NHS LANARKSHIRE RESPONSE, RECOVERY & REDESIGN PLAN

Version 2.1

4th June 2020

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In response to Scottish Government (SG) guidance this is the second version of the NHS Lanarkshire Response, Recovery and Redesign Plan. This will be developed over the coming weeks on receipt of further SG guidance.

1.0 INTRODUCTION

The NHS Lanarkshire Response, Recovery & Redesign Plan (RRR Plan) is a whole system plan for Health and Care Services in Lanarkshire and reflects the response to COVID-19 from NHS Lanarkshire, North Lanarkshire Health & Social Care Partnership and South Lanarkshire Health & Social Care Partnership. The development of the RRR Plan has been an iterative process, building on the "response" position detailed within the NHS Lanarkshire (NHSL) Mobilisation Plan (versions 1.0 to 9.0). The Area Partnership Forum and Area Clinical Forum have contributed throughout the development of the Mobilisation Plans and will continue to contribute to the ongoing development and implementation of the RRR Plan; chairs of both are also members of the newly established Response, Recovery & Redesign Oversight Group (section 1.3.1, below).

In response to the global COVID-19 emergency, extraordinary reorganisation of local services has taken place in Lanarkshire leading to a number of remarkable achievements. The scale of such rapid and significant change has been challenging and, across the Health and Social Care system in Lanarkshire, we have seen exceptional work from individuals and teams. As we enter into the recovery and redesign phase, work is underway to retain and build on these positive changes and on the innovation and transformation that has been achieved, while maintaining a focus on quality and safety.

COVID-19 it likely to be with us for some time and, as we move forward, planning is underway to ensure that we achieve a balance between maintaining a significant COVID-19 response in line with modelling assumptions alongside a commitment to provide safe primary and secondary care. This will be undertaken while establishing capacity within the system to safely and incrementally recover services which have been paused due to COVID-19. Significant work is also underway with partnerships, local authority and NHS staff to provide: ongoing support to the care home sector; mutual aid and regional working; separation of COVID-19 and non COVID-19 treatment pathways; and utilisation of national facilities.

1.1 National/Regional Planning Context

There are a number of key principles which form the basis of NHS Lanarkshire's Response, Recovery & Redesign Plan, which have been developed in partnership with West of Scotland (WoS) Regional Planning and National Planning approaches. This Plan has been written in the context of remaining within COVID-19 emergency planning arrangements.

There are a number of necessary conditions to support the Health and Care system to commence re-mobilisation of elective services to resume a level of activity, whilst recognising that the Health and Care system will need to have a responsive capacity to meet the ongoing demands of COVID-19. The Planning Principles, Necessary Conditions and Risks & Mitigating Factors are detailed at Appendix 1.

The challenge of the COVID-19 pandemic is and will continue to pose a threat to the NHS over the coming weeks and months. As such, NHS Lanarkshire remains in an emergency situation 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 finding ways to undertake safe routine care. Details of Risks and Mitigating Factors are also listed at Appendix 1.

1.2 Local Planning Structure

1.2.1 Response, Recovery & Redesign Oversight Group (RRROG)

In response to the need for significant capacity to be realised across NHS Lanarkshire to deal with the predicted numbers of COVID-19 patients who will require care, a data capture exercise was undertaken. The aim was to ensure effective governance was maintained in what was a rapidly changing situation, impacting on almost all Health Operational Functions within NHS Lanarkshire and leading to disruption to the delivery of service processes.

To ensure the organisation was well placed to recover at the earliest opportunity, Pandemic Response work was undertaken in relation to capturing COVID-19 Clinical Service Models Reconfiguration and Recovery Plans.

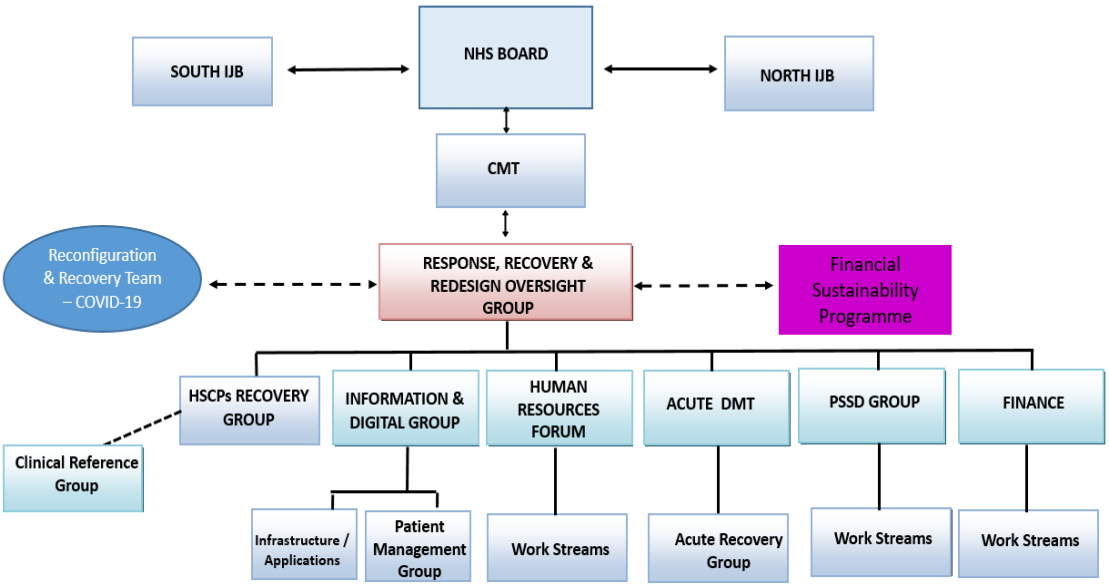
A Response, Recovery & Redesign Oversight Group (RRROG) was established which subsumed the remit of the NHSL Strategic Delivery Team (Achieving Excellence) and established links to the NHSL Financial Sustainability Programme Board. The first meeting of the RRROG was held on 7th May 2020.

The RRROG will ensure oversight linked to established operational governance mechanisms and approve all recovery and reconfiguration proposals, ensuring plans are clearly defined and evidence based. Service recovery proposals will be presented through the use of an approval template which includes a requirement to detail benefits and risks and a range of essential information to enable effective and transparent decision making. The RRROG will agree overall priorities for planned response, recovery or redesign programmes.

As part of the governance arrangements for NHS Lanarkshire, and in response to the COVID -19 situation, the Oversight Group has been established to:

- maintain good corporate governance and oversight of redesign and/or recovery arrangements to optimise the process, including the good governance of staff;
- ensure strong and supportive links to Integration Joint Boards (IJBs) across Lanarkshire;
- provide assurance to the NHS Board on scrutiny and probity of the redesign and recovery approach;
- maintain oversight of clinical modelling within existing budget and, where possible, to be efficiency releasing;
- seek out innovative solutions aligned to redesign of services for effectiveness (outcomes) and efficiencies (invest to save), optimising workforce;
- provide a forum for noting emerging clinical risks associated with the step down of services and risk of service change during the redesign, recovery and reconfiguration process;
- optimise recovery and reconfiguration opportunities to ensure NHS Lanarkshire emerges as a modern fit for purpose, effective and dynamic NHS Board;
- ensure alignment to clinical needs to ensure patient safety and quality of care are embedded in redesign activity; and
- provide a clear mechanism for reporting and updating the NHS Board with links into the wider corporate governance structures.

Response, Recovery & Redesign Oversight Group – Governance



The Response, Recovery & Redesign Oversight Group (RRROG) will report to the Lanarkshire NHS Board and provide update reports to each meeting.

Terms of Reference for The Response, Recovery & Redesign Oversight Group can be found at Appendix 2a.

1.2.1.1 Response, Recovery & Redesign Processes- Approval Flow Chart & Form

To facilitate the rapid recovery of key priority services, the Response, Recovery & Redesign Oversight Group developed a process to ascertain if key factors have been considered, benefits recognised, risks identified and mitigated, when services are being considered for recovery. Thereby enabling effective and transparent decision making.

The Response, Recovery & Redesign Flow Chart illustrates the process and is detailed in Appendix 2b.

The **Response, Recovery & Redesign Approval Form** must be completed for each service seeking to recover, and recovery can only progress if approved by the RRROG.

The Approval Form requires each service seeking to recover to provide details on:

- **Situation** - *What have you been doing recently in response to COVID-19 i.e. what was reconfigured?*
- **Background** - *What was happening to that part of the service before reconfiguration?*
- **Assessment** - *What needs to change soon and why? This is provided via an assessment of interdependencies and a risk assessment which based on the risks that might materialise by taking forward the proposals described by risk category and risk calculation*
- **Engagement** - *What engagement has been carried out? (public engagement, means of staff engagement and partnership engagement)*

- **Record Of RRROG Decision** - *Fully Supported, Supported in Part, Not Supported, EQIA, Financial Assessment, Environmental Assessment*
- **Process Of Enactment** - Initial response phase with no additional action required at this time; Initial response phase with action required; For immediate recovery with no change; For immediate recovery with minor changes; Redesign service process for NHSL Board sign off and immediate enactment or Redesign service process required, therefore must have NHSL Board sign off and inclusion in the revised AE Strategy

The Response, Recovery & Redesign Approval Form can be located at Appendix 2c.

2.0 NHS LANARKSHIRE COVID-19 POSITION

2.1 Background

NHS Lanarkshire (NHSL) is the third largest health board in Scotland with a population of 655,000 across rural and urban communities. There are around 12,000 staff working in communities, health centres, clinics and offices and at our three district general hospitals (DGH) – University Hospital Hairmyres (UHH), University Hospital Monklands (UHM) and University Hospital Wishaw (UHW).

Planning for the management of the COVID-19 pandemic is in line with the NHS Lanarkshire Pandemic Influenza Plan, with the subsequent planning for response, recovery and redesign in line with Scottish Government guidance.

2.2 Weekly COVID-19 Situation Report

NHS Lanarkshire has developed a COVID-19 weekly activity report and the NHSL COVID-19 Dashboard which is considered weekly by the NHSL Corporate Management Team (CMT). An example of this is shown in Table 1, below. Full details can be found at Appendix 3.

Table 1 – Example of C-19 Sit Rep

NHS LANARKSHIRE UPDATED SITUATION REPORT AS AT 19/05/2020

	Inpatient				ICU				Cumulative Deaths	Community (See Key)				
Date	UHH	UHM	UHW	NHSL	UHH	UHM	UHW	NHSL	NHSL	1	2	3	4	5
Weekly % Difference	+12%	-16%	-22%	-12%	+50%	+100%	+33%	+54%	+9%	-5%	+15%	0%	+10%	+27%
17/05/20	37	31	35	103	6	6	8	20	187	89	30	13	11	14
10/05/2020	33	37	45	117*	4	3	6	13	172	94	26	13	10	11

Weekly % Difference - Key

Any 'minus' % figure denotes a decrease; 'positive' denotes increase 

Community Data - Key
1 =Number of Patients Triaged to the COVID-19 Hub
2 =Number of Patients Triaged to Community Assessment Centres (CAC) by HUB
3 =Number of Patients who Attended A&E from Community Assessment Pathway (Hub & CAC)
4 =Number of Patients Admitted to Hospital from A&E from Community Assessment Pathway (Hub & CAC)
5 =Number of Patients Admitted to Hospital from Community Assessment Pathway (Hub & CAC)

Acute Site Totals - the Site totals that are shown in Table 1 include data from associated sites (UHH-Stonehouse & Udston, UHW – Kello, Lady Home & Airbles Rd and UHM – Coathill, Victoria & Wester Moffat).

*NHSL Total - includes All Mental Health Inpatients North & South. (The NHSL total on 11/05/2020 = 117 which includes x2 Mental Health Inpatients North & South)

From the Weekly %Difference:

- NHSL Inpatients: there has been a decrease in Inpatient cases at the same time point from the previous week, some 14 fewer inpatients;
- NHSL ICU: there has been an increase in ICU cases at the same time point from the previous week, some 7 more patients;
- NHSL Cumulative Deaths: there has been an increase in deaths from previous week, some 15 more deaths;
- Patients Triaged to the COVID-19 Hub: there has been a decrease in patients at the same time point from previous week, some 5 fewer patients;
- Patients Triaged to Community Assessment Centres (CAC) by HUB there has been an increase at same time point from previous week, some 4 more patients;
- Patients who Attended A&E from Community Assessment Pathway (Hub & CAC): this has remained the same as at same time point from previous week;
- Patients Admitted to Hospital from A&E from Community Assessment Pathway (Hub & CAC): there has been an increase in patient admittances at same time point from previous week, with 1 more patient; and
- Patients Admitted to Hospital from Community Assessment Pathway (Hub & CAC): there has been an increase in patient admittances at same time point from previous week, with 3 more patients.

2.3 COVID-19 Demand & Capacity Modelling- NHS Lanarkshire[1]

NHSL continues to work in partnership with Strathclyde University in the development of a simulation model. Details of the updated Strathclyde University Discrete Event Simulation (DES) modelled predictions at 19 May 2020 should be read with reference to the initial report of 6 April 2020, and subsequent updates. These reports can be found at Appendix 4.

In undertaking modelling work, there are currently two key questions to consider. Namely: (1) what is the role and importance of intra-hospital transmission (or, more generally, healthcare associated infection) of COVID-19; and (2) what is the likelihood of a second COVID-19 wave and when might it start?

2.3.1 Role and importance of intra-hospital transmission of COVID-19

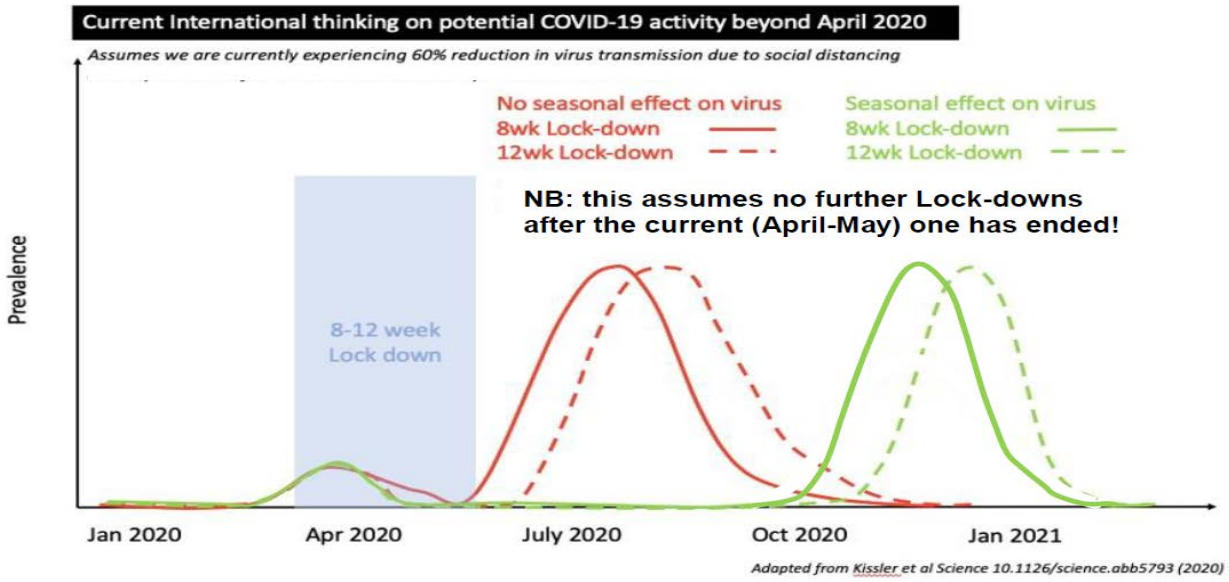
As non-COVID-19 healthcare activities are stepped up, it is extremely important to get a detailed quantitative understanding of the true extent of intra-hospital transmission of COVID-19 in Scottish hospitals. Gathering such data would enable the simulation model to be refined and could also suggest effective methods to further reduce COVID-19 transmission within the hospital setting.

2.3.2 Predicting a second wave of COVID-19

Given that current estimates of population infection rates with COVID-19 are relatively low, the vast majority of the Scottish population will not yet have been exposed to COVID-19 infection. This makes a second wave of COVID-19 infections in Scotland – and Europe more widely – highly likely. In terms of predicting the timing of a second wave, a key factor is the possibility of a seasonal effect in COVID-19 infection and transmission. The diagram below shows some

[1] Van De Meer, R et al (2020, 19 May) *COVID-19 Demand and Capacity Modelling: NHS Lanarkshire Updates to Report,* Dept of Management Science, University of Strathclyde, Business School

possible infection trends for COVID-19, based on knowledge about previous influenza pandemics.



The current COVID-19 infection wave is shown in the diagram as a comparatively low curve in March-April-May; this reflects the success of social distancing and lockdown measures taken.

The current (April-May) period of lockdown has been eased (to a lesser or greater degree) in Scotland from the end of May. The diagram indicates possible timings of a second wave, on the assumption that an effective vaccine or curative treatment will not yet be available. If we assume:

- **NO** significant seasonal variation in viral activity, then we potentially face a new and steep rise in COVID-19 presentations in July-August. The precise timing of a possible summer wave depends on a number of factors, including how long the current lock-down can be effectively extended into the month of June.
- there **IS** a significant seasonal element to infection and transmission (that is, the important 'R number' for COVID-19 transmission is consistently, but temporarily, lower in the northern-hemisphere summer months), then a second wave is likely to start in October-November, coinciding with the expected onset of the winter flu season.

In either case, the size of the new wave could far outstrip the current March-April-May wave (as indicated by the high peaks in the above diagram) – **UNLESS** the new Test & Protect policy proves to be highly effective in containing the size of any new outbreak or a sufficiently strict lockdown regime is re-imposed at an early stage of the new wave.

Seasonality of the SARS-CoV-2 virus

There are a significant number of infectious diseases that display seasonal patterns, including some human coronaviruses. However, the task of determining possible seasonality of COVID-19 is complex, especially given substantial Public Health interventions. The quality and quantity of research in this area is not sufficient to determine reliably whether there is a seasonal effect on COVID-19 or indeed the extent of any effects. Current evidence is often flawed or incomplete and should be critically observed. Seasonality should however continue to be a point of interest, although it is unlikely that COVID-19 will have significant seasonal effects.

Contingency Provision

The Strathclyde University analysis clearly identifies a high risk of further "waves" of virus and/or the continuing prevalence of the disease in our population. In accord with the Planning Assumptions identified in John Connaghan's letter to Chief Executives (20 May 2020), NHS Lanarkshire will prepare a deployable contingency of acute general beds and intensive care unit beds to create inpatient capacity to respond to further waves. Similar contingency will be included in all other clinical and corporate services.

3.0 NHS LANARKSHIRE CLINICAL SERVICE PRIORITIES

NHS Lanarkshire has identified a number of key services for priority recovery over the next six weeks (below) and full details are listed at Appendix 5.

- Urgent and routine surgery and care
- Cancer
- Cardiovascular Disease, Heart Attacks and Stroke
- Maternity
- Primary Care
  - General Practice
  - Dentistry
  - Independent Pharmacy
  - Optometry
- Community Services
- Mental Health and Learning Disability/ Autism service
- Screening and Immunisations
- Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

Section 4 describes Primary and Community Health Services (including Mental Health) and Section 5 describes Acute Services.

4.0 HEALTH AND SOCIAL CARE SERVICE PROVISION

4.1 Primary and Community Health Services: May - June 2020

NHS Lanarkshire and the 2 respective H&SCPs have agreed a process whereby services will be asked to consider recovery plans in line with clinical prioritisation and taking account of other logistical requirements, e.g. observing 'social distancing' and continuing to protect 'shielded' and 'vulnerable over 70's' by providing the majority of services to people in these groups via home visiting. This will be undertaken in line with the recognised recovery process in NHS Lanarkshire through the Response, Recovery & Redesign Oversight Group.

Specifically, a clinical reference group has been formed to assist in the establishment of clinical priorities – inclusive of GP Sub Committee representation as well as a joint H&SCP Recovery Group.

The terms of reference for the group are at Appendix 6a.

4.2 Service Recovery Priorities

The service priorities for the HSCPs are detailed in the table below.

Area of work	Baseline (Current status of the service, May 2020)	Aim (Expected status of the service, end of July 2020)	Actions required
General Practice	GPs have been predominantly operating at Stage 2 'managed suspension of services'	No immediate change to this is planned as we need to be able to re-establish a range of supporting services to be able to allow all practices to move back to level 1. This will be based on the clinical prioritisation of services and the associated establishment of elements of service to support same. It is recognised that this is a very complex issue as many will have co-dependencies with other service areas. The detail of this is included in the clinical prioritisation paper attached at Appendix 6b.	On-going involvement in prioritisation and communication as to which services can be prioritised and established accordingly. This will also require consideration of social distancing in the respective health facilities and associated planning. Crucially, it also requires acute services to be mobilised to provide the necessary supporting services, e.g. diagnostics.
	Currently, 99 of the 102 practices have been set up to be able to perform 'near me' consultations. Between 1.3.20 and 30.5.20, GPs carried out 5,679 Near Me consultations (excl. OOH and Covid Hub)	Many practices have already indicated that they will continue to use telephone triage; use of 'near me' as part of the future delivery of services. Of the 184 GP responses in a recent survey, over 80% felt there was a role for telephone consultations for default patient assessments, GP assessment following navigation by Reception, and follow up of previous encounters. 46% felt there was a role for Near Me for nurse assessment/long term condition management and 45% for Near Me in joint consultations with other clinicians.	Continue to engage with GPs to support the continued use of remote consultations by telephone and Near Me. Both will enable reduced footfall through practices to observe social distancing requirements.

Out of Hours Services	Service being provided alongside Covid Assessment Centre.	All calls are now offered a telephone/Near me consultation prior to the person being invited to attend an Out of Hours Centre and or receive a home visit. The technology advances now also allow an increased number of staff to work remotely and able to assess/consult via Near Me from outwith the OOH Hub. Additionally, advances also allow access to clinical portal and e mailing of prescriptions to local pharmacies thereby precluding the need for many patients to visit one of the centres to receive a prescription and/or faxing of same to pharmacies.	It is envisaged this form of working will continue such that social distancing can be observed as well as reduced incidence of any cross infection risk.
Covid Assessment Hub and Covid Assessment Centres	Hub established in Airdrie HC and 2 x CACs operating from Airdrie and Douglas St clinic in hours. In the OOH period, service provided alongside OOH service in Douglas St Hamilton. The numbers of patients seen throughout the process is included in the attached Appendix 6c. However, in summary, a total of 9,150 patients were triaged by the Hub between 23.3.20 and 2.6.20, 2,839 of whom (31%) were then triaged to one of the CACs. 848 (9%) patients from the Hub/CACs were sent to hospital, 775 attended a Lanarkshire hospital and 584 were admitted.	Work ongoing to review future model/staffing as numbers of patients coming through the CAC route. This is now being reviewed taking account of ongoing staffing issues as a number of staff move back to their routine place of work as well as some of the trainees who were deployed having to move elsewhere to complete their respective training programme.	Further modelling in relation to future requirements and model of service delivery to ensure a separate primary care flow for suspected Covi19 patients. This will include discussion with wider GP colleagues and acute clinicians. It should be recognised that there requires to be much further work before aspirations re expanding the role of Covid Hubs and Assessment Centres could be considered.
Community Nursing Services	All community district nursing services are operating a curtailed visiting schedule on a home visit basis and telephone triage process in line with clinical triage and SG guidance	It is anticipated this will continue for the foreseeable future but will require review of guidance. Community nursing staff have also being providing direct support to the care home sector in a number of ways, including direct service provision when insufficient staffing in a given home; supportive visits, and providing a dedicated care home liaison service. There has also been significant input	Further work required to provide all staff with necessary IM&T support to allow current remote working to continue post Covid. Much of the shape of the current demand is dictated by the Scottish Government policy on shielded and over 70s vulnerable patients requiring to receive all hands on care in the patient's own homes.

		from Infection Control specialists to support those homes reporting Covid incidence by either staff or residents. This will be further increased to support the staff and residents testing announcements which were made.	
Treatment Room Services	All treatment room services were stood down and moved to a home based visiting service for those patients requiring urgent interventions/tests etc A prioritised clinical list of procedures to be stood back up has been agreed – as attached, and this will guide the nature and scale of step up.	The work of the clinical reference group will identify those patients who would fit the criteria of requiring to be seen in the first cohort of activity recovered in the treatment room setting. Given the scale of normal activity in treatment rooms - over 50,000 treatments per month, an impact assessment is being undertaken as to the risk associated with seeing 'shielded'/'vulnerable over 70s' patients in a care home setting as opposed to in their own homes.	Recovery plans will be produced which take account of staffing resources, social distancing, limitations of current accommodation and potential requirement to relocate some activity to other areas. Work is also underway with Council colleagues to identify the additional accommodation which will be required to be able to see the required numbers of people in a clinic setting whilst observing social distancing. Key to the scope of delivery will be updated Scottish Government Guidance on 'shielding and over 70s' vulnerable people requiring to be cared for in their own homes as opposed to being able to attend clinic spaces.
Minor Injury Services in Community Hospitals	Currently, the minor injury units have been stood down to allow social distancing as well as recognising infection risk associated with additional footfall in community hospitals	It is anticipated the status quo will be maintained for the next few months	No further action at this point
Substance Misuse Services - CAReS	Currently the clinical activity is being prioritised in relation to individual risk assessment & level of clinical need. There is a reduction in clinic based appointments with the majority of contact with service users taking place via the telephone based. However an increase in home visits is required in response to increased clinical risk due to deterioration in patients' mental health and or management of substance misuse problems. Occasionally face to face clinic appointments are	The current position of service provision is under review as limitations with virtual contact for some existing patients is becoming evident and in view of the rise in referrals to the service and impact of lockdown measures on patients' mental health and ability to continue managing substance misuse problems.	Inclusion of Substance misuse services in locality planning and prioritisation of which services can begin to return to a level of face to face service provision which is deemed necessary due to clinical or associated public protection risks.

	required if home visits are not advisable due to risk to staff. Telephone consultation takes place prior to any Face to Face contact		
Health Visiting / Family Nurse Partnership	Work has been done on the basis of an agreed reduced visiting schedule as per SG Guidance and prior telephone consultation.	It is anticipated this will continue through May/June with a view to establishing increased visiting in line with reduced limitations on face to face consultations.	Work being overseen by specific service review group and clinical reference group Further work required to provide staff with necessary IM&T support to facilitate this.
Vaccine Transformation Programme	The major issue faced in relation to establishing the flu vaccination programme will be the logistical issues associated with social distancing as well as observing the respective arrangements which may be in place for 'shielded'/'vulnerable' patients depending on the guidance at the time of the programme commencing.	Work is ongoing in identifying the logistical issues associated with delivery of flu vaccines to a similar level as 2019/20.	Identification of potential accommodation to support such a high volume of patients to receive vaccine. Potentially outwith NHSL estate.
AHP Services Detailed below for individual services	All AHP services operating remotely where possible, offering advice and support via telephone support, or the use of Near Me. The majority of AHP services have included the use of Near Me in their service. A few elements of service have continued through the period in particular in Diabetes wound care, nail surgery and MSK Physiotherapy seeing high-risk condition. AHPs have gained additional skills such as phlebotomy Advance practitioner physiotherapists and podiatrists have been assisting in Orthopaedics fracture clinics. A number of the AHPs are also deployed to areas in support of additional beds to manage Covid inpatient flow.	All AHP services are currently reviewing the areas they would prioritise for initial tranche of recovery work as well as reviewing potential service models. Such prioritisation will also take account of the clinical priorities identified by the clinical reference group such that area/system wide consistency can be achieved.	Review of current service models and identifying resource implications of where face to face contact/group work is difficult to enact as a result of social distancing. A scoping exercise looking at elements of AHP services that potentially could be relocated into non-NHS premises is being initiated to assist with social distancing and reducing footfall in Hospitals and Health Centres.
Support for hospital flow and	Additional resource has been mobilized to maximise flow through the hospitals into the community. This includes utilisation of a number of staff from other roles	Work is continuing to maximise flow, however this has been impacted by the need to redirect resources to support care homes.	Ongoing support from Public Health Department with a view to reiterating extant

complex patient discharges	to support re-ablement and maximisation of independence prior to person getting to home.	However, work has been undertaken to maximise patients' independence with medicines.	PHS Guidance (albeit this changes very regularly). Increased staffing required to action the latest range of guidance/requirements from Scottish Government. Seek to expand this learning into other hospital sites and indeed look to see how reablement including medication alignment within the community to support patients and their families to become as independent as possible with their medication.
Dietetics Acute Adult Service	Continued provision of assessment and treatment of inpatients. Significant increase in service to ventilated patients within ICU across the sites. Suspension of direct face to face consultations to Acute outpatient clinics. Lists triaged with interventions provided via telephone contact or Near Me platform.	Aim to return all dietetic services to pre-COVID levels through new models of delivery. It is estimated that 50% of all dietetic outpatient interventions will be provided remotely. Albeit there may be scope to increase this number following EDIA assessments to ensure that all necessary support is in place for those who may be unable to participate in the new ways of working.	Review of current service models and available technology.
Acute Paediatric Service	Continuation of MDT clinics with paediatric team via Near Me platform. This was practice prior to COVID lockdown. Neonatal unit provided with service remotely liaising with staff.	Identify capacity for provision of face to face interventions.	Identify physical space to provide face to face consultations. This could be relocated into non-NHS premises is being initiated to assist with social distancing and reducing footfall in Hospitals and Health Centres.
Dietetic Gastro Service	Suspension of direct face to face consultations to Gastro outpatient clinics. Lists triaged with interventions provided via telephone contact or Near Me platform.		Scope use of clinical measurement clinics to gather information for remote consultations. Develop protocol to identify patients who require face to face interventions as part of treatment.
Community Outpatient Clinic Service	Suspension of direct face to face consultations to community outpatient clinics. Lists triaged with		Work with national dietetic network to ensure equity across Scotland.

	interventions provided via telephone contact or Near Me platform.		
Community Domiciliary Service	Suspension of domiciliary visits to caseload. Continued provision of assessment and treatment of nutritional compromised patients via telephone and to a lesser extent Near Me platform (due to age and frailty of client group) Face to face nursing service as specified in Nutritional Support Contract has continued to provide support with issues relating to feeding tubes and training on feeding pumps has continued. The result has been the avoidance of admission and timeous discharge in this client group.		Consult with public and patient partnership groups to ensure patients are involved in protocol development.
Community Learning Disability Service	Suspension of domiciliary visits to caseload. Continued provision of assessment and treatment of nutritional compromised patients via telephone and to a lesser extent Near Me platform to patients and family. Suspension of healthy improvement group work		
Community Mental Health Service	Suspension of direct face to face consultations to community mental Health outpatient clinics. Lists triaged with interventions provided via telephone contact or Near Me platform. Suspension of domiciliary visits to caseload. Continued provision of assessment and treatment of nutritional compromised patients via telephone and to a lesser extent Near Me platform to patients and family.		
Community Tier Two Eating Disorder Service	Suspension of direct face to face consultations to outpatient clinics. Lists triaged with interventions provided via telephone contact or Near Me platform		
Occupational Therapy	Priority 1- CRITICAL caseloads maintained across all care groups and clinical specialties. Priority 2- SUBSTANTIAL caseloads also maintained for Acute & Community Teams; Stroke/Neuro/ CBIT; Acute MH/LD ; Forensics, Addictions Priority 3 & 4 – MODERATE/LOW cases stepped down across all care groups and out-patient specialties.	Phased return of small primary care OT team back to General Practice to support patients who are shielding or who have increasing mental health and wellbeing needs (n = 7) Phased return of C&YP OT team to support P1 & P2 cases, including children with mental health, behavioural/neurodevelopmental, and postural management needs (n = 10)	Consideration to management of outstanding P3 & P4 waiting lists. Review of accommodation and rostering arrangements to support social distancing.

	OT staff deployed from primary care OT (GP), C&YP and MH/LD care groups to support acute and community rehab teams. Telephone/Near Me Triage, Assessment and Treatment interventions utilised whenever possible. Signposting to self-management materials or patient education resources where relevant. Additional skills training undertaken to support nursing and homecare roles e.g. phlebotomy, vital signs/clinical observations, and medicines management	Step up of rheumatology and hand injury out-patient services to include P2 substantial cases. Phased return of MH/LD/Addictions staff to ensure continued support to P1 & P2 cases. Continued step down of P3 and P4 cases	Continued use of Near Me, Webex, Remote Group technologies, MS Teams to support more agile working practices. eHealth support to ensure access to electronic record keeping systems which will further enhance remote/home working solutions; remote access to Vision for OTs in GP practice. Additional resources to support alternative working patterns, and cost of increased telecommunications & IT equipment.
Physiotherapy Services	All inpatient activity continues as normal GP Advanced Practice MSK service maintained Caseloads Triaged and those patients classified as Urgent have been maintained across MSK/Community/Neuro/Learning Disability/Falls/Pulmonary Rehab/Paediatrics OP services using Near me or telephone - face to face only if necessary due to risks identified Caseloads triaged as routine across MSK/Respiratory/Amputees/Paediatric/Learning Disability services have been suspended to allow staff to be redeployed to assist acute and community workforce as part of the COVID response Caseloads triaged as routine have been maintained within Falls/Neuro/community services Cardiac Rehab Services adapted and maintained Telephone/Near Me Triage, Assessment and Treatment interventions utilised whenever possible. Signposting to self-management materials or patient education resources where relevant.	All redeployed staff return from acute/community settings to substantive roles Reinstate all OP services across all specialties where able - delivering remotely using near me/telephone/digital platforms by default and face to face only if high risk identified during remote assessment	Waiting List Validation Development of Physiotherapy Website to promote self-management Continued use of Near Me, WebEx, Remote Group technologies, MS Teams to support more agile working practices Scoping of additional resources to support alternative working patterns, and cost of increased telecommunications & IT equipment eHealth support to ensure access to electronic record keeping systems which will further enhance remote/home working solutions Review of accommodation and rostering arrangements to support social distancing

Orthoptics and paediatric optometry	At present all orthoptic patients were coded as green therefore service stopped all outpatient appointments. Orthoptics has been supporting ophthalmology seeing any red patients and ROP clinics.	All staff back from redeployment triaging patients as paediatric patients will be changing from green to amber/red as per the royal college of ophthalmologist guidelines. This will be a mixture of face2face consultations and telephone/ attend anywhere consultations for orthoptics. Optometry service seeing urgent paediatric patients for refractions.	Proposal forms required to be submitted to the RR Group. Looking at changing the orthoptic service to 5 day 8am-8pm and changing to 3 session days. Further modelling in relation to future requirements and model of service delivery. Taking advice from the Royal college of ophthalmology and the British and Irish Orthoptic Society. Increased staffing would be required due to social distancing to enable patients to be seen and cover the 3 acute hospital sites.
Podiatry	At present the Podiatry service is delivering essential services to patients which include; nail surgery, wound care and some MSK.	New model of care are currently being designed and will be implemented using digital technology to greatly reduce face to face consultation and at the same time will assist the organisation in managing the need for facilities as the recovery programme progresses. This will initially focus on MSK services but will become a standard across all specialities within Podiatry.	Standard operating procedure put in place, engagement with patients and some test of change will be included to evaluate the model. Some additional IT equipment will be required to facilitate the new ways of working.
AHP- Speech and Language Therapy Service	Adult Service continue to assess and treat high risk patients clients +/- COVID-19 directly and remotely in hospitals, Children and Young People service continued remote assessment and treatment of High risk clients. Universal and targeted supports are available using our helpline number 01698 575707 and email sltenquiry@lanarkshire.scot.nhs.uk 17 SLT staff are still redeployed to staff care NHS Lanarkshire has asked all services to continue to review the most effective ways to adapt services to safely deliver the best possible care to our patients in	SLT service will be using a blended service model with remote consultations being the default and direct face-to-face consultations only arranged if risk assessment deems necessary. Staff will be working at home and in clinics using Near Me and seeing urgent out-patients. For CYP- universal and targeted supports will continue to be available on our helpline, email NHSL website and social media. Consultation with Education in North Lanarkshire and	Further modelling of remote vs face to face working for clients with swallowing and communication difficulties is required as well as models for multidisciplinary and multiagency working. Proposal forms require to be submitted to the RR&ROG as follows ADULT and Adult Learning Disability 1. Recovery of urgent OP services 2. Recovery and redesign of routine services if capacity allows

	Lanarkshire. A centralised approach is in place to capitalise on the many innovations that surfaced in response to the pandemic. An approval process is in place, and a proposal form must be completed and approved by the Boards RR&ROG group before any service can recover, redesign or reconfigure. The first proposal form for SLT CYP service has been submitted to the RR&ROG and fully supported. This is a review of the speech and language needs of children and young people on the existing caseload, not involving any direct patient contact. The service will discuss and identify digital opportunities with families ahead of the next stage in our recovery plan given the strong likelihood that this will involve the various e-health options available.	South Lanarkshire Councils to plan Education Contract services.	CHILDREN AND YOUNG PEOPLE 1. Recovery and redesign of routine services in health centres 2. Recovery and redesign of routine services in schools, nurseries, family learning centres and homes
Orthotics	The orthotic service had taken the decision that all out-patient services would be delivered remotely with an escalation process in place ensuring patients are managed appropriately and safely. Of the 1800 remote consultations undertaken, 200 have thus far necessitated a face to face appointment on the basis of clinical need.	Active Clinical Referral Triage to be in place to manage patients more appropriately with patients being empowered to take responsibility for their own care where possible. Remote consultation to be the first point of contact for all orthotic patients. With an appropriate escalation process in place to ensure only patients truly requiring face to face consultation are managed in this way Anticipated 50% of all future work could be undertaken remotely.	Confirmation of necessary accommodation and IM&T capacity required to support ongoing new ways of working.
Palliative Care Services	Services have moved to support patient across hospitals, hospices and community. A community focus has been taken and teams operating virtually through the use of 'teams' and ensuring continued multi-disciplinary meetings and review of patients. Kilbryde Hospice was initially mobilised to provide additional palliative care for Covid patients on the Hairmyres site.	Current working arrangements will continue with view to building on current working for future service delivery. Kilbryde now stood down as dedicated support for Hairmyres and reverting to specialist palliative care inpatient provision.	Continue to review on basis of revised relaxation of 'lockdown' rules. Assess potential to resurrect community hospice project – CLAN Introduce PGD to support DNs ability to provide end of life medications. A range of other techniques such as the availability of TTO oral and injectable palliative

			care medications, within A&E and OOH centres along with a process for repurposing of medicines in care homes have also been developed. The overall aim is to provide a service which is quickly responsive to patient need and efficient in terms of minimising waste of medication (which may be in short supply)
Community Pharmacies	Community pharmacy services have been operating a range of services throughout the last few months with on a number of occasions, having to close for periods throughout the day to allow staff to catch up with demand. Support was also provided by Council colleagues and other volunteers to maintain social distancing/'crowd control'.	Pharmacies have now managed to move to a more 'level' service model and appear to be managing demand. They have been supported by both North and South Lanarkshire Councils to establish/enhance delivery services for those patients in the shielded and vulnerable categories who do not have someone to collect prescriptions on their behalf. It is envisaged this system will continue throughout the next few months. Pharmacies will be open on Public Holidays in May to support the GP practice who will also be open. Going forward the aim is that Community pharmacy services will find new ways of working which are safe and sustainable for the new working environment and which will make their maximal contribution to the overall priorities for NHS Lanarkshire and the HSCPs Community pharmacies are now the places where the majority of smoking cessation services take place and the vast majority of Emergency Hormonal Contraception is delivered. However consultation rooms within pharmacies tend to be very small and social	Continue to review and support. As part of the wider recovery process, a series of areas are being looked at in terms of community pharmacy. These include:- ***Pharmacy First*** - which expands the range of clinical conditions which can be treated within a pharmacy without a patient needing to go to a GP Practice. – ***Independent Prescribing Common Clinical Conditions*** - services to be provided from community pharmacies ***Serial Prescribing*** - which has the potential to cut down markedly on work for GP Practices, Community Pharmacies and patients. Further work ongoing in relation to environmental audits and understanding implications of social distancing.

		distancing is challenging. Assessment is required to address this and new technology/Near Me may help. Similar issues are being worked through in relation to Opiate Replacement Therapy administration.	
Dental Services	All GDPs and Community Dental Services were closed with emergency services being provided from a number of dental hubs 'UDCC's.	It is envisaged that paediatric emergency dental surgery for children with special needs will be re-established w/c 25 May. Work will be undertaken to action the advice received from the CDO, received 20 May 2020.	Walk round of theatres to ensure all logistical and PPE issues identified and plans in place to safely resurrect service Action required to understand implications associated with expanding current UDCCs recognising these are in community health facilities and growth in footfall here could adversely impact on ability of recovery of other services in the same area. Notification of required pace of recovery to 'environment' group such that action can be taken to ensure social distancing, signposting etc.
Optometry Services	Services closed with emergency support being available via the 8 emergency hubs	The existing EETCs are providing the full range of extended eye care as per guidance. Discussion is also ongoing with acute colleagues to ensure as much shared care is provided as possible.	Further guidance awaited from Scottish Government as to when services might reconvene in keeping with the '4 phase' plan. In due course, further consideration will require to be given to IPC guidance and provision of appropriate PPE to independent optometrists recognising the need to be close to the patient as part of routine eye care.
Shielding	At 20.5.10 there were 23,093 patients in Lanarkshire in the 'shielded' category representing 3.5% of our population. 89% of those in North and 92% in South Lanarkshire have been contacted by the respective Councils to ensure they are able to access food, medicines and other vital goods. 40% in North and 72% in South Lanarkshire required support and/or signposting to other services.	All such patients are now coded on the respective GP systems and will be highlighted at time of transfer to acute/other services. Council colleagues continue to support provision of essential services.	A core group will be established to continue to oversee provision of service to this group of patients as well as supporting any additional cohorts identified.

Implementing virtual team working	Microsoft Teams is in place and working well alongside existing email and other systems, with most team meetings now held over a virtual system	Consolidate this experience and learning and ensure that the best of this forms the basis for guidance going forward. Ensure that virtual team working is delivering good team performance	Ensure cameras and microphones available for each team member, along with remote working equipment where available Evaluate Team working
Sexual Health Services	All patients are having telephone consultations by either nursing staff, doctors and/or Consultants. All routine contraception is being posted to patients following telephone consultation. Should a patient require a face to face consultation for urgent or priority conditions these are vetted by Consultants so that face to face interaction with patients is minimal and all clinics are maintaining a face to face service on a daily basis in very few sites. This is to enable urgent or priority conditions who need examined only to be seen. Testing for STIs and BBV is extremely limited due to reduced lab capacity and also reduction in face to face consultations. PrEP patients are managed where possible via telephone consultations but there have been no new patients on PrEP. All LARC activity is suspended except implant fitting post termination and emergency IUD fitting. All patients on injectable contraception have been switched to self-administering this where possible. Extended hours in office for telephone consultations has enabled safe distancing of staff.	We intend to maintain a fully operational remote consultation and telephone consultation service however there remains a significant proportion of patients who require face to face consultation. Site visits have shown some clinic premises to be suitable for social distancing and these are the sites we are operating out of, however, the footfall has greatly reduced.	There is an urgent requirement for postal/online testing for all STIs and BBVs as soon as possible to enable patients to access tests without requiring to come into the clinic. Also there is an urgent requirement to open LARC in a stepwise fashion however this is dependent on premises and safe distancing and appropriate robust risk assessments to ensure patient and clinician safely. There is an urgent requirement to identify premises suitable for young people to be seen at safe distances should we be unable to re-establish our drop-in Young Persons Clinics and Health Centres.
School Nursing	Work has been done on the basis of an agreed reduced visiting schedule as per SG Guidance.	Continue with outlined SG guidance with focus on child protection, LAC and vulnerability	Clinical reference group providing guidance and oversight
Specialist Nursing (Neurology)	Consultations being undertaken both face to face and introduction of 'near me'	Consideration if triaged required for face to face consultation and use of NHS Near me built in to service delivery	Continue to review and ensure access to IM&T
Health and Homeless Services	Work has been done on the basis of an agreed reduced visiting schedule and prior telephone consultation.	It is anticipated this will continue through May/June with a view to establishing increased visiting in line with reduced limitations on face to face consultations	Work being overseen by specific service review group and in partnership with housing authorities

Area of work	Baseline (Current status of the service, May 2020)	Aim (Expected status of the service, end of July 2020)	Actions required
Urgent and Emergency response (Community)	CMHTs (including specific specialty teams) have continued to operate throughout the pandemic and continue to receive and review urgent and emergency work. The use of remote reviews (Near Me and Phone calls) have been used to support this, lowering infection risk and ensuring rapid response.	No change to this would take place, with this remaining one of the highest priority areas of the service. We need to carefully monitor referrals as these are anticipated to increase	Monitor demand
Urgent and Emergency response (Emergency Departments)	Assessment and decision areas are operating within each University Hospital Site. These divert people with mental health problems from the ED waiting areas to separate waiting areas and assessment areas near Mental Health wards. This reduces the number of people in ED, and thus the infection risk.	These developments have been a very positive part of the "response" element of COVID19 and plans to retain these will be explored within the service.	Write business case for long term existence of these arrangements
Communication	Phone calls are made to those already open to the service and who need more immediate help (those that have been prioritised as higher risk or more in need of help).	Contact by letter to each person on the waiting list and each person who is referred to advise of other sources of help during their wait and how to escalate concerns if that is required with the team they have been referred to.	New template letters New process for sending out these letters New Process for people who wish to contact the service
COVID19 and Non-COVID19 inpatient settings	Patients tested positive are cohorted in side rooms or bed bays. Testing occurs on admission for those over 70 (and every 4 days thereafter), on emergence of any symptoms of COVID 19, and prior to nursing home discharge, in each case in line with national guidance.	Services will adhere to the advice from infection control and appropriate governance structures are in place to achieve that.	Hygiene groups are re-established to support the R&R of services
Moving patients through the system quickly	Nurses with a specified remit for those ready for discharge manage these situations	Move earlier to focus on those likely to require additional support prior to discharge (i.e. those needing care homes)	Delayed Discharge nursing team to pro-actively link with wards and consultants to identify those patients
Implementing virtual team working	Microsoft Teams is in place and working well alongside existing email and WhatsApp systems, with most team meetings now held over a virtual system	Consolidate this experience and learning and ensure that the best of this forms the basis for guidance going forward Ensure that virtual team working is delivering good team performance	Ensure cameras and microphones available for each team member, along with remote working equipment where available Evaluate Team working
Clinical service delivery arrangements	Urgent, high risk and those with high levels of need are "seen" mostly via phone or Near me, and if indicated via a face to face contact in their home	Establish which presentations and cases can and will be seen and which can have their needs met by other services, and pathways and guidance for this to be implemented.	Recovery groups now exist, including a clinical reference group, which will help determine priorities and process Establish clear language and guidance

		Establish clear language and guidance for remote assessments and assessments under less than ideal circumstances (i.e. without usual tests being done) so that service users and clinicians appreciate the limitations. Establish clear criteria for face to face assessments and how these would be set up either via home visit or clinic attendance	
Online mental health wellbeing information, advice and support available to staff	Information is available on the SG hub website and NHSL website.	NHS Lanarkshire's Guidelines website https://nhslguidelines.scot.nhs.uk/ is intended as a source of information and guidance relating to COVID-19. The advice and guidance on Covid-19, including mental health and wellbeing support is updated regularly on FirstPort. The NHS Lanarkshire staff care and wellbeing service, in collaboration with NHS Lanarkshire psychological services, is focused on how to help all staff during the Covid-19 pandemic. There is a page of useful resources at http://firstport2/staff-support/staff-care-wellbeing/default.aspx. A 24-hour staff care and wellbeing support line is in operation. This offers psychological support to all staff who want it. Following an initial telephone discussion, further contact can be arranged by phone, video call or face-to-face if needed. The 24-hour helpline is available on **01698 752000**. Video messages have been prepared by senior clinical leads and promulgated via Twitter, YouTube, Facebook, and Vimeo, alongside information on websites for support. Staff are being directed to the national staff support website: PROMIS.scot, and to the NHS Inform website	Monitor use and continue to update

Online mental health wellbeing information, advice and support available to local population	Information is available on Element, NHSL website and Making Life Easier.	The NHS Lanarkshire Comms team are making effective use of social media to identify sources of support and highlight this to the public. Video messages have been prepared by senior clinical leads and promulgated via Twitter, YouTube, FaceBook, and Vimeo, alongside information on websites for support. A public access helpline is being provided by Psychological Services, and this is advertised across social media. The NHS Lanarkshire FirstPort website also contains information on supports available to the public. GPs are referring to SilverCloud and Beating the Blues online CBT in increasing numbers.	Monitor use and continue to update
Modelling likely future demand for mental health services	This has been limited so far, given that the national evidence is unclear.	A potential increase in demand is at least possible, however we do not know if this will be mild or severe cases and thus it is very difficult to plan ahead for this.	We will monitor referral numbers to ascertain the demand.

4.3 Mental Health and Learning Disabilities Services

Baseline detail
Some changes have been common practice across all services with Mental Health and Learning Disabilities within NHS Lanarkshire.

Prioritisation: At the start of the pandemic service medical, nursing and psychology were asked to draw up guidance of what would be in three categories.

1. Urgent and important (including urgent new presentations, unstable community cases, high risk, inpatient cases, depot, clozapine)
2. Those who required occasional phone/near me contact and who could be managed on a more remote basis or with advice to other agencies (symptomatic but not acutely changing or high risk, those with medication changes, people wishing to contact the service for support)
3. Those who could safely not be seen by the service. This group received written communication when the time came that they would have been seen.

This system is analogous to a RAG system, however more detail was distributed to clinicians to aid their decision making. When it was evident the situation would last for more than a few weeks, proactive phoning of those in groups 2(Amber) and then 3(Green) began. Continuity has been preserved, with those open to a professional contacted by that professional if at all possible.

Moving forwards through the recovery process, the service is fully tied into the partnership's Clinical Reference Group to aid decision making around the collective prioritisation of services and subsequent decisions around service models and accommodation requirements.

Routine work: Routine work (group 3 and to an extent group 2) has been deferred to a later date, meaning that scheduled home visits and clinics have not taken place, however these patients have in most case been contacted or engaged with services, often to a less intense degree and a "keeping in touch" call rather than a therapeutic intervention. No patients have been discharged as a result of any new process.

Psychological Services patients identified as having the greatest need/risk/vulnerability continued to receive support/therapy as appropriate via telephone and/or NearMe. Other service users were advised that their next appointment would be deferred. Group-based interventions, central to many department's routine service delivery, were deferred. Neuropsychological assessment largely ceased, given practicality and reliability of VC-based neuropsychological testing. Services have continued to accept new referrals, and these are screened, triaged and signposted where appropriate. All service users receive information on available self-help and online resources, and continued use is being made of cCBT – including the additional SilverCloud modules.

Cessations: No service has been stopped as a result of the pandemic.

Different methods of service provision: All services have stopped routine face to face contact. Face to face contact is still provided but only now where there is a clear clinical rationale, and with screening processes and PPE in place to minimise risk. Patients are often contacted and reviewed via phone and in many situations now by "Near Me". Roll out of technology has been fast and wide spread.

Management of referrals: Referrals are received and recorded and placed on waiting lists. Examples of these are noted below on a per service basis

Innovations
ED Assessment and decision areas: a separate area for patients triaged by ED as having no physical issues and who are in need of a mental health assessment is now operated. This makes use of currently underused ward space and ward staff (due to decreased demand).
Clozapine clinics: a move toward locality Clozapine clinics (instead of hospital based) has been positive and is likely to remain

Psychological Services had already been trialling the use of Near Me in the Clydesdale locality. The current pandemic has meant that all teams are now using this extensively in contact with service users. Whilst some service users have declined near ME (and phone) contact, there does appear to be a general acceptance of using VC psychotherapeutically. A number of service users advised that they actually preferred this mode of service delivery, and where this is not having a detrimental impact on the reason for input (e.g. with individuals with social anxiety/ agoraphobia), this would be continued. It can also be beneficial in minimising clinic visits for service users. Within our long-term condition population, it is anticipated that there may be better attendance rates via telephone/near Me, given that many of these service users cancel/DNA as they are physically not well enough to attend a clinic on the day of their appointment. It also means that housebound patients can be seen, as this was difficult to arrange in the past due to staffing resources. The remote nature of therapy opens up possibilities for working across localities where typically the population is reluctant to travel. Additionally, some communities served in Lanarkshire are very remote/ rural, and can be difficult to access in poor weather. The wide availability of such technology now also opens up the possibility for flexible working for staff, including evening and weekend working, towards greater flexibility in meeting service demand. A working group is being established to further explore this across departments. Less time travelling to meetings has meant more time available to focus on core business.

Service	Recent Demand	Waiting position
Child and Adolescent Mental Health Services	Referral number dropped to about 25% of normal during April 2020, but have risen in May 2020. More work is resulting from known cases who are needing additional support.	We propose to use existing clinical capacity to start telephone and video assessments of cases on wait list and as a return to service as normal.
	All routine work including assessments, individual and group intervention programmes and routine reviews have been deferred.	We will provide advice, guidance and signposting of those cases that do not meet the clinical access criteria for the service and these cases will be discharged from the wait list.
	All clinically urgent assessments and interventions have been delivered using telephone or Near me videoing conference. Unavoidable face to face clinical contacts have been delivered applying PPE guidance where appropriate.	We will scope delivering the CAMHS service over 6 days to allow for flexible working and ways of spreading out footfall to reduce risk.
	We have established an advice line for public and professionals and we will continue to monitor how this is being accessed by patients and staff	Those cases that meet the clinical threshold criteria will be assessed and urgent cases will be allocated for intervention using telecoms/video in first line and face to face where unavoidable.

		Cases able to wait for intervention will be placed on intervention wait list.
Psychological Services	In April and May, routine referrals of patients from GPs for psychological services decreased significantly compared to the monthly norm. GPs were advised that routine referrals would be deferred, and encouraged to make use of online cCBT (Beating the Blues and SilverCloud). Referrals to both have increased, and 300 patients were referred in May – with all able to commence within 14 days of receipt of referral.	With all new appointments deferred since the end of March, other than some urgent cases, the longest wait for psychological services in adult services is around 52 weeks. All patients are being contacted to establish their current needs/priority – with a view to standing-up routine contact via Near Me/phone. Standardised materials for remote working, digital forms etc., are being identified/collated; standard letters to service users are being prepared; methods for appropriate recording of clinical sessions on Trakcare have been identified More extensive use will be made of all adjuncts to therapy, including additional signposting resources, use of cCBT, SilverCloud, and ieCBT.
Community Mental Health Teams (general adult)	Referral number dropped to about 25% of normal during April 2020, but have risen to half of normal during May 2020. Demand is increasing. Face to face contact is still provided but only now where there is a clear clinical rationale, and with screening processes and PPE in place to minimise risk.	The waiting list shows a small number waiting at the moment, and a larger number who have been waiting since the beginning of the pandemic (in the range 12-19 weeks) and very few otherwise.
Community Learning Disability and Autistic Spectrum Disorder services	New referrals have decreased to almost zero, however existing cases are causing considerable work due to changes in social care provision	No waiting list
Community Drug and Alcohol Services	Referrals reduced to almost zero during April, however a small number have started to come through in May from community teams. It is anticipated this will increase when services resume.	No waiting list
Community Older People's Mental Health Services	Referral had reduced to 25% of normal in April 2020, but are back to 50% of normal in May 2020. Face to face contact is still provided but only now where there is a clear clinical rationale, and with screening processes and PPE in place to minimise risk.	The waiting list shows a small number waiting at the moment, and a larger number who have been waiting since the beginning of the pandemic (in the range 12-19 weeks) and very few otherwise
Eating Disorders	Referrals have significantly reduced in April and May as compared to March. However, the team has been offering 'treatment as usual'	No waiting list

	(predominantly via video call) for all patients on the TESS existing caseload.	
Perinatal	Comparing 2019 to 2020. Mar – May show 13% reduction in referrals however referrals Jan to May show an increase of 10 %. All patients offered Near me or telephone contact there has been a mixed response in terms of patient preference Near me vs phone contact. Domiciliary Visiting has been carried out on occasion due to significant clinical concerns.	No waiting list.
Rehabilitation	Continue to receive referrals. Restriction on ability to work through discharge planning arrangements with provider organisations due to current restrictions. Community patients continue to receive face to face visits as required. Both services using Microsoft Teams and Near Me to carry out MDT reviews and care planning meetings.	A waiting list is in place due to the restrictions imposed by Covid-19 on community support teams.
Community Forensic	Referral numbers have been largely consistent. New patient demand for this service is small as the case load tends to be small numbers of highly complex patients.	n/a
Out of Hours/ Crisis response services including intensive home treatment services	Lanarkshire uses existing services within CMHTs to manage crisis.	n/a
General Hospital Liaison Service	Most referrals to the service are now being seen and managed remotely via video and phone reviews. Ed input is described above.	n/a
Care Home Liaison Service	Overall service activity has increased, no waiting list. Advice and reviews carried out by telephone or Microsoft Teams Weekend cover has been put in place due to increased demand for advice to care homes.	n/a
Inpatient – Adult	A decrease in both admissions and occupancy overall, although a marked initial decrease has levelled out now.	n/a
Inpatient – Older Adult	An increase in admissions has occurred	n/a
Inpatient – Dementia	After a marked decrease in admissions at the start of the capacity this has reversed and admissions and occupancy are now higher than usual.	n/a
Inpatient – IPCU	Usually at capacity, as was the case prepandemic	n/a
Inpatient – Forensic	No change to pre-pandemic	n/a
Inpatient – Learning Disability	There are increasing numbers of complex patients and delays are being experienced in making appointments.	n/a

Wellbeing Services for the Public
Psychological Services provides a telephone helpline, staffed Monday to Friday, 10am to 6pm. This offers tiered psychological support to the public. Whilst many are managed within a single session, a small number have required more intensive (up to 6) brief therapy sessions. Some patients have called in crisis, and been directed towards psychiatric/CMHT services. A handful have been directed to their GP, with generic mental health concerns that would merit a standard, routine referral to mental health services.

Further public support has been via use of social media, signposting to various local and national resources (online and telephone-based).

Mental Health Wider Partnership
Maximising choice, control and independence, through safe, sustainable and economically viable responses to support planning remained key throughout the COVID 19 outbreak.

Access to information, advice and signposting are critical factors in ensuring that supported people get the right type of support and at the right place and time- irrespective of whether they are well, self-isolating or shielding. The pyramid of support options around choice and control - commencing with self -help, ranging through family support where available, local community responses, wider community responses, third sector responses and ultimately statutory service responses is vital in ensuring appropriate and timeous support, where support is required.

The need to ensure protective factors remain in place and the need to build resilience need to inform our future actions across the spectrum.

Learning from the COVID19 outbreak:
Self help
Many supported people have the ability to make their own arrangements, whether online shopping, grocery or medication delivery, or access online support around health and well-being - or to mitigate many of the impacts associated with loneliness or isolation.

Digital Exclusion
This remains a major issue in North Lanarkshire and future planning will need to ensure greater connectivity and access to online support and resources. For many of our citizens, access to online information, advice, support, or on call or remote support was not an available option through the COVID19 outbreak.

Family Support
In many instances family members offered much greater support than their usual unpaid caring role would generally entail. Many families opted to have a family member, who required a level of support, to move in with them, thus reducing pressure on services, but potentially with some physically, emotionally, financially or emotional cost to the family.

Many families opted to reduce or suspend any paid support that had been in place through an Individual Budget place before the COVID19 outbreak. This generally enabled support provider organisations to redeploy available staff to those individuals who required ongoing support and where other support options were not available.

Third Sector
Local and across the authority third sector organisations were, in many instances, able to repurpose their normal role into different responses – such as the delivery of groceries or medication to individuals who were self- isolating or shielding. As well as meeting the individual needs of those concerned, these actions served to reduce pressures and demand on statutory

services. Some organisations were able to do this within existing funding, whilst others may have sought funding through funding streams such as the Third Sector Resilience Fund.

Statutory Support

Some Social Work service provision was not available to people in the same way. Examples include Respite Care, Locality Support Services and Integrated Day Services. Where possible, alternative means of support / delivering support were sought, but in many instances this resulted in an onus on families. Given that services and supports were often put in place to alleviate pressure on families, it could reasonably be anticipated that as we move forwards, there is likely to be an increasing demand for supports across these services. We will continue to liaise with families and carers as the lockdown rules are lifted to ensure that we are supporting individuals where required and appropriately within the guidelines from the SG.

Support Provider Organisations

Support providers will continue to map their provision, using "Red, Amber, Green –to identify who requires essential support or where minimal support may be robust enough.

Weekly conference calls with both framework and non-framework providers will continue to remain in place during the COVID19 outbreak and the recovery planning.

Assessment, Reviews and Budget Allocation

Assessment, review and individual budget allocation processes remained in place throughout with many reviews being remotely. However, some reviews and statutory legislation based meetings had to be held face to face or deferred, where IT systems were not compatible.

Interim SDS Option 1 and 2 Arrangements

The Scottish Government Guidance on interim arrangements regarding SDS Options 1 and 2 proved very helpful, as this enabled family members, in emergency situations, to be offered the option of becoming paid Personal Assistants. Whilst the need to implement such arrangements locally was small, it proved invaluable in assisting in what may have otherwise been problematic situations.

In line with national guidance, NLC committed to ensuring that existing commitments in terms of individual budgets continued to be met, irrespective of any reduced or suspended support, whether through personal choice, or provider led reduction in support, due to staff, or Personal assistants self -isolating or shielding.

Carer Budgets

We have not yet seen any significant increased demand for Individual Carer budgets locally. Prior to the COVID19 outbreak, unpaid care in Scotland had an estimated value of approximately £11 billion annually. IT could reasonably be anticipated that the need \ demand for carer budgets may well increase as we move forwards.

Looking ahead

Advance planning and outcome focused support remain key to SDS and to any future actions. By ensuring that support plans capture:

- Specific, intended outcomes
- How the person will be supported
- How an individual budget will be used
- How will support be managed
- How will the person stay in control
- An Action plan is in place

Ensuring that we can be more confident around future support arrangements.

Advocacy
Advocacy remains involved in all aspects of the work we do although primarily the statutory cases. Their contact with service users has primarily been over the phone which can present some challenges, particularly for those in hospital as a result of a deterioration of their MH. We will continue to link with Advocacy services as we go forward with recovery planning and lockdown restrictions are lifted.

Addictions
New work from Covid:

- Additional risk assessments for every service user.
- Delivering medications
- Letters to all SU offering advice, guidance, emotional support and a list of online and telephone support services.
- Telephone contact regular including full assessments
- Medical apt via telephone prescriptions faxed/emailed
- Increase in auditing – e.g. outcome stars
- Telephone contact for mental health and wellbeing checks
- Outcome stars via telephone for ongoing assessment
- Crisis input/advice
- Linking with other voluntary agencies
- Take home medication prescription/provision of lock boxes
- Distribution of naloxone
- Increased coordination with Harm reduction team

What is working well?

- Some instances take home medication has worked well
- Emailing prescriptions and telephone consultations
- accessing treatment quicker
- Telephone consultations reduced DNA and increased contacts
- More family/natural supports involved
- More responsibility taking by SU
- Assessment via telephone, on occasions
- Recording with service users/ reduce DNA
- Greater level of engagement across service user group
- Peer support increased Again some teams seem to be reporting more supportive working arrangements between staff who are relying on each other for handover information, recording systems where there is not enough technology to support remote working etc.
- Screening and assessment has worked well via telephone but ongoing support is not as good if not face to face.

Less success with:

- Medicals – starting and not being seen or confirmatory urine screen pre commencement on treatment.
- Service users joining meetings – they lack technology Lack of face to face observations impacting on undertaking thorough risk assessments in process.
- Structure set up: service users attend office appointments/ or call by in crisis, but we need to work towards greater outreach model.

4.4 Details of Dependencies

1. The importance of primary care and community services is recognised in the **reconfiguration and recovery structures** which have been introduced to ensure the safe and effective mobilisation of resources.
2. **Digital infrastructure**: NHSL and the two HSCPs have seen a huge increase in the roll out of Near Me technology with more than 3,000 virtual consultations each week. All GP practices in Lanarkshire are now utilising the technology. In relation to MH services, planning is underway to clarify procedures for Near Me calls to take place in shared office spaces and in the homes of staff. (Wi-Fi is not available in some CMHTs and inpatient wards).
3. **Accommodation**: This is variable from area to area and includes staff issues and clinical issues. Staff are often working in relatively small spaces adhering to the 5 members of staff to 3 desks policy. In most areas this will not comply with social distancing and thus working at home is required. This links with dependencies 1 and 3. Clinic space is limited, and waiting rooms more so, thus processes are needed to restrict flow and ensure distancing can be observed.
4. **PPE**: PPE is in good supply across all areas
5. **Staff Support**: Staff will require additional childcare support and guidance – current guidance is that if working from home, children should remain at home and be home-schooled. This is not feasible if staff have to provide clinical/other services on an on-going basis.
6. **Patients travel arrangements**: Many people will use public transport and this can be an area of risk which needs to be factored into any developments.
7. **Structures within the Health and Social Care Partnerships:** work will continue to support the changes to the construction of localities across Lanarkshire and to recognise the many inter dependencies of various areas of community activity
8. **Shielding and those more vulnerable/isolating**: As above, a risk assessment around the need for assessment must incorporate the additional potential risks to the patients of COVID19, but also the risk of not being seen or having input from community services. There are over 50,000 treatment room attendances per month in Lanarkshire; there are over 100,000 eligible for flu vaccination; many of the national screening programmes run to many thousands. If such services are to be provided to vulnerable groups in their own homes, there will not be sufficient capacity to deliver all of these programmes.
9. **Access to IT:** Increasing numbers of staff require access to IT equipment to support remote / mobile working. This will support ongoing Near Me consultations and support with physical distancing as outlined in bullet point 3.

5.0 ACUTE SERVICE PROVISION

NHSL Acute Services Recovery and Renewal May – July 2020

5.1 Introduction and Principles

The initial Covid-19 recovery and renewal phase within NHSL will be focused on reinstating urgent outpatients, diagnostics and surgery during the period end of May until the end of July 2020. This provision is contingent on a situation where Covid-19 presentations remain under control and with the proviso that if activity starts to increase again to a point where ITU capacity is over 200%, NHSL's Covid-19 mobilisation plan will be invoked.

During this period both the team at University Hospital Hairmyres (UHH) and the team at University Hospital Monklands (UHM) plan to bring on line a range of services to treat our clinically urgent patients. At this point there are no plans to deliver urgent elective care in University Hospital Wishaw (UHW) however that situation is being kept under active review. The plan for UHH is to treat clinically urgent ophthalmology and urgent surgical and vascular inpatients. At UHM the plan is to provide a range of urgent day surgical procedures and endoscopies along with an urgent head and neck outpatient assessment service.

Independent Sector - Colleagues at Scottish Govt have confirmed (in email) that NHSL will have access to the IS until the end of July and that discussion is ongoing for the period from 1st August onwards. The outcome of this will inform the next phase of the Mobilisation Plan. As part of the acute recovery process, a clinical reference group is being established which will support the clinical prioritisation of clinically urgent activity which is being commissioned.

Re-commencement of routine Elective Services - NHSL is currently undertaking a waiting list validation exercise and this will inform the clinical prioritisation of elective patients. An initial focus will be on the inpatients waiting over 52 weeks by clinical specialty as detailed below:

- Total Number of in Patients waiting over 52 weeks = 64
- A Covid holding list was created for return outpatient appointments which were cancelled and each specialty team is reviewing the patients on the list to determine a plan for each patient. In addition NHSL has engaged with formal contracted insourcing external providers to commence discussions about how the outpatient activity is remobilised taking account of the requirement to maintain social distancing.

The following set of cross system clinical priorities have been agreed around service activation for general secondary care services with an aim to:

- Strengthen 111 capacity and sustain appropriate ambulance services 'hear and treat' and 'see and treat' models. Increase the availability of booked appointments and open up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Undertake simulation that takes into account the human factors to give staff and patient reassurance of Covid-19 free areas within sites.
- Ensure staff receive appropriate training to undertake new roles on an ongoing basis.
- Provide local support to the new national NHS communications campaign encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.
- Provide urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-Covid19 levels of capacity. The Royal College of Surgeons has produced helpful advice on surgical prioritisation available at:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf

- Prior to face-to-face contact being re-instated, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.
- Solid organ transplant services should continue to operate in conjunction with the clinical guidance developed and published by NHS Blood and Transplant.
- Make full use of all contracted independent sector hospital and diagnostic capacity e.g. at GJNH.

5.2 Governance

a) NHS Lanarkshire has established a Response, Recovery and Redesign Oversight Board and full details can be found at section 1.2.1.

b) In order to progress redesign and recovery within the Acute division, an Acute Recovery Board has also been established. The primary focus is to oversee and approve recovery in acute services for diagnostics, outpatients and inpatients recovery in terms of patient safety, efficiency, demand, capacity and flow.

5.3 Protected Capacity to Respond to Current and Predicted Future Covid-19 Levels

a) NHSL is maintaining Covid-19 capacity in terms of ICU, acute beds, theatre capacity and workforce for patients currently in hospital and sufficient capacity immediately available for an increase of up to 50% more patients than current on an ongoing basis. This is being monitored on an ongoing daily basis. The capacity required to reinstate NHSL share of the original re-purposed 3,000 beds surge capacity is also identified capacity and available to be switched back on with 7 days' notice.

b) Any surge in Covid-19 patients beyond this will require this recovery plan to be paused and in fact reversed for a number of services.

c) The current Covid-19 service ensures patients and staff safety, Covid-19 screening and testing of patients and staff and good infection control. It includes capacity in use in the Emergency Departments, Covid-19 receiving wards, ICUs and emergency theatres as well as all of the associated staffing capacity.

5.4 Ongoing Commitment to Patients Requiring Emergency, Urgent and Maternity Services

The following services were maintained throughout the first Covid-19 surge (March to May 2020) or have recently been started/restarted:

a) Cancer Services within the Independent Sector – As the Covid-19 surge approached, NHS Lanarkshire quickly established urgent Cancer surgery capacity at The Nuffield in Glasgow. This covers urgent cases for Skin, Breast, Gynaecology and Urology. NHSL provide surgeons from each speciality. The Nuffield provide theatres staff and ward staff care post operatively.

The Breast Service has largely maintained the one stop clinics at the Nuffield and have continued to carry out cancer surgery on 94 patients to date with 9 patients pending surgery. NHSL provide surgeons, Speciality Doctors, Cancer Nurse Specialist Support and Administration support staff due to the one stop clinic requirement to ensure all patients attending receive the care required within the offsite facility. The Breast team have prioritised each individual patient and commenced hormones for those who are hormones sensitive, these patients will require surgery as their next treatment modality. There are 20 patients in total with a plan to utilise further off site capacity at the GJNH in June 2020 (see below).

b) More recently, capacity for urgent Cancer cases has also been established at GJNH. This consists of Colonoscopy (one list a day, going to two per day in early June), Urology (one list a week), Gynaecology (two lists a week), ENT (two lists a week), Breast (one list a fortnight), and Upper GI (ad hoc due to complexity of surgery). In addition, lists for

Plastics and Colorectal are in the process of being established to support a parallel service as local services begin to mobilise.

c) Cancer Service within NHSL have sustained all oncology and Haematology clinics with no impact to patients waiting more the 2 weeks.

d) Systemic anti-cancer Treatments (SACT) - To sustain SACT delivery locally the service reduced from three site delivery to a two site model to enable a viable approach for delivery that would be sustainable during the Covid-19 surge. All new patients commenced treatment within 2 weeks of diagnosis. Existing patients on treatment were reassessed to consider whether systemic therapies could be given in alternative regimens, different locations or via other modes of administration to minimise patient exposure and maximise resources. All treatment decisions were made on a case-by-case basis with input from both patients and the Multi-Disciplinary Team with the prioritisation details overseen by the nominated haemato-oncology leads.
   There was a general approach to prioritising patients on systemic anti-cancer therapy:
   - Categorise patients by treatment intent and risk-benefit ratio associated with treatment.
   - Consider alternative and less resource-intensive treatment regimes.
   - Seek alternative methods to monitor and review patients receiving systemic therapies.
   - Changing intravenous treatments to subcutaneous or oral if there are alternatives.
   - Selecting regimens that are shorter in duration.
   - Consider using 4-weekly or 6-weekly immunotherapy regimens rather than 2-weekly and 3-weekly.
   - Consider alternative models for supply of oral systemic anticancer treatments to minimise hospital attendance.
   - Consider deferring supportive therapies such as densoumab and zoledronic acid treatments (except for hypercalcaemia).
   - Consider treatment breaks for long-term treatments when risk of coronavirus is high.

e) Diagnostic Services - Radiology continued to provide 24/7 cover for all In Patient and Emergency activity and all requests triaged as Red (Suspicion of Cancer/ Clinically Urgent).

f) Cardiology – NHSL provides Cath Lab services for the West of Scotland in UHH. While a full emergency / Urgent service was maintained for Lanarkshire patients referrals from NHS D&G and A&A were initially transferred to the GJNH. From 18th May 2020 this service has been reinstated within NHSL. In the coming weeks it is expected that the Cath Lab will return to full capacity.

g) Stroke – a full emergency stroke service was maintained within the three Acute sites across NHSL. This included full access to Thrombolysis. Community facilities within Udston Hospital were utilised to facilitate Stroke Rehabilitation. It is expected that this service will return to UHW by July 2020.

h) Maternity – Core Maternity services have continued within NHSL as noted within the Covid-19 mobilisation plan. This was done with a number of amendments to normal working, specifically in relation to antenatal services, cancellation of home births, reduced visiting and priority audiology screening. Online Antenatal classes have been launched and electronic follow up will be implemented shortly. Improve access for partners during birth and access to neonates is currently being reviewed.

i) Trauma – As part of NHSL's planned centralisation of Trauma to one site, the move of all Trauma to Wishaw was expedited. This move has worked well during the initial Covid-19 surge and has enabled an efficient, safe service to be delivered to patients. UHW now has an Ambulatory Trauma Unit with appropriate Covid-19 risk assessment of patients and streaming down two pathways to Covid-19 and Non-Covid-19 wards. Given the PPE and Infection Control cleaning requirements for theatres for operating on Covid-19 positive or suspected case, a 'Red/Green' Risk Assessment has been developed to ensure that patients in the Green stream can safely be operated on with normal PPE and normal, rather than extended, cleaning requirements between cases. This has ensured

both safety for patients and theatre staff as well as efficiency of the number of cases on a list.

j) CEPOD General Surgery Theatres – Emergency General Surgery was concentrated on a single site at UHW during the first Covid-19 surge. This model is currently being evaluated and it is intended that NHSL moves back to a three site model. There will be a contingency in place to move back to the one site model if there is a further Covid-19 surge.

5.5 Priority Services in Process of Being Reinstated

a) Prior to the Covid-19 surge, UHH ran six elective theatres per day. The NHSL Response, Redesign and Recovery Oversight Board has agreed a phased plan to reintroduce theatre capacity at UHH to treat clinically urgent inpatients. This will be balanced against required Covid-19 capacity including theatre and Anaesthetic staff and Level 3 ITU capacity.
   - CEPOD is being maintained around the clock for vascular and ophthalmic patients. In addition, any General Surgery patients too unstable to transfer to UH Wishaw are treated.
   - To be implemented from 25th May 2020 - Emergency Surgery will continue as described. In addition, 3 session days will be provided in two theatres over 5 days. One theatre will be dedicated to Colorectal Cancer (15 sessions per week) and the second shared between Ophthalmology (6 sessions) and Vascular (5 Sessions).
   - To be implemented from 1st June 2020 - Continue as above (Vascular increasing to 9 sessions) with regular review and evaluation. This will include ongoing monitoring of a range of factors not least the impact on critical care capacity.

b) Establish an Ophthalmology Diagnostic Hub at UHH. This service is aimed at those patients who were initially stratified as “amber” during the pandemic .There is a concern that some of these patients may have progressive conditions that could have deteriorated while waiting e.g. macular degeneration. The diagnostic hub will facilitate re-assessment of all urgent patients. The hub will facilitate specialist ophthalmic imaging, visual acuity and ocular pressure tests. These results will be reviewed electronically by a consultant ophthalmologist and follow up will be provided, for the majority of patients, via telephone or Attend Anywhere. Initial focus will be on Medical retina patients expanding to other patient groups over time. The Hub will see 120 patients a week as of June 2020.

c) UHM will provide a range of urgent day surgical procedures and endoscopies. The Day Surgery unit at UHM is a stand-alone unit, separate from main theatre. The endoscopy unit similarly is self-contained situated at the rear of the hospital. The layout provides an opportunity not only to maintain Covid-19 pathways but also to create a 23 hour care facility maximising the theatres in day surgery. The following activity is planned;
   - Continuing 24/7 access to emergency surgery
   - Establishing 2 sessions per day Monday to Friday for use by ENT / OMFS / Urology Surgery or others as required.
   - Establish 5 urgent endoscopy sessions Monday to Friday for use by medical specialties
   - Establish 5 Endoscopy sessions per week Monday to Friday for cystoscopy (Urology)

d) Head and Neck clinics and one stop neck lump / biopsy clinic (UHM). The implementation of active vetting and telephone review as part of the COVID 19 response has reduced the requirement to see face to face head and neck patients to a minimum. However, as the number of referral start to increase there is a clinical priority to restart regular clinics, specifically those with a diagnostic element. The intention is to run 2 head and neck clinics and 1 neck lump / biopsy clinic per week.

e) Radiology is currently working through those requests triaged as Amber and include:
   - Examinations where there is suspicion of malignancy that have not been performed during COVID crisis.

- Examinations to assess treatment response that were not performed during COVID crisis
- Examinations to diagnose and/or treat significant disease or injury and/or alter treatment plan
- Routine surveillance of patients on a cancer pathway

f) Community Dental Services (UHM). The community dental service pre- Covid 19 provided paediatric General Anaesthetic (GA) sessions within UH Monklands day surgery unit. An initial 40 paediatric patients have been identified that require urgent dental treatment under GA. These patient all have special needs ranging from mild to profound disability. Additional simulation work is under way to ensure safety with regard to Covid 19 pathways and appropriate requirements are in place to meet the needs of this patient group. It is planned to treat an initial 20 patients by July 2020.

5.6 Priority Capacity for Urgent Activity Up To End July 2020

a) Estimation of Clinically Prioritised Activity covered by 5.4a, 5.4b above (Cancer).

Due to early discussion with the Independent sector providers, NHSL has been able to undertake cancer surgery for all Level 1 cases with the availability of offsite capacity. Planning and identification continues with GJNH and Nuffield to list Level 2 patients which will ensure capacity to accommodate those waiting by the end of July 2020. This has been exclusively at Level 1 (Urgent and emergency surgery required, for example obstructing colonic cancer) and Level 2 (Surgery within 4 weeks required to avoid disease or symptom progression with a high likelihood of curative resection).

The Table below details the normal surgical demand:

Cancer	Annual Surgical Demand	New Pathway Surgical Demand*	Anticipated monthly demand for surgical procedures*	No. Currently Waiting
Pancreatic	23	6	<1	0
Oesophageal and gastric	75	19	<2	1
Liver (WoS) (most go to ERI)	12	3	<1	0
Cervical	70	18	<2	0
Ovarian	137	34	<3	5
Endometrial	275	69	6	0
Colorectal	1091	273	23	28
Renal	211	53	4	7
TURBT	646	162	14	19
Cystectomy	63	16	<2	3
Orchidectomy	75	75	6	0
Prostate	189	189	16	8
Breast	2074	2074	173	20
Lung	368	92	8	0
Skin	614	614	51	10
Sarcoma	117	29	<3	0
H&N	264	66	6	23

b) Estimation of Clinically Prioritised Activity covered by 5.5 above.

The allocation of lists to specialties will be under regular review to ensure that the most clinically urgent cases are treated. For example, no Orthopaedic numbers have been included below but the urgent cases require a solution that may include GJNH for some cases (Urgent Revisions). However urgent cases that cannot be treated at GJNH will be allocated theatre capacity at UHH.

Inpatient / Day Case Capacity			
Planned Activity	**Urgency of Treatment Patients Currently on Waiting List**		**Number of Patients to be Treated Based on Available Capacity (June – July)**
	< 3 Months	**over 3 Months**	
Urgent Inpatient Ophthalmology (UHH)	27	181	144
Urgent Colorectal Inpatients (UHH)	30	209	90
Urgent Vascular Inpatients (UHH)	52	46	81
Urgent 23 Hours Care (UHM);			
ENT	126	377	63
Urology	66	768	56
Dental (GA)	40	20	20

- All patients have been clinically risk stratified. Revised clinical priority criteria currently being introduced
- UHM 23 hour care open to a range of specialties. Initial focus on those based in UHM
- ENT includes capacity for urgent Head and Neck Scopes.

Outpatients Capacity		
Planned Activity	**Numbers Waiting**	**Number of Patients to be Treated Based on Available Capacity (June – July)**
Urgent Cystoscopies	751	350
Urgent Head and Neck	94	270
Neck lump / Biopsy	70	90
Ophthalmology Hub	320	1180

- Cystoscopy included Haematuria, flexi-scope and urgent repeats
- Cystoscopy Capacity also available at Nuffield
- All patients have been stratified by risk. A proportion reviewed electronically
- Ophthalmology Diagnostic up to see all patients.
- Medical scoping capacity at UHM – emergency service
- Ophthalmology Hub will initially see 320 patients - other patient cohorts to be included when established.

5.7 Prioritisation of Further Clinically Urgent Activity

a) **Cancer** – USOC referral rates have fallen by up to 60% across all cancer types. This is thought to be due to patients not presenting to primary care with symptoms and staying at home. This has been reviewed at Regional Cancer Action Group (RCAG) and there is no evidence that GPs are not referring patients. GP's have highlighted that patients with breast lumps have continued to attend with appropriate USOC referrals continuing to be received. It is anticipated that there will be an increase in USOC referral when the COVID surge has decreased. All USOC referrals pending (as described in the table below) pre Covid-19 have gone through an enhanced vetting process by each speciality clinical team and have been prioritised as low risk therefore able to wait 12 weeks. However it has been noted that a proportion have been offered an appointment and declined due to Covid-19 concerns and remain on the waiting list with this level of status following further clinical prioritisation discussion with the GP to obtain further clinical information.

Parent Specialty	No. of Urgent Suspicion of Cancer waiting	Weekly Urgent Suspicion of cancer demand
Dermatology	8	70
Gastroenterology	1	62
Respiratory Med	6	43
Breast	51	113
Oral and Maxillofacial Surgery	14	
ENT	79	89
Ophthalmology	6	
Plastic Surgery	5	
Urology	23	58
Gynaecology	27	16
Hysteroscopy	42	32
Haematology- Lymphoma	2	9
Grand Total	**264**	

Each service are currently working through plans that will accommodate this activity by the end of July 2020 in addition to meeting the increased surge of USOC referrals predicted each week that will take the demand back to normal referral rates.

Cancer Diagnostics- Urology

Currently there are 293 patients on the waiting list for a Flexi scope, 11 of whom are isolating and 102 patients on the haematuria waiting list, 17 of whom are isolating.

Offsite capacity has been secured at the Nuffield and this can facilitate 24 patients each week however this capacity will not meet the demand by the end of July. Planning is underway to support additional local capacity.

b) Principles for Reinstating Further Urgent Services – All outpatient, diagnostic and therapeutic/surgical services that are reinstated will be evaluated against the following principles:

- Clinically-led whole systems recovery where all services consider - Quality, safety, digitally enabled, patient centred.
- Emergency care should be scheduled where possible.
- Services should be safely and incrementally restored through testing of pathways and simulation, with new and effective ways of working.
- Consideration should be given to the split of hot/cold sites, or at least physically discrete sections of sites to provide Covid-protected services
- Staff and stakeholder engagement is paramount.
- Benefits of regional working should be considered.
- The availability and financial implications of all resource required to reinstate a service must be considered e.g. PPE, anaesthetic medicines in short supply, workforce in short supply, bed requirements.
- Transformation – As part of the Covid-19 mobilisation plan, all specialties are required to adopt new ways of working. These included Remote Consultations (Near me or Telephone Consultations), Active Vetting and Patient Initiated Review. This work had begun previously through the Modernising Outpatients programme and the Access Collaboratives, particularly within Orthopaedics, ENT and Gastroenterology. The intention going forward is to work with each of the specialties to determine how these new ways of working can be embeds as part of recovery planning. Work is currently

underway to evaluate use and support requirements by specialty (Appendix 1). NHSL has discussed with other boards including NHS A&A and NHS FV to determine if this could be supported on a cross-board basis (e.g. learning from areas of good practice).

- Efficient flow of pathways and prompt discharge of inpatients is required.
- IT infrastructure may need to be strengthened.

c) Demand and Capacity Planning

The senior medical leadership team have undertaken an initial review of the entire NHSL surgical waiting list by urgency to stratify patients into 2 cohorts – i.e. patients who require treatment within 3 months and patients who can wait longer than 3 months. There is a recognition that these numbers have a degree of overlap with other figures given earlier in this plan. There is also a recognition that this stratification will be further refined following a waiting list validation exercise which is underway and by clinical review of individual patients.

NHSL Waiting List Stratified by Urgency of Wait			
Specialty	**<3 months**	**over 3 months**	**Total**
A1 General Medicine	10	0	10
A2 Cardiology	53	0	53
AR Rheumatology	0	2	2
C1 General Surgery	189	1893*	2082
C12 Vascular Surgery	52	46	98
C13 Oral and Maxillofacial Surgery	0	182	182
C31 Chronic Pain	0	259	259
C5 ENT Surgery	126	377	503
C7 Ophthalmology	27	181	208
C7B NHSL Cataract List	0	1193	1193
C8 Orthopaedics	41	1217	1258
CA Surgical Paediatrics	0	3	3
CB Urology	66	768	834
D1 Public Dental Service	0	24	24
F2 Gynaecology	19	481	500
H1 Clinical Radiology	0	7	7
Totals:	**583**	**6633**	**7216**

*Gen surgery includes 1342 breast for repeat Mammography

- NHSL are undertaking a process to establish the backlog of Demand for Outpatient, Diagnostic and Therapeutic/Procedure/Surgical services by Specialty and by Urgency (e.g. Cancer, Suspicion of Cancer, Urgent and Routine). This includes all patients currently waiting for services, including those cancelled as the Covid-19 surge approached.
- For Outpatients this process includes a strong drive within all specialties to transform pathways to include as much virtual consultation (telephone, letters, clinical questionnaires, Near Me, patient opt-in, virtual decisions etc.) as possible to minimise the need for face-to-face consultation. Waiting List validation is also being undertaken.
- For Diagnostics and Therapeutic/Procedure/Surgical this includes waiting list validation to ensure the patient still requires/wants the intervention.
- Surgical urgency for all patients on the Inpatient/Daycase waiting list is being classified according to the Royal College of Surgeons classification by procedure to enable cross-specialty prioritisation.
- Capacity is being established by examining the physical environment (outpatient rooms, theatres etc.) and workforce. Both of these elements of capacity are currently reduced

from pre-Covid-19 levels due to the need to continue a Covid-19 stream through hospitals and by the need for social distancing and allowance for shielding patients.

- The above process will result in an ability to model and match available capacity with the highest urgency of demand in a quantified and structured manner.
- The services with the greatest volume of urgent patients will be reinstated, although almost certainly with reduced capacity from pre-Covid-19 levels and with service redesign where possible.
- There are likely to be a number of shielding patients for whom, despite the intended intervention being urgent, the clinical assessment of Covid-19 risk or patient choice results in the intervention being delayed.
- For those services/interventions identified as less urgent and where insufficient capacity is available to reinstate before the end of July 2020, a plan will be put in place for the patients affected. Communication with patients, waiting list validation, discussion regarding 'realistic care' and an option to contact the service if symptoms worsen are likely to be included. A national approach to 'procedures of low clinical value' would be extremely beneficial.

5.8 Managing Unscheduled Care in the Recovery Phase and in the New Normal

The risk of COVID 19 is a new factor that will influence management of unscheduled care across the Health and Care System in the weeks and months to come. This requires us, as a matter of urgency, to review pathways and alter approaches to assessment and treatment of urgent and emergency care patients to reflect this new and additional risk; re-evaluate and change we provide assessment and care in all healthcare settings; taking account of needs of the population across physical and mental health through a clear clinical prioritisation process.

The most important priority identified by the Medical and Nurse Directors going forward is to move from a model of unplanned attendance or assessment to one that is in a planned appointed clinical system. There is strong support for using what has been learnt across the whole system to maintain and expand the new ways of working. The potential safety gains of a more controlled approach to unscheduled care attendance to any healthcare setting will be significant by avoiding overcrowding and unnecessary face to face contact and may play an important factor in mitigating or reducing winter pressures generally and any additional COVID 19 pressures that emerge in the future.

As management pathways are adapted it will be important to understand the implications for both staff and patients of how we organise services to accommodate the social distancing and infection prevention and control measures to minimise the risk of preventable harm from transmission of the virus to keep staff and patients safe at the same time using the available capacity to best effect.

Boards will require to consider their arrangements locally to support care recognising that where COVID free 'green' sites are not available or feasible, separate designated areas on acute sites (amber zones) will be essential to allow separate streaming of proven and suspected COVID-19 patients (managed in red zones). This includes dedicated access points for patients and admission processes as well as inpatient areas separate from those where COVID-19 patients are being treated.

In planning for and in the delivery of unscheduled care there are constraints that require explicit consideration such as diagnostics. This is recognised as a constraint within both scheduled and unscheduled work due to both an increased requirement for diagnostic tests to support increasing volume of urgent work and the reduced throughput consequent on the changed way of working from Covid restrictions of social distancing and PPE.

Adopting New Models to Support the Urgent and Emergency Care Response
Going forward it will be important to ensure joined up pathways and models of response to unscheduled care across NHS24, SAS, GP In-hours, GP Out of Hours and Emergency Departments.

NHS 24 Model of Triage - Building Further Capacity
The NHS 24 model of triage into Covid hubs has been well received by patients and professionals and delivered safe, consistent care. It has also supported more self-management and self-care, and links clearly to the wider primary care resources of Community Pharmacy and optometry. Going forward it is essential to strengthen the 111 capacity to support a similar approach for secondary care for ED attendance/ emergency care admission.

Scottish Ambulance Service – Extending the New Ways of Working

- SAS have identified opportunities to join up parts of the service and consider they can play an important part in the move to the greater scheduling of unscheduled care; Sustaining and strengthening appropriate ambulance services such as 'hear and treat' and 'see and treat' models by implementing across the whole system for maximum impact.

- NHSL has worked closely with SAS during the Covid escalation period and plans to continue this productive joint working into the recovery period. SAS report that the additional pathways and prof-to-prof support put in place during Covid have really helped to increase non conveyance rates and, in turn, this has further reduced A&E department activity. The main issues around recovery for SAS are capacity to support a return to pre-Covid levels of PTS activity with physical distancing in place as the service are restricted to one patient per PTS vehicle at present.

Supporting Urgent Care in Primary Care and GP In Hours and Out of Hours Services
In Hours
In response to Covid-19, General Practice has reduced significantly their face to face contacts managing more than 85% of consultations remotely. GP Practices are continuing to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained. Details of the use of Near me are included at Appendix 6c

To support this it will be important to:

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns;
- Stratify and proactively contact high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In particular, proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to Covid19, to ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary. Details of the clinical prioritisation are included in Appendix 6b
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.

Out of Hours

- The multi-disciplinary Covid Hubs and Assessment Centres during the first wave demonstrated consistency and effective use of skilled resources. Further work will be required to see if this model can be continued for the management of Covid patients for the foreseeable future, It is important to identify if a similar model could be applied to a much wider range of unplanned care presentations that builds on the principles of these new approaches. This will require developing further the NHS 24/ Community Assessment Centre

and work across acute services approaches to triage and to manage demand for unscheduled care safely in the right place at the right time by the right person or team.

Acute Care

- Adopting an approach which increases the availability of booked appointments across the urgent and emergency care system; establishing this as the new normal supported by strengthened 111 capacity to support a similar approach for secondary care for ED attendance/ emergency care admission as is currently used to support the GP Out of Hours and Community Assessment Hubs
- Opening up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Providing urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.

Enabling Requirements

Communications Campaign to Support New Ways of Working

- National public messaging/engagement - in respect of the setting the direction of travel for the new normal; informing and engaging on redesign of service provision and to ensure the public understand the changes emerging new service models.
- Strong messaging on using other pathways of care and the importance of triage virtually through NHS 24/GP/ Near Me as a necessary step to reduce self-presentation at Emergency Departments and other Urgent Care Facilities will be essential to keep activity at a level that allows safe distancing and flow.
- Clear information on what the public do across a range of symptoms in hours and out of hours as an alternative to self-presenting at ED will be essential.

Reducing the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

- Expansion of the digital platforms – to expand the opportunities to provide care out with health care settings in to people's homes, allowing new approaches to be used across primary and community care; sharing information across organisations to improve health outcomes; minimising the need for patients and staff to travel, wherever possible.

Supporting Policies and Processes

- Explicit policies on the use of virtual/remote technology to support service provision will be required with clear policies and processes for the system for those professionals who are taking telephone calls or carrying out virtual or face to face assessments to 'schedule' attendance for those patients who need to attend ED. We need also to ensure patients can be directed to the nearest ED with capacity if the most local ED is full and unable to offer safe social distancing. This will require some sort of real time dashboard on ED 'appointment' availability;
- An electronic referral which tells the ED who to expect and when as well as giving the patient clear guidance on this will be required to support this model as well as a policy on what to do with self-presenters who may turn up at ED without professional referral. If the policy is to triage and then divert will need some resource and determination to ensure this can be implemented supported by strong national messaging on that policy.
- In delivering these new models clear policies about waiting areas and how to secure social distancing would be helpful and should extend to cover the position on relatives of patients. New ways of working are being developed and Appendix 7 provides details of questionnaire developed to capture this information.

6.0 CORPORATE SERVICES PROVISION

6.1 Recovery Priorities

The sections below encompass the corporate service priorities for NHS Lanarkshire.

6.2 Public Health Burden of Pandemic Response

The majority of routine public health work has been stood down to allow for the massive upsurge in public health responsibilities generated by the COVID-19 response. There is an expectation that Public Health Departments will play a major role as Scotland exits lockdown and transitions into the new normal. It is anticipated this could be for a sustained period, possibly 18 - 24 months. Since the containment phase of Covid-19, the department has been severely stretched, as have many other departments, and there is a need to support the resilience of the department going forward.

Prior to COVID-19, the Public Health department carried out the following core activities:

- Health Protection
- Population Screening Programmes
- Cancer cluster and cancer prevention work
- Child and Maternal Public Health (including Child Health Commissioner role)
- Healthcare Services Public Health
- Public Health Information and Intelligence
- Caldicott Guardian
- Dental Public Health
- Mental Health
- Injury Control
- Asylum Seekers (Dungavel Detention Centre)
- Prison Health
- Liaison with Health and Social Care Partnerships
- Public Health Governance

Since March 2020, the majority of the above services have been put on hold to allow the department to manage the enormous increase in workload generated by COVID-19. Only a very limited number of key activities are currently being sustained:

- TB services (DOTS, contact tracing, immunisation)
- Pre-school immunisation
- Pregnancy and Newborn Screening
- Child Health Commissioner role (although the focus has shifted to mitigating the risks caused by COVID-19)

Four major pressures have resulted from COVID-19:

1. **Care Homes**
   Whilst the Public Health department has always been responsible for managing care home outbreaks of infectious disease, COVID-19 has generated an unprecedented amount of additional work around managing cases/outbreaks and the coordination of testing of staff and residents, followed by results provision and ongoing support/guidance. This currently accounts for the majority of the department's workload (both strategic and operational) and requires additional public health input way above that of the department's current capacity, in order to be able to deliver this service seven days per week. Recent major accountability changes have been introduced by Scottish Government with immediate effect which have enormous implications for the Director of Public Health and the wider team. This will be operationalised on a single system basis and Appendix 8 outlines the arrangement that has been agreed with our two Councils.

2. **Test & Protect**
   The Lanarkshire contact tracing service went-live on Monday 25 May. Capacity will be increased over the subsequent three weeks and workforce is planned to cover the interim phase (phase 1) to end of July 20. There will be a 7 day service over the hours of 9am to 7pm, operating in shift patterns. An additional 70 WTE staff (ranging from Band 3 to band 8D/Consultant Grade) are required to deliver this service. (Further details are listed at Section 6.3 – 6.3.3).

3. **Shielding**
   Public Health has taken a lead role in the coordination and implementation of the shielding programme along with a number of key stakeholders, this has involved a significant amount of time and effort. A number of key tasks have been completed, but, further work is required to transition this as part of business as usual.

4. **Population Health**

- Delivery of the inequalities focused 6 Public Health priorities
- University of Strathclyde inequalities/analytics work, particularly around Monklands Replacement Project (MRP)
- Children and Young People' Health

In order to effectively respond the challenges over the next 18 - 24 months, it is anticipated that the Public Health department will require additional staff at CPHM/Specialist/HPN and administrative levels.

It is anticipated that some of this resource will be allocated to Track/Trace/Isolate (TTIS), although this has not been confirmed. In a paper submitted to Scottish Government a high level assessment of the staff required to undertake TTIS was highlighted. It should be noted this is an early assessment as the TTIS model is evolving on a daily basis.

There has been ongoing concern about the fragility of the Community TB Service going forward if there is a loss of staff and the difficulty to recruit to any vacancies/sick leave.

There is a risk of delay in the development and implementation of a number of strategic plans and thereby coordinated delivery of support to vulnerable families because of the suspension of strategic activity within maternal, child health and inequalities. This could lead to uncoordinated responses to vulnerable families, unidentified need, delayed or missed early intervention opportunities and risk to those who may be vulnerable to neglect, maltreatment and poverty.

The pressures on the department are excessive and there is a risk that the Public Health department is not able to provide a comprehensive COVID-19 response as well as maintaining and restarting key non-COVID-19 public health activities, as well as a reputational risk to NHS Lanarkshire around its ability to protect the population and reduce inequalities.

Detailed work will be now being undertaken to quantify the workforce and finance requirements necessary to deliver a robust COVID-19 response as well as maintaining vital non-COVID-19 public health activities.

6.2.1 COVID-19 and Health Inequalities

The impact of the COVID-19 pandemic will be more severe on those who are most socio-economically disadvantaged and experiencing inequality.

There is emerging evidence that the ***direct*** disease burden from COVID-19 may disproportionately affect those who are more socio-economically deprived and vulnerable. The evidence suggests the societal response to the pandemic will have negative ***indirect*** impacts on the wider economic and social determinants of health inequalities. These include the short

and long term impact on incomes, the mental and physical health impacts of social isolation, and the disruption to essential services and education. These impacts are likely to be borne disproportionately by people who already have fewer resources and poorer health.

Therefore, whilst it is imperative that a robust health protection response is mobilised to manage the immediate pandemic, there is also an urgent need to retain a strong focus on prioritising whole system preventative population health approaches to reduce the persistent and pervasive health inequalities which have existed across Lanarkshire pre COVID-19, and which are likely to significantly worsen as a result of the impacts of the pandemic.

In order to mitigate such risks, Equality Impact Assessments (EQIA), with a strong focus on health inequalities, are integral to NHSL's response, recovery and redesign processes.

NHS Lanarkshire will also prioritise working with Community Planning Partners to assess the wider socio-economic impacts of COVID-19 and address these through system wide delivery of the six national public health priorities.

6.3 Test & Protect

6.3.1 National Context

A number of issues require to be resolved at a national level to support the development of the NHS Lanarkshire Testing and Contact Tracing approach. This includes:

- clarification of the function, purpose and capacity of the national proposed model and the timelines around this to accurately and appropriately plan a local contact tracing response;
- the availability of a functioning national digital tool to support the delivery of the service.
- publication of a Scottish Government/Public Health Scotland overarching strategy which outlines the suite of control measures for COVID-19 and how Test, Trace, Isolate fits with and complements these other measures;
- nationally, clear outlines of roles and responsibilities of national and local contact tracing services, with Standing Operating Procedures (SOPs) detailing how both services would work together, governance structures and processes.

6.3.2 NHSL Approach to Testing

COVID-19 PCR testing identifies the presence of virus particles and indicates current or a clearing infection (symptomatic or asymptomatic). The detection of virus particles does not necessarily mean the person is infectious. The day to day real-time position for testing capability is very uncertain in respect of key items/consumables needed to deliver tests against a backdrop of high clinical, organisational and national expectation to deliver testing services.

NHS Lanarkshire's strategic objectives for COVID-19 PCR (Polymerase Chain Reaction) testing are grouped into four categories:

- maximising testing capacity;
- understanding clinical demand;
- use of prioritisation when required (demand exceeds capacity, temporary or longer term);
- streamlining and utilising outputs (data);

to mitigate the impact of COVID-19 by keeping R <1 in combination with other measures.

Processes – managing related workloads

The following were identified as some of the specific areas to help manage the immediate situation with demand and supply:

- Keep single daily testing requests to <150% of capacity. Average 3/7 or 5/7 requests to <100% of capacity OTHERWISE times for results will be delayed
- Prioritise testing hierarchy and if necessary involve ethics committee for prioritisation decisions. Ensure clinical governance for process, e.g., who is directing the testing policy
- Clarify the daily pro-rata amount of tests for Lanarkshire at the West of Scotland Regional Virus Laboratory or East of Scotland Regional Virus Laboratory meanwhile to work off a theoretical number of available tests on a pro rata basis.

A number of areas/groups were identified for priority testing.

Work is on-going across NHS Lanarkshire to continue to develop this model.

Details of testing undertaken in Lanarkshire are detailed in Appendix 2 Slides COV-1.3 to 1.5

6.3.3 NHSL Contact Tracing (CT) Approach

NHS Lanarkshire's Contact Tracing (CT) proposals are in line with the National Testing Strategy. The Contact Tracing service model will be delivered over three phases:

Phase 1: This immediate phase is the local contact tracing service delivered by the health board that will focus only on the contact tracing of laboratory confirmed positive cases in persons associated with closed settings i.e. care homes, educational settings, acute, primary care, prisons and detention centres within Lanarkshire. We will draw on colleagues who can start contact tracing rapidly because of their previous experience e.g. EHOs

Phase 2: This phase will be concerned with the deployment of a national service, delivered by Public Health Scotland (PHS) to expand contact tracing to the general population. Cases associated with closed settings, as well as clusters and hot spots being referred to the local NHS Lanarkshire CT service. This phase would need to occur before lockdown measures start to be rolled back with the attendant increase in cases in the population. NHS Lanarkshire would be able to provide numbers which could help the national contact tracing service model their requirements for workforce.

Phase 3: This phase will see a significant expansion in the capacity of the national contact tracing service delivered by PHS so it can provide surge capacity to support local health boards with contact tracing in instances when contact tracing demands in closed settings, clusters or outbreaks exceed the capacity of these health boards.

The first meeting of the Contact Tracing Programme Board took place on 7 May 2020 and agreed on the development of a workplan for Phase 1 consisting of:

Stage 1 – early set up stage seconding staff who have experience of contact tracing e.g. EHOs, other healthcare staff. Consideration of working arrangements, accommodation required, development of data requirements, reporting and performance management indicators and processes, training, finance, IT and data management, infrastructure requirements etc. National training resources, associated information, guidelines and protocols required.

Stage 2: Recruitment of one year fixed term staff to replace seconded staff as they return to original roles in UK pandemic recovery phase

Key approaches for successful Contact tracing and isolation are:

- Accurate and timely gathering of contact information from case;
- Contact and advise contacts;
- Provision of clear and consistent advice;
- Monitoring of contacts (active or passive);
- Support to contacts to help maintain isolation; and

- Quick access to testing for symptomatic contacts

Future Requirements
The contact tracing service will need to consider longer term operational plans which will be influenced by future decisions regarding the role of national contact tracing, and other factors. It is likely that there will be increased requirement for an extended period of time managing the pandemic response until a vaccine is available. It is anticipated that this will be 18 months or longer. Therefore, we would be anticipating that in addition to Contact Tracer roles, we would require an increase in substantive Public Health roles to support this ongoing effort. Again, this needs scoped further by our programme board/ project team but we would envisage this would likely include additional Consultant/s in Public Health, Health Protection Nurses, administrators. Work is on-going across NHS Lanarkshire to develop this model.

6.4 IM&T

The eHealth and Technology Enabled Care (TEC) teams have been fully engaged with the agile delivery of solutions to meet Covid-19 response needs. This has seen the introduction of new capabilities as well as extending the use of existing systems.

- NearMe (powered by AttendAnywhere) has been deployed across; General Practice, Care Homes, Primary Care and our Acute Hospitals. This allows for virtual/remote consultations. Significant week on week increase in remote consultations has been achieved with over 9500 since 1 March 2020.
- Microsoft Teams has been introduced as a collaboration platform. We have over 2500 users who are using it on a daily basis to attend meetings from home, from NHS premises, local, regional and national.
- We have increased our remote access service to enable a large proportion of our workforce to work at home. We now have 3748 registered users and 1400 remote users on a daily basis during peak times.
- We have deployed 1527 devices (laptops and ipads) as part of our response.
- We have introduced a digital visiting solution available across all ward areas. This is based on iPads and enabled patients to connect with their friends and family at this time.
- We have supported the information and digital requirements of the community hubs.
- We have been fully engaged in the *Strathclyde* modelling and NHSS shielding work.
- We have enabled the sharing of Covid-19 results from Lothian and GG&C.
- We have extended the use of Clinical Portal including access to Forth valley
- We continued to provide health records and associated services. Including appointment cancellation/rescheduling.
- We have extended access to the Emergency Care Summary (ECS) to Pharmacists, Dentists and Optometrists
- We have introduced Covid based patient alerts to our key systems including TrakCare and GP Systems.
- TTIS we have supported the design and implementation of the national TTIS solution and are an early adopter.
- We have provided training and facilitation support to enable new users and services to introduce the new ways of working.

Following the initial response, we are now focusing on Response, Recovery and Redesign where we will support the return of activity from an information and digital perspective. This is likely to harness and build upon the key activities listed above.

NearMe has provided an opportunity to deliver remote consultations and this will play a key role in the future delivery of services.

We are exploring opportunities to continue the planned eHealth programmes by re-starting the community IT Programme, Order Communications, EPR programme and completion of the HEPMA implementation.

The introduction of MS Teams has been transformational and we will consider the opportunity to accelerated the adoption of Microsoft 365 to enable new models of working.

We will explore opportunities through national solutions including the recently awarded Home Health Monitoring solution.

6.5 Support Services & Facilities

6.5.1 NHS Lanarkshire's Premises - Covid-19 Adaptations

COVID-19 is a health risk that brings worry and uncertainty for staff, patients and managers. To support the continued effectiveness of services to respond to the Healthcare needs of patients whilst safeguarding staff, there is a need to ensure that NHS Lanarkshire Services are adequately prepared.

NHS Lanarkshire operates from 56 distinct locations, with a diverse range of functions taking place in these premises, mainly the direct provision of primary, secondary and community healthcare; but also administrative functions and support services such as laundry. The number of staff, patients and visitors who access these premises is not measured, but will certainly involve tens of thousands of physical visits each day to these 56 locations.

Staff, Staff Side Representatives and Line Managers/Supervisors have engaged positively during the COVID-19 Incident with a variety of measures introduced to protect staff and patients from transmission of the virus, e.g., use of personal protective equipment, homeworking etc. While there may be some immediate "once-for-Lanarkshire" measures which could be implemented consistently in all appropriate areas, the diversity of functions and the differing volumes of human traffic across the estate means that there cannot be a one-size-fits-all approach to the provision of a safer environment where COVID-19 is endemic.

At 14 May 2020, Logistics Silver Command had received a significant number of requests for urgent modification to buildings based on local teams making judgements on how safety can be improved, which alone would involve a spend of close to £100,000.

In the absence of Scottish Government guidance on measures which constitute a reasonable approach to providing a safer environment, NHSL will develop local policies and processes to provide a safer environment. As such, a Short Life Working Group (SLWG) was formed on 7th May to consider measures/adaptations which could improve protection against COVID-19 in NHS Lanarkshire owned or leased premises.

6.5.2 Procurement Implications

6.5.2.1 Supply Chain / PPE

The key items of PPE are required to protect both staff and patients when working in an environment where there is a possibility of exposure to Covid 19 (C19). The Health Protection Guidance differentiates between PPE needed in environments where there are aerosol generating procedures (AGP) (higher risk of transmission) and those where there is no AGP (lower risk of transmission).
The key items of PPE as described in health protection guidance are:

- Face-fitted masks (known as FFP3 masks)
- Fluid Resistant Surgical Masks (known as FRSM or 11R masks)
- Gowns for AGP
- Gowns for non-AGP
- Eye protection (visors, glasses, goggles)
- Aprons
- Gloves
- Hand sanitizer

NHS Lanarkshire, in coordination with our staff, our professional advisors, NHS National Services Scotland (NSS) and local suppliers has taken a range of measures to mitigate the risk that sufficient and suitable PPE may not be available where needed in accord with Four Nations Health Protection Guidance.

The steps adopted to meet these challenges include:

- Sourcing of alternate supplies of PPE by NSS and by NHS Lanarkshire.
- Establishment of twice weekly national PPE conference calls between NHS Board and NSS.
- Publication of daily PPE stock levels for NDC by NSS and twice daily for NHSL by procurement/supplies bronze.
- Establishment by NSS of specific ordering and supply lines for primary care and for social/community care in addition to supply lines for acute care.
- Establishment of 3 new central PPE stores for North Lanarkshire, South Lanarkshire and NHSL acute.
- Establishment of 3 new PPE buffer stores in University Hospitals Monklands, Hairmyres and Wishaw.
- Establishment of a PPECovid19 mailbox to request emergency PPE and enable timeously concerns regarding orders.
- Designation of PPE leads in each acute site and Partnership to address issues/concerns as they arise.
- Appointment of NHSL clinical lead for PPE and designated infection control lead for PPE to support the bronze command and to interface with clinical and non-clinical teams.
- Implementation of daily team call with 3 site acute sites/ NHSL clinical lead for PPE, procurement, control of infection and Health & Safety to ensure daily assessment of PPE provision for staff.
- Escalation routes for concerns to through the Incident command structure and from NHSL to NSS.
- As at week beginning 1st June 2020, NHSL supplies staff will be distributing the first major batch of PPE to Lanarkshire's General Dental Practitioners.

As at 4th June 2020, the NHSL supply of PPE for acute is adequate for our needs in acute, community, primary care and to augment the needs of care homes. The prognosis for secure and reliable supplies through NDC is improving week-on-week.

6.5.2.2 Medical Equipment

Clarity is required on Redesign and Recovery plans in terms of medical equipment. There is a draft medical equipment capital plan focused mainly on replacements, but also some major projects such as the Hairmyres Hybrid Theatre project and Angiography Room replacement.

However, this may need to be re-prioritised if services are to be reconfigured again and immediate needs change.
There has also been displacement of medical equipment purchased particularly towards the end of the 2019/20 financial year and, where safe to do so, equipment has been repurposed and the life span of the equipment extended.

Procurement and Medical Physics will look to bring forward a separate paper to accelerate the rollout of Radio Frequency Identification (RFID). This is not about re-stating the case for RFID as that investment has already been made, but about accelerating its deployment. This in itself does not solve the underlying issues stated, but would help visibility and decision making.

6.5.2.3 Procurement Workplans

Reconfiguration and ongoing management of COVID related supply chain issues will continue to divert local Procurement resources into maintaining operational supply chain resilience in

terms of PPE in particular but also security of supply given global supply chain challenges. Diversion of resource from other planned work will have an opportunity cost in terms of project work with associated financial savings targets. In addition, National Procurement have updated their 20/21 workplan which sees the postponement of many of the planned tendering activities, opting to extend national contracts instead. Whilst this will not have a negative financial impact as prices should remain largely fixed, it will not generate financial savings opportunities for the Board in the way that we have come to expect each year.

6.6 Pharmacy Services

The Pharmacy Service response to COVID-19 is detailed below.

- **Pharmacy First** – we are well placed to support community pharmacies maximise their contribution via this service when launched. The service was previously funded locally and our pharmacy contactors have always been supportive.
- **Management of Repeat Prescriptions** – the GMS 2018 pharmacotherapy work stream had work ongoing to roll out Serial Prescribing within GP practices in all localities. This work has been stalled and needs to be picked up again. Serial Prescribing would help to avoid the confusion that GP practices and community pharmacies experienced in the early weeks of Covid when there was unprecedented patient demand for prescriptions. Serial Prescribing would also contribute to GP business continuity plans going forward – however to be successful we need GP practices to engage with this work. We can provide support to them and will endeavour to make it as simple a process as possible.
- **Availability of critical care medicines** – this is an ongoing national issue and we are working with SG on the issues of securing supplies of both propofol and midazolam. Our supplies are satisfactory at present.

6.7 Occupational Health Supporting Our Staff

Services have been developed and continue to be adapted in line with guidance to support the needs of staff. These include:

- **COVID-19 Helpline** - real time response to specific questions available to all staff. Provides advice relating to HPS guidance, PPE, staff testing, Shielding, Risk Assessment and accessing Occupational Health.
- **Staff Stressline** - available 09:00-19:00, 7 days allowing staff to discuss issues causing them anxiety and distress. This service will be withdrawn in July following the introduction of the national staff helpline provided via NHS24 mental health hub within the Promis national venture. This new service will be extensively promoted within the organisation.
- **Early Access to Support for You (EASY**) - support to staff absent with a mental health issue. Provides access route to therapeutic services.
- **Confidential Counselling** - procured counselling service providing services 24/7. Telephone and face-2-face (although modified to Skype due to social distancing).
- **Management Referrals to Occupational Health** - prioritisation of COVID related referrals via telephone consults with Occupational Health Physicians. Expert advice on functional capacity with specific advice to those concerned regarding underlying health issues.
- **COVID Staff Testing** - delivery of testing to symptomatic staff and household members concerned re personal wellbeing. Scale will adjust dependent upon infection rates, but remain until no longer required.
- **Staff Care & Wellbeing Support Centres** - we have established staff rest and care areas: utilising restaurant space in Acute sector, and setup ‘Take 5’ rooms in our Assessment Centres, where staff can take a break for rest, information or water/snacks and they have access to peer support, Chaplains and Psychologists. We also have designated staff rest and support areas across the Health and Social Care localities It is

anticipated the demand will increase in the near future and the service will need to monitor referrals and adapt accordingly.

- **Staff Care and Wellbeing Support Line** - 24 hr. support line staffed by chaplains and psychologists available to respond in real time.
- **Manager Support Briefings** – recorded video briefings (around 10-15 minutes each) which signpost managers to resources to assist them in supporting their teams and looking after themselves.
- **Staff Care & Wellbeing Activities** - provision of mindfulness, physical exercise e.g. yoga & Pilates (social distanced) and value based reflective practice sessions.
- **Bereavement Support Service** - specific support developed for staff suffering bereavement during the COVID19 outbreak.

6.8 Communication & Engagement

COVID-19 has had a significant on Lanarkshire's Health and Social Care systems. To address the challenges NHSL introduced a range of emergency, urgent or temporary changes to services in order to manage staff and other resources to combat COVID-19 and provide care where it is most needed. This has been achieved through innovation with resultant significant financial impacts and by working smarter within available resources. Such developments have been undertaken while ensuring that quality is maintained.

Work is now underway to evaluate the success of such developments and determine the potential for them to be retained. This work will take cognizance of SG guidance in relation to planning and delivering service change and the associated NHS Board duties in relation to staff and public engagement and consultation in relation to retaining urgent or temporary changes. Consideration will be given as to how this will be best achieved.

6.8.1 Staff Communication

A new Staff Support information page has been developed on NHS Lanarkshire's Intranet - "Firstport". This page will ensure that all staff are able to keep up to date with NHS Lanarkshire's COVID-19 Response, Recovery and Redesign progress. The site will provide information on how services apply to have approval to restart, templates for use in this process, with other tools added as required, to provide staff with the best opportunity to get involved.

7.0 WORKFORCE

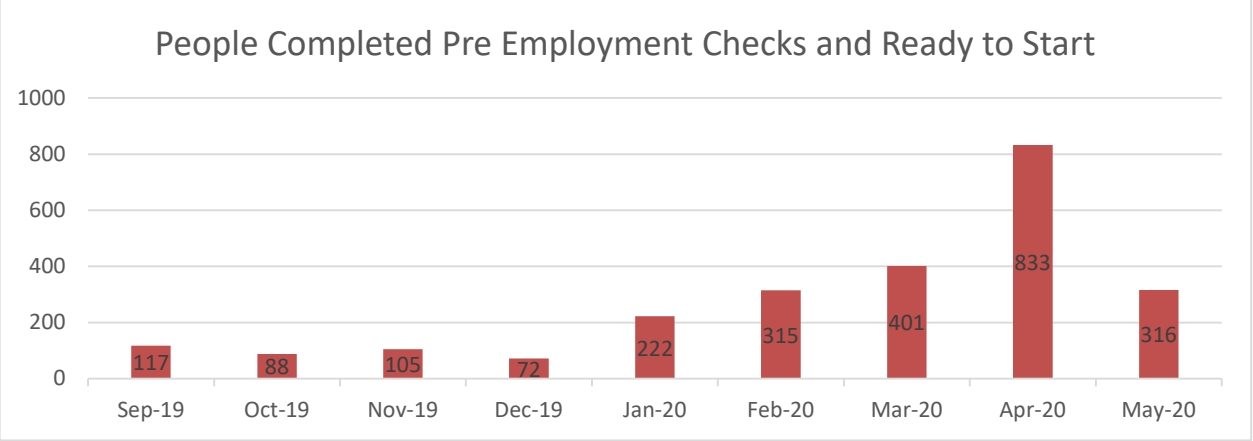
7.1 Workforce Response, Recovery and Redesign

The configuration of the NHS Lanarkshire workforce has changed to support the response to the COVID-19, with colleagues redeploying from elective pathways to support Intensive Care for example, alongside an extensive recruitment campaign to increase our available workforce. As the next stage of our response evolves the workforce will continue to adapt both in terms of numbers, roles and flexibility to ensure the recovery of services is as seamless as possible whilst continuing to deliver safe, effective person-centred care.

7.2 Redeployment and Recruitment

NHSL has redeployed staff from non-core frontline services to support the response to COVID-19. For example, colleagues working in administrative roles within outpatients are supporting the recruitment process for new clinical staff and healthcare support workers to both substantive roles and to the Staff Bank. A major recruitment campaign is underway to recruit staff and a series of measures are in place to accelerate existing recruitment processes to increase the number of bank workers and fixed term and substantive employees where appropriate.

The chart below illustrates the number of colleagues, both bank and substantive who have received an offer of employment in each of the last 4 months. Note that May's data is up to and including 18th May 2020.



7.3 Contact Tracing

NHSL is one of three Test, Trace and Isolate pilot Boards in Scotland. We have established a Contact Tracing Team, with the total number of staff supporting Contact Tracing will be in the region of 60.

7.4 Supplementary Staffing

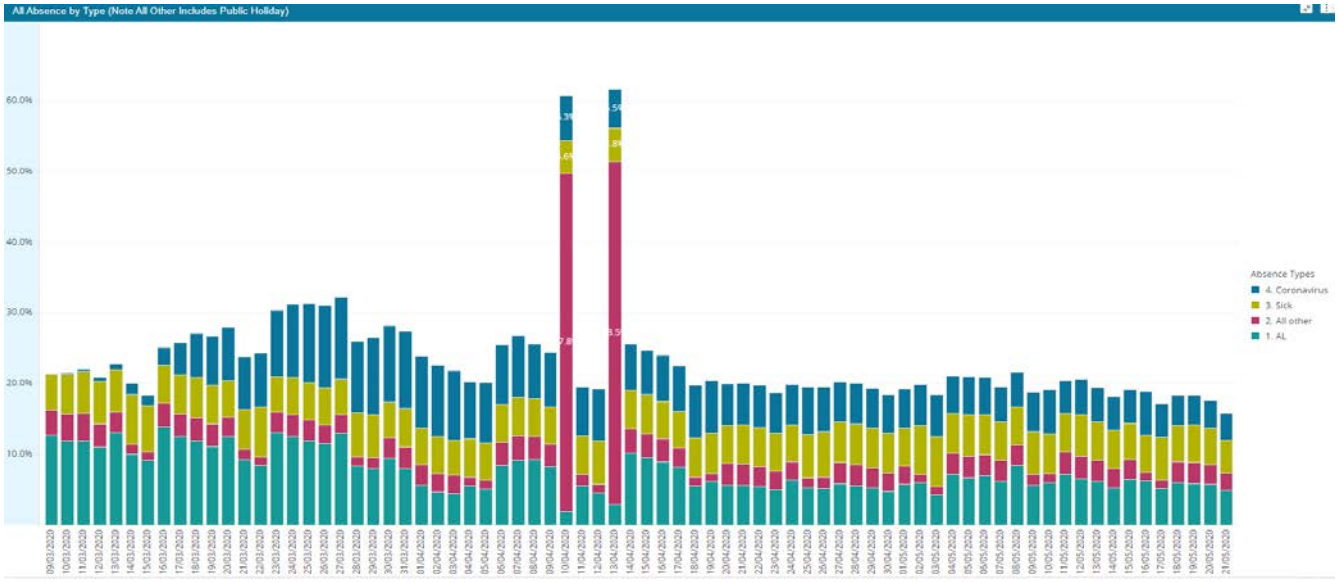
NHSL has extended its Staff Bank offering to include roles within the Property and Support Services Division including, Portering, Catering and Hotel Services.

To provide additional support to Care Homes within Lanarkshire, the Staff Bank has been extended to enable Care Homes to request additional staffing support via the NHSL Care Homes Liaison Team.

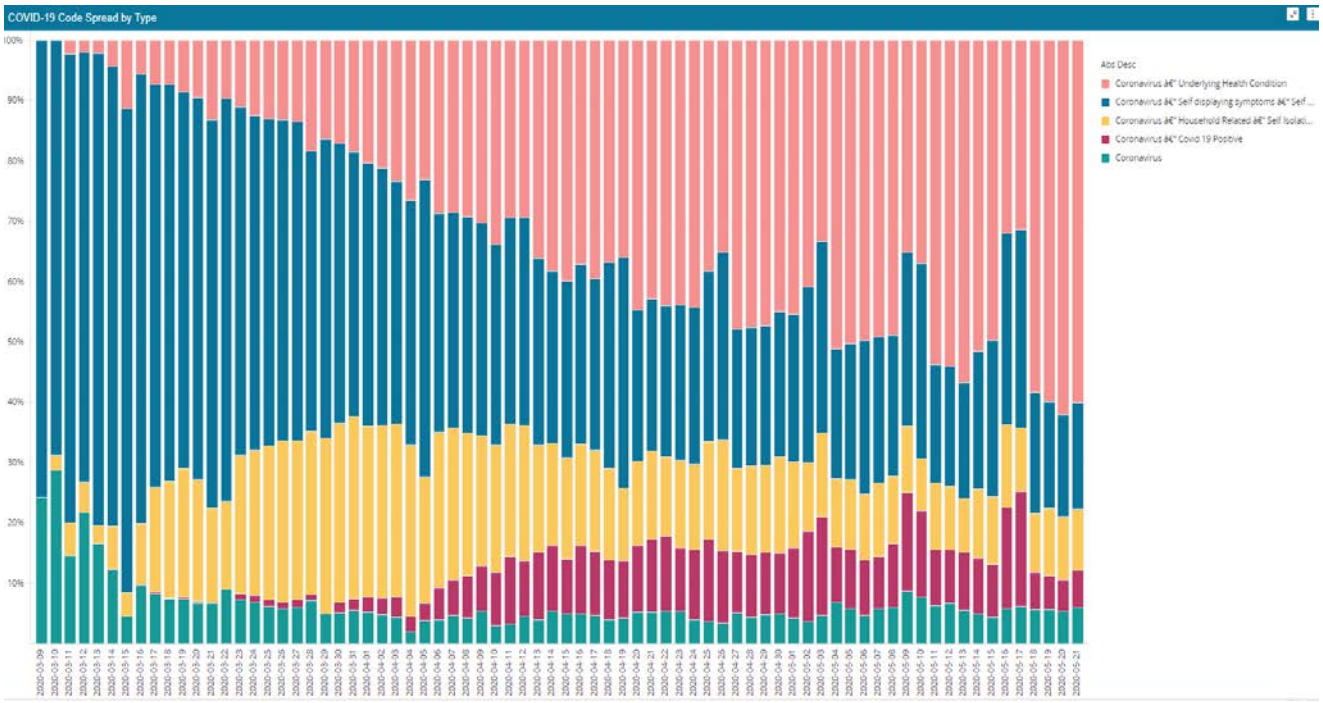
7.5 Absenteeism

In terms of absenteeism we are seeing a downward trend of Covid-19 related absence among our workforce from a peak in week commencing 23 March 2020 as illustrated below. The high

absence levels on the public holidays are attributable specifically to those staff taking the days as designated public holidays.



The composition of the Covid-19 absence is changing too, with the primary reason for covid-19 absence being those staff absent owing to an underlying health condition. The number of staff absent owing to testing positive remains small. The chart below provides further insight into the change in composition of Covid-19 leave since early March.



8.0 FINANCIAL IMPACT

Prior to the Covid 19 Pandemic NHS Lanarkshire was projecting a gap between expected costs and income. It had established a financial sustainability programme but had not identified how to fully close that gap. After savings, it was estimated that there would be a recurring gap of around £22.7m in 20/21, rising to £32.3m in 22/23. This was before any assumption of additional costs from demographic growth or safe staffing.

The response to the outbreak saw a rapid scaling up of ICU, bed, and assessment capacity. Less urgent services were stood down or reduced. Information technology was deployed on a large scale to permit functions to continue despite social distancing guidance. The ability to use technology or operate differently may open up future redesign potential.

For as long as COVID-19 remains a threat any service standing up will have to do so in a way that looks to mitigate the infection risk. Significant additional costs are likely for some time. However it is important that, wherever possible, the opportunity is taken to redesign to make a better value use of resources in the current environment. Ultimately, the aim will be for the overall portfolio of redesigned services to fit within the ongoing budget.

To steer this a series of principles and financial parameters have been agreed and are set out below – one for the response phase and another for the recovered phase.

Financial Parameters

- There will be additional financial support for COVID-19 costs during the emergency response.
- Initial high tolerance for costs of rapid scale up of services to prepare for the anticipated first wave will / is being replaced by far greater questioning of ongoing costs and efforts to get the most effective solution can be expected. SG has advised that authority is required before additional costs are incurred. Peer review has been instituted.
- Ultimately, ongoing services have to be delivered within a fixed budget that prior to COVID-19 was estimated to be £32.3m less than costs of ongoing services. In redesigning for the longer term costs, as an overall system, have to be lower than current budgets to be able to close the gap.
- As a Public Sector body NHSL has an ongoing duty to ensure best value
- eHealth solutions have a cost and, after initial purchase, there is periodic replacement, ongoing licensing, telecoms, running or support costs (either manufacturers or in house).

Financial (Use of Resource) Principles during the Response/Initial Recovery Stage	
a)	minimise physical attendance and optimise virtual engagement to protect against spread of infection and reduce the need for expanded space, PPE, cleaning and downtime between interactions
b)	Any services operating at budget plus due to the "crisis" response need to be subject to a review of additional costs / reduction on activity on a regular basis (to be defined by BCE and Director of Finance) and through the scrutiny panel process
Financial (Use of Resource) Principles during the Recovered Stage	
c)	"Recovered" Service models will be cost neutral or less
d)	Any services that cost more when "recovered" will only be approved if the "responsible" Director has identified savings in excess of the additional costs from another area.
e)	The "costs" of the new service must be inclusive of financial impacts on other services e.g. IT.
f)	All positive impacts from increased virtual engagement or streamlined processes should be captured in the design of the recovered service in so far as it is cost effective to do so.
g)	Inter dependencies with other services need to be taken into account to ensure cost is not passed elsewhere in the system.

9.0 CORPORATE GOVERNANCE

In line with other NHS Boards, NHS Lanarkshire faced unprecedented challenges in managing the response to the COVID-19 pandemic. While it was recognised that this was a fast moving situation and was subject to continual change, it was also widely accepted that effective management of the situation would require some changes to the existing corporate governance system. There were risks in continuing with existing governance arrangements, mainly:

- Existing arrangements around the cycle of Board/Governance Committee meetings would not allow the Board to have full oversight and assurance of the response to COVID 19 on a regular basis; and
- that the Senior Leadership Team will be unnecessarily diverted from directing their efforts and resources in the immediate response to the Coronavirus pandemic if they continue to service existing Governance arrangements and the full range of Governance Committees

These risks can be mitigated with a revision to existing Corporate Governance arrangements and it was proposed that a further assessment of risks should be undertaken by the Audit Committee.

In recognition of the Public Health emergency, approval to revise governance arrangements across NHS Boards had been given by the Scottish Government Director of Health Finance, Corporate Governance and Value in a letter to Board Chairs dated 26 March 2020. The key changes which will guide the new arrangements are set out below and will be reviewed at the June 2020 Board meeting.

Board Meetings

- The bi-monthly Planning, Performance & Resources Committee (PPRC) meetings have been stood down, and replaced by a Board meeting so that there will be a monthly Board meeting held as per the cycle of scheduled dates for Board/PPRC meetings.
- Board Meetings are not be held in public as before, due to COVID 19, and Government measures on staying safe. Board meetings are held virtually by telephone conference call, or other electronic means, on a monthly basis. A teleconference protocol was developed.
- The web site has been updated to reflect that Board meetings will be held on a monthly basis but the meeting will not be held in a central location, nor will it be held in public. The agenda and papers (with the exception of those deemed confidential) are available on the Board's web site to ensure continued transparency in decision making.
- In order to support the work of the Executive Team, the Board Chair, Chief Executive and Board Secretary have reviewed the Board work plan and each agenda to ensure that business conducted at Board meetings is appropriate and focused on decisions required, or items that provide assurance to the Board. This includes updates on the key issues and risks associated with the work being led on Recovery and Reconfiguration
- The Board accept Board papers in SBAR formats as appropriate. However, the papers must provide a clear statement of the risks associated with any proposals / decisions, any actions required of the Board, or assurance being provided.
- To support the expediency and effectiveness of holding Board meetings virtually, the Board Chair invites comments and questions on Board agenda items as appropriate, in advance of the Board meeting, with specific reference to those agenda items which are not for discussion.
- During this period the Board Chair can call any additional virtual meetings of the Board.
- Proposals for endorsement or approval may be circulated out with the scheduled Board meetings and signed off by Board Members by electronic means. Any such proposals must be reported to the next scheduled NHS Board meeting as an audit trail.

- The programme of Board Development activities, walk rounds and face to face visits/meetings was been suspended during this time.

Options were discussed with the Board and the option agreed was

- Continue virtually with the Audit Committee, Staff Governance Committee, and the Healthcare Quality Assurance and Improvement Committee, as and when required, to provide scrutiny, assurance and oversight of key aspects of the COVID 19 Mobilisation Plan and resilience response such as
    - the organisation's response in relation to the management of risks and overview of governance
    - the oversight of recovery plans;
    - staffing matters, including the continuation of oversight of staff health and wellbeing, and
    - clinical governance and patient safety issues.
- It will be for these Committees to prioritise their agendas and workplans focusing on the response to COVID 19 and they should only meet as and when required, with limited agendas.
- The Chairs of the Acute Governance and Population Health Committees would have the option of joining any of these Committee meetings as appropriate.

It is important to emphasise that other communication channels were established with Board Members to ensure that Board Members are kept apprised of key issues and decisions made by Gold Command, a number of additional measures have been put in place:

- Every Friday there is an email round up for Board Members including key Gold Command issues, key Scottish Government guidance; data and trends and any other issues pertinent for Board members to be sighted on;
- a weekly copy of the Gold Command Action Log is provided to Board Members;
- all Board Members receive the daily staff briefing on COVID 19;
- The Board Chair, with the Board Secretary, hold a Non -Executive Board Member Briefing by Teleconference in between Board meetings to maintain contact, raise any issues and have briefings on any specific areas which will come to the Board for formal approval in due course. The Board Chief Executive and other Executive Board Members or Corporate Management Team members join the briefing as required.

Audit Committee Meeting 20th May 2020

At the special Audit Committee meeting held on 20 May 2020 both the Internal and External Auditors were invited to comment on the revised governance arrangements. They stated that they had no concerns to raise about the revised governance arrangements, and were highly complementary about the way in which the Board responded to the challenge of revising governance arrangements at pace, while maintaining transparent assurance processes. One of the External Auditor's added that the Board ***"had put good arrangements in place, building on the strong foundation already in place***".

Care Homes - new NHS Board's Role and Responsibilities

The Board has assessed the impact of the guidance issued on 17 May 2020 to provide a response to Scottish Government on how the new accountability vested in the Executive Nursing Director around Care Homes is to be discharged. A "gap analysis" on this response is included as Appendix 8.

10.0 INNOVATION / OPPORTUNITIES FROM MOBILISATION

To achieve successful mobilisation whole system changes were introduced rapidly across Lanarkshire's Health and Care System. This includes: virtual primary care/outpatients; remote diagnostics; new approaches to triage; workforce models; use of volunteers; remote working; pace and urgency to decision making and, financial models. As part of the recovery process a systematic review is being undertaken to: catalogue the innovations made; evaluate the success of these innovations through a lessons learned process; determine those innovations to be retained and plan for widespread adoption where appropriate. Such development must meet the financial principles and parameters as set out in the Financial Impact section, above.

11.0 RISK ASSESSMENT

NHS Lanarkshire has continued to review and identify all areas of risk for response to, management of, and recovery from the Covid-19 pandemic whilst recognising the impact of the significant national and local work progressing with modelling of services, care homes and TTIS as we move forward. The key areas of significant risk for NHSL as at 21st May 2020 are set out at Appendix 9.

12.0 APPENDICES

Appendix 1 - Planning Principles, Necessary Conditions and Risks & Mitigating Factors

Appendix 1
Planning Principles,

Response, Recovery & Redesign Oversight Group (RRROG)
Appendix 2a Terms of Reference,
Appendix 2b Approval Flow Chart,
Appendix 2c Approval Form

Appendix 2a
Response Recovery

Appendix 2b RRR
Approval Flow Chart

Appendix 2c
RR&ROG Approval F

Appendix 3 - NHSL COVID-19 Activity Dashboard 19 May 2020

Appendix 3
COVID19 Dashboarc

Strathclyde University Modelling
Appendix 4a COVID-19 Modelling 7 April 2020,
Appendix 4b COVID-19 Modelling Update 19 May 20202,
Appendix 4c Future trends in COVID-19

Appendix 4a NHSL
COVID19 modelling

Appendix 4b
Strathclyde Universi

Appendix 4c Future
trends in COVID-19

Appendix 5 – NHS Lanarkshire Clinical Service Priorities

Appendix 5 NHSL
Clinical Service Prior

Appendix 6 HSCPs
Appendix 6a Response, Recovery & Redesign Governance Structure
Appendix 6b GP Clinical Prioritisation
Appendix 6c Near me Consultation Activity

Appendix 6a HSCP
Governance Structu

Appendix 6b
Clinical Prioritisatior

Appendix 6c Near
me Activity 31 05 20

Appendix 7 – Acute – New Ways of Working Questionnaire

Appendix 7 Acute -
New Ways of Worki

Appendix 8 - Enhanced professional clinical &care oversight of care homes - Lanarkshire Gap Analysis 20 May 2020

Appendix 8
Enhanced professio

Appendix 9 - COVID-19 Risk Analysis

Appendix 9
COVID-19 Risk Analy

Appendix 10 - NHSL Next Phase Mob Plans Template For Activity - 4 June 2020

Appendix 10 NHS
Lanarkshire - NEXT P