# Remobilisation 2

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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## Table of Contents

# 1.0 Remobilisation Planning 2

## 1.1 Introduction

This plan has been prepared as a single plan covering the mobilisation of health and care services across Ayrshire and Arran for the period August 2020 to March 2021. Whilst the plan concentrates on the planning period in scope it should be noted that where we are looking to build on reform of services that we have seen over the last few months this will continue beyond this planning period and will support the strategic intent for our health and care services as set out in our “Caring for Ayrshire” programme.

Whilst the plan does not provide detail on wider community planning partner services, NHS Ayrshire & Arran is working closely with our partners in support of the wider recovery that is required across our communities. This is evidenced by the collective work carried out through the Strategic Ayrshire Local Resilience Partnership and the Public Protection arrangements across the three Councils. It should also be noted that we are working with our partners on the wider strategic intent in support of the wider aims of regeneration.

As well as working with our Community Planning Partners we have also engaged and involved our Area Partnership Forum and Area Clinical Forum. Clinical and professional leadership in both the planning and execution of the plan is central to our approach as well as ensuring we have arrangements that are supported by the wider staff side bodies as we take forward the necessary reforms.

This remobilisation plan is, as of 31st July, in a "final draft" format. It has not been formally agreed by the NHS Board or East, North and South IJBs. We will, of course, engage with colleagues in SGHSCD on the fine detail before final approval.

Public Health Scotland have developed a range of scenario planning tools to help support the system recovery and remobilisation of services. We will work with our colleagues to scope out the capacity implications for the Health and Social care economy as we remobilise services. This tool will allow us to take account of winter pressures, accommodate new working practices (PPE etc.) and potentially face a second wave of COVID/ or local outbreaks*.*

In presenting this plan we have taken account of the three core tasks in “Re-mobilise, Recover, Re-design: The Framework for NHS Scotland”

- Moving to deliver as many of its normal services as possible, as safely as possible;
- Ensuring we have the capacity that is necessary to deal with the continuing presence of COVID-19; and
- Preparing the health and care services for the winter season, including replenishing stockpiles and readying services.

The plan also takes account of the range of guidance issued by Scottish Government in recent months including;

- Guidance letter from Director of Planning 6th July 2020;
- Guidance on Clinical Prioritisation 21 July 2020; and
- Key information, content and suggested structure for Mental Health section of Board mobilisation plans – August to March 2021 from Directorate for Mental Health, dated 16 July 2020.

This plan builds on our earlier Mobilisation and Remobilisation plans and endeavours to ensure that the following planning requirements are met:

- Surge capacity for COVID-19 patients is maintained to ensure capacity/ resilience in the system to respond to any future rise in cases;
- Patient and staff safety are ensured by appropriate streaming of COVID/non-COVID-19 pathways (plus continuing systems of staff support & wellbeing across health and care);
- We retain and build our public health capacity to provide a robust, sustainable service including delivery of all components of Test and Protect, taking account of new developments as they emerge;
- Strict infection prevention and control measures remain in place;
- COVID-19 screening and testing policies are fully and consistently implemented in line with national guidance, with Boards obliged to flag any risks to implementation;
- Inter-dependencies are factored in including workforce, transport, training and development;
- High quality care is delivered including patient experience and person-centred approaches to care;
- New and effective ways of working are maintained and built upon – avoiding reversion to previous working practices; subject to extant guidance on appropriate public engagement and participation, as set out in the Cabinet Secretary's associated letter to Board Chairs of 25 June; and
- The impact of physical distancing measures across the health and care sector on capacity is continually assessed.

This period of planning continues 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. Clinical prioritisation and safety are the foundations on which we have developed our plans across all services.

We also recognise that in bringing forward these plans we need to align our service ambitions with our workforce, the quality of care and best value.

## 2.0 Key Learning Points from Remobilisation 1

As we move through the different phases of re-mobilisation it is important that we reflect on the learning that has come from the previous phases and build forward into this plan. Ayrshire and Arran strives to be a learning organisation and has taken forward a range of activities that have drawn out learning that supports this plan and our work going forward.

**What have we learned?**

Our work thus far has drawn out a number of areas that we are taking forward. Key to this plan are:

- Continued development of digital as an enabler of reform in support of clinical care and patient access and communication;
- Building on our integrated approach we have seen teams across our health and care system remove barriers and work together as a "community" for the community;
- Enhancing staff wellbeing and wellness work through a network of wellbeing facilities;
- Stress testing of critical elements of plan. This learning came from our work with the Military Liaison Officers deployed to Ayrshire and Arran;
- Teams have the authority and power to act; and
- Embed new ways of working where they have brought benefit to patient care.

Many of these lessons build on our work over the last 12 months as we have progressed our "Daring to Succeed" programme across Ayrshire and Arran.

We are continuing to seek learning through our management and clinical teams and as part of the development of this plan we have asked for clarity on

- what we should retain and progress?;
- what we should stop?; and
- what further reform would add benefit?

Working with the Director of Human Resources and the Head of Organisational Development, an approach to support Reflective Practice is being developed to support teams to continue to look at the work they are doing and consider how they learn and evolve continuously. This work is underpinned by our approach to psychological safety and our stated intent that all voices should be heard.

A range of approaches and interventions have been taken to engage with staff to capture their views and also gain a better understanding of what their experience has been during COVID-19. This has included senior management walk rounds by the CEO with the Nurse and Medical Directors and local management teams to engage with front line staff and listen to their views on key lessons learned during COVID-19 and seek ideas and suggestions regarding new ways of working which is being used to inform local Recovery and Mobilisation Planning. In addition, surveys have been issued via the Health and Wellbeing Hubs to gain feedback on staff concerns, anxieties in response to COVID-19 and explore what additional support is required.

The NHS Board's People Strategy and the supporting annual People Plan have been reviewed and updated to ensure these priority actions have been captured and updates will be monitored throughout the year and reported via the People Strategy Steering Group, the Corporate Management Team, the Area Partnership Forum and the Staff Governance Committee.

**Summary of actions**

We will

- Continue with our Daring to Succeed programme.
- Continue to engage with staff over this phase on remobilisation.
- Continue to encourage and support learning and development.

## Public Protection

NHS Ayrshire & Arran is an active partner in each of the local authority Public Protection Chief Officer Groups (PPCOG). These have continued to meet virtually during the pandemic 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. There is also growing recognition, as we move out of lockdown, of the potential impact on connected services such as Sexual Health and Addiction Services. These are referenced in the relevant parts of this plan.

Our health teams continue 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 post lockdown from August 2020. During July 2020 all three PPCOGs have received reports which already indicate a move back to pre-COVID-19 levels of activity across the range of public protection streams.

Colleagues are undertaking horizon scanning based on evidence from other countries who are further down the journey of releasing lockdown measures than Scotland to enable a focussed analysis of potential risks and vulnerabilities. This analysis is also enabling consideration of any increased resources that may be required in order to manage and support any increase in public protection activity over the next 6 months.

From August 2020, Ayrshire and Arran will be recommencing our structured programme of work with regard to implementation of the HIS Rape & Sexual Assault Standards (2017). Our working group paused due to COVID-19 and began meeting again on 1 July 2020. Our priority between now and December 2020 is to recruit to our co-ordinator post and develop and agree our patient pathways to and from our new Forensic Examination Suite at Biggart Hospital. From January to March 2021, we expect to be participating fully in the West of Scotland hub and spoke model for this service. This is dependent on recruitment of peripatetic forensic examiner staff by NHS Greater Glasgow and Clyde.

**Summary of actions for public protection:**

**We will:**

- Continue to be active partners in public protection oversight, planning and activity monitoring.
- Plan for increased child protection, adult support & protection and Gender Based Violence activity.
- Restart our programmes of work to implement the HIS Rape & Sexual Assault Standards (2017).

**Summary of revenue consequence:**

- Additional Child Protection Advisor: ACF B7 to end March 2021 £40,539 (non recurring).
- Additional Adult Support and Protection officer: ACF B6 to end March 2021 £34,399 (non recurring).
- Adult Support and Protection Lead Officer/Manager to co-ordinate and lead the Rape & Sexual Assault programme: AFC B8A (B6 funding in budget and B6 coming from SG to fund this post).

## 3.0 Health and Social Inequalities

Within this section of our plan we set out core information about health inequalities in our population and emerging understanding about the effects of COVID-19 on the population.

### Health Inequalities in Ayrshire and Arran

Poverty and inequality remain the biggest challenge to our health as the majority of health inequalities find their root cause in differences in wealth and income. The health and socio-economic impacts of the COVID-19 pandemic is unequal and likely to increase pre-existing, long-standing inequalities. Being in an older age group, coming from a black and minority ethnic group, living in the 20% most deprived communities and certain specific underlying conditions such as diabetes and heart disease, are factors associated with increased risk of more severe symptoms and higher rates of death from COVID-19.

National Records for Scotland highlighted that between March and April the death rate from COVID-19 was 2.3 times higher in the most deprived areas than in the least deprived areas in Scotland. Public Health England analysed survival among COVID-19 cases and showed that after accounting for sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups.

BAME groups are often among the poorest socio-economic groups, experience low paid precarious work, poorer housing and structural inequalities, such as racism, in relation to accessing health, health information and other services.

## Wider impacts on the population

The Scottish Index of Multiple Deprivation already shows that there are high levels of multiple deprivation across Ayrshire and Arran. Those communities living in socio-economic disadvantage experience inequalities in health, including premature mortality, relatively more ill-health, earlier onset of long-term conditions, poorer mental wellbeing, higher levels of in-work poverty, low paid and precarious employment, low financial resilience and fuel and food poverty.

COVID-19 and the essential policies associated with it such as lockdown, loss of income, debt, arrears, the threat of job losses, reduced access to health and social care services and social isolation will have a disproportionately negative impact on the 20% most vulnerable areas and on vulnerable groups.

## COVID-19 Community Vulnerability Measure

The Scottish Public Health Observatory (ScotPHO) have developed a "Community Vulnerability Measure" to help guide the social mitigation response to the effects of COVID-19.

ScotPHO used routinely available data from the Health and Wellbeing Profiles. The criteria for selecting the indicators for the measure were:

- direct relevance to COVID-19 vulnerability (demographic or clinical); or
- relevance to other demands on clinical or public health services; or
- social factors likely to modify the impact of COVID-19 on communities.

The measure, based on demographic, social and clinical indicators, can be used to identify areas of vulnerability and where to target resources in East, North and South Ayrshire. The information could aid decision making by services to reflect the varying levels of need across Ayrshire and Arran. It can be used to aid prioritisation of clinical work including in the Recovery Phase planning process. The measure is an aid to decision making, other knowledge such as socio-economic data, ethnic minority and disabled communities will strengthen its use.

Figures 1 and 2 show that all three local authorities in Ayrshire and Arran are identified as being at high risk to COVID-19 and its wider impacts. The demographic vulnerability is based on higher proportions of people over 65 years of age. The areas with a high social or clinical vulnerability score are likely to have higher levels of multiple deprivation and experience health inequalities across the range of indicators. The vulnerability scores are

available in ranked order at intermediate and data zone level for East, North and South Ayrshire so targeting can be at a small level and tailored.

Figure 1: Top 10 areas in Scotland with highest demographic vulnerability

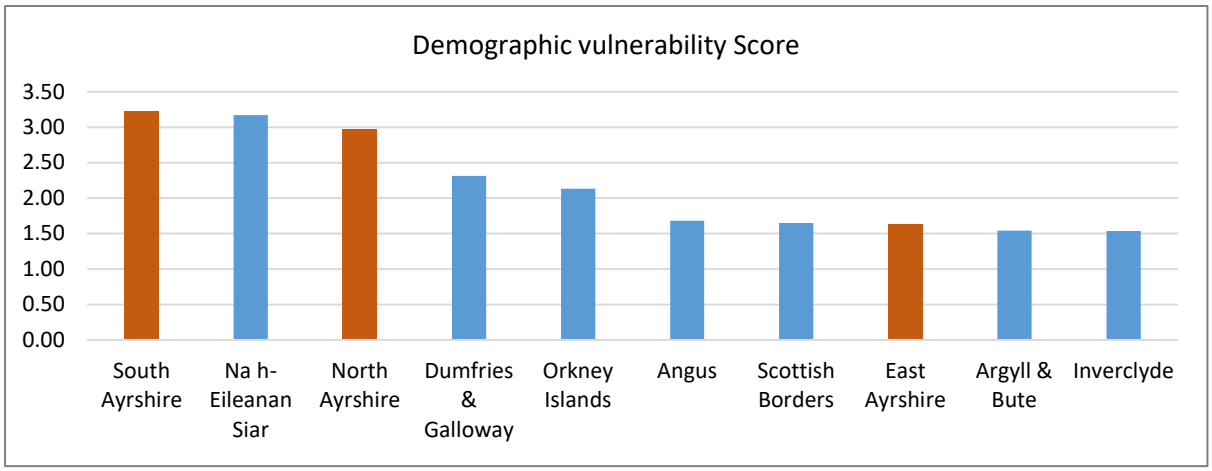
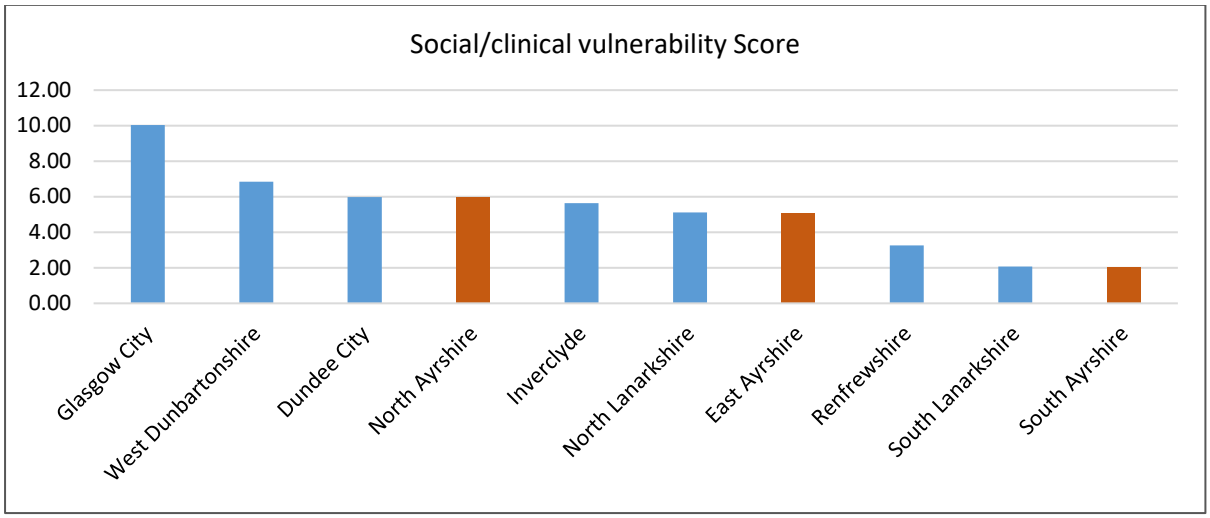



Figure 2: Top 10 areas in Scotland with highest social/clinical vulnerability



### The Local Economic Impact of COVID-19

The Improvement Service have developed a dashboard summarising local economic impact and uptake of government support in each local authority. Figure 3 shows the number of people aged 16-64 years of age claiming Job Seekers Allowance plus Universal Credit. The increase from lockdown in March to June is marked and adds up to 6,975 people. The percentage increase was 63% in East, 60% in North and 70% in South respectively although the largest number of new claims was in North Ayrshire. The total number of employments furloughed up to 31st May 2020 were 16,100 in East Ayrshire, 16,500 in North Ayrshire and 14,500 in South Ayrshire. The total furloughed per 100 of the 16-64 population are similar in Ayrshire and Arran to the Scottish rate per 100 of 21.1.

Figure 3: Total Monthly Unemployment Benefit Claimant Count January to June 2020

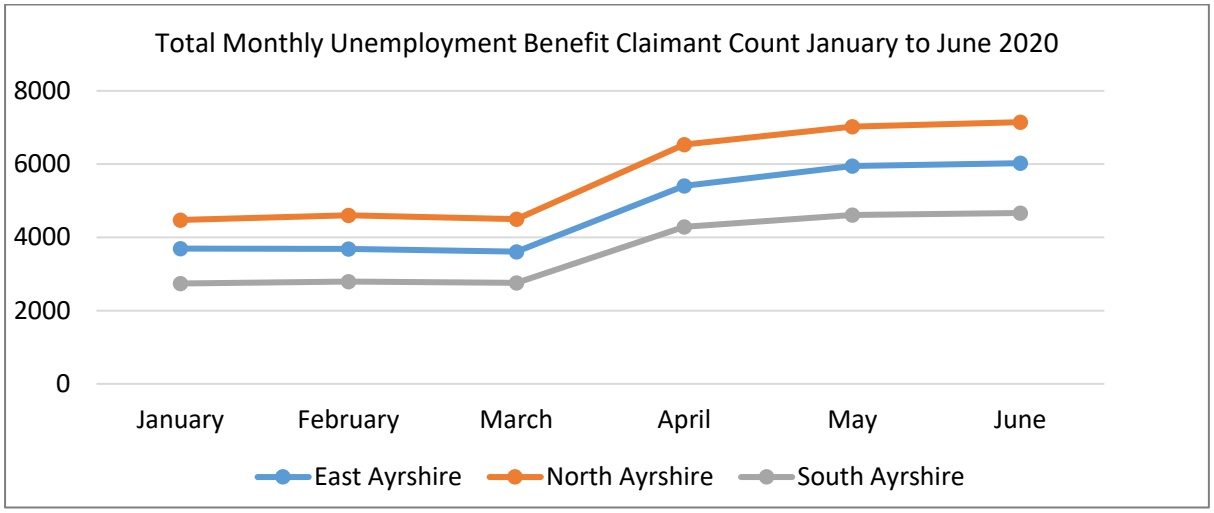



Figure 4: Current uptake of government support at 30th June 2020

| | Business Grants Small and Micro Businesses | Self-Employment Income Support Scheme claims |
|---|---|---|
| East Ayrshire | 1,828 | 3,700 |
| North Ayrshire | 2,178 | 3,500 |
| South Ayrshire | 1,975 | 3,100 |

The emerging evidence of the long-term impacts of COVID-19 signals challenging times for many, those with less financial resilience will experience hardship and health inequalities will be wider and deeper. Public Health will work in partnership to mitigate the social impacts at the local level however, policies at the macro level will have the most impact in reducing inequalities.

**Statement of the Short to Medium Term Priorities to Reduce Inequalities**

Scotland's Public Health Priorities provide the framework for NHS Ayrshire & Arran, its partners and communities to mitigate health inequalities that have been deepened by the COVID-19 pandemic. A whole system approach will be taken to the short and medium term activities, many of which are already established and can be further enhanced through collaborative working at the national level, with Public Health Scotland, Directors of Public Health and Social Security Scotland and at the local level with Community Planning and, Third Sector Partners, Alcohol and Drug Partnerships and communities.

The short and medium term priorities will involve practical mitigation actions to:

- encourage and sustain the physical activity and active travel that communities embraced during lockdown;
- assess the impact of the pandemic on children and young people and identify actions for medium term priorities;
- build on the mental health and wellbeing programmes of work that have been underway throughout lockdown and in particular those elements that tackle social isolation for the range of different age groups;
- continue partnership work with local and national money and energy advice agencies to address income and food insecurity and fuel poverty, and mitigate increasing levels of child poverty;
- adapt training programme to deliver training package for midwives around poverty and welfare reform and disseminate resources to support direct referral of pregnant women to money advice services becoming routine practice;
- promote inclusion health for vulnerable groups; currently monitoring the impact of the pandemic on people from ethnic minority groups, those with addictions, homeless people and people with a learning disability; and
- utilise local public health data and intelligence to monitor population health and evaluate key mitigation measures.

The socio-economic impact of the COVID-19 pandemic is significant and is likely to have a disproportionate impact on people living in areas of multiple deprivation; those who were not in a good position prior to the pandemic and those from ethnic minority groups. NHS Ayrshire & Arran works with Community Planning Partners and in East, North and South Ayrshire various fora are established to engage with communities directly.

**Summary of actions Health and Social Inequalities:**

We will:

- Utilise public health leadership, influence and expertise to ensure Health and Social Inequalities are embedded across all services within NHS Ayrshire & Arran and those of all other partners across Ayrshire and Arran.
- Ensure the voices of Ayrshire and Arran citizens are heard.
- Ensure the voices of children and young people in Ayrshire and Arran are heard.
- Work with vulnerable and underserved populations utilising the ethos of the Barrier Breakers.
- Provide a mechanism to work with communities and individuals to offer a Trauma Informed approach to health and social care and the overarching support offered to our citizens and to our staff.
- Establish NHS Ayrshire & Arran as an Anchor organisation using our influence to procure and employ locally.
- Work to address poverty and inequality through income, housing, education and employment programmes as part of Community Planning.
- Deliver smoking cessation, weight management and Diabetes Prevention to those with greatest need.
- Support the Staff Wellbeing Programme, including plans for the mainstreaming of Staff Wellbeing Services.
- Build capacity within the wider Public Health workforce e.g. DWP; AHPs.
- Take forward a Population Health Mental Health and Wellbeing Programme with particular emphasis on supporting children and young people.

**Summary of revenue consequence:**

- The delivery of essential public health actions to ensure a whole systems, multiagency approach necessary to impact positively on health and social inequalities across Ayrshire and Arran is totally dependent on having sufficient staff to mobilise a coordinated response. Adequate funding must be provided to allow the new and essential COVID-19 testing and contact tracing public health

responsibilities to be continued in tandem with core public health functions.

## 4.0 Primary Care

This section of the Remobilisation Plan has been prepared to set out the recovery arrangements for Primary Care services detailing the work being undertaken to remobilise and progress the previously agreed priorities as part of the reform of Primary Care across Scotland.

Prior to COVID-19 there was significant programme of work to transform how primary care services were delivered in Ayrshire and Arran, particularly the success and pace of implementing the Primary Care Improvement Plan (PCIP) which was on track to facilitate the implementation of the new GP contract by 2021/22.

The PCIP provided a foundation for developing a whole system health and care model which focuses on individuals, families and communities with general practice and primary care providing accessible, continuing and co-ordinated care. The aim across primary care recovery arrangements is to empower people to take control of their own health and care as far as possible, enabling self-management, promotion of wellbeing and prevention of ill health, use of telecare and telehealth and maximising care provided in and around communities, general practices, community optometrists, general dentists and community pharmacists.

During the pandemic many services across primary care quickly adapted to using various methods of digital software and technology. As part of the remobilisation arrangements there are a variety of projects nationally and locally to support new ways of working going forward. This includes products for triage of urgent care, monitoring devices, and also disease management software. There is a requirement to understand the products available and agree a pan Ayrshire approach to those the Board would support and how this will be resourced.

To support the introduction of more digital products, the deployment of corporate and public Wi-Fi, additional bandwidth provision to premises and improvements with the remote access platform will be required. This will support the multi-disciplinary team members working across various sites as well as extended roll out of NHS Near Me and Microsoft Teams collaboration which can be challenging in some areas due to connectivity.

## 4.1 General Practice

During lockdown to Phase 1 of the Scottish Government route map, General Practices were working to the agreed *'General Practice Capacity Challenge Escalation Plan Level 2: suspension of non-core services'*. This entailed preparation for pandemic planning, a move to total telephone and video consultation and stopping of some basic, non-essential services.

In line with phase 3 there is now a requirement for General Practice to move to recovery phase and deliver as comprehensive as possible level of General Medical Services to the citizens of Ayrshire and Arran.

Situation reporting on the levels of general practice was reported on a daily basis throughout Phase 1 and 2 is now reported on a weekly basis to Scottish Government. Three levels of escalation were established to be considered in light of national clinical priorities for primary care:

- Level 1 – Suspension of non-core activities (this would have applied to all practices in a Health Board's area during Phase 1). It was ultimately for Health Boards and local stakeholders to determine what they do not regard as being core.

- Level 2 – Managed suspension of services (this would be determined on a case by case basis) it is not possible for the practice to continue to provide all core services to patients.

- Level 3 – Full suspension of services (this would be determined on a case by case basis) - When circumstances arise that it is not safe or possible for the practice to continue to provide services (normally due to the non-availability of clinical staff or levels of demand mean that the normal level of service is unsustainable).

There are 48 GP Practices reporting to be at Level 1 and 5 GP Practices to be a Level 2. In order to fully understand each practice's current level of service provision and any challenges in relation to the implementation of physical distancing measures, the Primary Care Contract and Support Team will work with each individual practice to ensure delivery of the key priority aims below and develop specific action plans to support them back to comprehensive service delivery – Level 0. This will also be progressed in collaboration with the restart of secondary services to ensure there is an understanding across the system what level general practice is operating at.

Practices are also reporting any changes in their financial circumstances that affect their ability to provide services which will be captured and escalated as required.

A De-escalation Committee was established to oversee General Practice recovery back to full service. The Committee reports to Primary Care and Community Group is co-chaired by the Director of East Ayrshire Health and Social Care Partnership, as lead Director Primary Care, and the Chair of GP Sub Committee. It also comprises Secretary to GP Sub Committee, the Associate Medical Director of Primary Care, Clinical Lead for Out of Hours, and Heads of Service for Primary Care and Out of Hours. The Committee will remain in place throughout Phase 3 mobilisation.

Re-mobilisation of General Practice will require continued flexibility and resultant change in the way it operates and delivers services. Services within General Practice can only commence when they can be carried out safely. The priority aim is to meet the urgent and critical ongoing care needs of patients first, resuming routine, evidence based work as capacity allows while being cognisant of the health and safety of staff and patients with a continuing COVID-19 risk.

These aims include:

- To support the continuation of a primary care service prioritising cancer, mental health and urgent care with resuming other services as whole system capacity allows;
- To continue palliative care, care home and shielding patient care along with continuing Anticipatory Care Planning and formation of eKIS as a whole system; and
- Continue to have as specific COVID-19 pathway via NHS 24 and local Clinical Hub and Assessment Centre to provide a single point of contact for patients who present with deteriorating COVID-19 symptoms as well as reducing the infection risk in practices. This will ensure specific COVID-19 management expertise for all in the community to access also reduces unplanned COVID-19 related ED attendance and the risk of unnecessary hospital admissions.

Remobilisation will also have an impact on the timelines associated with the delivery of PCIP and new GP contract 2021/22 as previously planned.

## 4.2 Primary Care Improvement Plan (PCIP) 2020-22

As part of the 10 year vision whole system transformational programme of activity 'Caring for Ayrshire', NHS Ayrshire & Arran and the three IJBs worked collaboratively to develop the PCIP and define a model of care that links closely with wider locality teams to form a fully integrated health and care system.

The programme for introduction of multi-disciplinary teams (MDT) working is complex and the scale of change required across professions whilst challenging, is recognised to be a unique opportunity to progress a longer-term strategy of transformational change to deliver the vision for Primary Care.

The PCIP framework continues to be delivered throughout the pandemic with the recurring funding that was available with the workforce remaining in post. Feedback from GP Practices and the MDTs was during the peak of COVID-19 practice staff and the teams worked jointly to form solutions, developed good working relationships, and have enjoyed forming as an overall team. This learning and flexibility has been recognised and will be taken forward throughout the implementation.

**Pharmacotherapy -** all GP practices within Ayrshire and Arran have access to Pharmacotherapy services with good progress being made with implementing the Level One core service as part of the new contract. Additional recruitment has also taken place to complete the projected staffing model that was set out in the PCIP agreed across the system in December 2019.

**Additional MDT Members -** The MDT teams including Mental Health Practitioners, MSK Physiotherapists and Community Link Workers have continued to support practices reporting appointment numbers have remained at same levels as pre-COVID, and higher for some services. The service are mostly being delivered by telephone consultations/Near Me as first appointment.

**Community Treatment and Care (CTAC) Service** - development plans for the service, which was a significant commitment of 90 wte for 2020/21 were paused in March due to COVID-19.

Using the initial results from test of change pre COVID-19 and the learning from working alongside primary care and community nursing and general practice through the Clinical Assessment Centre model has helped inform the CTAC model further.

There was the opportunity to recruit newly qualified nurses through the recruitment of graduate nurse programme with the Board successfully recruited 33 new graduate Primary Care nursing posts to take up post through the Primary Care Improvement Fund (PCIF) in September 2020. This will form the foundation of the newly developed CTAC service with a first priority to support delivery of the flu campaign for over 160,000 residents across Ayrshire and Arran. The Board will invest in post graduate education through our local development programme to equip them for these new roles. This will also take into account the availability of new post-graduate programmes on offer form our local universities.

The funding of £605,553 is required to fund these posts until March 2021 with a recurring requirement of £1.2 million in 2021/22. It is anticipated the Primary Care Improvement Fund allocation for 2020/21 will cover these costs.

**Vaccination Transformation Programme –** many of the actions and funding associated with this programme were agreed early 2020 to be implemented by 2021 and implementation plans continued where possible during Phase 1 and 2. An update on each of the five agreed programmes is noted below.

1. Pre-school programme
   - A clinical delivery model was agreed pre-covid to transfer vaccines to the HSCPs and recruitment continued for the additional workforce model. Model for delivery of childhood flu being scoped as overall flu planning for winter 2020 using child health nursing teams to support this. On track to transfer fully.

2. School based programme
   - No changes were required to current delivery model.

3. Travel Vaccinations and Travel Health Advice
   - There was agreement to develop hub and spoke model along with other contractors (i.e. local pharmacies and interested GP practices). Operational aspects of hub and spoke model will continue to progress throughout 2020/21 to be implemented.

4. Adult Influenza
   - Agreement within the PCIP that delivery of flu clinics would be based on current practice models where possible using additional workforce recruited as part of CTAC.
   - Prior to COVID-19 progress was being made towards delivery of flu clinics in some GP practices by HSCP staff in winter 2020 with an aim of delivery transferring across to HSCP staff in Ayrshire and Arran by 2021.

- The emergency flu planning has followed a similar model supporting practices with HSCP primary care nursing resource as well as providing additional alternatives to GP Practices to support mass numbers. This model is described in more detail below and will allow learning and good practice for winter 2021.

5. At Risk and Age Group Programmes
   - Model was implemented in October 2018 through the midwifery service for delivery of pertussis and flu vaccines for pregnant women.
   - Pre-COVID-19 it was proposed the delivery of adult immunisations would be through the CTAC service late 2020 with the ongoing additional capacity in service. With the additional workforce being recruited late 2020, and the need to focus on flu delivery, it will be likely transfer of this programme will be early 2021 if the PCIF allocation allows further recruitment to reach the previously projected workforce number. The transfer will be phased as the workforce allows.

**Urgent Care -** Using Advanced Nurse Practitioners (ANP) to support COVID-19 and urgent care presentations working alongside Primary Care nurses in the COVID-19 assessment model has demonstrated an effective model for delivery and will be explored through new ways of working.

There was a commitment within the agreed PCIP to recruit 5 ANPs and 12 additional nurses to commence on ANP Training Academy aligned to GP Practices to train and develop current staff, and 'grow our own' workforce who aspire to become advanced practitioners with a structured funded training programme. Funding was allocated within the PCIF 2020/21 and further clarity is required on the allocation available to Ayrshire and Arran along with understanding the position with universities to support this model in the near future.

Urgent Care within General Practice should now be considered in line with the re-design of urgent care and considering how practices are now triaging and assessing patients at first point of contact.

The impact of COVID-19 and what this means for the current Memorandum of Understanding is not yet known. The actions committed for 2020/21 will continue to progress with a focus and alignment to the overall recovery planning for primary care and community.

In light of the recovery and mobilisation arrangements, it will be necessary to review the current PCIP programme structure and the areas within to reflect the wider recovery arrangements for Primary Care and Community.

## 4.3 Community Optometry

All static site community optometry practices, with the exception of one community optometry practice, which has two sites in North Ayrshire, re-opened on Monday 29th June following submission of an acceptable COVID -19 risk assessment to the Health Board. These practices have been providing emergency and essential eyecare with needs led eyecare from 3rd July 2020. Many practices are available in the out of hours period and where unavailable, practices will redirect patients to NHS 24 for assistance.

Practices continue to care for patients via telephone triage and digital solutions (Near Me), conducting face to face appointments for all emergency and essential cases; all optometry practices have been provided with Personal Protective Equipment (PPE).

Patients may be redirected to other optometry practices, referred to Eye Casualty at the hospital where clinically appropriate for ocular emergencies and to the Hospital Eye Service (HES) (Ophthalmology) via SCI Gateway for urgent and routine care.

Optometry practices are currently not permitted to provide routine eye examinations. The Diabetic Retinopathy Screening process is scheduled to recommence at the end of August in a reduced capacity but prioritising clinical need.

A number of development initiatives are being considered across primary care and secondary care. These are being explored and progressed via our local professional advisory and joint working groups including learning from good practice across other Board areas. These include:

- A revised eye care referral protocol document to support the referral process during the recovery and remobilisation phases. This is being developed in partnership with the Area Optical Professional Committee and Ophthalmology colleagues to take account of the current limitations on service provision being experienced by both primary and secondary care at this time;
- The hospital eye service are, where clinically appropriate and safe to do so, discharging patients from their outpatient review waiting lists for ongoing review within Primary Care Optometry; and
- An enhancement to EyeCare Ayrshire is being scoped with General Ophthalmic Services where co prescribing would take place between community optometrists and GP colleagues for conditions that would previously have been treated via secondary care colleagues. As well as enhancing the Community Optometrist skill

set and level of competence, this joint working would support secondary care colleagues by widening the scope of what can be safely managed within community optometry and safely undertaken in a community setting.

Access to clinical portal for optometrists is being pursued with Digital Services colleagues as encouraged by Scottish Government. Securing access for community optometry practices would support the following areas:-

- Improvement to patient experience/pathway and clinical care;
- Prevention of duplication of activity;
- Reduce inappropriate referrals from Optometrists;
- Reduce admin burden on both Optometrists and HES in terms of chasing outcomes or details of changes to management plans for specific patients;
- Improved clinical management decisions;
- Will enhance the ability of IP Optometrists to manage patients to their full scope of practice;
- Reduce the need for re-referrals and out of hour's attendances for previously diagnosed or chronic conditions;
- Support development of shared care programmes; and
- Enhance and streamline the Primary /Secondary Care interface.

Financial Implications - Practices are only able to generate minimal dispensing income currently in the absence of routine eye examinations and there are potential problems with practice viability should this arrangement be in place for any great period of time. Scottish Government has agreed funding to support practices and this has been implemented locally.

The HES are planning on utilising a cohort of Optometrists on a sessional basis within their department to co-manage specific outpatient groups with Ophthalmologist colleagues.

Future ways to develop remote consultations with secondary care colleagues utilising NEAR Me technology to reduce unnecessary referrals and to maximise management of the patient's condition within the community optometry setting are being explored

All of these exciting and progressive developments are only possible as a result of the strong relationship between primary and secondary care in optometry/ophthalmology and as a result of the positive focus of the Eyecare Integration Group.

## 4.4 Community Pharmacy

Community Pharmacies across Ayrshire and Arran are open and accessible to members of the public in hours and out of hours ensuring access to medicines and pharmacy services and also continue to provide delivery services to the vulnerable and members of the community in the shielding category.

The Board continues to support pharmacies as demand for services increase, supporting risk assessment for staff, access to COVID-19 testing during Test & Protect, and PPE supplies.

During the pandemic there was a real drive to implement the already scheduled serial prescribing roll out to all GP practices and community pharmacies using remote technology. This was a key enabler to the delivery of the Pharmacotherapy Service as part of the PCIP as serial prescribing reduces repeat prescription request volume and footfall at GP practices as patients can collect their repeat prescription direct from their chosen pharmacy.

It is essential to ensure that Community Pharmacy as a whole has the capacity required to deal with the continuing presence of Covid-19 and to do so the following measures have been put on place:

- All have Business Continuity Plans to ensure contracted national and local services are maintained, taking cognisance of potential closures due to the current pandemic;
- Collaborative working is ongoing between community pharmacy and primary care, including arrangements where required for the redeployment of managed service staff, to ensure maintenance of community pharmacy services;
- In the event multiple community pharmacies are unable to open, NHS Ayrshire & Arran in conjunction with contractor body Community Pharmacy Ayrshire & Arran, have a plan to contract service provision taking into consideration population, rurality, availability of other services, premises size, parking, participation in Palliative Care Scheme and opening hours. The plan would also consider any parallel pressure on GP practices opening to allow populations to be supported;
- Increase use of clinical email by pharmacies as the primary route of communication, to strengthen relationships with health and social care professionals and improve overall patient care;
- Increased use of electronic transmission of prescriptions using Adastra and the Unscheduled Care Framework which will support whole system working, assist with unscheduled care demand and

assure quick access to medicines, facilitating transformation and re-design; and

- Greater access to Emergency Care Summaries and patient discharge information will improve the primary-secondary care interface transition and support service transformation. Access to Clinical Portal would further enhance patient care by providing community pharmacists with key information out of hours that could reduce patients need to access urgent care.

Community Pharmacy is also preparing for the winter season, including access to medicines and readying services to support the use of community pharmacies as first port of call for common clinical conditions by focussing on:

- The launch of the new NHS Pharmacy First Scotland service;
- Reviewing current Community Pharmacy service models, removing outdated practice and developing local Patient Group Directives to treat new conditions;
- Developing a geographical network of Independent Pharmacist Prescribing clinics; and
- Developing use of Near Me through community pharmacy.

There are also lots of opportunities to develop Community Pharmacy further with plans to:

- Contribute to the Ayrshire and Arran mixed model for flu delivery by developing a Community Pharmacy Flu Vaccination Programme to increase access for eligible patients;
- Work with community pharmacy colleagues and GP clusters to support and enable shared learning and approaches to local pathways which best meet the needs of the local population.
- Increase use of social media to promote services e.g. Pharmacy First, Common Clinical Condition Clinics, Sexual Health Service, Smoking Cessation Service etc.;
- Develop new pathways to deliver pharmacy services closer to home and accelerate transformation and re-design e.g. provision of new biologic treatments dispensed at the Community Pharmacy instead of an acute setting;
- Support care homes and Care at Home services with access to medicines and advice about both medicines and available services including Pharmacy First, Palliative Care, MAR chart service;
- Engage Care at Home Pharmacy Technician Service as part of home care assessment, to ensure medicine review is completed and cost efficiencies are realised for both Care at Home services and the prescribing budget;

- Develop Community Pharmacy Addictions Services to include provision of Naloxone and increase the availability of Injecting Equipment Provision community pharmacy sites across the health board area; and
- Work with health and social care partners to identify new ways of working, promote third sector agency services, and enhance patient care in the community.

NHS Ayrshire & Arran Community Pharmacy Advisors (CPAs) will deliver education sessions to staff in Emergency Departments, Combined Assessment Units and Ayrshire Urgent Care Services to promote the Pharmacy First Service using promotional materials will be shared for display in these areas to raise awareness amongst staff, patients and the public.

The team will promote the service through a range of methods and the CPAs have been supporting community pharmacies prior to, during and after the launch of the service to ensure optimal use and, in particular to widen access to common clinical conditions clinics across Ayrshire and Arran.

## 4.5 General Dental Service

There have been two phases in the remobilisation of General Dental Practices across Scotland, these are:

- **Phase 2**: All dental practices were to open for face-to-face consultation for urgent care that could be provided using non-aerosol generating procedures. Boards were required to have Phase 2 implemented by 31 July 2021. In Ayrshire all dental practices are now operating at Phase 2 with the exception of one practice due their premises being flooded. This practice has arranged for patients to be seen at their branch site; and
- **Phase 3**: Face-to-face consultation to be expanded for patients that can be seen for routine care, including examination, and treatment that can also be provided using non-aerosol generating procedures (AGPs). There was no definitive date set for phase 3 implementation, this will be determined when practices are in a position to open following all recommended guidance. It is also noted that many routine procedures require aerosol generating equipment there for routine options are limited.

During both phases the Urgent Dental Care Centres will continue to see patients on referral for treatments involving aerosol generating procedures (AGP). These Urgent Dental Centres are located within the Public Dental Service (PDS) Dental Hubs in Ayr Hospital, Northwest Kilmarnock Area Centre, Ayrshire Central Hospital and Arran War Memorial Hospital.

As part of re-mobilising, practices were issued with templates from the Dental Management Team (DMT) for risk assessments and standard operating procedures (SOPs) that practices could use to develop re-opening plans and ensure robust clinical governance. Completed risk assessments and SOPs were submitted to the DMT for review and approval, only once approved could a practice re-open.

The DMT have a practice champion in place for each practice and have weekly Microsoft Teams calls to ensure practices are supported through this time and any concerns or issues are addressed.

Dental Practices identified lead nurses for re-opening arrangements who were provided with training via Microsoft Teams and provided with SOPs and videos that could be used to cascade training to the other staff in the practice.

For Phase 3 this process is being repeated with practices updating their plans and submitting to the DMT for approval. The practices have also been requested to consider and include AGP protocols to prepare for the next phase of remobilisation.

A further phase, yet to be determined, envisages a limited introduction of AGPs to dental practices, this will be dependent on PPE and the evidence of risk and possible mitigation.

In anticipation of this future phase, staff within the practice have been FFP3 mask face fitted. This has allowed practice teams to utilise the Urgent Dental Centres, seeing their own patients and completing the AGP treatment themselves. This allows the staff to experience working in these conditions while being supported. The feedback from the general dental practices has been extremely positive as this allows them to be prepared for seeing patients for these procedures back in their practice.

Financial Implications - Recognising the current service model is not the most appropriate vehicle of financial remuneration during this period of reduced activity, the Chief Dental Officer is reviewing alternative models of funding that will provide a more sustainable income level and ensure that appropriate NHS financial support measures are put in place for each phase of recovery.

As part of the Remobilisation Phase 2 the General Practice Allowance has been increased by 30%.

**Summary of actions:**

We will:

- Progress a Digital programme to support the priorities identified by Primary and Community services to improve access for the citizens of Ayrshire and Arran, the effectiveness and efficiency of services and the work / life balance of our health and care staff.
- Through our joint arrangements of the De-escalation Committee Continue to work closely with GP Practices and provide support in their plans to resume to full service including new ways of working.
- Continue to have as specific COVID-19 pathway via NHS 24 and local Clinical Hub and Assessment Centre.
- Implement the mixed flu programme delivery model by 1 October 2020
- Progress with the PCIP agreed actions and implementation timeframes as funding allowed with a particular focus on Community Treatment and Care to support stability in General Practice and delivery of the flu programme.
- Progress an ambitious programme of development in Optometry services including the interface hospital Ophthalmology services.

- Progress the innovation of Community Pharmacy including interface with General Practice and the introduction of Pharmacy First.
- Work closely with General Dental Services to increase service delivery where possible and safe to do so.
- Progress initiatives with wider stakeholders and Primary Care Contractors to support the safe transfer of any patient care which could be community led throughout remobilisation and in future models.

**Summary of revenue consequence:**

- £605,553 is required to fund the CTAC nursing posts until March 2021. It is anticipated this will be funded via PCIF in 2020/21. The recurring requirement of £1.2 million 2021/22 is anticipated to be covered within the PCIF allocation when this is confirmed to Boards, but is a risk if this is not received.
- Payments to GP practices in Ayrshire and Arran for staying open over public holidays in April and May amounted to around £0.7 million and a similar payment to pharmacists amounted to £0.3 million. Additional costs in GP practices for staff overtime, locum cover, equipment costs etc. was a further £0.8 million**.**
- A national group estimated that the impact of the COVID-19 pandemic on primary care prescribing volumes was a 1% increase therefore a cost of £0.8 million is included to reflect this, however in additional a price increase has been seen and this is estimated to cost an additional £5.2 million.

| | Year to Jun | July to March | Projected Expenditure |
|---|---|---|---|
| **Primary Care** | **£'000** | **£'000** | **£'000** |
| Additional FHS Payments- General Ophthalmic Services | **0** | **20** | **20** |
| Additional FHS Payments- GP Practices | 1,459 | 353 | 1,812 |
| Additional FHS Prescribing | - | 6,079 | 6,079 |
| Additional FHS Payments to Pharmacists | - | - | - |
| | **1,459** | **6,452** | **7,912** |

## 5.0 Community Services

This chapter will consider the following community services

- Clinical Hub
- Community Nursing
- Care at Home
- Community Hospitals

Partnership working in community is key to delivering cohesive integrated services from the perspective of the service user. Building on existing strong relationships, the period of the COVID pandemic has seen an enhanced sense of partnership with our staff, the independent and third sector providers. The Strategic Planning Groups of the IJBs have been a foundation of these relationships.

A particular focus has been our care homes given collective challenges and pressure experienced by HSCPs and care homes. Across the whole health and care system we are committed to build on this constructive relationship, to maintain strong supportive links with care homes and use current assurance exercises to build a new supportive quality assurance framework. Discussions around having a quality assurance framework are not new but this experience has highlighted the need to progress this piece of work.

Regular engagement with Third/Independent sector partners has continued to take place, and our employee representatives have been included in our planning and delivery arrangements.

## 5.1 Clinical Assessment Centre

As part of the COVID-19 Clinical Hub pathway there is one assessment centre co-located on the Lister Centre site with the Clinical Hub. A second site had opened on the Ailsa site, South Ayrshire but closed after six weeks due to very low numbers attending.

Ayrshire and Arran are keen to maximise the use of assessment centres providing a dedicated pathway for COVID-19 patients to be assessed face to face as well use the resource aligned to the hub to support the mobilisation of primary care and acute services.

Due to low numbers attending the assessment centre, the primary care nursing workforce aligned to the assessment centre have supported the restarting of some out-patient services by supporting the Ayrshire Community Blood service to deliver an enhanced community phlebotomy service to those out-patient services who are carrying out remote digital consultants and allowing patients, particularly those shielding, to have monitoring bloods done. Without this flexibility the mobilisation of these services would be delayed.

Work is ongoing through the whole system Strategic Interface Group arrangements to take forward the re-design of urgent care to determine how best to utilise the hub and assessment centre model to facilitate delivering care as close to home as possible, as well as developing pathways using the model we know has worked for COVID-19 specific symptoms to reduce the number of unscheduled urgent care presentations around the system.

## 5.2 Community Nursing

COVID-19 is likely to be in our communities for some time and it is important for community nursing 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 their home as possible. The planning assumption is that there will be an increase in demand for community nursing services and that this will impact on our district nursing capacity as we aim to meet the needs arising from remobilisation in the context of an aging population and workforce. This includes a potential need to provide increased support to care homes and their residents.

**Demand**

It is anticipated that demand pressures will increase for a number of reasons;

- the impact of physical distancing on General Practice capacity;

- the resumption of planned surgery locally; and
- the potential opening of beds at NHS Louisa Jordan to undertake delayed procedures.

All of the above pressures have the potential to impact significantly on the service.

It is anticipated that a number of Ayrshire & Arran residents will require District Nursing (DN) services on discharge from hospital, and also to help prevent their admission to hospital.

It is assumed that this will not be an insignificant number and in addition there will be increasing numbers of citizens requiring a range of post-operative interventions such as wound dressings, fragmin injections, eye drops and other procedures; and the potential for increasingly frail residents being kept in their own homes.

We will use the nationally developed workload tools to prioritise and manage this demand and inform our ongoing workforce planning arrangements. We are aware that the Nursing Midwifery Workload and Workforce Planning (NMWWP) tools are being further reviewed at the request of Scottish Executive Nurse Directors (SEND) to ensure that they reflect different ways of working which recognise the need for social/physical distancing and the doffing & donning of PPE for example.

**Workforce**

It is important that we plan to align the development of pre and post-operative nursing interventions with our Primary Care Transformation Plans as part of Remobilisation Phase 2. The opportunity to integrate the future redesign of community based nursing services to deliver interventions which have traditionally been delivered in hospital settings with the existing plans to develop primary care based Community Treatment and Care Services needs to be progressed at pace. This transformational approach needs to be whole system and integrated at the interface with the citizen.

We will be seeking to design the skill mix across our community nursing teams to be meet the range of scheduled and unscheduled needs of our citizens. This will require the continued investment in education and skills development for our community nurses thus establishing clear career progression for staff. Specifically we will invest in primary care and district nursing post graduate education and continue our investment in the development of our community nurse advanced practitioners who will be pivotal in leading and delivering urgent and unscheduled care to citizens in our communities.

**Summary of actions for Community Nursing:**

We will:

- Use the nationally developed workload tools to prioritise and manage this demand and inform our ongoing workforce planning arrangements.
- Align the development of pre and post-operative nursing interventions with our Primary Care Transformation Plans as part of Remobilisation Phase 2.
- Recruit 40 new graduate nurses to community nursing/CTAC posts in July 2020, to take up post in September 2020 and will invest in post graduate education through our HEIs and a local development programme to equip them for these new roles.
- Seek to design the skill mix across our community nursing teams to be meet the range of scheduled and unscheduled needs of our citizens.

**Summary of revenue consequence:**

- Costs yet to be determined in relation to capacity challenges in relation to workload tools and transfer of task from hospital to community.
- For Community Treatment and Care services to deliver on the GP Contract in 20/21 40 new graduate nurses (Band 5) - £1.4m (to be funded from Primary Care Improvement Fund) Note this includes the 33 nurses set out in the Primary Care Section

## 5.3 Care at Home

This section with the Community Services chapter sets out the Care at Home provision for the three health and social care partnerships.

**EAHSCP Care at Home**

The Care at Home service during earlier stages of lockdown emerged relatively unscathed in relation to delivery of its service although this was specifically as a result of a recruitment campaign ore COVID where 90 additional social care workers were employed to support development and sustainability of the service. In addition there were a number of requests for services to be suspended. The majority of those suspensions related to family availability due to furlough schemes and the contingency plans to prioritise work was therefore not required and service provision remained unchanged.

These suspended services are being regularly reviewed and some are coming back online whilst others are being provided with alternatives to formal care. This has released small pockets of capacity but generally the service remains close to full capacity at all times with some scope for manoeuvrability on a day to day basis.

When considering the impact of Winter Planning and / or a second wave of COVID-19 the delivery of the service from August to March will be dependent upon a number of variables and considerations:

- The likelihood of further requests for suspended services to balance potential spikes in staff absence and the subsequent requirement for reprioritising services to balance capacity and demand;
- The service is currently managing a gradual increase in hospital based activity and throughput but any further “spikes” in relation to winter planning, COVID-19 or changes to current reduced attendance patterns would present challenges in negotiating available capacity and would require further consideration of reprioritising services;
- The “Transition Beds” developed to support the COVID-19 response have not been used as a means of supporting hospital discharges but are a key component of our response to any future surges.
- The delay in provision of Occupational Therapy (OT) aids/ adaptations presents risks to the Care at Home Service;
- Telephone reviews do not sufficiently capture opportunities for enablement activity and subsequent demand management

- The available capacity in our Enhanced Intermediate Care and Rehabilitation is inextricably linked to the wider Care at Home Service;
- Externally delivered services showed minimal impact in relation to staff absence and or increased demand as the position pre COVID-19 limited the work being picked up by providers; and
- The support offered by Vibrant Communities and wider community supports has been invaluable to the delivery of Front Door Services and contributes to demand management in Care at Home.

**Additional Support Needs**

Whilst vacancy levels are at an all time low following recent recruitment drives, turnover and absence remains a risk to capacity. A further recruitment drive is planned for August 2020 to support Bank staff availability, turnover and winter planning.

An additional 24 Personal Carers to support ICT in prevention of admission to hospital and supporting discharge are required to support anticipated surges and 36 Personal Carers to support wider locality and Front Door delivery models including short term early intervention and prevention.

In terms of our existing workforce we require continued availability of wellbeing hubs to support Personal Carers, attendance at work levels and effective communication strategies.

A commitment to continue the community and Vibrant Communities links established to provide support at the current level – e.g. daily / weekly telephone contact / shopping support / pharmacy deliveries etc.

The requirement for Home Care Managers to Work from Home to support physical distancing in the longer term will have an impact on the wellbeing and connectedness of what is an already dispersed and fragile workforce. Greater opportunities to connect with PC's is required both virtually (provision of devices / email addresses) and physically (large spaces to meet with teams).

**East Ayrshire Community Health and Wellbeing Hub (former day hospital)**

Ensuring continuation of this safe, person centred balanced approach is an essential component of our mobilisation plans.

Key deliverables: March to August 2020

- General inpatient services have continued to operate, offering full capacity.
- Successful implementation of over 70s patient testing and weekly staff testing.
- Use of digital technology to support multidisciplinary team working by use of Microsoft Teams.
- Twice weekly huddles via MST with acute services to ensure flow capacity maximised.
- Current unused inpatient areas registered as residential care facilities with the Care Inspectorate to provide 25 beds to support any surge activity.
- Early re-establishment of OPD as an area wide centre to support specialities, eg anticoagulation therapy, orthoptics, renal phlebotomy and urgent reviews.
- Development of a wellbeing space for hospital, care home and partnership staff to support rest and recovery.
- Online mindfulness 8 week programme for staff underway led by partners at Dumfries House
- Engagement with staff to understand COVID-19 experience and capture learning to shape and deliver future models and ways of working.
- Health & Wellbeing centre (hub) re-provision to deliver community midwifery services
- NMAHP workforce planning and training needs analysis to identify requirements for new model of care.

Key actions: August 2020 to March 2021

- Development and implementation of an ANP-led model which will deliver a revised inpatient model and provide outreach support. This will allow bed utilisation to ensure that services can support all of East Ayrshire residents and contribute to a whole system approach.
- Establish new inpatient model of care including development of a rehabilitation unit (Roseburn ward) with associated workforce for a 7 day service which will deliver the aims of Caring for Ayrshire.
- Recruitment drive to ensure all vacant posts are filled.
- Further growth of outpatient capacity through a phased approach to support local demand and whole system model.
- Use of digital infrastructure to enable a blended approach of support via digital and face to face services. Introduction of NHS Near Me for inpatient and outpatients services once current network upgrade complete.
- Funding to ensure sustainability of a staff sanctuary in order to continue to support staff wellbeing in-house and for all community and partnership staff.

- Re-establish and enhance our Community Health and Wellbeing Hub in line with the new model of care and distancing requirements, through timely access to a full range of services and options.
- Additional capacity of 13 Residential beds available and although not required to date, can be mobilised with an agreed 48 hours notice.

Dependencies

- Investment of nursing and AHP workforce to support 7 day working model and deliver the new model of care informed by the new COVID-19 risk assessments. Full costings to be confirmed.
- Protected time for staff for wellbeing, training & development.
- Successful recruitment into current vacant posts.
- Availability of Care Homes and acceptance of individuals discharged from inpatient setting.
- Availability of digital technologies to support professional to professional contact, and patient review.
- Coproduction with staff, local community and partners.

## NAHSCP Care at Home

The Care at Home provision across North Ayrshire has continued to operate as normal and indeed has continued to grow the workforce within the NAHSCP during the pandemic.

There have been three recruitment events held with the venue for the events being risk assessed beforehand to ensure that physical distancing measures have been adhered to. Across the three events 224 individuals have attended and shown interest in the various flexible posts being offered across Care at Home services.

There was a temporary cessation of care at home service provision to those individuals with very low level needs undertaken in March/April 2020 to allow for increased capacity to support more complex discharges from hospital and to maintain individuals with higher level of needs in their own homes as opposed to being admitted to hospital or a longer term care unit.

Those individuals who had their care at home services temporary stopped have received weekly contact from the Locality Teams to ensure their wellbeing.

The PPE Hub has remained open over seven days a week with the Hub also remaining available out of hours on a call basis. The daily delivery of PPE bundles/packs to care at home staff at various drop off locations across North Ayrshire has continued.

## SAHSCP Care at Home

The impact of COVID-19 was always going to have a significant impact on frontline care workers. The initial plan to reduce this impact from the outset was to introduce a new out-of-hours rota designed to support carers 7 days per week. From an operational perspective this has been welcomed by all staff. The Care at Home service currently has 27 staff shielding at home.

The service will be led by local need and national and local guidance to ensure we can support staff to return to work safely. There has been an increase in purchased private care at home hours through 1st April to 1st July. The future design and commissioning of the Care at Home service will be led by other work around reducing delayed discharge, reablement, etc.

The Partnership is in discussions to consider the opening of the day care provision with older people as soon as we reach a phase that will allow this. At present, we are, and have been throughout the period of lock down, providing an outreach service for many vulnerable service users. This has supported both service users, carers and the care at home services.

A working group will be initiated to drive Care at Home and reablement improvement along with a focus on cultural change including provider sector. This group will work towards the implementation of a transformational strategy designed to minimise unscheduled hospital admissions, reduce delayed discharges and transform care at home services with the ultimate aim of shifting the balance of care.

The Provider Forum will be re-established to facilitate communication and engagement between services and operational teams.

A new out-of-hours rota has been implemented to support the management of the service and to provide reassurance for frontline staff during evenings and weekends.

An exercise on rebalancing activity and spend in care at home and district nursing will be undertaken as well as a review of care at home hours for private and in-house services.

**Digital**

The deployment of Office 365 and its associated collaboration tools along with a further deployment of mobile devices are scheduled for the remainder of this year. The deployment of clinical portal licenses and further EMISweb implementations will also enhance care within the community giving clinicians access to all patient data securely at the point of care. The further deployments of TEC to support patient care will enable safe remote monitoring of patients within the community.

**Summary of actions for Care at Home:**

We will:

- Continue to engage with existing service users and their families to ensure that care is prioritised to meet personal need in a fair and transparent way.
- Work with colleagues across Community / Primary / Acute health services to ensure that people are supported to be provided with care as close home as possible.
- Support our workforce in personal resilience to continue to provide a compassionate social care service.
- Support our workforce in developing new skills to support integrated models of working.
- Within available resources recruit an enhanced workforce that both provides the social care required and also provided valuable economic development in the heart of our communities.

**Summary of revenue consequence:**

**In East Ayrshire:** 60 Personal Carers (40 FTE) - £1.33m per annum. (6 month cost £0.665m)

**In North Ayrshire:** short term contracts offering additional hours were given to existing staff creating additional capacity across the workforce through the pandemic. This created an additional 6 wte and we recruited 20 Care at Home Staff over and above establishment. The full-year cost of this is approx. £650k.

**In South Ayrshire**: the Care at Home service has seen a 5% increase in care at home hours purchased, mainly due to deterioration of service users from social isolation, non-attendance at day care, on average care packages have increased by an additional hour per week. In order to continue to provide support to keep people safe at home, an additional 920 hours are expected to be required per week at an annual cost of £0.818m. The investment in purchased care will enable us to maintain service users at home. Further investment is required in the reablement team to maintain levels of delayed discharges; an additional 15 FTE Care at Home workers would be required at a cost of £0.235m.

## 5.4 Care Homes

NHS Ayrshire & Arran has worked closely with the Health and Social Care Partnerships, our three Council partners and Scottish Care to ensure that we have provided support to the care homes across the county. It is important that as we move through this next planning period that we continue to support our care homes as they provide an important care provision as part of the wider health and care sector.

**Support to Care Homes**

It is recognised that the care home sector has a number of risks and challenges to consider going forward. These include workforce, capacity and financial viability. The ask of care homes will remain extensive including new visiting models, new risk assessments, new testing regimes, reduced occupancy levels, working with families to manage concerns and maintaining effective communication. Given all of these challenges it is essential that we continue to support our care home sector as a key part of the wider health and care system.

A single point of contact number was put in place for care homes to access clinical or nursing advice directly from the Hub for COVID-19 concerns or from an OOH GP/ANP for any other concerns. Care homes are accessing this service regularly and this will continue until March 2021. As part of our response to the request for Nurse Directors to have increased accountability and to establish enhanced clinical and care professional oversight, our three HSCP Care Home Oversight Groups have taken forward a range of work set out below.

- met daily to discuss safety huddle information from the care homes in their area and identify any support required;
- prioritised and co-ordinated nursing and social work professional support visits to every care home in their area and considered the outputs from these support visits;
- received assurance with regard to progress of the COVID-19 testing programme underway for staff and residents;
- co-ordinated and facilitated any staffing requirements that the care homes were not able to meet from their own workforce. During this time each care home was able to register with the NHS Nurse Bank on Allocate in order to access this resource if required. 35 care homes registered. Thus far this support has not been required.
- escalated any immediate issues of concern to the HSCP Director and/or Nurse Director depending on the issue;

- provided a 3 minute Sit Rep report to every NHS Board Emergency Management Team (EMT) meeting detailing support activity undertaken and any resulting actions or escalations;
- specifically the Associate Nurse Directors have provided professional assurance to the Nurse Director with regard to the support enacted if required; and
- liaised closely with Care Inspectorate colleagues with regard to the very small number of care homes which persistently refused to allow a professional supportive visit to take place. This has involved triangulation with visiting health professionals, social work and Scottish Care colleagues to ascertain any concerns about standards of care or infection control. This has resulted in 2 care homes receiving 'virtual support visits' that have been satisfactory and one care home receiving a physical visit with support from Care Inspectorate colleagues.

**Care Home Support & Assurance**

Further to the variation letter from Scottish Government on 18 May 2020, 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.

NHS Ayrshire & Arran appointed an Interim Associate Nurse Director for Care Home Support and Assurance who is hosted in EA HSCP and reports directly to the Nurse Director. This has provided additional senior professional whole Ayrshire leadership during this time.

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

- established and Chaired an Expert Professional Advice Group*;
- undertaken a review of the support resources already available to Care Homes in order to build and strengthen these as required;
- led an education / training needs analysis based on the information gathered from the support visits and safety huddle data;
- developed the professional reporting mechanism for the resulting activity to the Nurse Director;
- worked in close collaboration with HSCP-ANDs and Scottish Care colleagues;
- developed an agreed process for the establishment of care home Rapid Response Teams in each HSCP should they be required;
- worked with Scottish Care colleagues to explore the most effective administrative support required to support care home staff testing; and
- contributed to the weekly DPH RAG report for Scottish Government.

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

The Expert Professional Advice Group meets weekly and provides advice in relation to their specialist area and care homes. The group considers the themes from the support visits, shares guidance relating to care homes and provides advice as required.

The group has undertaken a review of the current training and support resources available to our care home colleagues and are now adapting and shaping some of the resources to meet the changing requirements brought about due to COVID-19. The topics being covered are: Palliative care, Tissue Viability, Dementia Training, Adult Support and Protection, Professional Nursing, Infection, Prevention and Control and Psychology. A blended approach to providing training and support has been taken with recent PPE Safety Officer Training being delivered both face to face (adhering to physical distancing) and through the use of a virtual platform, giving options to care home providers to continue engaging in support whilst ensuring safety is maintained for staff.

The group has identified the significant benefits of our AHP colleagues in care homes and an AHP advisor is on the group, along with representation from Clinical Psychology, who will provide invaluable advice and support in relation to health and wellbeing of residents and staff during and post pandemic.

A professional forum for care home managers, to connect with the Interim Associate Nurse Director for Care Home Support and Assurance is being developed. It is anticipated that creating an open forum for sharing concerns and ideas, sharing good practice and giving time to discuss topics, selected by the care home staff, will facilitate the development of relationships with the members of the Expert Professional Advice Group and wider NHS and partnership colleagues.

A high level RAG rating summary and detailed report has been developed, to understand both at a glance and in more detail the status of the 64 older adult care homes across Ayrshire and Arran following the support and assurance visits. These reports were developed with input from each of the HSCP CHOGs, highlighting any actions which were identified during the visits and the supportive approaches which have been offered to care home providers, in order to be assured that in relation to infection control and fundamental care, there are no concerns. The report once finalised, will be shared regularly with EMT and updated accordingly following any follow-up visits.

A process has been developed in each partnership for the establishment of care home Rapid Response Teams. These teams are made up of nurses, healthcare support workers, personal carers and support staff, who can be mobilised urgently to support care homes should the need arise. These teams would only be mobilised once all the normal routes to access workforce through care homes business continuity plans have been exhausted. Urgent testing would be carried out for any staff member who was being deployed to a care home, be it planned or rapid deployment.

It is acknowledged that being deployed to an unfamiliar working environment can be stressful, therefore the type of support that for staff who have volunteered to support care homes in advance of a request in a crisis being made is being actively considered.

Each HSCP has a Community Elderly Mental Health Liaison Nurse for Care Homes which has been invaluable and we have identified through the mental health mobilisation plan the need for ANPs to support person centred and timely care and intervention. Each HSCP has a growing understanding of the need for increasing care home liaison nurse support going forward.

The Interim Associate Nurse Director for Care Support & Assurance will be required until end March 2021 in order to maximise the benefits in terms of support to our care homes, their residents and staff; particularly as we go into winter with the additional pressures that may bring in the context of COVID-19 still being present in our communities together with the usual winter viruses.

Maintaining the Associate Nurse Director post will require additional funding (AFC 8C) until March 2021 and a decision will then be taken on the substantive requirement for this pan-Ayrshire role further to any legislative changes and subsequent resulting accountabilities (cost £66,315 to end March 2021; full year costs if substantive from April 2021 £99,472).

The Care Home Liaison Team requirements within each HSCP will require additional funding going forward until the end of March 2021. As a minimum this will be an AFC B6 nurse for each HSCP (total cost £103,197 to end March 2021; full year costs if substantive from April 2021 £154, 794). The impact of these posts will then be reviewed and would require a revenue funding stream.

A further support for care homes has been the whole system Enhanced Care Home Learning and Improvement Group, chaired by the Joint Interim Director of Public Health and including membership from Care Inspectorate and Scottish Care. This has continued to meet weekly and report into the EMT. East, North and South Ayrshire all have local care home provider groups and these are also well connected to the Enhanced Care Home Learning and Improvement Group.

**Infection Control and PPE – Care Homes**

We have determined that it will be necessary to support and complement the work of the Health Protection Team by introducing additional capacity to the Infection Prevention and Control Team to provide specific advice and support to our Care Homes. This support will be for an initial period to end of March 2021 however subject to review it may be required on a permanent basis.

Each HSCP has provided a PPE Hub ‘hotline’ and responsive service for our care homes and this will be maintained through the winter until March 2021. This will have a resource implication as the staff currently manning this will need to return to their previous roles.

The in-house PPE Safety Officer training referred to above in order to enable a PPE champion approach in each care home will continue to be offered to all care homes from August 2020 to March 2021. As at the beginning of July 2020, 48 staff from 17 care homes have taken up this offer.

In order to provide continued IPC support to care homes, PPE support through the next 6 months and support the additional challenges that winter will bring across our communities there will be a need for additional Infection Control Nurse (ICN) support. This is described in the Infection Prevention and Control section of this plan and equates to a B6 ICN for each HSCP (cost £103,197 to end March 2021; full year costs if substantive from April 2021 £154,794). Please note, this funding requirement is within the Infection Prevention and Control section later in this plan.

## Staffing support for Care Homes

There is an expectation that each care home has a resilience plan in place for any additional / crisis staffing requirements. We also recognise that staffing to support our care homes requires to be considered from two perspectives:

- proactive and planned in response to potential positive COVID-19 testing. The potential staff will require to be tested and COVID-19 negative before deployment; and
- 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 mechanism for meeting this if required is described above in terms of the rapid response teams).

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 HSCPs who will support the care home to access staff. Any staffing needs which the care home cannot meet are flagged on the daily CHOG discussion and actions agreed to meet these.

Each care home across Ayrshire and Arran has also been offered the opportunity to join the NHS Allocate Nurse Bank system to access staff. As at 15 July 2020, 35 care homes have registered with the Nurse Bank (East – 13, North – 3 and South -19). This offer will remain open to all our care homes until March 2021. Thus far only one care home has used this facility for one registered nurse shift.

## Digital

The use of TEC solutions within a care home setting has the potential to enhance resident care and enable remote patient monitoring when clinical needs arise. Access by community and primary care staff to patient records remotely and securely will also enhance the delivery of care. The use of NHS Near Me and other associated collaboration tools will also assist.

## Health and Social Care Partnerships

Appendix 1 details the position of care home provision for each of the Health and Social Care Partnerships.

**Summary of actions for Care Homes:**

We will

- Continue to maintain the Enhanced Professional Clinical and Care Oversight arrangements.
- Continue to work closely and collaboratively with our Scottish Care and Care Inspectorate colleagues.
- Continue to identify any training and support needs for care home staff and resources / mechanisms to meet these needs.
- Continue to fund the Associate Nurse Director post.
- Establish IPC nurse and care home liaison nurse posts.
- Scope and model the further care home support/liaison requirements as a whole system.
- Continue to provide PPE hub support to care homes.
- Provide administrative support to care homes eg.re staff testing.
- Review the impact of Care home liaison nurses over the winter period.

**Summary of revenue consequence:**

The following costs have been identified for Care Homes:-

- Associate Nurse Director cost £66,315 to end March 2021.
- IPC Nurses *N.B. funding for these posts is included in the Infection Prevention and Control section of the plan.*
- Care home liaison nurses cost £103,197 to end March 2021.

## 5.5 Community Hospitals

### EAHSCP - East Ayrshire Community Hospital

Our community hospital currently provides a step up/down multidisciplinary inpatient service for rehabilitation, subacute care and palliative pathways of care, ensuring that when patients are identified as clinically ready to move that they are safely discharged home, or to a homely setting in a timely manner. The guiding principle which enables people to live as independently wherever possible, also underpins the activity and support provided in our specialist dementia unit, outpatient department and health & wellbeing centre.

Going forward the proposed model of health and wellbeing aligns with national and local strategy and in an inherent part of Caring for Ayrshire and East Ayrshire's strategic vision. Our proposed redesign of services will ensure that we have a flexible, responsive service that meets the needs of our local East Ayrshire residents.

### Current capacity

| Inpatients | Current build capacity | Currently utilised | New model |
|---|---|---|---|
| Burnock | 24 beds | 24 beds | 20 + 4-6 day case capacity |
| Roseburn | 12 beds | 0 | 10 |
| Holmburn | 13 beds | 0 | 13 |
| Marchburn (specialist dementia unit) | 20 beds | 12 beds | 12 |

**NAHSCP – Ayrshire Central**

**Current capacity**

| Inpatients | Current build capacity | Currently utilised | New model |
|---|---|---|---|
| Woodland View W1 | 30 beds | 30 | 30 |
| Woodland View W2 | 30 beds | 30 | 30 |
| Redburn | 30 beds | 30 | 20 |
| Douglas Grant | 16 beds | 16 | 19 |
| Arran War Memorial | 12 beds | 12 | 12 |
| Lady Margaret | 8 beds | 8 | 8 |

Ward 1 in Woodland View is a general rehabilitation ward for predominantly frail older people. The ward consistently operates at full capacity and length of stay has improved over the last couple of years. Our 20-bedded stroke rehabilitation ward in Redburn currently contains 10 additional general rehabilitation beds. We aim to begin focusing all general rehabilitation inpatient services in the North into Ward 1 and will also re-provision 10 beds in our Anam Cara respite resource into step-down beds. This will allow us to better focus our AHP workforce on the general rehabilitation pathway and improve outcomes.

COVID-19 surge capacity has been established in the Arran War Memorial Hospital that would allow us to increase bed capacity to 30 but, to date, has not been required.

We are working with West of Scotland colleagues through the Trauma network and it is planned to increase the capacity in the Douglas Grant Neuro-rehabilitation ward to include three trauma beds.

## SAHSCP – Biggart & Girvan Community Hospitals

### Biggart Community Hospital

Biggart Community Hospital (BCH) provides a multidisciplinary inpatient service for those unable to receive their rehabilitation at home, require rehabilitation in a hospital or more specialist rehab in a clinical setting. BCH is currently hosting Station 16 from UHA in Drummond ward where through the use of in-house AHPs, there is a robust Rehab service being provided for Stroke patients. McMillan ward provides palliative and End of Life care, with access to these beds from both Acute & Community sources. Lindsay ward provides Ortho/Vascular rehab and Urquhart ward provides more general/medical rehab. This model ensures that when patients are identified as clinically ready to move that they are safely discharged home, or to a homely setting in a timely manner.

Future modelling of BCH includes the move of the Stroke rehab ward from Drummond ward to Buchanan ward for a period of 12-18 months (Nov 2020). The utilisation of Lindsay ward for repatriation of vascular patients from Hairmyres hospital and the resumption of clinics in the Ferguson Day Hospital from August 2020. There will be access to community step up rehabilitation beds on Lindsay and Urquhart Wards with beds being accessed from the community or acute with clear criteria to identify those who will benefit from intensive rehabilitation.

In anticipation of winter COVID-19/flu pressures, Drummond Ward will be maintained at a state of readiness after the move of the stroke ward to Buchanan.

### Girvan Community Hospital

Girvan Community Hospital is operating most of its routine services; there are currently 20 inpatient beds with an extra six beds available for surge capacity if required. The Minor Injuries Unit will continue to operate on an 'appointment only' model for the foreseeable future. There is currently no plan in place to re-open Day Hospital but this will be considered in a future review.

**Biggart Hospital**

| Inpatients | Current build capacity | Currently utilised | New model |
|---|---|---|---|
| Lindsay ward | 30 | 28 (2 free to allow for emergency isolation of COVID-19 patients) | |
| Urquhart Ward | 30 | 28 (2 free to allow for emergency isolation of COVID-19 patients | |
| MacMillan Ward | 23 | 23 | |
| Drummond / station 16 – 22 | 22 | 22 | Decision to be taken around future usage |
| Buchanan ward | 30 | 0 | Due to be renovated to accommodate Drummond/station 16 to move over and will be a 24 bedded unit |

**Girvan Hospital**

| Inpatients | Current build capacity | Currently utilised | New model |
|---|---|---|---|
| Ward | 26 | 20 | Not staffed for 26 but 6 beds available in crisis |

**Summary of actions for Community Hospitals:**

We will:

- EAHSCP will undertake a redesign of Community Hospital services.
- NAHSCP will increase the capacity in the Douglas Grant Neuro-rehabilitation ward.
- SAHSCP will move the Stroke rehab ward from Drummond ward to Buchanan ward.
- SAHSCP will use Lindsay ward for repatriation of vascular patients from Hairmyres.
- SAHSCP will ensure Drummond Ward is maintained at a state of readiness after the move of the stroke ward to Buchanan.
- SAHSCP will resume the clinics in the Ferguson Day Hospital from August 2020

| Section 5<br>Community Services | Year to Jun<br>£'000 | July to March<br>£'000 | Projected Expenditure<br>£'000 |
|---|---|---|---|
| Delayed Discharge Reduction- Additional Care Home Beds | 444 | 225 | 670 |
| Delayed Discharge Reduction- Additional Care at Home Packages | 108 | 136 | 244 |
| Delayed Discharge Reduction- other measures | 254 | 712 | 966 |
| Delayed Discharge Reduction- equipment and adaptations | 263 | 42 | 304 |
| Estates & Facilities cost | 109 | 118 | 226 |
| Additional Staff Overtime and Enhancements | 467 | 1,239 | 1,706 |
| Additional temporary staff spend - Nurses & AHP | 510 | 773 | 1,283 |
| Additional temporary staff spend - Health and Support Care Workers | 202 | 631 | 832 |
| Additional temporary staff spend - All Other | 1 | 90 | 91 |
| Additional costs for externally provided services | 1,577 | 1,729 | 3,306 |
| Cost to 3rd Parties to Protect Services (where services are currently stopped) | - | 196 | 196 |
| Additional costs to support carers | 15 | 45 | 60 |
| Community Hubs | 425 | 1,369 | 1,794 |
| Other Community Care | 354 | 536 | 890 |
| Loss of income | 689 | 761 | 1,450 |
| Additional Travel Costs | 6 | - | 6 |
| IT & Telephony Costs | 56 | 111 | 167 |
| Equipment & Sundries | 77 | 64 | 141 |
| Children and Family Services | 25 | 214 | 239 |
| Prison Healthcare Costs | - | 184 | 184 |
| Additional Care at Home Packages (not delayed discharge) | 357 | 466 | 824 |

| | | | |
|---|---|---|---|
| Other (EAST) | 50 | 50 | 99 |
| | - | - | - |
| Offsetting cost reductions - HSCP | 734 | 706 | 1,440 |
| **Total** | **5,254** | **8,984** | **14,239** |

## 6.0 Redesigning Urgent Care

Redesign of whole system urgent care is a priority for NHS Ayrshire & Arran. We welcome the national programme and have taken forward local planning to support a direction for redesign that provides safe, person centred care and responds to and supports our General Practice and out of hours as well as Emergency Department and Combined Assessment Unit.

The national 24/7 pathway through 111 with clear access locally was a key success for the COVID-19 pathway in Ayrshire and Arran. This provided consistent triage at NHS 24, allowed a seamless pathway to local hubs for further clinical consultation and consistent onward referral for self-management and to other services in the community or acute setting as required.

## 6.1 Whole System Interface Group

In response to COVID 19, it is recognised that there are interfaces across the system where there are critical opportunities and risks which are arising as services mobilise and recover.

As a result of this, the Emergency Management Team has commissioned a clinically led Whole System Strategic Interface Group with senior management and professional leadership across primary and secondary services to guide and support recovery and mobilisation across the whole system.

The interface between Community, Primary and Acute clinical teams skills, knowledge and expertise requires clinicians and commissioners to deliver safe, high quality care tailored to the needs of both patients, communities and the organisation as NHS Ayrshire & Arran moves through the various stages of the Pandemic.

Tests of change are commissioned that impact on multiple services with tight timescales for delivery.

It is essential as part of recovery that the group considers solutions for new ways of working for our whole system in line with the strategic vision of NHS Ayrshire & Arran. We strive to offer a cohesive health and care system that is designed from the perspective of the person accessing services. The whole system approach to strategic planning, service design and service delivery as we recover from the impact of the pandemic is crucial in order to do this.

Current work streams commissioned by the leadership group to date include –

- Redesign of Urgent Care Pathways utilising the NHS 24 pathway utilising the Clinical Hub model to schedule attendances to the Emergency Department;
- Implementing appointment system for GP referrals to combined assessment unit;
- Mental Health Redirection;
- Development of community monitoring services including Community Phlebotomy to support Planned Care and provide specialist monitoring as close to patients' home as possible; and
- Frailty Liaison focusing on the Whole system Frailty Collaborative.

## 6.2 Acute Specific Redesign

In addition to the work being taken forward by the Interface Strategic Group, there is connected work being taken forward specifically within the acute hospital setting. This includes :

- The Advanced Nurse Practitioner (ANP) teams and Acute Care of the Elderly (ACE) Practitioners working closely with colleagues across the HSCPs;
- NHS Near Me virtual clinics; and
- Surgical/Orthopaedic GP Assessments Units (UHC only).

A number of reform principles underpin the above work :

- There should be a continuation of collaborative working between ED and CAU in all out of Hours periods;
- Rapid Assessment & Treatment model , moving away from current pathways;
- Development of a senior ANP decision making model within Initial Assessment;
- 'Day Zero' decision making, working more closely with Community interface to reduce front door presentations;
- Minor Injuries Unit;
- Frailty Unit (see below);
- Cardiac Unit, high sensitivity Troponin T which will support new pathways for cardiac flow;
- Continue to pilot Surgical/Orthopaedic GP assessment units;
- Consider the available multidisciplinary clinical and care workforce pan Ayrshire and how this drives and supports the reform agenda and Caring for Ayrshire; and
- In order ED's & CAU do not become overcrowded and unable to maintain safe physical distancing introduction of an appointment system will be necessary, in order to safely receive and manage red and green patients.

In order to ensure safe working it is vital to ensure appropriate senior Medical staffing levels at both front doors. Medical staffing at UHA remains challenging, and we have established a collaborative pan Ayrshire improvement approach, to enable both emergency departments to continue to support 24/7 cover.

Our Improvement plan includes the following actions:

- A single Clinical Director for both sites is under review to help support and drive this change;
- Shared medical recruitment, to a cross site rota;
- Nursing teams will establish a “buddy system” encouraging cross site working, learning & peer support; and
  Developing the NMAHP workforce; in particular ENPs, ANPs, Advanced AHPs and ACE practitioners.

In order for the Acute Sector to safely control the flow of red and green patients on an ongoing basis, a single point of contact who is an experienced nurse is required to undertake a risk assessment via the telephone to establish the patient’s presenting symptoms and risk factors for COVID-19. The patient will then be assigned to the most appropriate pathway. This individual will discuss with the referrer the appropriateness of same day attendance and establish an appointment based system based on the patient’s clinical need. To allow for safe assessment of both red and green patients separately there requires to be an additional initial assessment area based within the CAU. One for patients on the COVID-19 pathway and one for patients on the non COVID-19 pathway.

**Resource Required:**
Due to an enhanced nurse to bed ratio within an immediate assessment setting, nurse staffing enhancement is required as a combination of trained and support staff - £100,000 until March 2021. This would include the required band 6 senior nurse to take on the role of single point of contact with the relevant experience.

In response to the COVID-19 pandemic the Rapid Assessments and Treatment (RAT) model was established within the Combined Assessment Unit at UHC. This involved the early review by an Emergency Department physician with the clear aim to rapidly assess and redirect patients to the appropriate pathway on arrival to the Unit. On review the first doctor who sees the patient is able to make a competent initial assessment, define a care plan and make a decision whether the patient requires admission, discharge or onward speciality referral. During the four month period between March and July it has been evidenced that 30% of the patients assessed through this model did not require hospital admission. Therefore minimising the risk of COVID-19 transmission or other hospital acquired infections.

Due to awareness of consultant recruitment difficulties on a short time basis the team scoped the use of ANPs to perform the RAT Assessment model. A test of change was carried out using experienced ANPs. This proved to be a successful alternative with 24% of patients discharged on

assessment and therefore a more sustainable model. The test of change highlighted that this process could support the scheduling of unscheduled care presentations with a truly nurse led service.

**Resources required:**

5.4 wte – £295,000 until March 2021 24hrs 7 days

To enable scheduling of unscheduled care appointments a new model of care is required. In order to continue with the current emergency and on call pathways to meet the unscheduled demands a further senior decision maker would be required at the front door to allow for the scheduling of patients to run in parallel with the unscheduled activity. This post will provide a single point of contact and senior decision making support for the Clinical Hubs.

To further support scheduling unscheduled care there requires to be additional nursing resource.

**Resources required:**

1 wte Consultant – £83,000 until March 2021
Nursing staffing combination of trained and support staff - £100,000 until March 2021

To facilitate additional discharges within acute, to meet the increased demand during the evening period SAS will require to provide an increased service until 8pm each night. This will allow for safe transfer of patients and reduce the need for overnight stay of vulnerable patients. This will help reduce demand and occupancy levels on the site.

**Resources required:**

Based on 2019/20 this required additional resource of £3000/per month, therefore £24,000 as part of remobilisation.

## 6.3 Clinical Hub

NHS Ayrshire & Arran continues to have a single Clinical Hub based within Lister Street, University Hospital Crosshouse. From June activity from NHS 24 to the clinical hub has reduced significantly. There is an MDT approach to supporting the clinical hub including GPs, ANPs, and pharmacy technicians for the period 8 am – 6 pm. The pharmacy technicians have been instrumental in developing seamless processing of medications with community pharmacy or queries with the patient's GP Practice.

There is always one GP in the hub physically and the service encourages remote working from home or GP Practice. In addition to assessing calls transferred from NHS 24 there is also a pathways in place locally for care homes to access to hub direct for clinical advice in relation to residents experiencing COVID-19 symptoms or deteriorating COVID-19 patients who require clinical assessment. From June this activity has also reduced significantly.

From 6 pm – 8 am the COVID-19 pathway integrates with current out of hours model with one dedicated clinician during this time focussed on the specific COVID-19 advising queue from NHS 24.

It is recognised that as respiratory and symptoms associated with COVID-19 increase over the winter period then the activity via this pathway will increase. On this basis and looking towards to the re-design of urgent care, the clinical sessions have stayed in place with an additional clinical session in the evenings and overnight to support increased telephone consultations.

In hours patients who can come to the assessment centre are offered an appointment. Patients who require a home visit in hours or a more thorough assessment from their own GP Practice, who have access to more detailed information, are passed back to their GP Practice. This process works well and seamless.

In the out of hours period any patients requiring a face to face consultation will be seen by an out of hours clinician either at a Primary Care Centre or a home visit.

Aligned to the national programme and 11 associated workstreams, there has been a focus locally to move towards scheduling as much urgent care as possible throughout the system. Key priorities being progressed to be implemented by 1 October 2020 are noted below:

## 6.4 Scheduling Appointments at Emergency Department (ED)

The number of patients self-presenting to the ED at University Hospitals Ayr and Crosshouse has increased over the last number of weeks to nearly be in line with pre-covid levels of demand.

As well as patient self-presenting to ED, patients can also be advised by their GP Practice, NHS 24 or Out of Hours Services to attend ED. Reviewing recent data shows these referral sources account for up to a third of ED attendances.

Through re-design work there is opportunity to schedule all those who self-present or are directed to ED by other provider. This will facilitate an improved service for patients and allow the ED to plan appropriately for patients to arrive and be managed through the department safely. Scheduling of appointments will be progressed August – October 2020 phasing in the different elements using the data available to inform local flow model.

To manage with the increased activity of telephone consultations to carry out an initial assessment directed from NHS 24 for a patient to attend ED, or direct access for care homes as noted below will require additional clinical resource. Figures reviewed at this stage, based on a weekend of data, projects this would be approximately 200 additional calls per day to the Clinical Hub Saturday/Sunday, which would be double the telephone assessments currently carried out.

As well as additional weekend support, an increase to current clinical sessions needs to be in place Monday - Friday in anticipation of the projected increase of respiratory/COVID-19 symptoms being redirected to the Clinical Hub via NHS 24 during winter. Projected demand 6 pm – 8 am (out of hours period) to schedule ED attendances and provide direct care home support would be covered within the additional session.
In summary this will require the following additional sessions with total costs detailed in the final table below.

- 2 x additional sessions over the 24/7 period Monday-Friday (will take total daily sessions to 9 sessions per day)
- 5 x additional sessions over the 24/7 period Saturday/Sunday (will take total daily sessions to 14 sessions per day)

In line with the current process for the clinical hub, these sessions would be available and advertised to ANPs, GPs, and secondary care clinicians as additional paid sessions on a flexible monthly rota basis. It should be noted this will be an MDT approach to the workforce and cannot be assumed GPs or GP Practice staff will be able to support these sessions.

## 6.5 Scheduling GP Referrals to the Combined Assessment Unit (CAU)

A test of change is currently underway in University Hospital Ayr CAU to schedule GP referrals from GP Practices in hours on an appointment basis and prioritised based on clinical need.

In hours many urgent cases will present to the GP Practice in the morning or require a home visit which leads to the patients generally all being assessed by their GP Practice over the same time frame across Ayrshire. This in turn leads to a surge of referrals to CAU over certain time periods trying to support all practices.

Scheduling allows an opportunity to stagger patient arrival times and work collaboratively with the GPs to determine the best pathway for the patient, including what diagnostic/ambulatory care is required. The ongoing learning throughout this new of working will also align and inform the re-design of urgent care in GP Practices in line with the new GP contract. Complementary to testing and learning from this approach discussions are also underway with the CAU in University Hospital Crosshouse to identify what alternative ways of working could be built in via the Clinical Hub to support seamless pathway of patients from NHS 24, GP Practices, out of hours and the covid-19 pathways which is expected to see increased volume of patients presenting with respiratory/COVID-19 symptoms throughout winter. In addition to working towards scheduling referrals on both acute sites, the following areas will be taken forward August – October 2020:

- Scheduling to ambulatory pathway from GP Practice, out of hours and clinical hub within 24-48 hours;
- Dedicated enhanced advice support available from CAU to the Clinical Hub and also referring clinicians. This will require to be staged and phased similarly to the COVID-19 referral pathway;
- CAU clinicians to support enhanced care home/residential model as described in more detail below;
- Co-location of Clinical Hub, CAU and ED to develop joint working and support collaborative decision taking; and
- Recognition of increased respiratory symptom presentations through COVID-19 pathway via NHS 24 and GP Practices. CAU to develop similar guidance and criteria pathway for the Clinical Hub and GP Practices to support decision making – linking also to the dedicated advice/escalation.

It is projected that the additional clinical sessions required to enhance current pathways is in place already via the Clinical Hub as outlined above

would be able to absorb this activity working jointly with CAU/ED colleagues.

## 6.6 Direct Access to Clinical Hub for Care Homes

Building on the COVID-19 pathway for care homes encouraging direct access to the Clinical Hub and Ayrshire Urgent Care Service to support care homes with clinical advice or reassurance. Many care homes have good support from GP Practices in hours but there are various models of support which can result in a high volume calls going to NHS 24 in the out of hours period. It is noted within recent data there is also a large number of NHS 24 contacts from care homes across Ayrshire.

A proposal is being developed locally to enhance current arrangements and ensure consistency of support and in so doing reducing the need for local care homes or residential homes to be accessing clinical advice via NHS 24 or via Scottish Ambulance Service.

This will ensure local knowledge of services available and linkages with community nursing teams to support where possible. Using this pathway also links with the action outlined in the CAU proposals as well as the Frailty Liaison focusing on the Whole system Frailty Collaborative where our geriatrician colleagues support the clinical hub enhancing the specialist input to the frailty assessment for residents within care/residential homes who contact the Clinical Hub.

The additional resource required to support the direct access pathway is incorporated to the sessions above.

## 6.7 Joint Working with Scottish Ambulance Service

In support of the primary care transformation agenda and in direct support with primary care and out of hours, Ayrshire & Arran have worked jointly with Scottish Ambulance Service (SAS) to develop models for utilisation of Advanced Practice Paramedic Practitioners to support urgent care presentations. AUCS supported training and shadowing opportunities to advanced paramedics, which was paused during COVID-19 and have been in liaison with SAS colleagues to commence this programme again. SAS colleagues have also confirmed that, as part of their mobilisation plan, they will be introducing additional patient transport vehicles to transport patients from GP Practice in hours to try and mitigate the delay that can happen currently and is anticipated for winter months. It is also noted that patient transport vehicles will be limited to the number of patients who can travel on current patient transport vehicles. Working with GP Practices and the Clinical Hub on the scheduling model will also support the SAS Hub to coordinate resource and scheduling of pick up times.

There is an ongoing pilot with AUCS and SAS for professional to professional support when they respond to a 999 call, as well as the option for a paramedic to call AUCS directly and request a GP appointment or home visit should they feel this outcome would be more beneficial to the patient. There have been early discussions with SAS to enhance this pathway to care homes allowing the SAS Hub to liaise with the Clinical Hub should SAS feel a call to them could be better dealt with via the local Clinical Hub. Direct access for paramedics to the CAU and ED will also be explored to assist with decision making in those more urgent cases.

Developing the joint pathways with SAS will also result in additional activity to the Clinical Hub, at this time there is not enough data to know what the impact would be. It is proposed this is kept under close review aligned to the other developments to monitor activity levels.

## 6.8 GP Practice in hours Urgent Care

GP Practices will remain the first point of contact for patients requiring urgent care in-hours. As described in the earlier section under the Primary Care Improvement Plan, the overall redesign of urgent care will be require to be aligned to the different models for delivering urgent care in hours. As part of the new GP contract there was previous actions and funding associated with supporting practices to introduce a range of MDT professionals to support on the day demand and presentations. This included ANPs, Mental Health Practitioners, Advanced MSK Physiotherapists and Community Link Workers.

All of these practitioners support patients at the first point of contact when they call their GP Practice. For GP Practices to be able to respond to on the day demand, it will be a priority as part of the primary care transformation work to progress at pace with this work. This is also reliant on the previously projected funding via the primary care improvement fund to be available.

A range of community alternatives are also now available to improve access for urgent minor conditions as outlined in the primary care section of the plan including Pharmacy First and Eyecare Ayrshire. Due to current infection control guidance and physical distancing these services will not be utilised in the same way over the winter period and many of these patients will redirected either to their GP Practices or the Clinical Hub.

**Digital**

The implementation and availability of clinical portal will support the redesign of urgent care. Other technology implementations as detailed in the digital section will also support service redesign. This includes MDT and CTAC working utilising Microsoft Teams as a collaboration tool. The deployment of TEC and access to relevant TEC data to support the major disease groups to minimise exacerbation and unscheduled care activities. Remote patient monitoring through the use of TEC will assist in minimising winter pressure on unscheduled care services.

## 6.9 Resource required

To take the above workstreams forward at pace will need dedicated senior management leadership. Due to the links with AUCS the Clinical Hub arrangements have integrated to the current AUCS management structure which has now become a 24/7 urgent care response service. This has resulted in increased workload and current managers working on average 1 day extra per week to support the urgent complex and integrated pathways over the 24 hour period 7 days per week.

To take the proposed Clinical Hub model forward and ensure sufficient management and coordination of the service, there will require to be revised management and clinical leadership structure introduced. Currently this includes:

- 2 x additional sessions of the clinical lead time (usually 2 sessions per week and doing 4 just now). Would recommend 4 remains in place;
- Combined management support across Band 7 – Band 8c to make up 1 wte. Propose 1 wte Band 8a operational management support; and
- Project and coordination support redeployed from Primary Care Transformation Team to support the development and implementation. Propose 1wte Band 6 due to the current priorities now emerging across general practice and requirements to implement the remaining PCIP actions.

The additional clinical sessions, clinical leadership, management and coordination costs until March 2021 are noted within the tables below.

Cost of clinical sessions based on 33 weeks August – March 2021 is £446,193.

Additional management and implementation costs is £117,766.

Total additional cost for enhanced urgent care model broken below is £563,959.

| NEW COVID HUB MODEL COSTING WITH ADDITIONAL CLINICAL SESSIONS | | | | | | |
|---|---|---|---|---|---|---|
| | **Session time** | **No of GPs** | **Weekday (Cost per day)** | **Friday (Cost per day)** | **Sat/Sun (Cost per day)** | **Weekly Cost** |
| | 0800 - 1300 | 2 x M-F<br>3 x S&S | 600.00 | 600.00 | 1875.00 | |
| | 1000 – 1500 (extended to cover 7 days) | 1 | 300.00 | 300.00 | 625.00 | |
| | 1300 – 1800 | 2 x M-F<br>3 x S&S | 600.00 | 600.00 | 1875.00 | |
| | 1400 - 2000* | 1 x S&S | 0.00 | 0.00 | 625.00 | |
| | 1500 - 2000 (extended to cover 7 days) | 1 | 347.00 | 400.00 | 625.00 | |
| | 1800 – 0000 | 2 x M-F<br>3 x S&S | 1002.00 | 1320.00 | 2250.00 | |
| | 2000 – 0200 | 1 x M-F<br>2 x S&S | 494.00 | 670.00 | 1500.00 | |
| **TOTAL SESSION COSTS** | | | **£4,503.02** | **£5,239.83** | **£12,628.13** | **£48,508.16** |
| **Additional Sessions Cost** | | | **£871.51** | **£942.90** | **£4,546.13** | **£13,521.19** |

| ADDITIONAL OPERATIONAL MANAGEMENT COSTS | | | |
|---|---|---|---|
| **Band** | **Weekly Hours** | **Duration** | **Total (including employer costs)** |
| Clinical Lead | 8 | 9 months | £24,840 |
| 8B | 37.5 | 9 months | £59,166.00 |
| 6 | 37.5 | 9 months | £33,760.00 |
| | | **Total** | **£117,766** |

**Summary of actions for redesigning urgent care:**

We will:

- Continue to deliver against the priority agenda and workstreams developed by the strategic interface group.
- Have a whole system robust winter plan with a dedicated lead manager.

**Summary of revenue consequence:**

The following costs have been identified for redesigning urgent care:-

- £563,959 for expanded community hub functions.
- £602,000 for redesign within acute services

## 7.0 Acute Mobilisation

This chapter focusses on the approach that the service has taken to develop safe clinical pathways for red/green and specialised pathways.

## 7.1 Green/Red pathways

NHS Ayrshire & Arran Acute services will take an approach which ensures ongoing provision for the management of COVID-19 related illness, alongside safe delivery of non COVID-19 related emergency care, and balancing this with the safe incremental restoration of agreed elective services.

Detailed planning for COVID-19 and non-COVID-19 bed provision was undertaken in earlier phases, and has established a bed capacity plan which supports the separation of patients who are confirmed or suspected with COVID-19 from non-COVID-19 patients. This forms a good basis for the ongoing bed provision through remobilisation Plan 2.

## 7.2 Update on Bed provision / Bed Modelling

In the Phase 2 Plan we identified our commitment to make available an initial COVID-19 surge of up to 125 acute hospital beds and up to 203 acute hospital beds as part of a maximum COVID-19 surge. This remains the basis of the bed capacity planning although the numbers have changed slightly from earlier plans due to changes in inpatient bed configuration.

An Ayrshire wide approach is being taken to ensure there are adequate beds for winter demand whilst maintaining the flexibility to open surge beds to cope with further COVID-19 outbreaks.

A bed modelling exercise is underway with input from operational management and Business Intelligence colleagues to map the required footprint for all medical & surgical beds cross site, ensuring modelling is based on data analysis and are aligned with the extensive work ongoing across the reform agenda.

There are numerous  factors which impact the acute beds requirement but which have and are continuing to change in the current situation :

- The phased re-starting of elective surgical activity;
- Changes in public behaviour, backlog need and the remobilisation of primary care services impacting on unscheduled care demand; and
- The need to develop and clearly articulate a plan for winter.

Plans will be finalised with sufficient time to recruit adequate staff where this is required.

Both acute hospitals have historically had consistently high numbers of delayed discharges, and work is ongoing with the H&SCPs.  We aim to work collaboratively with our partners to ensure the current lower number of delays is maintained on site.

- May 2019  (72) delayed discharges over 2 weeks; and
- May 2020  (9) delayed discharges over 2 weeks.

We encourage the creation of additional capacity in the community to support early discharge, and maintain reduced delayed discharge patients in acute hospital beds.

- Operational management and Business Intelligence colleagues are using information to map the required footprint for medical and surgical beds working cross site;
- Acute Services is working closely with the three HSCPs to minimise delays;
- New cardiac care units are in place across both sites which creates some additional capacity on the UHC site.  The impact of this is being incorporated into the new bed modelling;
- Front door services & promotion of same day care working will increase turnover at our front doors, reducing in patient stays linking in specifically with the Interface Group on reduction of front door attendances and alternatives such as the community hubs;
- Bed modelling is being done in conjunction with front door redesign, ICU reform, the interface group-community hubs, frailty review & reconfiguration of stroke services;
- Redesign of other services including UHA's Vascular service, Trauma & Orthopaedic work and longer term pan Ayrshire ICU service;
- These separate pieces of work will all be considered as part of the bed modelling whilst maintaining the ability to maintain 43 surge COVID-19 beds within UHA and 82 surge COVID-19 beds within UHC;

- Consideration will be given to the use of additional beds in Kyle & Park Ward, at Ailsa Hospital in order to create surge capacity for UHA & UHC; and
- Regional Planning and structured weekly discussions between Regional Directors are now in place to ensure that any mutual aid which is required at times of surge can be facilitated quickly.

UHC and UHA will be prepared to respond to a COVID-19 spike by recognising elective work would be required to be cancelled where appropriate/as required.

Preparation for winter including front door redesign, ICU reform, the interface group-community hubs, frailty review and reconfiguration of stroke services and rehab will all impact on bed modelling. In addition, the redesign related to Vascular service at UHA, Trauma and Orthopaedics work and longer term ICU plans pan Ayrshire.

Whilst these are separate pieces of work, they all form part of the bed modelling and ability to maintain 43 surge COVID beds within UHA and 82 surge COVID-19 beds within UHC.

| | 50% above | | SURGE | | MAX |
|---|---|---|---|---|---|
| | | | | | |
| UHA | 10 red CAU | | St 15 - 12 new | | St 16 – 27 (13 new) |
| | 21 St 1 - new | | (43 total from +50% and surge) | | |
| | | | | | |
| UHC | 18 red CAU | | 5B 23 new | | 4E/4F - 42 new |
| | 18 ward 2B | | 2B 11 new | | 5A - 9 new |
| | 12 HASU 3F-new | | (82 total from +50% and surge) | | |
| | | | | | |
| NHS Ayrshire & Arran Total | 79 | | 125<br>(46 extra new) | | 203 (78 extra new) |
| | | | | | |
| Cum total | 79 | | 125 | | 203 |

COVID-19 led to reduced front door demand and a reduced number of elective admissions throughout Medicine & Surgery reducing overall capacity throughout acute services.

The redesign of urgent care services will be critical to supporting patient care being delivered in the right place and will have a positive impact on potential occupied bed days.

**Summary of actions for acute mobilisation:**

We will:

- Ensure continued provision of COVID-19 surge capacity at 125 surge and 203 maximum surge *note these figures have changed slightly from previous submissions due to reconfiguration of some inpatient wards.
- UHA will develop the (green) elective orthopaedic pathway – accepting patients from across Ayrshire and Arran. This 27 bedded area would ultimately become the UHA COVID-19 area if a further outbreak occurred with elective work being suspended.
- Oncology services on both sites are currently outwith their usual wards/stations & a plan for Ayrshire and Arran is being established to ensure cancer work continues safely - looking at all suitable estate whilst following Scottish Government advice to carry out chemotherapy outwith sites with active COVID-19 patients where possible.
- Continued use of Community Assessment Hubs to direct suspected COVID-19 patients who require hospital assessment to UHC & planning of one red ICU on the UHC site will not establish a completely separate red (COVID-19) and Green (non-COVID-19) hospital, however these changes in practice will potentially lead to more red (COVID-19 patients) on the UHC site.

**Summary of revenue consequence:**

- £300,000 capital spend to create chemotherapy facility outwith acute hospital site.
- General hospital beds £6.6 million full year gross costs.

## 7.3 Stroke – service delivery during COVID-19

Stroke services underwent some service changes in Phase 1 and 2 of the pandemic response which will be further adapted to support the remobilisation plan. Key aspects of the remobilisation plan include

July 2020

- Continue to deliver pan-Ayrshire hyper acute stroke services at UHC;
- Continue to deliver pan-Ayrshire acute stroke services at UHC.
- Review pan-Ayrshire stroke capacity; and
- Stroke rehab to continue to be delivered at Biggart Hospital.

August/September 2020

- Nurse led and Consultant TIA/stroke clinics to recommence, including some face to face nurse led and consultant TIA/stroke clinic services to improve preventative care and reduce inpatient emergency admissions, and also consideration to be given to the introduction of NHS Near Me virtual consultations for return patients;
- Establish VC/attend anywhere for stroke consultations prior to transfer to UHC for borderline cases to reduce repatriation needs;
- Complete work to clearly define stages of care – hyperacute, acute, neuro rehab;
- Establish pathways for patients not fitting criteria for the stroke rehab facility at Biggart Hospital;
- Establish pathways for palliative stroke patients; and
- Establish ICT pathway for early supported discharge.

The consequence of moving of station 16 to Drummond ward at Biggart hospital has unintentionally impacted upon the delivery of acute stroke care across Ayrshire and Arran. Biggart Hospital does not have appropriate facility to support patients in the hyperacute or acute phase of their journey following stroke which has an impact on the UHC site. (Biggart does not have 24hr access to onsite medical cover, radiology or labs). In addition to a review of the stroke service and pathway, additional beds (6) will be required at UHC to support the impact of increased length of stay for patients until clinically ready for rehab.

**Summary of actions for stoke:**

We will:

- Stroke rehab (St 16) currently at Biggart will remain within the Biggart for a 12-18 month period & undertake a service redesign/review in collaboration with the stroke MCN. This leaves the St 16 footprint estate available for pan-Ayrshire elective orthopaedic work.
- Stroke – review the pathway changes as a result of moving the stroke rehab from UHA to the Community Hospital at Biggart which resulted in an unintended consequence of extending length of stay at the hyper acute stroke unit at UHC.

**Summary of revenue consequence:**

- Junior medical staff £25k
- Consultant staff £39k
- 5.4 WTE RNs and 5.4 WTE for NAs for additional beds - £226K.

## 7.4 Supporting Reform

### Orthopaedics

NHS Ayrshire & Arran's earlier plans identified an ambition to commence inpatient elective Orthopaedic activity at University Hospital Ayr (UHA). This activity will take place on behalf of all citizens residing in NHS Ayrshire & Arran and is in line with our ambition of developing a "greener" site to protect elective activity/capacity for as long as is possible should we experience a second wave of COVID-19 infection circulating within our communities.

As a result of our urgent outpatient referrals together with referrals categorised as urgent cancer is suspected being seen throughout the COVID-19 pandemic this cohort of patients has continued to be added to the inpatient and day case waiting lists where surgery was indicated. This has resulted in an ongoing demand on our available theatre capacity which is not yet back to that of the pre COVID-19 level.

A weekly theatre meeting is in place which supports the allocation of available theatres to the specialties who have the highest clinical priority patients waiting. Initially one day per week was allocated to orthopaedics at UHA to manage the urgent revisions which were waiting. From August 2020 it has been possible to cover on average 4 days per week.

Throughout the month of August we will run our theatres at UHA with a combination of both UHA and University Hospital Crosshouse (UHC) staff in in order to support a shared learning and understanding of clinical practice.

From August 2020 through to March 2021 it is anticipated that we will provide 3 joint equivalent per day with the potential to increase to 4 joint equivalent per day following a test period of 3 per day through August. Therefore it is predicted that from September 2020 through to March 2021 a total of the equivalent of 20 joints per week will be delivered.

This approach will continue to be monitored by the Orthopaedic Service Steering Group supported by the overarching Theatre Restart Group which will ensure equitable service delivery to the citizens of NHS Ayrshire & Arran.

In order to support this approach we will continue to incrementally increase our day case and 23 hour planned activity.

**Reform**

We will continue to work collegiately thereby ensuring we continue to progress our ambition to deliver elective services at UHA.

In keeping with the Implementation of the National Major Trauma Network Strategy and the local delivery of Trauma and Orthopaedic services, NHS Ayrshire & Arran had previously set out its ambition to deliver all trauma services from UHC with all inpatient elective activity delivered at UHA.

This phased incremental approach to elective inpatient activity supports the transition of service provision in line with this ambition with a full transfer of service delivery provision expected by April 2021.

**Performance**

From May 2020 until week commencing 6 July 2020 a total of 33 inpatient elective procedures have been performed. The increase of activity from August through to March 2021 will see a further 490 joint equivalent procedures performed if current planning assumptions are maintained.

This predicted activity is reliant on our ability to continue to deliver our elective activity as described, however it is recognised that should we experience a second phase of COVID-19 infection circulating within our communities then it is possible that all elective activity may be paused.

In order to deliver this service for the citizens of Ayrshire and Arran, Consultants are required to adapt their job plans to work 5 days over 7. This will attract an enhanced rate of pay for those hours which are not covered under current contractual arrangements which is likely to incur an increased cost of £18k through to March 2021.

Additional nursing costs will also be incurred to support this new way of working and are estimated to be £142k through to March 2021.

**Summary of actions for orthopaedics:**

We will:

- Establish a pan-Ayrshire inpatient elective orthopaedic service at UHA by September 2020.

**Summary of revenue consequence:**

- The £160K to introduce a 7 day services for orthopaedics is included in the planned care costs.

## 7.5 Critical Care

This section provides the rationale around the decision to concentrate our COVID-19 intensive care response at University Hospital Crosshouse. This enables us to focus on a green critical care provision at University Hospital Ayr.

The most efficient and effective way to deliver COVID-19 additional Intensive Care Unit (ICU) capacity is to do so from a single additional “red” (COVID-19) ICU facility at University Hospital Crosshouse (UHC). This would be an interim facility to balance the high critical care demand response of any future C19 outbreak, whilst trying to preserve elective operating capacity as much as possible, primarily at University Hospital Ayr (UHA).

The Red ICU will be based within Day Surgery Unit (DSU) Recovery, UHC. This is an open, expansive area that easily lends itself to incrementally increasing and decreasing bed capacity and allows good ‘line of sight’ for monitoring patients.

In order to support this model of care capital investment is required at both the UHA and UHC sites. These costs (UHA: £60,000 / UHC: £300,000) have previously been approved by the Scottish Government as part of the board’s financial returns.

The additional revenue costs associated with the additional COVID-19 ICU capacity in remobilisation plan phase 2 will be £3.1 million between August 2020 and March 2021.

Works at UHA are primarily focused on creating two side rooms in which patients requiring level 3 care and whose COVID -19 status is not yet known could be admitted to whilst awaiting swab results. During these works, ICU will be provided in a temporary facility on the UHA site. The capital works at UHC are more extensive and are expected to be completed by mid-September. We will be able to run DSU, recovery and ICU simultaneously, thereby preserving elective activity, until there are 10 ICU patients in DSU ICU (i.e. moving into escalation Stage 4 below), at which point all other work-streams operating from the DSU would cease.

| Escalation Stage | Max Capacity | Level 3 beds | |
|---|---|---|---|
| 1 | 100% | 10 | Business as usual.<br>UHA: 4 green beds<br>UHC: 6 green beds |
| 2 | 160% | 16 | UHA: 4 green beds<br>UHC ICU 1 (core) : 6 red beds<br>UHC ICU 2 (DSU): 6 green beds |
| 3 | 200% | 20 | UHA: 4 green beds<br>UHC 1 (core): 6 green beds<br>UHC 2 (DSU): 10 red beds |
| 4 | 260% | 26 | UHA: 4 green beds<br>UHC 1: 6 green beds<br>UHC 2: Up to 16 red beds |
| 5 | >260% | >26beds | Additional red capacity opened on UHA site. |

There is no substantive change to 'green' ICU provision across NHS Ayrshire & Arran. Elective patients who require green ICU post-op care will still receive surgery at their normal site. Unscheduled admissions will continue to be assessed at their local hospital.

Where a patient is confirmed or suspected COVID-19, and is a suitable candidate for level 3 provision, there will be urgent transfer of this patient from UHA to UHC. The aim is to transfer COVID-19 positive patients from UHA to UHC before significant clinical deterioration and before they require ICU management thereby reducing the risk associated with transfers of critically unwell patients.

Both units have experience of transferring patient in pre-COVID-19 era, normally due to lack of onsite capacity. If there is further onset of COVID-19, it is likely that there will be more transfers than normal owing to the above pathway. There is a clear process in place to ensure these transfers would be done in safe, managed way. This, therefore represents both continuation of core service (i.e. existing green pathways) alongside development of new ways of working (i.e. increased intra board transfers arising from red pathway).

It is hoped that this pathway will enable UHA to be a 'greener' site, in which elective activity will be better protected from the impact of COVID-19, whereas in the first outbreak, there was wholescale reduction of elective programme at both acute sites. The surgical restart group would be used to enable clinical prioritisation of cases and lists across Ayrshire and Arran if there was reduction in programme at UHC, but if theatres continues at UHA. This represents a fundamentally different way of working, and is driven by our collective aim to ensure capacity and capability for any future COVID-19 outbreak as well as maintaining an elective programme as much as possible.

One of the primary reasons for undertaking this change is to maximise our multi-disciplinary workforce. UHC has a dedicated ICM trained consultant workforce and rotas whereas this is an integrated rota at UHA. Concentration of red ICU at UHC will mean that ICM consultants will focus on intensive care patients and theatre anaesthetists will continue with the elective programme. The move towards a bigger ICU unit in DSU will create staffing efficiencies for nursing, AHPs, pharmacy and others.

Digital Services will support critical care by providing regional clinical portal access to all clinical staff. In addition, the use of Microsoft Teams to support MDT and other clinician to clinician collaboration will enhance care. vCreate is currently implemented to support asynchronous video appointments.

**Summary of actions for critical care:**

We will:

- Establish a single 'Red' ICU at UHC by October 2020.
- ICU (recovery area) at UHC will undergo extensive estates work to become the red – pan-Ayrshire Critical Care Level 3 unit. Timescale: capital work due for completion by October 2020.
- ICU at UHA will develop the current estate, adding additional isolation spaces. This is in order to hold Level 2/Level 3 patients suspected COVID-19 patients awaiting test results in order to make decisions to transfer to UHC. Timescale October 2020.
- Medical high dependency red (UHC) & Green elective HDU (UHA) areas/footprint requires to review due to the need to have relevant infection control arrangements in caring for patients that require AGPs.

**Summary of revenue consequence:**

The following costs have been identified for Critical Care services:-

- £6.0 million for full year cost or £3.1 million for last 8 months of year. Should there be a significant surge requiring more capacity this would incur additional revenue spend.

## 8.0 Planned Care including cancer services

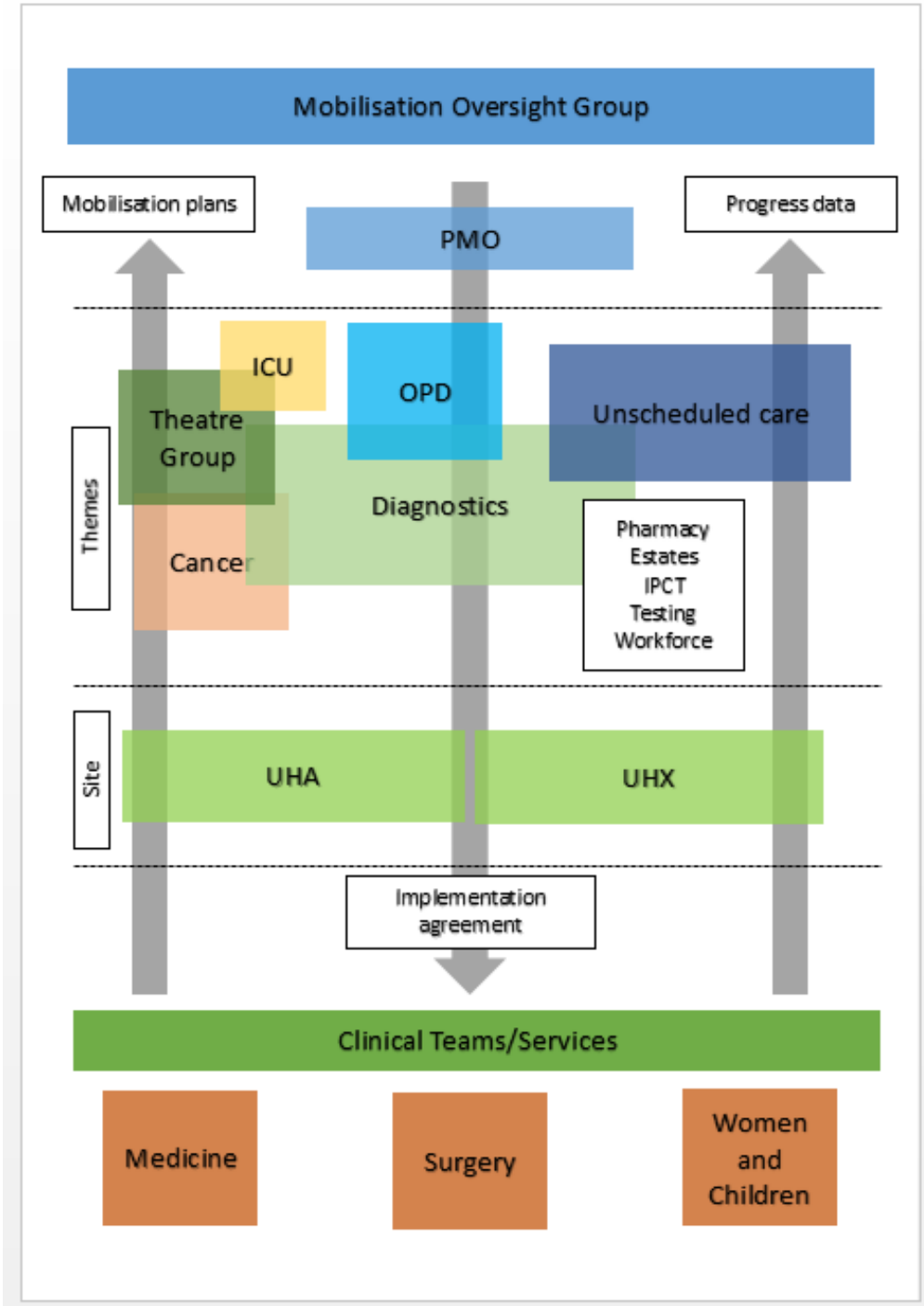
The ongoing mobilisation of planned care for Acute Services will continue to be facilitated by the Mobilisation Structure which was established in Phase 2. Underpinning this process are the key service re-start principles: Safe for Patients; Safe for Staff; Safe Service.

Service Teams are continuing to develop and implement plans for the safe re-start and phased expansion of services through remobilisation plan Phase 2. A co-ordinated and consistent approach is ensured through the support of a number of Operational Mobilisation groups, including:

- Theatre Re-Start Group UHA;
- Theatre Re-Start Group UHC;
- Outpatients Re-Mobilisation Group; and
- Endoscopy Re-Mobilisation Group.

Service plans, once confirmed by the appropriate operational Re-start Group are presented to the weekly Acute Mobilisation Steering Group for approval prior to implementation. This strategic group provided the overall governance and ensures a whole system approach through linkage with primary and community services.

Following this process, a total of 27 outpatient services, 7 surgery services and 12 supporting clinical services have been re-started as at 20 July.


Mobilisation Oversight Group
Mobilisation plans
PMO
Progress data
ICU
OPD
Theatre Group
Unscheduled care
Themes
Diagnostics
Cancer
Pharmacy
Estates
IPCT
Testing
Workforce
Site
UHA
UHX
Implementation agreement
Clinical Teams/Services
Medicine
Surgery
Women and Children

## 8.1 Cancer

### Local Implementation of Framework for Recovery of Cancer Surgery

The Scottish Government Framework for Recovery of Cancer Surgery is guiding the remobilisation of Cancer services in NHS Ayrshire & Arran based on :

- Clinical priority;
- Equitable access; and
- Delivery of care in the safest possible environment.

Although some cancer services and cancer surgery continued through Phase 1, this was limited and in the colorectal and upper GI surgery pathways, cancer surgery was suspended.

During Phase 2, the re-start of these surgical pathways was a priority, as was the prioritisation of clinical resources to address the backlogs of cancer cases which had developed in most cancer pathways.
The Surgical Re-Start process is outlined in more detail below. This process has been effective in addressing the cancer surgery backlogs, and as at July 2020 there are no notable backlogs for surgery in any cancer pathway, with the exception on a small number of cases who are awaiting specialist prostate cancer surgery in NHS Greater Glasgow and Clyde.

| **Patients awaiting Cancer Surgery*** | As at 12 May 2020 | As at 20 July 2020 |
|---|---|---|
| Breast | 45 | 6 (of which 5 have admission date) |
| Colorectal | 25 | 1 |
| Upper GI | 6 | 0 |

- Other cancer pathways were largely unaffected during Phase 1 COVID-19

Moving into remobilisation plan phase 2, the delivery and prioritisation of cancer surgery will remain an agile and reactive process. It is recognised that the re-starting of some diagnostic services such as Endoscopy, and the recommencement of screening programmes is likely to result in increased numbers of cancer diagnoses; resulting in a backlog of unmet need that has developed during Phases 1 and 2.

**Clinical Priority**
The prioritisation of the reduced operating theatre capacity will continue to be managed by the local Surgical Re-Start prioritisation groups. MDTs will be asked to take a more forward looking approach to upcoming surgical demand and to advise the Surgical Re-Start groups of this in order that, throughout remobilisation plan phase 2, theatre capacity is prioritised to those patients requiring cancer surgery.

**Equitable Access**
NHS Ayrshire & Arran is committed to supporting and delivering equitable access for patients who are considered clinical priorities across the West of Scotland. Senior clinical and managerial representation has been established on a newly formed Regional Cancer Prioritisation Board. Early discussions have begun to look at how current disparities arising from variations in Cancer Surgery capacity across the West of Scotland can be addressed on a mutual aid, or through other joint working.

**Delivery of Care in the Safest Possible environment.**
NHS Ayrshire & Arran will continue to deliver unscheduled care at both acute hospitals, and so will not have a COVID-19 free (green) site. However as outlined earlier, changes have been made to ensure the separation of green and red pathways, managing COVID-19 and non-COVID-19 patients separately, including some ‘super-green’ areas to support elective surgery where the post-operative risks of infection are higher.

Pre-operative pathways have been redesigned to include pre-procedure isolation, COVID-19 testing and symptom checks at various stages. Close attention is being paid to theatre timings and air exchanges to minimise patient cross-over and maintain patient safety.

A post-operative COVID-19 surveillance project has also been established as a joint approach between the surgical team and Public Health. Regular feedback from this work will ensure that any safety concerns are identified and addressed at an early stage,

Golden Jubilee National Hospital (GJNH) is supporting Boards in the re-mobilisation of cancer surgery and is ensuring patient safety through its protocols which support its position as a ‘super-green’ hospital. NHS

Ayrshire & Arran will be establishing some breast cancer surgery at GJNH from 12 August, this representing both supplementary operating capacity at a point when local operating capacity is reduced and also a contingency to ensure ongoing cancer operating capacity should a second wave of COVID-19 result in another pausing of surgery in NHS Ayrshire & Arran.

GJNH is also supporting NHS Ayrshire & Arran cancer services through the provision of additional endoscopy capacity and this is explained in more detail in the Endoscopy section of this paper.

To reduce the overall footprint of SACT prescribing and delivery and making attendance at hospital and pathway as safe as possible, we are exploring options for a medium term move of Tier 3 (low risk) chemotherapy to a site outwith either acute site. A preliminary option appraisal is underway to scope out potential solutions.

## 8.2 Inpatient & Daycase Surgery

As part of the Board's Phase 2 Mobilisation Plan, surgical restart meetings were established at each of UHA and UHC. The primary purpose for these weekly meetings was to ensure that surgical restart undertaken safely ensuring that was clinical oversight and prioritisation of cases being booked into theatre. These meetings have been chaired by Mr Roger Currie, OMFS Surgeon and have consisted of members of the following areas:

- Specialty surgeon representation;
- Dept. of anaesthetists;
- Microbiology and public health;
- Theatre and pre assessment team; and
- General management.

The development of surgical restart forum supports the ambitions of Caring for Ayrshire by taking a 'Board approach' to surgical restart and planning. The fact that these meetings are chaired by the same person ensures consistency in approach between Ayrshire's two acute hospitals and ensures shared learning between the two sites. This unified process of oversight has enabled increased cross site booking as there are slightly different pressures on each hospital's theatre complex.

More generally, it has created forum in which surgical reform can be discussed. This is especially pertinent for the orthopaedic service as we move towards implementation of the Board's trauma and orthopaedic reform plan (trauma being based at UHC and elective service based at UHA).

Throughout phase 2 the number of operating theatres and corresponding elective activity has increased. The initial focus of the restart groups was recommencement of surgical cancer which had been paused during the peak of 1st wave. This process was aligned to the direction set out in 'the framework for recovery of cancer surgery' and the Royal College of Surgeon (RCS) prioritisation matrix. These surgical cancer backlogs have now been largely addressed but we do expect there to be high cancer surgical demand owing to the number of patients currently awaiting outpatient appointment and or diagnostics.

Moving into remobilisation phase 2, this forum will continue to monitor utilisation of theatres and will drive forward effective utilisation of all theatres across the Ayrshire estate. The surgical mobilisation will continue to focus on the Re-start principles: Safe for Patients, Safe for Staff and Safe Services. Priority will continue to be given to those patients in the RCS categories 2 and then 3. Thereafter, where capacity is identified, some Category 4 work, particularly in Orthopaedic Surgery and Cataract Surgery, will also progress.

We intend to undertake waiting list validation of inpatient waiting lists to ensure that patients on the waiting list wish to proceed with surgery. This was not undertaken in phase 2 owing to limited theatre capacity available. Furthermore we are looking to code surgical waiting list entries onto PMS using the following RCS codes. This will help inform prioritisation of cases both at operational and strategic level. This will help augment existing processes rather than in any way replace them.

Level 2 – Surgery that can be deferred up to 4 weeks
Level 3 – Surgery that can delayed for up to 3 months
Level 4 - Surgery that can delayed for more than 3 months

Moreover this group will also continue to ensure that robust post-operative follow-up remains in place.

The chair of NHS Ayrshire & Arran surgical restart group contributes to the regional prioritisation group which aims to reduce any inequity of access across the West of Scotland.

## Post-COVID-19 Operating Capacity

Current indications are that elective operating capacity will return to between 50-60% of pre-COVID capacity.

Early analysis suggested that the prioritisation of Category 2 and 3 patients will require about 30% of this revised capacity.

This will leave capacity for around 800 ‘routine’, Category 4 patients per month within NHS Ayrshire and Arran. This is about 44% of the normal, pre-COVID routine throughput.

Any requirement to provide ‘mutual aid’ to other West of Scotland Boards as described above in the Cancer section, will further reduce the available routine capacity.

As at 27 July there are 3818 patients waiting over 12 weeks for surgery, and of these 1560 have waited over 26 weeks. On the basis of the above analysis, it is anticipated that the limited routine operating capacity will result in progressively longer and longer waits for these patients.

## COVID-19 Surveillance in the post-op phase

The Surgical Re-Start groups have also established a post-operative COVID-19 surveillance project, with patients being contacted by telephone at 7,14 and 21 days after discharge from hospital to elicit whether they have any symptoms suggestive of COVID-19 infection - cough, raised temperature (≥37.8$^{o}$C), or loss of taste or smell. The primary aim of this surveillance project is to provide quality assurance for the safety of recommencing elective surgery. A secondary benefit is be the added value of service provided to patients in the form of telephone support from a member of the surgical team at a time when access to post-operative assistance in the community is, or can be perceived as, being more difficult.

The project started on the 22$^{nd}$ June 2020 and will run for 10 weeks, **T**he data analysis and reporting is being led by the Public Health Department. Results are reported weekly to the NHS Ayrshire & Arran Surgery Restart Theatre Groups in order to inform the ongoing re-mobilisation process, with formal reports to be produced at weeks 4 and 10.

## 8.3 Outpatients

In remobilisation phase 2, we will continue to prioritise patient referrals in line with clinical priorities. In addition to focusing on UCS and Urgent cases clinical teams are expanding clinical activities to manage an increasing number of new referrals which have been categorised as “Routine” and follow-up patients whose consultation has required to be cancelled since commencement of the pandemic.

Each specialty has been asked to work through a plan to consider:

- Number and clinical priority of patients siting on the out-patient waiting list;
- Number and clinical priority of patients whose consultation has been postponed; and
- Number and clinical priority of patients with a forward booked return appointment scheduled till 31 March 2021.

**New Patients**

As referrals are being received a number of services are initiating Active Clinical Referral Triage methodology – reviewing wider Electronic Patient Record, making telephone contact with patients, ordering investigations, providing advice to referrer and patient.

Some services are clinically reviewing new patient referrals that are on the out-patient waiting list. Administrative and clinical validation is being undertaken and it is anticipated that around 5% of referrals will be able to be removed from the waiting list in this way. Other cases are being prioritised for investigation and telephone/near me and face to face consultation.

## Follow-up Patients

Clinicians are clinically reviewing the records of patients whose appointments were postponed. A range of alternative management strategies are being deployed including:

- Prioritise for telephone/NHS Near Me or face to face Consultation;
- Discharge;
- Patient Initiated Review Pathways;
- Devise and communicate clinical advice and management plan;
- Order investigations [to be undertaken by hospital and community services]; and
- Extend the horizon of the review date [telephone/NHS Near Me or face to face consultation].

In considering action plans, services are actively progressing re-design and the majority of clinical interactions are now undertaken using virtual modes of contact; clinical correspondence to referrer and patient, telephone/NHS Near Me consultation. The impact is that less than 50% of clinical consultations currently being undertaken are face to face.

Acute Services are being supported by Primary and Community Care Services e.g. Phlebotomy service, to enable compromised patient cohorts e.g. Renal Medicine, Haematology and Oncology services to have reduced hospital visits. Acute and Primary Care services have commissioned joint work to progress further initiatives.

## Governance

In order to safely manage the mobilisation of out-patient services an Out-patient Service Operational Group has been established. This group is chaired by the General Manager Access and Clinical Administration and has General Manager representation from each clinical service. As services begin to make plans to re-establish face to face consultations they require to draft and submit an agreed template describing their overall plan for recovery including re-design. Following consideration by the Operational Group the recovery template is tabled at the Acute Services Strategic Mobilisation Steering Group for approval.

## Workforce

In conjunction with redesign, services are considering requirements for new patient pathways including:

- Most suitable clinician to vet new referrals;
- Consider membership of clinical team and agree which disciplines and grades will undertake consultations at each stage of the patient pathway;
- Specialties considering restructure of job plans to support redesign of service;
- Increased agile working (within healthcare premises and from clinicians' homes);
- Restructure of clinical administration team to support redesigned patient pathways; and
- Modification of physical estate to enable clinicians to efficiently undertake telephone and VC consultations with appropriate access to clinical supervision.

We expect the culmination of the above actions will result in a high percentage of our patient consultations being facilitated through a virtual pathway and that face to face consultations will only be utilised whenever the clinical interaction requires it.

Consequently, redesign of patient pathways will result in an increase in clinical activity at the beginning of the patient journey ensuring a more efficient and seamless experience.

- Increased number of consultations undertaken by telephone and conversely reduction in face to face consultations;
- Increased number of clinical interactions undertaken through written correspondence;
- Reduced number of follow-up patients; and
- Opportunity for enhanced mobilisation of outpatient services.

**Review of Outpatient Facilities**

A limited number of face to face clinics are being reintroduced to accommodate those patients and presentations where this is necessary. The number of patients who can be accommodated on each clinic is reduced to allow for physical distancing in waiting areas, avoidance of cross-over of patients where possible, and additional time required for cleaning, sanitising and PPE.

At the same time, physical clinic capacity has been reduced by changes to other services including the establishment of the Community Assessment Centre and Staff Wellbeing Hubs, both of which have been housed in facilities which previously house Outpatient services.

A review of all available outpatient facilities within the Board area including Ayrshire Central Hospital, East Ayrshire Community Hospital and Girvan Hospital will be undertaken to ensure maximum use of available outpatient facilities.

**Louisa Jordan Clinics**

Following a pilot project undertaken by NHS Lanarkshire, considering the suitability of the Louisa Jordan facility at the SECC in Glasgow, NHS Ayrshire and Arran will review the opportunity, practicalities and deliverability of using the Louisa Jordan facility for outpatient clinics.

This work will be undertaken in conjunction with West of Scotland colleagues, as a regional approach is likely to be required to achieve the scale necessary to make this a feasible option. Implications for the local system in terms of staffing costs and availability, patient travel costs and practical arrangements will be undertaken, and a local view will be concluded by 24 August 2020.

## Digital Developments

Since the onset of the COVID-19 pandemic, the use of technology to support non face to face consultations has increased from 0% of consultations to 40% by June 2020.
This includes a majority of consultations delivered by telephone, and a steadily increasing volume of consultations delivered using NHS Near Me. There were initially some difficulties in capturing this activity, but this has now been addressed through a more systematic approach to the NHS Near Me roll out within the acute services.

NHS Near Me has been formally rolled out over 6 clinical areas - Respiratory Physiology, Urology, Medical Paediatrics, OMFS, Orthopaedics and Respiratory.

A further 12 clinical areas have requested NHS Near Me and this will be progressed through remobilisation plan phase 2 through the designation of an individual with specific responsibility for implementation.

| **Acute Specialty (one or more clinician requested NHS Near Me)** | **Configuration Complete** (build and schedules) | **Booking Processes/Schedule of Patients Agreed** | **Complete by** |
|---|---|---|---|
| **Cardiology** | By end August | By end September | October 2020 |
| **Geriatric Medicine** | | | |
| **Diabetic & Endocrinology** | | | |
| **Dermatology** | | | |
| **Gynaecology** | | | |
| **Haematology** | | | |
| **Infectious Diseases** | | | |
| **Neurology** | | | |
| **Obstetrics** | | | |
| **OMFS** | Yes | | Complete |
| **Oncology** | By end August | By end September | October 2020 |
| **Orthopaedics** | Yes | | Complete |
| **Orthoptics** | By end August | By end September | October 2020 |
| **Paediatrics** | Yes | | Partly complete. To be set up for other clinicians within Paediatrics |
| **Pain Management Service** | By end August | Complete by end October | October 2020 |
| **Renal** | | | |
| **Respiratory** | Yes | | Complete |
| **Respiratory Physiology** | Yes | | Complete |
| **Rheumatology** | By end August | By end September | October 2020 |
| **General Surgery** | | | October 2020 |
| **Urology** | Yes | | Partly complete. To be set up for other clinicians within Urology |

**Examples of Effective Outpatient Redesign during COVID-19**

| Specialty | |
|---|---|
| Paediatrics | Enhanced vetting coupled with telephone calls to parents from the extended paediatric team has demonstrated that a considerable referrals can be managed at vetting stage thereby reducing the number of patients requiring a face to face consultation. The out-patient waiting list has reduced from 388 in April to 209 in June 2020. |
| Renal: | Service redesign has enabled follow-up patients from four general, two transplant, one continuous ambulatory peritoneal dialysis and one polycystic kidney disease clinics to be moved to a virtual review model. The patient is scheduled to a virtual clinic date. The clinician orders investigations which are undertaken via the Community Phlebotomy Service and on receipt of the result the clinician reviews against the patient's EPR. Patients are advised of next steps with a significant number not requiring to attend a hospital clinic or engage in a telephone/VC consultation. The impact is that an increased consultant resource has been directed to new patient referrals and patients whose condition has deteriorated. The out-patient waiting list has reduced from 98 in April to 88 in June 2020 |
| Urology | Clinicians have actively reviewed the majority of follow-up patients whose appointment required to be cancelled. Outcome is that a proportion have been discharged to patient initiated review pathways and telephone consultations have been undertaken. Face to face capacity is being utilised for new patient referrals thereby helping to reduce the numbers of patients waiting. The out-patient waiting list has reduced from 1144 in April to 837 in June 2020. |
| Trauma and Orthopaedics | ESPs are continuing to enhance vet the longest waiting patients from the new outpatient waiting list. The patients are being telephoned and some can be discharged with advice, a proportion can be managed through AHP Services and those patients who require a face to face consultation with an Orthopaedic Surgeon are being prioritised as appropriate. In the first tranche from a cohort of 98 patients, 37 were deemed to require a consultation with an orthopaedic surgeon, 24 were discharged via advice pathway, 1 patient was prioritised to an urgent face to face consultation, 32 remained under the care of an ESP and 4 patients could not be contacted. |

## 8.4 Trajectories and DCAQ

**Impact of COVID-19 Phase 1 & 2 on Waiting Lists**

The suspension of non-urgent elective outpatient clinic and Inpatient/Daycase surgical services during Phase 1 of the COVID-19 response has resulted in a significant backlog of patients awaiting review and treatment.

| | Total New patients Waiting | | Total Patients waiting > 12 weeks | |
|---|---|---|---|---|
| | Pre-COVID-19 at 28 February 2020 | At 10 July 2020 | Pre-COVID-19 at 28 February 2020 | At 10 July 2020 |
| New Outpatients | 34881 | 34762 | 4012 | 14457 |
| Inpatient / Daycases | 5330 | 5725 | 1100 | 3547 |

| | Total New patients Waiting | | Total Patients waiting > 6 weeks | |
|---|---|---|---|---|
| | Pre-COVID-19 at 28 February 2020 | At 10 July 2020 | Pre-COVID-19 at 28 February 2020 | At 10 July 2020 |
| Endoscopy | 1822 | 2747 | 735 | 2135 |

Although significant work has been undertaken to redesign, and deliver services in different ways, as outlined earlier, during remobilisation plan phase 2 the capacity in both outpatient clinics and for surgery will remain significantly less than pre-COVID-19.

**DCAQ**

Service teams are experienced in using Demand, Capacity, Activity and Queue (DCAQ) models to help in the management of waiting lists. These models would normally be developed and updated using historical data and trends, such as the number of referrals normally received in a certain month, or the operating theatre capacity.

However in the current situation this historical information is less relevant. There have been many changes in both the demand and also on the capacity as services adjust to requirements such as physical distancing in waiting areas, infection control protocols in operating theatres and deployment of staff or facilities for other COVID-19 response uses.

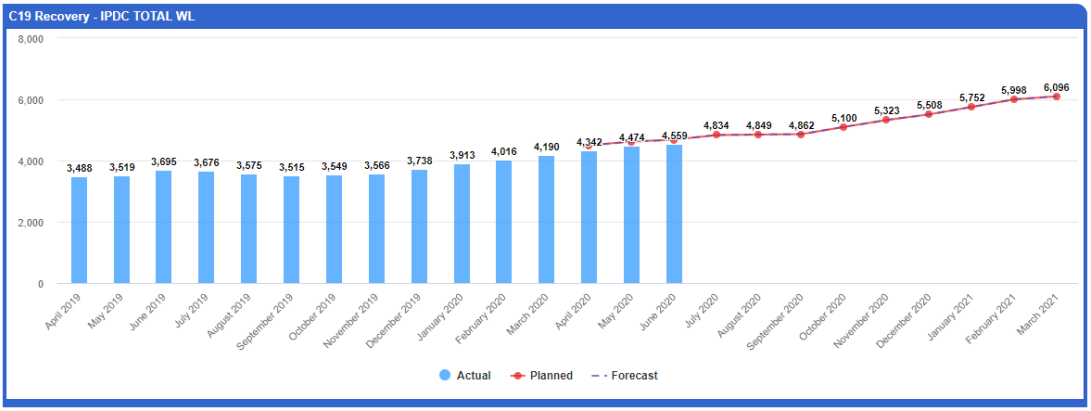
Nonetheless we recognise the importance of understanding the impact that the new ways of working are having on how long patients will wait to access planned care. Initial work has been undertaken to develop a revised DCAQ model specifically for remobilisation phase 2.

This modelling has had to make a range of assumptions which as yet are untested :

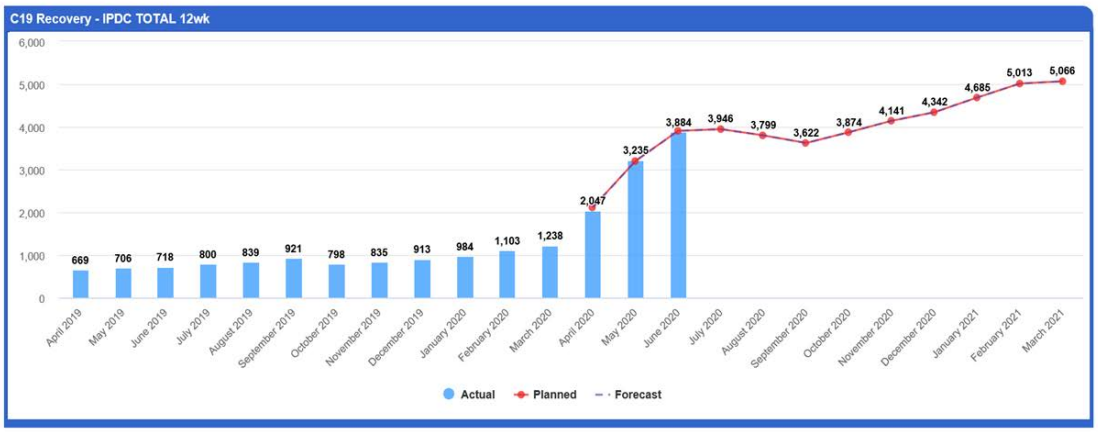
- To what extent will the referral rate for outpatient appointments recover to pre-COVID-19 levels and in what timescale;
- The capacity that is re-established for out-patient consultations and theatres will continue to change;
- What further services it will be possible to re-start beyond those already implemented;
- How will this affect the number of patients identified for inpatient and daycase surgery;
- Will the proportion of urgent versus routine patients referred and treated change;
- What further operating capacity will it be possible to re-start beyond that already implemented; and
- How much operating capacity will we need to reallocate to assist other Health Boards as part of a mutual aid approach.

The new DCAQ model is being shared with teams to assist in ongoing waiting list management. This will allow teams to have a clear picture of the backlogs and anticipated demand on their service, and will be considered in planning yet further services adaptations. The model will continue to be developed, with increased accuracy of prediction as some further current trends and patterns emerge.

## IP/DC Total Waiting List Size Trajectory as at 10 July 2020



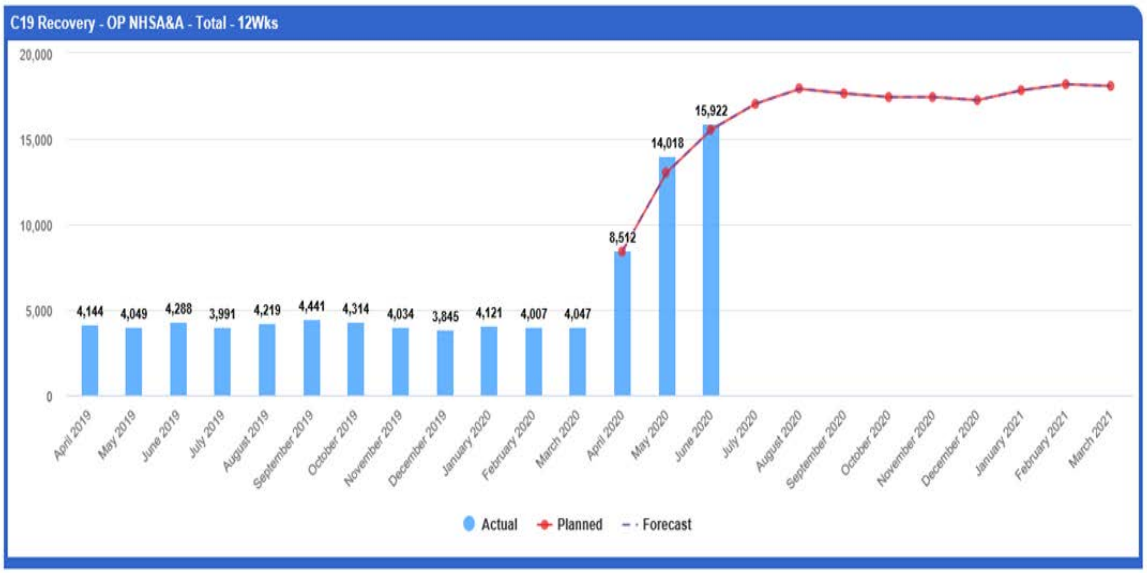

## IP/DC Total Patients Waiting > 12 weeks Trajectory as at 10 July




** Predicted Outpatient Waiting List Graph / trajectory**

## Outpatients Total Waiting List Size Trajectory as at 10 July 2020


## Outpatients Total Patients Waiting > 12 weeks Trajectory as at 10 July 2020



## 8.5 Diagnostics

### Diagnostics – Imaging

During Phase 1 of the COVID-19 response, there was a significant reduction in Imaging service, with the reduced capacity supporting only the Inpatient and UCS/Urgent workload.

The Imaging Services capacity has been reduced to support safe practice. This includes

- Promoting physical distancing within the waiting areas – currently 2 metres; and
- Altered Standard Operating Procedures for the cleaning of equipment have been updated in line with infection control.

This impacts on the available capacity, and so the remobilisation plan phase 2 for Imaging services reflects this.

| | |
|---|---|
| **CT** | Through peak COVID-19 we introduced weekend working; this was over and above the enhanced hours that were already in place. Only extra capacity was created for inpatients to allow red/green pathway. |
| **MRI** | We have the mobile van 7 days per week for next 6 months commencing on the 6th July. The MRI van will focus on the routine referrals.<br>Fixed site MRI activity is focused on urgent referrals (e.g. cancer suspected) |
| **Ultrasound** | From 6th July the General ultrasound service slowly re-started to include routine and planned referrals. Maternity ultrasound continued through Phase 1 largely unaffected. Some adaptations were made to ensure separation of green and red pathways. This will continue through remobilisation plan phase 2. Some changes were made limiting antenatal scans to mum attending alone in order to maintain safe physical distancing and this will be reviewed if physical distancing guidelines change |
| **General X-ray** | Through COVID-19 Phase 1 and 2 we provided plain film service for GP referrals at ACH. This was facilitated by the suspension of the DEXA scanning service and redeployment of staff to support general x-ray.<br><br>This allowed the acute sites to focus on ED, Inpatient and OPC activity.<br><br>During remobilisation plan phase 2, some GP general x-ray appointments are being introduced at UHC but capacity is limited. Moving forward we will utilise other community sites (EACH, Girvan) to see GP/OP referrals where ACH has no additional capacity.<br>Acute sites will continue to deliver as current |
| **Breast Screening** | During COVID-19 symptomatic breast imaging was moved to the Breast Screening Unit at ACH (where breast screening had been suspended). However, since Breast Screening will resume at the beginning of August, the symptomatic mammography service will move back to UHC. Much discussion has taken place regarding how we will run clinics etc., the clinic will run into the evening or twice per week in order to safely accommodate patients. |
| **DEXA Scanning** | Dexa scanning was suspended through Phase 1 and 2. The service plans to re-start in August 2020, with lengthened appointments of 30 minute appointments, with hope of returning to 20 minutes by November 2020, if physical distancing reduced.<br>Following Royal osteoporosis society guidelines we will bring patients for appointment in order of priority. Working through patients cancelled due to COVID-19 then outstanding examinations on pending. |

A number of other actions have also been taken to support the altered demands :

- Additional staff are rostered overnight and at weekends to ensure the ability to retain a designated room for “red pathway” patients;
- Enhanced vetting of the current referrals, waiting lists and new referrals; and
- New patient letter designed to inform patients about the new systems in place due to COVID-19 i.e. staff wearing PPE and requirement of face coverings.

**Imaging Demand and Capacity**

Whilst most other services continue to note a reduced demand for services, the Imaging Services department has noted that after an initial reduction in demand, the referral rate for Imaging investigations has returned to pre-COVID-19 referrals.
As a priority, some detailed analysis of this trend is being shared and discussed with clinical colleagues.

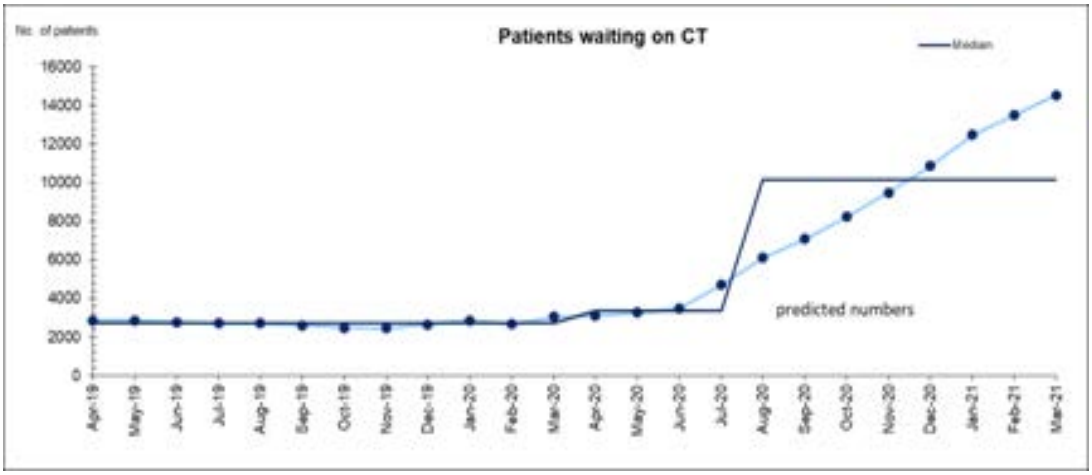
This has led to a significant imbalance between the demand for Imaging Services and the significantly reduced capacity available. Since a large proportion of this capacity is prioritised for the unscheduled care and UCS/Urgent demand, it is anticipated that there will be a growing wait for diagnostic imaging investigation of routine patients.

## Post COVID-19 Capacity US v's Demand

| Month | GJNH US | UHC US | UHA US | Total Capacity | Monthly unmet demand |
|---|---|---|---|---|---|
| Jul-20 | 160 | 975 | 542 | 1517 | 528 |
| Aug-20 | 160 | 975 | 542 | 1517 | 376 |
| Sep-20 | 160 | 975 | 542 | 1517 | 780 |
| Oct-20 | 160 | 975 | 542 | 1517 | 643 |
| Nov-20 | 160 | 975 | 542 | 1517 | 380 |
| Dec-20 | 160 | 975 | 542 | 1517 | 784 |
| Jan-21 | 160 | 975 | 542 | 1517 | 468 |
| Feb-21 | 160 | 975 | 542 | 1517 | 294 |
| Mar-21 | 160 | 975 | 542 | 1517 | 468 |

## Post COVID-19 capacity CT v's Demand

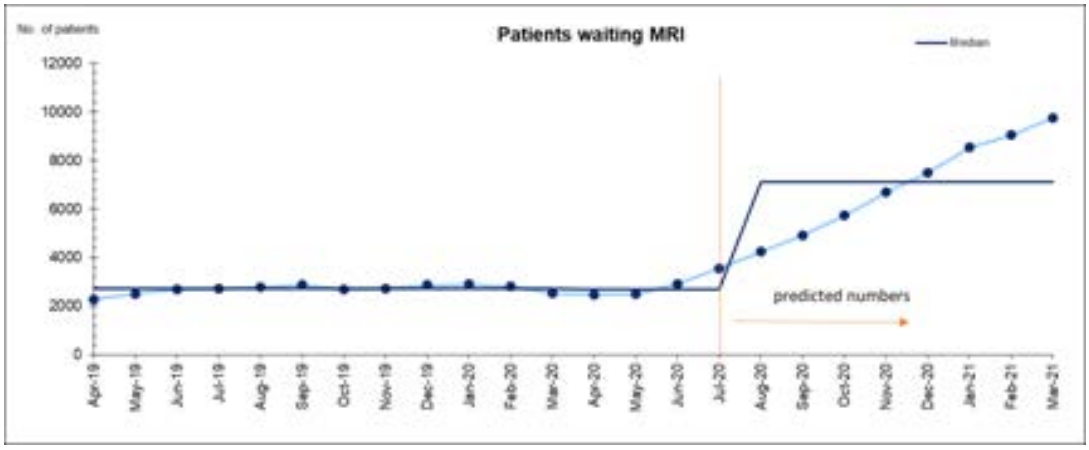
| | GJNH CT | UHC CT | UHA CT | Total Capacity | Monthly unmet demand |
|---|---|---|---|---|---|
| July 2020 | 65 | 1215 | 702 | 1982 | 1243 |
| August 2020 | 65 | 1215 | 702 | 1982 | 1387 |
| September 2020 | 65 | 1215 | 702 | 1982 | 983 |
| October 2020 | 65 | 1215 | 702 | 1982 | 1137 |
| November 2020 | 65 | 1215 | 702 | 1982 | 1249 |
| December 2020 | 40 | 1058 | 611 | 1709 | 1392 |
| January 2021 | 40 | 1058 | 611 | 1709 | 1606 |
| February 2021 | 65 | 1215 | 702 | 1982 | 1018 |
| March 2021 | 65 | 1215 | 702 | 1982 | 1042 |




Post COVID-19 capacity MRI v's Demand

MRI capacity has reduced by 42% as a result of COVID precautions, from 1555 scans per month to 896 scans per month

| | GJNH MRI | MRI van | UHC MRI | UHA MRI | Total Capacity | Unmet demand |
|---|---|---|---|---|---|---|
| July 2020 | 73 | 260 | 340 | 223 | 896 | 641 |
| August 2020 | 73 | 260 | 340 | 223 | 896 | 688 |
| September 2020 | 73 | 260 | 340 | 223 | 896 | 683 |
| October 2020 | 73 | 260 | 340 | 223 | 896 | 810 |
| November 2020 | 73 | 260 | 340 | 223 | 896 | 949 |
| December 2020 | 45 | 195 | 295 | 194 | 726 | 812 |
| January 2021 | 45 | 195 | 295 | 194 | 726 | 1027 |
| February 2021 | 73 | 260 | 340 | 223 | 896 | 514 |
| March 2021 | 73 | 260 | 340 | 223 | 896 | 710 |




A number of remobilisation phase 2 actions are proposed to mitigate this imbalance between demand and the reduced capacity:

- Scottish Government has funded the provision of a mobile MRI van, working 7 days per week for a period of 6 months. This will cost circa £420,000;
- It would be possible to increase CT scanning capacity by 240 additional appointments per month through appointment of 2 locum radiographers at a cost of circa £90,000 for 6 months;
- Ultra sound capacity could be increased through engagement of a locum sonographer at a cost of circa £60,000 for 6 months; and
- Evening and weekend sessions may be run to increase capacity.

**Diagnostics – Endoscopy**

**Endoscopy re-start**

Elective Endoscopy services were restarted in Phase 2 at both UHA and UHC. Having embedded and tested new pathways and processes, the remobilisation plan 2 involves an incremental and continually reviewed expansion of activity.

An indicative plan with timescales are below.

| | June | July | August | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Quantity deliverable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Initial Start, 2 patients per list, 2 rooms per hospital | | | | | | | | | | | 80 procedures /wk |
| Increase number of patients on each list | | | | | | | | | | | 60 extra procedures / wk |
| Open additional room at UHA | | | | | | | | | | | 30 extra procedures / wk |
| GJNH capacity in place | | | | | | | | | | | 8 procedures / wk, looking to negotiate increase to 16/wk |
| Implement qFiT | | | | | | | | | | | Reduce demand for colonoscopy |
| Implement Colon Capsule Endoscopy | | | | | | | | | | | 120 CCE procedures in 5 months (avoids 40 colonoscopies) |
| Implement cytosponge | | | | | | | | | | | 225 procedures (avoids 150 upper GI endoscopies tbc) |

It is also planned to re-establish some weekend endoscopy working, should funding be available to support this.

Pre-COVID-19 the Endoscopy service was delivered across two acute hospital sites, with separate waiting lists maintained. As part of early phases the service was merged, and a single waiting list was created in order to ensure that the re-mobilised endoscopy capacity would be directed to the most clinically urgent patients, regardless of postcode.

The Re-start of the endoscopy service has required a number of considerations and adaptations to the patient pathway :

- Enhanced pre-booking clinical phone consultation with patients;
- Pre-procedure patient self-isolation and COVID-19 testing;
- Post procedure contact for COVID-19 symptoms as part of NHS Ayrshire & Arran COVID-19 surveillance initiative; and
- Move to team based planning and delivery of service, as a 'pooled' list.

A range of additional reform and redesign projects are being introduced as outlined in more detail below.

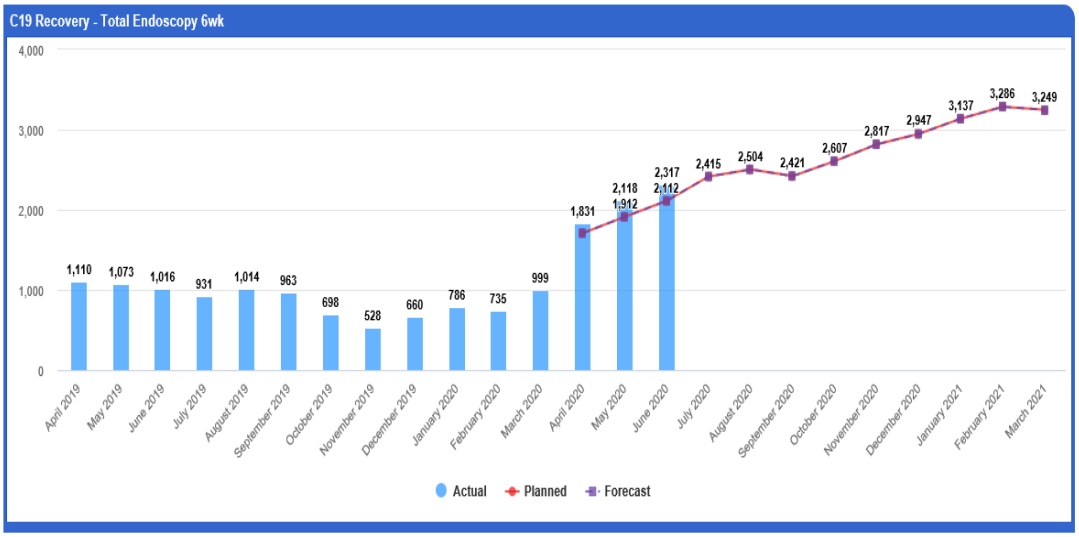
The endoscopy teams have moved to a more team based planning and delivery of the endoscopy service, in order to ensure maximum use of the available capacity. This has included a change to an Ayrshire-wide 'pooled' list.

The nurse endoscopists and endoscopy nurses have taken on some additional roles in the pre-procedure booking and COVID-19 screening processes.

There are some ongoing nurse staffing and admin staffing availability constraints with some staff who continue to be deployed into other roles. This will be a consideration in the readiness to roll out some of the above Plan.

It is planned that the endoscopy service will have re-mobilised 46% of its pre-COVID-19 capacity by the end of August 2020 and this has been factored in to the DCAQ trajectory below.

It should be noted that this graph is based on current known plans. The impact of qFIT, Colon capsule endoscopy and cytosponge are yet to be evaluated, and should further improve the predictions once they are incorporated.




**Implementation of quantitative faecal immunochemical testing (qFIT)**

NHS Ayrshire & Arran will be introducing qFIT week commencing 3rd August 2020.

The intention is to use qFIT as a means to stratify patient urgency in order to direct our reduced endoscopy capacity more effectively. Implementation of qFIT will support clinical triage and ensure that investigation of patients with colorectal symptoms, can be targeted to those with the highest risk of colorectal cancer to ensure that the patient is investigated in a timely fashion without any unnecessary delay in their pathway.

To begin with new referrals, regardless of vetting priority, will be issued with a qFIT test however this will thereafter be extended to the existing waiting list.

Initially the qFIT testing process will be coordinated by secondary care but through time, the intention is for this to be primary care based, and for General Practitioners to consider qFIT in their referral route for colonoscopy. Further discussions will take place in relation to this in October 2020.

A Service Level Agreement has been developed in conjunction with NHS Lanarkshire, as they will be processing and analysing the result of the test for all NHS Ayrshire & Arran patients.

It is estimated that qFIT testing will be undertaken in 1700 patients in 2020/21.

## Colon Capsule Endoscopy

NHS Ayrshire & Arran will introduce a Colon Capsule Endoscopy (CCE) service as part of the national roll-out programme.

CCE is a diagnostic tool which is proposed as an alternative to colonoscopy in selected patients. This involves suitable patients swallowing a capsule containing 2 cameras which take images of the bowel as the capsule passes through the intestine. Images are transmitted to a receiver, and will then be sent to a team of clinicians across Scotland for review and reporting.

Key benefits of this procedure in the current COVID-19 pandemic are that some patients can be managed on a 'light touch' basis with no need to attend hospital. It is anticipated that a proportion of patients who undergo this procedure will not require a colonoscopy procedure, thus reducing the demand on the hospital service in which colonoscopy capacity has been reduced. Furthermore, the results of the CCE can be used to stratify the urgency of those patients who do still require colonoscopy and so will assist in ensuring that the reduced colonoscopy capacity is directed to the most clinically urgent patients.

NHS Ayrshire & Arran anticipates that 120 patients will undertake CCE in 2020/21, and the associated cost of this is circa £100,000 which Scottish Government has indicated it will fund as part of the COVID-19 response in 2020/21.

The national roll-out timetable is still to be confirmed, but we would anticipate implementation by September 2020.

## Colonoscopy at Golden Jubilee National Hospital

NHS Ayrshire & Arran is working with GJNH to create additional colonoscopy capacity for Ayrshire and Arran patients, at GJNH. This activity will be undertaken by NHS Ayrshire & Arran Endoscopists working at GJNH, teamed with endoscopy support staff from GJNH.

The GJNH capacity will be utilised for the most clinically urgent patients and this will also include a cohort of Bowel Screening patients.

This elective programme will commence July 2020.
Activity has yet to be agreed with GJNH for the remainder of 2020/21 but it is anticipated that this will be in the region of 440 colonoscopies as part of the Endoscopy recovery.

## Cytosponge

NHS Ayrshire & Arran intends to introduce a cytosponge service as part of a national roll- out programme.

The cytosponge is a diagnostic tool which is proposed as an alternative to upper GI endoscopy in selected patients, such as patients with Barretts Oesophagus. Key benefits of this procedure are that it is considered non aerosol generating and so safer in the current COVID-19 situation, is less invasive for patients and has lesser facility and staffing requirements than an endoscopy procedure.

It is envisaged that during remobilisation phase 2, some existing NHS Ayrshire & Arran staff can be trained to perform and deliver the cytosponge procedure.

It is estimated that this will replace 225 upper GI endoscopies as part of the Endoscopy recovery in 2020/21. Scottish Government have indicated that they will be supporting the costs of this project in 2020/21, which are anticipated to be circa £150,000 for NHS Ayrshire & Arran.

The national roll-out timetable is still to be confirmed, but we would anticipate implementation by October 2020.

## Diagnostics – Clinical Physiology

The range of clinical physiology investigations for Cardiology, Respiratory, Vascular diagnostic investigations and Neurophysiology re-started as part of Phase 2. This has been redesigned to be delivered on a one-stop basis in order to reduce the number of visits which patients require to make to hospital, and capacity at each session is reduced to account for the requirement for increased physical distancing.

Through remobilisation plan phase 2, it is estimated that the service will be able to deliver a maximum of 50% of the pre-COVID-19 capacity. The delivery of outpatient clinical physiology investigations will continue to be progressed with clinical teams involved in re-vetting and triaging of referrals based on clinical urgency.

The plan will continue to be developed and some additional costs may be associated with scheduling of additional out of hours sessions.

## Digital

As a result of our plan to transform health and care services and being able to put in place contingency for managing patient care during the Covid-19 Pandemic, Health Records and Digital Service colleagues are supporting clinical teams within acute services to modernise clinical administration processes so that these are best aligned with delivering patient care.

Our out-patient clinics have experienced massive change to processes for clinical staff, initially as a result of the roll out of “paperlite working” and more recently during the pandemic. The “paperlite working” implementation began in May 2019 and quickly gathered momentum with the majority of outpatient consultations being undertaken through accessing clinical information electronically from Clinical Portal. All associated documentation generated from consultations is either scanned or the data is entered directly into an eform by the clinician using FormStream application including:

- Outpatient Medical Note – used at this time for medical outpatient consultations;
- Outpatient Nursing Note – used at this time for nursing outpatient consultations; and
- Additional Medical Note – used by a clinician when they wish to add a note to the patient’s record (eg an aide memoire for the next patient consultation, record of communication with the patient outwith the outpatient setting) – handy when reviewing investigation results and noting down management plan and next steps or even just that the result has been communicated or actioned.

This initiative has enabled clinicians to continue to work through the pandemic as there is now a comprehensive electronic patient record that clinical colleagues are able to view and update whilst vetting referrals, reviewing clinical correspondence/ investigation results and during patient consultations (face to face, by telephone or Video Conferencing) without the need of the paper case record. The record can be accessed on a 24/7 basis from any location including the clinician’s home.

During the last year and particularly during recent months our clinical services have required to consider alternative ways of working.
Work will jointly be progressed towards implementing phase 2 of the Acute Services EPR plan

Digital Services will progress work to further enhance and extend access to Orion Clinical Portal application:

- Through the deployment of an enterprise license to allow access to all clinicians within the organisation, this is to include inpatient and day case and associated nursing and AHP teams;
- Maintain links to clinical portals throughout the region ensuring seamless integration for clinicians accessing data across Health Board boundaries;
- Enable access to the platform by community teams across the three Partnerships;
- Integrate TEC solutions into the clinical portal with context launch for community and primary care staff; and
- Identify further 'data deficits' within portal and address these through integration links or interfaces with clinical systems and associated modalities, this includes out of hours services. Further integration opportunities will be investigated after the current HEPMA is upgraded, Maternity System and RIS are replaced.

Health Records Service will work with acute clinicians thereafter to implement a document scanning process for in-patient and day-case episodes. All paper documentation relating to in-patient/ day case episodes will be scanned following patient discharge thereby completing the acute electronic patient record.

## 8.6 Plan for implementation of Access Collaborative Initiatives

### Waiting List Validation

There will be continued waiting list validation of inpatient and daycase waiting lists to ensure that patients on the waiting list wish to proceed with surgery. This is being timed to coincide with the re-starting of some elective surgery in the Royal College of Surgeons (RCS) Category 4 priority group, which will include many of the patients who have waited the longest.

It is anticipated that around 5% of routine patients will be removed from the IP/DC waiting list as a result of the waiting list validation. This would equate to around 190 patients.

Furthermore, we are looking to code surgical waiting list entries onto Patient Management System using the RCS codes. This will help inform prioritisation of cases both at operational and strategic level throughout the remaining course of the pandemic. This will help augment existing processes.

### Team Service Planning

The Re-mobilisation of services during Phase 2, and as we move into remobilisation plan phase 2 has required clinical teams to work in different ways. New ways of working have been embraced including use of telephone and NHS Near Me consultations. Reduced capacity in both clinics and operating theatres has required teams to work flexibly to make the most effective use of available resources.

It is recognised that this new way of working represents an early form of Team Service Planning. To maximise the opportunity to implement further changes it will be important to build on what has been established during this time.

There is a commitment to develop this concept, putting some additional structure around this approach to consider the wider clinical team and include an overview of service demand.

During remobilisation plan phase 2 we will initiate this more structured approach to Team Service Planning in selected specialties in order to develop the local methodology and acceptance. This will include a detailed analysis of DCAQ for each service, engagement with clinical teams and service managers and action plans for each service to monitor and record actions/accountability. An individual timeline will be developed with each service.

**Implementation of Effective and Quality Interventions Pathway (EQUiP) within Dermatology and Surgical Services**

NHS Ayrshire & Arran plans to use the nationally supported EQUiP programme as an opportunity to harmonise and optimise clinical pathways for procedures that are considered to have a lesser value at a population level, recognising that they may have value at an individual patient level.

NHS Ayrshire & Arran will focus on 3 main pathways over the coming 4 months.

- Inguinal Hernia
- Haemorrhoids
- Benign Skin Lesions

A project plan will be developed, using the Access Collaborative toolkit and incorporating the Active Clinical Referral Triage (ACTR) methodology.

This will be an agreed NHS Ayrshire & Arran approach and indicative planned timescales are:

| | Aug 2020 | Sept | Oct | Nov |
|---|---|---|---|---|
| Identify Lead Clinician for each pathway | | | | |
| Review current pathways | | | | |
| Develop/adapt pathways in line with Scottish Access Collaborative (SAC) guidance | | | | |
| Implementation | | | | |

The implementation of these pathways will involve a change to an Ayrshire wide approach rather than being undertaken on an individual hospital site basis. This will involve the full commitment of the Service Manager, Lead Clinician & Lead Nurse. Specialty team engagement will be undertaken to optimise implementation.

These changes will help to bring demand and capacity into balance, improve length of waits, reduce the number of cancelled operations and improve team cohesion.

A Project / Action plan per specialty will be developed which will be audited from implementation to ensure that SAC standards are being maintained.

**ADePT**

NHS Ayrshire & Arran is committed to Accelerating the Development of Enhanced Practitioners (ADEPt) and has embraced Advanced Practice through the Transforming Roles programme. Governance structures including competence frameworks, prescribing frameworks, reflective practice, continuous professional development and clinical supervision are well embedded to ensure safe, effective and evidence based healthcare provision.

**Digital**

Enhanced pan region clinical portal access for all clinicians, utilisation of NHS Near Me and the use of Microsoft Teams for clinician to clinician collaboration and enhanced MDT working will enhance patient care. Implementation of an online patient booking service combined with enhanced appointment notification through text reminders will lower DNA rates. The implementation of a Radiology home working solution to support Radiologists and Reporting Radiographers which can increase capacity within this function which has the potential to shorten reporting times and thereby improving throughput.

**Summary of actions for Planned Care including cancer services:**

We will:

- Safely expand elective surgical activity to estimated 50-60% of Pre-COVID-19 level by October 2020.
- Enhance and embed digital solutions including further roll out of NHS Near Me, Clinical Portal for inpatients to replace paper casenotes, exploring online booking systems for outpatients and use of Microsoft Teams as the norm.
- Safely re-establish limited face to face clinics where clinically necessary
- Increased COVID-19 analysing capacity with further new analyser due to be implemented in August/September 2020.
- Introduce breast surgery and endoscopy capacity at GJNH by August 2020.
- Implement qFIT by August 2020.
- Implement Colon Capsule Endoscopy by November 2020.
- Implement cytosponge – timescale to be confirmed with SG.
- Expand Imaging throughput including introduction of MRI van by July 2020, additional CT sessions by September 2020 and with west of Scotland regional colleagues to optimise usage of mobile CT pods.
- Implement mutual aid approach to support other WoS regional boards to address their cancer backlogs, including delivery of UCS surgical activity on their behalf.

**Summary of revenue consequence:**

| | | Anticipated Funding from SG £'000 | Funding Required £'000 | | Comments |
|---|---|---|---|---|---|
| Current post funded from access | | | | | |
| | 2 wte AHPs | | 140 | | Podiatry + Physio |
| | Endoscopy | | 184 | | |
| | Improvement Support | | 84 | | |
| | Consultant Surgeon | | 84 | | |
| | Opthalmology Nurse | | 36 | | |
| | Consultant Plastics | | 124 | | |
| | Consultant Haematology | | 73 | | |
| | Admin | | 28 | | |
| | | | | | |
| | | | | | |
| Orthopaedics Elective | Weekend Working | | 200 | | Estimate, to be costed |
| | Private Sector | | 1,400 | | |
| | | | | | |
| Other Electives | Weekend Working | | 200 | | |
| | Evening Sessions | | 200 | | |
| | Private Sector | | 500 | | e.g. cataracts |
| | | | | | |
| Endoscopy | Colon Capsule | 100 | | | Bid submitted |
| | Cytosponge | 150 | | | |
| | GJNH | 175 | | | |
| | Weekend Lists | | 150 | | |
| | Hire of Modular Unit | | | | To be costed |
| | | | | | |
| Medical Specialties | Insourcing of OPs | | 157 | | Assumed 25% of original plan |
| | | | | | |
| Breast Clinics | 2 evening sessions | | 52 | | |
| | | | | | |
| Medical Imaging | Locum Sonographer | | 72 | | |
| | 2 locum CT radiographers | | 112 | | |
| | Mobile MRI | 420 | | | As per letter 14 July 2020 |
| | | | | | |
| Gastroenterology | Locum Dietician for OP | | 50 | | |
| | | | | | |
| Cancer | | 738 | | | As per letter 17 July 2020 |
| | | | | | |
| Ophtalmology | Shared Care | 142 | | | As advised by Cath Taysum |
| **TOTAL** | | **1,725** | **3,846** | | |

## 9.0 Planning for Winter

Redesigning urgent care services is a critical factor in managing the demands of the winter months.

This year's Winter Plan has been formulated within the context of what is predicted to be a particularly challenging winter, where there is potential for a resurgence of COVID-19 in addition to a continuing increase in demand for Emergency Care. It reflects collaborative working across our Health and Care Teams and takes account of lessons learnt from last winter.

We are mindful that in addition to continuing high levels of demand, our preparations need to take into account:

- Contingencies in the event of a second wave of COVID-19;
- Contingencies in the event of an outbreak of influenza;
- Continuing financial challenges; and
- The modelled assumptions for delivery the restart of planned care.

Our system has faced a significant period of challenge over the last few months with the impact of the pandemic being felt in all areas of our health and care systems. We will ensure that we have the ability to meet variation in demand ensuring an agile and flexible response to changing activity. We know through our modelling approach that there is a significant degree of predictability in patterns of demand throughout the winter period and, indeed, across the year. Acknowledging this affords us the opportunity to plan, rather than react to the challenges that this variation brings.

It is anticipated that if there is a significant increase in COVID-19, capacity within the acute hospital settings will be challenged, and therefore surge capacity has been built in to this mobilisation plan. This is supported by an Escalation Policy describing trigger points and expected action.

With physical distancing a priority in reducing the spread of COVID-19 it is essential that plans are put in place to minimise overcrowding in the Emergency Departments and Combined Assessment Units. This will include the introduction of a pre-triage system, with redesign of high volume, complex pathways to ensure care is provided as close to home as possible. This work is reflected in the previous paragraphs on redesign of urgent care.

Other work already underway to support reducing demand on hospital services includes

- enhancement of the Intermediate Care Teams;
- further expansion of Pulmonary Rehabilitation;
- establishment of Discharge to Assess models; and
- supported and enhanced End of Life care.

From Autumn 2020 in Scotland, NHS and Health Social Care staff will be eligible for free influenza vaccination, with the aim to protect the vulnerable groups of people that they provide care for. NHS Ayrshire and Arran and the three Health and Social Care Partners have worked with colleagues in Public Health to define the vaccination programme. Further information can be found later in the document.

## 9.1 Service Specific redesign

The Health and Social Care Partnerships and Acute Directorate have continued with a joint approach to winter planning. The following describes the focus for each area to support the period of mobilisation during Winter.

### Acute Services

The acute services directorate along with support from Health and Social Care are focussed in two specific areas for Winter including Frailty and Paediatrics.

Over the winter period the frailty leadership team will develop models of care to support the vision for Geriatric Services within NHS Ayrshire & Arran in that any person living with moderate or severe frailty who is admitted to hospital will have a comprehensive geriatric assessment (CGA) completed. This should be delivered through a frailty liaison model consisting of a blended workforce model, including Consultant Geriatrician, training grade doctors and advance nurse & AHP practitioners. To implement this model and minimise length of stay and maximise the use of integrated community rehab and support services including the utilisation of all community hospitals a leadership team has been established with the request to have supplementary staffing to support the programme of work over the winter period.

### EAHSCP Winter Planning

- Within EAHSCP Managers and Teams now have IT equipment that enables them to remotely access systems, reducing the requirement for an office presence when not meeting face to face with patients and service users;
- Managers and Teams can also now participate remotely in teleconferencing and video conferencing, reducing travelling time and associated expenditure;
- Where appropriate, clinics are now using NHS Near Me, reducing the travel burden on patients and creating clinical time to see patients face to face where required; and
- To make this approach sustainable East Ayrshire Council IT are required to increase network and server capacity to support this new way of working and provide room for growth within this area.

### NAHSCP Winter Planning

To enhance capacity within Intermediate Care and in particular the Care at Home service, ensuring the reablement service is optimised, and investment is required at a cost of £0.100m. This investment will help to provide the following from October 2020 to March 2021.

- Enhanced capacity within the Care at Home service to meet the increased demand over winter thus reducing delayed discharges for those who are awaiting packages of care; and
- Enhanced cover to provide a seven day service, operating over the weekends, onsite and based within the discharge hub and within CAU. This will complement the activity and services being delivered within Acute to ensure flow across the services during the pressures of winter.

In previous years North Ayrshire HSCP has been able to fully operationalise and reduce attendances and avoid unnecessary admissions by managing care closer to home, improving flow through the hospital to reduce length of stay and facilitating smoother transfer or discharge of patients on the health and care pathway. The programmes include:

- Care at Home;
- Intermediate Care and Rehabilitation;
- Supported End of Life Care with pathways from acute to district nursing, care at home and Ward 2 at Woodland View;
- Hospital Social Work Team based within Crosshouse; and
- A review of the admission processes to Elderly Care and Rehabilitation Wards 1 and 2 in Woodland View has reduced the length of stay for patients.

There are considerable challenges expected this year due to the pandemic on the following issues:

- The continued focus on testing of staff across sectors could have an impact on our ability to provide safe staffing levels throughout the winter period;
- The testing of patients for COVID-19 leaving hospital and before admittance to a care home may extend the length of stay;
- The testing of patients for COVID-19 before leaving their home to be admitted to a care home, in crisis situations, may extend the demand for additional complex care at home support therefore reducing the capacity within the Care at Home service to manage hospital discharges timeously;
- The reduction of people with complex conditions not presenting to Primary and/or Secondary care over the recent months may result in a surge in demand during the winter peak period; and
- Public and provider perception has been adversely affected by the impact of the COVID-19 outbreak on care homes and families may

be resistant to using these in the future. This may increase the levels and complexity of individuals requiring support at home, which will further reduce the numbers and patient flows across the system.

Within North Ayrshire HSCP there has been a continued focus on the reduction of delayed discharges. At 19 June 2020 the number of individuals delayed reduced to 5. This is the lowest number of individuals delayed in a day for the Partnership throughout the entire reporting period. The Partnership has continued to see the benefits of the temporary deployment of staff to focus solely on delayed discharges; the temporary extra capacity within care at home and the daily scrutiny and monitoring of performance across the Service areas. However, the Partnership has also seen a sharp rise in the number of referrals for care at home provision and the requests for assessments of individuals' longer-term needs, from acute sites during the month of June 2020. Therefore, the daily scrutiny and performance monitoring is key in ensuring that flow is maintained, that individuals are recorded appropriately, and delays are managed accordingly.

Despite the increased activity within, and referrals from, the secondary care settings over the last two months, we have continued to maintain delayed discharges at minimal levels. The number of delayed discharge occupied bed days dropped further in May 2020 (Apr 2020: 787; May 2020: 466). These current levels provide a good platform upon which to build as we prepare for the additional demands of winter.

Within winter we will require additional capacity to enhance Care at Home provision, Telecare/Digital services and District Nursing to meet the increasing demands across North Ayrshire HSCP. This provides alternatives to acute hospital admission and supporting early discharge from acute hospital sites. Our Care at Home Service and enhanced ICT will remain fully operational seven days a week through winter.

Our Care at Home Services and Community Alert/Telecare Services are resourced to provide 365-day cover and so, as in previous years, festive rotas are already established.

Business continuity plans are in place across community services to respond as appropriate to winter challenges from inclement weather to higher levels of staff absence due to illness.

## Resources

We will provide additional weekend presence in the acute hospital site through winter including Social Worker, Care at Home Manager and ICT presence (predominantly Occupational Therapist) at a cost of approx. £19,000.

We will increase the capacity of our care at home service by 160 hours per week over the winter period at the cost of approximately £81,000.

**SAHSCP Winter Planning**

**For South Ayrshire, in addition to the significant work to improve the effectiveness of the care at home service through the delivery of new models of reablement a number of key actions for winter include:**

- Supporting agile MDT working within GP practices to enable early discharge and prevent hospital admission;
- National COVID-19 safe staffing huddle and escalation plan for community nursing is in development and will be implemented to support National workforce tools;
- Continued activity to reduce delayed discharge by providing appropriate community capacity; and
- Investment to enhance capacity within Intermediate Care and in particular the Care at Home service.

**Resources**

We will invest £20,000 in additional rehabilitation capacity in the intermediate care team in order to both reduce the risk of admission and facilitate discharge.

We will also increase the capacity of our care at home service by 300 hours per week over the 4 months from December to March at the cost of approximately £80,000

## 9.2 Resource consequence

NHS Ayrshire & Arran anticipates the recurring funding of £709,728 as previously confirmed by Scottish Government. The table below sets out how those funds will be used.

| Proposed Resource Investment | Costs |
|---|---|
| **Health and Social Care Partnerships (HSCPs)**<br>Investment to enhance capacity within Intermediate Care and in particular the Care at Home service. | |
| **South Ayrshire Health & Social Care Partnership**<br>Support additional rehabilitation capacity in the intermediate care team in order to both reduce the risk of admission and speed discharge. | **£0.020m** |
| Increase home care capacity by 180 hours per week over the 6 months from October to March. | **£0.080m** |
| **North Ayrshire Health & Social Care Partnership**<br>We will provide additional weekend presence in the acute hospital site through winter includes Social Worker, Care at Home Manager and ICT presence (predominantly Occupational Therapist) at a cost of approx. £19,000. | **£0.019m** |
| We will increase the capacity of our care at home by 160 hours per week over the winter period at the cost of approximately £81,000. | **£0.081m** |
| **East Ayrshire Health & Social Care Partnership**<br>Our Enhanced Intermediate Care and Rehabilitation service provides an essential interface in preventing admission to hospital and facilitating transfers home or more appropriate care settings. We will enhance capacity within Intermediate Care including the attached the Care at Home service, ensuring that the reablement service is optimised. | **£0.100m** |

| Proposed Resource Investment | Costs |
|---|---|
| **Acute**<br><br>The following resources are considered to be priority for winter 20-21.<br><br>Frailty Liaison to support the mobilisation and delivery over the winter period of a comprehensive geriatric assessment model of care, Requiring AHP resource, education and training and additional consultant sessions.<br><br>Paediatric – increase in RSV patients requiring additional nursing resource.<br><br>**UHA/UHC**<br>• Enhanced staffing in Discharge Lounge in the evenings<br>• Weekend Pharmacy support with tailored start and finish times to support discharge<br>• Increase Red Cross, Home from Hospital Service and SAS vehicle<br>• Diagnostic Extended Hours | <br><br><br><br>**£0.134m**<br><br><br><br>**£0.121m**<br><br><br><br><br>**£0.016m**<br><br>**£0.010m**<br><br>**£0.066m**<br>**£0.031m** |
| **Near Patient Influenza Testing** - Experience from winter 19/20 demonstrated the positive impact of Near Patient Influenza testing. | **£0.058m** |

We will take a systematic approach to improvement in our winter preparation. This will be achieved through the following key phases:

| Key phases | Timescale |
|---|---|
| Predictive analytics - planning anticipated demand Modelling outputs allowing us to anticipate periods of high demand and inform workforce planning | August 2020 |
| Winter Workshop where we will bring together senior clinicians and management leads from across both Acute sites and the three Health & Social Care Partnerships | August 2020 |
| Planning Immunisation programmes for staff | August 2020 |
| Refine escalation plans for mobilisation and winter capacity | September 2020 |

| | |
|---|---|
| Collective planning across the whole system to meet anticipated demand | September 2020 |
| Planning additionality to facilitate discharge over 7 days | September 2020 |
| Implementing identified measures to meet additional winter demand | October 2020 - March 2021 |
| Evaluation of impact of measures taken | April 2021 |

## 10.0 Mental Health

In preparing our Remobilisation Plan (phase 2) we have taken in to account the ask in the letter of 6th July from the Director of Planning in relation to Mental Health Services. This asked that we look at how we would:

- describe how we are continuing to provide a level of service to meet the mental health needs of our communities;
- manage an expected increase in demand for services associated with the COVID-19 pandemic;
- restart services that had paused, describing any innovative approaches; and
- describe our approach to Mental Health Wellbeing Hubs and Mental Health Assessment Units

Our planning has looked at how we respond to the mental health needs of our communities and how we are able to respond across our mental health services accordingly. We have specifically looked at the redesign of mental health assessment in order to manage urgent mental health presentations effectively.

However, subsequently we received a letter issued from the Directorate of Mental Health on 16th July asking for a more comprehensive review, looking beyond the immediate timeframes of the remobilisation plan period. Given the time available to prepare our response it hasn't been possible to complete detailed discussions across our system and conclude our governance processes. We have therefore decided to separate the draft response to the Directorate of Mental Health letter from the remainder of our remobilisation Plan. This separate response should be seen as a draft discussion document that represents the views of our mental health service. We intend to continue our discussions in the days and weeks ahead, looking to refine the content and associated costs to be detailed in our Remobilisation Plan (phase2).

## 11.0 Women and Children's Services

### Community Children and Families Services

The impact of COVID-19 on social work and social care is likely to result in increased demand on services. As the restrictions impacted on services across the whole system that supports children, their families and carers, those involved with Justice Social Work, and vulnerable adults and older people, the HSCPs continued to deliver services direct to individuals. The value of the services offered in terms of keeping people safe in their own homes and managing protection activity across all services areas has shown to be of significant importance.

The restrictions put in place to manage the spread of the disease have resulted in children and young people being out of education and early years since 23 March 2020, with them returning on 11 August 2020. Throughout this time health visitors and school nurses have continued to maintain contact with the most vulnerable and at risk children and young people. Social work practitioners have continued to support young people to remain in their community and their interventions have prevented the need for expensive hospital and residential placements.

As the restrictions ease and access increases it is likely that people who have been living in difficult, harmful and abusive circumstances will start to disclose what they have experienced. This means that it is reasonable to anticipate:

- An increase in reported domestic incidents, with some being very significant will result in an increase in demand across all services. Progress with MARAC across Ayrshire and Arran could be critical in ensuring people receive the right support;
- Children will be able to access the safe environments and people they trust outwith the family and will tell of some difficult and abusive experiences, this may lead to increase in Child protection activity and registration, children being accommodated in foster care and external placements;
- The courts stood down all but the most serious cases and as the courts resume their business this will result in increasing demand on court services such as court reports and disposals that may be difficult to service such as unpaid work. This a service where there is already a considerable backlog due to the impact of the restrictions on orders being serviced and the imposition of new orders to deal with the backlog. It is fair to anticipate that increased capacity will be required to manage this; and

- We also anticipate a significant backlog of Children's Hearings many of which were suspended through the lockdown.

Children are a group that are likely to be significantly affected in terms of the impact of the restrictions. Research is indicating that the impact on emotional health and wellbeing, particularly loneliness and isolation will be profound. Developing the Wellbeing Model for children in terms of early help through family support will be critical in mitigating the escalation of difficulties to statutory services. Family Support and Allied Health Professionals working alongside school nurses and health visitors in a coordinated and focused way is important in managing this.

The delivery of childhood immunisations has been maintained throughout the COVID-19 pandemic with safe mechanisms in place to minimise the contact between the immunisation nurse and the parent and child.

The Infant Children and Young People's Programme Board restarted as a virtual board in May 2020 and has been meeting every 2 to 3 weeks to identify key issues. The two main areas of concern we have focused on throughout lockdown and will continue to escalate are:

- The Health and Wellbeing of Care Experienced Children and Young People; and
- Developing a sustainable and robust distressed children's pathway.

**Maternity Services**

Whilst the majority of maternity services have continued throughout the pandemic, there are some services that require to recommence.

Moving into remobilisation plan phase 2 the following services are planned to restart:

- Home birth services were commenced 5th June 2020 and there has been an increase in referrals for this service. Currently we are operating a normal service and we will monitor and review our ability to meet increased demand;
- Introduction of hypnobirthing classes via NHS Near Me to start 27th July 2020;
- Holistic clinics (reflexology, reiki, and aromatherapy) remain postponed as we cannot support physical distancing requirements. Awaiting further guidance from SG;
- The programme to replace our existing electronic patient record with Badgernet which had been paused as a result of COVID-19 is re-commencing from August 2020 – March 2021; and

- Implementation and roll out of HEPMA across maternity and neonatal services from July 2020 – March 2020, commencing in neonatal and EPAS.

Maternity Services continue to ensure preparedness for a second wave of COVID-19 as we will require to continue to deliver services, taking account of new ways of working and COVID-19 plans to ensure staff and patient safety.

**Best Start**

This is a Five-Year Forward Plan for Maternity and Neonatal Care in Scotland and our local implementation plans had been paused. SG have advised that this will require to be paused until June 2021. However there are work streams that we plan to recommence:

- continuity of care teams;
- transitional care; and
- MCA clinics.

During remobilisation plan phase 2, a number of workforce matters will be progressed :

- A small number of midwifery staff who were mobilised to other areas have returned to maternity services and their enhanced skills will support service delivery;
- An amended shift pattern for staff to support physical distancing is being explored in consultation with staff and trade unions;
- All mandatory training in line with CMO and CNO guidance is paused until March 2022, however a hybrid model for skills and drills training has been developed locally. This will continue along with K2 online training which includes PPH and maternal collapse training. Currently SLA for training and education with UWS is paused; and
- Recruitment of all Band 4 final year midwifery students to permanent posts – 7.2wte. Awaiting guidance re clinical placements for midwifery students September 2020.

Developing plans for shielding staff to enable remote access and home working.

## Paediatrics

Paediatric Services are preparing for a second wave of COVID-19, taking account of new ways of working and COVID-19 plans to ensure staff and patient safety. This will take account of our winter period (September-March) where there is an increase in the acuity of patients and number of patients requiring assessment and admission to hospital.

Through earlier stages, Acute Paediatric services has been particularly successful in implementing new ways of working and this will continue through remobilisation plan phase 2. This approach includes enhanced vetting, consultant telephone consultation, NHS Near Me consultations for both new and review patients.

Through August and September 2020, a number of face to face sub specialty paediatric outpatient clinics are being re-established where children cannot be reviewed in an alternative way: Allergy, Endocrine, Constipation, Enuresis, Epilepsy, Rheumatology and Cardiology Outreach.

For community paediatrics a number of face to face outpatient appointments were suspended in Phase 1, and have recently been re-started in Phase 2 on a reduced basis, with capacity slightly less than 50% or normal.. To mitigate this, an increase in the number of telephone and NHS Near Me appointments will be instigated for first assessment. This technology will be adopted for review appointments where possible, where it is not possible, e.g. tone clinic, necessary reviews will be made.

Through remobilisation phase 2 a number of face to face Community Paediatrics new and review clinics will be established as there are a significant number of patients who require to be seen for ongoing management and treatment. These children often have complex needs and require support of the multidisciplinary team.

Setting up virtual teaching sessions for healthcare in schools which includes the development of a resource app. This will allow release of paediatric nursing resource to support other aspects of service delivery.

Paediatrics nursing staff have demonstrated a flexible deployment of the workforce to meet the changing demands during the COVID-19 pandemic, and this will continue as required through remobilisation plan phase 2. A number of paediatric nursing staff were redeployed from community paediatrics to support the inpatient ward and patient flow within the Emergency Department, their enhanced skills will support service delivery.

During COVID-19 all paediatric medical staff from Acute and Community services contributed to the paediatric rota, covering acute paediatric

services 7 days per week, as the junior doctors have been removed to contribute to the general hospital COVID-19 response. This model supported a resident consultant being available until 10.00pm in the acute paediatric areas and was compliant with the Royal College of Paediatrics and Child Health (RCPCH) guidelines. The availability of a senior decision maker supported timeous assessment and review of children and increased numbers of Advanced Paediatric Nurse Practitioners were crucial in ensuring a safe and responsive service.

The adoption of the technology outlined within the digital section will significantly enhance women and children's services. From greater access to clinical portal, clinician to clinician collaboration via Microsoft Teams, access to TEC and the data will all benefit these services. Further deployment of vCreate will also assist paediatric and neonatal services. The implementation of a replacement maternity system linked to portal will also enhance this service both within acute and also within the community.

**Summary of actions for women and children's services:**

We will:

- Continue to ensure that the Universal Health Visiting Pathway and FNP programme is implemented for young children. This will include assessing the safe restart of face to face contacts where this is required to meet the needs of children and families.
- Continue to proactively work on a multiagency basis with vulnerable children and families to keep them safe as services restart and child protection activity has the potential to increase.
- Monitor and assess the need for increased capacity across these important services due to the post-COVID-19 impact
- Continue to focus on key priorities raised by our Infant Children and Young People's Programme Board, chaired by our Child Health Commissioner
- Restart those Maternity Services which were paused
- Continue and re-establish acute and community paediatrics

**Summary of revenue consequence:**

## 12.0 Rehabilitation

Allied Health Professional (AHP) and Rehabilitation Services have been planning how they will restart services in a safe and person centred way, in order to limit risk and provide responsive services with a flexible staff, that can ebb and flow depending on COVID-19 infection rates within the population. This is a complex challenge which will require whole system transformation focussing on new and emerging good practice from service mobilisation to date. Services are developing a coordinated pan-Ayrshire plan including timescales for restarting those services which are currently paused.

Where possible this will commence from the beginning of August 2020 across Ayrshire and Arran, however there are restrictions due to physical distancing risk assessments and the limitations this places on accommodation.

**Workforce**

In the absence of agreed national workforce planning validated tools for Allied Health Professionals (AHPs) the local AHP Senior Management Team has begun work to scope and map our workforce profile and create a plan for future workforce requirements based on capacity, demand and service reform. We are reviewing our model of AHP service delivery and early work has recognised deficits for our model in the future. This plan focusses on the next 8 months; however it is acknowledged that this is intertwined with our longer term reform plans and it is difficult to separate some parts of this at times due to the co-dependencies.

The COVID-19 pandemic has escalated the pace of this work and underlined the required scrutiny of AHP staffing. AHP and rehabilitation services have created and refined a professional judgement workforce tool created locally in the absence of a national tool, using the principles of the Nursing and Midwifery tool used in the common staffing method. We have prioritised focus on the demand for the next 8 months.

While planning to restart services we need to consider how to bridge the gap between the current resources within Rehabilitation Services and what is required over the next 8 months to respond to COVID-19 needs and restart services in a different environment. This will then enable AHPs to reduce areas of highest clinical risk and target areas of demand most impacted by COVID-19.

Immediate investment in new AHP graduates and non-registered staff would allow services to develop a flexible workforce that can bolster immediate post-COVID-19 rehabilitation requirements over the next 8 months and lay the foundations for the ambitions of Caring for Ayrshire.

For this particular plan, an assumption has been made of 50:50% skill mix ratio for registered to non-registered staff; and in addition to that a further 50:50 ratio of AFC B5 to AFC B6 within that 50% registered workforce. The costs associated with the workforce tables detailed below for Acute and Community Hospitals is based on this skill mix assumption. We recognise our ability to recruit swiftly will impact on our ability to spend the associated funds requested.

This resource to support the necessary activity between August 2020 and March 2021 (£1.28M) needs to be balanced against the costs associated with increased lengths of stay, additional winter beds, impact on community services resulting in delay to our patients which was in the region of £1.36M in additional nursing costs alone for beds in our Acute Hospitals in 2019/2020 (not including the additional domestic services and supplies costs for these additional beds).

This does not take into account the additional costs to our HSCPs, additional home care packages and residual cost to the patient in terms of outcomes and continuing needs for care and intervention that could have been avoided.

The plan for red/ green COVID-19 pathways, continued surge capacity, elective orthopaedic surgery re-starts, winter planning and changes to unscheduled and urgent care provision will quickly create pressure points within the system and result in poorer outcomes and potential harm if not supported by the requisite AHP services.

The greatest impact on the following services is highlighted in the sections below:

- Adult Acute Rehabilitation Services;
- Adult Community Mental Health Teams *(this detail is provided in the Mental Health chapter of this plan); and*
- Adult Community Hospital Inpatients.

**Adult Acute Rehabilitation Services**

The increased presence of AHPs within Acute Wards is a critical success factor for the future of Care of the Elderly Services, planned Unscheduled and Urgent Care and the reduction of unnecessary hospital admissions in the Combined Assessment Units in this next recovery phase post-COVID. These AHPs are focussed on discharge to assess models and have ensured faster discharge and reduced length of stay for patients. We are already seeing delays beginning to show in our system while patients await AHP assessment.

The planning need for escalation to an increased ICU capacity at University Hospital Crosshouse (UHC) from within current resources will require an element of flex and double running within services unless we move back to full mobilisation in the event of a second wave of COVID-19. At present there is no AHP bank or locum/agency staff for these roles which have specialist skills, are difficult to recruit and are very expensive.

The table below illustrates the staffing level required to deliver the Adult Acute Rehabilitation services safely during remobilisation plan phase 2.

| Acute AHP Rehabilitation Service Area | WTE TOTAL Funded establishment | WTE TOTAL Required inc travel and PAA | Requested uplift of staff |
|---|---|---|---|
| Physiotherapy Acute UHA | **12.60** | **20.69** | **8.09** |
| Physiotherapy Acute UHC | **19.98** | **32.89** | **12.91** |
| **Total Acute Physiotherapy** | | | **21.00** |
| Speech and Language Therapy UHA Acute | **1.80** | **2.74** | **0.94** |
| Speech and Language Therapy UHC Acute | **2.70** | **4.21** | **1.51** |
| **Total Acute Speech and Language Therapy** | | | **2.45** |
| Dietetics Acute UHA | **4.30** | **7.45** | **3.15** |
| Dietetics Acute UHC | **7.23** | **11.35** | **4.12** |
| **Total Acute Dietetics** | | | **7.27** |
| **TOTAL:** | | | **30.72** |

## Physiotherapy

The mobilisation of Physiotherapy staff into acute services enabled patients to receive the input they required. As staff have begun to move back into their substantive roles across our system as restart commences, the outcome will be an increased length of stay with the potential for a poorer long-term outcome for the patient. Increased staffing is required to deliver rehabilitation for unscheduled and urgent care in the acute setting, to ensure patients can return to their home or homely setting as quickly as possible.

## Speech and Language Therapy

Capacity to meet the clinical needs across the whole population continues to be a challenge despite SLT prioritising caseloads daily to respond to the patients with the highest levels of risk and potential for harm. This does not include the Head & Neck cancer SLT service at UHC which also has a significant waiting list. Increased staffing is required urgently to meet the demands presented by COVID-19.

## Dietetics

Two thirds of staffing resource has been transferred to the Biggart Hospital to support the move of the Stoke Ward, further reducing the resource at University Hospital Ayr (UHA). This has created clinical risk as an inexperienced Dietitian may be most senior member of staff on duty. Additional resource is required to provide basic input to patients within acute services to meet their food, fluid and nutritional needs.

## Trauma and Orthopaedics (including elective surgery restart)

The Orthopaedic Inpatient Elective and Trauma Care model will deliver the following benefits: a renewed focus in the delivery of care, reduced hospital stay, seven day service delivery and an improved patient experience with more intensive MDT approaches.

To deliver this clinical model successfully, due consideration and capacity will be required and the workforce model required is under active consideration and being led by the Acute Services Team.

## Vascular and Stroke

AHP's are engaging with colleagues across acute services and HSCP's in planning current and possible future configuration of Vascular and Stroke services. There are opportunities for improving stroke rehabilitation pathway following relocation of Stroke Rehabilitation ward from UHA to Biggart Hospital being developed on pan-Ayrshire basis.

Vascular rehabilitation will continue to use near me and telephone reviews where appropriate. It is anticipated that 70% of patients will require face to face walking rehabilitation and that 40% of those will change from being outpatient and group sessions to being community visits.

## Adult Community Hospital Inpatients

People in rehabilitation in-patient areas post COVID-19 are requiring more intensive therapy in line with documented evidence creating a larger demand on therapeutic time. These wards have seen an increased proportion of patients who require active rehabilitation compared to the period before COVID-19. In order to provide adequate rehabilitation to this vulnerable group of patients an increase in resource is required. This will allow people to move on to being in their home or homely setting more quickly and also allow for increased flow of patients from acute settings where required.

| Community Hospitals<br>AHP Rehabilitation Service Area | WTE TOTAL Funded establishment | WTE TOTAL Required inc travel and PAA | Requested uplift of staff |
|---|---|---|---|
| Occupational Therapy Community Hospitals North | **1.20** | **2.73** | **1.53** |
| Occupational Therapy Community Hospitals East | **1.40** | **3.35** | **1.95** |
| Occupational Therapy Community Hospitals South | **5.40** | **7.39** | **1.99** |
| **Occupational Therapy Total** | | | **5.47** |
| Physiotherapy Redburn Ward Ayrshire Central Hospital COE | **1.15** | **2.47** | **1.32** |
| Physiotherapy Ward 1 Woodland View | **2.00** | **6.09** | **4.09** |
| Physiotherapy Girvan Community Hospital | **1.80** | **2.14** | **0.34** |
| Physiotherapy Biggart Hospital | **4.70** | **8.51** | **3.81** |
| Physiotherapy East Ayrshire Community Hospital | **1.30** | **2.77** | **1.47** |
| **Physiotherapy Total** | | | **11.03** |
| Dietetics East Ayrshire Community Hospital | **0.10** | **0.65** | **0.55** |
| Dietetics Community Hospitals North | **1.50** | **1.97** | **0.47** |
| Dietetics Community Biggart Hospital | **0.40** | **1.63** | **1.23** |
| Dietetics Community Girvan Community Hospital | **0.10** | **0.19** | **0.09** |
| **Dietetics Total** | | ***0.00*** | **2.34** |
| Speech and Language Therapy North | **2.20** | **2.82** | **0.62** |

| | | | |
|---|---|---|---|
| Speech and Language Therapy South | **0.80** | **2.39** | **1.59** |
| **Speech and Language Therapy Total** | | | **2.21** |
| **TOTAL:** | | | **21.14** |

**MSK Primary Care**

MSK demand in primary care is unscheduled, therefore, all categories of patients have continued to be seen throughout the pandemic. A clinical escalation model will remain in place as we move into Remobilisation Phase 2 with patients first being triaged via telephone consultation; patients can then be escalated to a Near Me consultation. Where appropriate, patients will be directed to self-management resources as first line of management with safety netting advice. Existing evidence from the service indicates that 70% of patients will self-manage their condition with appropriate resources and advice.

If it is deemed there is a clinical need following the virtual consultation patients will be escalated to a face to face appointment and managed appropriately including onward referral.

Some staff continue to work remotely as practices manage footfall into the building. We will liaise closely with all practices about repatriating staff when it is safe to do so. Where staff are working remotely there are processes in place to ensure patients who require a face to face appointment can be accommodated.

**AHP Led MSK**

Performance against the MSK target of 90% of patients being seen within 4 weeks from referral to first clinical outpatient appointment was 53.1% in February 2020 but at the end of June 2020 was 16.46% due to the impact of COVID-19.

In March 2020, MSK staff were redeployed in other areas to cope with the pandemic. This created a back log of long waiting lists (5,958 patients) and current caseloads to be cleared. Current caseloads are now cleared and 2 streams of work are planned to target: new ways of managing referrals (Active Clinical Referral Triage) and reducing waiting times – currently 2,064 patients (July 2020).

Within MSK outpatient activity has been significantly impacted by the COVID-19 restrictions. Very few MSK face to face consultations have continued for high priority patients, with telephone and Near Me consultations being introduced in to the service. Escalation pathways to orthopaedic Advanced Practice Physiotherapists are in place for patient safety.

For the return of paused services, the new norm will be virtual consultations, with face to face consultations guided by strict guidelines. Digital, Social media and the public facing web page have been increased significantly to provide self-management and exercise advice.

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

**Podiatry Enablement and High Risk/Diabetes Pathways**

The service will continue to triage all new referrals during the next phase of remobilisation, prioritise new and existing patients with active foot disease/acute wounds and deliver minor surgical interventions to those patients with an acute nail infection.

In remobilisation plan phase 2, the following areas of the service will be slowly re-introduced and delivered in community settings (clinics, hospital, care homes, domiciliary, prison) where appropriate:

- Minor surgical procedures - chronic conditions;
- Routine interventions - all Podiatry pathways;
- Moderate Risk foot protection patients - e.g Diabetes, Vascular; and
- Low > Mod risk Diabetes, Vascular stage 1 & 2, Renal up to stage 4.

The existing Enablement caseload (approximately 3,800 patients) currently placed on hold are being lettered with the option to request a telephone consultation in the first instance with self-care management advice being provided. Patients will be prioritised based on risk/need and offered a face to face appointment if appropriate.

## Innovation and Digital Technology

Teams are using digital technology such as NHS Near Me and developing patient facing websites, social media platforms and online resources for self-management across services. Systems such as Patient Initiated Review and Active Referral Clinical Triage are being implemented in order to streamline wait times wherever possible and direct people who do not require statutory services to the correct support and resources. This is facilitated by placing key clinical decision makers at the front of service assessment and the provision of telephone review, validated by service user qualitative feedback.

## Transforming roles

There is urgent work underway to scope the development of further non-medical models of care in a variety of clinical areas including Care of the Elderly, the Frailty pathway, Community Hospitals, Combined Assessment Units and Emergency Departments. These developments include AHP Consultant roles to lead rehabilitation inpatient wards to provide a modernised and effective service. This work will also explore an increased number of Acute Care of the Elderly Practitioners to deliver high quality person centred assessment and rehabilitation to patients within unscheduled and urgent care settings.

AHP and Rehabilitation services are also exploring the use of First Contact Practitioners in Acute, Community and Primary Care settings for Advanced Practice Dietitians, Occupational Therapists, Physiotherapist and Podiatrists. These dynamic and effective roles reduce the need for medical input and ensure the patient sees the right clinician at the right time for whole patient pathway.

## Recruitment

Immediate recruitment of new AHP graduates and non-registered staff would allow services to develop a flexible workforce that can deliver our immediate rehabilitation demand requirements based on the service needs identified above.

We have Practice Based Learning Agreements with five Scottish universities who have around 800 AHP students from all professions that graduate each year. Our immediate recruitment plan includes targeting Physiotherapy, Occupational Therapy and Dietetic undergraduate students who graduate in July/August 2020. If resource is available we predict an ability to recruit between 15-20% of the total of these newly qualified practitioners from these professions.

At present in other regional areas many students are employed before they graduate in un-registered roles. If we could adopt this approach within Ayrshire & Arran, it would allow us to be proactive in recruitment for Masters students who will graduate Jan/Feb 2021.

We recognise the need to act quickly to reduce risk in the areas identified above. In order to facilitate this we plan to recruit un-registered staff into our AHP workforce as we know we routinely attract a large number of good quality applicants to these roles.

We need to balance the attractiveness of fixed term contracts and the impact on our ability to recruit when other Boards are also recruiting these staff on a substantive basis across the West of Scotland. This will impact on our capacity and capability to deliver our mobilisation plan.

We will model our ability to recruit to substantive posts based on our AHP staff turnover in Acute is approximately 4% and in HSPCs 7%; which equates to 50 – 60 staff across our system. In addition these staff groups have a younger age profile and the maternity leave rate is higher than elsewhere in the organisation, with the added complexity that they want part time hours on their return.

**Summary of actions for rehabilitation services:**

- By the end of Aug 2020: Restart priority paused services enhanced by continued use of innovation and digital technology.
- Urgently scope the demand for advanced practice roles to support the flexibility required within services for the next 9 months
- By the end of October 2020: Review and prioritise all other paused services while expanding the use of innovation and digital technology.
- Develop a short term AHP workforce plan for recruitment and sustainability, with a focus on skill mix and development of both unregistered and advanced roles including non-medical lead roles to support priority work streams.
- Agree the funding arrangements for the expansion of AHP advanced practice in terms of increased number of roles and education.
- Review and prioritise all other paused services by the end of October 2020

**Summary of revenue consequence:**

**This would be non-recurring funding to provide service through to March 2021. Work is ongoing to explore ongoing resource requirements beyond March.**

**Acute AHP Rehabilitation Services:**

**30.72WTE = £765,500**

**Community Hospital AHP Rehabilitation Services:**

**21.14WTE = £524,500**

**In total: £1,290,000**

## 13.0 Public Health Core Functions Overview

Local Public Health Teams have risen to the challenge over the last few months, many working in excess of their contracted hours. This has impacted both on Health Protection teams directly as well as the wider department. We are fortunate in Ayrshire and Arran to have an integrated team with health improvement, health protection and healthcare public health functions delivered together. This model has allowed us to flexibly respond to the COVID-19 pandemic, wrapping additional support from the wider team round our small specialist health protection colleagues. This is not sustainable in the longer term and we now require to put in place additional resource to backfill key roles and ensure wider priorities can be progressed.

**Public Health capacity and resilience**

The specialist public health workforce in Ayrshire & Arran have been providing a range of additional inputs to support health service and community response to the pandemic. As we move into the recovery phase the focus is now to enable the Scottish Government vision of 'virtual elimination' of the virus and thus ensure a more normal and sustainable approach to service delivery and to life in society more generally. Planning is guided by early calculations by Public Health Scotland and by experience of the additional support that has been put in place to support both the specialist workforce and the wider contact tracing team.

**Public Health workforce and planning**

It is anticipated that plans for enhanced Public Health teams necessary to support Test & protect should be sustainable for at least two years. The introduction of the national contact tracing programme means that some workload will be managed centrally but the most complex cases will always require local management.

The summary table below sets out the anticipated requirements of an enhanced specialist Public Health team over the next two years which will ensure resilience of response. Extract from calculations produced by Public Health Scotland.

Table 1: specialist workforce requirements (extract from PHS calculations)

| NHS Ayrshire & Arran: Enhanced Tier 2 support | | |
|---|---|---|
| Health Protection Nurse or equivalent *(Band 7)* | Data/Admin *(Band 4)* | Public Health Consultant/equivalent *(Band 8D)* |
| 4.7 | 4.7 | 0.9 |

Test and Protect requirements are described in the separate chapter, this specialist Health Protection team support is absolutely essential to safe delivery of that programme. A separate business case has been developed for laboratory services to ensure that capacity and resilience is embedded throughout the Test & Protect process.

**Current Health Protection, Healthcare Public Health and Health Improvement priorities, provision and preparedness**

The Public Health perspective on the recovery phase will focus on the following Health Protection, Health Improvement and Healthcare Public Health priority areas:

- Management of community based outbreaks of COVID19 in line with nationally agreed guidance;
- Ongoing support to protect vulnerable people, including Care Homes, people with learning disabilities, addiction or other underlying conditions which may make them more susceptible to infection;
- Surveillance of non-COVID illness, deaths, challenges and some of the health behaviours and wider social factors that are likely to impact on these;
- Build on work to support staff health and wellbeing during the pandemic and mainstream our programme to support the mental and physical wellbeing of our staff;
- Contribute to the multi-agency and partnership work to help address the wider social and economic factors that are likely to impact on health;
- Build into our work Health in All Policies approach, along with introducing Health Inequality Impact Assessments on evolving plans, strategies, policies and guidance;
- Re-introduction and management of services with a major population focus such as immunisations, population screening programmes and child health surveillance;
- Further development of whole-system response to support Children and Young people's health and wellbeing;

- Re-introduction of programmes that relate to national public health priority areas such as mental health, sexual health, blood-borne viruses, smoking cessation, alcohol use and harmful drug use; and
- Support the re-introduction and management of mainstream acute NHS and primary care services.

**Public Health Intelligence**

Public health surveillance for non-COVID will be scaled up as capacity permits to include some or all of the following elements:

- Deaths from all causes; deaths under and over 75 years of age; deaths from cancer, cardiovascular disease, respiratory disease and dementia; drug deaths; perinatal deaths, infant deaths and neonatal deaths;
- Life expectancy at birth and at 65 years of age;
- Emergency hospital admissions for cancer, cardio-vascular disease, respiratory disease; mental health; alcohol related hospital stays; drug-related hospital stays;
- A&E attendances (and reason for attendance);
- Uptake of screening programmes and immunisation programmes;
- Child healthy weight, oral health; and
- Termination of pregnancy, uptake of long-acting reversible contraception.

The list of measures described above for Ayrshire and Arran will be refined and added to as intelligence from Public Health Scotland emerges.

**Resumption of Health Improvement**

Health Improvement staff have been providing mutual aid to the Health Protection function since the outbreak of the pandemic and continue to do so within Test and Protect. Alongside this we have continued to deliver our services within the constraints of lockdown e.g. telephone and video contact as part of smoking cessation and the child healthy weight programmes, and we have also continued to work with partners on mitigating the impacts of the pandemic.

Undertaking our full commitment in working across the NHS and with partners to improve health and reduce inequalities will be conditional upon our Health Improvement staff being freed up from this mutual aid role in assisting Health Protection. We would anticipate that our staff will have returned to their core duties by the end of October. This will allow time for recruitment into the Test and Trace Programme. Health Improvement staff will of course be available for Health Protection surge capacity, should the need arise.

The greatest gains for those facing the highest levels of inequality, which have been exacerbated during the COVID-19 pandemic, will come from addressing the social and economic determinants of health and as such this will be the focus of our activity for the remainder of 2020/2021 and into 2021/2022.

**Summary of actions for Public Health:**

We will:

- Work to address poverty and inequality through income, housing, education and employment programmes as part of Community Planning.
- Establish NHS Ayrshire & Arran as an Anchor organisation using our influence to procure and employ locally.
- Deliver smoking cessation, weight management and Diabetes Prevention to those with greatest need.
- Support the Staff Wellbeing Programme, including plans for the mainstreaming of Staff Wellbeing Services.
- Build capacity within the wider Public Health workforce e.g. DWP; AHPs.
- Take forward a Population Health Mental Health and Wellbeing Programme with particular emphasis on supporting children and young people.

**Summary of revenue consequence:**

| **COVID-19 Enhanced Public Health Function<br>Responsible Office: Director of Public Health** | | | |
|---|---|---|---|
| **Enhance Health Protection Function** | Consultant in Public Health | Band 8D / Medical Dental | 0.9WTE |
| | Health Protection Nurse | Band 7 | 4.7 WTE |
| | Administrator | Band 4 | 4.7 WTE |
| | | | |
| **Total Cost of Enhanced Public Health Function for 6 Month Period: £284,000** | | | |

## Resumption of screening services

### Pregnancy & Newborn Screening (PNBS)

The Pregnancy & Newborn Screening (PNBS) programme continued during the pandemic. The first face-to-face appointments are happening at a later gestational age than previously but are still well within required timelines: women assessed at being high risk are appointed earlier as required.

**Numbers:**

Universal Newborn Hearing Screening (UNHS) is the programme most affected, with babies discharged more quickly than usual and without hearing screening, requiring utilisation of Community Clinics. Around 20 babies require alternative screening, which is being actively planned, and of these a small number will require hearing assessment appointments later than usual: this is being actively managed by Audiology Service.

**Capacity:**

Maternity services have been affected by staff absences due to covid19 but have coped well, with additional shift patterns worked. Capacity within UNHS has been a significant issue but recent recruitment of several new screeners is having a significant impact.

**Key Steps**

- The pause in implementation of the new maternity system, BadgerNet, will impact on anticipated effective reporting against new national KPIs for 2020/2021. Local liaison with implementation programme lead is planned July/August 2020; and
- The implementation of screening for new trisomies and a new second-line screen for Down's Syndrome (NIPT) continues to be delayed. Local training to be delivered when national resources available, anticipated Sept/Oct 2020.

## Breast Screening

Breast Screening will recommence at the South West Centre at Ayrshire Central Hospital in the week beginning 3rd August. The use of mobile screening vans will be phased in over subsequent weeks, to enable planned restart of IT systems and identify any QA issues.

**Numbers:**

Around 7,240 women would have received breast screening appointments since March 23rd to date, subject to acceptance.

**Capacity:**

The service has not identified any significant capacity issues at this point.

**Next Steps**

- One mobile unit will begin to provide screening at ACH (w/c 10th August);
- The second mobile unit will start screening in Cumnock (w/c 17th August);
- Assessment clinics will also re-start week (w/c 17th August); and
- New covid-19 compliant locations have been agreed for the mobile units to be located at in the medium term.

## Diabetic Retinopathy Screening (DRS)

The Ayrshire Programme is delivered by community accredited optometrists at various locations throughout Ayrshire, as well as the Medical Photography Department at the Diabetic Day Centre (DDC) at both UHC and UHA. The national DRS Programme was paused by the Scottish Government on the 24th March 2020.

### Numbers

Since early April 2020, a small number of very high risk patients identified by the Programme locally have been offered screening in the hospital eye service. DRS is due to restart nationally on the 29th July for high risk patients. This is an extended list to those already being screened locally.

**Next steps**:

- Confirmation of use of the DRS room at the DDC at UHA to screen high risk patient group (early July 2020);
- Obtain additional admin to appoint patients in-house (early July 2020);
- Roll out DRS software Optomize to all community screening locations throughout Ayrshire (Digital Services) (July/August 2020);
- Commence invitations to the low risk group (late August/early Sept); and
- Further service development with new Optical Coherence Tomography (OCT) scanner to be rolled out September 2020.

## Bowel Screening

The call-recall element of bowel screening is organised nationally from Dundee, from where home-test screening kits are issued and returned to once completed. People who screen positive are usually referred for a colonoscopy with local services at UHA or UHC. Bowel screening was paused at the end of March 2020, but home tests completed before then were processed by the national laboratory.

### Numbers

A total of 230 people from Ayrshire and Arran received a positive screening result, indicating they are at a higher risk of bowel cancer, and are awaiting a colonoscopy. Of these, 56 have been prioritized for colonoscopy at The Golden Jubilee using data supplied by the national laboratory. There is a challenge in that some patients are unwilling to travel outwith Ayrshire for their colonoscopy.

### Capacity

Endoscopy capacity in NHS Ayrshire & Arran has been significantly affected by Covid19, due to workforce issues and reallocation of some endoscopy clinical areas to covid-related functions. A full-day session per week of colonoscopies has been arranged at The Golden Jubilee.

**Next Steps**

- Agree steps to ensure screening colonoscopy sessions available locally (Aug-Sept);
- Complete colonoscopies for 56 high-risk patients at Golden Jubilee (mid-Sept);
- Postal self-completion test kits will begin to be issued (Sept/Oct): this will impact significantly on NHS Ayrshire & Arran colonoscopy capacity; and
- Discussions are required locally to prepare mitigation plans as a resurgence of covid19 will impact on endoscopy capacity.

## Cervical Screening

The different elements of Cervical screening, including: call-recall, smear-taking, pathology and cytology have all confirmed readiness to proceed with the restart of the service.

Ratification of the re-start plans has been obtained through the agreed governance pathway via the GMS de-escalation committee.

All general practices in Ayrshire and Arran have been provided with the practice-specific details of the re-start plans, including the number of individuals who will be eligible for screening.

### Numbers

Women invited for cervical screening but unable to take up the invitation due to cvoid-19 are being prioritized for the resumption of the service. Women at higher risk of cervical cancer are invited for screening more frequently than usual and are also being prioritized. These women were asked to contact their GP practice and make arrangements for cervical screening. A total of 184 high-risk women have done this in Ayrshire and Arran since 29th June 2020, which is in line with uptake in comparable Health Boards.

### Capacity

Work is ongoing to ensure that sufficient training capacity is available for new smear takers as a result of concerns raised about primary care nursing capacity.

### Next Steps:

- Priority women asked to contact GP for cervical screening (from June 29th);
- Appointment letters and reminders for priority women issued (mid-July); and
- Invitations for all other eligible women to begin (Oct).
-

## Abdominal Aortic Aneurysm (AAA)

Invitations to participate in the AAA screening programme in NHS Ayrshire & Arran are managed by local call/recall services. Scans for AAA are delivered by sonographers and assistant sonographers in local Acute settings and also in the Northwest Kilmarnock Area Centre. Treatment for those men with AAA deemed suitable for treatment is mostly delivered at Hairmyers Hospital in NHS Lanarkshire. The AAA screening was paused in line with all adult screening programmes in March 2020. Invitations to some eligible participants began to be issued again in July 2020.

All men aged 65 are invited for a scan. Those with medium-sized AAA are placed on a three-monthly screening programme; those with a larger AA are prioritized for treatment.

**Numbers**

There are 29 men in Ayrshire and Arran on the three-month surveillance programme, and these men are being prioritised for a scan, as their aneurysm could enlarge and require treatment at any time. In addition, 205 men turned 65 during the lockdown period, and these men comprise the second priority group that require AAA scans ahead of the men turning 65 on resumption of the AA screening programme nationally.

**Capacity**

There are no issues with AAA screening capacity in NHS Ayrshire & Arran, and a return to business as usual is anticipated from October 2020.

**Next Steps:**

- Recovery plan for AAA approved (July);
- Men with medium AAA on surveillance programme re-scanned (July-Aug);
- AAA scanning will commence for men who turned 65 during lockdown (Aug-Oct); and
- Scanning to begin for all eligible men from the resumption of the AAA screening programme (Oct).

**Summary of actions Resumption of screening services:**

We will:

- Provide specialist input to support Testing and Test and Protect Programmes (see separate chapter)
- Progress staged re-start of the national screening programmes
- Support seasonal flu immunisation campaign
- Work to address poverty and inequality through income, housing, education and employment programmes as part of Community Planning
- Establish NHS Ayrshire & Arran as an Anchor organisation using our influence to procure and employ locally
- Deliver smoking cessation, weight management and Diabetes Prevention to those with greatest need
- Support the Staff Wellbeing Programme, including plans for the mainstreaming of Staff Wellbeing Services
- Build capacity within the wider Public Health workforce e.g. DWP; AHPs
- Take forward a Population Health Mental Health and Wellbeing Programme with particular emphasis on supporting children and young people
- Provide Public Health surveillance of non-COVID health outcomes as capacity allows

**Summary of revenue consequence:**

- All of the above priorities are contingent on funding of Test and Protect as well as Enhanced Health Protection team (see test and protect summary).
-

## 14.0 COVID-19Testing Programme Service and Test and Protect

The COVID-19 pandemic has required Public Health departments across Scotland to address significant challenges and pressures. Since the start of 2020, an entire pathway has been created for testing for COVID-19 and a new team of contact tracers has been put in place to support outbreak management. Six months ago these services did not exist. The specialist Health Protection team has required additional staffing resource to support all of the additional response to the pandemic. As a consequence of these developments there are key areas of workforce that need to increase.

Enhanced health protection team, contact tracing and the testing pathway and related key elements require to be put on a sustainable footing.

In their COVID-19 Framework for Decision Making, Scottish Government identified testing, case finding, contact tracing and quarantining as one of six key measures to be taken in their approach to easing current lockdown restrictions. The government acknowledge that additional Public Health and wider capacity will be required to deliver this function.

The management and resource required to test individuals along with the associated analysis, dissemination of results plus the additional person centred contact tracing will undoubtedly affect NHS Ayrshire & Arran's overarching mobilisation plans. With flu season only 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.

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 react to increased demand for testing.

**The purpose of testing is to support the:**

- Early identification of positive cases and initiation of isolation and contact tracing arrangements to slow the spread of transmission;
- Prioritisation and determination of appropriate clinical treatment;
- Early identification of outbreaks and to enable appropriate infection control arrangements to be established;
- Identification of negative key staff members and/or their family or household members, allowing them to safely return to work, supporting business continuity; and
- Supporting enhanced surveillance.

The eligible groups for testing are wide ranging and complex to implement, support, collect data and monitor. Recent testing policy has included: weekly testing offered to care home staff and hospital staff working in key areas (oncology, haematology, long stay care of the elderly and psychiatric care of the elderly units). These have been complex programmes to put in place and manage, we are monitoring these carefully to ensure the correct support is offered and this additional time pressure on staff doesn't impact negatively on clinical and social care commitments.

The full summary of all NHS Ayrshire & Arran COVID-19 Testing implementation and progress in line with current Scottish Government policy is summarised in the table below.

| Care Home Testing | Route | Test Status |
|---|---|---|
| **Community Admission to Care Home:**<br><br>• COVID-19 negative (1 x negative test) | Testing completed by NHS Ayrshire & Arran. NHS Ayrshire & Arran laboratory analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br><br>**Implemented** |
| **Outbreak identification:**<br><br>• **Symptomatic Resident**<br><br>• **Symptomatic Staff** | Care Home Manager: immediately contacts Health Protection Team.<br><br>Testing completed by NHS Ayrshire & Arran in care home, analysis and results dissemination.<br><br>Care Home Manager: contacts SPOC in IHSCP. Testing completed by NHS Ayrshire & Arran, analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br><br>**Implemented** |
| **Outbreak confirmed and Mass testing offered to Staff and Residents:** | Laboratory confirmed test sample. All staff and residents offered COVID-19 test. NHS Ayrshire & Arran complete | Standard Operating Procedures (SOPs), |

| | | |
|---|---|---|
| • **Weekly Staff Testing when there is an outbreak**<br><br>• **Replacement staff testing completed 48 hours before deployment in care homes to cover staff absence and then weekly, if necessary**<br><br>• **Care Homes with linked staff during an outbreak.** | testing, analysis and results dissemination.<br><br>NHS Ayrshire & Arran complete testing, analysis and results dissemination.<br><br>NHS Ayrshire & Arran complete testing, analysis and results dissemination.<br><br>Identified via outbreak management procedures.<br><br>NHS Ayrshire & Arran complete testing, analysis and results dissemination. | governance and monitoring in place.<br><br>**Implemented** |
| **Surveillance Testing where no outbreak identified (10% staff and residents):** | Seven-weekly rolling programme for all care homes and staff training offered. NHS Ayrshire & Arran complete testing, analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br><br>**Implemented** |

| | | |
|---|---|---|
| **Weekly Testing Care Home Staff**<br><br>**Weekly Scottish Government Data Collection in place** | Scottish Government<br><br>➢ **Social Care Portal –** (*also referred to as Care Home Portal*) swabs delivered and retrieved from care home.<br>➢ **Employer Portal**: Lighthouse Testing Facility – staff need to attend the relevant identified testing sites.<br>➢ **Home Testing Kit**.<br>➢ **Mobile Lighthouse Testing Facility**<br><br>Testing, analysis and results dissemination via Lighthouse Laboratory and Care Home Managers. Positive results link to Test & Protect Contract Tracing. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br><br>**Implemented** |
| **Hospital Patient Testing** | **Route** | **Test Status** |
| **Hospital discharge to care home:**<br><br>• COVID-19 positive (2 x negative tests)<br>• COVID-19 negative (1 x negative test) | Testing completed in hospital. NHS Ayrshire & Arran laboratory analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br><br>**Implemented** |

| | | |
|---|---|---|
| | | |
| **Over 70s patient testing (testing on admission then day 4, 8 and 12)**<br><br>**Daily Scottish Government Reporting in place** | Testing completed in hospital. NHS Ayrshire & Arran laboratory analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br><br>**Implemented** |
| **Clinical testing of Symptomatic Individuals** | Testing completed in hospital. NHS Ayrshire & Arran laboratory analysis and results dissemination. | Determined by Clinical need<br><br>**Implemented** |
| **Pre-Procedure Testing** | Testing completed in hospital. NHS Ayrshire & Arran laboratory analysis and results dissemination. | Determined by Clinical need<br><br>**Implemented** |
| **Post-operative COVID-19 surveillance** | Testing completed in hospital. NHS Ayrshire & Arran | Determined by Clinical need |

| | | |
|---|---|---|
| | laboratory analysis and results dissemination. | **Implemented** |
| **Hospital Staff Testing** | **Route** | **Test Status** |
| **Symptomatic Staff Testing** | Testing completed in hospital via drive through facility or home visit. NHS Ayrshire & Arran laboratory analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br>**Implemented** |
| **Asymptomatic Staff Weekly Testing**<br>**Clinical, AHP, domestic, porter and clerical staff and volunteers including volunteer drivers, etc.**<br>**Weekly Scottish Government data collection in place** | Testing completed in hospital with NHS Ayrshire & Arran laboratory analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place.<br>**Implemented** |

| Key Worker Testing | Route | Test Status |
|---|---|---|
| **Partners Agencies Symptomatic Staff**<br>• H&SCP LA employed staff and their household contacts; and<br>• Police Scotland, SAS, Scottish Fire & Rescue Service, SERCO, Hospice, etc<br>**Primary Care Providers**<br>• GPs; Dentists; Pharmacies; and Optometrists. | Testing completed in hospital via drive through facility or home visit. NHS Ayrshire & Arran laboratory analysis and results dissemination. | Referral Pathways, Standard Operating Procedures (SOPs), governance and monitoring in place.<br>**Implemented** |
| **Community Outbreaks** | **Route** | **Test Status** |
| • Prison outbreaks;<br>• LA children's homes; and<br>• Private provision in residential settings (e.g. Mental Health; Substance misuse step down). | Testing completed by NHS Ayrshire & Arran Testing Team with in-house laboratory analysis and results dissemination. | Health Protection Referral Pathways and Guidance in place<br>**Implemented** |
| **Community Enhanced Surveillance**<br>• Clinical hub – referrals meeting the criteria; and<br>• NHS24 minor symptomatic – referrals meeting the criteria. | Testing completed by NHS Ayrshire & Arran Testing Team with in-house laboratory analysis and results dissemination. | Standard Operating Procedures (SOPs), governance and monitoring in place. |

| | | |
|---|---|---|
| | | **Implemented** |
| **Test and Protect**<br><br>• Symptomatic contacts of positive case. | Testing completed by NHS Ayrshire & Arran Testing Team with in-house laboratory analysis and results dissemination.<br><br>Plus Lighthouse Facilities | Standard Operating Procedures (SOPs), governance and monitoring in place.<br><br>**Implemented** |
| **Testing for Vulnerable Groups**<br><br>• Homeless people, drug and alcohol addictions, asylum seekers, migrant workers, travellers, etc | Testing completed by NHS Ayrshire & Arran Testing Team with in-house laboratory analysis and results dissemination. | Referral Pathways and appropriate testing routes in place along with additional support for self-isolation and test and protect processes<br><br>**Implemented** |
| **Symptomatic Community Testing for all over 5 years of age** | Lighthouse Facilities | Determined by Clinical need<br><br>**Implemented** |

| | | |
|---|---|---|
| **Large scale community outbreaks and large clusters requiring multiagency resilience intervention** | Mixed model of testing as required including:<br><br>• In house NHS testing teams and Laboratory analysis / results distribution<br><br>• Mobile Lighthouse Testing Facilities<br><br>• Regional Lighthouse Testing Facilities | Community Outbreak Resilience Escalation Plan and community outbreak management in place<br><br>**Implemented** |

Our testing capacity is increasing in line with demand to ensure we meet the needs of the citizens of Ayrshire and Arran. Our testing strategy utilises a mixed model and includes utilising our local hospital laboratory, regional laboratory services, the Lighthouse Regional and Mobile facilities, the Social Care Portal and Employer Portal where most appropriate in order to fully meet projected future need over the next year to 18 months.

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 are, 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.

## 14.1 Test and Protect Contact Tracing

Since 15th July simple contact tracing functions transferred to the national contact tracing team. There will remain a requirement for contact tracing capacity at the local level who will follow up more complex cases or outbreak situations and will work alongside the enhanced Health Protection team. It is anticipated that both local contact tracing and enhanced Health Protection teams will require to be sustained locally for at least two years.

The Health Protection Team (HPT) within the Public Health Department of NHS Ayrshire & Arran is responsible for the prevention of the transmission of communicable diseases both in healthcare settings and the wider community, investigation and management of outbreaks and incidents. This team will provide the central expert resource to support the Contact Tracing function locally. Their additional requirements are set out in more detail in the Public Health capacity and resilience section of our plan.

### Contact Tracing: Ayrshire and Arran Model of delivery

Our testing, results, and outbreak response infrastructure have been developed over the course of the pandemic and we have strong arrangements in place for contact tracing.

While the introduction of the national contact tracing programme, ('tier 1 provision') in the middle of July, provides welcome resilience for contact tracing simpler cases; knowledge of the local system and local relationships are crucial to more complex situations. We welcome the opportunity to deliver this key service for our local area.

### Two local tiers of Contact Tracing

While local contact tracing is one single service, we have built on our practical experience over the pandemic and have developed two interrelating tiers.

The Community Contact Tracing Team (CCTT) undertake contact tracing of cases and contacts linked to outbreaks in the community, such as those in residential settings but also those that could arise in workplaces or businesses. This is our tier '2b' outbreak/complex case team and it works most closely with the Health Protection Team.

The Results Hub deals with all other positive cases, providing results and advice to patients at home or in hospital. This provides starting point for 'tier 2a provision' comprising contact tracing support for individuals in

hospital or healthcare workers within the acute setting. Links with occupational health and infection control are key interdependencies.

Public Health already work closely with Resilience, Environmental Health teams, and other partnership staff to deliver on Health Protection activity. All provide essential support to the management of outbreaks in the community working closely with our specialist Health Protection team.

**Contact tracing work**

Nurses or other trained staff (band 5 minimum) contact each positive case via telephone and all information is collected following national guidance on the CMS system. Staff identify all contacts, and provide advice to the case on self-isolation, assessment or testing if necessary and sign-post to online resources. If the patient cannot be contacted, or can be contacted but there are concerns (regarding compliance, coping skills, ability to self-isolate) then our existing third sector partners will assist.

Outbreaks can potentially result in rapid escalation of contact tracing requirements. This could necessitate involvement of additional workforce or indeed the national contact tracing team.

The proposed escalation plan below, demonstrates how this would be achieved.

| Escalation Level | Health Protection Consultant | Health Protection Nurse | Contact Tracing Team Lead | Contract Tracer | Data Handler Monday to Friday only | Additional Info |
|---|---|---|---|---|---|---|
| **Low Prevalence** | 0.4 wte | 0.4 wte | 2.0 wte | 2.0 wte | 1.0 wte | Core |
| **Increased transmission and outbreaks** | 0.4 wte | 0.4 wte | 2.0 wte | 4.0 wte | 1.0 wte | Surge response increasing |
| **Significant transmission and outbreaks** | 0.6 wte | 0.6 wte | 2.0 wte | 8.0 wte | 1.0 wte | Surge response increasing |
| **High Level Prevalence with Lockdown measures likely** | 1.0 wte | 1.0 wte | 2.0 wte | 20.0 wte | 1.0 wte | Plus assistance from wider NHS and partners |

## COVID-19Testing Programme Service and Test and Protect:

## Resource Requirements

The scale and duration of COVID-19 Testing and Test and Protect contact tracing which will be required to respond to the COVID-19 pandemic is unprecedented and as such it is not surprising that this has required a substantial resource from experienced NHS staff.

To date this resource has been found through staff with other substantive roles who have been redeployed to support the function during lockdown. These staff now require to return to their substantive posts. There is a substantial opportunity cost to the organisation as either core posts will remain vacant or COVID-19 Testing and Test and Protect contact tracing will be unsupported.

Clear leadership, coordination, delivery and monitoring of the COVID-19 Testing and Test and Protect contact tracing function will assist but the fundamental challenge remains to deliver this key function within the existing funding envelope which would appear unachievable as our services across the NHS return to a post COVID-19 normal.

There is an additional risk that lack of capacity creates direct pressure on other core health protection functions, such as management of outbreaks of other infectious diseases. With other areas of public health heavily involved in running the COVID-19 Testing and Test and Protect contact tracing programmes key areas of vulnerability such as children's public health; including care experienced children and young people, emotional health and wellbeing, foetal alcohol spectrum disorders, trauma informed practice and care; sexual health and blood borne virus services; multiagency support to schools, paediatric, health and social care services to name a few. These are all areas where we know there have been additional risks incurred during lockdown and require targeted support.

## Necessity for additional resource

Without additional resources, there is a direct risk to the success of the COVID-19 Testing and Contact Tracing efforts locally. This would reduce our ability to identify and interrupt chains of transmission, resulting in the high likelihood of significant spread of COVID-19 throughout our communities. Increased COVID-19 infection rates would result in larger numbers of individuals becoming seriously unwell, and a greater number of lives lost to this illness. The impact of consequent large numbers of unwell patients putting pressure on acute and community health and care services is obvious. This would be a key risk going into the winter season.

Contact tracing is an essential measure to prevent an increase in the number of cases of COVID-19. A fast and responsive contact tracing function is essential and as such the workforce aligned to support contact tracing needs to be able to respond at pace – and in an unpredictable environment.

A core team, backed-up by staff able to respond at times where spikes occur (as part of surge capacity), who are skilled to undertake the contact tracing function will be key to interrupting the chain of transmission. The release of staff from this as part of surge capacity, at very short notice will be required.

Our plan is to recruit workforce and transition over the next three months to allow staff to return to their substantive duties. This will enable us to restart key health improvement programmes and wider work with our partners to support population health improvement. The funding needed to do this is set out separately. Without this resource, core public health tasks will not happen and it would significantly impact on the remobilisation of screening programmes and our preparations for the winter flu season.

The estimated funding attached to this Mobilisation Plan demonstrates the workforce required to ensure a robust response to increased prevalence of COVID-19 within our communities.

**Labs and testing provision**

Moving into remobilisation phase 2, and supporting the ongoing need to manage both COVID-19 and non-COVID-19 demands, there are a number of further plans within the department :

**Analyser**
The new SeeGene Analyser platform went live on the agreed date of w/c 13/07/20. Capacity for testing has increased with this additional platform by almost 60%, and this will further increase when staff training has been completed.

Enabling works are currently underway in preparation for delivery and installation of an Alinity platform, expected to be installed during August 2020. National allocation of testing kits not available until September and currently we have no indication of quantity of allocation. In addition there is an agreement with NHS Lothian to provide surge testing capacity.

**Containment Level 3 (CL3) Room:**

A single Class 1 safety cabinet is housed in the Containment Level 3 room and is a limiting factor in the decontamination process during the pre-analytical phase. Work to install a new CL3 room with 2/3 class 1 safety cabinets is being scoped and which will increase the flow of samples through this stage of the process.

**Staffing:**

The Microbiology Laboratory previously operated Mon-Fri 9am-9pm with out of hours cover at evenings and weekends. To accommodate COVID-19 testing, the laboratory now operates 7am-11pm, 7 days per week.

Staff within Microbiology were required to undertake enhanced roles to deliver a COVID-19 testing service. The microbiology team have also been supported by the redeployment of colleagues from the Pathology department into Microbiology. The enhanced skills that they gained will support service delivery and future contingency planning.

Additional investment in staffing has been agreed to support this ongoing requirement, although there will continue to be a requirement for current staff to continue with extended hours of work during the period of new staff training.

Other laboratory services are supporting the remobilisation of clinical services :

**Pathology:**
At present we continue to support urgent suspicion of cancer, urgent referrals and a number of MDT's. Activity is increasing in response to departmental mobilisation plans and national screening programmes being re commenced. In additional pathology staff are participation in the Theatre Recovery Group to support the elective surgical programme remobilisation plans.

**Biochemistry:**
At present we are operating at around 65% of our normal activity. This has increased in response increased attendances, admissions within Acute, mobilisations plans from Acute Services and Health and Social Care Partnerships.

**Haematology / Blood Transfusion:**

At present we are operating at around 80% of our normal activity. This has increased in response to increased attendances and admissions within Acute, mobilisations plans from Acute Services and Health and Social Care Partnerships.

To increase capacity to deal with COVID-19 positive or suspected COVID-19 samples, additional equipment has also been purchased for other laboratories.

At both UHA and UHC additional microbiology safety cabinets will be installed in July / August 2020 and centrifuges will enable an increase in capacity to deal safely with COVID-19 positive or suspected samples.

**Digital**

Digital Services will continue to support and enhance the test and protect service. In addition, the digital services work on staff testing and patient visiting will also supply automated data feeds to the national test and protect platform.

**Summary of actions for Test and Protect Contact Tracing**

We will:

- Provide strong local leadership, influence and expertise to ensure Testing Policy and the Test and Protect programme are implemented and monitored robustly.
- Provide local oversight and management of COVID-19 clusters and outbreaks.
- Provide enhanced Contact Tracing for complex situations in the community.
- Provide Contact Tracing for hospital and other healthcare settings.
- Deliver Testing requirements in line with national policy.

**Summary of revenue consequence:**

The following costs have been identified for Test and Protect.

- Clinical Testing Team - £364K (6 months).
- Results Hub and Contact Tracing tier 2A and 2B- £383K (6 months).
- Occupational Health - £58K.
- Public Health Oversight Team - £133K
- Additional laboratory staff - £182k (7 months).
- Lab test - consumable costs - £603k (annual)
- Negative Results Team - £211k

## 14.2 COVID-19 Local Outbreaks

It is recognised that the virus could re-emerge as a single workplace cluster; a local community outbreak; within the health or care systems as a wider local level problem. There are well established mechanisms in place involving a multi-tiered, multi-agency coordinated approach i.e. the Management of Public Health Incidents and Guidance and NHS Ayrshire & Arran Public Health Incident Management Plan but to outline the wider role of the Ayrshire Local Resilience Partnerships we have developed multiagency guidelines "Managing Community Clusters/Outbreaks of COVID-19 within Ayrshire". These guidelines detail the response, across all partners, to a suspicion or confirmed cluster of cases or an outbreak of COVID-19 within the NHS Ayrshire & Arran area, with the cluster confined to one local authority area or across two or all three.

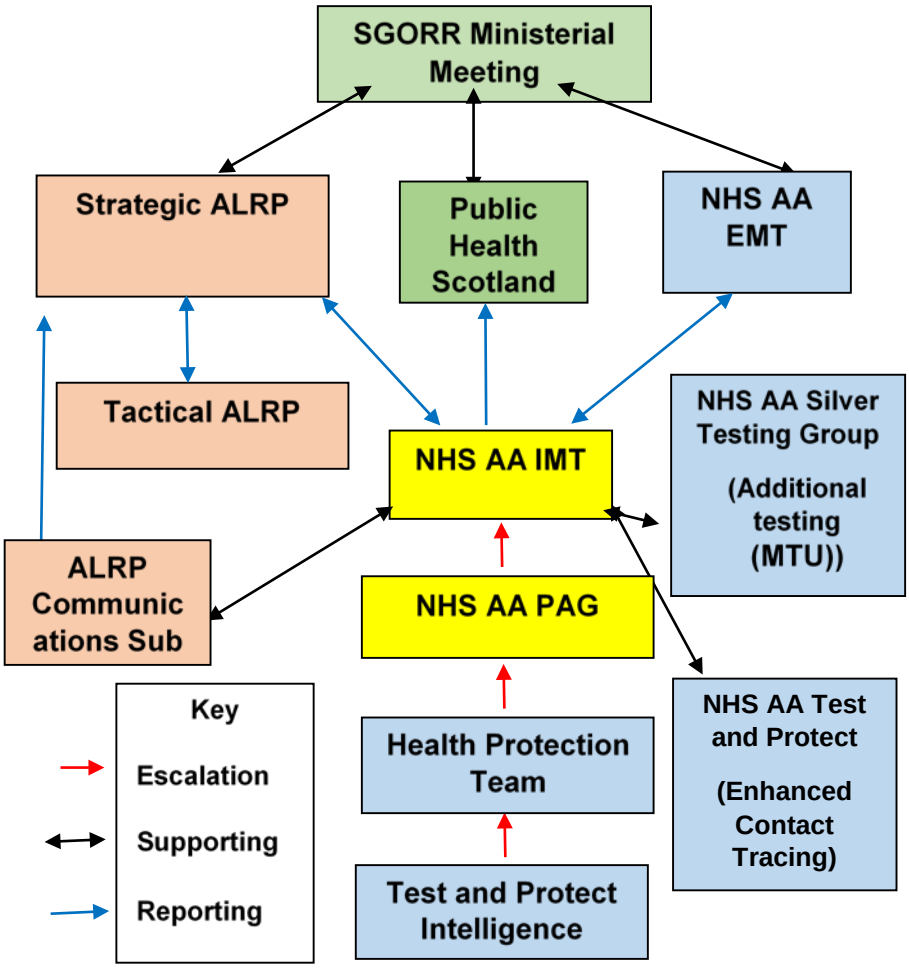
Surveillance data and other intelligence i.e. through Test and Protect is reported to the Health Protection Team (HPT) enabling the team to monitor single cases, identify any possible clusters and outbreaks. On any suspicion of a local cluster or outbreak the HPT would quickly establish a Problem Assessment Group (PAG) to assess the information and escalate to an Incident Management Team (IMT) if required. The IMT is an independent group set up specifically to investigate and manage the response, including assessing the risk, identifying the source and putting measures in place to reduce/stop the spread. The IMT Chair's leadership role is delegated by the DPH on behalf of the NHS Board Chief Executive and the NHS Board, as the lead agency for protecting public health.

If the outbreak is considered as having or has the potential to have a significant impact on the community; is complex in nature; has Scottish Government interest and/or requires enhanced public messaging then the Strategic Ayrshire Local Resilience Partnership (ALRP) would be established to support the decision making of the IMT. The Tactical ALRP would also be set up to support the IMT with managing the consequences of the outbreak and the control measures required to reduce the spread.

Additional escalation measures would be put in place to support the above, and these would include bringing in additional contact tracers, utilising the mobile testing units for additional community testing and the establishment of a multiagency communication team to provide public reassurance and reinforce public health messaging. Arrangements are also in place with our neighbouring boards to ensure that information is shared on suspected clusters and outbreaks.

When developing our local processes consideration was given to the learning from the outbreaks in Lanarkshire and Leicester. The guidance document has also been stress tested with partners giving consideration to several scenarios including an escalating situation across Ayrshire, an outbreak on Arran and Educational establishments.

**Response Structure**



## 14.4 Mutual Aid WOS

There are established arrangements in principle to provide mutual public health support between Health Board teams. Broadly, this approach would be necessary in the event of an incident, with actual or potential risk to the public health, outstripping the capacity of a single NHS Board public health department.

The exact threshold for seeking support will vary depending on the nature of the incident and the resource available to the 'incident' NHS Board public health department. Each NHS Board must have appropriate internal surge arrangements, both in and out of hours, to manage reasonably foreseeable events and it would be expected that these had already been activated prior to seeking aid.

Locally, NHS Ayrshire & Arran Public Health Department incorporates health protection, health improvement, healthcare public health and resilience specialist staff. The structure is such that internal surge capacity in response to COVID-19 has been provided from the other specialist areas. This internal capacity has been utilised to full effect in providing enhanced support to our local Health Protection team and establishing the contact tracing and testing elements of our response.

In the event of continued pressure or escalation, mutual aid from other West of Scotland Board areas would be sought.

**Governance (Liability, Immunity, Indemnity)**

Actions taken by a professional not employed by our Board would be indemnified by NHS Ayrshire & Arran, except for issues relating to the professional standards (e.g. gross negligence or wilful misconduct or acting out with competencies) of the individual that would follow normal governance procedures of the employing Board. The Public Health Scotland Act, 2008, permits Designated Competent Persons to act on behalf of other Board areas within Scotland.

**Summary of Revenue Consequences**

| COVID-19 Testing Programme and Tier 2A Test and Protect Service Responsible Officer Director of Public Health | | | |
|---|---|---|---|
| **PH Oversight Management Team** | Consultant in Public Health | From Core Budget | 1 WTE |
| | Programme Manager | Band 8A | 1WTE |
| | Senior Analyst | Band 6 | 1WTE |
| | Administrator | Band 4 | 1 WTE |
| | | | |
| **Testing Results Hub and Tier 2A Test and Protect support and interface Team** | Programme Manager | Band 7 | 1 WTE |
| | Interface Coordination Manager | Band 6 | 1WTE |
| | Administrator Supervisor | Band 5 | 1 WTE |
| | Results Dissemination, Triage and liaison with Test and Protect Teams | Band 4 | 8 WTE |
| **Testing Results Hub Test and Protect Clinical Team** | Senior Nurse Lead | Band 7 | 0.8 WTE |
| | Deputy Senior Nurse | Band 6 | 0.8 WTE |
| **Contact Tracing Tier 2A Acute Services** | Nursing | Band 5 | 4 WTE |
| | | | |
| **Clinical COVID-19 Testing Team** | Clinical Lead / Coordinator | Band 7 | 1 WTE |
| | Nursing | Band 6 | 2.6 WTE |
| | Nursing | Band 5 | 5 WTE |
| | | | |
| | Nursing Assistants | Band 3 | 5 WTE |
| | Administration | Band 3 | 4 WTE |
| | Porter Staff | Band 2 | 3 WTE |
| | | | |
| **Occupational Health** | | | |
| | Nursing Assistants | Band 3 | 2 WTE |
| | Administrators | Band 3 | 2 WTE |
| **Total Cost of Testing Programme Service and Test and Protect Tier 2A Teams for 6 Month Period: £890,913** | | | |

## 15.0 Flu Vaccination

NHS Ayrshire & Arran continue to provide their staff with the flu vaccine annually and in recent years have been among the top performing NHS Boards in terms of uptake in Scotland. This programme will continue again for 2020/21. For this year there is a new requirement to immunise social care staff.

To support GP practices with the delivery of the 2020 seasonal flu vaccine programme in the context of COVID-19, and the implications for plans around mass delivery, it has been agreed a mixed model of delivery will be developed to deliver flu vaccines safely and taking into consideration the additional patient groups who will be eligible for the vaccine this year (54-65 year olds). It is proposed this will be delivered through GP Practices, drive through sites, home visits, community pharmacies, additional community sites and schools.

**Staff Flu Vaccination**

From Autumn 2020 in Scotland, social care staff delivering direct personal care will be eligible for free influenza vaccination, with the aim to protect the vulnerable groups of people that they provide care for. This is a decision made during the COVID-19 pandemic in 2020, when many of those cared for are in vulnerable groups for COVID-19 with high risk of serious complications of infection. Many individuals in these groups are shielding – that is withdrawn from society in order to prevent exposure to COVID-19.

The intention is that eligibility covers frontline social care staff within these settings, who are employed by public, private or third sector employers as well as personal assistants who are contracted directly by clients.

Immunisation of social care workers has not been policy in Scotland before 2020, however the majority of NHS Boards already provide immunisation to some (for example social care staff employed by the HSCP) or all of this group of workers.

Discussion has taken place at NHS Ayrshire & Arran's Seasonal Flu Vaccination Group and the preferred method of delivery in NHS Ayrshire & Arran is via Occupational Health. This is based on our previous success with the H1N1 vaccination of these staff in 2009 (where NHS Ayrshire & Arran achieved the highest uptake in NHS Scotland for this group of staff); the fact that we have expertise in delivering the vaccine and the infrastructure to support the programme; and that we expect this to be a dry run for delivery of the COVID-19 vaccine to this group of staff. It should be noted that when the COVID-19 vaccine becomes available it will be very

short notice and without immediately available resilience to deliver this then delays in delivering it will be inevitable.

Additional nursing and administration support required to successfully deliver on this new requirement has been identified (6 WTE nursing staff and 1 admin member of staff) for a 6 month period. This allows a period of training and also to provide resilience with the other significant extra work that will be coming to Occupational Health. Without this additional support Occupational Health will not be able to deliver this new Scottish Government requirement.

Due to the short notice and tight timescales, planning is well advanced and each of the local authorities have identified their key contacts in order that we are in a position to successfully deliver this programme. Meetings have taken place with our local authority colleagues who have agreed to take on the arrangements for ensuring social care staff get booked to attend the relevant clinic to get their flu vaccine. This process served us well during the successful H1N1 campaign for this group of staff.

In order to deliver this requirement a minimum of 6000 vaccines (but could be up to 10000 vaccines) require to be ordered. Local authority contacts are currently working on confirming this figure. In terms of the cost of the vaccine Public Health have advised that vaccine costs for national programmes are usually reimbursed to NHS Boards at the end of the financial year.

Given the current situation that continues to cause significant pressure on the service we plan to deliver the vast bulk of the campaign this year as quickly as possible (in 4-6 weeks) with a period of mop-up and consolidation to follow during the month of November. During the initial 4-6 week consolidated effort at least 60 specific clinics for this group of staff will be needed for them to get their flu vaccine.

**Flu Vaccination Programme – Community**

A Task and Finish Group was established in June 2020 to urgently review local flu plans for winter 2020 and consider how mass immunisations could be delivered with physical distancing guidelines and enhanced infection control measures.

Scottish Government are expected to announce that as well as including all previous cohorts for flu (over 65's, 2-5 year olds, primary school age children, 'at risk' patients, carers), vaccine is currently being procured nationally to allow inclusion of 55-64 year olds and household members of shielded individuals in the flu vaccination programme this year. Within Ayrshire and Arran, it is projected 234,250 patients are eligible to receive the flu vaccination in 2020. This figure includes an estimation of the number of people in households who have been shielding.

NHS Ayrshire & Arran are committed to increasing the update rates by 19% in 2020 for all eligible groups. In previous years the uptake rate would be 56% however, it is expected that there will be an increased uptake from patients this year due to COVID-19. On this basis uptake figures have been projected at 75% which equates to 175,687 patient appointments required

Whilst most of the vaccine stock will be available by the end of September, the Board have been advised the extra vaccine procured may not be available until November/December and planning has been made on this basis.

Detailed modelling work has taken place to understand patient groups at a GP Practice and locality cluster level. To give a baseline to planning assumptions scoping work has taken place with GP Practices to determine what they would be in a position to deliver safely.

Based on the projected numbers and feedback from GP Practices and clinical teams, a mixed model of flu delivery will be implemented through:

- GP Practices – supporting practices will additional resource, walk through and drive through tents where required;
- Main drive through sites;
- Home visits;
- Community pharmacies;
- Additional community sites; and
- Child Health Nursing Teams and schools.

Further analysis will now be undertaken at a GP practice level with the Primary Care Transformation Team working closely with each GP practice to ascertain whether the expected number for each practice is achievable and to provide alternative options where this may be challenging. Additional capacity has been included across other options as an escalation route for GP Practices should the need arise. Out of the total number of eligible patients 3,500 patients live on Arran or Cumbrae. Agreement has been reached with the GP Practices on the islands how their numbers will be delivered and resourced.

The costs associated with the flu delivery programme include the nursing resource (49wte) for four months October 2020 – January 2021, supplies and set up costs of drive through tents. It has been agreed with GP Practices the model will remain flexible and agile as the uptake numbers are continuously monitored. Using the delivery models as set out above allows the workforce and sites to be altered based on demand and delivery timescales allowing the overall cost to remain the same.

Revenue required – £880k

**Summary of actions for flu vaccination:**

We will:

- Seasonal adult flu vaccination delivery by district nursing, supporting residential care homes and for patients unable to attend clinics.

**Summary of revenue consequence:**

- The overall cost associated with this including workforce and supplies is £2,153,000 from September 2020 – March 2021.

| | Year to Jun | July to March | Projected Expenditure |
|---|---|---|---|
| **Flu Vaccinations** | **£'000** | **£'000** | **£'000** |
| Additional Flu Vaccination Costs (Consumables) | - | 922 | 922 |
| Additional Flu Vaccination Costs (Staffing) | - | 1,231 | 1,231 |
| | **-** | **2,153** | **2,153** |

## 16.0 Infection Prevention and Control

### Overview

Effective prevention and control of infection during the next phase of remobilisation will be critical for the successful restart of services, and the continued safety of our patients, staff and their families.

Our Infection Prevention and Control Team has worked unstintingly throughout the pandemic and lessons learned during this time have shaped and informed key elements of this plan with regard to resource requirements both between August 2020 – March 2021, and going forward for the future in a very different environment.

Correspondence from the CNO and CMO throughout the pandemic has guided us with regard to infection prevention and control practice, PPE and stepping down surveillance.

Most recently on 29 June the CNO contacted al NHS Boards with regard to expected additional measures for infection prevention and control, including additional cleaning of high volume areas, management and testing of built environment (water), physical distancing zoning across healthcare system, COVID-19 and non-COVID-19 pathways for patients during care, staff uniform guidance and safe staff movement and rostering.

## 16.1 Infection Prevention & Control – Support & Advice

As it became evident nationally in March 2020 that COVID-19 was spreading there was a significant increase in preparations 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; and
- General IPCT presence in clinical areas.

Non-COVID-19 activity was primarily restricted to:

- Alert organism surveillance;
- Non-COVID-19 outbreak and incident management; and

- Water safety – continue to assess high risk areas for signs of Pseudomonas infection with potential links to water system.

During Phase 1 the CNO issued guidance with regard to cessation on a temporary basis of the national routine infection surveillance programmes. This derogation is still in place as at 23 July 2020.

If this is lifted and the activity requires to resume from August 2020, there will be a resource implication in order to ensure that the IPC expertise can remain focussed on the COVID-19/non-COVID-19 activity required.

Advice and guidance from the IPCT has been crucial in order to manage and mitigate the associated risks and prevent the nosocomial spread of the virus, as we maintain COVID-19 and non-COVID-19 patient pathways. This will continue to be the case during Remobilisation Phase 2 planning as we plan to restart and recover services; keeping our staff, patients and communities safe.

The IPCT Recovery Programme has commenced. Restarted activities include hand hygiene and other Standard Infection Control Precaution Audits; enhanced investigation of key alert organisms, e.g. Staphylococcus aureus bacteraemias and support for the HAI SCRIBE process. A paper detailing the areas of increased activity and those activities which remain outstanding was discussed at the Prevention and Control of Infection Committee on 16 July 2020.

It is important to acknowledge that the IPC Recovery Plan is not just about restarting previous activity, but recognising there is an opportunity to take different approaches. The IPC measures that were introduced for the management of COVID-19 have impacted on how staff implement SICPS and Transmission Based Precautions. Specifically the continuous and sessional use of PPE is a very different way of working. Staff need increased support on how to do so safely. In addition existing audit tools are not necessarily applicable for these new ways of working. As part of the Recovery Plan the IPCT are proposing to undertake ward based education sessions based on local observations of practice, and this will be prioritised over audit activity. This will provide additional support to staff in the clinical settings and enable a reset of fundamental IPC practice in what is a very different clinical environment.

The IPCT Recovery Plan is - by nature of the COVID-19 situation and the need to step up and respond swiftly - fragile and implementation is subject to a number of risks that could adversely impact on the programme including demands from the wider organisation to support recovery plans, the need to respond to outbreaks and increased incidence of COVID-19 within the hospital setting.

The onset of winter will bring with it the potential for increases in Norovirus, influenza and other respiratory viruses against a background of COVID-19 activity. This will not only demand significant input from the IPCT but also add a level of complexity to the management of incidents from that experienced in the past.

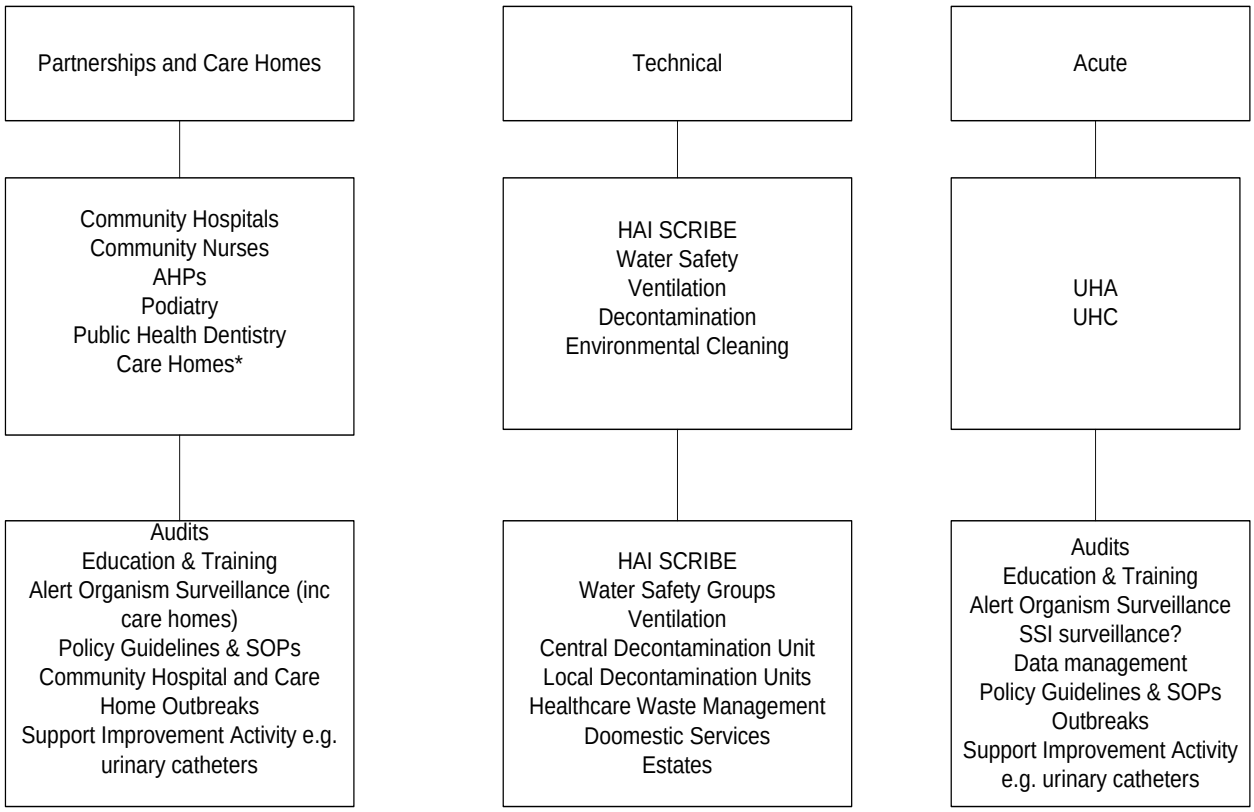
The Control of Infection Committee resumed its business meetings in May 2020, (only one meeting of this important committee was cancelled due to COVID-19) reporting into the Healthcare Governance Committee in June 2020. This usual governance oversight is now fully restored between these two committees in order to give Board assurance.

**Summary of actions for support and advice**

We will:

- Meet the continued COVID-19 / non-COVID-19 advice needs, including outbreak management.
- Plan and prioritise the resumption of routine IPC activity.
- 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.
- Identify additional areas of intervention and support to strengthen the implementation of the national Healthcare Associated Infection and Antimicrobial Resistance policy requirements.
- Implement recommendations and requirements that will arise out of the various national investigations into the Built Environment and the impact on HAI.
- Ensure capacity and resilience within the IPCT.
- At the current time it is estimated that an additional 7WTE across the team will be required to meet the increased activity and demand across community care settings (including care homes), acute settings and the technical built environment advice requirements.

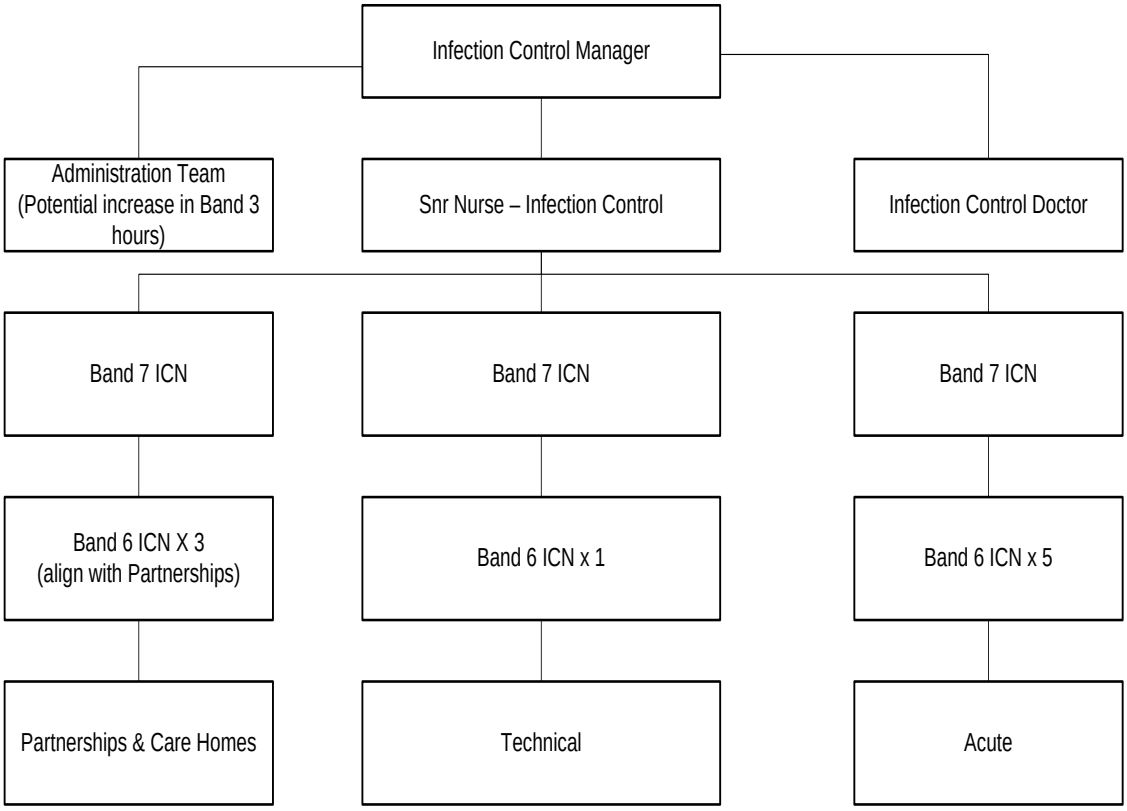
## Proposed IPC Team approach from August 2020 – March 2021 (and potentially beyond)




* Depends on national requirements

## Proposed IPC Team structure August 2020 – March 2021

**Infection Prevention and Control Team**




Creation of 3 x Band 7 posts. Overall WTE increased by 7. Potential for band 6 presence at weekends (Organisational change for existing ICNs)
Uncertain if local and national pool of appropriate staff available
Unable to adjust to sudden increase in workforce – will require staged intervention to ensure appropriate support for the number of new staff.
Potentially all 9 Band 6s with limited or no experience. Funding required for training

## 16.2 PPE

We recognised the importance of PPE as one of the key triumvirate actions to effectively manage the virus, keep our staff and patients safe and prevent the nosocomial spread of COVID-19 across our health and care settings: hand washing and use of hand sanitiser, social/physical distancing and effective use of PPE.

The Ayrshire and Arran Bronze PPE Team continue to model and understand our system wide PPE usage and demand, and map out daily stock requirements. The Bronze Team reports into the Emergency Management Team and we have a PPE Escalation Plan in place. The team meet weekly with the understanding that this will increase in frequency as any PPE issues emerge.

Three days a week a status report on PPE availability is provided to the Emergency Management Team. Daily usage modelling is updated weekly and takes cognisance of current stock, changes in guidance and the mobilisation of elective and outpatient activity.

We established PPE Safety Officer Training and this has continued to spread throughout our Acute and Community services as well as the Care Home Sector. The clear purpose of the training is to support the PPE officers to develop an understanding of their local situation in terms of their needs, their fears and their PPE usage. The training includes basic information about the virus and how it spreads as well as PPE and how and why it varies between clinical settings. There is information on psychology regarding why people behave as they do along with how to approach people without escalating a situation. (Information as to how to de-escalate situations was also provided).

To date 110 individuals have been trained as PPE safety officers across NHS Ayrshire & Arran's Acute, Community and Care Home services. The training has developed through time to include key messages including physical distancing and visiting.

**Summary of action for PPE**

We will:

- Continue to maintain the PPE Bronze team to ensure that there is essential oversight and responsiveness to all PPE issues.
- Continue to roll out our PPE Safety Officer training across our system.

## 16.3 Uniform Guidance for staff

The Board is compliant with the national uniform policy and has provided staff with guidance on the home laundering of uniforms which are not contaminated with blood and body fluids.

Staff have been advised that home laundering of uniforms which are contaminated with blood and body fluids is not permitted and these are laundered within the onsite patient laundry services available or the Regional Laundry provided NHS Lanarkshire.

These arrangements have been highlighted to staff on a number of occasions using the Board's well established staff communication processes.

**Summary of actions for uniform guidance for staff:**

We will:

- Continue to ensure that staff are aware of the appropriate guidance for uniform policy and laundry to keep them, their patients and their families safe.

## 16.4 Staff movement -COVID-19 and non-COVID-19 patient pathways

NHS Ayrshire & Arran continue to implement the national infection control guidance for COVID-19 including ensuring the segregation of suspected and confirmed cases from the wider hospital population. These patients are isolated in single rooms with the appropriate transmission based precautions in areas designated as Red Pathway Zones. Where practicable dedicated staff are allocated to the red pathway zones with minimal movement between areas.

The plans allow for flexibility to allow for the scaling up and scaling down of red pathway areas based on the number of suspected and confirmed cases. If cases increase significantly then confirmed cases may be nursed in a cohort with other confirmed cases. Suspected cases are always allocated to a single room pending test results.

At present the number of cases are at the lowest level since the onset of the pandemic and the emergence of cases locally in mid-March.

**Summary of actions for staff movements**

We will:

- continue to implement the national infection control guidance for COVID-19 including ensuring the segregation of suspected and confirmed cases from the wider hospital population.
- ensure that where practicable dedicated staff are allocated to the red pathway zones with minimal movement between areas.

## 16.5 Water Safety

Due to the current restrictions on visitors, elective activity and the repurposing of wards/ departments within acute and community facilities resulting from the overall response to COVID-19; there has been a need to ensure measures are in place in order to maintain water usage at outlets (taps and showers) and turnover of storage.

Sector Water Safety leads have proactively engaged with Infection Prevention & Control and clinical services to provide the latest guidance and to understand whether there have been any significant changes to the usage of existing buildings across the retained estate and PFI/NPD sites which could have an impact on water usage.

Flushing regimes are in place ensuring water turnover is maintained to acceptable levels. Where infrequently used outlets have been identified, flushing regimes are currently in place and being carried out by Estates, domestic services or building users and recorded.

A communication was released to highlight that it is essential for all areas to undertake a regular assessment of what water outlets are used infrequently and where these exist then ensure flushing regimes are implemented. A weekly reminder is now included within NHS Board Daily digest internal communication as part of enhanced monitoring and assurance during this time.

The Board Water Safety Group reports into the Prevention and Control of Infection Committee and recommenced regular meetings in July 2020, with published guidance on the agenda for further discussion and agreement on actions required.

**Summary of actions for water safety**

We will:

- Continue to proactively engage with Infection Prevention & Control and clinical services in order to provide the latest guidance and understand where significant changes to the usage of existing buildings across the retained estate and PFI/NPD sites are likely during this next 6 months which could impact on water usage.
- Continue to ensure necessary flushing regimes are in place ensuring water turnover is maintained to acceptable levels.

## 16.6 Domestic Services

During March – July 2020 there has been no requirement to increase the number of domestics to carry out the increased cleaning of touch surfaces; this has been possible due to the significant reduction in clinical activity and in-patient reduction across all sites. As the clinical activity starts to increase, to ensure we continue to meet the National Cleaning Services Specification and increase touch surface cleaning in general, we are going to require additional resource and this is being modelled.

Clinical staff are taking responsibility for cleaning between patients within clinical areas which is assisting to share this burden, and has a consequential impact on their own workload.

The following service areas which will be restarting require to be considered to determine the domestic arrangements as we move into the next recovery phase:

**Outpatients Depts**: there are currently no domestic staff in these areas during clinic operational times therefore we are unable to increase cleaning frequency. It is expected that clinical staff will wipe touch surfaces between patients using clinical wipes which are now widely available.

If outpatients move to offer services over 7 days instead of the current 5 days, weekend staff will be required to clean these areas at the weekend.

The average time to clean an open clinic suite is 3 hours, and this would be required at the end of the clinical session if more than 1 suite is operational, the same resource would be required for each one. We should therefore plan for additional weekend cover on both Acute sites. We would be directed by the General Managers/ Site Directors to determine exact requirements, but it is likely that we would require 6 hours Saturday and 6 hours Sunday as a minimum on both sites at a cost of approximately £34,000 per year in total.

**Public toilets on all sites**: these are cleaned twice daily at main entrances, ED and CAU. Toilets in clinic waiting areas in the Outpatients Department do not have domestic staff during clinic operational times. There is a rapid response service on both sites for dealing with any urgent issues, and we do not envisage increasing the frequencies as the main areas used are the public toilets at entrances

**Communal Reception Areas**: As per public toilets, cleaned twice daily, outpatients once, at the end of clinic. Again, the clinical staff are wiping down the touch surfaces regularly.

The desk cleaning protocol which has recently been implemented will cover the increased touch surface within ward and administration areas.

Additional cleaning will be required in CAU/ ED to meet the enhanced cleaning requirements and the estimate for this is £237,800.

As a minimum, and if weekend clinics are implemented on both acute sites, the cost of additional cleaning will be £271,800

**Summary of actions for Domestic services**

We will:

- Ensure we continue to meet the National Cleaning Services Specification during the next 6 months including any national. changes that may be made to take account of new ways of working.
- To deliver this there will be a resource cost identified above.

The supporting technologies detailed within the digital section in particular the remote working, remote monitoring and associated solutions will enhance infection control by ensuring staff can work securely, remotely and effectively monitoring patients without direct contact.

**Summary of revenue consequence:**

The following costs have been identified within Infection Prevention and Control

- IPC Team resource required to end March 2021 (and potentially beyond in the current COVID-19 environment):
    - Three B7 senior ICNs: costs to end March 2021: £164,670
    - Four B6 ICNs: costs to end March 2021: £205,316 *(this includes the 3 ICNs to support care homes referenced earlier in the plan*)
- Personal Protection Equipment - £5,710,000
- Deep Cleans – £532,000
- Other – Security costs PPE Store (North) - £48,000

| **Section 16**<br>**Infection Prevention and Control** | **Year to Jun**<br>**£'000** | **July to March**<br>**£'000** | **Projected Expenditure**<br>**£'000** |
|---|---|---|---|
| Personal protection equipment | 2,111 | 3,598 | 5,710 |
| Deep cleans | 48 | 484 | 532 |
| Other- Security Costs PPE Store (North) | 24 | 24 | 48 |

| | | | |
|---|---|---|---|
| IPC Team | - | 277 | |
| Public Health | 136 | 622 | 759 |
| | **2,319** | **4,729** | **7,326** |

## 17.0 Pharmacy

**Priorities/Outcomes aiming to deliver:**

**Pre-winter – by end Oct 2020**

- Support launch of NHS Scotland Pharmacy First (as described in Community Pharmacy section);
- Flu vaccine: order and agree distribution of supplies for staff vaccination programme;
- Agree pharmacy services to support winter plan where appropriate and implement any changes;
- Review clinical pharmacy service in acute to ensure adequate support for COVID-19 and non-COVID-19 patient activity, in particular support for critical care surge capacity;
- Support remaining GP practices to implement serial prescribing
- Plan for aseptic dispensing of critical care medicines to support critical care surge capacity;
- Implement RxInfo Define and Extend to support national oversight of critical care medicines stock availability and usage;
- Evaluate pharmacotherapy service;
- Complete gap analysis of provision of pharmaceutical support to care homes and develop business case for additional resource if necessary;
- Rollout HEPMA to remaining inpatient areas (maternity and Ailsa Hospital wards); and
- Scope use of NHS Near Me across all pharmacy services: acute, mental health, primary and community care and community pharmacy.

**By end March 2021**

- Support NHS Ayrshire & Arran winter plan with additional pharmacy services as appropriate;
- Support the Vaccine Transformation Programme with delivery of flu vaccination and, if available, COVID-19 vaccination;
- Support development of Community Pharmacy common clinical conditions clinics to optimise access for patients across Ayrshire & Arran;
- Develop and implement local PGDs for NHS Scotland Pharmacy First service as agreed with CPS Ayrshire and Arran;
- Increase uptake of serial prescribing in practices where it is zero or below Scottish average (2.6%);
- Through the pharmacotherapy team contribute to development of primary care MDT working to support GPs as expert general medical practitioners;
- Optimise the pharmacotherapy service within the staffing budget available;

- Reform clinical pharmacy service in acute hospitals to ensure right care is delivered by the right person using COVID-19 ICU model as blueprint for pharmacist role;
- Implement pharmaceutical support for care homes across NHS Ayrshire & Arran, level to be determined by gap analysis;
- Complete upgrade of HEPMA to version 2019 across all inpatient areas of NHS Ayrshire & Arran; and
- Implement use of NHS Near Me across pharmacy services in accordance with scoping exercise and further develop use as appropriate.

**Signal priorities beyond March 2021 – local and regional/national**

- Continue to develop Pharmacy First in line with unscheduled care priorities;
- Increase access to Community Pharmacy common clinical conditions clinics so that patients can access care as close to home as possible;
- Continue to develop the pharmacotherapy service in line with the GMS contract;
- Continue to develop pharmaceutical care within care homes as resource allows; and
- Support other Boards with HEPMA implementation and benefits realisation.

**Supporting workforce**

- Workforce plan in place for COVID-19 to support service delivery if second wave occurs. This includes support for community pharmacy from within the NHS Ayrshire & Arran pharmacy team;
- Support has been provided for staff in preparation for deployment into other parts of the pharmacy service;
- Pharmacy team continues to support pre-registration pharmacists and pharmacy technicians and is reviewing delivery of undergraduate placements to ensure these can take place; and
- Pharmacy team has a number of peer vaccinators to support staff to receive flu vaccination: this improved uptake last year so is a model we wish to maintain and would consider for COVID-19 vaccination if appropriate.

**Risks**

- Medicines supplies: critical care medicines in the event of further surges of COVID-19 and general risk associated with EU transition;
- Service delivery: risk of being unable to supply medicines should significant staff absences occur. Workforce plan in place to mitigate the risk and protect core supply function; and
- Service delivery community pharmacy: risk of widespread closures should significant staff absences occur. CPs have business continuity plans and NHS Ayrshire & Arran pharmacy team has a workforce plan in place to mitigate the risk.

**National approach beneficial**

- Support from NP to maintain medicines supplies;
- Electronic transmission of prescriptions in primary care;
- Community Pharmacist access to Clinical Portal; and
- Guidance on pharmaceutical care provision to care home residents.

## 18.0 Workforce

## 18.1 Workforce Planning

Workforce planning continues to be intrinsic to our recovery planning, balancing workforce flexibility, should there be the variation in COVID-19 related services demand, as well as ensuring the safe re-commencement of services and forward planning for the winter period.

Our established Workforce Planning & Deployment Group (WPDG), as detailed in our Phase 2 mobilisation plan, will continue to provide oversight in matching staff supply to meet service demand as the organisation progresses in Remobilisation Phase 2. This Group continues to meet frequently 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).
All work in relation to workforce is undertaken in partnership with staff side colleagues with the Area Partnership Forum being regularly appraised. Underpinning, and intrinsic to successfully delivery across our key areas of focus in Remobilisation Phase 2, as detailed below, is ensuring our staff wellbeing and resilience.

The areas highlighted below provide a high level overview of key areas of focus in relation to the workforce for Remobilisation Phase 2:

**Summary of actions for Workforce Planning**

We will:

- As detailed in earlier sections, we need to robustly identify workforce demand and balance this with supply to meet key operational priority areas - Ongoing to March 2021.
- Identify the AHP workforce implications arising from both COVID-19 related rehabilitation needs and latent service demand as services re-commence - August 2020.
- Assess whether the NES recruitment portal provide further supply that could be utilised within NHS Ayrshire & Arran - July 2020.
- Rollout of the asymptomatic staff testing for designated priority ward areas and associated support staffing (domestics, pharmacy, medical and AHP colleagues) - July 2020 and ongoing weekly.
- Planning for the safe return, where possible, of colleagues who have been shielding, by undertaking a programme of risk assessment, so as to ensure colleagues are appropriately assured and supported in transitioning back to appropriate work environments. We have started a programme of telephone risk assessments for staff members who are shielding and planning to return to work which will assist line managers in supporting staff in returning to the workplace as well as reviewing long term absence cases and ensuring support through our Occupational Health Service. August 2020 (March 2021 for those nurses graduating in January 2021).
- Continuing to make best use of technological solutions that enable, where possible and appropriate, staff to work from home in a supported manner - Ongoing to March 2021.
- Pro-actively increasing our nursing workforce supply through ongoing recruitment to the nurse bank and undertaking a recruitment programme for all final year nursing students, a large proportion of whom are currently employed in Band 4 roles, who wish to work in Ayrshire and Arran in substantive Band 5 roles - August 2020.
- Continuing to support the health and wellbeing of colleagues post pandemic peak.. Ongoing to March 2021.
- Planning for the seasonal flu vaccination programme - August 2020.
- Encouraging staff to use annual leave so as there is no 'bottlenecking' of leave later in the year, specifically within the winter period of October – February. In partnership with staff side colleagues, and as discussed at the Area Partnership Forum the principles for applying DL(2020) 9&16 have been agreed. In addition staff are to be reminded and encouraged of the importance of ensuring periodic rest and recuperation and annual leave should be regularly spaced out where possible. Staff will be encouraged to use at least 3 weeks by the end of September 2020 and have an absolute maximum of two weeks to use up within the last quarter of

the leave year. We will monitor the use of annual leave, compared to the trend of use in the previous financial year, to mitigate potential risk to service delivery caused by deferment / backlogging - Monthly monitoring.

- Continue to monitor all aspects of leave organisationally. Our sickness absence levels have consistently been below 4% since April 2020 (in the range 3.11 to 3.31%). COVID-19 related special leave has begun to decrease, from a peak of 6.95% in April to 3.95% in June 2020, and it is likely this will further decrease as shielded colleagues return to work - Monthly monitoring to March 2021.
- Continue to utilise our central staff hub for the reporting of absence, and recording detail within SSTS, going into the winter period. Whilst we have been able to scale back the hours of operation the use and success of this solution at the peak of pandemic means we can scale this back up as necessary to meet any change in COVID-19 activity and or seasonal flu related activity during the winter period - Ongoing to March 2021.
- NHS Ayrshire & Arran has participated regionally in identifying staff (pharmacy, nursing, and medical) who have attended induction, to support NHS Louisa Jordan should these beds become active in response to a surge in COVID-19 - Dependent upon demand for usage.
- Organisationally we have undertaken significant work to ensure we comply with our legislative requirements in terms of physical distancing and being COVID-19 secure by risk assessing our workplaces which materially impacts on both staff and patients. Having undertaken this work we would anticipate a positive impact of reducing the risk of occupationally acquired ill health to its lowest reasonably practicable level, thereby reducing the potential for coronavirus related absence - August 2020.
- Consider restarting professional clinical education that has been paused in collaboration with F/HEI colleagues regarding timescales – both at pre and post graduate level. There is a definite plan for restart of post graduate NMAHP education with local HEIs including: health visiting, district nursing, advanced clinical practice and non-medical prescribing. As a result of the pandemic the experience of undergraduate clinical staff will be significantly altered for the foreseeable future, as will be common to all NHS Boards and it is likely blended learning will need to be delivered and education is aligned to the strategic needs of the organisation, recognising that placement capacity may be impacted, and learners. NES have been commissioned by CNO to undertake an impact report to understand what action is required.
- We will prioritise 3rd year nursing and midwifery student placements (minimum of 12 weeks), who were unable to undertake Band 4 employment opportunity, to support completion of their programme by the end of the calendar year - December 2020.

**Pre-registration Nurse and Midwifery Education**

**Student Nurses/Midwives**

In March 2020, all 1st and 2nd year supernumerary student nurses and midwives were removed by the Universities from their clinical placements due to the COVID-19 pandemic. In agreement with the NMC and NES all 2nd and 3rd year nurse students were offered the option to take up a paid non supernumerary student placement based on a national job description and become employees of the organisation.

**The 2nd year students were employed at AFC B3 for a maximum of 30 hours per week (academic works still required) until 31 August 2020. The 3rd year students were employed as AFC B4 for 37.5 hours per week (as all academic requirements have been completed) until 30 September 2020. These salary costs are covered by NES.**

Non Supernumerary Students

Currently there are 150 2nd year students on paid placement across Adult, Mental Health, Learning Disabilities, Midwifery and Paediatric programmes. Only a handful of these placements are within community services. These students will return back to their full-time academic programme at the end of August 2020.

**We will need to model the impact of this on our teams and triangulate against the continued number of COVID-19 related staff absences for impact on services. The potential return to work of staff currently shielding should help ease this process.**

142 3rd year students across all programmes took up the offer of a paid placement with their contract ending on 30 September 2020. These students will have completed their final academic assessment and practice hours and will register with the Nursing and Midwifery Council in September 2020 to take up registered nurse posts. Not all 142 will take up posts in Ayrshire and Arran.

Supernumerary Students

Due to the legacy of disruption from the 2019-20 academic session, during which placements were cancelled, students will need to catch up on the required clinical placement time across the remaining period of their education programme. We can expect an accumulation of students once supernumerary placements become available. This is the result of 1st year students not being out on placement during COVID-19 plus 55 2nd year

and 25 3rd year students not taking the option of a paid non supernumerary placement; some may have been shielding or had carer responsibilities.

We will prioritise 3rd year placements (minimum of 12 weeks) to support completion of their programme and SG has extended the student bursary until 31st December 2020 to facilitate this.

We are currently aiming to re-start supernumerary student placements from September 2020 as the decision from the Scottish Government regarding Death in Service indemnity for student has now been resolved by the Cabinet Secretary.

Ongoing disruption in the 2020-21 academic session due to restrictions in place as a result of COVID-19 will reduce capacity in health and care placement providers. Reconfiguration of services will take cognisance of the on-going capacity to support supernumerary student numbers.

**This has the potential to put pressure on our clinical areas and is an issue across Scotland. NES has been commissioned by CNOD to scope the impact of COVID-19 on practice placements on our NMAHP students through into 2021.**

Working towards March 2021, we will ensure that creative consideration be applied to ensure placement capacity in all settings to support the return of supernumerary placements. This will be cognisant of accommodation, support and supervision requirements for students out on placement and the exploration of additional placement opportunities as services change. Practice Education Facilitators will be well informed regarding changes in service deliver that will either increase or decrease student placement capacity.

Clear communication has been given to clinical areas that pre-registration students from 1st to 3rd year will be allocated to all areas where learning outcomes can be achieved, this will ensure that we are maximising the all teaching environments.

## Newly Registered Nurse/Midwife Recruitment

In May 2020 we initiated a recruitment process to recruit the September 2020 newly registered nurses and midwives into vacant posts across NHS Ayrshire & Arran.

This recruitment process will be mainly complete by August 2020 with 115 applications received and 89 students matched into posts. We are working with colleagues across the system with regard to the remaining nine students who will be available in September. We also offered employment to 10 student midwives and 2 paediatric students who register in September 2020.

We will ensure that the 3rd year students (16) graduating in January 2021 are aligned to vacancies throughout the organisation.

## Nurse/Midwife Post-registration Programmes

Our main post-registration programme provider the University for the West of Scotland (UWS) paused all their face to face programmes in March 2020 – the online modules continued.

Key programmes effected by this pause included:

- District Nurse (Specialist Practitioner) (Postgraduate Diploma);
- Health Visiting (Specialist Community Public Health Nursing) (Postgraduate Diploma);
- Advanced Clinical Practitioner (MSc); and
- Non-Medical Prescribing (NMP).

Proposed changes by the University at this time may affect programme delivery and impact on not just the numbers able to undertake these qualifications, but also could delay qualification due to the extended length of programme. This in turn impacts on these staff being able to undertake their full scope of role for which they are employed by us, and could impact on our pace of service change.

We are working in partnership with our West of Scotland Board colleagues and the University during August and September 2020 to ensure that blended learning is delivered and education is aligned to the strategic needs of the organisation and learners between now and March 2021.

## 18.2 Staff wellbeing and resilience

Staff wellbeing and resilience is at the heart of maintaining high quality and sustainable services and we have mobilised our Wellbeing Hubs, Staff Care and Chaplaincy Services and more recently implemented Listening Service. We believe that well-being is aligned to our recovery and renewal as an exemplar employer and communicates to our staff our commitment to their wellbeing. Our experience during the response phase of the Pandemic has demonstrated that our workforce are experiencing challenges beyond the normal physical and emotional demands at home and at work. As the pandemic progresses through the recovery phases and potential winter pressures it is anticipated there will be a significant increase in demand for mental health and well-being services to support NHS Ayrshire & Arran staff. It is vital that we prepare for and ensure adequate resources are available to meet this demand. NHS Ayrshire & Arran has an established wellbeing infrastructure, delivered by our Well Being Hub and Staff Care and Chaplaincy Services, which has provided immediate and person centred support to staff.

Our Board is committed to continuing this care and in ensuring our current Staff Well Being programme is strengthened and sustained to take us through the remobilisation stage and winter period. Our key areas of focus in relation to staff wellbeing and resilience for Remobilisation Phase 2 are listed below:

**Summary of actions for staff wellbeing and resilience**

We will:

- Continue Our Wellbeing Hubs within our Acute Hospitals and provide open access 24/7 to staff. - Ongoing to March 2021.
- Embed our non-Acute wellbeing arrangements in H&SCPs – drop in centres and hubs - Ongoing and under review.
- Review ongoing Well Being accommodation needs - By March 2021.
- Developing a staffing structure / requirements, with agreed resource and leadership structure, within the Well-being Hub and align core Well-being programmes delivered by Occupational health and Public Health to ensure that we are harnessing the collective contribution of our wellbeing services. - August 2020.
- Establish a dedicated staff listening service which augments and supports current support arrangements providing access to staff for the opportunity to talk, emotions stabilise and decompress the immediate impact of an emotional experience and through skilled listening and compassion, help staff reset and maintain their well-being and ability to attend work. The service is open from 09.00 to 22.00. Funding has been allocated until the 31st March 2021 for the listening service and a full assessment of the service will be undertaken to establish the qualitative impact of the service - July 2020 to March 2021.
- Rollout Distress Thermometer screening tool and associated well-being list will serve as a screening tool to determine which psychosocial factors need to be addressed and, in turn, if further referral is required to other Services - September 2020.
- Develop a hub and spoke model of care to bring together and progress staff well-being services. The spokes of the model will be building partnerships with new staff support services recently established throughout the community. This collaborative approach will enable much wider access for staff needing psychosocial support. It will also ensure the continued strengthening and building of staff well-being resources from both an acute and community perspective - September 2020.

**Summary of revenue consequence:**

| | Year to Jun | July to March | Projected Expenditure |
|---|---|---|---|
| **Workforce** | **£'000** | **£'000** | **£'000** |
| Additional Staff Overtime and Enhancements | 476 | 1,429 | 1,906 |
| Additional temporary staff spend - Returning Staff | 20 | - | 20 |
| Additional temporary staff spend - Student Nurses & AHP | 824 | 1,034 | 1,858 |
| Additional temporary staff spend - All Other | 592 | 1,776 | 2,369 |
| | **1,912** | **4,240** | **6,152** |

## 19.0 Digital

### Overview

There are significant opportunities for digital services to be at the front of the remobilisation and recovery core tasks particularly with the use of TEC to minimise face to face consultations. There is the opportunity to centralise the monitoring of TEC outputs through the changed use of the existing clinical hub facility. Patients with significant care needs are effectively monitored remotely and any exacerbations are dealt with promptly without the need for unscheduled activity. This includes the effective monitoring of patients who are in the backlog of planned care. There is additional opportunity using the national TEC solutions to monitor patients in all the major disease groups including support for mental health patients and staff.

## 19.1 Digital & Innovation

There are a number of foundational activities to support the delivery of the digital solutions identified further on this section. These activities improve the resilience of the underlying digital infrastructure and are a prerequisite for any further activities.

**Digital Foundation Activities:**

- Implement the replacement clinical portal hardware;
- Further develop mobile phone apps to support clinical signposting within the Ayrshire and Arran ‘container’ app;
- Further infrastructure activity to increase the resilience of the remote access platform;
- Continued deployment of Office 365 throughout the organisation in conjunction with NSS and Microsoft;
- Further deployment of mobile devices to support remote working;
- Improvements in Primary Care infrastructure to support NHS Near Me, Microsoft Teams, MDT and CTAC working – including corporate and public Wi-Fi, additional bandwidth provision and piloting hosting GP systems centrally to provide additional resilience and ubiquitous access;

- Increase the resilience of our remote access and Bring Your own Device (BYoD) solutions to support effective remote/community working;

- Improvements in Digital Services infrastructure to support Office 365 deployment and end user experience – connectivity and resilience for internet access; and

- Further improvements in Wi-Fi coverage within clinical areas including maternity and mental health to support HEPMA and patient access.

Specifically, in support of the organisation's remobilisation plans this year our actions are: -

**Clinical Portal**

- Through the deployment of an enterprise license allow access to all clinicians within the organisation, this is to include inpatient and day case and associated nursing and AHP teams;

- Maintain links to clinical portals throughout the region ensuring seamless integration for clinicians accessing data across Health Board boundaries;

- Enable access to the platform by community teams across the three Partnerships;

- Integrate TEC solutions into the clinical portal with context launch for community and primary care staff; and

- Identify further 'data deficits' within portal and address these through integration links or interfaces with clinical systems and associated modalities, this includes out of hours services. Further integration opportunities will be investigated after the current HEPMA is upgraded, maternity system and RIS are replaced.

**TEC - community**

- Implement COVID-19 related support;

- Continue BP Scale Up activity;

- Deployment of TEC solution to support cardiology patients;

- Implementation of TEC solutions to support the Respiratory Rapid Response (RRR) service and associated respiratory pathway;

- Replace the existing TEC solutions that support Chronic Heart Failure (CHF) and CoPD; and

- Implement a TEC solution for Asthma.

**Support the major disease groups and mental health services, specifically aligned with the NHS Near me priority lists. Initial focus to include:**

- Haematology
- Maternity including Gynaecology
- Oncology
- Paediatrics
- Renal
- Respiratory

**Video Consultation**

- Further cycles of NHS Near Me deployments in acute, community and primary care to support remote video consultations. There is an opportunity to replicate the NHS Lothian model 'call mia' this is video consultation for minor injuries assessment. Digital Services will be specifically targeting the Scottish Government priority areas as below:
    - Haematology
    - Maternity including Gynaecology
    - Mental Health Services
    - Oncology
    - Paediatrics
    - Renal
    - Respiratory

- In addition, further areas have been identified where there is opportunity for video consultations to be used including:
    - Surgical
    - AHP
    - Nurse led outpatient clinics
    - Out of hours services

- Support further implementations of vCreate to deliver asynchronous video consultations. The vCreate solution is currently being used within ICU and paediatrics. Currently working with colleagues from SG to identify additional use cases

## Collaboration and Communication

Implementing the following Office 365 use cases:

- Clinician to clinician communication – multiple secure methods of communication, instant messaging, shared files accessible anywhere and on any device. This solution gives the ability for healthcare professionals to discuss patient care in real time and collaborate ensuring the best outcomes for patients;

- Frontline workers – seamless communication, collaboration to support MDT working in acute, community and primary care locally, regionally and nationally. The ability to support healthcare professionals regardless of location or time of day and promoting effective community treatment and care (CTAC);

- Healthcare messaging – extensive list of healthcare opportunities for the effective and secure sharing of data and images to support patient care; and

- Culture and employee engagement – efficient and rapid sharing of data, collaborate in a single place or hub, channel meetings. Help to improve employee wellness – supports access from anywhere and flexible working, increases productivity.

Other activities in support of the organisations COVID-19 response:

- Carry out initial scoping work for an online patient booking solution for hospital outpatient appointments as a method to provide flexibility for patients, reduce costs and improved DNA rates – initial scoping work to focus on hospital outpatient appointments;

- Represented on and working with the Scottish Government Remote Monitoring COVID-19 Response Group to identify additional opportunities to support mobilisation using integrated TEC solutions;

- Further development of a Radiology Home Working solution to support both Radiologists and Reporting Radiographers to work from home; and

- Deployment of an SMS campaigner to deliver informative text messages to patient cohorts. To include outpatient appointment reminders and TEC notification services for patients.

**Further deployment of EMISweb to support community-based clinicians to work remotely and safely.** The current areas of implementation are: -

- District Nursing (East)
- Podiatry
- Diabetic Nurse Specialists
- Douglas Grant Rehabilitation Centre (DGRC)
- Physiotherapy (North)

Senior management within Digital Services continue to work extremely closely with other Health Boards and Scottish Government eHealth colleagues alike. We recognise that Government colleagues are ready to assist wherever possible and we will reach out for assistance if and when required.

The implementation of clinical portal throughout primary and secondary care is a key enabler, so that all clinicians regardless of speciality have visibility of the relevant, up to date, real time view of patient data available to them to make effective decisions on patients care. This approach will positively impact the organisations ability to effectively manage ED and acute hospital attendances, increasing the focus on whole system working while informing future opportunities to accelerate transformation and re-design. In addition, the inclusion of TEC data within the clinical portal will further enhance the usefulness and value of the portal.

Further utilisation of Office 365 components to support resilience colleagues in implementing emergency messaging and emergency planning solution.

A successful implementation of an emergency messaging solution will deliver the following benefits: increase visibility of acknowledgments for time critical messages, improved multi agency collaboration, document collaboration and video/audio calls and conferencing.

The development and deployment of an emergency planning solution will deliver these benefits: virtual team working, agile/rapid meetings, seamless secure communication and collaboration, through chat and video/audio calling.

Current activities to support patient visiting, staff testing and track and trace service including integration into the national tracking service will continue delivering enhancements throughout the remainder of the year.

The rapid deployment of new technologies during this pandemic has enabled the organisation to continue to work as effectively as possible, it has not transformed our services, but instead presented the possibility of

how services could be transformed. This change was rapid and unplanned, and whilst remediation will be required there is an opportunity to build and enhance on the work done to date.

It's important also to consider that technology is a key enabler to change, nevertheless making a service digital in itself won't transform our services. Technology change needs to be founded on service transformation.

There are several key technology enablers required to support sustained agility and remote working, those include:

- Improvement in networks, access to Wi-Fi and technology stability;
- Deployment of Office 365 to obtain full functionality of Microsoft Teams and other products within the suite;
- Increased access to laptops/mobile devices for all staff;
- Deployment of SurfaceHub technology to allow a blended approach to attendance at meetings, MDTs and any other collaborative work;
- Deployment of mobile devices to all staff – to increase access to technology and ability to engage with staff;
- Full deployment of clinical portal across all partners;
- Wide deployment of TEC solutions, in particular inHealthcare remote patient monitoring; and
- Targeted work Identification of both clinical and non-clinical service redesign opportunities for digital technology to improve patient pathways.

## Digital Solutions

The lack of effective capacity can be the rate limiting factor, effective capacity management is currently under review by digital services programme managers.

There is a very clear digital demand throughout this document. The implementation of portal plus an effective TEC deployment coupled with the appropriate remote monitoring resources has the opportunity to deliver reform although there are elements of the organisations culture that will require some refinement to ensure a consistent adoption.

## Digital Priorities 21/22

- The move to a new version of Trakcare will be scheduled for next financial year and the potential for moving to a hosted solution will be investigated. Furthermore, a review of additional Trakcare modules will be carried out;

- Further enhancements to the clinical portal including primary care and social care data and access and access to clinical portal data by independent contractors;

- Continued deployment of Office 365 and associated automated workflows creating efficiencies throughout the organisation. Data migration from on premise to lower data centre footprint;

- Adopt a cloud first approach looking to introduce further efficiencies by migrating on premise services to public cloud, initial analysis will be carried out in the current financial year;

- For primary care further hosting of GP systems to alleviate the pressure to replace existing hardware and provide ubiquitous access to primary care systems; and

- A focus on further deployments of TEC to support the remote monitoring of patients.

**Summary of actions of Digital services:**

We will:

- Implement a highly resilient, scalable clinical portal solution and deploy licenses to all clinicians within acute and community providing the clinicians with secure access to a patient's medical record regardless of time or location.
- Deploy a comprehensive suite of TEC solutions, further deployment of NHS Near Me and complimentary 'apps' putting the patient in the driving seat of their own care and allowing clinicians to remotely monitor patients. This will minimise exacerbations and lower unscheduled hospital attendances while protecting both clinician and patient from unnecessary contact.
- Deliver a comprehensive infrastructure for general practice that will deliver more resilient bandwidth and Wi-Fi services to further enable remote consultation using NHS Near Me, and support MDT and CTAC working.
- Continue to fully deploy the Microsoft Office 365 product suite to enable efficiencies throughout the organisation and support remote working.

**Summary of revenue consequence:**

Affordability of this work depends on NHS Ayrshire & Arran's allocation of the Strategic Digital Fund as well as re-prioritisation of existing projects and resources.

# 20.0 Engaging with our Communities

## Overview

This section covers the following:

- Third sector engagement
- Communication
- EQIA
- Feedback and complaints recovery
- Visiting

## 20.1 Third Sector Engagement

Through the continued work of the Third Sector interface already being delivered within our communities we will commit to engaging people at a grass roots level. Through supporting smaller groups and organisations to flourish and find their voice we break down barriers and encourage people to develop their community participation. By building on the successful engagement rate of the COVID-19 Small Grants Fund accessed and awarded to local groups we will continue to develop strong pathways alongside communities who will contribute to the basis of our future health and social care system.

### EAHSCP

CVO East Ayrshire were successful in securing Wellbeing Funding for work specifically aimed at keeping well during COVID-19. Working in partnership with East Ayrshire Health & Social Care Partnership, CVO hosts TEC hubs in two of our buildings and have a team member who works on the Scottish Government TEC Pathfinders Programme. Through our learning in this area we have already began to embed digital approaches to care in service delivery. Well-being funding is being used to build an on-line tool kit, delivering life skills classes, training and home learning resources, activity programmes, group chats and well-being activities such as mindfulness or yoga. An example of some of the activities we have already delivered is the provision of enterprise packs to employability trainees which included ingredients and a recipe card with systematic instruction on how to cook a basic nutritious meal – the response to this has been overwhelmingly positive.

We will take a more human approach and include input from statutory and third sector partners on how they have cared for their own well-being during lockdown. Bearing in mind, a large number of our population suffer from digital poverty therefore a portion of the well-being fund is for the development of a lending library to allow us to reach more vulnerable community members, build digital skills and work towards a more inclusive

community. We will produce easy-to-use start up guides and our Community Connector service will distribute devices to users. This service will be available to individuals, groups and organisations who have members who are not digitally connected therefore promoting integration and inclusion.

Some of our team are already involved in the Connecting Scotland Digital Champion programme meaning that we are already ahead of the curve in this area. Upskilling the workforce in digital care has become a natural part of our work, with learning being shared across the organisation. The lending library and digital tool kit will serve as an excellent platform to continue to work from and develop as we progress with mobilisation plans. This facility will be accessible to those involved in health and social care delivery.

**NAHSCP**

The whole system dialogue - described in earlier phases - with patients, service users, staff and partners at a local Ayrshire and Arran and regional basis has continued. Existing relationships have been strengthened and new relationships have been formed.

From August 2020, the formal governance and engagement/participation arrangements across HSCPs and the Ayrshire mental health services will reconvene and remobilisation is on the agendas for the Integration Joint Boards, Strategic Planning Groups and pan-Ayrshire Mental Health Transformation Board.

**SAHSCP**

**Partnership working**
Numerous examples of good and improved partnership working have been highlighted in feedback; including more coordinated approaches being taken between agencies where multi-disciplinary working was required to ensure that service users were supported and had their needs met. The resilience and widespread support from community and third sector partners is of particular note. We will continue to build on this by supporting our partner providers, community and third sector resources and continuing to work in partnership in a proactive rather than reactive way and improving signposting to community services where appropriate to do so, instead of solely referring to social work.

## 20.2 Communication

Work is progressing well to deliver a Communication, Informing & Engagement Strategy with accompanying action plan for our mobilisation planning and recovery.

This action plan will seek to make use of creative methods of engagement that facilitate communication and engagement whilst still ensure that health and safety requirements and physical distancing is maintained and will build on our existing stakeholder framework established to support the Caring for Ayrshire Programme.

## 20.3 EQIA

NHS Ayrshire & Arran recognises that the remobilisation of our health and care services, whilst beneficial for both staff and service users, has the potential to have differential impacts on different groups in our community.

We are committed to ensuring that as we re-introduce our services in this new environment, we undertake Equality Impact Assessments to help us identify any potential barriers that new ways of working may present.

That will enable the appropriate steps to be taken to mitigate or minimise those impacts to ensure our services are as accessible as can be for our population over the next 9 months.

## 20.4 Feedback and Complaints Recovery

Ayrshire and Arran recognises the importance of maintaining systems for our patients and their families to share their experiences of care they have received during the pandemic. We have maintained our local feedback mechanisms, encouraged the use of Care Opinion and responded to complaints in order to learn from what has gone well and what we need to do better. We will continue to maintain these mechanisms and work towards pre-COVID-19 ambitions during August 202 – March 2021.

Due to the coronavirus pandemic a number of aspects of our Complaint Handling Process had to be altered and the following changes were made based on SPSO recommendations:
The 20 working day response target was extended to 40 working days
Cancellation of all face to face meetings with complainants
Suspension of weekly reporting to services on complaint activity
All new complainants were contacted by a member of the complaints team to try and resolve the issues before escalating to service managers for resolution.

- All live complaints received a letter explaining the delay. This was in addition to the normal letter complainants receive when a complaint will not meet the 20 working day deadline;
- All complainants were advised that unfortunately their complaint might take longer to respond to due to the current climate; and
- All complainants were contacted by a member of the complaints team at 20 and 30 working days to update them of the progress of their complaint response.

As a result of these measures, and a noticeable reduction in new complaints during the period March 2020 – June 2020, the complaints team were able to progress the following:

- Out of time complaints: the team were able to complete and close approximately 80% of all out of time activity;
- All Stage 1 complaints were handled by the complaints officers and closed within 5 working days; and
- Test of virtual solutions for complainant meetings.

In June 2020 complaint activity began to increase again and the following recovery plans is being implemented through to March 2021:

- Pre-COVID-19 complaint response times reintroduced for all new complaints from July 2020 and our Complaints Handling Process has now been fully reinstated; and
- Introduction of the NHS Near Me application to support virtual complainant meetings.

NHS Ayrshire & Arran is committed to learning and improving from feedback and complaints. Work has recently been carried out to improve our processes and to develop a more person centred and effective approach to how feedback and complaints are dealt with, and our commitment in the next 6 months is to continue this learning.

**Summary of actions for feedback and complaints**

We will:

- Fully re-instate the Complaint Handling Process with pre-COVID-19 response times
- Introduce NHS Near Me for complainant meetings
- Continue to maximise our learning from complaints and feedback

## 20.5 Visiting

Not being able to routinely visit and support loved ones in our hospitals has been distressing across our communities during the early stages of the pandemic. During this time NHS Ayrshire & Arran implemented the guidance from Scottish Government with regard to Stage 1 Essential Visiting and also responded in a person centred and compassionate way to individual circumstances when requests outwith this guidance were made by families.

On 30 June 2020 guidance was issued to NHS Boards from Scottish Government to support a staged approach to the reintroduction of visiting in hospitals from the pandemic Stage 1 essential visits in a safe and planned way. Stage 2 of a four staged approach was effective from the 13 July 2020 and this was safely implemented in NHS Ayrshire & Arran

To support the phased reintroduction of visiting in NHS Ayrshire & Arran, a Visiting Bronze team was convened with representatives from Acute and Community hospitals including Infection Control, Health and Safety and Communications. The team has considered the guidance in terms of interpretation, communication and implementation thus far for Stage 2 and we will follow this Bronze Team approach for the next stages as guidance is issued from Scottish Government colleagues from August 2020.

At this time this means that:

- One designated person (who is COVID-19 symptom free) is nominated to visit their loved one (this will change as stages are moved through safely);
- Visitors are asked to provide their contact details with these being recorded in the patient's notes for test and protect purposes;
- An appointment system is in operation to make sure we can accommodate a set number of visitors within the clinical areas, while observing physical distancing rules and enable cleaning time between visitors. Trakcare is being used to support the visiting appointment system; and
- Visitors are asked to observe hand hygiene guidance, two metre physical distancing rules and to wear appropriate PPE when entering the clinical area.

There has been a communication plan put in place consisting of the following elements and these will be refreshed for each of the next Stages as they are announced:

- Press statement and video from Nurse Director;
- Visiting leaflet based on a combination of National and Local guidance;
- Visiting poster for display in main public areas;
- Dining room and toilet posters for display; and

- Information for staff on the proposed changes including FAQ and Daily bulletin updates.

**Digital**

Patient facing apps combined with comprehensive TEC solutions can all contribute toward effective person-centred care by enabling patients to be in the driving seat of their own care with the ability to schedule appointments online, interact with clinical teams from the comfort of their own home and engage in providing feedback.

**Summary of actions for visiting**:

We will:

- Continue to implement the Scottish Government guidance progressing through the outlined stages to re-introduce visiting as safely as our recovery plans allow, to enable us to continue to protect our patients, staff and visitors from COVID-19.

**Summary of revenue consequence:**

None identified at this time.

## 21.0 Quality Improvement

### Overview

NHS Ayrshire & Arran has a strong focus on quality improvement and patient safety. Whilst we have continued to ensure our services are delivered safely for patients and staff through the initial COVID-19 response we did pause much of our quality Improvement work as we deployed staff to support clinical teams. As we move into this planning period we will see staff return to their quality improvement roles and we will restart a number of our programmes.

### Quality Improvement Mobilisation

Our clear aim towards March 2021, is to empower teams to lead their on Quality Improvement priorities in line with NHS Ayrshire & Arran's strategic direction and using our 4 pillar approach (Service People Quality Finance). The recovery plan focuses on three distinct phases; Recovery – a time to heal, Reset – a time to think differently and Re-launch – a time to work differently. Figure 1 describes our approach.

Key areas of work that we will restart are;

### Value Management Approach

- To refocus and achieve our original ambition of a VMA infrastructure the QI team will continue to support and empower teams to take greater ownership of the four pillars framework (Service, People, Quality, Finance) and drive their own improvement where capacity in teams allows
- Working towards March 2021 we will have reintroduced the VMA approach in already identified areas focusing clinical areas on improving the 4 pillars of people, finance, service and quality.

### Excellence in Care

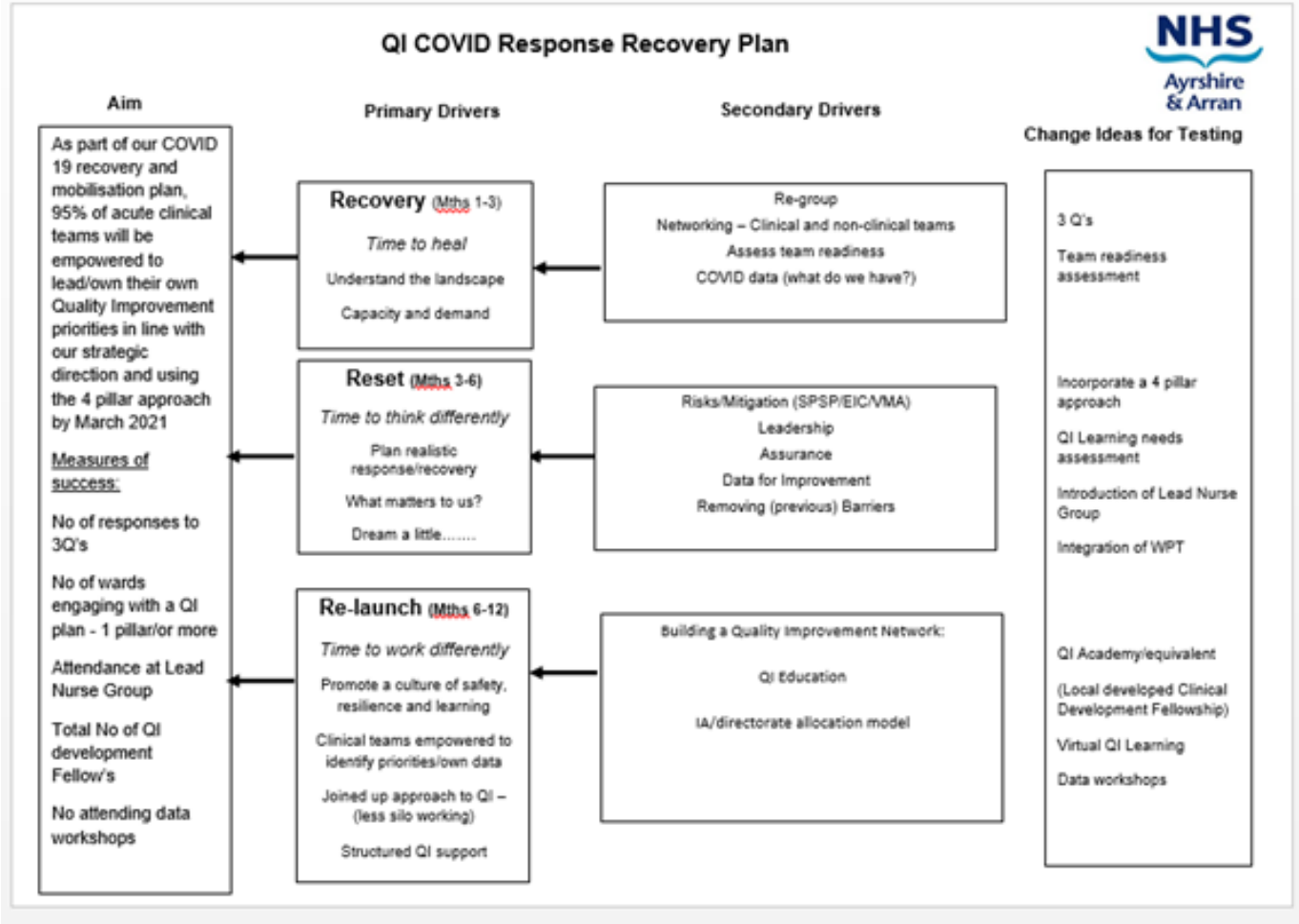
- Data submission will be recommenced on 1 August 2020. .
- The Acute Adult measures that will be restarted in August 2020 are:
    - Correct frequency or Early Warning Score
    - Accurate Calculation of Early Warning Score
    - Falls Rate
    - Pressure Ulcer Rate
- Working towards March 2021, the newly established Excellence in Care Implementation group will progress the implementation of the current and upcoming measures and prioritise improvement.

**Care Assurance**

- A tool has been tested across both acute sites and community hospitals. We are currently working with our digital colleagues to load the tool onto the clinical portal to allow reports to be generated and ensure robust governance. This will be ready for testing on 1 August 2020. The care assurance tool will be implemented, with the appropriate governance structures, by October 2020.

**Building QI capability and capacity**

- The QI team will have a clear focus on supporting remobilisation and reform. By December 2020, we will introduce a locally delivered education programme based on the Scottish Improvement Foundations Skills course as well as a bespoke Clinical Development programme with a focus on leadership and Quality Improvement to support change, service redesign and our new ways of working post COVID-19.


QI COVID Response Recovery Plan
NHS Ayrshire & Arran
Aim
Primary Drivers
Secondary Drivers
Change Ideas for Testing
As part of our COVID 19 recovery and mobilisation plan, 95% of acute clinical teams will be empowered to lead/own their own Quality Improvement priorities in line with our strategic direction and using the 4 pillar approach by March 2021
Measures of success:
No of responses to 3Q's
No of wards engaging with a QI plan - 1 pillar/or more
Attendance at Lead Nurse Group
Total No of QI development Fellow's
No attending data workshops
Recovery (Mths 1-3)
Time to heal
Understand the landscape
Capacity and demand
Re-group
Networking – Clinical and non-clinical teams
Assess team readiness
COVID data (what do we have?)
3 Q's
Team readiness assessment
Reset (Mths 3-6)
Time to think differently
Plan realistic response/recovery
What matters to us?
Dream a little.....
Risks/Mitigation (SPSP/EIC/VMA)
Leadership
Assurance
Data for Improvement
Removing (previous) Barriers
Incorporate a 4 pillar approach
QI Learning needs assessment
Introduction of Lead Nurse Group
Integration of WPT
Re-launch (Mths 6-12)
Time to work differently
Promote a culture of safety, resilience and learning
Clinical teams empowered to identify priorities/own data
Joined up approach to QI – (less silo working)
Structured QI support
Building a Quality Improvement Network:
QI Education
IA/directorate allocation model
QI Academy/equivalent
(Local developed Clinical Development Fellowship)
Virtual QI Learning
Data workshops

**Summary of actions for quality improvement:**

We will:

- Restart our three year implementation plan for Value Management with improvement activity refocusing clinical areas on the pillars of people, finance, quality and service during remobilisation.
- Integrate QI support with clinical teams supporting remobilisation and build QI capacity through coaching / education.
- Provide monthly monitoring and reporting, including improvement support for all SPSP and EiC measures thus providing quality assurance throughout remobilisation.

**Summary of revenue consequence:**

There are no anticipated revenue consequences associated with this work.

## 22.0 Finance

### Overview

### Primary, community and social care

Payments to GP practices in Ayrshire and Arran for staying open over public holidays in April and May amounted to around £0.7 million and a similar payment to pharmacists amounted to £0.3 million. Additional costs in GP practices for staff overtime, locum cover, equipment costs etc. was a further £0.8 million**. It is assumed that going forward the costs will be minimal unless there is a significant second wave over the winter period.**

A national group estimated that the impact of the COVID-19 pandemic on primary care prescribing volumes was a 1% increase therefore a cost of £0.8 million is included to reflect this, however in additional a price increase has been seen and this is estimated to cost an additional £5.2 million.

Scottish Government agreed with COSLA that any reasonable additional costs caused by COVID-19 (including staff absence) would be reimbursed to external providers (including care homes). Additional costs of local procurement of personal protective equipment for care homes as well as staff to backfill for sick staff and financial support for empty beds will be significant. These were time limited support although when they will be withdrawn remains uncertain. **Costs averaged about £0.5 million per month in the first quarter but are expected to reduce over the year, however are projected to total £3.3 million for the year.**

A community assessment hub for people with worsening COVID-19 symptoms was established at Crosshouse Hospital in March and in April a second hub was established at Ailsa Hospital. As demand has reduced the second hub has closed, however **it is planned to maintain one community assessment hub as part of managing unscheduled care flow of patients at a cost of about £1.5 million for the year.**

Loss of income to local authorities from not being able to charge for services provided is partially offset by reduced costs of those services, however physical distancing requirements will continue to restrict day care provision for the foreseeable future. **Costs of about £0.23 million per month for the first half of the year but are planned to cease as services resume in the second half of the year therefore an anticipated annual cost of £1.4 million**.

Influenza vaccination costs have not yet been incurred, but are even more important in the context of a potential second wave of COVID-19. The Scottish Government have therefore extended eligibility to over 50s (where previously over 60s). The delivery of flu vaccine will not be able to be done through GP surgeries due to physical distancing restrictions and about 50 WTE additional nursing staff and 20 WTE admin support will be required (at a **cost of around £200,000 per month**) to administer flu jabs in drive through facilities and community settings as well as utilising pharmacy practices.

Additional staff will be required to administer a COVID-19 vaccination programme vaccine becomes available. This is likely to be similar to the flu vaccination team above therefore at a **cost of £200,000 per month**. Additional care home and care at home capacity commissioned in March was important to reduce the number of delayed discharges in hospital in anticipation of an increased COVID-19 hospital demand and to prevent admissions to hospital. The costs of the people discharged will continue for some time as will costs for equipment and adaptations. It is important to maintain this low level of delayed discharges, however this should be on a more 'business as usual' basis going forward therefore **the £350,000 per month charged to COVID-19 in the first quarter should diminish significantly over the remainder of the year, however is projected to cost £2.1 million for the year.**

Social care employed staff have required to work overtime and donning and doffing PPE for community based staff is time consuming. **The cost of overtime and enhancements was £150,000 per month for social care staff in the first quarter and is projected at £1.7 million for the year.**

Savings plans for Health and Social Care Partnerships have been impacted by the pandemic with a **projected £2.8 million underachievement in the year**.

**Acute care**

Hospitals in NHS Ayrshire & Arran increased capacity for COVID-19 patients by tripling ITU capacity and opening additional beds, however this expansion largely used existing staff as a result of the cancellation of elective inpatients and day case surgery and hospital outpatient activity. Theatre nurses and anaesthetists were deployed to ITU while surgical ward staff were deployed to additional COVID-19 wards. During June and July most acute staff have returned to their core roles in preparation for remobilisation of outpatients, day cases and elective operations therefore the level of offsetting savings to cover the cost of increased ITU and ward capacity will reduce for the remainder of the year resulting in an increased net cost.

During the first three months of 20/21 about £6.4 million was charged to acute COVID-19 cost centres. Much of this was existing staff working in COVID-19 wards or ITU, or junior medical staff having training rotas changed to support medicine and these would have corresponding offsetting savings. There were net additional costs for medical and nursing staff to maintain separate red and green pathways through the acute hospital and there has now been some consolidation of these going forward (eg. Combined Assessment Units will handle both red and green patients). A COVID-19 positive ward will however be retained on both acute hospital sites with scope to flex up as required. Seven additional clinical fellows have been employed for six months to ensure that ITU can be at double capacity within a week and at treble capacity in two weeks, where nurse staffing can be flexed to a certain level (through use of nurse bank) beyond which elective surgery would need to be stopped.

**In the first quarter of the year the extra ITU beds cost about £2.3 million and general hospital beds about £2 million. From August to March, the additional 10 bed ITU capacity is estimated to cost £0.38 million per month and the 45 additional general hospital beds about £0.5 million per month.**

Much of the above acute hospital costs in the first quarter were offset by underspends in budgets where staff were redeployed from. In the first quarter there was over £5 million of offsetting savings. The main net additional cost in hospitals in the first quarter was for student nurses who were employed by Health Boards during April with **additional costs of over £0.6 million each month until August**. This cost and capacity reduces in September.

Other additional temporary staff incurred £0.7 million of costs in the first quarter of 2020/21. Bank nursing costs constitute a significant proportion of this, however this is expected to reduce to about **£200,000 per month** during the remainder of the year unless there is a second wave.

£8.3 million of planned cash releasing efficiency savings were not able to be implemented due to COVID-19 and are anticipated to be a shortfall at year-end as preparedness for a second wave and winter pressures such as flu will prevent consolidation of acute wards, reduction in use of gloves and other supplies etc. Property planned to be disposed of or rented out has been retained in case it is required for ward accommodation in a second wave and savings plans in Infrastructure and Support Services have been delayed**. Planned savings of around £0.8 million per month will not be able to be achieved.**

A range of health board staff have undergone induction at the Louisa Jordan hospital and a recently retired manager is the operations director. The only costs in the plan (**about £9K per month**) are for this retired manager, however should the Louisa Jordon hospital have to become operational then the costs of staffing would escalate.

Staff wellbeing hubs have been created in hospitals to support staff who are working long hours in gruelling conditions. This has been supported in the short term from charitable funds, but in the longer term may require exchequer funding.

**Supporting delivery**

Most NHS Personal protective equipment (PPE) is supplied from the national pandemic stock which was centrally funded, however Council and care home employed staff were to be supplied with PPE by their employer except if supply failed when safety net provision is available from a PPE hub. Costs to Councils in Ayrshire in April and May for **PPE is about £0.6 million per month** which reflects price increases and exponential increase in requirements to use PPE. A monthly cost of about £0.4 million is likely to continue for the rest of the financial year whilst COVID-19 is in sustained transmission within the community giving an **annual cost of about £5.4 million**. A business case for national procurement of PPE for council and care home employees may reduce this cost due to better rates being able to be secured due to volumes of purchase.

Laboratory testing capacity has had to be significantly increased to test for COVID-19. New equipment with a cost of £161,000 has been procured in the first three months of the year, however capital works to create a decontamination facility within the labs will be a £300,000 cost in the second quarter. Additional testing supplies costs are only £78,000 from April to June due to national provision of test kits. While this is expected to continue, testing costs are expected to rise significantly following expansion of testing of hospital and care home staff from June and July requiring increased microbiology staffing capacity at a cost of about £350,000 per annum. During the first quarter of the year staff from other parts of the laboratory were redeployed to assist microbiology laboratory with COVID-19 testing, however they are now needing to go back to their

routine roles. **Labs testing costs are expected to be around £80,000 per month.**

Expansion of COVID-19 antigen testing requires staff to carry out the testing. This may be done in a clinical or community setting, including drive-through testing facilities. **The cost of the testing team and occupational health support is estimated at £63,000 per month.**

Public health have been at the centre of managing the pandemic and staff were redeployed from sexual health, smoking cessation and other areas to staff a control centre, reporting hub etc. as well as some additional staff being engaged to support care homes. As part of the test and protect plans for the next twelve months, public health will need extra capacity in the Health Protection team to deal with outbreaks and extra staff for the reporting hub who notify test results and do contact tracing, at a **cost of about £60,000 per month**.

The cost of additional overtime from April to June was £0.6 million. Most of this was in Infrastructure and Support Services for estates, domestic and other logistical services. **Overtime costs should reduce to about £160,000 per month over the remainder of the year so long as a second wave does not occur.**

£10 million of COVID-19 funding nationally was prioritised for supporting hospices and NHS Ayrshire & Arran received £792,000 of this to cover the first quarter for the Ayrshire Hospice. This was mainly to compensate for lost income and shops should be opening, however there is expected to remain some impairment to fundraising for hospices for the remainder of the year, therefore **continued support of about £60,000 may be required.**

Ayrshire Cancer Support (ACS) provide a transport service for Ayrshire patients going for cancer treatment at the Beatson Oncology Centre. The costs of this service have escalated due to physical distancing as only one patient can be transported in a car where previously this could have been three. ACS have secured endowment and government grants to keep them going thus far, but a need for **£76,000 per month support in the second half of the year is anticipated**.

## Digital

The effective use of Microsoft Teams, other Office 365 components and remote working will create efficiencies both within the finance department and also the wider organisation.

## Summary of revenue consequence:

**Section 22**

| Finance/Other | Year to Jun | July to March | Projected Expenditure |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Hospice and Voluntary | 792 | 1,003 | 1,795 |
| Offsetting Savings | (5,090) | (3,200) | (8,290) |
| Unachieved CRES Health Board | 1,287 | 6,760 | 8,047 |
| Unachieved CRES HSCP | 1,017 | 1,777 | 2,794 |
| | **(1,994)** | **6,340** | **4,346** |

## Summary of Chapter Costs

| SUMMARY FINANCIAL TABLE | | Year to Jun | July to March | Projected Expenditure |
|---|---|---|---|---|
| Section | Name | £'000 | £'000 | £'000 |
| 2 | Public Protection | - | 84 | 84 |
| 4 | Primary Care | 1,459 | 6,452 | 7,912 |
| 5 | Community | 5,254 | 8,984 | 14,239 |
| 5 | Care Homes | - | 269 | 269 |
| 6 | New ways of working/ Systems transformation | - | 1,166 | 1,166 |
| 7 | Urgent Care | 4,351 | 7,681 | 12,032 |
| 8 | Access | - | 5,571 | 5,571 |
| 9 | Winter | - | 710 | 710 |
| 10 | Mental Health | 21 | 1,764 | 1,785 |
| 12 | Rehabilitation | - | 1,290 | 1,290 |

| | | | | |
|---|---|---|---|---|
| 13 | Public Health Core Function | - | 284 | 284 |
| 14 | Test and Protect | 136 | 1,797 | 1,932 |
| 15 | Vaccinations | - | 2,153 | 2,153 |
| 16 | Infection Prevention and Control | 2,319 | 5,006 | 7,326 |
| 18 | Workforce | 1,912 | 4,240 | 6,152 |
| 22 | Hospice and Voluntary | 792 | 1,003 | 1,795 |
| 22 | Offsetting Savings | (5,090) | (3,200) | (8,290) |
| 22 | Unachieved CRES Health Board | 1,287 | 6,760 | 8,047 |
| 22 | Unachieved CRES HSCP | 1,017 | 1,777 | 2,794 |
| | **Total** | **12,441** | **52,016** | **67,251** |

## Summary of Capital Costs

| Capital | Year to Jun £000 | July to March £000 | Projected Expenditure £000 |
|---|---|---|---|
| 2 x Centrufuge Labs | 8 | 8 | 16 |
| CMAC video laryngoscopes | - | - | - |
| CMAC video laryngoscopes | 9 | 48 | 58 |
| Maternity 7 X Fetal Monitors & 7 Labour Suite beds | 59 | 79 | 138 |
| Cardiology VSCanners | - | 12 | 12 |
| Cepheid Module Pathology | 65 | - | 65 |
| Ayr Microbiology Safety Cabinet | 9 | - | 9 |
| Safety Microbiology Cabinet XH | - | 9 | 9 |
| XH Haematology Centrifuge | - | 8 | 8 |
| XH ICU Transfer Trolley | - | 31 | 31 |
| Labs Clean Room 3 | - | 425 | 425 |
| 10 dialysis machines | 31 | 99 | 130 |
| Drummond / Buchanan fire safety works | - | 58 | 58 |
| Lochranza Chemotherapy Green area | - | 300 | 300 |
| | **181** | **1,076** | **1,258** |

## 23.0 Governance and Risk

This chapter sets out assurance that NHS Ayrshire & Arran has a whole system governance arrangement to ensure operational grip through this planning period as well as the ability to monitor and scrutinise delivery of this remobilisation plan. This chapter will cover the emergency management arrangements, NHS Board governance, IJB commissioning and risk.

## 23.1 Governance

**Structure of Emergency Management Team**

The Chief Executive established the Emergency Management Team and its supporting emergency management structures below on behalf of the Board to ensure that the health and care system was able to respond effectively and deliver services that were safe for patients and staff.

As of the 1st August the Emergency Management Team will be refocused.

The aim of the Emergency Management Team:

- Collective accountability for delivering on the mobilisation plan; and
- Provide collective leadership and effective response throughout winter.

In doing so will:

- Mobilise services safety for staff, patients and visitors;
- Respond to changing demand flexibly and effectively;
- Ensure a state of readiness;
- Ensure the ability to respond to the added demands of winter;
- EU Exit ready;
- Communicate effectively across the Health and Care systems; and
- Maintain an understanding of service response.

The EMT will continue to meet on Monday, Wednesday and Friday through to the end of March. Monday and Friday meetings will continue as managing the response and recovery to COVID-19. The meeting on Monday will be used to review activity over the weekend and plan for the week ahead with Friday's meeting being used to review the week and prepare for the weekend. The meeting on a Wednesday will focus on monitoring performance against the mobilisation plan, EU Exit and Risk Management.

## Overarching Board governance

At the NHS Ayrshire & Arran Board Meeting on Monday 25 May 2020, Members approved the recommencement of the Board's normal governance arrangements and return to the normal cycle of governance committees. The Board Chair and Chief Executive had reviewed the temporary corporate governance arrangements agreed by the NHS Board on 30 March 2020, to ensure a minimum period of pause. The interim temporary arrangements had paused a range of governance meetings and enabled a more flexible approach to NHS Board meetings if required, giving authority to the Chief Executive and Chair to call extraordinary meetings of Board or Governance Committees if required. This enabled the organisation to plan, prepare and respond to COVID-19 under emergency planning conditions. It has been agreed that the Board Chair and Chief Executive would keep these temporary arrangements under review.

Members recognised that the organisation is still working under emergency planning conditions and looking at next steps of mobilisation and recovery, they agreed however that we should bring forward, through the normal timetable, Governance Committees to deal with papers necessary to good governance, assurance, and legal and statutory requirements. Members agreed that where Governance Committees were not due to meet within the next six weeks, the Chair of each Governance Committee would discuss and agree with the Lead Director if there were agenda items that required consideration and whether a meeting should be arranged. It was agreed that additional meetings may be scheduled as we look to re-establish our committees in line with the normal timetable.

As we work towards a return to our normal timetable, Governance Committee and Board business may still be reduced and Members agreed that it will be acceptable for committees to receive verbal updates and only those papers necessary to ensure good governance, assurance and meeting any legal and statutory requirement. Committee workplans are being considered and adjusted as appropriate to ensure Members receive assurance about how we are conducting business and making decisions during emergency planning conditions and moving towards recovery.

As we continue to follow Government guidance related to physical distancing our Board meetings will continue to be held using Microsoft Teams videoconference, supporting our members to participate without coming together in one place. In publishing our Board papers, a note has been added to our to public website, advising our citizens that to comply with UK and Scottish Government guidance on physical distancing our meetings will not currently be held in public.

In resuming our Governance and Standing Committee timetable all requirements of the agreed Board Standing Orders will be

followed. Members were given assurance that any verbal items and discussions will be correctly and accurately recorded in the minute, as a recorded reference of the issue reported to committees.

As a Board we are considering how we can make our Microsoft Teams Board meetings accessible to the public and are liaising with colleagues nationally on a solution.

Similarly the three Integration Joint Boards have initiated interim governance arrangements with meetings being facilitated through tele / video conferencing. This has seen consideration of essential business including unaudited financial accounts and assurance in respect of COVID-19 response. The wider constituents of the IJBs have continued to engage through Strategic Planning Groups again utilising digital technology. Over the period August to March full governance committees will be reinstated when safe within physical distancing arrangements.

## 23.2 IJB Commissioning

During 20/21 there is a scheduled review of the Strategic Plans. The opportunity will be taken to develop these plans with clear commissioning intent supported by Directions.

To support whole system change, where appropriate, IJBs will co-ordinate Directions to deliver change through Lead Partnership Services or Acute services.

## 23.3 Risk

NHS Ayrshire & Arran has been planning, preparing and responding to the demands of COVID-19. As part of that response the Chief Executive established emergency management structures to ensure that the health and care system was able to respond effectively and deliver services that were safe for patients and staff. The Emergency Management Team (EMT) has co-ordinated the Board's response and throughout has considered the emergent risks and how they should be managed. This has been a dynamic process and continues to be a key part of the NHS Board's approach to the next phases of planning and delivery

NHS Board assurance for COVID-19 risks is provided through the Integrated Governance Committee. Membership of the Integrated Governance Committee consist of all NHS Board Governance Committee Chairs and the respective Executive Directors.

As we develop our next phase of mobilisation through to March 2021 we will ensure that we are identifying and managing risk to deliver services that are safe for patients and staff. We will also ensure we risk assess our buildings in relation to physical distancing. Moving to the 'new norm' will require NHS Ayrshire & Arran to plan for recovery to manage health and care capacity to meet our populations needs and to consider how we retain and build on the positive changes that have been made during this time.

As we move through our mobilisation phases it is inevitable that new risks will be identified. These risk will have an impact on areas such as; workforce, finance, digital, safety for staff and safety for patients.
In addition to previously identified risks, the Risk and Resilience Scrutiny and Assurance Group has identified a number of emerging risk during the meeting on 12 June 2020. The group considered a number of potential risks and have instructed the relevant directors to develop these risks further. Emerging risks are as follows:

- Failure to ensure continued support for care homes;
- Failure to have adequate planning data will lead to sub optimal planning across the health and care sector;
- Failure to adequately plan for meeting future COVID-19 demand and other clinically prioritised care will impact on patient care and staffing;
- Failure to embed new ways of working will lead to access challenges for patients and safe delivery of care;
- Failure to clinically prioritise planned care and manage patient and staff expectation will lead to patient and public frustration about the backlog of care;

- Failure to plan and recalibrate a service for reduced capacity driven by patients and staff safety will lead to unrealistic expectation of the recovery and remobilisation of health and care services;
- Failure to support staff will lead to higher levels of absence and dissatisfaction;
- Failure to effectively communicate with the public on the need to deliver health and care services differently will lead to reputational damage through complaints, concerns and adverse media; and
- Failure to recognise the cost of mobilisation and recovery will lead to financial overspends across health and care.

There is still uncertainty relating to the EU Withdrawal (Brexit). Information is limited and therefore various national, regional and local groups are continuing to develop strategies and business continuity plans to try to ensure essential services continue without or with as limited disruption as possible.

NHS Ayrshire & Arran has identified the following risk relating to EU Withdrawal (Brexit). The risk will be managed through the Emergency Management Team as part of our mobilisation planning and emergency management arrangements.

Inadequate post-Brexit arrangements may lead to difficulties with recruitment and retention, delays/inaccessible vital resources such as medicines and radioisotopes, inability to initiate and maintain essential patient treatments, inadequate skills mix of staff and inadequate medical supplies.

It is clear that COVID-19 has resulted in a different type of working environment from that which was previously in place. A key aspect of this is the requirement to minimise the risk of the spread of the virus by the implementation of physical distancing.

Physical distancing in the workplace and preparing for increased footfall within our premises 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 & Arran has completed a process to risk assess all our workplaces to ensure that we meet the requirements of physical distancing and where we are unable to do this, implement the necessary mitigation measures. This includes a focus on ensuring staff apply physical 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.

NHS Ayrshire & Arran has developed and approved a core set of principles and generic risk assessments which have been applied in a

variety of workplace contexts, assisting Directors in the recommencement of services.

As a result of this work, we are now in the position whereby responsible managers have completed the risk assessment process across NHS Ayrshire & Arran. Where remedial action is required this is being actively managed through a Task and Finish Group that was established to oversee the process. This has resulted in the Chief Executive being provided with the necessary assurance to enable the signing of the "Staying COVID-19 Secure in 2020" for display in the relevant premises.

**Summary of actions for governance and risk:**

We will:

- Continue to actively scrutinise COVID-19 strategic risks through the Emergency Management Team structure;
- Fully develop the identified emerging risks ensuring that we have suitable mitigation measures identifying and implementing further control measures where required;
- Continue to provide the Integrated Governance Committee and NHS Board with assurance that emerging risks are being considered and that agreed COVID-19 strategic risks are being actively managed; and
- Continue with the implementation of identified social distancing additional measures and develop/implement an audit process to measure the effectiveness of our mitigation measures.

**Summary of revenue consequence:**

Revenue requirements for this section are identified through the respective sections of the mobilisation plan.

## 24.0 National and Regional working

**Overview**

The challenge of COVID-19 pandemic is and will continue to pose a threat to the NHS over the coming weeks and months of 2020 and is likely to remain through 2021. As such the NHS will continue to work in an emergency planning environment focused on stratifying care to avoid loss of life and minimise harm to patients who have urgent and ongoing health care needs as well as to find a way to undertake and increase the level of routine care.

In planning for this, the West of Scotland Boards under the Mutual Aid agreement have considered and agreed a regional approach to a number of areas outlined below. The regional response is in line with the planning assumptions set out by Scottish Government to optimise what we can do collectively in these challenging times.

## 24.1 National Boards, Partnership working, Mutual Aid

Building on the effectiveness of the COVID-19 response and the expectations of the Cabinet Secretary of progress in implementing a consistent national approach to urgent care before winter (October 2020) the Boards within the West of Scotland continue to build on the collective position set out the in phase 2 mobilisation plans where the most important priority identified by the Medical and Nurse Directors going forward was to move from a model of unplanned attendance or assessment to one based on a planned appointed clinical system.

This requires the adoption of new models to support the urgent and emergency care response across the wider healthcare system encouraging joined up pathways and models of response to unscheduled care involving NHS24, SAS, GP In-hours, GP Out of Hours and Emergency Departments.

In line with the work being undertaken nationally, this is about the creation of a national 24/7 pathway with clear access to urgent care through 111, providing consistent triage then linked to local hubs for further clinical consultation and flow management locally if required. The Board plans set out the information in the relevant sections which will see the creation of MDTs to support the local hubs, with the hubs/ MDT providing virtual consultation to determine if face to face assessment is required and, if so, to make onward appointments to the hub or to ED or to direct to another

service. The initial focus is to provide a pathway into urgent care for those who currently self-present at ED (typically, 50-60% attendances), the ultimate goal is to develop a model across all urgent care that is 24/7, i.e. ED, MIU, GPs, SAS and to have made significant steps forward in implementing that by October.

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.

**Cancer and Scheduled Care**

During the first wave of the COVID-19 Pandemic specialty specific groups reviewed their pathways and altered their approaches to treatment to reflect this new and additional risk to minimise the risk of preventable harm and optimise outcomes, for patients requiring cancer treatment including surgery, systemic anti cancer therapies or radiotherapy. Much of this work was facilitated through the regional Managed Clinical Network and Multi-disciplinary teams.

In this next phase of mobilisation we will continue to follow the guidance set out in the *'Framework for Recovery of Cancer Surgery'* formulated by the Scottish Government COVID-19 Cancer Treatment Response Group.

It is recognised as surgery services increasingly enter into the recovery phase in the coming weeks and months there will be competing demands from various surgical specialties to gain access to a limited surgery resource. Each of the Boards within the West of Scotland have developed local clinical prioritisation groups to ensure fair and reasonable access to a limited surgery resource in terms of both hospital beds and elective green-site theatre capacity.

Whilst there is an expectation that all boards will upscale their elective cancer surgery capacity in the coming months to address the backlog there needs to be a recognition that there is a reduction in theatre capacity across the Boards and the region which will require cooperative working arrangements to be put in place to ensure patients with the greatest priority are treated and patients in Board areas seeing a higher level of COVID-19 admissions are not unfairly disadvantaged.

**Setting the Collective Response**

In planning for the next 6-12 months, recognising the above and uncertainty around COVID-19, we have considered five possible scenarios to determine our collective responses and actions. This work primarily relates to acute care and hospital services.

Our aim is to gradually and safely, increase the level of services provided for our population, building on our mutual aid agreement to provide the best level of service across the region whilst continuing to ensure outcomes from other life limiting or life threatening conditions is not impacted. In doing this we will also work with our partner agencies particularly SAS, NHS 24 and the NHSGJNH and NHS Louisa Jordan (NHSLJ) where required.

The scenarios identified are as follows:

1) The Rate remains below 1 and hospital and specifically critical care admissions remain on the current trajectory allowing us to steadily increase the level and range of services we offer.

2) Small localised outbreaks in areas within the region that requires the Board to have a focused response to testing, tracing and isolating with localised lock downs which may require hospitals services to be temporarily reduced or suspended and mutual aid is required across the boards to support and minimise disruption to the care of urgent patients.

3) Several areas show significant spikes that require alterations to patient flows and support from services from neighbouring boards to reduce disruption to access appropriate clinical care for urgent and planned patient care.

4) The rate increases and we face a similar situation to the first wave and we require to implement mutual aid across the system in relation to critical care, acute emergency flows at the same time maintaining priority 1 treatments/ interventions.

5) The second wave is greater than the first and there is full implementation of the critical care network plans and NHS Louisa Jordan is required to provide the support envisaged at the time of initial commissioning.

In considering these different scenarios we recognise in the period August 2020 to March 2021 these may be compounded by the increased unscheduled care demand routinely experienced in all hospitals in the winter period particularly if there is a combination of a significant flu outbreak, and low uptake of flu immunisation amongst higher risk groups.

Recognising the uncertainty the NHS is facing and in response to the above positions, under our commitment to supporting mutual aid across the region, a number of cross board approaches have been developed. This has involved working collectively to set out the direction for unscheduled and cancer and scheduled care across the region supported

by the establishment of a number of networks within the region, which are outlined in this paper. Supporting papers, setting out the detail of the working arrangements, are available. Within these documents the escalation approach is described and the expectation of support from NHS GJNH and from NHS LJ.

**West of Scotland Acute Care Network**

The Acute Care Network was established to allow us to plan collectively and coordinate action within acute services across the region during the COVID-19 pandemic when required. This group is linked to the West of Scotland Critical Care Network, taking cognisance of the changing position within critical care across hospitals and boards which was crucial during the first wave of the pandemic. Both of these networks are supported by the Regional Planning Team.

This network is set up with the remit to support and co-ordinate the collective emergency response to COVID-19 and to pressures in acute services when required. Weekly calls have been established with the Acute Directors or their nominated representatives to support closer working and more joined up approaches as well as to plan recovery and remobilisation together and share learning in these challenging times.

The frequency of meeting is determined by the level of escalation based on the level of COVID-19 admissions to the hospital or where acute emergency care services are under duress. The group is supported in its decision making through the collation of essential information agreed by the Acute Directors in relation to their Boards to allow a shared understanding of the position across the region to support, where possible, ensuring patients get access to the most appropriate level of care. This is based on the premise that we will have the ability to direct people to another site like diverting GP calls to different site or transfer of patients between sites to use the available capacity to greatest effect.

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 incident response; and
- have sufficient workforce.

This group will also identify when pressures are mounting that will trigger the need for national action and the implementation of the plans for NHS LJ in line with the position issued nationally during the first wave.

**West of Scotland Critical Care Network**

The Boards and Hospitals in the West of Scotland established a West of Scotland Critical Care Network early in the first wave of COVID-19 pandemic. This included establishing a daily critical care network teleconference call covering an agreed set of questions. The call allowed us to coordinate critical care services across the region during that period. This call is attended by an Intensive Care Consultant or Senior Charge Nurse from every unit which provides Intensive Care who is responsible for providing the essential regional activity information to allow an understanding of the position across the region to be quickly gathered to help ensure where possible patients get access to the most appropriate level of care. This network works on the premise we have the ability to transfer patients between sites to use the available capacity to greatest effect. Part of the West of Scotland Critical Care Network is providing a transfer team to support this when required. Going forward the role of NHS LJ in contributing ICU expansion, if any, will need to be clarified.

The daily activity monitoring provides a regional overview of critical care network activity and capacity on a daily basis and helps identify rapidly where Intensive Care Units (ICUs) may require support. This is also a platform for sharing issues encountered, successes and challenges for shared learning purposes.

When a strong regional response is required calls are scheduled for 1.30pm daily unless otherwise agreed by the co-chairs in discussion with WoS Board representatives. If occupancy in the 12 general ICUs is less than 140% of baseline and 80 or more staffed beds are available on a Friday then weekend calls are not be undertaken. However the information is still collated and shared across the region. The network chairs review the information and contact ICUs if there is a significant deterioration in capacity.

If less than 50 patients with COVID-19 are in ITUs, occupancy is less than 90% of baseline and more than 50 staffed beds are available then the weekly calls are suspended. Data returns continue to be collated, with the chairs reviewing the information daily and contacting ITUs if there is a significant deterioration in capacity.

Calls are suspended when the activity levels are within the baseline however the group continues to meet as required to share learning and consider the collated position and trend in activity. The daily call will recommence if it becomes apparent that the amount of COVID-19 activity

indicates an impending spikes or a second or subsequent surge, agreed with Medical Directors as 140% of baseline as the trigger point for the daily calls. The network reports to the West of Scotland Medical Directors in terms of governance.

**Regional Cancer Prioritisation, Scheduled Care and Diagnostics**

Building on the work undertaken in the first wave by the specialty specific groups through the MCNs and MDTs to review their approaches to treatment and prioritisation to reflect this new and additional risk the local clinical prioritisation groups in Boards will link with the Regional Clinical Prioritisation Group which has been established. This involves both senior clinical leaders and senior manager involved in managing cancer and access programmes in each Board across the region.

An overall governance and performance approach is central to implementation of the Surgical Prioritisation Framework within the West of Scotland. The development of this regional group will support the principles and aims of the Surgical Prioritisation Framework through the development of a planned approach to meet the needs of patients treated within the West of Scotland and ensure timely access to surgery.

The purpose of this group is to monitor performance against the approved framework and plan appropriate regional working where a risk has been determined. Boards will need to work together to collectively and collegiately plan access to surgery and this may require transfer of patients or staff (or both) to adjacent and or co-located Health Boards within the network.

Through the West of Scotland Surgical Prioritisation Group the aim is for patients to be treated and listed for surgery in order of clinical priority in the same way across the region to ensure equitability; working together to ensure patients are offered the earliest available appointment. This group will also consider how to maintain services and address the backlogs in the event of increased COVID-19 activity.

NHS GJNH will be an important participant in this group to ensure the capacity available at the GJNH can be maximised to support the treatment of patients within the region where surgery capacity does not allow this within the board of residence.

It is recognised that this is a challenging task, and there may be significant need for cross HB working and/or national support and rescue of some cancer services on a temporary basis. In doing this it will be important to use capacity most suitable to meet the clinical need; recognising the importance of the wider clinical team in supporting patient care post-operatively to optimise patient outcomes.

In terms of the wider planned care requirements to support outpatients and diagnostic investigation of patients the West of Scotland Boards are also considering the opportunities the NHSLJ may offer when not required to provide inpatient care to support the response to COVID-19. Some test of change have been carried out for orthopaedics and plastic surgery and the review of the learning from these will be considered to explore the wider use of this capacity to support outpatient activity as well as diagnostic capacity in the coming months.

Part of the work being undertaken across the region is reviewing the capacity and demand for diagnostic tests to support patient management. This work will be used to support the Clinical Prioritisation Groups locally and regionally and inform the dialogue with our primary care colleagues to use the available capacity to best effect.

## Summary of Potential Mutual Aid

Table 1 summarising the levels of potential support at each stage

| Responses | Scenario 1 | Scenario 2 | Scenario 3 | Scenario 4 | Scenario 5 |
|---|---|---|---|---|---|
| Acute Care Network | Planning and Monitoring Sharing Learning | Planning and Monitoring Sharing Learning | Monitoring need for escalation and supporting care as required | Escalation plans being implemented Supporting care as required | Full escalation and support across the system |
| Critical Care Network | Planning and Monitoring Sharing Learning | Planning and Monitoring Sharing Learning | Monitoring need for escalation and supporting care as required | Escalation plans being implemented Supporting care as required | Full escalation and support across the system |
| Cancer and scheduled care | Developing capacity plans and aligning demand based on clinical priority | Monitoring and supporting priority patients treatment where required | Monitoring and supporting priority treatment where required/ review reducing elective surgery activity | Supporting priority treatment only | Supporting emergency treatment only |
| Diagnostics | Developing capacity plans and aligning demand based on clinical priority | Monitoring and supporting priority patients treatment where required | Monitoring and supporting priority treatment where required/ review reducing elective diagnostic activity | Supporting priority diagnostics only | Supporting emergency diagnostics only |

## Mitigating Risks and Rate Limiting Factors

Recognising we are managing a situation where COVID-19 is endemic in the population and is likely to remain for the foreseeable future it means that we may face a number of challenges across the services where parts of services may be temporarily reduced or suspended because of staff also getting infected. This requires us to have the agility and flexibility to support care for the most critical patients at any time and this may require a greater level of cross board working than we have required to date.

Also recognising the levels of demand for services particularly during the winter period could prove challenging based on past experience it is important that we recognise what we require to do to sustain capacity to respond to rapidly changing numbers of COVID-19 patients and emergency demand.

Key to this are:

- Use the data to provide an Early Warning System to guide our decision and levels of escalation linking also with SAS and NHS 24 to use the data they are also gathering to ensure we can monitor the position and identify patterns that are causing concern to trigger our collective response;

- Shared understanding of the capacity we have to support care recognising the need to keep capacity to support an ongoing level of COVID-19 patients both in terms of critical care capacity and respiratory care. This is particularly important as we build our surgical capacity to ensure we have the agility and flexibility to adjust quickly to changing situations minimising the level of disruption this could cause;

- Having a clear strategy for testing and a framework that sets out the different levels of testing and response at different levels of escalation;

- Further work is planned to explore mutual aid to support resilience across the region recognising the different levels of risk in the scenarios outlined above for our Test and Protect Services in relation to demand and capacity, particularly recognising the similarities of some of the symptoms between COVID-19 and flu. Consideration will be given to a developing a framework of response to manage the different risks that might arise especially if we return to scenario 4 or escalate to scenario 5;

- Ongoing education and training of staff will be required to maintain and enhance the wider team development, working to cope with the increase in clinical activity in the critical care areas, and beyond

(e.g. early CPAP in ward areas). Consideration of critical care nursing skills becoming more generic within the workforce would also be beneficial;

- Being clear about the PPE requirement and supplies availability to support acute/ critical care as well as elective activity especially as we increase our endoscopy capacity where there is a heavy requirement for PPE- visors and gowns; and

- Recognising the importance of Pharmacy and Medical Supplies to all aspect of patient care covered in this paper it is important that consideration is given to how the Pharmacy teams work together to support the necessary input to patient care, particularly in areas where there is a small cohort with specialist knowledge and skills such as for critical care.

To prepare for any further potential surges in COVID-19 activity across the region medicine supplies require to be coordinated centrally as Boards will reintroduce services at varying levels. This needs to consider NHS Boards reporting medicine supply levels and potential related planned activity to a central point. A list of the most commonly used drugs and level of stockpile agreed in terms of quantity, location and access to ensure if scenario 5 comes about there is sufficient stock around to meet demand.

Clearly defining future mutual aid to support cross board working in managing the supplies would be helpful this should consider agreement that medicine supplies are co-ordinated across Scotland and supply follows the patient need.

## Appendices and Addendum

## Appendix 1 – HSCP Care Home provision

## EAHSCP

Care homes provide a vital element in Health and Wellbeing contributing to an outcome that people, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting.

We currently have nineteen Older Peoples Care home providers in East Ayrshire. (2 residential, 4 nursing and the rest have dual registration) and four registered providers for Adults (usually under 65) and a specialist veterans provision through Combat Stress.

The combined capacity of the older peoples care homes in in the region of 875 beds, (with average utilisation of 660 beds. Care is provided in care homes when needed and usually without delay based on assessment for people who are unable to manage at home or for whom after a period of treatment in hospital, are assessed as requiring ongoing care in a residential setting.

Ensuring continuation of this person centred balanced approach is essential during our mobilisation plan from August.

Key deliverables March to August 2020 which will continue from August through March 2021.

The majority of Care homes remained open for admissions of new residents, this allowed us to ensure care continued to be provided at the right place and time and with very few days in hospital beyond the clinically Ready for Discharge date, and where this did occur it was usually to accommodate testing and safe transfer to the care home. This also enabled people to be admitted to their first choice of care home for the vast majority of cases.

Care homes commissioning retained sufficient capacity to ensure timely admission from community or hospital further preventing any pressure on Acute Hospital flow.

* Respite services purchased from care homes have been retained and increased to enable timely and adequate capacity especially to support the cumulative impact of the pandemic on carers.
* Commissioned Palliative Care bed in a care home setting for end of life care in the Southern Locality to avoid hospital admission/timely discharge
** Additional capacity of 16 Care Home beds were purchased
** Additional capacity of 12 Residential beds was commissioned but was not required and can be mobilised with 48 Hours notice.

**Local Enhanced Professional Clinical & Care Oversight Group has been established and will continue to deliver its oversight function and by providing enhanced support to the sector through training, learning, development and specialist support such as the specialist roles mentioned below. This group has assigned roles to the Senior Nurse and a Senior SW Manager. These roles will require the capacity to deliver their oversight visits on an ongoing basis (cost tbc).

We've retained our Community Elderly Mental Health Liaison Nurse for Care Homes and have identified through the mental health mobilisation plan the need for ANPs in this speciality, additional equipment to support assessment at home/care home.

A new Care Home Liaison Nurse role was initiated should care homes require clinical nursing advice or guidance at any time, this dedicated community nurse role will work very closely with the newly appointed associate nurse director for Care Homes.

Provided a PPE Hub 'hotline' and responsive service.

The pan-Ayrshire Enhanced Care Home Learning & Improvement Group, led by public health meets on a weekly basis to discuss current issues and how to support care homes

Local and national guidance has been distributed through the Health & Social Care Partnerships to Care Homes throughout the pandemic. Each guidance was accompanied by dedicated group and or individual discussion and FAQ/ summary of key points.

Most recently the introduction of Visiting Guidance has required the development of Risk Assessments from Each Provider and this was supported by HSCP Commissioning and Health & Safety services. Providers have also been supported to develop their Business Contingency Plans in line with the threat of COVID-19, indeed this has been further supported by Workforce Sustainability Guidance developed by our Workforce Development Team.

Intensive support to care home managers through networks, relationships, cooperative working

Examples include:

- A single point of contact number was put in place for care homes to access clinical or nursing advice directly from the Hub for COVID-19 concerns or from an OOH GP/ANP for any other concerns. Care homes are accessing this service regularly; and
- Minimum of Weekly conference calls for Care Home Managers attended by stakeholders associated with care homes, including Senior Manager, Head of Service, IJB Chief Officer, EAC Chief

Executive, Commissioning Officers, Care Inspectorate, Scottish Care, Public Health, District Nursing, Senior Nursing, Pharmacy and many others this provided real time discussion problem solving and support.

These calls were further enhanced by daily telephone contact to each care home by stakeholders, two very active WhatsApp groups one for clinical questions and the other for all other COVID-19 related business and networking as well as increased frequency of the Providers Forum using Zoom. This provides an excellent opportunity for providers to discuss latest developments and consider practical application of new policy and/or guidance with the support of invited thematic specialists.
Dependencies

Further development of mutually supportive partnerships with Care Home Providers promoting resilience/self-sufficiency and independence enhanced through networking and developing relationships. By changing the way we interact and the way we monitor to a more developmental and outcomes focused model we have transformed the provider group into more of a community with the benefits no more evident than during this COVID-19 crisis.

The Care home sector nationally has been under media scrutiny which at times may have led to negative public perceptions of the overall quality of care provided this needs balanced to ensure sustainability and further development of the sector as a whole through promotion of quality of care, sustained investment for financial viability and general promotion of quality achievements such as CAPA, My Home Life and others

Funding to continue items above* or commission**responsive service model based on the last 4+ months experience.

Financial concerns for care homes due to COVID-19 response have been addressed by adhering to the National Principles for Sustainability Payments to Social Care Providers. This financial support has been extended from 30th June to 31st July. Demands on care homes beyond this date will remain extensive to comply with all monitoring and reporting examples of the demands include new visiting models, new risk assessments, new testing regimes, reduced occupancy levels, increased communication with relatives, less relatives involved in care provision as a result. An extension of this fund to March 2021 would be welcomed.

Care homes are concerned about the impact on their core care capacity and the overall impact on their staff physical and mental wellbeing. They welcome continuation and expansion of staff support services, volunteering roles, reinstatement to the full model of care enhanced by many of the areas developed in the community that they and their residents have been unable to access. The East Ayrshire IJB has agreed to prioritise workforce

and community wellbeing and investment in this as part of its plans for recovery and renewal.

**SAHSCP**

South Ayrshire currently has a total of 31 registered care homes including 3 which are Council operated service and the remaining 28 are external provision:

- 6 of the external provision are registered as older people (65 and over) but can accept adult placements (under 65);
- 1 of the external provision specialises in adults and older people with Learning Disabilities;
- 3 of the external provision is registered as residential care only
- 2 Council operated services;
- The combined capacity of the older peoples care homes including in-house and external provision is in the region of 1114 beds. Care is provided in care homes when needed and usually without delay based on assessment for people who are unable to manage at home or for whom after a period of treatment in hospital, are assessed as requiring ongoing care in a residential or nursing care home setting;
- 1 of the Council operated service is registered as a care home, however, the service delivery model is respite for up to 4 individuals with Learning Disabilities/ Autism /Physical Disabilities;
- 4 of the external provision is registered as a care home, however, the service delivery model is supported living, residential care and respite care broken down as follows:
    - 1 is a service that provides supported living care to people who have a tenancy within a complex;
    - 2 services are both residential care for people with Learning Disabilities, who are older and some also have dementia up to a maximum of 20 places;
    - 1 service is a respite unit that can support up to 8 people with Learning Disabilities/Autism support needs; and
    - 1 service is a residential support unit that accommodate 9 service users at a time.

From March 2020 a range of structures and processes were put in place to support care home providers and to offer assurance to the partnership around care homes' ability to cope with additional pressures placed on them. Early on, the partnership placed an emphasis on supporting and maintaining good engagement with our care home providers in the area and we have built extremely strong relationships with care home managers and Scottish Care reps.

Our approach has been built on a sense of partnership and collaboration and our engagement with care homes has included the following continuous activity:

- Weekly calls with all care home providers and relevant HSCP management staff, chaired by the Head of Adult Services;
- Regular email bulletin from the HSCP commissioning team outlining local updates, signposting to new national developments (e.g. guidance and legislation) and offering general support;
- Regular calls from a member of the District Nursing Team (often daily) to offer clinical guidance and support. Areas of support include: PPE, educational needs, emotional support, symptom control and palliative medicine support;
- Maintenance of a staff bank;
- GP Practices are largely aligned to particular Care Homes to ensure better continuity of clinical support. GP Practices (GPs, ANPs and wider staff) work alongside HSCP staff (e.g. District Nurses, AHPs) to ensure co-ordinated care. GPs are actively in contact with their aligned care homes and supporting through remote means or, where appropriate, in-situ;
- Open lines of communication and regular liaison with the HSCP commissioning team; and
- Support visits and support to resume visiting of residents.

The HSCP plans to build on all of the good work established over recent months to institute a new approach to quality assurance of registered services within South Ayrshire.

One challenge the partnership has faced is around testing which was, initially, markedly low. We identified a number of factors driving this low return, including the complexity of navigating the various testing routes available, some logistical problems with delivery routes being established, concerns around staff being taken away from their working duties (e.g. if they are not close to a testing site and need to spend time travelling) and, in a small number of cases, refusal to take up the offer. Most of these challenges have now been addressed and testing numbers within South Ayrshire increasing – we will continue to encourage further uptake.

**NAHSCP**

Within North Ayrshire the HSCP operate and manage an older people's residential care home on the island of Arran which is a 30 bedded site and within the Kilbirnie area, an older people's Residential Dementia Respite unit which has 14 beds and an Adult complex care unit, in Irvine, which has 6 beds.

Within the independent sector there are 17 Older People's care homes across the localities of North Ayrshire including the island of Arran, (4 are Residential, 5 are Nursing and 8 are Dual Registered) and 6 registered providers for Adults including one situated on the island of Cumbrae.

The combined capacity of the older people's care homes is in the region of 913 beds. Care is provided following a needs-led assessment where it has been identified that the individual can no longer live safely at home and requires ongoing care in a residential setting.

Public and provider perception has been adversely affected by the impact of the COVID-19 outbreak on care homes and families may be resistant to using these in the future. This may increase the levels and complexity of individuals requiring support at home, which will further reduce the numbers and patient flows across the system.

The District Nursing service has continued to provide essential visits and telephone support to individuals living within care homes.

Assurance Visits to care homes were undertaken by two identified NAHSCP staff across 26 care homes within North Ayrshire. 19 of those being Older People's care homes and 7 being Adult care homes.

From August to March 2021 support to Care Homes will be enhanced by the following actions:

- The Care Home Liaison will increase the number of visits to care homes as lockdown restrictions ease however it is anticipated that support required by care homes is likely to increase as a result of the complexity of individuals, the requirements placed on care homes to meet increased standards and workforce considerations;
- There will continue to be utilisation of telephone support by care home liaison and essential visits by the DN service. However, month on month there will be a steady increase of care home visits by the care home liaison nurses with the easing of lock down restrictions;
- It is envisaged that DN activity will increase (increased housebound patients, increased requirement for long term condition management, and increased palliative care implementations) and the capacity of the DN service to provide extensive and complex interventions to nursing homes (excluding residential homes) may be affected;
- Administrative support will continue to be available to care homes until the 31 March 2021;
- Our Care Home Social Work team will continue to undertake reviews of service user needs with more on-site reviews being undertaken as lockdown arrangements ease;
- Fortnightly meetings with all care homes will continue to be facilitated by HSCP Service Leads and Commissioning Team; and
- We will utilise the funding provided via Chief Social Work Officer route to appoint a team manager to enhance HSCP management capacity until the end of March 2021.

# Addendum to the Remobilisation 2 Plan submitted to Scottish Government on 31st July 2020 by NHS Ayrshire & Arran.

## Introduction

On 31st July 2020 NHS Ayrshire and Arran submitted their Remobilisation 2 Plan to Scottish Government. An update was required to some of the financial information, therefore a further amended version was submitted on 18th August 2020.

This plan was accompanied by a second document which was in response to the letter from the Scottish Government Mental Health Directorate. This additional document is currently being reviewed following feedback from Scottish Government colleagues and will be published in due course. On publication this additional document will form an integral part of the Remobilisation 2 Plan.

Since submission of the Remobilisation 2 Plan on 18th August further developments have taken place in a number of areas. This additional information is provided below in respect of the following sections:

**Section 6.0:** Redesigning Urgent Care

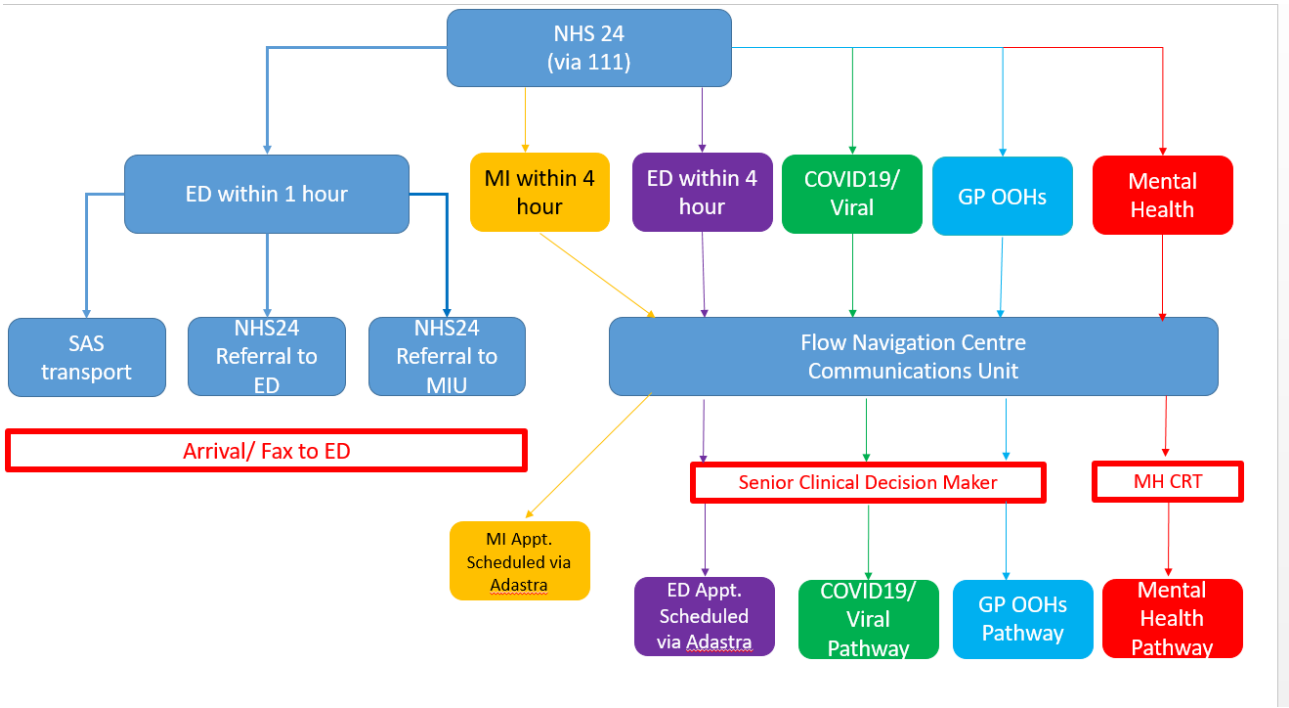
**Section 8.0:** Planned Care including cancer services

**Section 10.0:** Mental Health

**Section 14.0:** COVID-19Testing Programme Service and Test and Protect

## Addendum to Section 6.0: Redesigning Urgent Care

Work described within our Remobilisation 2 Plan on Redesigning Urgent Care continues. In addition to that described within the document the following diagram provides an overview on the design of the Flow Navigation Centre. This should be viewed in conjunction with the various sub-sections within Section 6.0 to understand the overall redesign approach.




The Flow Navigation Centre Communication Unit will be managed as an administration function with call handler support 24/7. Cases received from NHS24 will come through the Flow Navigation Centre in a recommended set pathway based on NHS 24 clinical triage. Clinicians, either located in the Flow Navigation Centre or by accessing remotely, will carry out a further clinical assessment from these pathways.

It will build on the existing function of Ayrshire Urgent Care Service and established Covid-19 respiratory hub where the infrastructure, support team and established systems are already in place. Additional workforce will be identified across the system as a multi-disciplinary workforce from primary and secondary care to cover on a 24/7 basis to deliver on the extended pathways within the Flow Navigation Centre.

It is recognised that through daily feedback and reporting from across the system the model will require to be flexible and processes around pathways adjusted. This will include feedback from GP Practices and wider independent contractors where patients may be re-directed to.

Management and clinical leadership arrangements for the Flow Navigation Centre are being integrated into the current Ayrshire Urgent Care Service.

**Addendum to Section 8.0: Planned Care including cancer services**
**Update to Introductory Section**

As at the end of July the following information was correct.

*Following this process, a total of 27 outpatient services, 7 surgery services and 12 supporting clinical services have been re-started as at 20 July.*

This information has now been updated as follows and should replace this paragraph.

*86 outpatient services, 10 surgery services and 19 supporting clinical services have been re-started as at 07 October.*

**Update to section 8.1 Cancer**

Further to the work described within the Remobilisation 2 Plan submitted in July 2020 when the backlog of cancer surgery had been addressed, there have since been some changes in demand for these services. With the re-start of Endoscopy in particular, we are beginning to see an increasing number of patients being diagnosed with cancer. A small waiting list of patients awaiting surgery has started to develop due to this increase in diagnoses and operating theatre capacity is being allocated and deployed accordingly to minimise the waits for surgery.
Additionally, Breast Cancer services at GJNH which were planned to start in August have commenced.

**Update to section 8.2 Inpatient and Daycases**

Further to the work described within the Remobilisation 2 Plan submitted in July 2020, Inpatient and Daycase surgery was expected to reach 50-60% throughput. The most up to date position is that this has reached 61% (mid-September).

In addition, further progress has been made in gaining agreement on service provision from NHS Louisa Jordan. The following areas have plans agreed for some services to be provided at NHS Louisa Jordan:

- Dermatology;
- Gastroenterology; and
- Orthopaedic shoulder and hand clinics.

**Update to section 8.5 Diagnostics**

Since July, funding has been identified to increase CT staffing to run additional sessions. These additional sessions will be undertaken where staffing is available. There has been a delay to the national roll out of Colon Capsule Endoscopy / Cystosponge service which has come to light since the submission of the Remobilisation 2 Plan and definitive timescales are not known at this time. This should be taken into account when considering the information in this section of the Plan.

## Addendum to Section 10.0: Mental Health

In addition to that described within our Remobilisation 2 Plan the following information should be considered.

The Mental Health plan was outlined in 2 stages, the first stage outlining provision from June 2020 to August 2020 and the second stage from September 2020 to March 2021.

The first phase plan outlined our mental health baseline provision and provided detail how we were responding to immediate needs (COVID-19 direct, and non-direct). The next phase of mobilisation takes account of the learning from COVID-19 response so far, and covers August 2020 to March 2021. The plan illustrates, in alignment the development of new ways of working and innovations in service delivery, which will be delivered on renewal and redesign.

### Key deliverables actioned - June-August 2020

The following areas have been implemented across the totality of mental health services to ensure that service mobilisation from 1st of August 2020 was implemented effectively.

- Inpatient services have continued to be delivered throughout the COVID-19 outbreak,
- Community Services operated a tiered staffing shift system to maximise use of space and delivered services throughout the COVID-19 outbreak,
- Every patient and service user was assessed for current risk or vulnerability and frequency of required contact agreed,
- Shielded patients prioritised and received a weekly contact/check-in,
- Engagement with staff-side organisations and O&HR colleagues considered how best to maximise use of our staffing resource without increasing risk of transmission. Services continued to adapt shift patterns and tolerable levels of staffing in line with guidance from Government,
- Wellbeing hubs for staff have opened and on-line support resources are available. These continue to be evaluated,
- Use of digital technology such as NHS Near Me, Microsoft Teams has been optimised to support screening/ referral meetings and physical distancing across all services,
- Evaluation of available estate for administrative work and clinical work to ensure physical distancing in place,
- Monitoring of access to public transport within our remote and rural communities and wider Ayrshire region to ensure that any change in service provision is accessible,
- Joint transition planning continues between children's and adult services to ensure that the delivery of alternative service options is aligned with identified need.

The pandemic has fundamentally limited the progress we have been able to make in recommencing face to face services, treatment and care approaches in implementing some aspects of service detailed in the second phase of our plan.

The gradual re-introduction of face to face services will continue to be closely monitored to ensure it continues to be in line with Scottish Government guidance as this develops with the state of the pandemic.

**Expected Demand**

Scottish Government acknowledge that mental health will be an area of demand growth post-COVID-19. It is anticipated that demand for the overall service will increase by at least 4% as we move out of lockdown back into the “new normal”.

Anticipating this potential surge in referral and demand across the whole mental health system, requires us to continue to consider new, effective methods of delivery. However, even with new ways of working, there will be significant additional resource required to continue to meet this expected growth in demand as a direct result of the pandemic.

**Key deliverables – September 2020 onwards**

- We will continue to ensure a focus on whole system working for mental health services going forward, engaging and working with IJBs, the third sector, primary care, unions and service users/ carers around mental health plans and how they plan to work in partnership with them going forward,
- We will continue to work with the support provided from Scottish Government to implement the plans,
- We will continue to ensure arrangements are in place to support staff and carers mental health and wellbeing,
- We will continue to model demand in liaison and with input from Public Health & Health Improvement Scotland,
- We will continue to link with GP and unscheduled care services such as NHS24, to enhance key programmes of Pan Ayrshire multi-agency work – particularly the delivery of the Mental Health assessment unit, address suicide prevention, distressed young person’s pathway development, health and homelessness and drug death prevention forums linked to Alcohol and Drug Partnerships (ADP),
- We will continue to create capacity through use of new digital approaches and new service models, new ways of working

## Addendum to Section 14.0: COVID-19Testing Programme Service and Test and Protect

Update to section 14.1 Test and Protect Contact Tracing

### Contact Tracing Staffing Levels

Reviewed the need to ensure our Public Health team are supported and can meet the requirements, as such we have established a roster that will plan the staffing for 4 weeks ahead. In order to meet the requirement for 14 core contact tracers working across a 12 hour day seven days per week we have assessed the need for 24wte staff. We have identified and trained a further 28 staff who can be deployed within 24 hours.

Update to section 14.2 COVID-18 Local Outbreaks

### Testing

As a vital part of our overall Test and Protect programme our testing capacity is increasing in line with demand to ensure we meet the needs of the citizens of Ayrshire.

Changing policy for mobilisation of services and asymptomatic testing for pre-operative and pre-diagnostic patients has increased substantially over the last month. This is particularly pertinent where there are complex cases and testing is required to be done in their own home. This takes considerable time to arrange and undertake. This asymptomatic testing is pivotal to the restart of services and the overarching safety of our patients. In order to meet these demands we have established a second testing site in the South of the Board's area to meet the demand of drive through testing.

Given the increasing demands on our Testing Service and the imminent return of students to UWS and Ayrshire College as well as the need to support businesses as they return and vulnerable places we are scoping what additional test and protect resource may be required.

### Screening Services

We see the restart of screening services as requiring strong programme management. The national route-map for screening is guiding our actions with regard to remobilisation. Screening coordinators are working with the Clinical leads across each of the 'paused' programmes on the restart and this is a significant workload. Some programmes were already part-way through changes to their core model when the pandemic began, Our overall assessment is that we can cautiously progress but those programmes which are delivered within a primary care setting face particular challenges as a result of the combination of social distancing, infection control and wider service pressures across primary care services.

**Surveillance analysis and monitoring of local data**

This enables identification of ‘hot-spots’ of infectious disease and gives early warning analytics. It also allows us to model evolving trends. This will support our response to manage the impact of the COVID-19 pandemic on health and social care services as well as across our resilience partners and the wider community.