NHS LANARKSHIRE

REMOBILISATION PLAN

August 2020 – March 2021

Final Draft

Version 2

(submitted to Scottish Government on 31st July 2020)

CONTENTS

In response to Scottish Government guidance this Remobilisation Plan has been developed and reviewed by the NHS Lanarkshire Corporate Management Team. However, due to time constraints, the Remobilisation Plan has not been formally agreed by the NHS Board. This Plan is a final draft which will be shared with the Area Partnership Forum and Area Clinical Forum in August, ahead of being considered for approval by the Lanarkshire NHS Board on 26th August. It is anticipated that there will be an ongoing dialogue with colleagues in SGHSCD on the fine detail before final approval.

1.0 INTRODUCTION

The NHS Lanarkshire Remobilisation 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 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), and the Response, Recovery & Redesign Plan. The Area Partnership Forum and Area Clinical Forum have contributed throughout the development of the Plans and will continue to contribute to the ongoing development and implementation of the Plan; chairs of both are also members of the Response, Recovery & Redesign Oversight Group (section 1.2.1, below).

This work sits within a wider context where leaders from Health, Integration Joint Boards, Local Authorities, Third and Independent Sectors, citizens and other public bodies are working to maximise recovery in Lanarkshire.

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 & Local Context

1.1.1 Context

The challenge of COVID-19 pandemic is and will continue to pose a threat to the NHS over the coming weeks and months of 2020 and is likely to remain through 2021. As such the NHS will continue to work in an emergency planning environment focused on stratifying care to avoid loss of life and minimise harm to patients who have urgent and ongoing health care needs as well as to find a way to undertake and increase the level of routine care.

In planning for this, the West of Scotland Boards under the Mutual Aid agreement have considered and agreed a regional approach to a number of areas outlined below. The regional response is in line with the planning assumptions set out by Scottish Government to optimise what we can do collectively in these challenging times. Details of NHS Lanarkshire's approach are available at sections 5 and 6.

1.1.1.1 Unscheduled Care

Building on the effectiveness of the COVID-19 response, and the expectations of the Cabinet Secretary of progress in implementing a consistent national approach to urgent care before winter (October 2020), the Boards within the West of Scotland continue to build on the collective position set out in the phase 2 mobilisation plans where the most important priority identified by the Medical and Nurse Directors going forward was to move from a model of unplanned attendance or assessment to one based on a planned appointed clinical system in both primary and acute care sectors.

This requires the adoption of new models to support the urgent and emergency care response across the wider healthcare system encouraging joined up pathways and models of response to unscheduled care involving GP In-hours, NHS24, GP Out of Hours and Emergency Departments and SAS. Sections 5 and 6 provide details of the NHSL approach.

In line with the work being undertaken nationally, this is about the creation of a pathway with clear access to urgent care (primary and secondary), providing consistent triage to clinical consultation and flow management locally, if required. This Plan sets out the information in the relevant sections which will see the creation of Multi-Disciplinary Teams (MDTs) to support Lanarkshire hub(s), with the hub(s)/ MDT providing remote consultation to determine if face to face assessment is required and, if so, to make onward appointments to the appropriate service. It should be stressed that for the vast majority of people, same day support for 'urgent care' will be via the person's own GP. The initial focus is to provide a pathway into hospital care for those who currently require urgent access to secondary care services and/or who self-present at Emergency Departments (ED) (typically, 50-60% attendances). The ultimate goal is to develop a model across all urgent care that is 24/7, i.e. GPs, ED, MIU, SAS and to have made significant steps forward in implementing that by October 2020.

Lanarkshire is primed in having an established Emergency Response Centre (ERC) which in essence works as a Flow Centre. Whilst currently routing for referral is limited, work is well in progress to establish a single point of access for the ERC, with the potential to build on the navigation options for heralded (primary care) and unheralded (minor self-presenters) referrals. Building on the capacity of an ERC would support admission avoidance by facilitating professional to professional discussion thus enabling advice, scheduling to a clinic and or scheduled attendance for those deemed necessary.

A proof of concept of this model was undertaken during the pandemic peak and demonstrated that the ERC has the ability to support primary care referrals without the need for emergency department interventions. In addition to this, the introduction of a remote (virtual) minor assessment approach supports attendance avoidance thus optimising rapid assessment and navigation of care when emergency department (ED) face to face is not necessary. That said, the availability of face to face consultations would remain, however, attendance would be scheduled thus maintaining ED capacity requirements. It is recognised that shifting the balance of care from EDs has the potential to impact other services, however, the aim of virtual minor assessment is to support self-care options and develop public awareness on self-management and advice routes. This reduces the burden on health providers when management can be supported in alternate ways such as through remote routes.

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. Details of the NHSL approach are available at section 6.7.

1.1.1.2 Cancer and Scheduled Care

During the first wave of the COVID-19 Pandemic, specialty specific groups reviewed their pathways and altered their approaches to treatment to reflect this new and additional risk. This minimised the risk of preventable harm and optimised outcomes for patients requiring cancer treatment including surgery, systemic anti cancer therapies or radiotherapy. Much of this work was facilitated through the regional Managed Clinical Network and Multi-disciplinary teams.

In this next phase of mobilisation we will continue to follow the guidance set out in the *'Framework for Recovery of Cancer Surgery'* formulated by the Scottish Government COVID-19 Cancer Treatment Response Group.

It is recognised that, as surgery services increasingly enter into the recovery phase in the coming weeks and months, there will be competing demands from various surgical specialties to gain access to a limited surgery resource. Each of the Boards within the West of Scotland have developed local clinical prioritisation groups to ensure fair and reasonable access to a limited surgery resource in terms of both hospital beds and elective green-site theatre capacity.

Whilst there is an expectation that all Boards will upscale their elective cancer surgery capacity in the coming months, to address the backlog there needs to be a recognition that there is a reduction in theatre capacity across the Boards and the region which will require cooperative working arrangements to be put in place to ensure patients with the greatest priority are treated and patients in Board areas seeing a higher level of COVID-19 admissions are not unfairly disadvantaged.

1.1.2 Setting the Collective Response

In planning for the next 6-12 months, recognising the above and uncertainty around COVID-19, we have considered five possible scenarios to determine our collective responses and actions. This work primarily relates to acute care and hospital services.

Our aim is to gradually and safely increase the level of services provided for our population. Building on our mutual aid agreement, we will provide the best level of service across the region, whilst continuing to ensure outcomes from other life limiting or life threatening conditions is not impacted. In doing this we will also work with our partner agencies particularly SAS, NHS 24 and the NHSGJNH and NHS Louisa Jordan (NHSLJ) where required.

The scenarios identified are as follows:

1) The Rate remains below 1 and hospital and specifically critical care admissions remain on the current trajectory allowing us to steadily increase the level and range of services we offer.
2) Small localised outbreaks in areas within the region that requires the Board to have a focused response to testing, tracing and isolating with localised lock downs which may require hospitals services to be temporarily reduced or suspended and mutual aid is required across the Boards to support and minimise disruption to the care of urgent patients.
3) Several areas show significant spikes that require alterations to patient flows and support from services from neighbouring Boards to reduce disruption to access appropriate clinical care for urgent and planned patient care.
4) The rate increases and we face a similar situation to the first wave and we require to implement mutual aid across the system in relation to critical care, acute emergency flows at the same time maintaining priority 1 treatments/ interventions.
5) The second wave is greater than the first and there is full implementation of the critical care network plans and NHS Louisa Jordan is required to provide the support envisaged at the time of initial commissioning.

In considering these different scenarios we recognise that, in the period August 2020 to March 2021, these may be compounded by the increased unscheduled care demand routinely experienced in all hospitals in the winter period. Particularly, if there is a combination of a significant flu outbreak and low uptake of flu immunisation amongst higher risk groups.

Recognising the uncertainty the NHS is facing and in response to the above positions, under our commitment to supporting mutual aid across the region, a number of cross board approaches have been developed. This has involved working collectively to set out the direction for unscheduled, cancer and scheduled care across the region supported by the establishment of a number of networks within the region: the escalation approach is described and the expectation of support from NHS GJNH and from NHS LJ.

1.1.2.1 West of Scotland Acute Care Network

The Acute Care Network was established to allow us to plan collectively and coordinate action within acute services across the region during the COVID-19 pandemic when required. This group is linked to the West of Scotland Critical Care Network, taking cognisance of the changing position within critical care across hospitals and boards which was crucial during the first wave of the pandemic. Both of these networks are supported by the Regional Planning Team.

This network is set up with the remit to support and co-ordinate the collective emergency response to COVID-19 and to pressures in acute services when required. Weekly calls have been established with the Acute Directors or their nominated representatives to support closer working and more joined up approaches, as well as to plan recovery and remobilisation together and share learning in these challenging times.

The frequency of meeting is determined by the level of escalation based on the level of COVID-19 admissions to the hospital or where acute emergency care services are under duress. The group is supported in its decision making through the collation of essential information agreed by the Acute Directors in relation to their Boards. This enables a shared understanding of the position across the region to support, where possible, ensuring patients get access to the most appropriate level of care. This is based on the premise that we will have the ability to direct people to another site, such as, diverting GP calls to different sites, or transfer of patients between sites to use the available capacity to greatest effect.

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

- maintain business critical services
- maintain emergency care pathway
- support major incident response
- have sufficient workforce

This group will also identify when pressures are mounting that will trigger the need for national action and the implementation of the plans for NHS LJ. This is in line with the position issued nationally during the first wave.

1.1.2.2 West of Scotland Critical Care Network

The Boards and Hospitals in the West of Scotland established a West of Scotland Critical Care Network early in the first wave of COVID-19 pandemic. This included establishing a daily critical care network teleconference call covering an agreed set of questions. The call allowed us to coordinate critical care services across the region during that period. This call is attended by an Intensive Care Consultant or Senior Charge Nurse from every unit which provides Intensive Care who is responsible for providing the essential regional activity information to allow an understanding of the position across the region to be quickly gathered. This helps to ensure, where possible, patients get access to the most appropriate level of care. This network works on the premise that we have the ability to transfer patients between sites to use the available capacity to greatest effect. Part of the West of Scotland Critical Care Network is providing a transfer team to support this when required. Going forward the role of NHS LJ in contributing ICU expansion, if any, will need to be clarified.

Daily activity monitoring provides a regional overview of critical care network activity and capacity on a daily basis and helps identify rapidly where Intensive Care Units (ICUs) may require support. This is also a platform for sharing issues encountered, successes and challenges for shared learning purposes.

When a strong regional response is required calls are scheduled for 1.30pm daily unless otherwise agreed by the co-chairs in discussion with WoS Board representatives. If occupancy in the 12 general ICUs is less than 140% of baseline and 80 or more staffed beds are available on a Friday, then weekend calls are not be undertaken. However the information is still collated and shared across the region. The network chairs review the information and contact ICUs if there is a significant deterioration in capacity.

If less than 50 patients with COVID-19 are in ITUs, occupancy is less than 90% of baseline and more than 50 staffed beds are available then the weekly calls are suspended. Data returns continue to be collated, with the chairs reviewing the information daily and contacting ITUs if there is a significant deterioration in capacity.

Calls are suspended when the activity levels are within the baseline however the group continues to meet as required to share learning and consider the collated position and trend in activity. The daily call will recommence if it becomes apparent that the amount of COVID-19 activity indicates an impending spike or a second or subsequent surge. This has been agreed with Medical Directors as 140% of baseline as the trigger point for the daily calls. The network reports to the West of Scotland Medical Directors in terms of governance.

1.1.2.3 Regional Cancer Prioritisation, Scheduled Care and Diagnostics

Building on the work undertaken in the first wave by the specialty specific groups, the MCNs and MDTs have agreed to review their approaches to treatment and prioritisation. To reflect this new and additional risk, the local clinical prioritisation groups in Boards will link with the Regional Clinical Prioritisation Group which has been established. This involves both senior clinical leaders and senior managers involved in managing cancer and access programmes in each Board across the region.

An overall governance and performance approach is central to implementation of the Surgical Prioritisation Framework within the West of Scotland. The development of this regional group will support the principles and aims of the Surgical Prioritisation Framework through the development of a planned approach to meet the needs of patients treated within the West of Scotland and ensure timely access to surgery.

The purpose of this group is to monitor performance against the approved framework and plan appropriate regional working where a risk has been determined. Boards will need to work together to collectively and collegiately plan access to surgery and this may require transfer of patients or staff (or both) to adjacent and or co-located Health Boards within the network.

Through the West of Scotland Surgical Prioritisation Group the aim is for patients to be treated and listed for surgery in order of clinical priority. The same approach will be utilised across the region to ensure equitability; working together to ensure patients are offered the earliest available appointment. This group will also consider how to maintain services and address the backlogs in the event of increased COVID-19 activity.

NHS GJNH will be an important participant in this group to ensure the capacity available at the GJNH can be maximised to support the treatment of patients within the region where surgery capacity does not allow this within the Board of residence.

It is recognised that this is a challenging task, and there may be significant need for cross Board working and/or national support and rescue of some cancer services on a temporary basis. In doing this it will be important to use capacity most suitable to meet the clinical need; recognising the importance of the wider clinical team in supporting patient care post-operatively to optimise patient outcomes.

In terms of the wider planned care requirements to support outpatients and the diagnostic investigation of patients, the West of Scotland Boards are also considering the opportunities the NHSLJ may offer when not required to provide inpatient care to support the response to COVID-19. Some test of change have been carried out for orthopaedics and plastic surgery and the review of the learning from these will be considered to explore the wider use of this capacity to support outpatient activity as well as diagnostic capacity in the coming months.

Part of the work being undertaken across the region is reviewing the capacity and demand for diagnostic tests to support patient management. This work will be used to support the Clinical Prioritisation Groups, locally and regionally, and inform the dialogue with our primary care colleagues to use the available capacity to best effect.

1.1.2.4 Summary of Potential Mutual Aid

Table 1 summarising the levels of potential support at each stage

Responses	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Acute Care Network	Planning and Monitoring Sharing Learning	Planning and Monitoring Sharing Learning	Monitoring need for escalation and supporting care as required	Escalation plans being implemented Supporting care as required	Full escalation and support across the system
Critical Care Network	Planning and Monitoring Sharing Learning	Planning and Monitoring Sharing Learning	Monitoring need for escalation and supporting care as required	Escalation plans being implemented Supporting care as required	Full escalation and support across the system
Cancer and scheduled care	Developing capacity plans and aligning demand based on clinical priority	Monitoring and supporting priority patients treatment where required	Monitoring and supporting priority treatment where required/ review reducing elective surgery activity	Supporting priority treatment only	Supporting emergency treatment only
Diagnostics	Developing capacity plans and aligning demand based on clinical priority	Monitoring and supporting priority patients treatment where required	Monitoring and supporting priority treatment where required/ review reducing elective diagnostic activity	Supporting priority diagnostics only	Supporting emergency diagnostics only

1.1.3 Mitigating Risks and Rate Limiting Factors

We are managing a situation where COVID-19 is endemic in the population and is likely to remain for the foreseeable future. This means we may face a number of challenges across the services, where parts of services may be temporarily reduced or suspended because of staff also getting infected. This requires us to have the agility and flexibility to support care for the most critical patients at any time and this may require a greater level of cross board working than we have required to date.

Also, as levels of demand for services particularly during the winter period could prove challenging based on past experience, it is important that we recognise what we require to do to sustain capacity to respond to rapidly changing numbers of COVID-19 patients and emergency demand.

Key to this will be:

- Use of available data to provide an Early Warning System to guide decisions and levels of escalation. Key to this will be links with the SAS and NHS 24 to use the data they are also gathering to ensure we can monitor the position and identify patterns that are causing concern. This will inform the triggering of our collective response.
- Shared understanding of the capacity we have to support care, recognising the need to keep capacity to support an ongoing level of COVID-19 patients (both in terms of critical care capacity and respiratory care). This is particularly important as we build our surgical capacity to ensure we have the agility and flexibility to adjust quickly to changing situations, minimising the level of disruption this could cause.
- Having a clear strategy for testing and a framework that sets out the different levels of testing and response at different levels of escalation.

Further work is planned to explore mutual aid to support resilience across the region. This will recognise the different levels of risk in the scenarios outlined above for our Test and Protect services in relation to demand and capacity, particularly recognising the similarities of some of the symptoms between COVID-19 and flu. Consideration will be given to a developing a framework of response to manage the different risks that might arise, especially if we return to scenario 4 or escalate to scenario 5.

- The requirement for ongoing education and training of staff to maintain and enhance the wider team development, working to cope with the increase in clinical activity in the critical care areas, and beyond (e.g. early CPAP in ward areas). Consideration of critical care nursing skills becoming more generic within the workforce would also be beneficial.
- Being clear about the PPE requirement and the availability of supplies to support acute/ critical care, as well as elective activity. This will be especially important as we increase our endoscopy capacity where there is a heavy requirement for PPE- visors and gowns.
- Recognising the importance of Pharmacy and Medical Supplies to all aspect of patient care. It is important that consideration is given to how the Pharmacy teams work together to support the necessary input to patient care, particularly in areas where there is a small cohort with specialist knowledge and skills, such as for critical care.

To prepare for any further potential surges in COVID-19 activity across the region, medicine supplies require to be coordinated centrally as Boards will reintroduce services at varying levels. Consideration needs to be given to NHS Boards reporting medicine supply levels and potential related planned activity to a central point. Such a report should include a list of the most commonly used drugs and

levels of stockpiles in terms of quantity, location and access. This will ensure that, should scenario 5 occur, there will be sufficient stock to meet demand.

Clearly defining future mutual aid to support cross board working in managing the supplies would be helpful. This should consider agreement that medicine supplies are co-ordinated across Scotland and supply follows the patient need.

1.2 Local Planning Structure

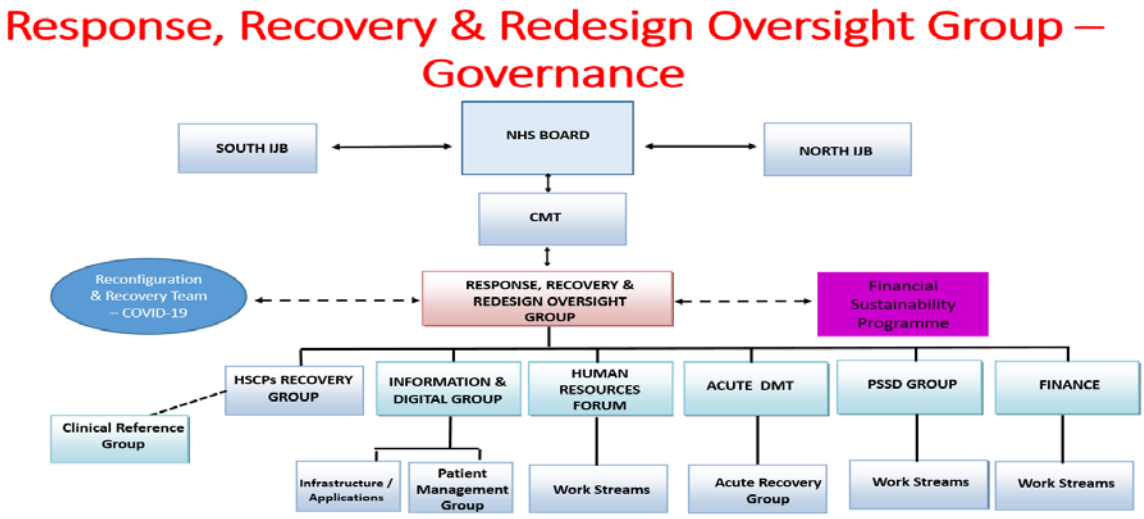
1.2.1 Response, Recovery & Redesign Oversight Group (RRROG)

In response to the need for significant capacity to be realised across NHS Lanarkshire to deal with COVID-19, and to ensure the organisation was well placed to recover at the earliest opportunity, 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 RRROG ensures oversight linked to established operational governance mechanisms and considers all recovery and reconfiguration proposals, ensuring plans are clearly defined and evidence based.

As part of the governance arrangements for NHS Lanarkshire, and in response to the COVID19 situation, the Oversight Group was established to:

- maintain good corporate governance and oversight of redesign and/or recovery arrangements, 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 via regular progress reporting;
- 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.



1.2.2 Response, Recovery & Redesign Oversight Group (RRROG) – Progress to Date

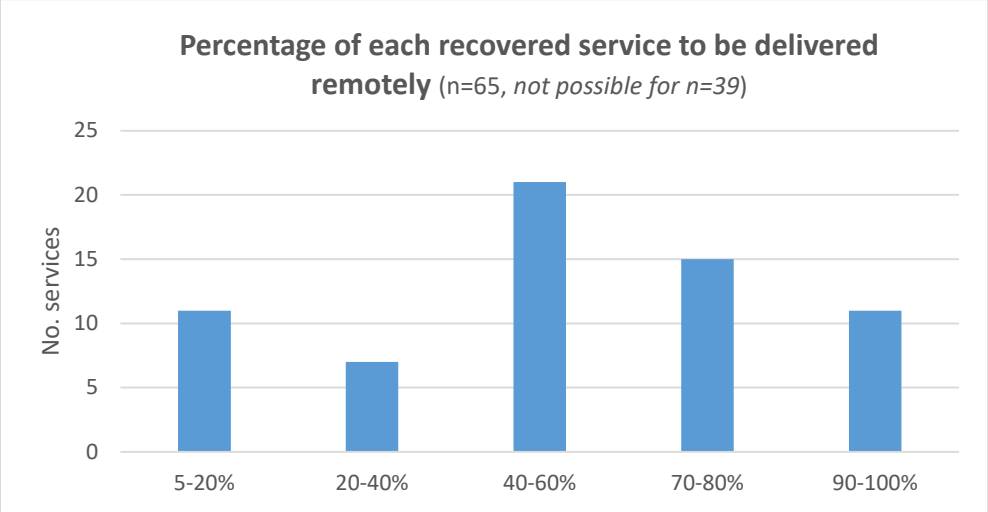
Since the RRROG's first meeting on 7th May 2020, a total of 104 services (as of 30th July) have been stood up/partially stood up and categorised as a service "response", "recovery" or "redesign". (An explanation of the "response", "recovery" or "redesign" definitions is available at appendix 1). Approval by the RRROG does not necessarily mean services can resume delivery as a number of issues need to be considered by the relevant operating divisions.

The process of approval has been developed over a number of months and, to ensure that it continues to meet the needs and complexities of the whole-system, a review of aspects of the approval process is now underway. For example, currently the RRROG will consider service proposals once they have been approved via the local operational recovery groups (Acute Recovery Group and Health and Social Care Partnerships (HSCPs) Joint Recovery Group). Consideration is now being given to developing specific criteria/parameters which would support the devolution of certain service recovery decision-making responsibilities to operational recovery groups, potentially increasing the pace of service recovery. It is anticipated that such an approach could speed up the rate of approvals while maintaining appropriate governance. (Details of the current approval process are listed at appendix 2).

A key component of the approval process had been the identification and management of risks. To support this process, and assure governance, a suite of documents has been developed to identify cross cutting impacts, logistical and digital supports, and any financial implications.

From the service proposals considered, clear trends and new ways of working are emerging, with a commitment to continue remote working where possible. Of the 104 services that have been approved for recovery, 65 of them will to some extent be delivered remotely i.e. by telephone or video (Near Me) consultation. (Position as of 30th July 2020).

The figure below shows that the majority of recovered services aim to have a very large proportion of remote contacts i.e. 47 propose 40% or more. The vast majority of these would previously have been conducted face-to-face.



The remaining 39 recovered services can only be delivered face-to-face e.g. surgical intervention or cancer screening.

Current & Anticipated Work of the Response, Recovery and Redesign Oversight Group

The volume of service proposals being considered by the RRROG is steadily increasing, with the majority categorised as "recovery" as is illustrated by the infographic at appendix 3. As of 30 July there had been 81 services approved.

Indications are that the volume of service proposals being developed through local operational recovery groups (Acute Recovery Group and HSCPs Recovery Group) will continue to grow for the foreseeable future, with an estimated 15-20 proposals submitted weekly for RRROG consideration.

Future Work

Work is now underway to determine at a more granular level the number of sub-functions to be recovered, which is of increasing importance as services recover in phases. The outcome from this exercise will support future reporting on service recovery, enabling an analysis of the proportion of services approved against those yet to be recovered.

1.3 Equality Impact Assessment

NHS Lanarkshire recognises that the remobilisation of services, whilst beneficial for both staff and service users, has the potential to have differential impacts on different groups in our community. We are committed to ensuring that as we re-introduce our services, in this new way of working, that we undertake Equality Impact Assessments to help us identify any potential barriers that these new ways of working may present. From there we will take appropriate steps to mitigate or minimise those impacts to ensure our services are as accessible as can be for our population

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 Tables 1 & 2, below. Full details can be found at appendix 4.

Table 1 – Example of C-19 Sit Rep

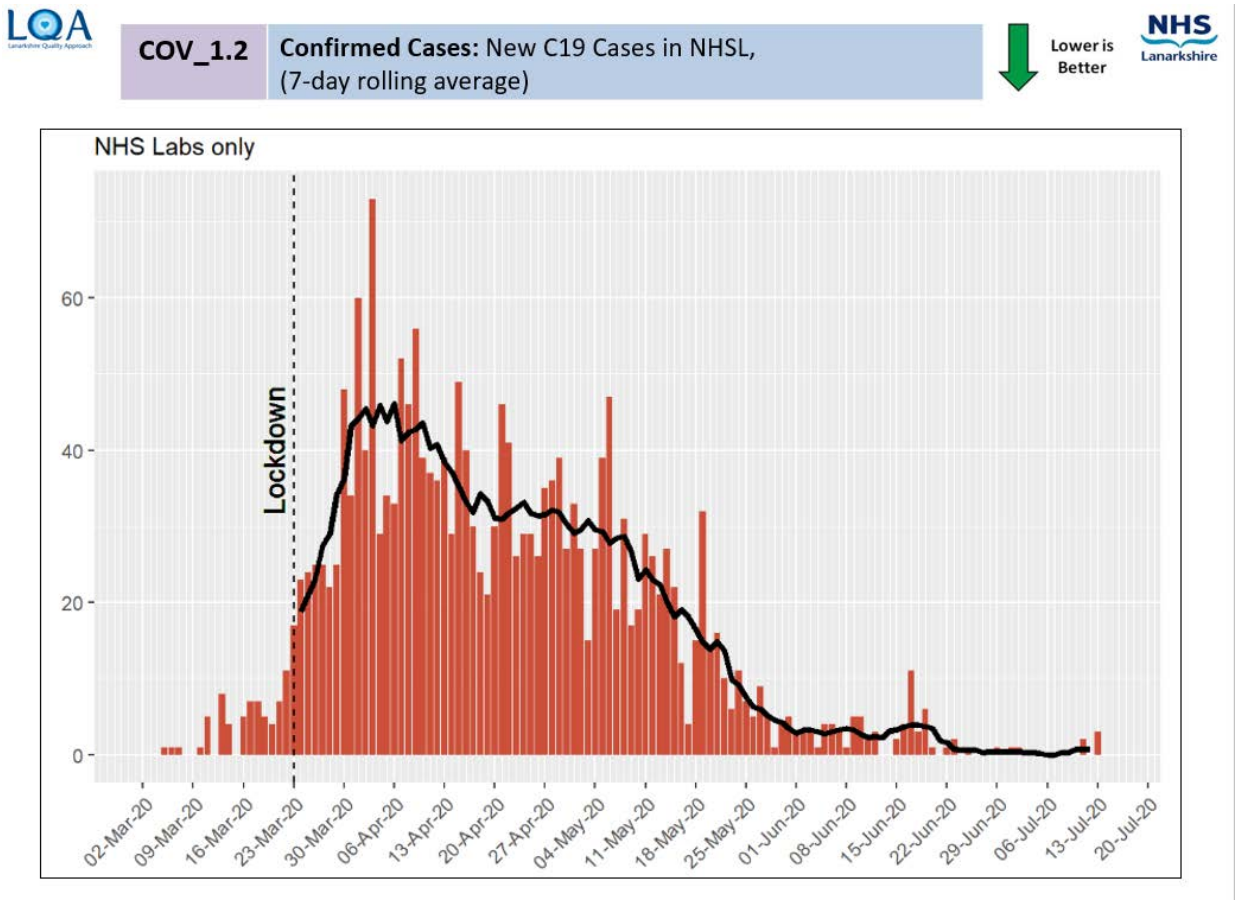
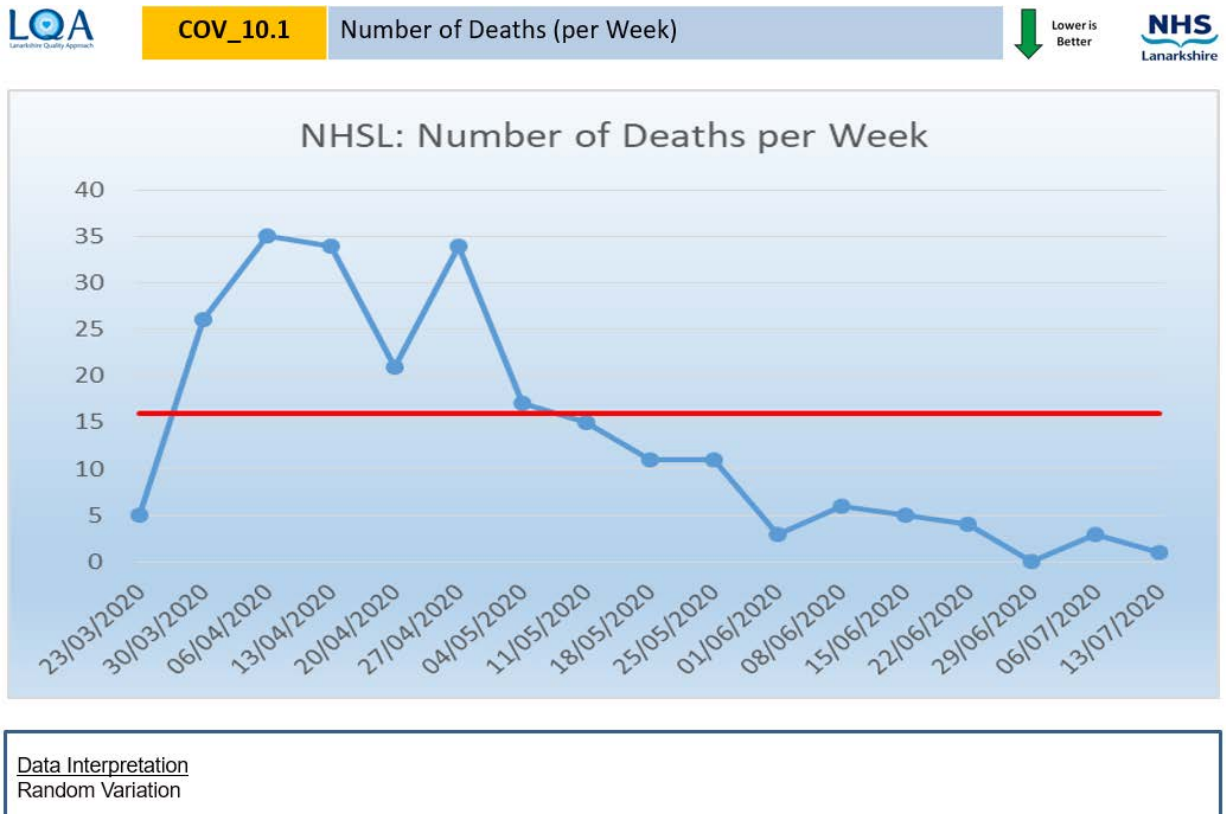


Table 2 – Example of C-19 Sit Rep



2.3 Scenarios Regarding Second Peak in the COVID-19 Pandemic (as of 30th July 2020)[1]

NHSL continues to work in partnership with Strathclyde University in the development of a simulation model. Details of the updated Strathclyde University modelled predictions as of 30th July 2020 are detailed below.

2.3.1 Introductory Observations

- Although the nature of the COVID-19 pandemic is global, there are significant geographic differences. For example, in the UK there has been a distinct peak in spring 2020, whereas in the USA the incidence has continued to rise substantially into summer 2020. To assess the situation in the UK in general, and Scotland in particular, the most informative comparisons are with other countries in Western Europe.
- In West European countries, there was a distinct peak in new infections in March – April 2020, generally followed by a more gradual decline in cases during May – June 2020.
- More recently, coming to the end of July 2020, there are relatively strong signs of local resurgence in many West European countries; for example, Belgium and Spain. However, this does not (yet) amount to the emergence of a distinct second peak in these countries.
- Localised outbreaks appear to take various forms, depending on where they start and how widely they spread. For example, they can range from a rapid rise in infections among poorly-housed workers in a local meat processing plant in Germany to a much more widely spread outbreak in Catalonia. There are indications that many of the people involved in the current

[1] Van De Meer, R et al (2020, 30 July) *Scenarios Regarding Second Peak in the COVID-19 Pandemic Report (as of 30th July 2020),* Dept of Management Science, University of Strathclyde, Business School

outbreaks belong to younger age categories and have a greater number of contacts, but are less likely to show symptoms requiring hospitalisation.

- At the end of July 2020, the picture in the UK is, broadly speaking, as follows. In England, the incidence of COVID-19 has generally been rising, with some widely reported local outbreaks; for example, Leicester from the end of June and Oldham more recently where an increase in cases led to specific control measures not necessarily a lockdown. In Scotland, the incidence appeared to reach very low levels by mid-July. However, local outbreaks have started to emerge since then; for example, at the Sitel call centre in Motherwell.

2.3.2 Factors that we can be reasonably sure about in Scotland

- The level of population immunity against COVID-19 is still likely to be low. In addition, there is no convincing evidence that COVID-19 has become less virulent. An effective vaccine may not become available for some time yet – possibly not until spring or summer 2021 (if at all).
- Therefore, a second peak in the incidence of COVID-19 is still likely, possibly highly likely, to occur between late August and spring 2021.
- However, there are now more and better treatment options available; for example, the use of dexamethasone for certain patients. Therefore, both morbidity and mortality may be lower than in the first COVID-19 peak.
- Based on the recent experience in Western Europe, including the UK, local COVID-19 outbreaks are the 'new normal' and will remain so for the foreseeable future. There are key questions about how 'deep' (in terms of prevalence) these clusters may become and how widely they will tend to spread.
- To identify, contain and suppress such local outbreaks in Scotland, the Test & Protect service must be highly responsive and effective. In many cases, this may lead to time-limited local lockdowns.
- In addition to the implementation of the Test & Protect service, valuable lessons have been learned and implemented around effective infection control in hospitals, other healthcare facilities and care homes. This should help to limit the spread of COVID-19 in these facilities in future outbreaks, compared to the experience of the first peak.

2.3.3 Factors that we are still unsure about

- There is still a relatively high degree of uncertainty about the existence of a 'seasonal effect' in the incidence of COVID-19. If there is such a seasonal effect – that is, if the incidence is likely to be significantly lower in the summer season – then it is clear from the world-wide evidence that that effect is by no means dominant. In other words, a seasonal effect could, at most, be one of the (possibly many) factors explaining the incidence of COVID-19 at any particular place and time, but it could be 'swamped' by other factors. On the other hand, there is good empirical evidence that outdoor transmission of COVID-19, keeping other factors more or less equal, is substantially more difficult than indoor transmission. That alone suggests that the seasonal effect is unlikely to be zero in urban societies.
- If there is a positive, albeit relatively weak, seasonal effect in the incidence of COVID-19 in Western Europe, then that increases the likelihood of a more general resurgence in the latter part of 2020, as first summer turns to autumn and then autumn turns to winter. However, we do not quite know by how much.
- By general consensus, the level of population immunity against COVID-19 in Scotland is still likely to be low. However, arguments have been made that some level of 'cross-immunity' may have

built up in the general population, through exposure to other respiratory viruses or otherwise. If that were to be the case, then it would obviously decrease the likelihood of a more general resurgence later this year. However, the empirical evidence for substantial cross-immunity does not appear to be particularly strong at this point.

2.3.4 Three possible scenarios relating to a second peak in COVID-19 incidence

- The level of uncertainty about future developments in the COVID-19 pandemic in Scotland is still very high. Moreover, this uncertainty is of an 'epistemic' nature ("we don't know what we don't know") rather than an 'aleatoric' nature ("we know what we don't know"). Therefore, at this point, it is practically impossible to develop statistical predictions – that is, predictions associated with statistical estimates of likelihood. The best that we can do at this stage is to suggest a limited number of possible 'scenarios' – that is, logically coherent and plausible narratives of sequences of events that are mainly qualitative in nature but with which we can associate some quantitative projections (without statistical estimates of likelihood).
- Based on our current level of knowledge and understanding, we outline three possible scenarios about the earliest appearance of a second peak, without stating which scenario is more likely at this point. Although these three scenarios cover relatively distinct time periods, it is possible that the first one could somehow lead into the second and, subsequently, the second into the third.

First scenario: covering the late summer period from mid-August to end of September 2020.

- Schools reopening in mid-August eventually lead to localised outbreaks in one or more towns or regions in Scotland.
- The Test & Protect service is likely to identify, contain and suppress these localised outbreaks – all the more so as the prevalence of COVID-19 in the general population is still low after the early-July 'dip' in incidence. Time-limited local lockdowns may be imposed.
- However, localised outbreaks (in schools and possibly other places) could start to feed into each other or greatly expand otherwise through some kind of 'external impulse' (e.g., imported cases through tourism). In that case, a more general (Scotland or Central Belt wide) second peak may begin to develop, necessitating some form of national lockdown. This is likely to be of time-limited (rather than indefinite) character.
- Pressure on health and social care is likely to be severe in some places (but not necessarily everywhere) but time-limited. This could be driven by schools going back, resurgence in care homes, people returning to work and increasing use of public transport.

Second scenario: covering the autumn period from October to Christmas 2020.

- Local outbreaks occur relatively frequently across Scotland, emerging from a variety of locations. Some of these local outbreaks could fuse with each other to drive outbreaks at a wider regional level.
- The Test & Protect service is still capable of suppressing these outbreaks. However, this is becoming more difficult because of a rising prevalence of COVID-19 in the general population. Time-limited suppression measures and lockdowns are common at local or regional level.
- October sees the usual onset of the winter flu season, although it is not yet clear how severe this will be. The COVID-19 pandemic may start interacting with the influenza virus in various expected (e.g., through overlap of symptoms) and not-so-expected ways. A more general (Scotland or Central Belt wide) second peak may develop, necessitating some form of national lockdown – which may, depending on severity, be time-limited or of indefinite duration.

- Pressure on health and social care is likely to be severe in many places (particularly across the Central Belt) and may be prolonged in duration – that is, unlikely to ease up significantly before spring 2021.

Third scenario: covering the winter period from Christmas 2020 to March 2021.

- This third (winter) scenario may naturally follow on from the second (autumn) scenario or may emerge after a relatively 'quiet' autumn period as far as COVID-19 is concerned (that is, multiple local or regional outbreaks but no obvious second peak).
- The 2020 Christmas holiday period, with its normally sharp increase in population interaction and movement, constitutes a potential trigger for a winter scenario.
- Prevalence of COVID-19 in the general population has tended to rise throughout the autumn period and is now relatively high, making the suppression of local outbreaks more and more cumbersome. A variety of other adverse factors (including health & care staff absences, etc.) combine to produce a kind of 'pressure cooker' effect.
- A generalised second COVID-19 peak develops over Christmas 2020 or from the start of January 2021 (if it had not already emerged before then), necessitating a national lockdown of indefinite duration – that is not dissimilar to the situation in the first peak.
- However, lessons have been learnt at both Government and NHS Board levels. Lockdown will be faster (more responsive) and more effective than in the first peak (for example, infection control procedures in health and care facilities will be effectively resourced and managed). Therefore, the height of the second COVID-19 peak (in terms of new infections, hospital admissions, ICU admissions and deaths) will not exceed that of the first peak (in March-April 2020) and may be substantially lower than that.
- On the other hand, as in the first peak, non-COVID-related health and social care will be severely impacted; although, even in this scenario, new ways of providing care may offer some measure of relief.

As already noted, the above scenarios are meant to represent logically coherent and plausible narratives of sequences of events that are mainly qualitative in nature. Work is now underway to develop some quantitative projections (for new infections, hospital admissions, ICU admissions, etc.) to go with these scenarios.

2.4 Contingency Provision

The Strathclyde University analysis clearly identifies the continuing prevalence of the disease in our population and describes a number of possible scenarios relating to a second peak in COVID-19 incidence. In accordance with the Planning Assumptions identified in John Connaghan's letter to Chief Executives (20 May 2020), NHS Lanarkshire has prepared 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.

We are now actively planning our response based on five possible scenarios. The scenarios identified are as follows:

1) The Rate remains below 1 and hospital and specifically critical care admissions remain on the current trajectory allowing us to steadily increase the level and range of services we offer.
2) Small localised outbreaks in areas within the region that requires the Board to have a focused response to testing, tracing and isolating with localised lock downs which may require hospitals services to be temporarily reduced or suspended and mutual aid is required across the Boards to support and minimise disruption to the care of urgent patients.

3) Several areas show significant spikes that require alterations to patient flows and support from services from neighbouring Boards to reduce disruption to access appropriate clinical care for urgent and planned patient care.
4) The rate increases and we face a similar situation to the first wave and we require to implement mutual aid across the system in relation to critical care, acute emergency flows at the same time maintaining priority 1 treatments/ interventions.
5) The second wave is greater than the first and there is full implementation of the critical care network plans and NHS Louisa Jordan is required to provide the support envisaged at the time of initial commissioning.

Further details of the work underway at a national, regional & local level is outlined at section 1.1.

3.0 NHS LANARKSHIRE CLINICAL SERVICE PRIORITIES

Given the above modelling in section 2, NHSL recognises a need to prioritise redesign of unscheduled care in order to reduce unplanned footfall in emergency services including GP OOH, EDs & acute hospital emergency receiving areas. We are working both regionally and nationally to facilitate this work and progressing local initiatives at pace.

NHS Lanarkshire has identified a number of key services for priority recovery:

- 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

In our approach to the management of individual patients within these services, we will be guided by agreed clinical prioritisation systems such as those developed by the National Cancer Treatment Group and also the Royal College of Surgeons

https://www.rcsed.ac.uk/media/681261/clinical-guide-to-surgical-prioritisation-during-the-coronavirus-pandemic-version-2-8-june-2020.pdf

Section 5 describes Primary and Community Health Services (including Mental Health) and Section 6 describes Acute Services.

4.0 PLANNING FOR WINTER

Planning for Winter 2020/21 has commenced and, as in previous years, is a multi-agency approach across NHS Lanarkshire, North and South Lanarkshire Councils together with the respective supports, e.g. SAS, NHS 24 etc. It is anticipated that the planning will be finalised by October 2020. There is a range of specific workstreams which have subsequently been identified to take forward the respective work areas as below.

a) Flu Vaccine Programme – Public

It has been estimated that approximately 240k people will be eligible for a flu vaccine in 2020. Work has been undertaken to assess the time and associated staffing required to undertake this number of vaccines as well as the physical accommodation requirements to undertake same. Early discussions have been had with GP colleagues to assess how they/their staff may be able to assist in same and the respective implications.

b) Flu Vaccine Programme – Health and Social Care Staff

Approximately 8,000 social care staff from both Council and independent and voluntary sectors in Lanarkshire will be eligible for a flu vaccine. Salus – the NHSL occupational health service – will coordinate this, alongside the NHS staff vaccine flu campaign, working with staff and representatives of all sectors. Planning is well underway in this regard.

c) COVID Hub and Assessment Centre (Re-designing Unscheduled Care)

It is not known at this stage the exact make up of what COVID (or respiratory/unplanned urgent care) hubs and assessment centres will be asked to manage. This will require further work at national, regional and local level and will also be dependent on some of the agreements with other Boards, e.g. NHS 24. Whilst the detail is not known at this stage, early work has commenced in discussion with GPs/other clinical staff what such a response might look like and how maintaining 'red and green' flows for COVID /non COVID patients will be maintained throughout the winter period. This will require more detailed staff/workforce planning recognising that some of the staff who were able to assist in the first phase of COVID may not be able to assist in the same way in any second phase.

d) GP and Pharmacy Opening

Depending on what is agreed re c) there may be the need to consider GP and pharmacy opening over the 4 day public holiday period. If this is to happen, it is likely that the proposed additional opening day would be on Monday 28 January and Monday 4 January.

e) Planning for Winter and COVID (Preparing for a Challenging Winter – Academy of Medical Sciences)

The Winter Planning group had received the paper from the Academy of Medical Sciences (AMS) and using this to model a number of eventualities and associated planning of mitigating actions as part of the winter plan for 2020/21.

f) Planning for Additional Deaths

The resilience planning officers of North and South Lanarkshire are working alongside local undertakers to ensure there is sufficient 'pace' of funeral services – both burials and cremations – to support the eventuality of a significant excess of deaths over the winter period. The

additional mortuary capacity identified for COVID is still in place and will continue to be available over the winter period. (Full details of mortuary provision are available at appendix 5).

g) Staffing

All departments are planning to ensure sufficient staffing to respond to the potential needs over the period – again, borrowing on some of the eventualities laid out in the AMS paper described at e) above.

h) Surge/Bed Capacity

Additional surge capacity identified for management of COVID is again being made available/retained as part of the planning for winter surge. A key component of the planning going forward is the modelling work being undertaken by a range of agencies in predicting inpatient/ITU/other capacity requirements depending on the numbers of patients and length of time associated with a 2nd wave of COVID. This is in addition to any additional winter deaths. In this respect, it is envisaged that a good take up of flu vaccine across all relevant individuals will assist in reducing incidence of flu in the community and associated strain in hospital/ITU beds.

i) Adverse Weather

A series of actions is open to the Board in managing adverse weather and these have been refined over many years of winter planning.

j) Overall Resilience Planning

A review of the plan will be undertaken by the NHSL/NLC/SLC resilience planners to give objective opinion as to the range and extent of the mitigating factors introduced to reduce the impact of winter on the overall system.

5.0 HEALTH AND SOCIAL CARE SERVICE PROVISION

5.1 Primary and Community Health Services: - March 2021

The health and social care services delivered by our HSCPs are pivotal to the safe and effective recovery from the pandemic. 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.

5.2 Service Recovery Priorities

The service priorities for the HSCPs are detailed in the table below. The RRROG has considered a number of service recovery proposals and a summary of the decisions to date is available in appendix 3.

Area of work	Baseline (Current status of the service, July 2020)	Aim (Expected status of the service, end of March 2021)	Actions required
General Practice	GPs were predominantly operating at Stage 2 'managed suspension of services'. This changed to a return to level 1 working for the vast majority of GP practices on 21 July 2020. 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-19 Hub).	The service may need to move back to level 2 working depending on any 2nd wave of COVID-19 as well as the potential shape and subsequent responsibilities of primary care in the mobilisation of a community based approach for all respiratory and covid patients over the winter period. 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.	On-going involvement in prioritisation and communication as to which services can be prioritised and established accordingly. 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 (OOH)	Service being provided alongside COVID-19 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	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. OOH working will also be an important factor in the management of any subsequent expanded Respiratory response as part of planning for this winter.

		able to assess/consult via Near Me from outwith the OOH Hub. Additionally, advances also allow access to clinical portal and emailing 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.	
COVID Assessment Hub and COVID Assessment Centres (CAC)	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. Given the drop in numbers – and more especially COVID-19 patients, the decision was taken to close one of the CACs (Airdrie) in June whilst the other CAC (Hamilton) has continued – albeit on a reduced basis.	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. Planning is commencing to understand how CACs might be replaced with 'respiratory assessment centres' should this model be adopted this winter. In such circumstances, given the significant increase in numbers involved, it is likely to mean a significant increase in the number of 'centres.	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.	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.

Treatment Room Services	All treatment room services were initially 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 was agreed – as attached, which guided the nature and scale of step up. This is being extended as more people have priorities addressed and increased numbers of patients can be seen in a health clinic facility.	The work of the clinical reference group identified 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 a number of these patients in accommodation other than treatment room facilities.	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.	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. Face to face clinic appointments are being increased in recognition if the number of people who are finding difficulty to engage using virtual consultations. Telephone consultation takes place prior to any Face to Face contact.	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.

Health Visiting / Family Nurse Partnership (FNP)	Work has been done on the basis of an agreed reduced visiting schedule as per SG Guidance and prior telephone consultation.	The FNP service resumed full working following RRROG approval in July Unless there is a 2nd phase of COVID-19, it is anticipated that health visiting will be back to full capacity by March 2021.	Work being overseen by a specific service review group and a clinical reference group. Further work required to provide staff with necessary IM&T support to facilitate full 'remote' working.
Vaccine Transformation Programme (See Winter planning section for flu vaccine plan, section 4)	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. Likely to be out with NHSL estate.
Allied Health Professional (AHP) Services Detailed below for individual services	All AHP services are 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 were also deployed to areas in support of additional beds to manage COVID-19 inpatient flow.	All AHP services have reviewed the areas they would prioritise for an initial tranche of recovery work as well as reviewing potential service models. In turn these are being approved through the RRROG process. 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 complex patient discharges	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 to support re-ablement and maximisation of independence prior to person getting to home.	Work is continuing to maximise flow, however this has been impacted by the need to redirect resources to support care homes. Specific work in Hairmyres has moved to improved joint working to support discharges to an agreed timeframe thereby reducing Delayed Discharges. Work has also been undertaken to maximise patients' independence with medicines. It is anticipated that as funding to sustain empty beds in care homes reduces, then so there may be more of a preparedness to accept new admissions more readily.	Ongoing support from Public Health Department with a view to reiterating extant PHS Guidance (albeit this changes very regularly). Seek to expand this learning into other hospital sites and indeed look to see how re-ablement 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 EQIA 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 Multi-Disciplinary Team (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. Capacity plan re future recovery and associated waiting times is included in the attached activity templates.	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.	Capacity plans included as part of overall recovery with anticipated return to pre-COVID-19 levels by 31 March 2021	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 interventions provided via telephone contact or Near Me platform.	Capacity plans included as part of overall recovery with anticipated return to pre-COVID-19 levels by 31 March 2021	Work with national dietetic network to ensure equity across Scotland.
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	Prioritised face to face visits will be resumed following RRROG approval in July.	It is anticipated that there will be some additional face to face.
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	Prioritised face to face visits will be resumed following RRROG approval in July.	Work is ongoing in revisiting capacity plans to identify timescale to manage waiting times back to pre-COVID-19 levels.

	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. 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	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) 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	Consideration to management of outstanding P3 & P4 waiting lists. Review of accommodation and rostering arrangements to support social distancing. 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	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	Waiting List Validation Development of Physiotherapy Website to promote self-management

	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.	face to face only if high risk identified during remote assessment	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 face to face 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. Additional face to face clinics have also been re-established in some areas to support increased activity concentrating in priority patients.
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 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	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 South Lanarkshire Councils to plan Education Contract services.	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 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

	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.		
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. Face to face clinics now approved via RRROG process and work in hand to establish capacity planning to establish all waits within agreed timeframes.
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. Full service resumed in all inpatient hospice beds.	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 distancing is challenging. Assessment is required to address this and new technology/Near Me may help.	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. Work is ongoing to have this fully embedded before winter. ***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.

		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.	Paediatric emergency dental surgery for children with special needs has been re-established w/c 25 May. Work was also undertaken to action the advice received from the CDO, received 20 May 2020 and subsequent guidance in moving towards re-establishing wider dental services	Walk round of theatres to ensure all logistical and PPE issues identified and plans in place to safely resurrect service. Further guidance awaited as to when sufficient PPE will be available to support return of full AGPs in GDP service.
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. PPE now available to support services from the EETCs and to support to independent optometrists recognising the need to be close to the patient as part of routine eye care.
Shielding	Over 25,000 patients in Lanarkshire were identified in the 'shielded' category, representing 3.5% of our population. There is a list of around 400 people where additional attempts are being made to establish contact by the respective Councils. All others have been provided support 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. The undernoted services are in the process of being stood up: -Long Acting Reversible Contraception (LARC) insertion for post abortion, pregnancy in the last year, under 25s, vulnerable for other reasons at staff discretion. -Routine HIV PREP provision (Pre exposure prophylaxis). -Hepatitis A/B vaccination completion in high risk groups. -Active contact/communication for under 18s to alert service availability.	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. 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. Work is ongoing in considering how to move to the next tranche of priority services.
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. Approval given to re-establish Parkinson's and MS nursing services	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

5.3 Mental Health and Learning Disabilities Services

Baseline detail
Some changes have been common practice across all services within Mental Health and Learning Disabilities in 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) (Red)
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) (Amber)
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. (Green)

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.

Routine work: Routine work (group 3 and to an extent group 2) were deferred to a later date, meaning that scheduled home visits and clinics did not taken place. However these patients have in most cases 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.

Recovery: Moving forwards through the recovery process, the service is fully tied into the Clinical Reference Group established jointly by the two Health and Social Care Partnerships to aid decision making around the collective prioritisation of services and subsequent decisions around service models and accommodation requirements. All elements of service are being taken forward collaboratively on a pan-Lanarkshire basis.

Updates for each individual service are shown below.

Area of work	Baseline (Current status of the service, July 2020)	Aim (Expected status of the service, end of March 2021)	Actions required
CAMHS	Initially, all routine work including assessments, individual and group intervention programmes and routine reviews was deferred. Clinicians utilised the RAG rating system as used across all MH services to compile active case lists, with lists continually reviewed. Referral vetting by locality team Co-ordinator has been undertaken twice weekly using MS Teams carried out by a small team of Clinical Manager and 2 Team Coordinators. New assessments are being undertaken by telephone and Near me, including people on the waiting list. Referrals not meeting the service threshold where no clinical intervention is indicated are offered advice, access to resources and signposting as appropriate and cases discharged. Urgent cases requiring intervention are offered follow up intervention from an appropriate clinician. We also established a central telephone advice line available for the public and professionals to call for advice or help, operating Monday to Friday, 9am to 5pm.	We are scoping to deliver CAMHS service over a 12 hour day to allow for flexible working and ways of spreading out footfall to reduce risk. There will be a phased resumption of group therapy interventions including parenting interventions and group therapy elements of our Dialectic Behaviour Therapy programme for young people with severe emotional dysregulation, self-harming and suicidal behaviours as the virtual platforms available to us do not currently support multi person use to the scale required whilst offering secure connection. Recommence routine 'green' rated cases utilising telephone and near me consultations where possible and face to face only if required. The vulnerability of the client group means that first appointments will be seen face to face mainly but return and less at risk groups will utilise the Near Me platform. Unscheduled care team seeing urgent unscheduled referrals ensuring a quick response. Reducing impact on routine work.	Continued use of telephone and Near Me consultations to reduce footfall and observe social distancing requirements. Roll out of new IT systems for the service (Morse, Trak) to support more efficient referral and case management. New accommodation required to support the service to retract onto fewer sites, creating greater resilience and supporting social distancing requirements. Work ongoing to provide an appropriate platform for delivery of group interventions securely. Consolidate the learning from telephone triage which has addressed some issues earlier preventing a long wait. Telephone discussions with referrers have ensured missing referral data is available at assessment.
Psychological Therapies	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). While no service was completely stopped within Psychological Services, the RAG rating was used and those	Standardised materials for remote working continue to be created, with standard letters to service users prepared, methods for appropriate recording on Trakcare and more extensive use of all adjuncts to therapy including additional signposting resources, use of cCBT, SilverCloud, and ieCBT. There will be a phased return to group-based interventions, central to many department's routine service delivery.	Continued use of telephone and Near Me consultations to reduce footfall and observe social distancing requirements. Phase 3, and a move to increase face-to-face clinical appointments for routine patients is contingent upon the Lanarkshire-wide review of clinical capacity across the estate. Psychological Services will feed our anticipated needs into these plans.

	with the greatest level of need/vulnerability/risk continued to be seen, largely via phone or Near Me consultation, with face to face only when required. Referrals have again increased and with routine cases deferred, the longest wait has increased to 52wks (largely due to a few outliers) with most specialties having a waiting time of around 18wks and most PT teams with waiting times under 25wks.	Approval has been given for Psychological Services to move to Phase 2 of our remobilisation plan. It is anticipated that Phase 2 will continue for the next several months. Phase 2 includes: **1.** Continued prioritisation of urgent referrals and patients with significant need/vulnerability across all Psychological Services teams and specialities. • Contact will routinely be via Near me/phone in the majority of cases. • Face to Face consultations will take place on a clinical needs basis, where remote consultation is not feasible. **2.** Those patients categorised as amber and green, including new referrals and patients who already commenced therapies, will be contacted by phone/letter. • Patients able to do Near me/phone will be scheduled for a consultation. • Patients who opt to be seen only face-to-face will be waitlisted until such time as clinic access is permitted.	There will be a phased return to group-based interventions, central to many department's routine service delivery. Work ongoing to provide an appropriate platform for delivery of group interventions securely. As part of the wider H&SC recovery plan, work in underway to review accommodation requirements for near me and face to face contacts The ten adult Psychological Therapies Teams are locality/geographically based. Discussions are now underway around the impact of triaging those patients who opt for remote consultation centrally/HB-wide, whilst patients who want face-to-face appointments continue to be offered local consultation.
Community Mental Health Teams	Referrals dropped to approximately 25% of normal activity in April 2020, but has increased back to over 50% in May and June, with a significant increase in the number of crisis referrals received (approx. 5 per day). Clinical teams have continued to offer ongoing support to existing caseloads and adapted their working practices to ensure appropriate interventions continue at times of crisis i.e. mental health crisis, social crisis, or public protection concerns. As per RAG rating, existing caseloads are broken down as follows (average):- • Red - 37%	CMHT's staff will continue to see all urgent/high risk patient group preferably via Near Me or by telephone where possible though offering face to face consultations either at home or at clinics where this is not possible based on identified level of risk. In addition all medium risk and routine new referrals will be offered assessment appointments via Near Me/Telephone. Again, where this is not possible, a face to face appointment will be offered either at clinic or at patient's home depending on level of risk identified and patient preference.	Only small numbers waiting at present, with focus on new ways of engagement using telephone/Near Me and face to face as required. As part of the wider H&SC recovery plan, work in underway to review accommodation requirements for near me and face to face contacts. Redesign Clozapine Clinic operational management structures to ensure they are more locality focussed.

	• Amber - 29% • Green - 34% Referrals continue to be received by CMHTs and they are screened in the same manner as before i.e. via a one door access meeting. Referrals are RAG rated/prioritised based on the information contained within the referral. They are then allocated or placed on a deferred list. Allocated referrals are offered assessment via telephone/near me, with face to face contact only provided where there is a clear clinical rationale, and with screening processes and PPE in place to minimise risk. Deferred referrals have initial contact made to determine level of need and signposting to other services if required. There is then 4 weekly contact maintained by the team mainly by telephone. If there are any changes to the mental health needs of individuals, they are allocated to a member of staff for full assessment. Deferred lists have significantly reduced over the past 3 – 4 weeks due to staff having capacity to assess and support patients although a small number have advised their preference is to wait for face to face contact to resume. Telephone contact continues with this small minority.	A move toward locality Clozapine clinics (instead of hospital based) has been positive and is likely to remain. MARAC, MAST and any public protection meetings continue via conference calls or Microsoft Teams. Various feedback on use of technology for patient contact - younger generation preferring same, however a number of older patients do not have access to appropriate equipment. Reduction noted in rate of 'Did Not Attends' for assessments carried out digitally resulting in increase in initial assessments being completed.	
Community LD and ASD	Referrals across LD Adult service, CAMHS LD and ASD all significantly decreased, though starting to increase again. All services have used the RAG rating for patients to prioritise activity. For ASD, assessments are all started with the background information gathering to support the assessment process though no direct visits at present. Previous ALDS assessments requested, review of referral information and autism screening tool, review of early developmental information, school reports, educational psychology &	Phased return of adult healthy improvement group work is now underway. Day opportunities and respite offered by SW changed to more individualised supports and will continue in this way to ensure safety. Significant increase in routine check-in calls undertaken in line with RAG rating (daily, weekly, fortnightly/as required appointments) with information recorded in notes.	Anticipated there will be some additional face to face consultations, but moving to a mixed economy with use of telephone and Near Me. As part of the wider H&SC recovery plan, work in underway to review accommodation requirements for near me and face to face contacts.

	speech and language assessments accessed via child health records. For CAMHS LD, urgent referrals were picked up immediately with others receiving initial input to stabilise situation and placed back on waiting list. For Adult LD, all referred contacted by phone, with some initial therapeutic work undertaken. Risk has been assessed via discussion with referrer, patient (if appropriate), carers and SW.	Increased use of Near Me consultations, expanding beyond those in red group. Essential domiciliary visits continue covering depot injections, mental health assessments and physiotherapy assessments, plus other priority cases such as possible family breakdown.	
Community Drug and Alcohol Services	Referrals continue to be received, including self-referrals. All are screened by the Team Lead on a daily basis (North) and Allocation Meeting (South). They are allocated for assessment to individual workers within the Team. Prioritisation is given to new referrals by: • Review of referral information • Review of previous contacts with service • Review of SWIS • If required contact with the individual and /or referrer All are allocated immediately. No individuals have been placed on a waiting list to be allocated at a later date. Method of contact and assessment has changed. Telephone contact and assessment has been primary route of communication during this period. Efforts are being made to contact all individuals for whom a referral has been made. If they cannot be reached on contact number provided a letter is sent. If there is evidence of increased concern from referral info or from research of electronically held information details case is reviewed and decision made between Team Lead and worker whether visit is required before decision made to close case.	Work on going to look at future model of delivery, focused on: • Mix of telephone, Near Me and face to face • Support arrangements for access to ORT • Psychological supports for individuals • Review of dispensing arrangements • Review of clinic activity	Develop and sign off new models that are cognisant of the needs of the patient group.

	Average wait for contact has been reduced from 9 days to 7 days with some areas managing to turn around urgent cases within 2 days. No significant reduction in caseload size has been noted during time period. All caseloads have been reviewed and in conjunction with Team Lead a RAG status has been applied. The RAG status has dictated the level of contact provided. ***High (Red) RAG Status*** have had 2 levels:- **1.** Regular face: face contact maintained with service and with attendance at Pharmacy **2.** Three times a week contact by telephone (This has been dictated by assessment of risk and co-existent mental or physical conditions). ***Medium (Amber) RAG Status*** have been contacted weekly and agreement made between individual and worker if that contact is not made what next steps should be (i.e. Review of dispensing arrangements/ alternative contacts). ***Low (Green) RAG Status*** - Telephone contact requirements agreed between worker and individual. This has ranged between fortnightly and monthly. Signposting and links to additional supports have been made to supplement statutory service provision (linkage to virtual Recovery Communities and agreed additional telephone contacts from commissioned services).		
Community Older People's Mental Health Services	The service continues to provide an ongoing response to all existing caseloads. Staff have adapted their method of response accordingly due to the restrictions imposed by the covid pandemic. This has mainly been telephone contact though face to face appointments and/or domiciliary visits	Community Older Peoples Teams will continue to see all urgent/high risk patient group preferably via Near Me or by telephone where possible though offering face to face consultations either at home or at clinics where this is not possible based on identified level of risk. In addition all	As part of the wider H&SC recovery plan, work in underway to review accommodation requirements for near me and face to face contacts.

	continue depending on degree of urgency e.g. mental health/social crisis and public protection issues. Referral rates reduced by around 60% thought increasing again. All referrals are risk assessed and prioritised based on the information contained within the referral. Referrals come via SCI Gateway and are discussed at the MDT with the nursing team, consultants and AHP's where a decision is made on level of priority, and whether face to face, attend anywhere of telephone contact is appropriate.	medium risk and routine new referrals will be offered assessment appointments via Near Me/Telephone. Again, where this is not possible, a face to face appointment will be offered either at clinic or at patient's home depending on level of risk identified and patient preference. Staff are adapting to changes in working practice with increased telephone contact, less face to face consultations and often a component of working from home to accommodate social distancing within the workplace. More written information posted to patient group with advice and sign posting to on line and alternative, available supports. Memory management groups and carers groups are currently suspended and are being reviewed to look at alternative methods of provision.	
Community Specialist Services	The Eating Disorders team has been offering 'treatment as usual' (predominantly via video call) for all patients on the TESS existing caseload. Caseload management is discussed on an individual basis and where face to face engagement is risk assessed to be required then this is offered. The referral process has remained the same over the pandemic period with the only team modification being the introduction of Microsoft teams to facilitate referral management and MDT discussion. For Perinatal, all patients offered Near me or telephone contact with a mixed response in terms of patient preference for Near me or phone contact. Domiciliary Visiting has been carried out on occasion due to significant clinical concerns. The Perinatal referral process has remained the same with the only team modification being	Currently no waiting list and new mixed economy of Near Me, telephone and face to face to continue. Currently no waiting list and new mixed economy of Near Me, telephone and face to face to continue.	

	the introduction of Microsoft Teams to facilitate referral management and MDT discussion. The Community Rehab Team have continued to provide a mixture of Near me and domiciliary visits due to the complex nature of the mental health needs as well as individual identified risks. The team have used Microsoft Teams and Near Me to carry out MDT reviews and care planning meetings.		Further work required on community support packages available, which have been impacted by Covid.
Community Forensic	Referral numbers have remained largely consistent. The Forensic CMHT continue to visit patients at home, work within the Court and now have access to a 'virtual court' if required. Plans are in place to increase support to patients in stage 2. The Forensic Rehab unit has re-commenced planning for patients with a re-engagement of community supports and Care Programmes Approach meetings via Microsoft Teams. The Forensic Service has developed a Route Map to the delivery of services in line with the Scottish Government paper. This plan includes all disciplines. Both NHS Lanarkshire and the Forensic Service Clinical Psychology Team will continue to offer support and guidance for staff throughout this progressive delivery plan: **Stage 1** • Inpatient services have been in contact with out of area Forensic Services to prepare plans for transfer to NHS Lanarkshire's Low secure unit. This is an individually considered patient centred plan based on a number of factors. Advice has been given by Infection Control and this will be incorporated as part of the transfer process.	**Stage 2** • Planned transfer of patients will take place when it's the right time to do so. Advice from Infection Control will be adhered too. • Inpatients will have increased time out in line with Government guidance. This will be both on their own and with staff support. • Route and adhoc risk management measures will be re-introduced as patient's activity increases. This will include drugs of abuse screening alcohol monitoring and searches. • Visits may take place in a designated area of the unit if the Scottish Government guidance changes and support is given from NHS Lanarkshire. • Small integrated therapeutic groups will be possible outdoors if social distance rules are applied. • The use of remote access consultations will continue. All disciples will consider the need for face-face consultation and this will take place on an urgent basis. Social distance rules must be adhered to. • Community support for patients at home will increase.	

	• Unplanned admissions to the Low Secure continue and there continues to be capacity for this to happen. • The Forensic Rehab unit has re-commenced planning for patients with a re-engagement of community supports and Care Programmes Approach meetings via Microsoft Teams. • Relatives and visitors are now able to visit the site and have visits with patients in the garden area. Advice has been given regarding social distance. Numbers are limited and planned to ensure safe social distance. No visitors are able to access the buildings. • The Forensic CMHT continue to visit patients at home, work within the Court and now have access to a 'virtual court' if required. Plans are in place to increase support to patients in stage 2. • Patients who were thought to be de-stabilising have been given access to on-site activity co-ordinated by the Occupational Therapy and nursing team. The community and inpatient groups are kept separate and refreshment areas have been set up to allow for social distance.	**Stage 3** • An increase in face-face contact will be considered although multi-disciplinary meetings will still be conducted remotely. • Inpatients who required progressive, careful re-integration to the community including discharge planning will increase. Access to community support will be established. • Support in the community should be determined by the needs of the patient with increased support available. • Integrated inpatient and community activity will increase. • Outpatient accommodation will have been risk assessed and modified for safe use. **Stage 4** • Social distance and adherence to government guidelines will allow for as 'near normal' return to practice for all parts of the service.	
Out of Hours/ Crisis	The function of the duty nurse within the CMHT is to provide brief and rapid therapeutic interventions to individuals suffering from acute mental health symptoms. The following referral pathway supports ease of access to CMHT Duty Service: • Referral received from GP, self-referral from active patient on caseload, other services within mental health network. • The referrer will have had contact with the individual being referred within a 4 hour period.	Referral to Crisis element of CMHT was still in place during initial stages of lockdown.	Link in with SLWG to review development of Mental health Assessment centres.

	• Duty worker completes referral pro forma with referrer (usually over telephone) Referral process includes completion of risk assessment. • Assess urgency of referral with referrer. • Referred individual will be seen, assessed and offered appropriate intensive interventions. • Where the duty worker cannot provide an immediate response the duty worker will refer on to the Psychiatric Liaison Nursing Service based within the ED department at one of the 3 District General Hospital. • Outcome(s) of assessment will be shared with referrer. Crisis referrals to CMHTs during the last three months of Covid are rising and are now on average 4/5 referrals per day, which is an increase in referrals which were previously on average 5/7 per week. All referrals are screened using the above process, and face to face assessment completed if required. If a referral is not deemed to require immediate support, they are allocated to a CPN for assessment via Telephone or Near Me.		
Acute Hospital Based Mental Health Services	Mental health assessments that were previously carried out by Liaison Psychiatry within the Emergency Departments in Monklands, Hairmyres and Wishaw have now been relocated to mental health assessment areas which have been developed within our inpatient service environment. This change of practice required a dedicated environment and additional staffing resource.	The aim moving forward will be to focus on continued development of safe and effective mental health hubs out-with the ED departments across Lanarkshire. They are currently working well utilising the ED assessment pathway which requires good communication between Liaison, services, ED and Mental health Inpatient units. Work will continue with consultation with a range of disciplines in Mental health and Acute in regards to the medical assessment of mental health presentations.	In the next 3 months we will seek to; Set up a SLWG to develop Mental Health Assessment Centres in line with the request from Mental Health Directorate SG. In the next 3 months we will seek to; • Define the model • Identify appropriate accommodation • Identify appropriate staffing and skill mix. • A business case will require to be submitted for additional funding if a new model is to be established.

Inpatient Psychiatric Units	No Inpatient services have stopped or have been consolidated, all inpatient units continue to provide inpatient treatment. • Focus on reducing ward footfall • There has been a minimum reduction in Occupational Therapy activity • Restrictions on visiting • Early adoption of Near Me • Clear communication given PPE • There have been restrictions in periods of planned leave (passes) • All new admissions who are symptomatic are subject to testing and a 14 day isolation in a side room • Routes to communication have been adapted and enhanced to ensure a digital presence at multi professional meetings or family consultations which now can take place via Near Me or MS Teams. • New developments included the use of IPads to enable visual communication with relatives and friends with the deferment of Hospital Visiting. **Inpatient Adult** A decrease in both admissions and occupancy overall, although the marked initial decrease has begun to level out. **Inpatient Older Adult** Admissions to older adult functional units have been sustained and at manageable pre Covid levels. Routine swabbing of over 70s admissions is in place. **Inpatient Dementia** After a marked decrease in admissions at the beginning of Covid, this has subsequently reversed and admissions and occupancy are now higher than usual. This is occurring in part to carers becoming ill and unable to sustain carer	No Inpatient services have stopped or have been consolidated, all inpatient units continue to provide inpatient treatment.	As part of the wider H&SC recovery plan, work in underway to review respite provision.

	responsibilities to their wife or husband etc. There has also been a decline in respite admissions via care homes due to Covid closure and therefore admissions to inpatients services have provided a default position. Routine swabbing of over 70s admissions is in place. **Inpatient IPCU** This 6 bedded unit is usually at capacity, as was the case pre-pandemic. During the last 12 weeks there has been a notable increase in acuity and psychiatric presentation.		

Current estimated activity and waiting lists for priority areas are included in Activity Templates 1, 2 & 3 which are available on the appendices page.

More detailed information has been shared with colleagues in the Mental Health Directorate as part of our scheduled weekly meetings with the Scottish Government team.

Wellbeing Services for Staff: There has been significant development around staff health and wellbeing throughout the pandemic, including extensive self-help resources, 24hr staff helpline, rest rooms across a wide range of services and settings and occupational health supports including stress line. Work is ongoing to build the holistic model for the rest of the financial year. Further details of the services available to support staff are outlined at section 9.5.

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.

5.4 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 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.

6.0 ACUTE SERVICE PROVISION

NHSL Acute Services Recovery and Renewal - August 2020 to March 2021

6.1 Introduction and Principles

From August 2020 to March 2021, Acute services will focus on continuing to provide the urgent outpatients, diagnostics, inpatient and surgical activity that was maintained throughout the COVID-19 surge (March to May 2020) and on reinstating further high priority services. Clinical prioritisation of patients is at the forefront in the planning process to determine which services are a priority to reinstate. These priority services have been through a rigorous approval process that includes making sure all options for redesign and reduction in Face-to-Face [F2F] contact have been considered and included in the plan. Some of these services are already up and running and others are close to restarting. These and details of the regional approach (as discussed at section 1.1.1) are described in the following sections.

The plan to continue services that were maintained throughout, those that have recently been reinstated and those in the process of being reinstated in the next few weeks are all contingent on a situation where COVID-19 presentations remain low. However, should COVID-19 activity start to increase to a point where ITU capacity is over 200%, NHSL will escalate our workforce and service plans to meet this additional demand.

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

- Move from a model of unplanned unscheduled care attendance or assessment to one based on a planned appointed clinical system. This requires the adoption of new models to support the urgent and emergency care response across the wider healthcare system encouraging joined up pathways and models of response to unscheduled care involving NHS24, SAS, GP In-hours, GP Out of Hours and Emergency Departments.
- 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-COVID-19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-COVID-19 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 Nuffield and NHS Golden Jubilee National Hospital (NHSGJNH).

6.2 Governance

a) NHSL has established a Response, Recovery and Redesign Oversight Board (see 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.

6.3 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 basis. The capacity required to reinstate the 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.

6.4 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 restarted:

a) Cancer Services

NHSL had early discussions with the Nuffield and GJNH and have been able to undertake cancer surgery for all Level 1 patients (Urgent and emergency surgery required, for example obstructing colonic cancer) and for the majority of Level 2 patients (Surgery within 4 weeks required to avoid disease or symptom progression with a high likelihood of curative resection).

i. Nuffield – Capacity at the Nuffield has been secured for 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 and Plastics Service has largely maintained their one stop clinics at the Nuffield and have continued to carry out cancer 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. During this time, day case rates have been increased significantly to the highest rates in Scotland. The Breast team have prioritised each individual patient and commenced

hormone treatment for those who are hormones sensitive. These patients will require surgery as their next treatment modality.

Plans have been agreed with SG to reduce access to services at Nuffield. This will be undertaken in a phased approach, reducing Nuffield activity by 25% in July, 50% in August and 75% in September enabling all activity to be phased out of Nuffield by end September 2020.

As part of the phased approach, new patient USOC and result capacity has been recovered to University Hospital Hairmyres (UHH) and University Hospital Monklands (UHM). Planning is underway to recover services at University Hospital Wishaw (UHW) and increase site activity aligned to the Recovery, Redesign and Mobilisation pathway within NHSL. This approach will ensure there is sufficient capacity to meet the demand of Breast referrals including the trajectory for the recovery of Breast Screening referrals.

ii. GJNH - Urgent Cancer surgery is also being undertaken at GJNH. This currently consists of:
- **a.** Colonoscopy (eight full day lists a week)
- **b.** Urology (one list a week)
- **c.** Gynaecology (two lists a week)
- **d.** ENT (two lists a week)
- **e.** Ad hoc lists used for further surgery for the specialties listed and for urgent Upper GI, Colorectal and Plastics cases.

iii. Cancer Service within NHSL have sustained all Oncology and Haematology clinics with no patients waiting more the 2 weeks.

iv. Cancer surgery has recently been reinstated at NHSL with a limited number of theatre lists now running. These are currently being used for Colorectal, Gynaecology and Urology. Colorectal was reinstated in a phased approach initially on one Acute Site at UHH and then increasing sessions at UHW in July 2020.

v. Systemic anti-cancer Treatments (SACT) - To sustain SACT delivery locally the service reduced from three site delivery model to a two site model to enable a sustainable approach 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.

b) Diagnostic Services

a. Radiology continued to provide 24/7 service for all In Patient and Emergency activity and all requests triaged as Red (Suspicion of Cancer/ Clinically Urgent). Radiology is currently reviewing 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.
   - From June to Sept 2020 diagnostic capacity at Glasgow Nuffield is being utilised to support Red/Amber CT, MRI and Breast examinations.
   - Continue to utilise available capacity at GJNH for CT, MRI and Ultrasound examinations.
   - A Waiting List Validation exercise is ongoing for all Routine examinations that have waited over 12 weeks.
   - CT and Ultrasound are currently operating at 65% capacity with MRI 70% capacity to ensure current social distancing measures are adhered to and to allow appropriate cleaning between patients.
   - Ad-hoc waiting lists are being undertaken for CT, MRI and Ultrasound to help manage the shortfall in capacity.
   - To reduce waiting times, extended 7 day working is being discussed with staff and partnership representatives. However, it is recognised that this will not be feasible without an increase to current staffing.
   - Where appropriate patients will be offered appointments for general x-ray OP/GP examinations rather than having Open Access and this has been beneficial in managing social distancing while maximising capacity.
   - Discussions are continuing with colleagues at SG about access to a CT pod at the Louisa Jordan supported by NHSL radiography staff.

b. Access to Urgent Laboratory tests has continued throughout. Although overall demand is down for Laboratory tests, Microbiology and Pathology have faced significant challenges managing Covid 19 testing due to instability of reagent supply, availability of analysers and changes to staff working to accommodate the volume of tests and manage turnaround times. In particular Microbiology services are under significant stress due to the requirement to provide 7 day access to Covid 19 testing and other aspects of clinically urgent services e.g. sexual health testing is also contributing to the workload.

c) Maternity and Neonates

Core Maternity services have continued throughout. This was achieved with a number of changes to normal working, specifically in relation to antenatal services, cancellation of home births, reduced visiting and priority new born hearing screening. Online Antenatal classes have been launched and electronic follow up will be implemented shortly. Improved access for partners during birth and access to neonates is currently being reviewed. Home births have now been reinstated, antenatal care is being provided through a blended approach of face to face and near me/attend anywhere.

Online antenatal classes continue. Face to face Newborn audiology service has recommenced. There is a staged approach to reinstating satellite services and visiting has been reintroduced along with partner accompaniment at appointments. Access to neonates has been a graduated approach and is almost back to open access with a plan for reinstating essential face to face clinics.

d) Trauma

- **a.** As part of NHSL's planned centralisation of Trauma to one site, the move of all Trauma to UHW was expedited in March 2020. This move worked well during the initial COVID-19 surge and enabled an efficient, safe service to be delivered to patients. As services are recovered, the delivery of trauma will be maintained at UHW with the restart of elective activity scheduled for the beginning of August at UHH. This is the service model planned as part of the orthopaedic redesign.
- **b.** Trauma theatres – Two full day lists are running at UHW 7 days a week with an additional 3rd ad hoc list added when daily trauma demand requires. A separate COVID-19 ward is no longer required and patients are prioritised for a side room or follow the local cohorting guidance should this not be achievable. Given the PPE and Infection Control cleaning requirements for theatres for operating on COVID-19 positive or suspected case, a 'Red/Green' Risk Assessment continues to be utilised 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.
- **c.** An Ambulatory Trauma Unit is running at UHW with appropriate COVID-19 risk assessment of patients.
- **d.** Fracture clinics returned to the 3 acute sites in June 2020. The clinic capacity has reduced to allow physical distancing which has resulted in an increase from 18 fracture clinics pre COVID-19 to 20 clinics in the current model.
- **e.** Orthopaedic paediatric baby hip clinic has continued to be delivered at UHW with no delay in assessment.
- **f.** Urgent elective referrals (those triaged as red) were assessed in June/July 2020 at the Glasgow Nuffield by NHSL clinicians. From August 2020 these patients will be assessed within core elective clinics within NHSL.
- **g.** Urgent revisions have been operated on at GJNH. Further revision capacity is soon to be available and will commence in August 2020 at UHH.

e) Emergency and CEPOD Theatres

- **a.** Emergency General Surgery receiving was concentrated on a single site at UHW during the first Covid-19 surge. NHSL moved back to a three site receiving model in June 2020. There is a contingency plan in place to move back to the one site model if there is a further Covid-19 surge.
- **b.** CEPOD theatres are running on a daily basis at all three sites.

f) Outpatients

The following outpatient services maintained an element of their service for clinically urgent patients or have recently restarted a service: Cardiology, Neurology, Stroke, Ophthalmology, Head and Neck, Community Dental, Dermatology, Gastroenterology, Diabetes and Endocrinology, Respiratory Medicine and Gynaecology. For further information see appendix 6.

g) Scopes

i. Endoscopy – Referrals were triaged and only the urgent red category were performed in NHSL during the Covid-19 surge. These patients continue to be managed through CEDOD and urgent ad hoc lists. Lists for urgent patients are currently being run in theatres. Eight list a week are running at GJNH supported by NHSL surgeons and nurse endoscopists. Further planning is underway to enable a full re-start of endoscopy services, however this will be subject to confirmation of appropriate ventilation/air exchanges.

ii. Cystoscopy (Urology) – The Urology service maintained 1 weekly scope list at the Nuffield Hospital. This allowed the most urgent haematuria patients to be treated, however, there were limitations to the types of patients that they could accommodate, so a number of urgent patients required to wait until services resumed within NHSL. This number continued to increase as USOC continued to be received as well as paused bladder cancer surveillance scopes. A limited flexible cystoscopy service has been resumed on the UHM site from mid-June onwards. UHM has the advantage of a completely separate Endoscopy Unit which supports the ability to maintain a Green stream for these elective patients with a separate entrance.

h) Pre-Assessment Service

a. A limited service is currently up and running with plans for expansion. A one stop Pre-Assessment service is running at UHH 3 days a week for 4 patients a day. This is currently only for high risk patients undergoing major surgery. It has been predominantly colorectal and vascular patients but it is being expanded for other specialties as required.

b. A drive through COVID-19 screening area is available at UHH.

c. A Telephone Pre-Assessment service commenced at the end of June at UHW that aims to deal with a higher volume of lower risk cases (elective Orthopaedics, Urology, ENT, Oral and Maxilliofacial, Gynaecology, General surgery and Breast).

d. Demand is now increasing and there is capacity for a total of 75 patients per week.

e. The service clinical leads are developing a business case for an electronic record for Pre-Assessment which should increase capacity.

i) Surgery – Clinically High Priority Cancer and Elective

a. NHSL have recently implemented a new set of clinical prioritisation codes for the TTG waiting list held on Trakcare. The categories are based on Royal College Surgeons criteria but with clinical discretion encouraged. The coding is based on each individual patient and their need. The majority of patients with a particular condition/waiting for a specific procedure should fall into the category indicated by the Royal College document but a clinician should increase the urgency of a specific patient where appropriate (e.g. due to severe pain, impact on life, complexity of case). The categories are:

i. USOC
ii. Cancer
iii. Within 4 weeks
iv. Within 3 months
v. Over 3 Months

b. NHSL clinical and managerial teams have worked collaboratively to undertake a clinical review of over 7,000 existing patients on the specialty waiting lists to ensure that each patient has been categorised appropriately.

c. The aim is to:

- **i.** Be able to quantify demand easily by specialty, by urgency that is consistent across specialties and by length of wait.
- **ii.** Operationalise the allocation of the limited elective theatre sessions available to specialties to accommodate the demand on the basis of number of cases by urgency and length of wait.
- **iii.** Be able to answer questions on Demand vs Capacity balance and the management of urgency more easily. This includes being able to split surgical cancer cases from urgent non-cancer cases easily and accurately.

d. This categorisation is being used to manage and monitor the specialties allocated lists and the cases undertaken for both the Day Case and Inpatient capacity detailed below. This is often a complex balance of theatre, beds, ITU and staff (surgeons, anaesthetists and theatre staff) capacity as well as the location of specialist equipment and expertise.

e. The intention is to monitor how long patients in each category have been waiting and to increase the priority of cases in a category that are nearing the end of the clinically indicated time limit for the category. Particular attention will be paid to the 'Over 3 months' category in recognition that this is longer than the TTG Guarantee. Patients in this category have been deemed clinically acceptable to wait for over 3 months. NHSL intend to recover back to a position where, although patients will be assigned this category, they will not actually wait that long. Full recovery to this position is likely to take many months, if not years. This will include a review of patients listed for procedures of 'lower clinical value' and whether each of them should remain on the list for good clinical reason or whether they should be removed from the list and offered alternative management of their condition.

f. NHSL is also participating in regional West of Scotland discussion regarding whether urgent cases, where there is insufficient capacity at the host Board to undertake the surgery in a clinically appropriate timescale, can be undertaken at another Board. This is over and above the plan for cancer cases described in the Cancer section. Further details can be found in section 1.1).

j) Day Case Surgery

a. UHM – A range of high priority urgent day surgical procedures have been reinstated. The Day Surgery unit at UHM is a stand-alone unit, separate from main theatre. The layout provides an opportunity not only to maintain 'green' pathways but also to create a 23 hour care facility maximising the theatres in day surgery. One all day list a day is currently running Monday to Friday for use by ENT / OMFS / Urology /General Surgery/ Community Dental / Vascular / or others as required.

b. UHW - There is no day case surgery being carried out as the elective theatre is being utilised for cancer cases.

c. UHH - Day case surgery has recommenced, in particular ophthalmic surgery. Current provision is approximately 20% of pre-COVID delivery. A proposal has been prepared that will see this increase to approximately 70% of pre-COVID delivery by mid-August, pending assurances that delivery of this activity can be achieved without posing an unacceptable risk of COVID-19 transmission.

k) Inpatient Surgery

a. UHH – Previously, 6 elective theatres ran per day. A phased plan to reintroduce theatre capacity to treat clinically urgent elective inpatients is in progress. The impact on critical care capacity will be balanced against required Covid-19 capacity including theatre and Anaesthetic staff and Level 3 ITU capacity. Activity started with 3 session days in 1 to 2 theatres/day up to 5 days a week. Almost all outstanding Colorectal Cancer resections have been completed and the Vascular team are working 9 Sessions a week and have capacity to deal with all urgent cases. Ophthalmology are working up to 6 sessions a week and are operating on urgent cases. From the beginning of August, the plan is to run 2.5 session days in 4 theatres a week. This will allow the resumption of urgent orthopaedic surgery and these lists will be shared with general surgery, vascular surgery, ophthalmology and orthopaedics according to clinical priority. Further recovery of elective capacity is being assessed for September onwards.

b. **UHW** – For August, the plan is to run 1 elective theatre five days a week for urgent patients for Upper GI, Colorectal and Respiratory patients. Further recovery of elective capacity is being assessed for September onwards.

c. **UHM –** For August, the plan is to run 2 elective theatres five days a week for urgent cases. Further recovery of elective capacity is being assessed for September onwards.

d. Ongoing theatre capacity is contingent on the provision of a safe staffing model and the return to work of a number of staff who are currently shielding. Elective theatre capacity at UHW is adversely impacted by the requirement to provide 6 emergency theatres per day for obstetrics, CEPOD and trauma.

Activity Data

e. Outpatient Activity – This table shows the level of new outpatient appointments undertaken by specialty in the last four weeks, compared with activity undertaken in the same four weeks last year. It is sorted on the % comparison with previous activity undertaken in the most recent week. The data is for booked activity and includes DNAs. It includes activity undertaken at other locations such as the Nuffield, GJNH and the Louisa Jordan.

Parent Specialty	22/06/2020	% Prev Year	29/06/2020	% Prev Year	06/07/2020	% Prev Year	13/07/2020	% Prev Year
J4 Haematology	32	94.1%	30	>100%	23	85.2%	23	>100%
C12 Vascular Surgery	28	70.0%	12	27.9%	14	46.7%	21	>100%
AD Medical Oncology	27	>100%	21	95.5%	22	68.8%	25	78.1%
F2 Gynaecology	151	56.1%	156	76.5%	152	61.0%	119	74.8%
C8 Orthopaedics	263	63.8%	226	72.7%	132	38.2%	235	70.4%
AF Medical Paediatrics	79	>100%	58	>100%	68	74.7%	39	63.9%
A8 Endocrinology	8	13.8%	2	4.4%	7	23.3%	16	61.5%
C5 ENT Surgery	138	39.8%	118	46.5%	105	39.0%	126	57.3%
C13 Oral and Maxillofacial Surgery	27	16.8%	26	26.0%	29	25.0%	20	51.3%
AH Neurology	64	49.6%	61	93.8%	12	48.0%	21	47.7%
C7 Ophthalmology	58	19.0%	87	32.2%	72	30.9%	69	47.3%
C1 General Surgery	122	30.1%	147	49.2%	149	50.2%	101	41.1%
AQ Respiratory Med	37	34.3%	27	28.4%	32	47.1%	25	39.1%
C9 Plastic Surgery	50	>100%	61	>100%	5	12.2%	16	38.1%
AR Rheumatology	12	26.1%	18	>100%	12	26.7%	16	32.0%
A6 Infectious Diseases	2	11.1%	2	8.3%	3	15.0%	5	31.3%
AB Geriatric Medicine	24	28.2%	24	33.8%	22	34.4%	21	30.9%
A2 Cardiology	32	40.0%	26	29.5%	26	44.8%	18	25.0%
A1 General Medicine	0	0.0%	7	>100%	0	0.0%	2	25.0%
A7 Dermatology	75	28.4%	87	56.9%	83	18.6%	73	23.6%
AG Nephrology	0	0.0%	0	0.0%	1	33.3%	2	20.0%
A9 Gastroenterology	8	15.1%	10	20.4%	7	13.7%	10	14.7%
CB Urology	8	22.2%	9	11.0%	17	16.0%	11	12.0%
Grand Total	**1245**	**38.5%**	**1215**	**50.1%**	**993**	**35.2%**	**1014**	**45.1%**

f. Diagnostics

Radiology	22/6/2020	% Prev Year	29/06/2020	% Prev Year	06/07/2020	% Prev Year	13/07/2020	% Prev Year
Radiology All OP/GP Activity	1909	53%	1976	54%	2013	60%	1946	61%
CT OP/GP Activity	246	50%	261	59%	269	60%	253	56%
MR OP/GP Activity	236	95%	213	91%	245	120%	209	79%
US OP/GP Activity	685	86%	682	63%	681	89%	628	74%

g. Scopes - This table shows the level of scopes activity undertaken in the last four weeks, compared with activity undertaken in the same four weeks last year. It includes activity undertaken at other locations such as the Nuffield and GJNH.

Procedure Grouping	22/06-28/06	% Prev Year	29/06-05/07	% Prev Year	06/07-12/07	% Prev Year	13/07-19/07	% Prev Year
Upper	11	7.4%	3	1.9%	24	11.9%	17	9.6%
Lower	0	0.0%	2	5.9%	0	0.0%	2	6.7%
Colonoscopy	31	16.6%	35	22.2%	73	34.0%	43	32.6%
Cystoscopy	19	33.9%	31	45.6%	43	52.4%	29	53.7%
Grand Total	**61**	**14.5%**	**71**	**16.9%**	**140**	**26.5%**	**91**	**23.1%**

h. TTG Surgical Activity - This table shows the level of elective surgical activity undertaken by specialty in the last four weeks, compared with activity undertaken in the same four weeks last year. It is sorted on the % comparison with previous activity undertaken in the most recent week. It includes activity undertaken at other locations such as the Nuffield and GJNH.

Parent Specialty	22/06-28/06	% Prev Year	29/06-05/07	% Prev Year	06/07-12/07	% Prev Year	13/07-19/07	% Prev Year
A2 Cardiology	6	35.3%	9	52.9%	5	62.5%	9	>100%
AR Rheumatology	2	66.7%	2	100.0%	3	100.0%	3	>100%
C12 Vascular Surgery	7	77.8%	7	100.0%	9	90.0%	5	83.3%
A1 General Medicine	1	8.3%	2	16.7%	3	27.3%	6	60.0%
CB Urology	14	36.8%	8	16.0%	15	48.4%	6	35.3%
C5 ENT Surgery	10	13.2%	3	6.1%	4	19.0%	11	31.4%
H1 Clinical Radiology	1	7.1%	2	33.3%	3	21.4%	1	20.0%
C7B NHSL Cataract List	2	2.2%	13	18.8%	15	19.2%	10	15.6%
C1 General Surgery	15	16.9%	15	19.2%	14	27.5%	10	14.1%
C8 Orthopaedics	1	1.2%	1	1.3%	4	4.2%	4	5.4%
F2 Gynaecology	12	14.3%	17	20.0%	8	10.0%	4	4.9%
AQ Respiratory Med	0	0.0%	0	0.0%	1	25.0%	0	0.0%
C13 Oral and Maxillofacial Surgery	0	0.0%	0	0.0%	1	8.3%	0	0.0%
C7 Ophthalmology	2	20.0%	1	100.0%	1	>100%	0	0.0%
D1 Public Dental Service	0	0.0%	6	21.4%	8	40.0%	0	0.0%
Grand Total	**73**	**12.6%**	**86**	**17.0%**	**94**	**20.9%**	**69**	**16.6%**

6.5 Priority Services in Process of Being Reinstated

a) 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, digital enablement and patient centred re-design.
- Emergency care should be scheduled where possible.
- Simulation, with new and effective ways of working.
- Consideration should be given to 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 – All specialties are required to adopt *Outpatient Services - New Ways of Working*.
- Efficient flow of pathways and prompt discharge of inpatients is required.
- IT infrastructure may need to be strengthened.

b) Outpatient Services - *New Ways of Working*

i. Principles – The following principles have been defined:

- All patients should receive the clinical input they require, in a timescale appropriate to their clinical urgency.

- Use of all capacity in terms of workforce skills/expertise/time, physical space and diagnostics should be used as efficiently as possible to achieve the first principle. This may involve changes to Job Plans.
- All clinicians and service managers for each specialty should implement and embed the *New Ways of Working* detailed in the Acute Outpatient Recovery SOP such that efficient and clinically effective pathways make optimum use of Active Clinical Referral Triage, Waiting List Validation and Vetting to Remote Consultation options and moving appropriate cohorts of patients to Patient Initiated Reviews.
- A face-to-face (F2F) attendance should only occur if there is a clinical need, i.e. it adds value, such as physical examination/treatment required.
- All activity and vetting outcomes should be recorded accurately on the Patient Management System (TrakCare).
- All governance for Remote consultations must be followed [definition of governance in progress, led by Medical Director].
- The ethos and practice of Realistic Medicine, keeping patients as the central focus of our care including shared decision making, should be embedded in all of our outpatient pathways through vetting, consultations, diagnostic tests and recommended treatments as we develop our *New Ways of Working*.

ii. Action Plan

- Every specialty is being encouraged and supported to implement *New Ways of Working* and pathways for vetting, outpatient consultation, review, diagnostic and treatment appointments.
- An SOP has been distributed that provides a practical guide to implementation. It includes:
    i. Admin and Clinical Waiting List Validation
    ii. Active Clinical Referral and Triage (including vetting to Remote Consultation and 'Opt-in')
    iii. Remote Consultations (Telephone and Near Me)
    iv. Patient Initiated Reviews
- Implementation of *New Ways of Working* at pace is important to ensure all patients receive the clinical input they require, in a timescale appropriate to their clinical urgency. Due to social distancing NHSL does not have the capacity to undertake this clinical input as F2F appointments at the same volume of patient's pre-Covid. All capacity (workforce, physical space and diagnostic) therefore needs to be used as effectively as possible. This may require changes to Job Plans and will require implementation of the concepts of 'Team Working' as has been achieved in the Breast service.
- 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 embedded as part of recovery planning. Work is currently underway to evaluate use and support requirements by specialty.

c) Outpatient Services – Increase in Efficient Use of Capacity

a. Each of the three sites is in the process of calculating the Face to Face capacity they estimate is safe to utilise with all Covid-19 social distancing and mitigation of risk taken into account. This is being calculated as clinic slots per day on the basis of factors affecting each site differently such as: Flow and One-way systems, Waiting Areas, the need for diagnostic tests, the use of two clinic rooms for one clinic to allow cleaning, arrangements for shielding patients etc.
b. The current estimate for F2F capacity is approximately 30% of previous F2F capacity.
c. Each site has been targeted to be fully utilising this capacity for high priority clinical activity signed off by the Remobilisation, Recovery and Redesign Group by end July 2020.
d. Each site will then evaluate the flow and 'pinch-points' and identify whether the 30% can be safely increased.
e. In addition, each specialty is being supported to increase their overall activity (including Remote activity) up to the capacity available in Job Plans. Job Plans will require changing to accommodate Remote rather than F2F clinics.

d) **Specific Outpatient Services**

See appendix 6 for details on the reinstating of further services for Ophthalmology, Diabetes and Endocrinology, Dermatology, Audiology, Orthotics, Care of the Elderly, Physiotherapy, Medical Paediatrics, INSP!RE programme and Phlebotomy patients.

e) **Use of the Louisa Jordan Hospital for Outpatients**

NHSL and SG are in discussion regarding the use of the Louisa Jordan [LJ] for a number of specialties with a need for high volume outpatient appointments. Tests of change has been undertaken in orthopaedics and plastics that will inform further expansion of services at LJ. Orthopaedics are particularly keen to resume outpatient activity to start recovering the achievements of the 'Bringing It Together' programme where a large waiting list from 2017 had been reduced to no patients waiting over 12 weeks by February 2020. This was largely achieved through implementation of ACRT, an Opt-in approach for common non-urgent conditions and Patient Initiated Reviews.

f) Diagnostics

a. Radiology
   - Additional CT capacity will be available at NHS Louisa Jordan from beginning September 2020 till Jan 2021 to further support Red /Amber category examinations and to assist with the significant backlog of routine CT examinations.
   - Ongoing review of booking templates for CT, MRI and Ultrasound to maximise capacity while still managing to maintain social distancing and infection control measures.
   - Reinstate CT Colon examinations – 4 patients a week at UHH and UHW.
   - Ad-hoc waiting lists are being undertaken for CT, MRI and Ultrasound to help manage the shortfall in capacity – these are a mix of short term change to staff hours and overtime hours.

- To manage waiting times going forward, extended 7 day working is being discussed with staff and partnership representatives. However, it is recognised that this will not be feasible without an increase to current staffing.

b. Laboratories
   - 30% of Microbiology staff are currently redeployed to manage Covid-19 testing. Department of Health have advised that HBs should plan for a similar level of testing for at least the next 2 years or until there is a vaccine available. Ramping up specific OP activity will have a direct impact on the ability of Microbiology to undertake the current level of Covid testing unless additional staffing and additional analysers are in place. Returning to full service for the following will have a direct impact on Covid testing – urogenital (currently at 50%), routine microscopy (currently suspended), routine GI infection (currently 60%). H.pylori antigen testing, MRSA screening, serology testing and routine elective wound swabs could be returned to normal request levels with no impact on Covid testing.
   - Discussions are ongoing regarding restarting full Sexual Health screening mid-August – currently meeting 40% demand.
   - Pathology have supported Microbiology in Covid testing and adapted 2 of their 3 platforms used for HPV screening to temporarily assist with Covid testing. At the current level of Covid testing the restart of the cervical screening programme which has been paused since March, should be manageable (restart scheduled for Sept 2020), however should the demand of Pathology Covid testing significantly increase to the maximum capacity of 5,000 week there will be significant pressure on staff resources to deliver all three elements of this complex inter-linked testing service: histopathology, cervical screening and Covid testing. If there is an overlap between Covid testing in Pathology and the return to normal histopathology activity, additional staffing resources will be required to support the Covid testing until the resources are available in Microbiology to carry out all Covid testing for NHSL. The ability to carry out Covid testing in Pathology should be retained in the medium to long term to provide a contingency or "expansion valve" if required to manage future pandemics.
   - Laboratory staff in all disciplines are looking at demand optimisation to identify any tests that may not be necessary and where appropriate develop new pathways in agreement with clinical staff.

g) Scopes

a. Endoscopy - At present endoscopy is being carried out in theatres but plans are in place to restart the scope room service at all three sites. A patient priority process has been put in place to manage the re-start. The start of regular lists have been hampered by ventilation problems in the endoscopy suites and continued staffing issues. The plan is to run up to 6 all day lists, 5 days a week from the beginning of August across the 3 sites. The patient numbers will be at approximately half normal capacity initially with a plan to move to full capacity over the next 4 months. Plans are also being discussed to address the backlog by assessing the feasibility of additional activity at weekends for more urgent cases. This is likely to be limited in volume until November at the earliest.

b. Colon Capsule Endoscopy - New pathways have been written and NHSL are working with the SG team on the introduction of colon capsule endoscopy. This will require re-vetting of the colonoscopy waiting list, for which SG funding is being agreed.
c. Cytosponge – NHSL are taking forward the introduction of cytosponge as a diagnostic tool for selected patients with upper GI symptoms. NHSL are planning a re-vetting of patients on the upper GI list to identify patients suitable for cytosponge and are setting up separate sessions for this.
d. A funding bid to support all of these initiatives has been submitted to SG at their request for £1.34M.

h) **Pre-Assessment**

Plans are being put in place to increase the number of patients that can be pre-assessed. In the short term this can be achieved by using spare phone assessment capacity and additional capacity may be available due to moving to one pre-op COVID screen.

i) Increase in Day Case Capacity

a. **UHM** - From August, the plan is to establish 2 sessions per day Monday to Friday for use by ENT / OMFS / Urology /General Surgery / Community Dental / Vascular or others as required.
b. **UHH** - A proposal has been drafted that will see this increase to approximately 70% of pre-COVID delivery by mid-August, pending assurances that delivery of this activity can be achieved without posing an unacceptable risk of COVID-19 transmission.

j) Increase in Inpatient Capacity

a. UHM - Work is underway to reinstate the Inpatient Theatre Pathway to enable inpatient elective surgery to resume. This is at an early stage and is likely to be late August at the earliest before it has gone through the required Recovery Process. Anaesthetic capacity is particularly challenging. The aim is for 1 Emergency theatre + 2 elective theatres (or 1 emergency + 1 CEPOD + 1 elective).
b. UHH - Will have 4 theatres in addition to CEPOD from the 3rd August. Cases will be prioritised by clinical urgency. When booking, consideration will be required for patient flow through DSU, capacity in 'Green Ward' for shielded patients, ITU capacity and the pre assessment capacity.
c. UHW - Currently only capacity for 1 elective list a day.
d. To support this process going forward the Theatre Allocation Group (TAG) has been established. This operates on the principles;
    1. Confirm patient are scheduled by clinical urgency
    2. Ensure maximum theatre utilisation of available capacity
    3. Escalation of priority patients of concern
    4. Identify and resolve Theatre resources issues (e.g. equipment, medical and nurse staffing)

    The TAG has a co-dependency with the Clinical Reference Group (CRG). This is a group of clinicians who can be consulted in the event of clinical disagreement. The CRG will provide clinical guidance on which patient cohorts should take priority.

k) Use of the Independent Sector

a. NHSL are not currently using the independent sector (other than the special arrangement to use facilities at the Nuffield). NHSL have contracts in place for dermatology, neurology, ENT, Opthalmology and Orthopaedics. Early discussions have commenced with external providers to identify return outpatients who require review and to work with them to adopt outpatient new ways of working.

l) **Resumption of Screening Programmes, Accelerating the Development of Advanced Practitioners [ADEPt] and Effective and Quality Interventions Pathways [EQuIP]** – See appendix 6 for details on these programmes.

6.6 Demand and Capacity Planning

a) Back Log Demand

Outpatients

The following table details the Outpatients waiting list by specialty and length of wait for the larger specialties (those with more than 200 patients waiting). The Total row includes all specialties. N.B. In addition, a significant number of Return appointments have been cancelled and the specialties are working through them to prioritise on clinical urgency, undertake remote consultation where possible and move appropriate cohorts of patients to Patient Initiated Return.

	Weeks Waiting			
Parent Specialty	**0-12**	**13-26**	**27-52**	**Grand Total**
A2 Cardiology	281	388	68	737
A7 Dermatology	1544	1769	21	3334
A8 Endocrinology	237	279	68	584
A9 Gastroenterology	255	484	68	807
AB Geriatric Medicine	105	125	2	232
AH Neurology	677	852	378	1907
AQ Respiratory Med	292	371	36	699
AR Rheumatology	240	157	38	435
C1 General Surgery	1665	886	5	2556
C12 Vascular Surgery	94	167	6	267
C13 Oral and Maxillofacial Surgery	258	1113	113	1484
C31 Chronic Pain	133	319	53	505
C5 ENT Surgery	584	875	15	1474
C7 Ophthalmology	371	1534	483	2388
C7B NHSL Cataract List	122	560	245	927
C8 Orthopaedics	895	829	62	1786
C9 Plastic Surgery	198	143	1	342
CB Urology	385	655	51	1091
F2 Gynaecology	938	952	35	1925
Total	9717	12926	1769	24412

Radiology	**0-6 weeks**	**6-12 weeks**	**+ 12 weeks**	**Total**
CT	806	258	654	1718
MR	363	150	416	929
US	1626	453	1105	3184

Scopes

The following table provides the Scopes waiting list by length of wait.

	Days Waiting Group					
Proposed Procedure Grouping	Up to 21 Days	22 to 49 Days	50 to 70 Days	71 to 91 Days	92 and Over	Grand Total
Upper	204	273	202	123	1311	2113
Lower	92	61	27	23	252	455
Colon	182	197	164	144	1351	2038
Cysto	134	123	57	45	295	654
Total	612	654	450	335	3209	5260

Theatres – TTG Waiting List

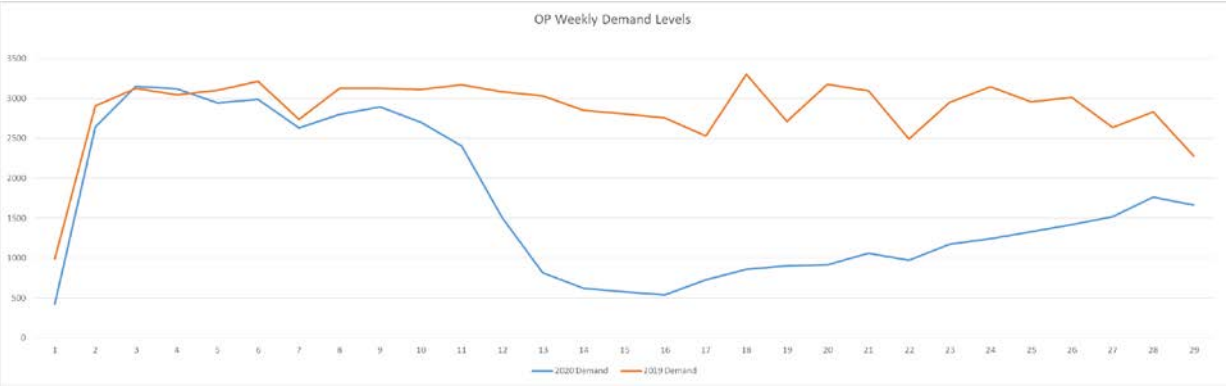
The following table provides the TTG Surgical Waiting List by priority and length of wait. The rows coloured in beige are the old codes. The rows below, starting with 'TTG' are the new Clinical Urgency Codes. This information is available by specialty. The red boxed area shows the number of patients waiting beyond the timeframe deemed clinically appropriate for the patient's condition. A review of these patients and scheduling their surgery as soon as possible will be a priority.

Days Waiting	0-28 days	28-84 days	85-126 days	127-182 days	182-365 days	>365 days	Grand Total
Urgency							
Routine	69	6	2	14	4		95
Suspicion Of Cancer	13	4					17
Urgent	14			1			15
TTG Cancer	25	12	5	7	2		51
TTG Urgent SoC	16	16	7	18	6		63
TTG Category 2 (within 4 weeks)	66	53	17	111	75	5	327
TTG Category 3 (within 12 weeks)	111	124	70	383	386	24	1098
TTG Category 4 (over 12 weeks)	168	347	142	2198	2479	125	5459
Grand Total	**482**	**562**	**243**	**2732**	**2952**	**154**	**7125**

b) Ongoing Demand

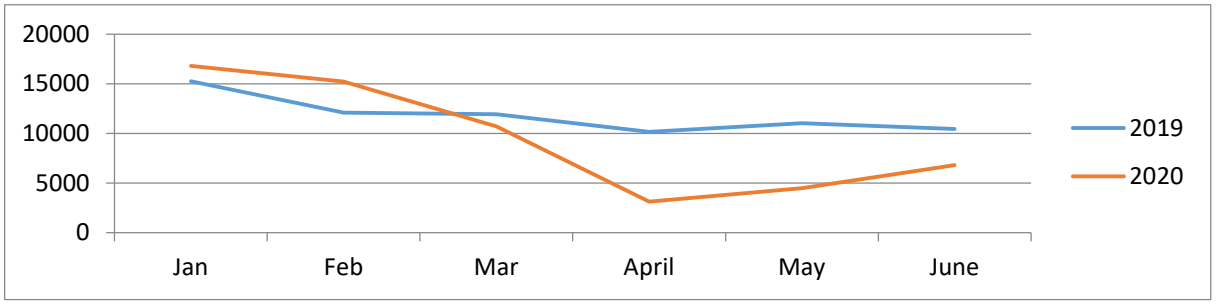
Outpatients

The following table shows the incoming outpatients demand by week from January to June 2020 compared with January to June 2019. This is also available by specialty. It shows that while demand was initially supressed during March/April, it has subsequently been rising steadily back towards pre-Covid levels.



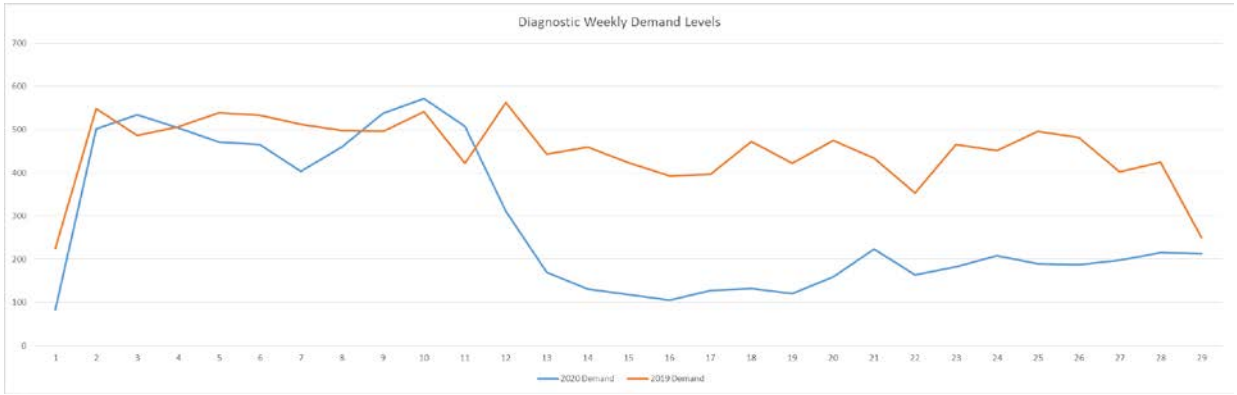
Radiology

The following table shows the incoming radiology out-patient/GP demand by month from January to June 2020 compared with January to June 2019. It shows that while demand has initially supressed in March/April, it is now rising towards pre-covid levels.



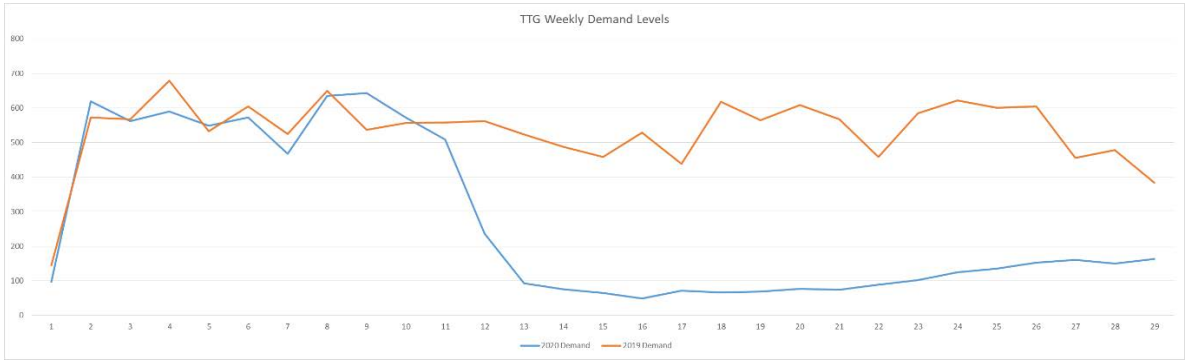
Diagnostic Scope Demand

The following table shows the incoming scope demand by week from January to June 2020 compared with January to June 2019. This is also available by type. It shows that while demand has initially supressed in March/April, it is now rising towards pre-covid levels.



TTG Surgical Demand

The following table shows the additions to the TTG list by week from January to June 2020 compared with January to June 2019. This is also available by specialty. It shows that while demand was initially suppressed, largely due to surgeons not seeing outpatients to make the decision to treat, it is now rising.



c) Capacity

The allocation of OP/DC and IP capacity to specialties will be under regular review to ensure that the most clinically urgent cases are seen and treated. This process will be managed by a Clinical Reference/Prioritisation Group. As described in previous sections, plans are progressing to increase Outpatient, Diagnostic, Scopes and TTG capacity over the coming months.

d) Demand and Capacity Analysis to Understand Gap

Demand and Capacity analysis is not yet possible with any degree of certainty as there are too many unknown factors, two examples being the extent to which theatre capacity can be reinstated and for outpatients, appropriate balance between Remote consultation and Face-to-Face for each specialty. It is, however, recognised as being extremely important to get to a position where analysis can be undertaken to establish how big the gap between capacity and demand is. This will enable an assessment of how long it will take, potentially how expensive it will be and the magnitude of the whole system actions required to address recovery.

For those services/interventions identified as less clinically urgent and where insufficient capacity is available to reinstate in the foreseeable future, a plan needs to be put in place for the patients affected based on the principles of realistic medicine. A national approach to 'interventions and procedures of low clinical value' would be extremely beneficial together with a national communication brief,

e) Demand and Capacity - Cancer Treatment and Surgery

Having the opportunity to utilise off-site capacity has enabled NHSL to continue to provide cancer surgery and diagnostics for Gynaecology (Hysteroscopy & Myosure) resulting in a total of 1040 surgical procedures performed from 29/03/20-21/06/20 as per table below.

Surgical Procedures Performed

Specialty	Nuffield Glasgow
Breast	335
Plastics	343
Urology	264
Gynaecology	85
Ophthalmology	13
Grand Total	**1040**

a) USOC

USOC referral rates fell 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 was anticipated that there would be an increase in USOC referral when the COVID surge has decreased. In July 2020, there was a mark increase noted with USOC GP referrals with 64% of normal weekly referrals being received. This was more evident within Breast, Colorectal and Upper GI.

The Clinical Teams have been undertaking Active Clinical Referral Triage (ACRT) of all GP referrals which includes Urgent Suspicion of Cancer referrals. This ensures that a senior clinical decision maker reviews all relevant electronic patient records, including imaging and laboratory results, and triages to locally agreed, evidence-based pathways thus ensures no impact to the pick-up rate of cancer from any USOC referrals. 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.

All USOC referrals pending (as described in the table below) have gone through the ACRT process by each speciality clinical team and have been prioritised as low risk.

Parent Specialty	No. of Urgent Suspicion of Cancer unbooked	Weekly Urgent Suspicion of cancer demand
Dermatology	0	70
Gastroenterology	0	62
Respiratory Med	0	43
Breast	66	113
H&N	38	89
Ophthalmology	0	0
Plastic Surgery	27	0
Urology	1	58
Gynaecology	32	16
Hysteroscopy	42	32
Lymphoma	0	9
Grand Total		

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

Nuffield Hospital has been utilised to support the Breast Service. This arrangement has seen 2329 Urgent Outpatient appointments between early April 2020 and late June 2020 (increasing from 117 a week to 397 a week).

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

Managing unscheduled care in new ways of working recognises the expectation to deliver the 4 hour A&E target of 95% and work towards a standard of 98% to ensure patients receive a safe and appropriate level of service delivery. NHSL is committed to working towards this standard of safe service delivery of care for patients that is underpinned by all necessary precautions associated with Covid-19. Recovery and re-design planning recognises the impact of historical increasing attendances to Emergency Departments and emergency admissions, and in 2018 and 2019 especially over the summer months. The table below demonstrates the attendances and the rising activity to pre-Covid-19 demand:

DATE	31/01/2020	29/02/2020	31/03/2020	30/04/2020	31/05/2020	30/06/2020
NHSL All Attendances	**17418**	**16065**	**12549**	**9278**	**13096**	**15103**

Recognising the attendance impact and COVID-19 implications focussed recovery & re-design planning is well trailed through both internal and external reviews with plans being presented to both the NHS Board and Corporate Management Team (CMT). These plans focus on the creation of pathways that manage urgent care in new ways and are led through strategic groups such as the Unscheduled Whole

System Care Board and Tactical Front Door Command Group and align to all 11 of the national work streams.

Details of the West of Scotland regional approach are available at section 1.1.1.1).

Current recovery & re-design work streams include:

- Revised Urgent Care pathways that reduces in hospital assessment for those who currently self-present, which is typically 50% of all attendances – the model in progress is to introduce Virtual Minor Assessment and NEAR ME video platform. In doing so there is the potential to reduce footfall to ED. Similarly all necessary face to face assessments will be scheduled thus maintaining effective capacity. This model is focussing on lessons learned from other NHS boards, such as Lothian, Portsmouth and Wales.
- Revised primary care/SAS/111 referral options to expand on scheduling care with alternative approaches other than in hospital assessment and or admission – the proposed introduction for professional to professional referral enhances the likelihood for advice, scheduling to general and or specialty clinic and admission avoidance. The model in review is looking at services such as Consultant Connect, NEAR ME and expansion to the present Emergency Response Centre (ERC).
- Revised discharge processes using the model of Planned Day of Discharge. This model is already in process within one acute site and is to be implemented across the board. Success so far indicates planning the day of discharge on admission necessitates any complex support preparation thus reduces any delay post clinical readiness.
- Acute site & ED recovery & re-design Covid-19 pathways that provide safe service delivery that segregates all symptomatic, suspected and shielding patients. Local site ED recovery plans are fluid in that Amber pathways are aligned to current Covid-19 demand with the potential to adapt back to Red(hot) and Blue(cold) as was the case during peak.

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 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 clinical 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.

It is also important that we recognise there may come a time of huge disparity in provision and in emergencies. This position needs to be monitored across the Boards within the region to understand what is happening in terms of patient care to allow a more system wide response that allows equitable access to care based on clinical need wherever possible.

Adopting New Models to Support the Urgent and Emergency Care Response

Going forward it will be important to ensure joined up pathways and models of response to unscheduled care across NHS24, SAS, GP In-hours, GP Out of Hours and Emergency Departments.

NHS 24 Model of Triage - Building Further Capacity

The NHS 24 model of triage into Covid 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.

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.

Current estimated activity and waiting lists for priority areas are included in Activity Templates 1, 2 & 3 which are available at the bottom of the appendices page.

7.0 PUBLIC HEALTH BURDEN OF PANDEMIC RESPONSE

Lanarkshire's health, like that of Scotland as a whole, was an improving picture pre-COVID-19. However, whilst improving, the gap in inequalities between the most and least deprived groups had grown. Evidence suggests the societal response to the pandemic will have significant 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.

The majority of routine public health work continues to be stood down to allow for the ongoing response required by COVID-19. Since the containment phase of COVID-19, public health capacity has been severely stretched. Recovery of services such as screening and immunisation are being prioritised. However, there is limited capacity to provide a robust and sustainable service covering the core work of the public health function, the Test and Protect service and the resilience that the function requires to respond to new developments or emergence of further community transmission, and the wider population health recovery.

Table 1 outlines the core activities of the department and the additional staff resourcing required to prioritise on the delivery priorities facing the department currently.

Four delivery priorities have been identified:

1. Recovery and redesign of services
2. Prevention and Mitigation of impact of COVID-19 on health and wellbeing of Lanarkshire communities
3. Preparedness and Testing
4. Delivery of Test and Protect.

7.1 Recovery and Redesign of Services

As part of the recovery and redesign processes, a departmental review of service capacity has taken place in order to present a whole system flexible and agile response to prevent and mitigate for COVID, respond to the imminent population health challenges as a consequence of COVID and recover core services.

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

Recovery and redesign of public health services are channelled through a public health recovery or health and social care partnership recovery group and then processed through the existing RROG structure prior to recovery.

As part of this process we will work proactively across the NHS system, with our Health and Social Care Partnerships, respective Community Planning Partners, the third sector and local communities to capitalise on the strengthened linkages with them that developed during our COVID response. We will ensure that we coproduce as we recover services and listen to the priorities that they are identifying.

Our recovery and redesign plan requires capacity and resource, but it will be flexible and capitalise on the knowledge and skills and flexibility of a range of existing staff and staff in the wider system. We anticipate that this will provide us with the flexibility to respond to spikes in the number of cases or in the worst case scenario a second wave over the coming winter.

7.2 Prevention and Mitigation of impact of COVID-19 on health and wellbeing of Lanarkshire communities

The six public health priorities (PHPs) for Scotland aim to improve population health and wellbeing and reduce health inequalities. The priorities have been agreed by Scottish Government and local government as key areas of focus for whole-system, partnership efforts to improve public health. Achievement of the public health priorities will require a preventative approach, long term action and collaborative leadership.

The draft NHS Lanarkshire Integrated Population Health Plan (IPHP) was developed in late 2019 under the leadership of the Director of Public Health, a Public Health Consultant and the Head of Health Improvement. The purpose of the plan was to align existing local strategies and plans with the six national public health priorities and include the ambitions of NHS Lanarkshire previous High-level Inequalities Plan, Achieving Excellence, HSCP Commissioning Plans and the CPP Community Plans. At the start of the COVID-19 outbreak the strategic leadership for delivery of population health programmes and the draft IPHP was paused as the senior Public Health /Health Improvement personnel involved were fully deployed to support management of the pandemic.

All programmes were risk assessed and mitigating actions were put in place. Many of these programmes are delivered within community settings thus delivery had to be significantly modified and reduced using other mechanisms such as postal delivery, online platforms and telephone support. The recovery of these are now being prioritised through the Public Health and HSCP Recovery process on a programme by programme basis in line with community restrictions being eased.

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 included in the IPHP 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.

Across Lanarkshire, there is recognition that the psychological and physical impact of COVID-19 is serious, widespread and potentially long lasting. For the first time in our lifetime there is a threat to life, fear/uncertainty about the future, and a requirement for enforced restriction of human contact. Although COVID-19 has affected everyone, the impact on mental health and wellbeing has been far from equitable with those in poverty or those who are vulnerable being more disadvantaged as a direct or indirect consequence of the virus.

People at increased risk of health inequalities make proportionately greater use of health services thus a key vehicle for maximising the NHS contribution to reducing health inequalities and mitigating the impact of COVID will be through ensuring delivery of the outcomes set in the Chief Medical Officer (CMO) letter (2018: 3) *Health Promoting Health Service (HPHS).* The CMO letter, outlines the settings-based inequalities focused approach which aims to support the development of a health promoting culture and embed effective health improvement practice within acute and community hospital settings as well as health and social care partnerships.

We will commit to prioritising delivery of the Good Mental Health For All work stream of the Lanarkshire Mental Health and Wellbeing strategy with a strong focus on implemented evidence based self-management approaches which make use of local assets through social prescribing and also addressing mental health stigma and discrimination. It should be noted however that social prescribing methodologies are contingent on a strong infrastructure of support services from Council and third sector partners (e.g. third sector, financial inclusion services and employment supports) thus these services will require to be fully resourced to meet the increased demand placed upon them.

We will further explore the impact and scope of COVID-19 on vulnerable populations (including patients, staff and the wider public who fall into these groups). In particular we will consider those in SIMD 1 and 2, BAME communities and other known high risk groups for COVID-19.

We will review the national and local data and evidence around COVID-19 and vulnerable groups and we will continue to invest in Keep Well to identify and support the most vulnerable populations who experience health inequalities due to their lifestyle, culture or disabilities.

We are also embedding an inequalities focused approach to recovery through ensuring Equality Impact Assessments (EQIA's), including consideration of socio-economic inequalities, are completed by each NHSL service as part of the recovery process.

7.3 Preparedness and Testing

COVID-19 PCR testing identifies the presence of virus particles and indicates current or a clearing infection (symptomatic or asymptomatic) or indeed a false positive. 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 an immediate situation during May 2020 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.

Since then capacity has increased considerably but so also have clinical pathways using testing particularly for asymptomatic people, care home residents, care home staff and HCW.

The biggest challenge has been the proper interpretation of positive results given the legacy infection which is being detected.

NHS Lanarkshire supports the DsPH paper highlighting the difficulty of testing asymptomatic people when incidence is very low. It also support the move to amending the criteria to determine a positive result (technical lab issue).

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

7.4 Test & Protect

Lanarkshire has a population of 661,900 to support through Test and Protect programme. From Monday 25 May, NHS Lanarkshire has delivered a local contact tracing service utilising existing redeployed staff from within the public health function and from other services. On Wednesday 15 July, NHS Lanarkshire joined the roll out of the National Contact Tracing Service. As part of this service delivery model more complex case investigation and contact tracing will be passed to NHS Board health protection specialists as a Tier 2 response. The Tier 2 service will be integrated into the public health function and placed under the leadership of the Director of Public Health. This team will provide all health protection management, case investigation and contact tracing of situations deemed too complex for the basic national contact tracing service.

This service is currently provided by the public health team, however, the team cannot provide sustainable cover in the future as the Recovery and Reconfiguration work of the public health commences across the organisation. There is an acute requirement that redeployed staff in the test and protect team are released back to duties such as the public health coordination of immunisation and population screening. Staff capacity to deliver this Tier 2 service has been scoped and submitted for additional funding until March 2022 as part of this remobilisation plan. This will allow redeployed staff to return to original roles in the recovery phase. Without additional resource, NHS Lanarkshire is not able to offer the Tier 2 service required within the national approach to Test and Protect.

7.5 COVID-19 Care Home Support

The Health Protection Team continues to support care homes across Lanarkshire. At 20 July 2020, six care homes had an active COVID-19 outbreak.

Care homes who had been 28 days ‘COVID free’ were able to open to Stage 2 outdoor visiting on 3 July 2020. The HPT and care home team worked collaboratively to review and approve all 93 designated visitor risk assessments and outdoor visiting protocols. A move to Stage 3 visiting (multiple outdoor and one designated indoor visitor) will commence when Scottish Government deems that it is safe to do so. Plans are in place to request and review updated risk assessments and indoor visiting protocols for those care homes who are eligible to re-commence indoor visiting at this time.

A daily care home safety huddle has been introduced to allow for oversight of emerging issues, challenges and best practice. A programme of supportive visits is being undertaken by the care home

team. There are plans to move to the electronic safety huddle tool over the next few weeks which will enable care homes to report daily (and weekly for testing) into a web-enabled platform which will facilitate electronic collation of data for Scottish government and other relevant organisations.

All care homes in Lanarkshire received a letter on 11 June to offer weekly staff testing through either the UK government social care portal (circa 4,500 staff) or NHS laboratories SALUS testing route (circa 1,200 staff). Care homes progressed with weekly staff testing from w/c 15 June 2020. Care homes submit a weekly return to NHS Lanarkshire every Monday on tests undertaken in the previous week and tests planned for the forthcoming week. Returns are collated and submitted to the Scottish government.

Ninety-two care homes returned templates on Monday 20th July with data relating to the previous week 10 to 16 July, reporting that 3872 staff and 453 residents were tested (please see Table 2 below). We follow up non-returns and returns from care homes where the incorrect template has been used.

Reporting week (w/c)	Number of care homes submitting data	Number of staff tested	Number of staff declined testing	Number of staff tests planned next week
8 June	65	435	0	1768
15 June	74	1937	31	3194
22 June	75	2747	186	3201
29 June	93	3855	311	4541
3 July	93	4034	248	4458
10 July	92	3872	348	4235

Table 2: weekly staff testing

The above data are self-reported by care homes.

7.6 Risks

The risks outlined in the previous iteration of the remobilisation plan continue. These include:

1. The risk to the delivery of the Community TB Service going forward because of the fragility of staffing component.
2. The 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.
3. The 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 because of the staffing pressure in the department are excessive. This could lead to reputational risk to NHS Lanarkshire around its ability to protect the population and reduce inequalities.

4. There is a risk that without additional resources, NHS Lanarkshire is not able to provide a Test and Protect Tier 2 service across Lanarkshire.
5. There is a risk that staff become overworked and experience increasing levels of stress because of the level of work expected within the COVID 19 response and management of other substantive roles. Without additional resources this could lead to increased staff sickness and further depletion of the team available to carry the workload.
6. The national prevention outcomes funding bundle (Tobacco Control, Adult and Child Weight management, Sexual health and BBV, Maternal and infant Nutrition) has been cut by 5% and this will create challenges and pressures at a time when the need for preventive approaches is greater than ever.

The resource necessary to deliver this service (in WTEs) is described in appendix 7.

8.0 INFECTION PREVENTION & CONTROL

In response to the overwhelming demand to provide assurance that all measures are and will continue to be taken to reduce the risk of transmission of COVID-19 (SARS-CoV-2), the Infection Prevention and Control Service took a whole systems approach to prevention across all of health and care from the onset of the pandemic.

The risk of ongoing transmission of COVID-19 within our healthcare environments is an ever present reality. Guidance on the management of the disease has been an evolving picture and as such has posed considerable logistical challenges to health and care staff alike. NHS Lanarkshire and our partners in care continue to ensure all steps are being taken to prepare and provide staff with the necessary information, guidance and skills to maintain their own safety and that of individuals in their care.

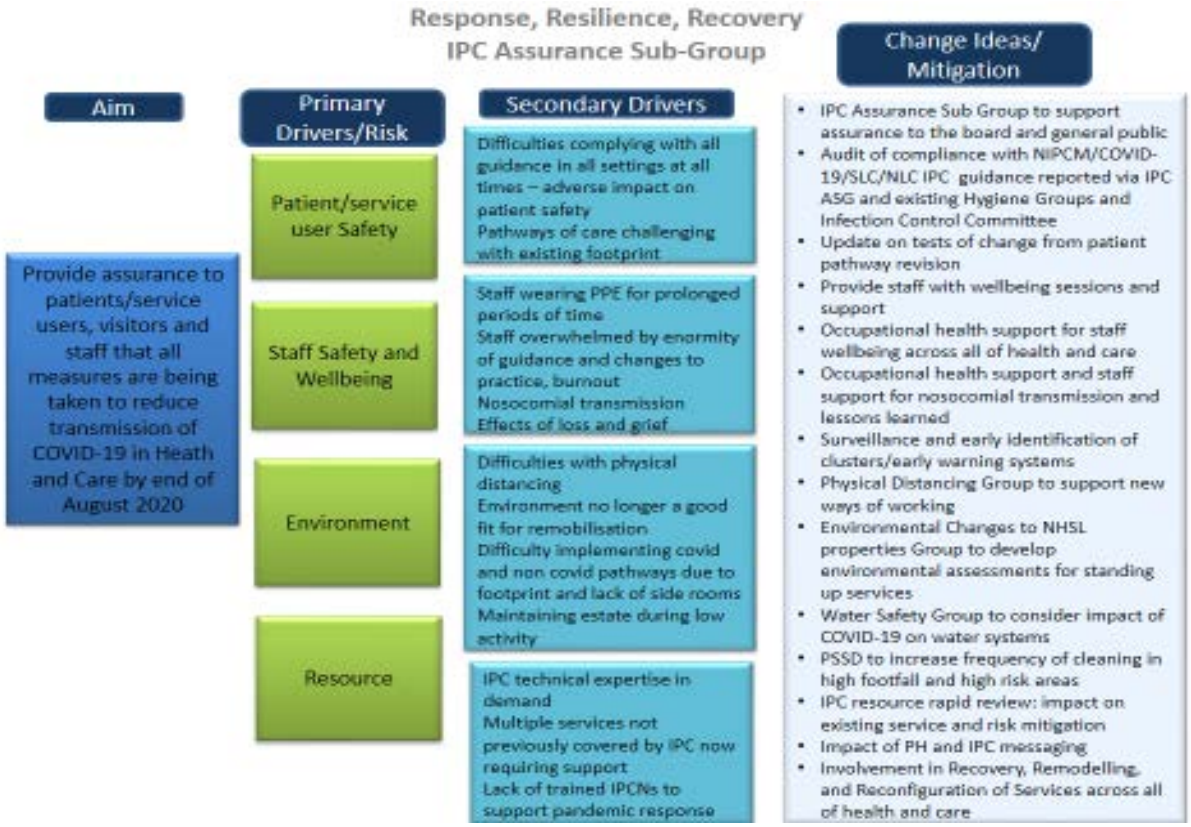
In order to achieve this overarching aim an Infection Prevention and Control (IPC) Assurance Group was formed with membership from primary, secondary care and the third sector with partnership involvement to review all systems in place and identify gaps in assurance. The work of this group is underpinned by the national quality strategy ambitions of person centeredness, safe and effective care. The function of the IPC Assurance Sub Group is to assure the NHS Lanarkshire Incident Management Team (IMT) all measures are being taken to ensure no individual either staff, patient or service user will be avoidably harmed as a result of non-compliance with IPC guidance, policies and procedures or due to any failure to act/intervene/action any deviations from the national infection prevention and control manual (NIPCM) and extant COVID-19 (SARS-CoV-2) guidance.

8.1 **Mitigation**:

- Undertake a full systems review of IPC across all of health and care to assure the C-19 IMT that all appropriate measures are in place and are being taken to ensure the safety of our staff and individuals in our care
- Provide assurance to the IMT and to the command structure that appropriate measures are being taken to ensure staff and the public are updated in a responsible timescale of any new IPC developments and guidance
- Promote the national IPC directives, four nations guidance, any CNO and CMO letters pertaining to IPC and develop, with relevant others, priorities and strategies to meet these demands via the IMT and other existing command and control structures
- Ensure there remains robust systems and processes in place to enable staff to access the National Infection Prevention and Control Manual, the NHSL Coronavirus information pages, social media platforms etc. videos, posters, education, training, observational practice, key messaging.

What success looks like	Aim: • Staff feel safe, supported, well informed and have the skills and the resources to carry out their respective roles • Individuals in our care are safe • To detail and give assurance that standards are being met through audit and ongoing monitoring.
How do we get there	• Consultation • Agreement • Communication • Education and Training • Compliance monitoring and support • Cooperation • Co-Production

IPC ASSURANCE DRIVER DIAGRAM



IPC ASSURANCE MEASUREMENT PLAN

IPC Assurance Sub Group Improvement Measurement Plan

Measure Name	Key Performance Indicator Aim Statement Rationale for measuring	Data Source	Reporting Levels (e.g. NHSL / Hospital / Local Authority Ward/Locality etc.)	Numerator	Denominator	Calculation (e.g. rate / % etc)	Inclusion / Exclusion criteria for measure	Data Definitions	Population (Full / Random Sample)	Measure Type (Process / Outcome / Balancing)	Frequency of reporting (Daily / Weekly / Monthly Quarterly / Yearly)	Reporting lag time	Chart Type Run / Control Chart Pareto / Histogram Scatterplot / Funnel Plot
100% compliance with staff use of PPE	Ensure staff comply with guidance on PPE	observational audit	Site Team	Number of staff complying with PPE requirements	5 opportunities/week	%	All staff in unit/ward/department	Observational audit of a sample of staff providing care	Sample	Outcome	Once weekly	real time	Run
Physical distancing is maintained between staff 100% of the time	Maintain safety where possible of all patients	observational audit	Site Team	Number of staff complying with physcial	5 opportunities/week	%	All staff in unit/ward/department	Observational audit of all a sample of staff in the unit	Sample	Outcome	Once weekly	real time	Run
100% compliance with hand hygiene	Maintain safety where possible of all patients	observational audit	Site Team	Number of staff complying with hand hygiene	5 opportunities/week	%	All staff in unit/ward/department	Observational audit of all a sample of staff in the unit	Sample	Outcome	Once weekly	real time	Run
compliance with the deontamination of the environment	Maintain safety where possible of all patients	observational audit	Site Team	Number of staff complying with decontamin	5 opportunities/week	%	All staff in unit/ward/department	Observational audit of all a sample of staff in the unit	Sample	Outcome	Once weekly	real time	Run

Details of the NHSL Infection Prevention and Control Assurance Framework - COVID-19 (SARS-CoV-2) Response, Resilience and Recovery are detailed at p 8.

8.2 Infection prevention and control: Ongoing Response - Mobilisation Plans: Reducing Risk of Nosocomial COVID-1

Throughout July the IPC focus has shifted significantly to the Response, Recovery and Redesign Phase across all of Health and Social Care. Whilst cases of COVID-19 continue to noticeably decline, the IPC work programme has re-aligned to the core function of recovery support while continuing with all mandatory and the business as usual programme of work. As recovery gains pace, a considerable number of service model reviews have been undertaken to support remobilisation of services across acute and in our partnership services. The complexity of this work to recover normal services where possible, as safely as possible, cannot be underestimated. This complexity is further magnified by the response time in national guidance in key areas such as ventilation, theatre, endoscopy and scheduled care for example. Collaborative working arrangements and clinical reference groups provide the technical expertise and clear and common purpose for key decision making in an environment where national guidance remains outstanding.

On a national level, The Chief Nursing Officer Directorate (CNOD), together with the Chief Medical Officer, have published a number of letters detailing new guidance for Healthcare. Interim guidance on the wider use of face masks and face coverings in healthcare was published on 25 June 2020. All acute adult hospitals (including Mental Health), community hospitals and care homes were asked to implement this guidance by 29 June 2020. NHS Lanarkshire took the additional step to extend this guidance to include Health Centres, GP practices, Dentists etc. to support an equitable approach to prevention across all of health and care. CNOD have recently also asked for an assurance position statement on our COVID-19 remobilisation plans for reducing the risk of nosocomial COVID-19. This return highlighted the efforts of an extensive number of key stakeholders involved in providing safe clean care during the pandemic and now during recovery. Fundamental areas for consideration included additional cleaning, the built environment, staff rostering and physical distancing measures.

9.0 CORPORATE SERVICES PROVISION

9.1 Recovery Priorities

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

9.2 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 24408 consultations since 1 March 2020.
- Microsoft Teams has been introduced as a collaboration platform. All 12,500 NHSL users are registered and able to utilise the system and over 2500 users are seen 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 approximately 5000 registered users and 1800 remote users on a daily basis during peak times.
- We have deployed 1931 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 Coved 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 building on 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 accelerate 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.

9.3 Support Services & Facilities

9.3.1 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 for any of the potential future scenarios.

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.

In the absence of Scottish Government guidance on measures which constitute a reasonable approach to providing a safer environment, NHSL developed local policies and processes to provide a safer environment. As such, a local risk assessment toolkit has been developed and applied across all locations to identify how accommodation should be adapted to reduce the risk from COVID-19 in the healthcare environment. This assessment tool is based on active walk-throughs of each facility by a group comprising health & safety, infection prevention & control, estates, local managers and staff side.

NHS Lanarkshire has a significant financial risk arising from the physical changes being made to our accommodation, which is being captured in the finance returns to SG.

9.3.2 Procurement Implications

9.3.2.1 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 ongoing steps adopted to meet these challenges include:

- Sourcing of alternate supplies of PPE by NSS and by NHS Lanarkshire.
- Establishment of improved communications between NHSL and National Services Scotland;
- 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 PPE Covid19 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.
- Publication of daily stock lists for PPE across Lanarkshire and distribution of PPE to Lanarkshire's primary care contractors.
- Providing a supplier-of-last resort to care homes and other facilities.

As at 30th 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.

9.4 Pharmacy Services

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

- **Pharmacy First** – This is an important national service. We have prepared all of the necessary local actions and publicised this e-mails to GPs and Community Pharmacists. We will publicise it further in accordance with the tone set by SG. Our local support materials have been published on our website
  https://www.communitypharmacy.scot.nhs.uk/nhs-boards/nhs-lanarkshire/
  We are also encouraging the use of Near Me within community pharmacies. We anticipate that this will be useful – particularly for some patient cohorts in the Autumn and Winter periods.
- **Management of Repeat Prescriptions** – We recognise that Serial Prescribing would help to avoid the confusion that GP practices and community pharmacies experienced in the early weeks of COVID-19 when there was unprecedented patient demand for prescriptions. Serial

Prescribing would also contribute to GP business continuity plans going forward. This has been debated with the LMC and while individual members agree the collective has not supported a roll out. However to be successful we need GP practices to engage with this work. Our latest move forward was to send information about the service to every GP Practice within NHS Lanarkshire along with a video from a GP Practice manager who provided an encouraging recommendation. This has led to some useful enquiries and we will support every GP surgery who wishes to take serial prescribing on board.

- **Remobilisation of the Pharmacotherapy and Prescribing Management Service**
  Formal discussion at the RRROG led to agreement of the remobilisation of the prescribing management and pharmacotherapy services within NHSL.
- **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.

9.5 Supporting Our Staff

The pandemic has ensured that staff health & wellbeing has become a priority witnessing significant partnership working and creation of staff support vehicles. It is intended that this good work will continue and be improved in line with the current challenge and that of winter planning. Some service provision has been revised following data analysis and staff feedback in order to make the support more visible and simpler to access. The services listed below are clearly defined to support both the statutory requirements regarding health & work and also specific to support the current and future challenges over the winter period. This will include staff mental health support, Musculo-skeletal issues & general fatigue.

Statutory & Core Services:

- **Occupational Health & Safety**
  The service will continue to apply the national guidance requirements associated with COVID-19 including specialist Management Referrals, Risk Assessment, Shielding Advice, Face Fit Testing & PPE support, Environmental Audits, DSE assessments (Home Working), Follow up consults with COVID-19 +ve staff and generic health related advice.
- **COVID-19 Staff Testing**
  Testing continues in line with Government guidance. This includes all symptomatic staff and the routine testing of asymptomatic Care Home staff and staff working with particularly vulnerable patients (currently Oncology, Care of the Elderly, Long Stay Psychiatry/Learning Disabilities).
- **Influenza Immunisation Programme**
  Design & Modelling is underway in preparation for the Influenza Immunisation programme for all staff including Social Care staff in line with Government guidance.
- A **COVID-19 Helpline** was originally set up to provide a single gateway support access portal for all staff. This was highly successful and evolved to provide multiple pathways of support to staff over a significant amount of topics (PPE, staff testing, shielding, safe working practice, hygiene etc). The Helpline will be maintained and scope developed further to include support for winter issues and wider HR queries. It is intended the Helpline will remain long term following its significant impact in reassuring staff during the pandemic.

Mental Health & Wellbeing Support

The following services are in place and will provide support to staff. The national Wellbeing Hub and the H&SC Workforce Wellbeing Helpline will be promoted locally and compliment the local services below.

- **Occupational Health Self-Referral**
  Encouragement of self-referral to Occupational Health for support regarding personal anxiety/stress or depressive conditions.
- **Confidential Staff Counselling**
  External counselling service providing services 24/7. Telephone and face-2-face (although modified to Skype due to social distancing).
- **Early Access to Support for You (EASY**) - support to staff absent with a mental health issue. Provides access route to therapeutic services.
- **Mental Health Case Management**
  Dedicated 20 week support programme for staff with complex mental health issues.
- **Staff Physiotherapy** service supporting staff with musculoskeletal problems, including those related to increased CSE requirements from home/remote working.

9.6 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.

9.6.1 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.

Recognising the importance to keep all staff informed, a weekly article in the staff briefing newsletter details the services that have been approved to restart. Also, the weekly CE video provides a reassuring message to staff about the changes being made and what to expect.

Throughout the pandemic, a video from leaders across all departments featured in the weekly staff reassuring message which is issued on the social channels every week. This has been continued with a view to continuing to provide the staff reassuring message throughout the recovery period.

9.6.2 Managing Public Expectations Post COVID-19

It has been acknowledged that the re-introduction of services gradually and safely has been welcomed by the public however there has been an increase in the number of MSPs and FOI requests questioning the reasons why some services are taking longer than might have been expected.

NHS Lanarkshire's communications department is supportive of the work Scottish Government's communications team is carrying out around communicating the recovery of the services. Locally in Lanarkshire, we are working with the print and broadcast media to help us communicate those changes including powerful recovery patient stories and illustrating the success of new technology such as Near Me.

Communicating the services changes in a positive way is challenging. By reassuring our staff and ensuring they are as well informed, allows them to alleviate any fears or concerns shown by patients. The website is a central hub for listing the service changes which is updated regularly.

The new 'Should you go to A&E' campaign is welcomed particularly as it has been noticed that the high number of patients attending A&E is on the increase. Consideration could be given to weaving in a harder hitting message although appreciate the timing of this is critical. Other issues such as patients not turning up for hospital appointments continue which is an area that could be addressed.

Behaviour change is always a long term ambition. This cannot be achieved in isolation, therefore the need for strong community and third sector partners is essential for addressing the challenges we face.

10.0 WORKFORCE

10.1 Workforce Response, Recovery and Redesign

The configuration of the NHS Lanarkshire workforce has changed, in light of the pandemic, to support the response, with colleagues redeploying from elective pathways to support Intensive Care. For example, alongside an extensive recruitment campaign to increase our available workforce.

Whilst responding to the pandemic it became clear that a large number of our colleagues' roles had changed and in doing so they had developed new ways of working and different approaches to ensure person-centred care continued to be at the heart of all we do whilst responding to the rise in COVID-related cases.

A good example of this was the extended role undertaken by some of our Physiotherapists where they would undertake phlebotomy duties and the recording of vital signs in addition to their core role – this therefore removed the need for a phlebotomist and a healthcare support worker both having to attend the same patient. This not only increased efficiency but meant fewer interruptions for the patient.

NHS Lanarkshire has committed to exploring if there are further good examples of changes to practice or roles where these could be further assessed to identify if they could become part of normal service delivery.

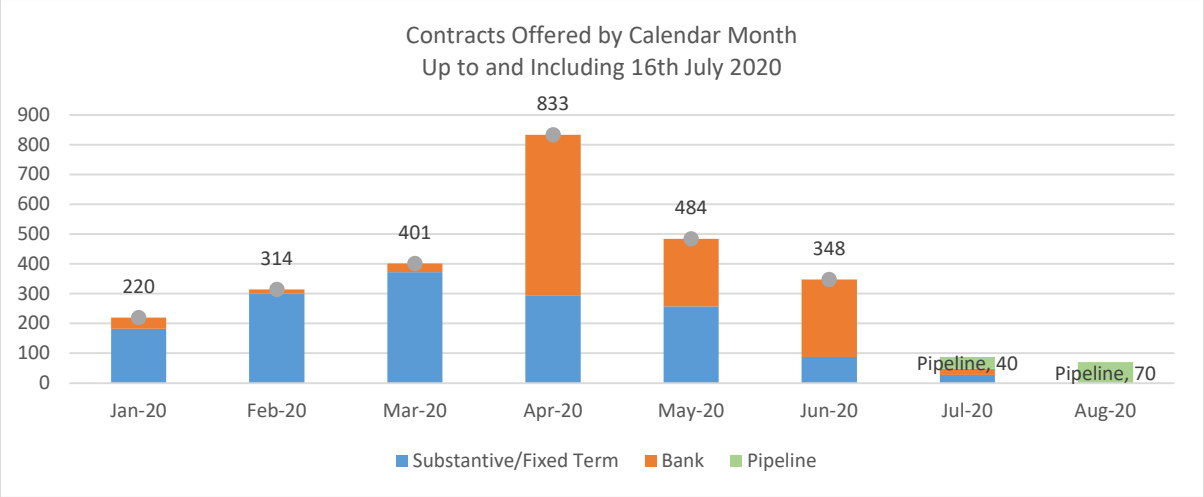
10.2 Test and Protect

NHS Lanarkshire has established an interim Test and Protect service which includes approximately 40 staff including call handlers, Public Health Consultants and administrative support staff for supporting the Test and Protect initiative Lanarkshire-wide. Planning is underway to identify the best model for sustaining this service in the medium-long term.

10.3 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 was completed 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 – showing both the average monthly trend prior to COVID-19 and after. The exceptionally high increase in April was predominantly driven by an increase in the Staff Bank workforce.



10.4 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.

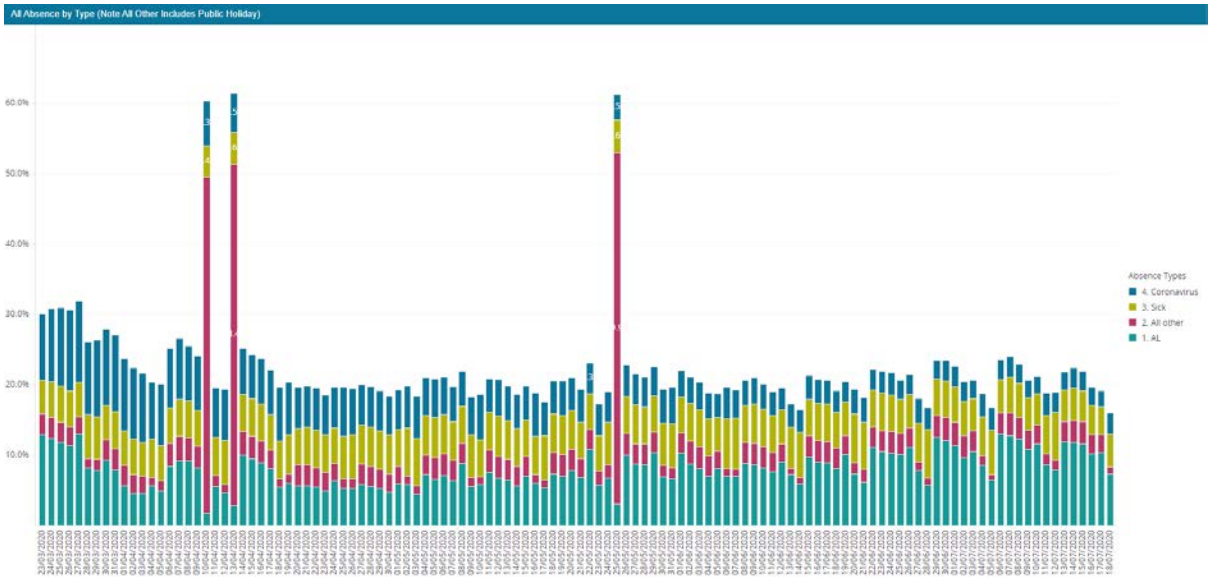
To further supplement the available workforce all workers on the Staff Bank were offered the option to taking a Fixed-Term Contract – where they would work a minimum number of hours per week. A small number of workers took up this option – with the majority who did not citing a need for flexibility they get from working on the bank as the primary driver.

NHSL is currently assessing the feasibility of further extending Staff Bank to include provision for the pharmacy workforce.

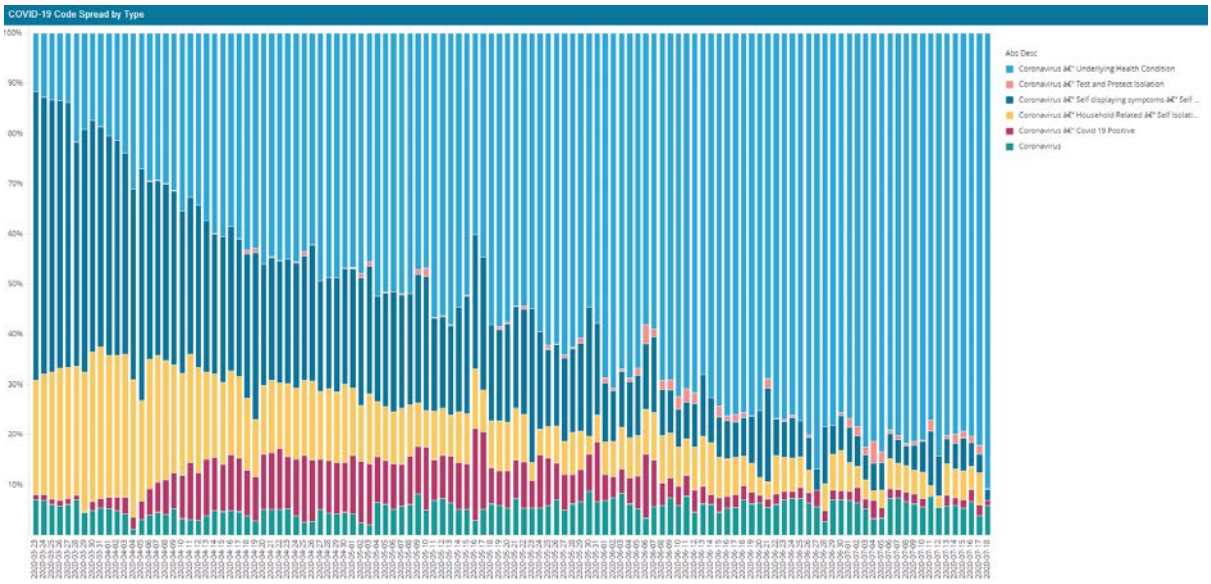
10.5 Absenteeism

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 number of staff taking annual leave has begun to return to normal following a significant reduction during the peak of the pandemic. This does mean a large number of staff will have a few days annual leave still to take from that period. Modelling suggests annual leave will need to run around 2 percentage points higher than its normal run rate to ensure colleagues are able to get the appropriate time off and we are considering this in our planning.



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. Around 3 out of 4 of NHSL's COVID-related absences are for shielding.



10.6 Home Working

NHSL has encouraged, where it is practical, colleagues to work from home, and have invested heavily in laptops and other related infrastructure to support this. It is recognised that a return to full-time office accommodation in the near-term is impractical and that home-working, for some roles, may be suitable in the longer term. To assess the implications of this, NHS Lanarkshire is establishing a Short Life Working Group to consider the requirements of implementing a home-working policy for staff for the longer-term.

10.7 Regional Collaboration and NHS Louisa Jordan

NHSL recognises the importance of having the NHS Louisa Jordan available for contingency and has supported the readiness of the Hospital by making staff available to support induction and encouraging some of our retired Senior Charge Nurses back to practice specifically to support the initiative. It is, of course, a testament to the people of Scotland in adhering to lockdown and supressing the virus that the bed capacity was not required and we are now working with our clinical teams to assess how we best use the available capacity within the NHS Louisa Jordan to support the remobilisation of clinics.

NHSL has been working closely with other West of Scotland Boards throughout the pandemic in understanding demand and seeking and offering support where necessary to ensure the population of the West of Scotland continued to receive the best care and support possible. NHSL will continue this collaborative approach as we recover our services.

10.8 Training & Development

In line with the national guidance provided by Scottish Government DL(2020)/5 (13th March 2020) NHS Lanarkshire postponed all non-urgent conferences and developmental training. Whilst this remains the default position, NHS Lanarkshire has commenced a review and re-instatement of development activities that can be provided through ensuring effective social distancing and without the requirement of large groups being in a single training room.

10.8.1 Turas Appraisal

NHS Lanarkshire agreed to recommence the appraisal process from the 1st June 2020. Acknowledging that this may not be feasible or appropriate for some areas at this time, it was agreed that managers should be encouraged to complete outstanding appraisals where COVID-19 and operational pressures allow. Social distancing recommendations were recommended and the use of technology such as Microsoft teams to conduct reviews actively encouraged.

10.8.2 Corporate Induction

The corporate induction programme aims to ensure that staff joining the organisation are provided with a warm welcome, information about the organisation and clarity of compulsory learning that is required to be completed by every member of staff commencing employment.

To ensure the effective implementation of social distancing guidance, the current face to face classroom based corporate induction programme has been temporarily replaced with an online learnPro induction module. This online module has been used in Lanarkshire since December 2017, with 12,291 individuals having completed the module.

The content of the learnPro module has been updated and was launched on 8th July 2020. An ongoing review of the classroom based corporate induction programme will continue to be completed during this time.

10.8.3 Leadership and Management Programmes

To comply with social distance requirements, NHS Lanarkshire have adapted current programmes to deliver content through remote learning. Programme have been reschedule to take account of annual leave that may be requested over the summer/school holidays and to ensure that participants have enough time to plan to re-introduce and protect learning into their working hours.

A range of approaches including blended learning will be used and will include lecture sessions via MS Teams, electronic course materials/ assessment submissions and one to one coaching available if required to assist with assessments.

10.8.4 Staff Awards

Acknowledged locally as one of the main features of the organisations events and celebrations, NHSL's 5th Annual staff wards was postponed this year due to COVID-19. In order to ensure that staff are recognised, acknowledged and celebrated, it is proposed that the Staff Awards processes are reactivated to enable a virtual Staff Awards Ceremony to be held during 2020.

10.8.5 Scoping a Virtual Learning Environment (VLE)

Learning teams across NHSL are investigating options to deliver instructor led training moving forward. One of the options being investigated is using a Virtual Learning Environment (VLE) platform to deliver training. Other options include, smaller groups and bigger training rooms. Although the need of the VLE has been prioritised due to social distancing requirements, a number of teams envisage virtual learning being a component of training delivery moving forward.

10.8.6 Health Care Support Workers Standards (HCSW)

Ongoing support has been provided throughout the COVID-19 period to managers of new starts. All relevant paperwork for the HCSW Induction Standards advising managers that these should be completed at the earliest opportunity but being managed through a flexible approach to respond and take account of the challenges faced.

NHS Lanarkshire agreed on 9th July 2020, to revert back to the national timescales and monitoring through a 'soft' re-introduction. This will include additional support (if required) and timescale extensions provided to ensure no detrimental impact on service delivery and taking account of patient safety.

Postgraduate Medical Trainees and Medical Undergraduates

10.8.7 Postgraduate Medical Trainees (DDit)

Many medical trainees showed remarkable flexibility and selfless commitment in either redeploying or adjusting their duties and hours at very short notice, and frequently, with concurrent significant change in their personal circumstances and support. The impact on training varied enormously. However many gained generic professional skills, and competencies and experience that they could capture in portfolios toward their training.

Nonetheless, going forward we will work with partners in National Education Scotland under guidance from Colleges and GMC. Linking closely with Associate Postgraduate Deans, Training Program Directors, Educational supervisors and the trainees, we will develop individual training plans to maximise opportunities for all trainees. We are ensuring that opportunities are maximised for the surgical specialties, and are working to ensure that opportunities such as accessing training in new locations such as GJNH and non NHS premises are captured. We have linked with NES to ensure appropriate GMC recognition is in place, as well as indemnity arrangements.

Concurrent implementation of new curricula particularly IMT is a significant challenge, using leads in each acute site, deputy directors of medical education and linking with service leads we will aim to deliver this curriculum where able, whilst maintaining a safe clinical learning environment.

We will continue to offer both physical and psychological wellbeing support, capturing the learning during the COVID-19 pandemic in this area. Similarly learning from the support that was put in place from FiY1, will be incorporated where appropriate.

10.8.8 Undergraduate Medical students

The COVID-19 pandemic resulted in all undergraduate medical placement being paused in March / April 2020. We welcomed 50 FiY1 to the board both individuals and departments involved significantly benefitted.

Partner universities delivered knowledge based learning to the relevant students during this period. Working in partnership with these universities we are actively re- designing our undergraduate programs to offer immersive clinical attachments, maximising clinical learning opportunities. Students in medical and surgical specialties in particular will be buddied with Foundation doctors and will have clinical teaching fellows to guide their learning and ensure that learning objectives are completed. This will be overseen and supported by existing Educational supervisor network.

Whilst COVID-19 represents a significant change, re-design and innovation will lead to improved learning environment, greater exposure to the clinical team and more supported experiential learning opportunities.

10.8.9 Space, Social Distancing and IPC

The changes from COVID-19 require us to make adjustments to teaching, learning and supervision to ensure appropriate social distancing and physical staff health for Trainer, patient and learner. We will through technologies such as MS Teams, Near me and simulation maximise learning whilst ensuring we meet national guidance for social distancing and IPC.
Medical undergraduates and postgraduates will have Occupational health support, linking with universities or health board partners, appropriate PPE will be used. Training opportunities will be maximised and adjusted on individual basis for those who have been shielding or are in a vulnerable group, ensuring educational plans are in place with university or NES.

Medical education is strongly linked into senior medical management and board governance and Management ensuring that support for medical trainees and students will remain reactive and responsive as NHS Lanarkshire moves through this re-mobilise, recover and re-design phase.

11.0 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. It is recognised that 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. As such, 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.

Areas where significant additional cost are expected are listed below.

1) **Test and Protect**: Early experience of outbreaks indicates the majority of the work will be the complex local tracing and outbreak control carried out by higher skilled Board staffing working in multi-agency incident teams. This outstrips any local capacity and requires new investment. The net cost of the NHS testing will also rise. In the early months of the outbreak with much routine work stood down, laboratory staff were redeployed on to COVID-19 testing. As routine work is stood up, investment in staff is required as well as ongoing costs of equipment and consumables.
2) **Support to care homes**: The additional responsibilities placed on Health Boards for the testing programme, infection control, assurance and staffing support has required additional resource.
3) **Flu Vaccination Programme** extension.
4) **Public Health and mental health** response to aftermath of COVID-19.
5) **Unscheduled Care**: With physical distancing and increased turnaround times between patients the A & E departments cannot cope with the previous high levels of attendances and new models are being explored nationally. These are likely to involve an additional layer of patient triage and a wider portfolio of other support to which patients can be directed.
6) **Scheduled Care**: In an environment with COVID-19 still circulating, throughput is still limited. At the same time there is a huge backlog in cases, stretching back to 18th of March. Solutions for additional activity over an extended period will be needed in order to reduce this backlog.
7) **Mental Health Assessment Centres**; these were stood up at additional cost during the initial phase of the COVID-19 pandemic to avoid patients presenting with a mental health issue having to go to the main A & E. These are likely to remain part of the future solution.
8) **Additional** ICU, General Bed capacity and the standing up of COVID-19 community assessment centres should there be a second spike especially if it were to coincide with Flu.

Every effort will be used to maximise self-help and virtual consultations, and to redesign pathways to make best use of available resource. Work is ongoing to develop these models and Finance will work alongside this to assess the additional resource. A SG return is due to be submitted on 14th August

which will capture the existing and near future costs, as well as begin to build up a picture of future costs. It is expected that this work will take several iterations before a reliable estimate is available.

12.0 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.

The Board have been discussing bringing back the two Standing Committees that were stood down, so that these Committees can play a full part in the recovery phase, as many of the services being recovered require careful and detailed planning across the Acute Division, with Primary care colleagues and other services managed by the Health & Social Care Partnerships.

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.

13.0 INNOVATION / OPPORTUNITIES FROM MOBILISATION

The Immediate Response

To achieve successful mobilisation whole system changes were introduced rapidly across Lanarkshire's Health and Care System. This includes: remote 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.

13.1 Using Quality Improvement Methodology to design New Ways of Working

COVID-19 has created a platform for change. Health and Social Care organisations are required to think and act as a system in ways we have not done before.

NHS Lanarkshire is implementing a consistent approach to the application of quality improvement methodology and the use of a learning framework to capture, share and act on the lessons learned.

NHS Lanarkshire and both HSCPs have developed a culture of learning and improvement over recent years. The NHS Lanarkshire Quality Strategy sets out its ambitions for improvement and innovation to use a consistent approach to improvement throughout the organisation that reflect all stages of the improvement journey and that apply to continuous daily improvement as well as large-scale transformational change.

NHS Lanarkshire has a well-established Lanarkshire Improvement Journey as part of our overall Lanarkshire Quality Approach. The Lanarkshire Improvement Journey has 5 stages:

1. Identifying the need for change
2. Designing a Change
3. Testing a Change
4. Implementing a Change
5. Spreading and Sustaining Improvement

The Quality Directorate Improvement Team has linked Improvement Advisors to each of its Operational Units; University Hospital Wishaw, University Hospital Hairmyres, University Hospital Monklands and North & South HSCPs to provide expertise and guidance in the use of quality improvement methods. They will support clinical and managerial staff to take forward any recovery and/or redesign plans using the improvement journey approach.

13.1.1 Implementation of the Learning Framework

An agreed Learning Framework is being used to capture lessons learned across the organisation. The framework enables learning to be captured at individual, organisation and system level. The Improvement Advisors and Improvement Coordinators will be able to capture learning in each operational unit using the agreed Collaborate CIC Learning Framework and facilitate the sharing of good practice and tests of change that work across all units.

The learning framework is divided into two parts:

1. Surfacing insights: 8 questions which can help identify how an individual, organisation, and the system are thinking and working in new ways.

2. Deepening insights: short sets of questions focussed around five key themes, giving the chance to reflect on and interrogate the learning more deeply.

There are 5 process steps within the framework:

Step 1. Coordinate the learning efforts
Step 2. Agree what information we want to collect
Step 3. Identify how to capture this information
Step 4. Agree how we want to share and act on the learning
Step 5. Create a learning culture
It is proposed that using this learning framework across all of our services will enable the organisation to capture the lessons learned in a robust and systematic way.

13.2 Covid-19 Lessons Learned – National Approach - Feedback to SG

NHSL has participated in the national programme of work to capture COVID-19 lessons learned across (i) NHSS (ii) the social care sector and (iii) SG Health and Social Care Directorates. This is being undertaken via the completion of a SG questionnaire.

14.0 RISK ASSESSMENT

NHS Lanarkshire continues 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 the test and protect programme as we move forward.

14.1 EU Withdrawal Position

The United Kingdom (UK) voted to leave the European Union (EU) by referendum in 2016. This is a matter reserved to the Westminster Parliament and has commonly become known as Brexit. Parliament subsequently voted to initiate the withdrawal process known as article 50.

The UK is currently in a transition period with full departure scheduled for 31 December 2020.

The discourse and debate on the issue has focused on greater willingness to leave with no deal in place if an agreement cannot be reached with the EU. The Government has remained firm on its stance of fully exiting the EU on the 31 December 2020. The ongoing negotiations and lack of agreement has created uncertainty across the public and private sectors.

The current circumstances of leaving the EU and the ongoing uncertainty has potential significant issues for NHS Lanarkshire (NHSL). In response the Corporate Management Team (CMT) declared a live incident on 10 April 2019 and put in place a Command and Control Structure to manage the impacts. NHSL planning followed the contingency arrangements set out in operation Yellowhammer.

The NHSL Brexit Command and Control Structure was stood down in January 2020 with the incident place in suspended mode. Due to ongoing risk and uncertainty key steps were agreed that the Resilience Team would monitor developments and Tactical Commanders would review risks at set intervals. The above being reported through CMT.

NHSL current position is:

1. **Maintain the live incident (suspended):**
    - The immediate risks and impacts may have significantly diminished with a transition agreement in place. However leaving the EU is a significant change and associated disruption cannot be fully ruled out. Maintaining the current status allows the structure established to be reactivated at short notice.
    - The trade negotiations may create further uncertainty which may potentially cause fluctuations in the risks across the negotiating period.
    - Uncertainty may continue amongst non UK staff.
    - Risks associated with returning expats may remain and may be influenced by information and reports associated with the details of ongoing negotiations and/or political discourse.

2. **Maintain EU Withdrawal risk monitoring:**
    - The risks are likely to remain albeit the risk ratings for the short term may have changed.
    - The risks and ratings may fluctuate over the negotiation period.

- Tactical Groups to review risks as at the 31st January and then at a 3 month intervals i.e. April, July and October. This shall ensure a good understanding of the circumstances and potential issues as we approach the December deadline.

3. Resilience Team maintain the EU Command & Control page:

- Resilience Team shall monitor and in collaboration with Tactical Commanders update the substantive risk registers.
- Monitor all information sources and provide updates to the Command Groups as appropriate.
- Ensure any significant changes to risks and threats are highlighted to the Strategic Group and/or CMT as appropriate.

15.0 PATIENT EXPERIENCES/PERSON CENTRED APPROACHES TO CARE

15.1 Patient Experience

NHS Lanarkshire provides mechanisms and tools to support and enable staff to engage service users about their experiences of care and use it for reflection, learning and action. We listen, learn and act on patient, family and carer experience through our Feedback, Comments, Concerns and Complaints systems (appendix 9) and our Public Engagement Groups.

NHS Lanarkshire captures information on patient experience using both solicited and unsolicited feedback.

Solicited feedback is captured using trained volunteers. An annual visit programme for adult acute physical health wards has been developed. Ward visits were suspended during pandemic but will be reinstated when it is safe to do so.

Unsolicited feedback is captured using Care Opinion. Monthly Care Opinion Reports of feedback activity, volume and themes is provided to Operational Sites and also to Corporate Management Team (appendix 10).

We engage public partners to discuss areas of interest and develop / deliver work based on their feedback through quarterly meetings of the Public Reference Forum (PRF) (appendix 11) and Public Partnership Forums (PPF). During the pandemic these meetings were suspended however we have explored use of web based systems to engage with PRF and PPF members in online meetings for the rest of this year.

15.2 Person Centred Approaches to Care

As part of the NHS Lanarkshire Quality Strategy we have a Person Centred Care Plan and annual Implementation Plan. This plan is overseen by the Person Centred Strategic Group (chaired by Executive Director of NMAHPs) and reports to the Healthcare Quality Assurance and Improvement Committee.

As part of the shared decision making section of the above plan new arrangements have been developed in relation to Anticipatory Care Plans (ACP) in community settings and Treatment Escalation/Limitation Plans for emergency admissions to acute hospitals.

We have designed and implemented a process (appendix 12) for all community staff groups to implement the shortened COVID-19 ACP developed by Healthcare Improvement Scotland.

A Coping with Crisis Booklet written by Prof. Robin Taylor has been provided to all Acute & Community Hospitals, Hospital at Home Team, Community Nursing Teams, GP Practices and Care Homes to support anticipatory care planning conversations between healthcare professionals and the public.

NHS Lanarkshire acute hospitals use a Treatment Escalation / Limitation Plan as part of the shared decision making approach to care and treatment. A new version of the Treatment Escalation / Limitation Plan (appendix 13) was developed for use with all patients admitted to hospital as an emergency during the pandemic. This new version was tested and feedback from clinicians informed an updated version which will continue to be used for all emergency admissions to hospital.

15.3 Patient Information

As part of our person centred care approach we ensure information is available to the public in accessible formats to support shared decision making. We have an annual subscription to EIDO Healthcare Download Centre to access consumer tested, Royal College endorsed procedure and condition information to aid informed consent. We have developed a survey programme to seek feedback from patients on content of procedural information issued.

During the pandemic additional Patient Information Leaflets have been developed for:

- Physiotherapy following COVID-19
- Occupational Therapy following COVID-19
- Speech & Language following COVID-19
- Attend Anywhere - Orthopaedic Paediatric appointment letter
- Virtual visiting – guide for patients
- Surgical consent

15.4 Person Centred Visiting

NHS Lanarkshire recognises the therapeutic importance of enabling patients to have access to their loved ones while in hospital; and therefore fully supports a person centred approach to visiting.

Face to face visiting has been restricted to essential visitors only during the pandemic. However ward staff have worked closely with families to find the most appropriate approach to meet the needs of their patients at this time. NHS Lanarkshire has provided iPad tablets to every ward to enable patients and loved ones to carry out 'virtual visits' and staff have proactively phoned relatives to ensure that they are regularly updated on their loved one's care in a timely manner.

As per stage 2 of the Scottish Government 'roadmap', from the 13th of July a level of face to face visiting has been re-established. Over the coming weeks, opportunities for face to face visiting will be increased in a measured way, whilst ensuring patient safety remains our prime focus.

15.5 COVID-19 - Patient Experiences/Person Centred Approaches to Care

In addition to ongoing efforts to ensure that person-centred, high quality care is driven by patient experience, specific feedback has been sought during the COVID-19 pandemic to inform re-mobilisation and recovery. This has had a particular focus on clinical priority groups, the use of technology, but also feeds into future service delivery. Due to the necessary timescales, some of this work is still ongoing, but will be useful to the iterative planning process as it becomes available. Further details of this work are available at appendix 14.

16.0 APPENDICES

Appendix 1 - Response, Recovery & Oversight Group (RRROG Response, Recovery & Redesign - Definitions  Appendix 1 Response, Recovery
Appendix 2 - RRROG - Approvals Process  Appendix 2 Recovery Redesign
Appendix 3 - RRROG - Approved Proposals as of 30 July 2020  Appendix 3 Approved proposals
Appendix 4 - Weekly COVID-19 Situation Report as at 17 July 2020  Appendix 4 Weekly COVID-19 Situation
Appendix 5 - Mortuary Provision in NHS Lanarkshire  Section 4 Mortuary Provision In NHSL.dc
Appendix 6 - Acute Outpatient Services – Maintained or Recently Restarted  Appendix 6 Acute Outpatient Services
Appendix 7 -- Public Health Remobilisation Costs  Appendix 7 Public Health Remobilisatic

Appendix 8 – Infection, Prevention & Control Infection Assurance Framework - COVID-19 (SARS-CoV-2) Response, Resilience and Recovery

Appendix 8
Infection Prevention

Appendix 9 - Feedback, Comments, Concerns and Complaints Annual Report

Appendix 9 Annual
Report Feedback + (

Appendix 10 - Monthly Care Opinion Summary June 2020

Appendix 10 Care
Opinion Summary Ju

Appendix 11 - Public Reference Forum Annual Report 2019/20

Appendix 11 Public
Reference Forum An

Appendix 12 - Anticipatory Care Plan SBAR

Appendix 12
Anticipatory Care Pla

Appendix 13 - NHSL Treatment Escalation/Limitation Plan

Appendix 13
Treatment Escalatior

Appendix 14 – COVID-19 - Patient Experiences/Person Centred Approaches To Care

Appendix 14
COVID-19 - Patient E

Activity Template 1 - Activity Projections – 07.08.20 Template 1 August 07082020.xlsx
Activity Template 2 –Diagnostic Tests, NOP and TTG - 05.08.20 Template 2 August 05082020.xlsx
Activity Template 3 – P1 and TTG Clinical Priorities – 05.08.20 Template 3 August 05082020.xlsx