to individual PPE products. The SPOC chairs the Silver Command Group with representation at Assistant Director level across appropriate clinical and non- clinical functions from the Health Board and three Partnerships. The SPOC is supported by the Bronze Command Group comprising appropriate clinical and non- clinical representatives from the Health Board and three Partnerships. Silver Command meets weekly and Bronze Command daily. All levels of the command groups are supported by our Military Liaison colleagues.

Critical supplies are managed by the Board's Procurement function with the majority of product requirements being sourced from the NHS National Services Scotland, National Distribution Centre (NDC) via established requisitioning and delivery processes. This includes provision of PPE to both acute hospitals as well as community hospitals as part of the Health and Social Care Partnerships.

General Practitioners receive deliveries of PPE from the Board, as and when released by SG via NDC. Social Care PPE requirements are met by Scottish Government via delivery from NDC into Local Authority Hubs. The daily status report on PPE availability is being extended to capture Health and Social Care to ensure visibility of PPE availability on a system wide basis.

10. Staff Wellbeing

10.1 Staff Wellbeing Hubs

The need to support staff health and wellbeing is well recognised in both literature and practice. Across our NHS and Local Authorities there are a range of support mechanisms that have been in place and well-established prior to COVID-19. We know however that many of these initiatives are underutilised and barriers such as stigma, lack of time and core funds has limited their uptake in the times prior to the pandemic.

Our ambition in Ayrshire and Arran is to provide the best support available to our staff, ensuring they can be as resilient and as well supported as possible in these challenging days and beyond.

It is recognised that during this COVID-19 pandemic our staff are not only at risk of adverse physical outcomes but also psychological and emotional effects on their mental health. Preliminary data from China, Italy and the USA, discuss the impacts of COVID-19 on staff and early measures which could be introduced to try and minimise or reduce these risks and their long term effects. In NHS A&A we have reviewed these recommendations and suggestions which are also in keeping with the expectations of Scottish Government reflected in the letter from Minister for Mental Health Claire Haughey MSP on 26th March 2020.

There has been both a National and local response to this.

National response

The Scottish Government has set up a Workforce Wellbeing Champion Network sharing expertise throughout all the health and social care sectors. An online “National Wellbeing Hub” which will act as a ‘front door’ to the wide range of support and wellbeing resources available in Scotland. NHS A&A is participating in this network. The Hub has been developed by PRoMIS, www.promis a collaborative project between NHS Greater Glasgow and Clyde’s Anchor Service and NHS Lothian’s Rivers Centre, with partners across health and social care. It is a resource for the whole workforce, including unpaid carers, volunteers deployed within health and social care services, and their families.

Local response

Realising the potential impact of C19 on our staff, in mid-March 2020 we convened a committee involving Human Resources, Health & Safety, Quality Improvement, Public Health, Staff care, Occupational Health, Medical Peer support/Staff wellbeing rep and Clinical Psychology to establish a plan initially focusing on our acute sites where the perceived increase risk to our staff was thought to be the highest.

Staff Wellbeing Hubs

Crosshouse /Ayr Hospital Staff Wellbeing Suite (Hubs)

On the 6th of April 2020 we opened our staff wellbeing suites in UHC/UHA. The wellbeing initiatives in these areas are supported by Medical Peer Support, Clinical Psychology Service, Psychiatry, Staff care and Chaplaincy as well as Domestic services. We aimed to provide a safe space for **ALL** staff to access, providing access to a variety of facilities and resources to support their physical and emotional wellbeing. The following support is offered:

Staff Wellbeing suites are situated within:

1. University Hospital Crosshouse	-	Maxwell suite
2. University Hospital Ayr	-	Occupational Therapy department

Available within the Suites

- Information about your health and wellbeing and signposting to appropriate services if required.
- Access to Medical Peer Support (Mon – Fri 9-5pm) Oncall phone advice 24/7
- Access to Clinical Psychology / Psychiatry (Mon –Fri 9-5pm)
- Access to Staff care
- Information on showers and oncall facilities
- Information on rooms available if staff were requiring to self isolate/ or chose to be apart from their families
- Prayer room
- Team meeting (debrief) room
- Free Hot / cold drinks and snacks
- Meals for staff unable to go home
- Quiet area with access to mindfulness activities/headphones/ massage chairs /comfortable seating.
- Bedroom / Restroom (4 in Wellbeing Suite & 5 in Audiology Dept)
- Toiletries/Towels/scrubs
- TV
- Games/ magazines/puzzles
- Exercise bike, weights, table tennis, yoga mats
- Open 24/7

Access to psychology services via clinical mailbox or can be made directly in suites.
Clinical_StaffWellbeingPsychologyServices_COVID19@aapct.scot.nhs.uk

Peer Support Programme

Medical Peer Support

Referrals can be made through a confidential mailbox to access to Medical Peer support. MedicalPeerSupport@aapct.scot.nhs.uk.

We already have an established medical peer support programme in Ayrshire and Arran for Consultants and Scottish Ambulance Service doctors, however during this COVID-19 pandemic we have extended our role to support all medical staff. We have increased our peer supporters' numbers from 14 to 28 and trained them in basic peer support and psychological first aid principles. We are currently working on both sites to establish medical trainee peer supporters and have extended our support to all medical trainees in the organisation.

Nurse peer support /input from staff care

Currently our staff care teams and volunteer senior nurses are also receiving training on peer support based on CISM principles which will also be available in these sites.

10.2 Staff Sanctuaries

Along with our staff wellbeing suites we opened up both of our chapels as other areas for staff to have a quiet area to reflect or speak to a trained member of staff if required. This also ensures we had enough areas for staff to safely social distance.

Our Staff Care staff and chaplaincy staff are situated within these areas in both UHA and UHC sanctuaries. We have overspill areas for staff in our volunteer areas. Staff from all health and social care areas can come along to have a quiet moment or speak to one of the team who offer a compassionate listening service. The sanctuary provides a very relaxing safe space for staff to unwind with the ambience required providing gentle music, aromatic smells and dimmed lighting. The sanctuaries have had many staff visit; some for quiet reflection, others for a supportive conversation. Staff have expressed gratitude for this support, saying it is so beneficial to be able to leave their work areas for a short time to ground themselves. These areas also have access to free tea/coffee/snacks 24/7.

A Staff Care Helpline ensures that all staff can access support if they are unable to attend the sanctuaries by telephone 07824 596 511 or email Access staff care mailbox.

The Clinical Psychology team has provided the staff care team with an essential level of supervision and guidance throughout this process and as mentioned above, important established links have now been made between Staff Care, Occupational Health, Clinical Psychology and Medical peer support within our organisation ensuring staff are seen quickly and efficiently by the correct team reducing potential time absent from work and waiting for referrals.

During the first 2 months we have collated data detailing the use of the suites and sanctuaries. There have been 4612 visits to the sanctuaries in total and in excess of 1200 visits to UHC wellbeing suite over a snap shot week. (10/5/20 – 17/5/20).

We are currently collecting data from the areas using a combination of surveys and capturing verbatim quotes as well as recording minimum reflective logs and formal clinical psychology notes.

The wellbeing team made up of Clinical Psychology, Medical peer support and Staff Care have been involved in group-work aimed at promoting staff wellness and have led sessions with staff from ICU/ED/Theatres/ redeployed ward staff . The team has been approached directly by staff seeking help and we have also “reached out” to other staff groups to offer similar sessions over the coming weeks.

Our data so far shows a consistent positive reflection on the services available with an overall need and want by staff for these areas to stay beyond COVID-19. The human connection and overall feel of these units is reflected in the positive feedback we have received to date.

Our aim would be to continue to listen and respect our staff on what is important to them with regards to their wellbeing at work, to continue to seek out ways in which we can work collegiately to ensure we have the best and most resilient workforce going forward.

10.3 Wellbeing Centres

Following on from the above, we have now established 2 wellbeing centres at Woodland View Hospital and Ayrshire Central Hospital.

Community staff - Staff Wellbeing Suites (Hubs)

Community Wellbeing Hubs have been developed across the three partnerships. The (drop in) Hubs are available for all staff within the Partnership who are working within the community. More detail on these hubs is provided below. These additional community supports are being well evaluated and use is increasing.

East Ayrshire

East Ayrshire Health and Social Care Partnership (HSCP) Staff Wellbeing Hubs are open Monday to Friday between 10am and 4pm in three locations:

- Rosebank Centre, Kilmarnock
- Boswell Centre, Auchinleck
- Loudoun Leisure Centre, Loudon Campus, Galston

North Ayrshire

There are now two staff wellbeing hubs available for our community-based care at home staff in North Ayrshire. Kilbirnie and Saltcoats library are now open from 8am to 5pm Monday to Friday. Care at home staff are welcome to drop in before or after their shift, or indeed during their breaks. Teas, coffees and other refreshments are available in an environment conducive to some comfortable down-time. Information on a whole number of things from PPE to staff support is also available.

We have restricted these hubs to only the HSCP care at home staff just now, simply to ensure that the numbers are manageable and we are able to provide this resource while ensuring social distancing measures are adhered to. We hope that over the coming weeks, we will be able to open hubs in other localities and to widen out access to all community-based staff across the partnership and our third and independent sector colleagues, including those working within care homes.

A third hub is available within the Training Centre on the Ayrshire Central site in Irvine. Open from 9am to 5pm Monday to Friday, this hub is open to all HSCP staff.

South Ayrshire

Three community staff wellness hubs have been developed across South Ayrshire for staff from South Ayrshire Health and Social Care Partnership, and care home and care at home partners. The hubs, which will be unmanned, have been designed to provide private drop-in spaces where community staff can go on their own or to meet up with a buddy, have a cuppa and take some time to meet their needs.

Tea, coffee and information on wellbeing resources and staff support helplines will be available in the hubs:

- Arrol Park Therapy Building available Monday to Friday from 8.30am to 4.30pm
- Girvan Community Hospital Quiet Room available Monday to Friday from 8am to 6.30pm
- Biggart Hospital Conference Room Monday to Friday from 8am to 7pm

10.4 Staff Listening Service

In additional to the staff sanctuaries and wellbeing centres a staff listening services is also being established.

Following discussions at the North Ayrshire HSCP Senior Management Team with representatives from many care delivery settings and organisations, at the Nurse Director's Professional Leadership Group, with Senior members of Public Health and the Pan Ayrshire Staff Wellbeing Group, it was agreed that a wider dedicated staff listening service should be established to augment expand the support arrangements already in place throughout Ayrshire & Arran.

The nature of this service will be in the form of a call centre managed by a Senior Mental Health Nurse who will oversee the structure, operational management and day to day running of the service. They will also be responsible for developing governance routes, escalation protocols in conjunction with Psychology and Mental Health Services and align these where appropriate to current pathways of escalation for specific staff groups. The Senior Nurse will also support call handlers in both responding to calls in real time and any required escalations. They will also be the first point of contact for supervision and support for the call handlers to ensure their own wellbeing is maintained. It is anticipated that the listening service will be operational by the end of May 2020.

The organisational Occupational Health Service continues to provide ongoing support to staff and managers in all HSCPs.

Next steps

Sustaining the huge progress that has been made supporting staff wellbeing is a priority for the Board and Health and Social Care Partnerships.

Our ambition is to provide the best care to our citizens by staff who are as good as they can be. In the current circumstances, staff have to remain well to provide this high quality care. This has greatly improved relationships, support and connectedness. The learning from this rapid expansion of our existing staff support and the positive feedback is that we need to sustain this in the next mobilisation phase. Evaluation is ongoing and it is likely to be a priority to maintain these staff support structures beyond COVID-19 to match our ambition to build the best workforce that supports the best care for our citizens.

10.5 Health & Safety

Whilst COVID-19 has resulted in a different type of working environment from that which was previously in place, NHS Ayrshire & Arran has continued to meet our legal duties in relation to the Health and Safety. During phase 1 our focus has been in supporting staff to work from home utilising technology and ensuring the provision of PPE for our staff.

As Scotland prepares to move into a new phase, NHS Ayrshire and Arran is addressing Social Distancing in the workplace and preparing for increased footfall within our premises. Social distancing has introduced a new risk to the workplace and has challenged our view on how we manage and organise services to minimise transmission. To manage the risk, NHS Ayrshire and Arran is implementing a process to risk assess all our workplaces to ensure that we meet the requirements of social distancing and where we are unable to do this, implement the necessary mitigation measures. This includes a focus on ensuring staff apply social distancing at work through enhancing staff awareness of the measures that can be taken. These range from using PPE, keeping a safe distance to regularly washing hands and ensuring shared surfaces are cleaned after use.

A short life group has been established with a specific remit to develop a Board wide approach to managing social distancing. The group has developed a core set of principles and generic risk assessments which can be applied in a variety of workplace contexts and will assist Directors in the recommencement of services. Clear governance is essential to this process and each Director has nominated a senior manager to progress this work for their area. They are in the process of prioritising their areas to ensure that those with the highest likelihood of transferring the virus to staff, patients or others who may be affected by our activities are addressed first. Risk assessments will be undertaken by a multi-disciplinary team and once complete, each Director will provide the Chief Executive with the necessary assurance to allow the Chief Executive to sign the “Staying COVID-19 Secure in 2020” for display in the relevant premises.

Whilst NHS Ayrshire & Arran is legally required to risk assess our premises we also recognise that we have many staff who work across our Health and Social Care Partnerships and we expect that these staff will be afforded the same protection as staff working in our premises. To achieve this and a consistency of approach, we are working closely with our Health & Social Care colleagues with senior representation on the social distancing group.

In addition to the existing requirement to assess our sites, we are also developing processes to support remote working for the medium to longer term. For those staff we have identified as requiring to return to the workplace, we will undertake risk assessments and consider shift patterns and start times and a balance between being at work and working from home.

11. Workforce

Workforce planning is an intrinsic aspect to our response to the COVID-19 pandemic. NHS Ayrshire & Arran has written a distinct COVID-19 Workforce Plan which details, at a high level, the key levers in terms of workforce supply (both local and national) which the organisation has, and will continue to, utilise in meeting workforce demand.

A key facet of balancing our workforce demand and supply was the early initiation of our staff hub which enabled all organisational absence to be recorded and managed centrally, and thus help inform staff mobilisation decisions. We will review the functioning and role of the staff hub going into phase 2.

Key demand considerations, in addition to staff absence, during Phase 1 related to:

- Providing the clinical treatment model for COVID-19 i.e. surge capacity;
- Maintaining infection control measures and wider health and safety;
- Ensuring our staff health and wellbeing;
- Supporting the operation of NHS Louisa Jordan; and
- Providing mutual aid to care homes.

In seeking to balance workforce demand we were mindful that 'additionality' in terms of supply is finite and as a Board we sought to use multiple supply levers including:

- Retirees / speculative applications for employment;
- Routine normal recruitment activity;
- Use of Nurse bank;
- NES accelerate portal – including the use of 2nd and 3rd year nursing students;
- Re-assignment of category C&D staff (from desirable and routine services form a business continuity aspect); and
- Consideration of mutuality across West of Scotland Boards in extremis.

In phase 2 we will continue to review our supply levers ensuring these meet organisational need and provide sufficient organisation flex which may be require rapid workforce mobilisation at short notice to respond to pandemic status.

We will also consider restarting professional education that has been paused and we are collaborating with our HEI colleagues regarding timescales.

Other Nursing, Midwifery and Allied Health Professionals (AHP) workforce additionality

We continue to monitor and consider workforce demand on an ongoing basis through established local mechanisms utilising a range of workforce supply options which include supplemental and substantive staffing options. Whilst we have made limited use of applicants from the NES portal to date, due to being able to balance our demand with internal supply levers to match service demand, we recognise this may provide proactive supply for key services as we proceed to the next stages, e.g. AHP rehabilitation needs, however in order to utilise this supply route more efficiently lead in times for the completion of recruitment checks by NES must be truncated to make best use of this resource.

Second and final year nursing students are in post undertaking Band 3 and 4 roles and we have commenced a process by which all final year nursing and midwifery students currently within Ayrshire & Arran will be offered substantive posts to fill vacancies.

Our Workforce Planning & Deployment Group (WPDG), established during phase 1, will provide oversight in matching staff supply to meet service demand as the organisation progresses into Phase 2. This will be against the backdrop of workforce supply resilience should there be emergent need to flex up of COVID-19 specific services.

This Group meets on fortnightly basis and is chaired by the Nurse Director / Interim Deputy Chief Executive with HR, service (from Acute, H&SCP and facilities/support services) and professional input (nursing, AHPs, medical).

In fulfilling its remit of ensuring staff resource is optimally deployed WPDG will:

- Consider workforce demand arising from version 2 of mobilisation plans taking particular cognisance of workforce demand arising from the recovery and rehabilitation needs of COVID-19 patients in community settings;
- Consider workforce demand and deployment arising from the staged recovery plan, recognising that some service changes will materially impact upon Caring for Ayrshire workforce models and planning;
- Facilitate planning to ensure that there is sufficient workforce supply, with requisite skills and competence, to support workforce flex should scale up be required at short notice to reflect change in pandemic status i.e. ICU capacity;
- Receive feedback and direct action based on feedback from professional / functional leads i.e. changes in operational provision;

- Have oversight of the additional staff that have entered the workforce during the pandemic on fixed term contracts to ensure their ongoing deployment reflects organisational need and financial planning;
- Have oversight of status of supply chains, local and national, for new staff, being cognisant that the labour market post pandemic is likely to be significantly constrained for some distinct clinical roles;
- Identify and consider any potential new supply routes and feasibility of introducing alternative roles to counter supply issues / skills gaps;
- Encourage services to continue to refine de-minimis staffing iteratively as per extant updating of business continuity plans taking learning from the first phase of the pandemic;
- Ensure there is clear and consistent messaging, and cascade of information to support effective staff deployment;
- Provide workforce planning support and guidance on the development of new clinical pathways and service redesign opportunities;
- Engage with Staff Side representatives in partnership on the iterative stages of workforce planning during recovery and Caring for Ayrshire; and
- Commence training and education mapping exercise to identify skills for medium and long term to help develop learning and education plan.

Nursing workforce modelling/planning as services plan to resume

Each Director is modelling their requirements according to the projected service need. This modelling will need to take into account the requirements to meet COVID related additionality and pathways, for example the requirement to maintain increased ITU capacity.

In order to assist with additional nursing requirements and enable our previous plans to be implemented (such as our Primary Care Transformation Plan) NHS Ayrshire and Arran has taken the decision to offer all our current final placement Y3 nursing students a post. Recruitment plans are in place for this to be completed by end of June 2020 and they will join as registered nurses on completion of their undergraduate programme (approximately132 in September 2020 and 25 in January 2021)

We have recruited all nine final year midwifery students and they will take up post with us later this year on completion of their programme. This enables us to succession plan for projected retirals and turnover.

In order to model the nursing workforce robustly for the recovery programme and maintenance of COVID patient pathways it would be helpful to know when the CNO guidance with regard to skill mix and nurse / patient ratios derogation is likely to be reviewed and rescinded.

Care Home Support

NHS Ayrshire & Arran has put in place a Care Home Governance Framework which covers the actions to be taken if staff are required to support care homes. This has been developed in partnership with our HSCP Directors, welcomed by local Scottish Care colleagues and provides clarity with regard to the testing of staff before working in care homes. The hierarchy of how we will work with care homes and HSCP colleagues to meet any staff needs is addressed in our COVID Workforce Plan.

We are clear that staffing to support care homes requires to be considered from two perspectives:

- **Proactive and planned in response to potential positive COVID testing:**
These potential staff will be tested and COVID negative before deployment

- **Reactive / rapid in response to an immediate care risk:**
1. Staff who require to be deployed in this urgent scenario may not have been tested and this risk will be managed by ensuring they provide care using PPE at all times until such time as the urgent risk has passed (max 24 hours) and staff can be deployed who are confirmed as COVID negative.
2. In order to meet an urgent care need a small MDT '*rapid response team*' is being explored for each HSCP who will be regularly tested and ready to be deployed if urgent need arises. (this team would include domestic as well as nursing staff)

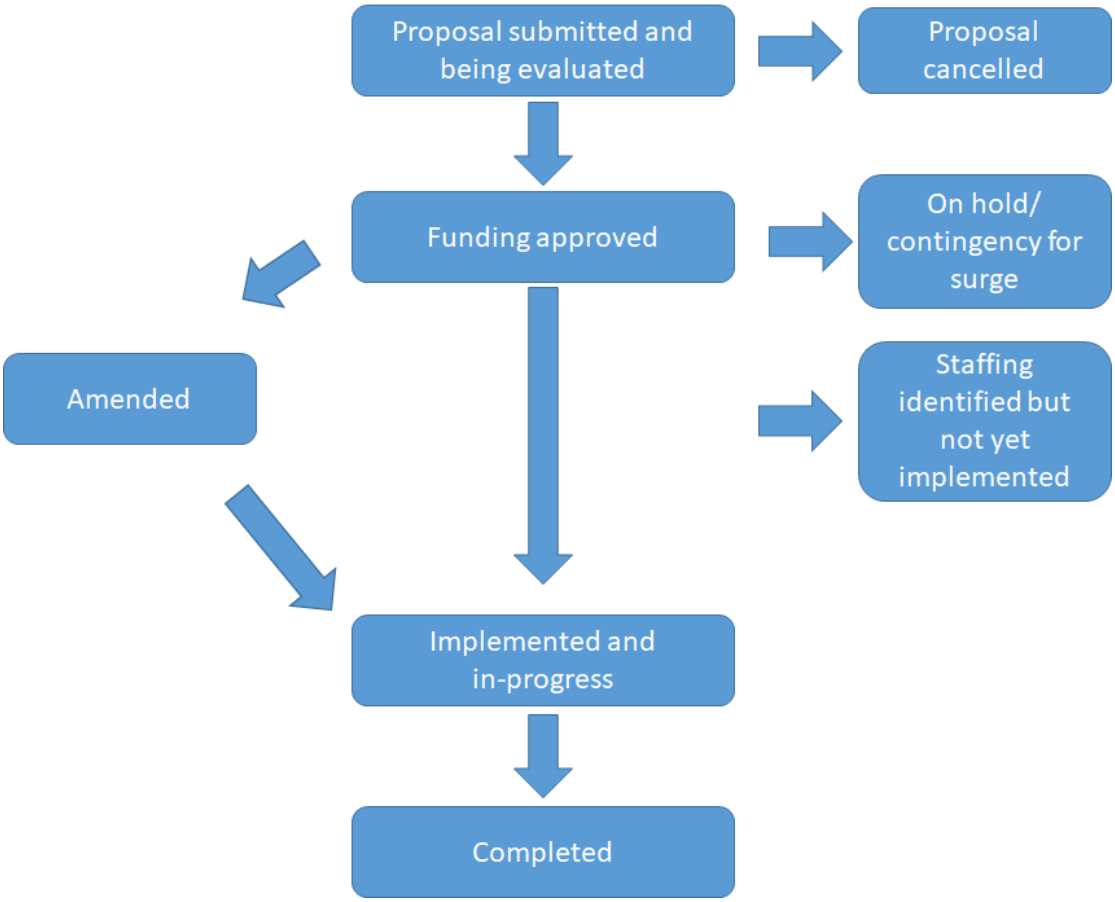
12. Finance

The financial consequences of Mobilisation Plan Phase 2 will adopt a similar approach to that of the Mobilisation Plan 1.

All proposals for costs will be considered locally through the appropriate governance routes and then submitted to Scottish Government Health Finance and Infrastructure for approval (if over £750,000), the following flowchart outlines the categories in the mobilisation tracker.

Process

The following process is proposed for new proposals associated with COVID-19. The definitions below provide further detail on each process.



Status of proposal	Definition
Proposal submitted and being evaluated	Proposal and cost has been submitted for consideration to PMO.
Amended	Action has been amended, please refer to new action XX put in place. e.g. ward x identified as the phase 2 COVID-19 Ward amended action would identify that ward x was replaced by ward y as the phase 2 COVID-19 ward.
Cancelled	Proposal has been cancelled due to not being viable.
Funding approved	Proposal and cost have been approved by Chief Executive and Director of Finance, Scottish Government (over £750K threshold)
On hold/contingency for surge	Action and cost agreed but action not required until surge capacity is reached. (identification of beds, location and equipment complete at this stage)
Staffing identified but not yet implemented	Staffing model developed to support action.
Implemented and in-progress	Action is implemented and is incurring cost
Completed	The action has been completed and no further costs will be incurred.

Following the categorising of the proposal a financial category will be applied as detailed below.

Finance category	Definition
Actual spend	Actual spend on planned action
On hold	This figure would be anticipated if the planned action was continued. At present it is on hold and not continuing at this time.

On a monthly basis, actual costs will be tracked and reported to EMT and submitted to Scottish Government.

The finance submissions and in particular the forecasts will reflect future iterations of the plan as these are developed.

It is anticipated that there will be a considerable amount of reductions to the “offset” figure, for example, if we reinstate Elective work some of the ward/day case/theatre/non pay savings will disappear.

Appendices

1. Clinical Priorities – Prepared by SAMD & SEND

1. This paper builds on SAMD and SEND discussions to inform the clinical prioritisation bullet point in CE paper, presented on 05 May 2020 on remobilisation, recognising all the principles within that paper:

    - **Clinical prioritisation** - addressing the needs of the population across physical and mental health through a clear clinical prioritisation process; developing a phased approach to the re-introduction of services and care based on need; aligning the available capacity recognising the preconditions of the different clinical specialties and the need for social distancing measures within hospitals; the need for infection prevention and control to be at the forefront of clinical prioritisation; high volume care as close to home as possible; complex low volume work concentrated in a small number of locations at regional and national levels, aligning clinical needs to the available capacity across Scotland.

    Discussions have identified the following areas of clinical priority and ways of working. Some ideas and proposals would extend far beyond the three months, which has sensibly been set as the next horizon for planning remobilisation.

2. Board led increase in their volume of planned work in acute hospital systems

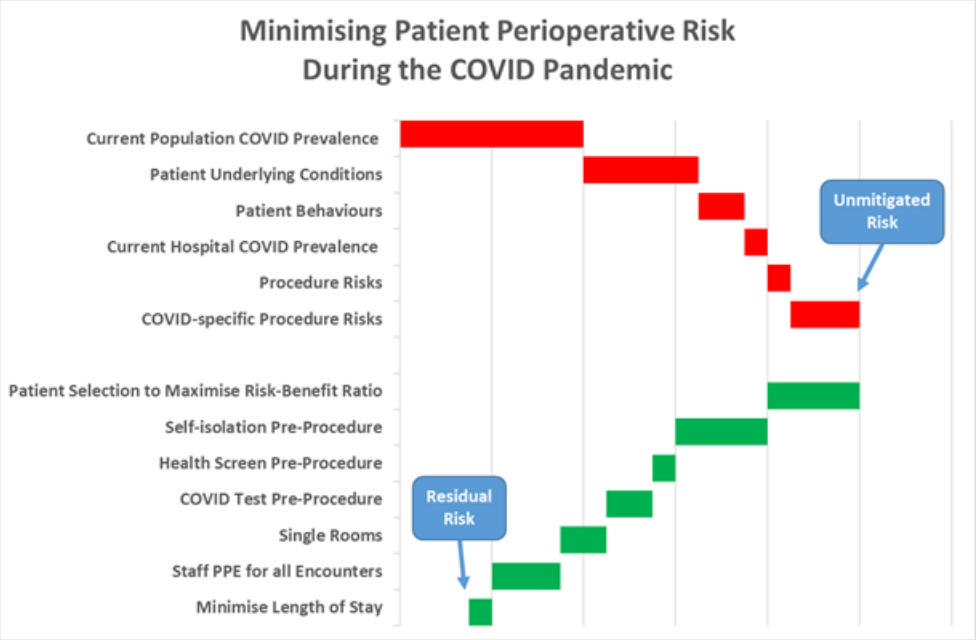
All boards are maintaining some level of urgent cancer and clinically urgent work in outpatients, diagnostics and inpatients and are seeking to extend this as they are able. The work that boards are undertaking currently and plan to expand in the next three months under this heading, is led by the principles orientated around the patient and their needs, and the local system. These are in line with the Framework for Recovery of Cancer Surgery produced by Scottish Government and with recent letter jointly published by the Kings Fund, Nuffield Trust and Health Foundation, indicating it will take some considerable time to return to routine work.

Patient factors that require to be optimised before proceeding:

- Agreement that the risk of procedure is less than the intended benefit
- That the level of urgency of the procedure supports proceeding at this time
- There has been explicit consideration and documentation of risk as part of the consent process and patient chooses to proceed. The impact of that choice on TTG status needs to be clarified so that the same adjustments and communications are applied across Scotland

System factors that require to be optimised before proceeding:

- There is no compromise to flow and levels of occupancy are at a safe level, including in critical care.
- There are adequate resources- of workforce and supplies (including medicines and PPE)
- The hospital environment is as safe as it can be: there are no hospital outbreaks suggesting in hospital transmission.



This visualisation of the components of risk (with thanks to MMacG from GJNH) is a useful way to bring these factors together to support patient discussions. There is opportunity for common language and demonstration of risk stratification.

The phrase “clinically urgent” may reflect the circumstances of the individual patient as well as the condition and extends beyond cancer based procedures. All agree this is a priority for the use of non COVID-19 capacity within individual health systems and will be need to be balanced with additional demands in unscheduled work. Within an outpatient setting, telephone and virtual consultations have been tried extensively and demonstrated to be acceptable ad effective, so should be maintained as the first approach to the patient. Evaluation of patient experience and outcomes need to be undertaken to inform their more deliberate use and to ensure that the consultation through this method functions as a replacement to a face to face consultation rather than an additional step.

There are constraints that require explicit consideration:

- Diagnostics are recognised as a constraint within both scheduled and unscheduled work- due to both an increased requirement for diagnostic tests to support increasing volume of urgent work and the reduced throughput consequent on the changed way of working from COVID-19 restrictions of social distancing and PPE.
- Most boards are cautious and concerned about moving to more routine work too quickly, particularly with PPE requirements still being very high for all clinical and interventional work including endoscopy.

Particular consideration should be given to the opportunities to resume the provision of services for children more rapidly, given the lifelong disadvantages they may face over poorer clinical outcomes that occur through further delay, and that these services are often geographically separated from other areas.

3. Unscheduled care

Converting unplanned attendance or assessment to one that is in a planned appointed clinical system is the most important priority for Medical and Nurse Directors and which should link clearly to the clinical priorities described in the remobilisation plans. There is strong support for not reverting to old ways of delivering unscheduled care but using what has been learnt across the whole system to maintain and expand the new ways of working. Most boards wish to continue to use the models established in COVID-19 hubs as a way of supporting more self-management and avoiding overcrowding and unnecessary face to face contact. The potential safety gains of a more controlled approach to unscheduled care attendance to any healthcare setting will be significant and may play an important factor in mitigating or reducing winter pressures generally and any additional COVID-19 pressures that emerge in the future.

The NHS 24 model of triage into COVID-19 hubs has been well received by patients and professionals and delivered safe, consistent care. It has also supported more self-management and self-care, and links clearly to the wider primary care resources of Community Pharmacy and optometry. SAS have identified opportunities to join up parts of the service and consider they can play an important part in the move to the greater scheduling of unscheduled care (the Danish model). These changes would need implemented across the whole system rather than on a piecemeal basis for maximum impact.

Consistency and effective use of skilled resources has been demonstrated by the GP led COVID-19 hubs and the maintenance of the principles of these for unscheduled care and the gains they have given has the strong support of Medical and Nurse Directors. A similar approach to urgent mental health assessments would provide a better patient experience in a safer and more timely way. In short, we should prioritise the development and expectation of clinical contact and conversation virtually before any attendance a necessary step and one that with appropriate localised clinical decision support benefits the patient and the system as a whole.

4. Prioritisation around Mental Health services

Changes introduced for urgent access and managing unscheduled demand have been effective and MH services are using new digital consultation approaches in unscheduled and scheduled settings well. Opportunities for more interventions to be delivered on line and with a focus, where appropriate, on self-management have been a feature of work in the last three months and there is strong support to continue these.

Rising levels of distress in individuals are noted and given these frequently result in urgent or unscheduled presentations, rapid access to appropriate assessment and support is recognised as a clinical priority. SAS have noted a rising number of mental health calls under the 999 category and without clear routes for onward support, these have the potential to result in additional unscheduled hospital attendances.

There are specific concerns about children and young people in CAMHS for whom social isolation and loss of regular contact through education has had significant impact.

5. Primary Care services

Our clinical priorities would be to support the opportunities to join up previously segmented areas of service in primary care to make things more straightforward for patients and staff and to reduce duplication. These include accelerating aspects such as the digitalisation of optometry and e prescribing. General Dental Practice work is emerging as a public concern around access and has particular issues about PPE and social distancing.

Self-care and self-management have been widely used and become more acceptable to the public and there are opportunities to provide good quality resources once across Scotland through NHS Inform and to link these to the individual’s postcode for the available options in their area with DHI input.

Maintaining or developing services in primary care that enable care to be delivered remotely, or which avoid the need for hospital attendance requires infrastructure and resources in ways that are consistent. Undertaking more tests in the community would avoid travel, inconvenience and risk for patients and will be necessary for the monitoring of shielded patients for their bloods, ECGs and other physiological parameters. Current models around local determination of such services at an individual HSCP level reduces the opportunities for successful interface working with secondary and tertiary care who may span multiple HSCPs. There are also opportunities for national boards to be part of this, and it would have a positive impact on health care in prisons and the State Hospital. Office 365 rollout will support better working across diverse teams.

Support for the ongoing vaccination of children needs to be well articulated and supported by public messages.

6. Population health and prevention: Screening

Following discussion, Medical Directors would not see reintroduction of screening services as a priority until the whole pathway from diagnosis to treatment for each individual patient can be supported.
Screening programmes are designed to identify patients whose detected disease is at an earlier stage and these individuals would not take priority over a patient presenting through an urgent pathway with more overt disease.

Reintroduction may miss an opportunity to consider whether any modernisation of screening pathways would be beneficial and whether there could be any alignment between USOC pathways and screening in a way that allows better risk stratification.

7. Managing Expectations

Nurse and Medical Directors recognise the need for consistent messaging and management of expectations and that some of these may be difficult to achieve with the flexible, urgent based, service provision which will be necessary in the next phase. These include managing the expectations of:

- patients: who expect that care will be safe and risks minimised, and that their choices about risk will be carefully discussed and that any decision to defer will not disadvantage them in the future
- carers and families- that care will be safe and they will have adequate opportunities to be involved
- the wider public- that care in one region matches another in terms of access and standards and who need to adjust to virtual contact proceeding or replacing face to face contact, except in the most urgent of circumstances.
- professionals that the principles of realistic medicine will be followed in managing interventions, choice and risk.
- the broader health and social care workforce in the use of technology as part of everyday clinical work, with consequent implications for its availability for all groups of staff, the expertise and skills to use it and its functionality in supporting the delivery of care in all sectors.
- Non Executive Directors and MSPs and others where the understanding of the impact of COVID-19 on productivity and ways of working may be less well understood, including the need for there to be sufficient time for staff to recover and for patients to feel safe in health care settings
- managers: safety will be strongly linked to levels of occupancy in all healthcare settings and we need to maintain lower levels of occupancy than previously tolerated or might seem efficient, particularly with all the complexities of red and green areas.

Using more real time data with defined trigger points to inform decisions about the need to flex capacity, pressures on supplies (e.g. PPE distribution) and early warning systems about pockets of COVID-19 activity would allow boards to proceed at the correct pace for local need but demonstrate that decisions are being made according to standard criteria, following the same principles, even if different boards are in different waves of COVID-19 activity.

8. A stronger clinical voice

To provide leadership and pace- we recognise that previous attempts at service reform have been hampered by individual views and preferences rather than what's best overall. Medical and Nurse Directors want to contribute more to seeing some work through, by bringing discussions about diverse clinical views to a conclusion and in being seen as a more direct resource for Chief Executives in accelerating whole scale adoption.

2. Unscheduled Care Position for Recovery - Regional Content

Managing Unscheduled Care in the Recovery Phase and in the New Normal

The risk of COVID-19 is a new factor that will influence management of unscheduled care across the Health and Care System in the weeks and months to come. This requires us, as a matter of urgency, to review pathways and alter approaches to assessment and treatment of urgent and emergency care patients to reflect this new and additional risk; re-evaluate and change we provide assessment and care in all healthcare settings; taking account of needs of the population across physical and mental health through a clear clinical prioritisation process.

The most important priority identified by the Medical and Nurse Directors going forward is to move from a model of unplanned attendance or assessment to one that is in a planned appointed clinical system. There is strong support for using what has been learnt across the whole system to maintain and expand the new ways of working. The potential safety gains of a more controlled approach to unscheduled care attendance to any healthcare setting will be significant by avoiding overcrowding and unnecessary face to face contact and may play an important factor in mitigating or reducing winter pressures generally and any additional COVID-19 pressures that emerge in the future.

As management pathways are adapted it will be important to understand the implications for both staff and patients of how we organise services to accommodate the social distancing and infection prevention and control measures to minimise the risk of preventable harm from transmission of the virus to keep staff and patients safe at the same time using the available capacity to best effect.

Boards will require to consider their arrangements locally to support care recognising that where COVID-19 free ‘green’ sites are not available or feasible, separate designated areas on acute sites (amber zones) will be essential to allow separate streaming of proven and suspected CODID-19 patients (managed in red zones). This includes dedicated access points for patients and admission processes as well as inpatient areas separate from those where COVID-19 patients are being treated.

In planning for and in the delivery of unscheduled care there are constraints that require explicit consideration such as diagnostics. This is recognised as a constraint within both scheduled and unscheduled work due to both an increased requirement for diagnostic tests to support increasing volume of urgent work and the reduced throughput consequent on the changed way of working from COVID-19 restrictions of social distancing and PPE.

It is also important that we recognise there may come a time of huge disparity in provision and in emergencies. This position needs to be monitored across the Boards within the region to understand what is happening in terms of patient care to allow a more system wide response that allows equitable access to care based on clinical need wherever possible.

Adopting New Models to Support the Urgent and Emergency Care Response

Going forward it will be important to ensure joined up pathways and models of response to unscheduled care across NHS24, SAS, GP In-hours, GP Out of Hours and Emergency Departments.

NHS 24 Model of Triage - Building Further Capacity

- The NHS 24 model of triage into COVID-19 hubs has been well received by patients and professionals and delivered safe, consistent care. It has also supported more self-management and self-care, and links clearly to the wider primary care resources of Community Pharmacy and optometry.

- Going forward it is essential to strengthen the 111 capacity to support a similar approach for secondary care for ED attendance/ emergency care admission.

Scottish Ambulance Service – Extending the New Ways of Working

- SAS have identified opportunities to join up parts of the service and consider they can play an important part in the move to the greater scheduling of unscheduled care; Sustaining and strengthening appropriate ambulance services such as ‘hear and treat’ and ‘see and treat’ models by implementing across the whole system for maximum impact.

Supporting Urgent Care in Primary Care and GP In Hours and Out of Hours Services

In Hours

In response to COVID-19, General Practice has reduced significantly their face to face contacts managing more than 85% of consultations remotely. GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained.

To support this it will be important to:

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns;
- Stratify and proactively contact high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In particular, proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to COVID-19, to ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.

Out of Hours

- The GP led COVID-19 Hubs during the first wave demonstrated consistency and effective use of skilled resources. It is important to maintain and build on the principles of these new Primary Care approaches.; developing further the NHS 24/ Community Assessment Centre approaches to triage and to manage demand for unscheduled care safely in the right place at the right time by the right person or team.

Acute Care

- Adopting an approach which increases the availability of booked appointments across the urgent and emergency care system; establishing this as the new normal supported by strengthened 111 capacity to support a similar approach for secondary care for ED attendance/ emergency care admission as is currently used to support the GP Out of Hours and Community Assessment Hubs
- Opening up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Providing urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-COVID-19 levels.
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.

Mental Health

- A similar approach to urgent mental health assessments would provide a better patient experience in a safer and timelier way. In short, we should prioritise the development and expectation of clinical contact and conversation virtually before any attendance a necessary step and one that with appropriate localised clinical decision support benefits the patient and the system as a whole.
- Establish all-age open access crisis services and help lines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.

Enabling Requirements

Communications Campaign to Support New Ways of Working

- National public messaging/engagement - in respect of the setting the direction of travel for the new normal; informing and engaging on redesign of service provision and to ensure the public understand the changes emerging new service models.
- Strong messaging on using other pathways of care and the importance of triage virtually through NHS 24/GP/ Near Me as a necessary step to reduce self presentation at Emergency Departments and other Urgent Care Facilities will be essential to keep activity at a level that allows safe distancing and flow. Clear information on what the public do across a range of symptoms in hours and out of hours as an alternative to self presenting at ED will be essential.

Reducing the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

- Expansion of the digital platforms – to expand the opportunities to provide care out with health care settings in to people's homes, allowing new approaches to be used across primary and community care; sharing information across organisations to improve health outcomes; minimising the need for patients and staff to travel, wherever possible.

Supporting Policies and Processes

- Explicit policies on the use of virtual/remote technology to support service provision will be required with clear policies and processes for the system for those professionals who are taking telephone calls or carrying out virtual or face to face assessments to 'schedule' attendance for those patients who need to attend ED. We need also to ensure patients can be directed to the nearest ED with capacity if the most local ED is full and unable to offer safe social distancing. This will require some sort of real time dashboard on ED 'appointment' availability;
- An electronic referral which tells the ED who to expect and when as well as giving the patient clear guidance on this will be required to support this model as well as a policy on what to do with self presenters who may turn up at ED without professional referral. If the policy is to triage and then divert will need some resource and determination to ensure this can be implemented supported by strong national messaging on that policy.
- In delivering these new models clear policies about waiting areas and how to secure social distancing would be helpful and should extend to cover the position on relatives of patients.

3 Phase 2 Expected activity SG Template

NHS Ayrshire & Arran		w/e	w/e	w/e	w/e	w/e	w/e	w/e	w/e	w/e	w/e
		31-May	07-Jun	14-Jun	21-Jun	28-Jun	05-Jul	12-Jul	19-Jul	26-Jul	02-Aug
TTG Inpatient Activity	urgent	26	26	26	26	26	30	30	30	30	30
(Definitions as per waiting times data mart)	routine	0	0	0	0	0	0	0	0	2	2
TTG Day case Actvity	urgent	18	18	18	18	18	23	23	23	23	23
(Definitions as per waiting times data mart)	routine	0	0	0	0	0	20	20	20	20	20
Elective colonoscopy activity	urgent	0	0	0	6	12	22	22	22	22	22
(Definitions as per Monthly Management Information)	routine	0	0	0	0	0	0	0	0	0	0
Elective lower endoscopy activity	urgent	0	0	0	0	2	2	2	2	2	2
(Definitions as per Monthly Management Information)	routine	0	0	0	0	0	0	0	0	0	0
Elective upper endoscopy activity	urgent	0	0	0	0	0	0	2	4	4	4
(Definitions as per Monthly Management Information)	routine	0	0	0	0	0	0	0	0	0	0
Elective cystoscopy activity *	urgent	25	25	25	25	25	25	25	25	25	25
(Definitions as per Monthly Management Information)	routine	0	0	0	0	0	0	0	0	0	0
OP Referrals Received **	urgent	600	650	700	750	800	850	900	900	900	900
(Definitions as per waiting times data mart)	routine	700	750	800	900	1000	1100	1300	1400	1400	1400
OP Activity - (including Virtual - telephone, NHS Near Me,...)	urgent	650	660	670	680	690	690	690	690	690	690
(Definitions as per waiting times data mart)	routine	2350	2440	2530	2620	2710	2810	2810	2810	2810	2810
A&E Attendance (system watch - core sites)		1661	1679	1569	1518	1648	1542	1505	1519	1554	1542
Emergency Admissions (Systemwatch - RAPID)		659	670	661	653	652	652	670	670	674	674
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)		120	120	120	120	120	120	120	120	120	120
31 Day Cancer - First Treatment (Definitions as per published statistics)		9	11	12	14	15	15	15	15	15	15
CAMHS - First Treatment (Definitions as per published statistics)		5	5	5	5	7	7	7	7	10	10
Minor Ailment Scheme		478	443	458	471	485	490	462	453	474	486
PC OOH – Home Visits		259	268	295	286	246	278	284	243	261	259
PC OOH – Centre attendances & telephone advice calls		558	555	570	542	572	552	491	521	524	558
* cystoscopies in NHSAA are done as outpatients											
** urgent referrals at about 50% normal volume as at end May, expect to increase to about 75% normal through June & July											
routine referrals at about 28% normal volume as at end May, expect to increase to about 50% through June & July											