Our System-Wide Remobilisation Plan

August 2020 to March 2021

Working together to protect the health and wellbeing of our patients and staff

Contents

Foreword

This System-wide Remobilisation Plan is in response to a new commission from the Scottish Government Health and Social Care Directorate to cover the period from August 2020 to March 2021. This Plan builds upon our achievements to date as we continue the journey of Re-mobilisation, Recovery and Re-design with our staff to increase our capacity not only in our hospitals, but also in our communities, working as part of our Health & Social Care Partnerships and with our Local Authority partners and public sector colleagues.

Public Health and Primary Care will continue to be centre stage in our response to resume services safely and incrementally within an affordable and sustainable framework. Clinical prioritisation will guide us in our work as we continue to pay attention to Test & Protect, Infection Prevention & Control including maintaining physical distancing and having access to PPE. Prevention will be critical and a plan to ensure we are prepared and able to begin our flu immunisation programme from mid September has been developed in collaboration with in particular our GPs as we get ready for winter. This was approved by our NHS Board in July 2020.

In addition to the seven principles set out 'Re-mobilise, Recover, Redesign: The Framework for NHS Scotland our Plan sets out how we will maintain and protect COVID-19 capacity whilst simultaneously mitigating the risk of nosocomial spread of the virus and by building our public health capacity to deliver all the components of Test & Protect. Patient and staff safety and wellbeing will be assured by appropriate streaming of COVID-19 vs. Non COVID-19 presentations to our hospitals and services.

To date we have also made huge inroads using technology to support virtual consultations including the widespread use of Near Me to help deliver outpatient appointments. Innovation and improvement will continue at the same pace and spread as we look to support high quality care and new and effective ways of working. In this regard the work led by our Ageing and Health Consultants to shift their location from hospital to community working alongside our Care Home Assessment & Rehabilitation Team has seen many more people looked after in their own homes, in care homes and the wider community. These new ways of working will continue as we invest in greater integration and services closer to home. Our HR Services throughout all of this have being there for staff and for managers and our psychology team and staff side colleagues have been instrumental in supporting our health and wellbeing approach.

Our resilience to date has been good, mutual aid and regional working, the support/development for staff and co-operation between services and with partners including transport providers and National NHS Board colleagues has never been stronger. But the people who make all of this happen is staff. Staff from across our health and social care system have worked with such compassion and commitment, I am in their debt and thank you all for everything you have done and continue to do to respond to the many challenges posed by this pandemic.

Cathie Cowan

Chief Executive

SECTION 1: ABOUT THIS PLAN

STATEMENT

This remobilisation plan is, as of 31 July 2020, in a final draft format. It has not been formally agreed by the NHS Forth Valley Board, and this will not be done until 25 August 2020. We will, of course, engage with colleagues in Scottish Government Health and Social Care Directorate on the fine detail before final approval.

DOCUMENT CONTROL

Date	Version	Revision/Amendment Details & Reason	Author
25/05/2020	**1.0**	**Original Version**	**Cathie Cowan Kerry Mackenzie**
05/06/2020	**1.1**	**Redrafting includes 27 May Scottish Government feedback and 1 June System Leadership Team consideration. Refresh (4 June) of Service/Partnership Next Phase of NHS Response Plans**	**Cathie Cowan Kerry Mackenzie**
31/07/20	**1.2**	**Refresh to inform next phase of remobilisation from August 2020 to March 2021**	**Cathie Cowan Kerry Mackenzie**

1.1 PLAN PURPOSE

The First Minister launched Scotland's route map through and out of the crisis[1]. The Route Map describes a number of phases by which the Government aims to ease lockdown following the 28 May end of cycle review of COVID-19 regulations. The Cabinet Secretary for Health and Sport on the 31 May then launched the 'Re-mobilise, Recover, Re-design: The Framework for NHS Scotland[2]. In response to this Framework our Remobilisation Plan set out how we would safely and incrementally start to resume services over a 100-day period. Our Next Phase Remobilisation Plan builds on the work undertaken and covers the period from August 2020 until March 2021. The Plan takes account of how we:

- retain and build on the many positive transformative changes inspired by staff who have come together to work differently during this Pandemic
- remain vigilant and able to respond to potential increases in future COVID-19 cases
- safely and incrementally informed by clinical prioritisation, and building on the work already underway, restart elective services including surgery, therapies, treatments and outpatient appointments
- adjust and continue to adapt to any new or ongoing challenges whilst living alongside this virus as we prepare for winter

In this regard NHS Forth Valley will continue to:

- instil and maintain the trust and confidence of our staff, public and partners by ensuring that they are involved and well informed in our plans
- look after the health and wellbeing of our staff
- work in partnership with our staff side and clinical advisory colleagues
- embed innovations and digital approaches into our everyday business
- plan and adapt our remobilisation and recovery work alongside our Directorates and H&SCPs and build on the strong collaborative response with our wider partners and communities with a focus on reducing health inequalities
- avoid unnecessary disruption or adverse economic impacts and in this regard connect to the renewal work led by Scottish Government

[1] https://www.gov.scot/publications/coronavirus-covid-19-framework-decsion-making-scotalnd-route-map-through-out-crisis/pages/4/

[2] https://www.gov.scot/publications/re-mobilse-recover-re-design-framework-nhs-scotland/

1.2 PLAN REMIT

Following mobilisation of the COVID-19 Response and subsequent work in relation to remobilisation, NHS Forth Valley through its recovery work, has continued a dialogue within the Health Board and System Leadership Team to plan for further resumption of services, this dialogue includes regular engagement with clinical and staff side colleagues.

This Plan takes account of the different ways in which we have been working during our COVID-19 response, supported by our initial remobilisation and considers the ongoing impact of this virus as we seek to move forward. This continues to be a living document which will be adapted and modified as we build our plans to resume our services.

1.3 PLANNING ASSUMPTIONS

NHS Forth Valley, as reported to the Health Board, temporarily suspended non urgent services including elective and routine care from 23 March 2020 whilst continuing to deliver emergency and urgent primary and community care, maternity, mental health and acute hospital services. For those people whose operations have been postponed they remain on a waiting list until it is clinically appropriate for elective care to recommence. It is recognised that any delay in tests or treatment can be distressing for patients and their families and we are therefore keen to incrementally increase capacity in relation to services as quickly and safely and possible. To guide the ongoing resumption of our services we have made a number of planning assumptions, notably:

- Sufficient public health and health system capacity is in place to implement the ‘test and protect’ strategy
- Separate community COVID-19 pathway maintained via the triage hubs and community assessment centres with flexibility to respond to daily fluctuations in workload
- Interfaces with primary and secondary care are maintained
- Adoption of Royal Colleges - clinical guide to clinical/surgical prioritisation
- Physical capacity across all sites may be reduced to maintain physical distancing measures
- Access to separate bed based COVID-19 of c. 60 acute beds and 7 level 3 ITU beds
- Care homes continue to receive our support
- PPE supplies and access to critical medicines continue
- Robust infection protection and control measures are maintained
- Health and Social Care workforce availability is sustained
- Access to transport continues
- New ways of working established during this pandemic continue and good practice is encouraged and supported
- Ongoing financial support from the Scottish Government will remain in place
- Outpatients capacity of 970 per week will remain consistent or increase
- Inpatients/ Daycases capacity of 154 per week will remain consistent or increase

- Access to the Golden Jubilee National Hospital and Louisa Jordan Hospital will add to our capacity

Alongside these assumptions are opportunities to rethink and to reshape how we deliver both scheduled and unscheduled care services as we live alongside COVID-19 and adhere to ongoing physical distancing. Our current unscheduled care system can sometimes be complicated to negotiate however recent challenges have provided opportunity for unscheduled care services to evolve and adapt beyond the initial COVID-19 mobilisation phase to provide safe and effective care for patients consistent with the national direction. Partnership working will continue to guide how we optimise enhanced community care in our localities. How we use Community Hospitals and Care Homes in the future also needs to play a more prominent role as we look to strengthen the interfaces and relationships that have emerged during this pandemic across primary and secondary care.

1.4 GOVERNANCE ARRANGEMENTS

NHS Forth Valley in response to COVID-19 reviewed its governance arrangements and introduced new arrangements. These interim arrangements were set out in a paper to our March Health Board and aimed to:

- enable the Board to effectively discharge its governance responsibilities during this pandemic and in particular deal with any necessary legislative or regulatory aspects of business
- provide assurance that plans were being developed in line with national direction and that resources were being deployed effectively
- maximise the time available for management and operational staff to respond to COVID-19
- minimise the need for people to physically attend meetings
- seek assurance through the fortnightly Chair, Vice Chair and Assurance Committee Chairs meetings

Arrangements have subsequently been reviewed by the Board with agreement to step up the Audit Committee to oversee end year accounts, Performance & Resources Committee to seek assurance on performance, and the Clinical Governance Committee to seek assurance on clinical matters and risks as services resume. Staff Governance Committee will meet in August 2020.

The COVID-19 System Leadership Team Daily Huddle and our Pandemic weekly Incident Management Team have been stood down. We have re-established our System Leadership Team (SLT) (meeting since May) and alongside our SLT is our Mobilisation Recovery Programme Board. The Programme Board will be the Forum to deliver our ambition to create direction, build readiness and lead transformation.

1.5 LINKS TO OTHER PLANS

- NHS Forth Valley Interim Pandemic COVID-19 Response Framework
- NHS Forth Valley Directorate/Partnership Remobilisation Plans

- NHS Forth Service Level Business Continuity Plans
- NHS Forth Valley Major Incident Plan
- Forth Valley Local Resilience Partnership COVID-19 Framework
- Health Protection Scotland COVID 19 Guidance (various)
- Scottish Government, Health and Social Care Guidance (various)

SECTION 2: PLAN ACTIVATION – REMOBILISATION

2.1 OVERVIEW

Our Mobilisation Plan and subsequent Remobilisation Plan were developed in partnership and adopted a whole system approach to support our initial response to COVID-19 and ensuing recovery. This whole system approach is reflected in our ongoing work to resume services which will be achieved in stages. Test & Protect and Infection Prevention & Control will inform how we continue to resume services and the throughput of these services whilst physical distancing requirements remain in place. It is assumed these measures will be required for some time; this has implications for how we use space, staff and equipment. The continued use of working from home where possible and appropriate will continue to be maximised. Overcoming capacity, workforce, logistics (PPE, drugs and other equipment), space/facilities, and transport challenges are all being taken into to consideration to support a progressive scale up of services aligned to Regional and National Plans.

Contact tracing, in conjunction with other measures will form an integral part of the roll out of 'Test & Protect' which has been in place since 28 May with the national element in place from 9 July. The work led by Public Health continues, with assistance from Local Authority Environmental Health Officers and good internal systems including local laboratory capacity to support the agreed testing pathways.

Our preparation to support safe and effective remobilisation is detailed in our planning assumptions set out above.

2.2 Enabling Activity

2.2.1 Digital & ehealth & Information Management Services

Since the end of March there have been at least 15 different supporting digital initiatives and technology solutions for the COVID-19 response. The main initiatives are noted as:

- accelerated roll out of 'Near Me' across all main care settings and GPs
- full Microsoft Teams roll out to all staff in NHS FV to support meetings and communications

- identified and introduced messaging solutions for clinical and operational teams
- increased wifi access for key staff at Forth Valley Royal Hospital
- established (doubled) remote access arrangements for staff bringing access up to c2/3rds coverage for primary care GPs
- procured additional laptops and mobile devices to support more agile and home working
- strengthened cyber security by rolling out Advanced Threat Protection (ATP) software
- reviewed and refreshed ICT business continuity plans including OOH support
- supported operational arrangements for key IM reports to be automatically generated to inform SITREP reporting externally and internally and to support decision making
- provided IT and Communication support for Hub & Assessment Centres e.g. Adastra and TRAK functionality along with telecoms
- rolled out ipads to support Critical Care and community hospital visiting
- implemented enhancements to the Patient Management System to monitor and record COVID-19 activity (via TRAK)
- enhanced 'Portal to Portal' and SCI Store links to share patient information across Health Boards boundaries
- rolled out access to Emergency Care Summaries (ECS) to Dental, Pharmacy and Optometrists in the community
- enhanced 'paper-lite' working in ICU
- implemented the Track and Trace software and digital platforms locally and provided extensive analytical support to Public Health

✓ **Appendix 1** Digital & eHealth Delivery Plan August 2020 to March 2021

2.2.2 Managing Quality & Safety

We continue to prioritise clinical governance and during the initial COVID-19 period implemented a rapid response to registering changes and developing, assessing and signing off COVID-19 guidelines and procedures through our command structure and daily SLT Huddle. We will refresh the pre-COVID processes specifically for clinical guidelines and procedures.

We continue, as part of remobilisation and recovery planning, to oversee information about changes to every service. A baseline data collection, has recorded services and care that have been temporarily postponed. This will guide our remobilisation efforts and will include risk assessments where appropriate to reflect these changes.

A new Safety and Assurance report will provide assurance for key performance measures which are National patient safety priorities. This includes HSMR, deteriorating patient & cardiac arrest, stroke bundle compliance, pressure ulcers and falls and will also include service assurance reports.

As part of a suite of supports during COVID-19, we established a local Ethical Advisory Group. This Group will continue to meet monthly to discuss and give advice on cases referred and develop their decision-making abilities.

We have maintained many of our Safety Programme interventions including falls prevention and clinicians are planning to build on our Best in Class knee problems programme. Safety workstreams are being enhanced using a quality management system approach identifying areas for targeted improvement support.

We plan to begin to systematically adopt specific Scottish Access Collaborative interventions in the outpatient remobilisation plan and specialty improvement plans. This has already included waiting list validation and will include extending Active Clinical Referral Triage and Patient Initiated Review. We will begin to utilise Team Service Planning, with the virtual support package offered by the National Team, and to explore the roll out of ADEPT to enable staff to work to the top of their licence.

We have restarted our Value Management Collaborative to support mobilisation and recovery plans and priorities in Day Medicine, Mental Health and Pathology. Restart of the Living Well in Community for Older People Collaborative and Early Intervention in Psychosis Accelerator are being explored jointly with Health and Social Care Partnership colleagues.

We have begun development of our new Quality Strategy and plan to complete this by end March 2021 and restart our development of our Quality and People Academy to be taken forward in partnership initially with the University of Stirling.

Our improvement training programme, a key element of this, is being redeveloped to enable virtual access to an increased number of people. We will have redeveloped 'Learning for Improvement' for delivery via MS Teams by the end of September. Forth Valley Quality, Organisational Development and our Corporate Portfolio Management Office will be testing a new Leadership learning opportunity from August.

2.2.3 Emphasis on innovation and transformation

Priorities for transformation have been integrated with service delivery sections of this mobilisation plan. A new Mobilisation Recovery Programme Board will reset our future ambitions for what our health and care system should look like in the short, medium and longer term with an eye to the 7 Principles of the Remobilise, Recover, Redesign: Framework for NHS Scotland and the eight objectives for safe and effective mobilisation. It will work within a whole system construct that builds a coherent and cohesive collaboration to deliver lasting reform. This will work alongside Transformation Infrastructure in the Health and Social Care Partnerships and Local Authorities.

NHS Forth Valley's most innovative clinicians and support services responded to COVID-19 by working closely with other teams, NHS Boards and Scottish Government to realise the potential benefits from existing and new projects.

Eye Health

The tele-ophthalmology real time virtual assessment of emergency and urgent eye conditions has been extended to community-based optometrists and formed the basis of national Emergency Eyecare Treatment Centres. Fewer patients have to travel; physical distancing is maintained for patients and healthcare providers and, in some cases, treatment, including medicines and emergency surgery, has been accessed more quickly than before. We plan to increase the types of eye conditions that can be assessed remotely.

We are leading development of an Eye Health Consortium as part of the *Catalyst for Health and Social Care Innovation in Scotland*. In September 2020 we are launching, via Innovate UK, an open innovation competition for an Eye Health Small Business Research Initiative. This will be a collaboration with a number of other NHS Boards, Academia, Industry and the National Waiting Times Centre. The competition process will be supported by NHS NSS Procurement. Contracts for feasibility studies will be awarded in February 2021 to proposals assessed as being the best fit for the challenge.

Dermatology Digital and AI/Machine learning

The Virtual Asynchronous Consultation (VAC) platform and app developed by our dermatologists and Storm ID has been put into routine use for a proportion of appointments, supporting people to self-manage and helping to diagnose benign skin lesions.

We will continue to work with NHS Grampian and NHS Greater Glasgow and Clyde, on behalf of NHSScotland, with the Chief Scientist Office and Scottish Government Access Team to complete, by October 2020, integration of the technology and process into Trakcare our patient information system. The information about use has been shared in a MS Teams meeting with other NHS Boards to increase engagement in adopting VAC.

We will also continue our work with colleagues in Tayside to utilise images to develop machine learning.

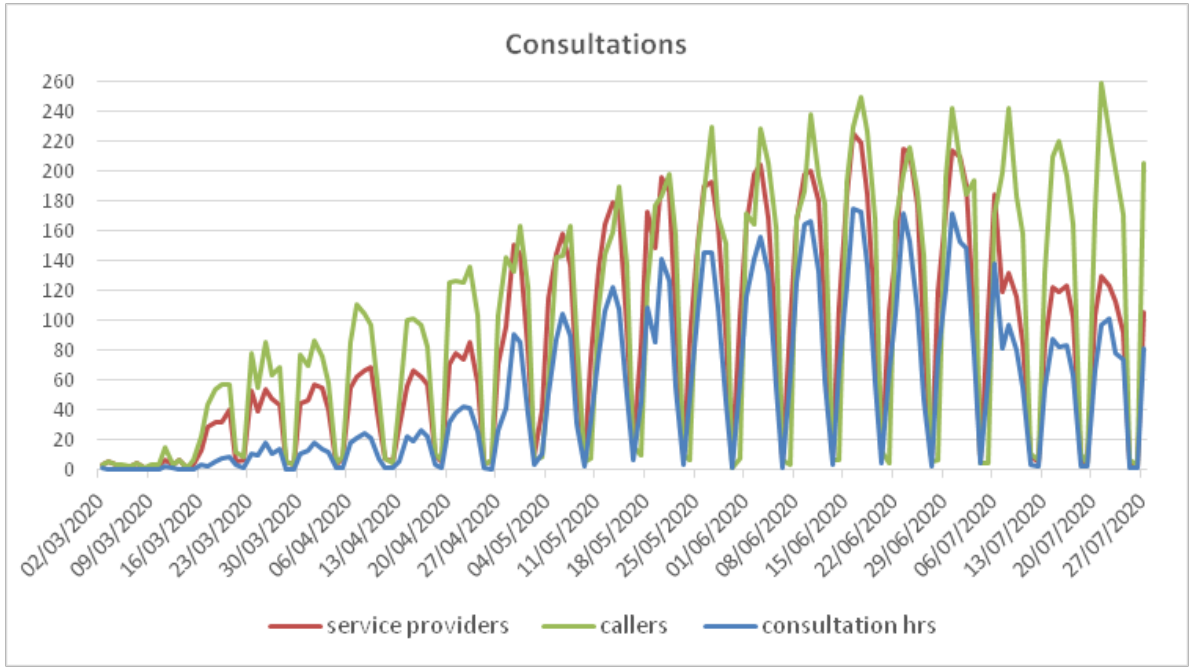
Remote spirometry

We contributed to the Chief Scientist Office's call for information about healthcare challenges that need innovative solutions, submitting a challenge to remotely monitor and respond to people with chronic respiratory problems requiring spirometry. We are being supported by Scottish Government's Modernising Patient Pathways Programme Team to take this forward and plan to have remote spirometry developed and tested.

We are sighted on other innovation for people with respiratory conditions that are underway in Scotland as part of the Catalyst including DynamicScot and in NHS England.

Near Me

In response to the COVID-19 outbreak, a team has been supporting the rapid scale up of Near Me across NHS Forth Valley to GP practices, primary and secondary care services. This report presents the growth and activity of Near Me on a daily basis from the 2nd March 2020.



The reach of Near Me has increased in Acute Services, Community Services and Oncology and to pharmacies and optometrists. There are 225 waiting areas spread across the following areas:

- ✓ 54 GP practices
- ✓ 38 Acute services
- ✓ 4 COVID centres
- ✓ 24 Mental Health services
- ✓ 20 Women & Children Services
- ✓ 44 Community Services
- ✓ 5 Oncology

- ✓ 15 Community Optometry
- ✓ 21 Community Pharmacy

We will continue to systematically embed Near Me into TRAK. We have incorporated Near Me into clinic bookings and patient information (via Netcall), as part of our outpatient remobilisation and recovery planning.We have set up multiple Near Me-friendly spaces that can be used by clinical staff for appointments. Training Near Me users will continue and we will move to business as usual support for Near Me. Our mental health services rapidly increased use of Near Me at the start of COVID-19 and are embedding it within their remobilisation plan.

We continue to take full advantage of Healthcare Improvement Scotland and Scottish Government's offers of support to work with priority outpatient specialties, maternity services and GP Practices and to prepare for future need for COVID-19 response and Winter.

2.2.4 Workforce

Our HR Director has been instrumental in developing a redeployment hub with input from AHP, medical including DME and senior nursing decision makers in line with clinical priorities and in response to staff absence as it presents across NHS Forth Valley. This measure, along with a comprehensive skills register, enables us to continue to reassign staff to temporary roles to support new services and ways of working. As we resume services this way of working becomes more important in supporting the ongoing safe delivery of our services.

2.2.5 Financial Sustainability

It is imperative that financial sustainability and value remain key factors which influence the development of our service and workforce plans. The principles of Value Based Healthcare and Realistic Medicine will be applied across the plan to maximise the opportunities to improve costs and patient outcomes. The financial impact of our COVID-19 remobilisation response will be reviewed and refreshed as part of the next iteration of the finance templates which are expected to be submitted in mid-August. This includes a full review of the quarter 1 position with indicative full year financial forecasts in respect of cost trends, savings programme, and an updated assessment of financial risk.

- ✓ **Appendix 2** Recovery, Innovation and Advancing Integration Remobilisation Plan August 2020 to March 2021

SECTION 3: SAFE AND EFFECTIVE REMOBILISATION

Section 3 of this Remobilisation Plan provides a summary of actions being taken to build on the work currently underway in respect of the resumption of services. The summaries set out have been informed by Service/Partnership Remobilisation Plans appended to this document.

3.1 Test & Protect

Outcome
Suppress the transmission of the virus and prevent/control nosocomial related infections and care home outbreaks

NHS Forth Valley will:

- ✓ continue to support the 'test and protect' pathways including surveillance in hospitals, care homes and for key workers and their households
- ✓ provide a 7 day per week contact tracing service
- ✓ maintain robust infection prevention and control measures within all its NHS sites/services
- ✓ sustain the enhanced assurance system to support care homes – Care Home Clinical and Care Professional Oversight Team known as the Assurance Team will meet 7 days per week with the Care Home Strategy Group meeting weekly

Summary

The key to driving down and then maintaining low virus levels continues to be the combination of effective public health measures observed by the whole population backed up by effective contact tracing and control measures undertaken by specialist health protection teams whenever positive cases or outbreaks occur. Contact tracing works most effectively to reduce the ongoing transmission of infection when the number of new infections in the community is low, and stays low. Specialists in health protection maintain constant surveillance for signs of possible hot spots or outbreaks and work with the community to identify and reduce risk.

NHS Forth Valley has implemented all of the Test & Protect Pathways.

Test and Protect has been in place in Forth Valley since 28 May 2020. All cases notified to NHS Forth Valley have been contacted and compliance appears to be good. Currently the service deals with around one or two suspected cases requiring their contacts to be traced each day however it has the capacity to respond to any increase in demand, if required. The National elements of Test and Protect are now in place support the local

NHS Forth Valley response. The local health protection teams continue to handle contact tracing for more complex incidents and enquiries linked to schools, care settings or workplaces.

The service is overseen by a local Contact Tracing Implementation Group with input from Public Health, Human Resources, Facilities & Infrastructure, IT, Information Management, Finance and Planning. The service model is largely resourced by staff from Public Health supported by other local staff redeployed from their substantive roles.

Care Homes continue to be an area of intensive multidisciplinary and cross agency focus. A daily care home meeting overseen by a weekly governance group continue to ensure the safety of local homes. In the week ending 19 July NHS Forth Valley oversaw the delivery and reporting of screening tests to over 2000 care home staff exceeding the government's target for screening coverage.

The majority of care homes in Forth Valley operate in the independent sector and were not under NHS management or oversight prior to the pandemic starting. In Scotland, the Care Inspectorate regulates and inspects care services to make sure that they meet the set standards. The outcome of inspections and visits, along with any recommendations, is now summarised in a report which is published by Care Inspectorate every fortnight.

Care Homes are now open for outdoors visits. This required the production of 66 individual risk assessments by Care Homes which were checked and approved by the Director of Public Health team. We will continue to support Care Homes with our partners in terms of administrative and professional input for as long as is necessary.

Risk and Mitigation

The is a risk NHS Forth Valley will be unable to suppress the virus and spread of nosocomial related infections and/or care home outbreaks

NHS Forth Valley has taken steps to:

- ✓ resource the Test & Protect programme and pathways
- ✓ resource a contact tracing service 7 days per week
- ✓ heighten Infection Prevention & Control awareness and monitoring across all of its NHS sites/services
- ✓ provide expert Infection Prevention & Control advice and support to care homes
- ✓ resource an enhanced care home system and response to maintain non-COVID care homes and/or promptly manage care home outbreaks with key partners
- ✓ maintain vaccination programmes and prepare for winter and the roll out of the flu programme
- ✓ prepare for winter

3.2 Building Resilience

Outcome
Maintain and enhance our preparedness and responsiveness to future potential COVID-19 waves

NHS Forth Valley will:

- ✓ support the roll out of 'Test & Protect' pathways
- ✓ continue to maintain appropriate community hub and assessment centre capacity
- ✓ maintain dedicated COVID-19 acute and ICU level 3 beds
- ✓ sustain SCI Gateway advice line and established primary/secondary care interfaces
- ✓ retain HR deployment hub to ensure access to workforce
- ✓ provide professional support and advice to care homes to maintain safe service delivery
- ✓ maintain robust Infection Prevention & Control measures
- ✓ encourage and support ongoing innovation

Summary

With very low virus levels, active surveillance and rapid intensive response by our health protection team are now the highest priority in controlling and responding to any local outbreaks or clusters.

Levels of COVID-19 disease are continuing to fall steadily. National deaths data has now confirmed a continuing downward trend for the twelfth successive week. The seven-day rolling average deaths per day has effectively reached zero with only one death recorded in the 15 days 08-22 July, having been as high as 50 deaths every day in early May and 13 deaths per day at start of June. Daily test confirmed case numbers now average just below 20 for all Scotland (rolling seven-day average is now about 12 cases). This includes asymptomatic test positives identified through widespread screening of health and social care staff and patients.

There are currently no COVID-19 positive patients in FVRH and only 2 ITU cases in Scotland (at 23 July 2020). The cumulative number of confirmed COVID-19 inpatients that have been discharged has now reached 219.

National planning is now beginning to look at the potential changes in COVID-19 infections and transmission when colder weather drives more indoor contact. Concerns also exist around the combined effect of COVID-19 alongside seasonal influenza. NHS winter planning teams will assess and work to counter these potential risks. A number of national groups have been formed to begin this important preparatory work. NHS

Forth Valley is working to develop its response our winter plan, Pandemic Influenza Plan, System-wide Remobilisation Plan and COVID-19 Pandemic Framework to ensure we are prepared for winter.

Risk and Mitigation
There is a risk that NHS Forth Valley is unable to respond a future COVID-19 recurrence

NHS Forth Valley has taken steps to ensure it will have capacity and reserve in the event of a COVID-19 second wave, these include:

- ✓ continued timely access to appropriate PPE
- ✓ ongoing robust Infection Prevention & Control measures including physical distancing requirements
- ✓ community hub and assessment centre – primary care capacity
- ✓ acute site reconfiguration to ensure resilience by supporting co-location of services, alignment of medical and surgical specialties, development of new and improved pathways
- ✓ 7 ITU level 3 beds to support segregation and cohorting of patients with a further 10 level 2 and 2 level 1 beds, if required
- ✓ capacity to ventilate 28 patients
- ✓ supporting 'Test & Protect'
- ✓ access Louisa Jordan capacity, if required

3.3 Non COVID-19 urgent care

Outcome
Commit to supporting the National Screening Recovery Plan - Cervical, Bowel, Breast, Triple AAA, Diabetic Retinopathy

NHS Forth Valley will:

- ✓ continue to support the Screening Recovery Plan
- ✓ ensure local assessment of readiness is undertaken prior to each phase of recovery
- ✓ contribute to national and local messaging

Summary

NHS Forth Valley is working to follow the National Screening Recovery Plan and has moved into Stage 2 with work currently underway to ensure this stage is fully established.

Screening recommenced:

- ✓ Bowel Screening
- ✓ Breast Screening
- ✓ Cervical Screening

Diabetic Retinopathy Screening – It is anticipated that services will be re-established by the end of July

Abdominal Aortic Aneurysm – A number of issues in relation to room availability have been worked through with our Estates Team. It is estimated that we will be ready at the end of July at our Falkirk Community Hospital site and Clackmannanshire Community Healthcare Centre.

NHS Forth Valley will continue to engage in the national AAA and DRS screening programmes and will be guided by NHS NSS and NSD.

Risk and Mitigation

There is a risk that NHS Forth Valley will be unable to support the Screening Programme

NHS Forth Valley will take steps to:

- ✓ work with the NSD to inform prioritisation of highrisk screening participants
- ✓ continue to inform risk mitigation national discussions – i.e. to ensure access to local treatment capacity and ongoing capacity going into winter
- ✓ stabilise capacity to ensure programmes can be delivered in a timely manner

- ✓ **Appendix 3** Public Health Remobilisation Plan August 2020 to March 2021

3.4 Re-establish Primary Care Services

Outcome
Resume services based on 3 principles, namely: safety, clinical prioritisation and population need

NHS Forth Valley has:

- ✓ established a local recovery management team led by the Deputy Primary Care Medical Director to include acute interface representatives
- ✓ established a Triage and Assessment centre model flexible to demand with ability to scale up if required
- ✓ established a Care Home Assessment Response Team (CHART) providing flexible response to support care homes
- ✓ Cluster Plans in place for localised segregated response to any potential COVID-19 resurgence
- ✓ processes in place to support and protect shielding patients in line with guidance
- ✓ continued to update documentation – ACPs, KIS and ReSPECT
- ✓ maintained assessment and management of undifferentiated presentations to primary care practice - routine and urgent
- ✓ maintained the use of secondary care SCI - Gateway advice access and quick response times of this, avoiding referrals to secondary care
- ✓ National Pharmacy First is fully available across all community pharmacists with local Pharmacy First Extension Service (skin conditions and infections)
- ✓ with social distancing and infection control measures in place, all community pharmacies remain open providing core services
- ✓ maintained Treatment Rooms for essential face to face ambulatory appointments
- ✓ supported EETC model through three Emergency Eyecare Treatment Centres
- ✓ supported the phased approach to resuming dental services with Phase 1 in place
- ✓ community Optometry management of patients through telephone or video consultation
- ✓ clear pathways in place for onward referral to Independent Prescriber optometrists and a designated community pharmacy pathway
- ✓ worked to ensure that the flu vaccination programme is taken forward effectively in collaboration with the NHS Board (Plan approved by Board on 28 July)

Summary

As we move into the next phases of COVID-19, with small numbers of patients going through the triage hubs and assessment centres, activity is increasing across all areas of Primary Care. The number of services are increasing as is the general volume of activity. It should be noted also that primary care continue to provide the majority of resource to cover the triage hub (in close association with the OOH service) and the Community Assessment Centre (CAC) and the Care Home Assessment and Response Team (CHART).

We have established a local recovery management team led by the Deputy Primary Care Medical Director including acute interface representatives to oversee recovery.

3.4.1 General Practice

All Practices have maintained assessment and management of undifferentiated presentations to primary care.

Infection control measures such as reducing footfall through the practice and physical distancing within the waiting rooms has had a major impact on patient flow within practices. Practices are responding to this by increasing the number of consultations via telephone or Near Me, but still arranging face to face consultations where appropriate. There has been an increase in the use of the clinical mailbox to allow patients to send in photographs of skin lesions / rashes etc, to enhance the telephone consultation.

The wider uptake of Near Me is dependent on access to appropriate IT equipment and infrastructure, including webcams which have been in short supply nationally, but this highlights the need for a review and significant investment in IT solutions for primary care. This would also support remote working for GPs and practice staff and effective hub working for the Primary Care Improvement Teams. Both hardware and software solutions are required to make the most efficient use of both human and estate resource. A Primary Care IT Programme Board has been convened to take this forward as a priority.

Physical adaptations to the workplace have also been required to ensure practices are as safe as possible but there are also longstanding pressures on the physical infrastructure in practices, with a programme of works paused because of COVID-19. It is essential to resume theseworks as quickly as possible and to revisit the new needs of practices given the significant restrictions caused by new infection control measures. Some capital investment is being made to help meet some of these measures, especially in regard to floor coverings.

It is important, with the increasing numbers being seen in primary care, and the upcoming immunisation programmes for flu and potentially COVID-19 that the supply chain for PPE remains strong and responsive to need.

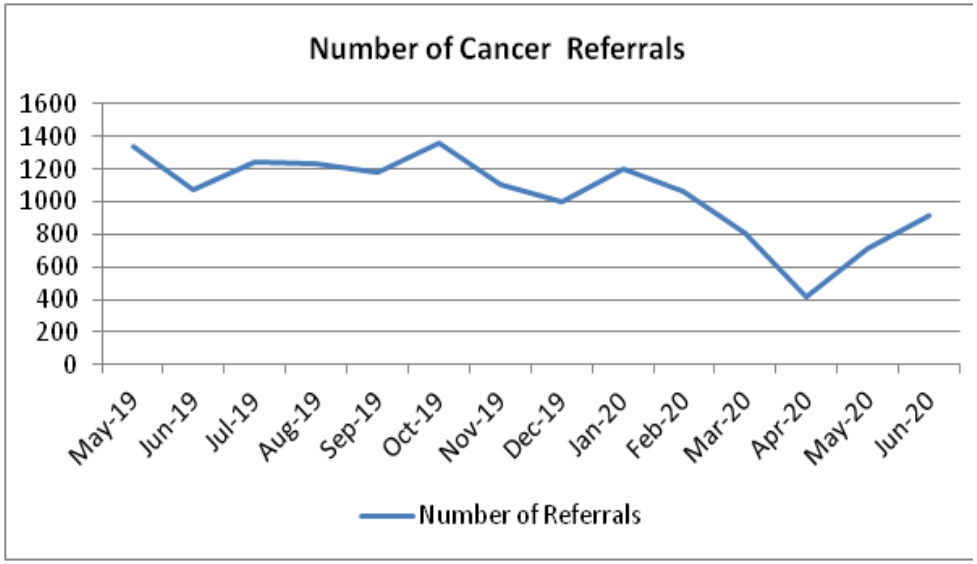
Other factors potentially impacting on the overall capacity within primary care going forward include sickness absence, self-isolation and shielding of practice staff, backlog of leave and understandable fatigue from the large and rapid response from primary care to new ways of working.

While general referrals have reduced, detailed in table 1, that is mainly due to reduced attendances at Practices. GPs are still referring, where appropriate, and the referrals have been ‘held’ within the system in secondary care. Cancer referral pathways, highlighted in chart 1, have not changed significantly, although in some cases further information is requested in order to allow risk stratification at the hospital, e.g. qFit to prioritise colonoscopy. Local media campaigns have highlighted the fact that practices as well as other primary care services including dentists, pharmacies and opticians are open, encouraging patients to contact if they have any concerning symptoms.

Table 1: Outpatient Referrals

Change in Referrals to NHS Forth Valley Acute Services New Outpatient Services March 2019 to June 2019 compared with March 20 to June 2020					
01 March to 29 February	March	April	May	June	prorata
2019-2020	8046	6274	9521	6701	30542
2020-2021	5221	1762	2750	3608	13341
Change	2825	4512	6771	3093	17201

Chart 1: Cancer Referrals



Chronic disease management is starting to recover, especially where this can be done remotely. This is being supported by the resumption of phlebotomy services and should allow a return to normal levels over the coming months. Assessment of lung function using spirometry will be one of the later investigations to be resumed and will be guided by advice from the Primary Care Respiratory Society and the Association for Respiratory Technology and Physiology.

Services such as joint injections and insertion of Long Acting Contraceptive devices such as coils and implants have restarted in some areas. The Diabetes Explained course has been redeveloped to be delivered online.

Cervical screening is resuming, in a phased manner, and AAA screening and Diabetic Retinopathy screening are resuming as per national guidelines.

Anticipatory Care Planning numbers increased rapidly because of the care home work and shielding, and will continue to be a priority. The safety of shielding patients remains a priority and an appropriate risk assessment is made before deciding on the most suitable place for a shielded patient to be seen. Work is ongoing to produce an electronic version of the RESPECT document as part of anticipatory care planning. The GP as expert medical generalist, should be leading the primary care MDT model to deliver care for patients with complex medical care needs as per the Memorandum of Understanding 2018.

There is an expectation that there will be an increase in primary care presentations as we return to a more usual way of working. Mild to moderate mental health presentations due to a combination of factors including health anxiety and socio-economic factors are likely to figure highly in increasing GP contacts. It is important that Primary Care and General Practice have a voice in developing services that allow access to evidence based treatments in a timely fashion for these patients.

Existing health inequalities may be exacerbated by both the economic impact of the pandemic and wider economic issues. Being a frontline service, General Practice is likely to bear the biggest burden from this. The interface with social services and third sector organisations is key to allow patients to be signposted to the appropriate available services. Close working with our colleagues across local Health and Social Care Partnerships is essential to ensure we can continue to deliver support within our communities and localities.

Workforce resilience is being supported by the provision of psychological and wellbeing tools that can be accessed by all staff. Access to rapid testing allows for minimal time off if staff or members of their household have symptoms.

There has been a significant increase in the numbers of specialties offering advice through the SCI gateway and there has been increasing use, especially as the responses have been turned around very quickly often within 24-48 hours.

GP clusters have been meeting remotely, with more regular meetings, often weekly in some areas, providing peer support and sharing ideas for new ways of working. They have developed escalation plans on a cluster as well as Practice basis. There is a wealth of primary care experience in the clusters that could be harnessed, through their extrinsic role, to interface with our colleagues in other areas to develop systems and pathways that work for patients and the wider community.

Interface working with our colleagues in acute will be crucial to delivering recovery plans. Good communication is key to ensuring a smooth journey for patients in the post-COVID-19 period, with clear delineation as to where responsibilities lie for ensuring undertaking of investigations, processing of results and subsequent delivery of treatment plans. Development of new pathways to allow delivery of quality care to patients while adhering to current infection control measures such as physical distancing should be designed end to end, with input from all stakeholders, otherwise we run the risk of creating new pressure points and points of potential failure. Some resource has been identified to support this and will be led by the Medical Director and the 2 Deputy Medical Directors for acute and primary care.

To help deliver this then it is important that we continue to develop the Forth Valley Primary Care Improvement Plan, in line with the direction of travel previously agreed. We have strong tri-partite engagement, ensuring that the programme of development continues at pace. We have increasingly well-developed services in various GP clusters across Forth Valley, with the plan to deliver the contract in full by April 2021. This should support sustainability of the Practices across Forth Valley, and allow GPs to spend more time with patients at most need.

It must be noted however that there are 2 areas that may impact on the deliverability of this:

- the recurrent funding shortfall that needs to be addressed to be able to fully support practices going forward
- the current lack of Primary Care IT infrastructure to fully support Near Me, remote working for GPs and Hub working to deliver cluster and Board-wide services

3.4.2 COVID-19 Workstream

The ongoing maintenance of the separate COVID-19 pathway via the triage hubs and CAC has also given some reassurance to those working in the non-COVID pathways, although they are ever mindful of the potential for asymptomatic COVID-19 patients. With the current primary care estate, especially in older premises, there are likely to be difficulties for some Practices to identify appropriate areas or flow to allow for adequate separation of Red and Green zones within the Practice, maintaining a separate COVID-19 pathway helps these Practices recover services more quickly and efficiently. However there continues to be low levels of COVID-19 in the system, and we have taken the opportunity to merge the CAC and CHART into one response team, flexible enough to respond to daily fluctuations in workload but smaller to allow more staff to return to core work in preparation for recovery. This is kept under ongoing review and other models will be assessed as dictated by workload, staffing and efficiencies. These could include cluster or practice-based models. These services are designed such that they can be stepped up again at short notice should there be a surge in demand. There is current funding identified up until September for this.

Thought has been given to how these teams and pathways may be adapted for different use in the future e.g. an urgent care home response team (Non-COVID)

3.4.3 Care Homes

GP Practices undertook to review their care home patients to ensure appropriate Anticipatory Care Plans (ACP). Key Information Summaries (KIS) and Adults with Incapacity (AWI) documentation was in place. This was supported by the Care Home Liaison Nurses (CHLN). The Care Home Assessment & Response Team (CHART) continues to provide support and we are now looking at how that model may be able to support Care Homes for non-COVID-related presentations going forward.

Close working with each of our Health & Social Care Partnerships has helped develop new pathways including step-up facilities and COVID-19 assessments. These developments are also informing a larger Hospital at Home model building on the work of the current Enhanced Community Team.

3.4.4 Optometry Services

NHS Forth Valley delivered an EETC model through three Emergency Eyecare Treatment Centres and Community Optometry continued to manage a large number of patients within the community through telephone or video consultation, advice and treatment including clear pathways for onward referral to Independent Prescriber optometrists and a designated community pharmacy pathway.

Emergency Eyecare Treatment Centres at Forth Valley Royal Hospital and Stirling Health and Care Village ceased to operate after 28th June 2020, with any patient requiring to see an optician for emergency/essential eyecare, now contacting a local optician from 29th June 2020.

By using additional SG funding, there should be an increase in the range of conditions seen in the community in line with the 'Recovery from COVID-19 for Eyecare in Forth Valley plan'. A range of eHealth initiatives have been implemented to assist with eye care and these need to be continued over the next few months e.g. Open Eyes, Emergency Care Summary, Near Me/Attend Anywhere and vCreate. The roll out of CAT20 is being supported across all practices to improve speed and connectivity of community optometry and NHS systems.

3.4.5 Dental Services

NHS Forth Valley continues to provide urgent dental care through the Public Dental Service (PDS) Urgent Dental Care Centres (UDCCs) at Clackmannanshire Community Healthcare Centre, Falkirk Community Hospital, and St Ninian's Health Centre, Stirling. We have expanded capacity in the UDCCs to increase the scope of treatments available to patients. UDCCs will move as soon as possible towards providing an expanded list of treatment for acute and essential care.

Although premises have been closed, NHS General Dental Practices have remained open to phone calls, and have continued to manage a large number of patients through telephone consultation, advice and treatment including clear pathways for onward referral to UDCCs for Aerosol Generating Procedures (AGPs).

Re-starting NHS General Dental Services

The Senior Dental Management Team continues to work with primary care towards restarting NHS dental services in practice. There are now two identifiable steps that link to the Phases 2 and 3 as described within the Scottish Governments route map:

- **Phase 2** From 22 June 2020 all NHS dental practices are permitted to re-open to see NHS patients for face-to-face consultation who are in need of urgent care, using non AGPs.
- **Phase 3** From 13 July 2020 face-to-face consultation can be expanded for patients that can be seen for routine care, including examination, and treatment that can also be provided using non-AGPs.

Introducing AGPs to Dental Practices

We envisage a limited introduction of AGPs to dental practices within Phase 4; this will be dependent on evidence of risk and possible mitigation.

The main focus at present is on a staged recovery as outlined above.

3.4.6 Community Pharmacy

Movement of Repeat Prescription from GP Practice to Community Pharmacy

A Roll out of Serial Prescription Approach has been agreed by the Pharmacotherapy Implementation Group and one cluster identified where serial prescriptions are already in place for a small number of patients. The work is on track. Furthermore, additional clusters have been identified as part of a phased roll out plan. The group has agreed an aim of 20% of those who receive a repeat prescription to be moved to serial prescription per GP practice.

NHS Pharmacy First Scotland Service

The Community Pharmacy Development Team and Pharmacy Champions will support the national roll out of the NHS Pharmacy First Scotland services in Forth Valley. The following actions have already been undertaken:

- Production of supporting documentation/checklist to aid pharmacy champion visits to brief Community Pharmacy Teams on service requirements
- Pharmacy champions briefed on new service and aware of requirements
- Scenarios prepared to aid training

The aim is to ensure Forth Valley community pharmacies are in a state of readiness when the service launches on 29 of July, and are aware of the requirements of the service. Our aim is for Community Pharmacies to start making changes to their daily practice prior to the service launch so new processes become embedded in daily practice for example recording activity. Where pharmacy champion visits are not possible due to physical distancing the Community Pharmacy Development Team will explore alternative solutions including video conferencing, online meetings and utilising email communications. The local Community Pharmacy website has been updated to include all local resources and to signpost to Community Pharmacy Scotland website for additional support materials.

Along with the national NES webinar a local MS Teams event has also been held to allow community pharmacies to ask questions regarding the new service and discussion implementation with peers. Following the launch on 29 July the pharmacy champions will be utilised to follow up with community pharmacies 2-4 weeks post launch to answer any outstanding questions or offer support/suggest new ways of working to ensure service implementation is successful.

3.4.7 Flu Vaccine Campaign 2020/21

The flu immunisation programme is recognised as a national and local priority. As a result of the COVID-19 pandemic, delivery of the programme this year will be particularly challenging due to guidance about physical distancing, managing patient flow, the need for PPE, shielding guidance, workforce availability, lack of space in practice premises, IT limitations and probable extension of the eligible population.

While the vast majority of the programme is reliant on General Practice the very significant increase in associated workload to deliver the programme is both challenging and could potentially impact on practices' ability to deliver other GMS.

Significant work is ongoing to ensure that the programme is taken forward effectively in collaboration with the NHS Board. To date planning has focussed on the risks and challenges of limited space in primary care premises, IT issues and identifying an additional workforce to support practices.

Solutions are being sought through commissioning external venues and considering innovative drive through immunisation delivery models. Work is also underway to scope out an additional clinical and administrative support workforce. It is also clear that successful delivery of the flu immunisation programme will have significant resource implications. The NHS Board approved the Flu Immunisation Plan at its 28 July meeting.

3.4.8 Treatment Rooms and Phlebotomy

Some treatment room services and phlebotomy have been retained during the pandemic but we are increasing the capacity to provide more phlebotomy and B12 injections to support recovery in primary care. We have also worked with acute services to pilot a phlebotomy hub in Falkirk which provides phlebotomy for both primary and secondary care services. This could provide a model for a shared phlebotomy service across Forth Valley, and could be adapted to include other investigations such as ECG and Blood Pressure.

Risk and Mitigation

There is a risk that NHS Forth Valley will be unable to meet a resurgence in primary care demand

NHS Forth Valley will:

- ✓ continue to work alongside primary care colleagues at a Practice and Cluster level to ensure we have capacity to meet demand

- ✓ support ongoing interface (primary/secondary care) ways of working to improve referral management
- ✓ promote a realistic medicine approach to support patient choice
- ✓ look to support social prescribing to help people self-manage long term conditions
- ✓ continue to support the implementation of the Primary Care Improvement Plan and the MOU/GMS contract negotiations
- ✓ expand remote consultation using telephone triage and Near Me
- ✓ increase access to treatment room and phlebotomy services

- ✓ **Appendix 4** Primary Care Remobilisation Plan Tracker August 2020 to March 2021

- ✓ **Appendix 5** Expansion of Shared Essential Care beyond Emergency New Appointments in COVID-19 Recovery

3.5 Re-establishing Elective (Hospital) Care Services

Outcome
Resume services based on 3 principles, namely: safety, clinical prioritisation and population need

NHS Forth Valley has:

- ✓ established a scheduled care delivery group with operational management for scheduled care and waiting times management
- ✓ developed/agreed clear clinical prioritisation protocols to reflect local and national needs
- ✓ assessed surgical workload to include deferred/backlog cases pre COVID-19 and new referrals since lockdown with this work ongoing
- ✓ reviewed all waiting lists including diagnostics adopting a realistic medicine approach to inform patient choice
- ✓ commenced reconfiguration of services on acute site to segregate COVID-19 and non-COVID-19 admissions
- ✓ expanded remote consultation across all acute specialties using telephone triage and Near Me
- ✓ utilised digital and treatment innovations with work continuing
- ✓ worked with regional colleagues in the West Region to inform our local and regional cancer remobilisation plans

Summary

In March 2020 the NHS Forth Valley Acute Services Directorate responded to the COVID-19 Pandemic by suspending non-urgent surgery, planned outpatient and diagnostic services. Urgent and cancer treatment continued based on clinical prioritisation and risk stratification, to support the NHS Board and Scottish Government Health Department approach to COVID-19. Since then Forth Valley Royal Hospital has transformed its service delivery to adapt to the challenges faced from COVID-19 and the potential for severe impact to the Forth Valley communities. As part of the ongoing recovery planning a scheduled care recovery framework has been developed to both strategically plan and operationally manage recovery and resumption of scheduled care activity.

Comparing the period March 2019 to 30 June 2019 with the same period during the scheduled care COVID-19 pause there was a 56% reduction in the number of referrals for outpatient appointments and a 58% reduction in the number of patient referrals to be added to the treatment list. The effect of this reduction in demand is that the waiting list sizes have remained stable but waiting times have increased.

NHS Forth Valley remains committed to addressing the cases that have built up since pre-COVID-19, however this needs to be safely managed using a clinically led risk-based prioritisation approach. We have begun to systematically adopt specific Scottish Access Collaborative interventions in our remobilisation plan. This has already included waiting list validation and we have extended Active Clinical Referral Triage, Patient Initiated Reviews and Effective Quality Interventions Pathways. Working with the Independent Sector and Golden Jubilee National Hospital (GJNH) to increase our capacity will help address our waiting times challenges. Use of the Independent Sector will reduce as capacity in GJNH is stepped up and the Louisa Jordan Hospital becomes available to us to deliver outpatient clinics and diagnostic tests, as required.

The current waiting times position is highlighted in table 2.

Table 2

Summary Table

	End Mar-20	29 Jul-20
IP/DC Total waiting	2,914	3,213
IP/DC > 12 weeks	1,026	2,497
OP Total Waiting	11,686	13,248
OP > 12 weeks	2,315	8,271

Our activity projections are detailed in Appendix 3a with table 3 detailing new outpatient activity projections up to the quarter ending March 2021. Table 4 highlights projection for the same time period in respect of Treatment Time Guarantee activity.

Table 3

New Outpatient (12 Week Standard) Activity Projections		Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021
All Specialties	Urgent	1669	4380	4380	4824
	Routine	2897	6672	6734	7413

Table 4

TTG Activity Projections		Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021
All Specialties	Urgent	187	504	470	519
	Routine	568	1530	1409	1557

As part of the approach to remobilising for planned care, the benefit of taking a consistent national approach to clinical prioritisation for elective activity has been acknowledged, while allowing for flexibility to reflect local circumstances. It is intended to ensure available capacity is used to treat those with the most urgent clinical need and that the approach taken is consistent across the country. It also reflects demand that has been built-up and the impact that working within COVID-19 safe protocols will have on productivity levels in theatres. The proposed approach follows recent guidance published by a number of Royal Colleges and other professional groups. Adopting this approach, the expectation is that all Category P1 patients should be seen within the timescales set out, in order to avoid potential patient harm.

NHS Forth Valley's initial assessment of P1, 1a (emergency - operation needed within 24 hours) and 1b (urgent – operation needed within 72 hours) capacity used and P2, P3 and P4 category patients waiting is detailed in Appendix 3b and noted in table 5.

Table 5

P1 Capacity and TTG Total Waiting List (all specialties, on-going waits)	
Clinical Priorities	As at 31/07/2020
P1 (% capacity used)	26%
P2 (number waiting)	52
P3 (number waiting)	300
P4 (number waiting)	2,948

3.5.1 Hospital Services

Elective surgery being suspended was seen as a logical and necessary response to COVID-19 however The Royal Colleges highlighted a decline in hospital presentations/admissions, ITU occupancy during the pandemic and all NHS Boards are now considering how best to build on the initial resumption of acute including surgical activity, in line with national guidance. The Acute Services Directorate has resumed surgical activity although capacity has been reduced by the need for physical distancing and additional infection control measures.

Work to deliver as many of our services as possible, as safely as possible is well underway informed by good levels of clinical engagement. To ensure the benefits of the new models of care invoked during the pandemic are utilised, a programme of work is underway to model what the service demand and capacity in terms of virtual (ARCT, Near Me, telephone) and face to face appointments would look like. This will enable the mapping of OPD capacity to the needs of the service. Scheduling software has been purchased to support this programme of work and is being rolled out with the support of e-health. As part of this demand and capacity modelling, consideration will be taken around the offer of support from other facilities including the GJNH and the NHS Louisa Jordan. There are a number of regional groups currently working to understand the overall capacity and what mutual aid may be required as progress through remobilisation.

To accommodate challenges in bed configuration for COVID-19 response and to provide bed capacity for parallel programmes, such as, the national elective unit, specialist rehab services and regional working a programme of site reconfiguration is underway. The reconfiguration will work to provide capacity for a potential future surge of COVID-19 including increased capacity of ITU facilities, establish an integrated Surgical Assessment & Speciality Admissions Unit, facilitate the planned move of tier 3 & 4 vascular patients to Glasgow, develop a Specialist Rehabilitation Unit as well as provide inpatient beds for the national elective care programme.

With the reduction in demand and activity the outpatient and inpatient waiting lists have remained stable but waiting times have increased significantly. As part of recovery planning accelerating enablers within the services to address waiting times have been progressed, these include

Patient Hub, Bookwise and Patient Initiated Review (PIR). The team will progress PIR as an action throughout August to support the site going into winter.

3.5.2 Cancer Services

Urgent suspected cancer activity has been maintained throughout mobilisation by utilising both in house and independent sector facilities. We have robust monitoring in place and are tracking those additions to our 31 day and 62 cancer pathways linking with the cancer team at the Scottish Government on a weekly basis.

3.5.3 Diagnostics

Imaging and endoscopy services were significantly reduced as a result of the COVID-19 pandemic however focussed recovery work has supported a reduction in the number waiting beyond 42 days.

Endoscopy

Due to the aerosol generation of upper GI endoscopy, this has had a significant impact on overall delivery of this component of the endoscopy service. Planning within this service now includes trans nasal endoscopy which will allow the service flexibility in diagnosis and treatment for patients. Clinical Leads for the service are working on the potential implementation of Cytosponge as a further development within the service.

Colonoscopy services resumed as part of cycle one recovery. Patients have been identified as priority using Qfit results and listed appropriately. Colon Capsule Endoscopy is one of the Scottish Government Programmes that that the team are currently working in partnership with for implementation – this is expected to begin in October 2020.

Imaging

Although radiology has had a reduction in demand, their early resumption plan, taking into consideration all PPE requirements and the need for additional cleaning of imaging equipment and waiting areas, has facilitated a reduction in the number of patients waiting over 6 weeks. There is a notable decrease in the number of patients waiting over 42 days from 632 patients in April 2020 to 89 patients in June 2020.

3.5.4 Outpatients

During COVID-19 mobilisation the outpatients department was able to maintain urgent outpatient capacity, whilst also supporting acute clinical assessment. As we have continued to resume services and more routine care is restored, there has been a 20% reduction in physical space due to physical distancing. To combat this, a MDT was set up to review outpatient allocation and resourcing. The outputs from this group are that there

is a greater requirement to manage outpatient flow more effectively, whilst also providing the same level of outpatient consultations pre-COVID-19. To manage this, the team has developed local protocols and procedures and have extended the waiting room into the main hospital atrium to comply with physical distancing requirements. To further enhance the capacity within OPD, there is an increasing need to harness new technologies to support effective management of outpatients.

3.5.5 Inpatients and daycases

Ensuring agility to flex elective services, two weekly cycles of recovery delivery have been established, these allow for flexibility to introduce both urgent and routine elective care capacity whilst maintaining cancer services. These recovery cycles allow for rapid suspension of services should a surge of COVID-19 occur. However, this challenges services in regard to intensity of workload.

3.5.6 Inpatient Surge Capacity and overall responsiveness

A robust model is in place to maintain inpatient ward capacity for both COVID-19 and non-COVID admissions with planning assumptions taking further surges in COVID-19 or seasonal outbreaks during winter into consideration; the key trigger being acuity and bed occupancy reaching levels that impact whole system capacity and flow. In addition, the model allows for phased increase of high-risk capacity as required.

Plans are in place to accommodate the changing landscape of arrangements for testing and isolating patients with confirmed or suspected COVID-19, in addition to meeting the requirements to protect patients identified as high-risk and patients over 70 who require regular screening. The system will remain flexible to be able to meet any further additional requirements, around screening, testing and safe placement of patients.

3.5.7 Resuming Priority Services

The Acute Services Directorate is implementing their delivery plan for the resumption of priority services. This implementation plan encompasses both strategic and operational intelligence on the benefits realisation of resuming priority services. Baseline strategic service intelligence data has been captured and synthesised into clear operational recovery plans at a service level. These recovery and resumption plans, in conjunction with the clinical prioritisation framework will allow clinical services to expand their remit from their maintenance of urgent care pathways to the inclusion of more routine pathways. The recommencement of national screening programmes has not been factored into the Acute Services Remobilisation Plan; however, collaboration with NSS and work with our screening coordinator will guide the continued reintroduction of these programmes aligned to the National Screening Recovery Plan.

This model will be supported by analytical data that allows for both capacity and demand to be modelled on an ongoing basis in line with new measures on physical distancing and governmental guidance. In addition to this a clinical prioritisation approach based on the guidance from the relevant Royal Colleges and professional bodies presents the potential opportunity to encompass the principles of realistic medicine, following a

person centred approach to clinical treatment, treating those cases first that are most urgent and ensuring that activity levels are aligned with available space, systems, staff and stuff (PPE, medicines, equipment, and consumables).

3.5.7 Emergency Care

Our current unscheduled care system can sometimes be complicated to negotiate however recent challenges have provided opportunities for unscheduled care services to evolve and adapt beyond the initial COVID-19 mobilisation phase to provide safe and effective care for patients consistent with the national direction.

It is key that Unscheduled Care workstreams are structured to reflect this changed context. The NHS Forth Valley & HSCP's Unscheduled Care Group agreed that the Forth Valley approach moving into winter will therefore blend:

- Existing workstreams from 6EA and Getting ForthRight that are still pertinent, post COVID-19. This includes aspects of front door redesign and community-based admission prevention model
- The changes in Unscheduled Care necessitated by COVID-19 response. This includes triaging and redirection successes, Minor Injuries scale up and redesign of Geriatrician service
- The national directions for a Flow Management Centre and new unscheduled care pathways and approaches with the infrastructure these will require
- Support for General Practice and community resources who will revert to a pre-Covid Unscheduled Care pathway model, as per national direction

The number of people presenting to ED during the COVID-19 pandemic has been significantly reduced compared to usual levels. As the population moves out of lockdown presentations to ED are rising. If demand continues to rise to pre COVID-19 levels there will be challenges, including sufficient space, to continue to have both COVID-19 positive and negative pathways and zones, to maintain physical distancing and ensure minimum risk of nosocomial infections.

As such, there is a clear imperative to develop a safe, sustainable model. Fortunately, during the first phase of mobilisation, people became much more familiar using telephone and electronic forms of communication. Therefore, it is proposed that in order to mitigate the demand and access challenges, three key areas of work in relation to – triage models, capacity within urgent unscheduled care services, maintaining flow - will be progressed as NHS Forth Valley Unscheduled Care services re-mobilise, recover and re-design, blending elements of previous and new workstreams.

- ✓ **Appendix 6** Acute Services Directorate Next Phase August 2020 to March 2021
- ✓ **Appendix 6a** Activity Projections to quarter ending March 20210
- ✓ **Appendix 6b** Clinical Prioritisation template

Risk and Mitigation

There is a risk that NHS Forth Valley will be unable to address the pre COVID-19 backlog and new elective demand post COVID-19

NHS Forth Valley will:

- ✓ access Golden Jubilee National Hospital capacity
- ✓ work alongside the independent sector (IS) to maximise internal and IS capacity to address long waits based on Royal College surgical prioritisation criteria
- ✓ expand hospital capacity to include scheduling modifications (e.g. working day/7 day working)
- ✓ access Louisa Jordan capacity if required
- ✓ maintain a scheduled approach to urgent care presentations

3.6 Re-establishing Community Care

Outcome

Resume services based on 3 principles, namely: safety, clinical prioritisation and population need

3.6.1 Mental Health

Throughout the COVID-19 response, Mental Health & Learning Disability Services have operated to a single mobilisation plan to ensure consistency. Although part of the Women's & Children's Directorate Child & Adolescent Mental Health Services there has been close engagement between Child & Adolescent Mental Health Services and adult Mental Health & Learning Disability Services.

Access to urgent & emergency care services were recognised as a clinical priority from the outset and were maintained throughout. Some community staff were initially redeployed to these areas. This ensured that inpatient services were fully supported.

NHS Forth Valley has continued to provide:

- ✓ assessment and treatment for people with drug and alcohol issues
- ✓ urgent assessments of new patients referred to Mental Health & Learning Disability services by primary care
- ✓ Emergency Mental Health Act Assessments in the community
- ✓ assertive outreach with patients already known to Mental Health & Learning Disability services who are at significant risk of harm to themselves
- ✓ follow up of patients recently discharged from Mental Health & Learning Disability inpatient units
- ✓ depot administration
- ✓ Clozapine clinics
- ✓ regular contact with patients identified as high risk and requiring ongoing input
- ✓ treatment of patients whose psychological difficulties, if left unmanaged, are likely to result in increased use of inpatient services or emergency outpatient services across the Health Board
- ✓ reviews of patients subject to the Mental Health Act

Mental Health Leads (managers and clinicians) have been working collaboratively with colleagues noting the interdependency between primary and secondary (acute hospital) care services. In order to support the functioning of the acute hospital, the Mental Health Assessment and Treatment Service (MHAATS) redesigned their model of service delivery to the Emergency Department (ED). MHAATS began triaging people who attended ED with a psychiatric complaint. This meant that these patients were redirected from ED to the Mental Health Unit, located nearby.

It is widely predicted that there will be an increase in demand for mental health support, including in our staff, as a result of the impact of COVID-19. Admissions to the Mental Health Unit have been around 30% above what would be expected when compared against last year, and this alone creates significant additional demand, not only during the period of admission, but also in the community upon discharge. Although community referrals have been reduced recently, they are now starting to increase.

It is anticipated therefore that Mental Health & Learning Disability services will not only have to manage existing demand in the form of the care of people who have had their usual treatment interrupted by the response COVID-19, but also respond to significantly increased future demand. This is all in the context of sizeable pre-COVID-19 waiting lists for some specialties e.g. psychological therapies. In order to manage this demand, Mental Health & Learning Disability services are in the process of developing and embedding several clinical initiatives and revised models of care.

Use of eHealth

Near Me has been used very successfully within Mental Health & Learning Disability services, and will continue to play a key role in service delivery. The availability of online Cognitive Behavioural Therapy (CBT) packages have also been expanded, with the existing package for

depression (Beating the Blues) being augmented by new packages for health anxiety and anxiety/low mood associated with several long term health conditions, including chronic pain and diabetes. The Scottish Government has funded a trial of the use of individualised online CBT, which will be offered to appropriate patients who are currently waiting for individual psychological therapy. This is in the process of being rolled out in Forth Valley. Finally, the mental health pages of NHS Forth Valley's website are being reviewed, and will host links to a variety of clinically approved self-help resources available for open public access.

Waiting List Validation/Patient Preference Exercise

Within Psychological Services there is a large pre-existing waiting list for a number of therapies, and as routine new assessments have been suspended this list has grown steadily. In order to ascertain the current status of those patients who have been waiting longest, patients at the top of the existing waiting list are being contacted by a clinician. The ensuing discussion is intended to establish whether or not the patient still wishes to be seen, and whether or not a remote treatment method would be appropriate. This will ensure that when routine assessment appointments are reintroduced from 3 August onwards, they are offered to those most likely to benefit.

Clinical Pathways

It is clear that no single profession, service or organisation will be sufficient, or indeed appropriate, to fully meet the mental health needs of the people of Forth Valley. In order to deliver fully integrated care, the development of clear pathways of care for common mental health difficulties is required. Initial consultation and scoping work across primary care, secondary care and the Health & Social Care Partnerships indicated five areas where clinical pathways could bring significant benefit: depression, anxiety disorders, dementia, emotional instability and drug & alcohol issues. QI support is being requested to support this work to be taken forward rapidly.

- ✓ **Appendix 7** Mental Health and Learning Disability Services Remobilisation Plan August 2020 to March 2021

3.6.2 Health & Social Care Partnerships

NHS Forth Valley continues to work with its two Partnerships and three Local Authorities as part of local resilience partnership arrangements to support our most vulnerable people and communities and to enhance and maximise the benefits of integration. There is agreement across Forth Valley to deliver whole system planning aligning Health & Social Care Strategic Commissioning Plans and joint activity.

In regard to health and social care services work is advanced in both of our Partnerships to respond to:

- anticipated ongoing significant increases in demand and complexity of care in the community (at home and for people rehabilitating from COVID-19) and community intermediate care and community hospital facilities
- delayed discharges within our health system and work to discharge all acute delayed discharges and at least 95% of people currently delayed in our community and mental health beds continues
- Care Home Support and implementing the enhanced care home assurance system, including the enhanced clinical and professional care oversight of care homes, is well established in Forth Valley and a number of innovative ways of working across primary and secondary care supported by public health have emerged and are being supported

3.6.3 Falkirk Health and Social Care Partnership (HSCP)

Falkirk's Integration Joint Board's existing delivery plan is particularly relevant in terms of next phase COVID-19 planning and it is recognised that our ability to remobilise, recover and redesign will require a number of our existing delivery plan actions to be brought forward at pace. A whole system approach is critical in order to address inequality and strengthen community-based care through improved care pathways, review of the community bed base and shifting the balance of care.

The Partnership will remobilise and recover key services aligned to the COVID-19 route map, as it is safe to do so with physical distancing and Infection Prevention & Control requirements, taking the opportunity to review and redesign services for post COVID-19 delivery.

The H&SCP recovery and redesign is framed in the key priority actions where we can:

- accelerate integration
- sustain new models of care where they have proved effective
- redesign services/ alternatives (for example day services) to meet individual needs and safe distancing requirements
- review how we can accelerate the shift in the balance of care to extend community-based support for people to stay at home longer and support carers
- continue to develop and build support and assurance model for care homes
- review community bed base across our whole system
- review of care homes
- progress the review of community bed-based care and care at home
- build on the COVID-19 'supporting communities' work to develop locality working

✓ **Appendix 8** Falkirk Health & Social Care Partnership Remobilisation Plan August 2020 to March 2021

3.6.4 Clackmannanshire & Stirling Health and Social Care Partnership (HSCP)

The fundamental principles driving the Clackmannanshire & Stirling HSCP approach to recovery are the vision and strategic priorities of the HSCP Strategic Plan 2019 – 2022 which continue to be as relevant to the planning and delivery of health and social care services during remobilisation as they were before the COVID-19 outbreak.

Whilst the scale and pace of innovation and service transformation has been necessarily accelerated by the requirement to respond to the pandemic, any changes to services and service models reflect and complement the vision and priorities laid out in the Strategic Plan and do not constitute a shift in the strategic direction of the HSCP. That is to say, there continues to be a commitment to move to more services being provided in the community, closer to home and a focus on prevention, improving life expectancy and promoting physical and mental health, and supporting people to live healthy lives.

As lockdown eases and services are remobilised across the public, third and independent sector, as a HSCP there is a need to understand the long-term impact and keep under constant review the changes applied, collecting feedback from relevant stakeholders to inform ongoing recovery and planning for the future.

Through remobilisation activity the HSCP seeks to harness, identify and support innovation and embrace new approaches and ways of working. In doing so, the HSCP will promote and advance local integration to meet individual needs and renew to a better health and social care system.

- ✓ **Appendix 9** Clackmannanshire & Stirling Health & Social Care Partnership Remobilisation Plan August 2020 to March 2021

3.6.5 Allied Health Professions

- ✓ **Appendix 10** Allied Health Professions Remobilisation Plan August 2020 to March 2021

3.6.6 Women & Children's Services

Directorate has taken a phased approach to restarting services in line with Scottish Government guidance and in compliance with the Roadmap to recovery. Currently the Directorate is working within Phase 2 but planning for schools returning in Phase 3. It is anticipated that there may be

some changes, to allow the recovery of activity which has been stopped as a result of the COVID-19 pandemic. As part of this recovery, it is understood that services will resume but may be organised differently with a greater emphasis on utilising technology. The shape of some services will be influenced by local decision making and planning and some mandated by national directives.

Table 6: Summary detail of services

Service area	Current status	Exceptions/Unable to restart	Comments
Inpatient Maternity Services/ Community Maternity Services	Minor adjustments made-near normal service delivery	Group Parent Education sessions suspended	Directed by national framework for maternity services
Gynaecology Inpatient Services	Minor adjustments made-near normal service delivery		Cancer Inpatient/outpatient care, TOP and EPAS have been prioritised throughout
Gynaecology Outpatient Services	Measured recommencement of routine services.	Smear services will restart before end of July Sub-fertility services dependent on tertiary services	Increase in use of Near me to support all services. Active clinical triage being undertaken. Adjustments required to waiting areas and clinic lists
Paediatric Inpatient Service	Minor adjustments made-near normal service delivery		
Community Children's Nursing (CCN) Service	Adjustments made-near normal service delivery		Less home visits/increased use of Near Me
Paediatric Diabetic Service	Adjustments made-near normal service delivery		increase telephone clinics and drive through HBA1C testing
Paediatric Outpatients Services		Suspension of non-urgent paediatric new and FU appointments and outreach speciality clinics	
Paediatric Day Care	Services restarting on risk assessed basis	Suspension of no- urgent phlebotomy, scheduled surgery, dental surgery, tongue tie service skin prick testing, botox service, food challenges, pre op service and diagnostic investigations	Adjustments required to waiting areas and clinic lists

Paediatric Community	Services restarting on risk assessed basis	ASD/NDD assessments, national guidance awaited.	Adjustments required to community waiting areas and clinic lists
Sexual Health Services	Adjustments made to prioritise according to risk/routine services restarting	Routine sexual health screens, vaccinations,	Adjustments required to community waiting areas and clinic lists
Children's AHP Services*	Adjustments made to prioritise according to risk/routine services restarting prioritise those waiting the longest	Groupwork programmes and work with parents Re-starting services has been challenging due to lack of available community accommodation	Directed by national framework. Adjustments required to community waiting areas and clinic lists. As many AHPs work within education establishments further partnership discussion need to support therapists returning
Child Protection	Minor adjustments made-near normal service delivery	Face to face child protection learning and development is suspended Face to face supervision has also been suspended	Multi agency meetings and quality assurance work has been reduced and/or adapted Service are looking at how they can further use and develop use of IT platforms/solutions.
CAMHS (see below for indepth report)	Adjustments made to prioritise according to risk/routine services restarting prioritise those waiting the longest	Group work programmes. ASD/NDD assessments, national guidance awaited	High take up of Near Me (second highest in health board) which would be even greater if service had access to additional IT equipment. Adjustments required to waiting areas and clinic lists.
Universal Services-Health Visiting, SN & Family Nurse Partnership (F)*	Minor adjustments made-near normal service delivery	Additional risk assessments required if families decline routine visits	Directed by national framework
Immunisation*	Pre-school immunisation/HPV programme continuing as normal	Re-starting services has been challenged due to lack of available community accommodation	

Women & Children's Services are keen to build on early practice-based evidence identifying improvement and efficiencies in care and treatment pathways. All services have attempted to embed mediation against the impact of lockdown on our patients and families balancing this against the need to continue to adapt clinical areas however projections and models of care need to be refined with work ongoing.

- ✓ Work stream 4 highlighted in **Appendix 3** Acute Services Directorate Next Phase August 2020 to March 2021 details Women & Children's Services remobilisation

Risk and Mitigation

There is a risk that NHS Forth Valley will be unable to re-establish community services in response to population need

NHS Forth Valley will:

- ✓ focus on improved population health and wellbeing
- ✓ work with partners to address health inequalities
- ✓ continue to invest in prevention and community-based support and interventions
- ✓ recognise and support early intervention in response to mental illness
- ✓ pay attention to non-COVID-19 related harm and in particular public protection issues such as child and adult protection and domestic abuse
- ✓ strengthen relationship-based approaches
- ✓ develop and co-produce with staff, partners and the public new ways of working that are routed in National Performance Framework outcomes
- ✓ continue to promote and accelerate innovation and reform that deliver better outcomes for the people of Forth Valley

SECTION 4: FINANCE

Financial sustainability is a key feature in planning remobilisation and our Mobilisation Recovery Programme Board chaired by the Chief Executive will set direction and drive positive change and promote innovation, recognising there are some historic ways of working which may no longer be appropriate in the new context. It is anticipated that proposals for service change with clear financial implications will be developed through that group to harness opportunities for more efficient and effective ways of working and to maximise value alongside patient safety. One example will be a review in investment in our digital infrastructure to accelerate remote virtual consultations for patients, where appropriate, to deliver sustainable financial and quality improvements.

It is expected that variable costs for supplies, theatre consumables and diagnostic services will increase in line with the phased reintroduction of non-urgent clinical services and that expenditure trends in these areas will largely revert to historic levels by October 2020.

There are a number of new requirements to ensure staff and patient safety measures which are expected to give rise to increase in future spending and these continue to be worked up in detail to fully quantify implications. These include

- physical distancing requirements which impact on available capacity
- maintaining enhanced infection control measures in place, including support for care homes
- ongoing testing arrangements and contact tracing
- ensuring that our workforce is adequately supported in terms of PPE and their wellbeing
- deliver consistent approaches to unscheduled care and the associated workforce requirements, in line with national direction
- costs associated with immunisation and vaccination over the winter period
- any future change in COVID-19 infection rates which necessitate additional ICU and ward capacity for a period of time

We will also continue to identify longer term service delivery models which optimise the use of our resources in primary care and community settings with a focus on prevention and early intervention and which harness the opportunities from health and social care integration.

SECTION 5: WEST OF SCOTLAND REGIONAL PLANNING

Context

The challenge of COVID-19 pandemic is and will continue to pose challenges to the NHS over the coming weeks and months.. As such the NHS will continue to work focus on stratifying care to help avoid loss of life and minimise harm to patients who have urgent and ongoing health care needs as well as finding wasy 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.

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 the in phase 2 mobilisation plans where the most important priority identified by the Medical and Nurse Directors going forward was tobuild on the approaches developed during the pandemic to manage unscheduled care in a more planned and consistent way..

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.

The potential safety gains of a more planned, consistent and managed approach to unscheduled care attendance to any healthcare setting will be significant by avoiding overcrowding and unnecessary face to face contact and may play an important factor in mitigating or reducing winter pressures generally and any additional COVID-19 pressures that emerge in the future.

Cancer and Scheduled Care

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

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

It is recognised as surgery services increasingly enter into the recovery phase in the coming weeks and months there will be competing demands from various surgical specialties to gain access to a limited surgery resource. Each of the NHS 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 NHS 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 NHS 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 NHS Board areas seeing a higher level of COVID-19 admissions are not unfairly disadvantaged.

Setting the Collective Response

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

Our aim is to gradually and safely, increase the level of services provided for our population, building on our mutual aid agreement to provide the best level of service across the region whilst continuing to ensure outcomes from other life limiting or life-threatening conditions is not impacted. In doing this we will also work with our partner agencies particularly SAS, NHS 24 and the NHS GJNH 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 NHS 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 beginning of the pandemic 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) A potential second wave is greater than the first and there is full implementation of the critical care network plans and NHS Louisa Jordan is required to provide the support envisaged at the time of initial commissioning.

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

Recognising the uncertainty the NHS is facing, and in response to the above positions, under our commitment to supporting mutual aid across the region, a number of cross board approaches have been developed. This has involved working collectively to set out the direction for unscheduled and cancer and scheduled care across the region supported by the establishment of a number of networks within the region, which are outlined in this paper. Supporting papers, setting out the detail of the working arrangements, are available. Within these documents the escalation approach is described and the expectation of support from NHS GJNH and from NHS Louisa Jordan.

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 early stages of the pandemic. Both of these networks are supported by the Regional Planning Team.

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

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

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

- maintain business critical services
- maintain emergency care pathway
- support major incident response
- 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 Louisa Jordan in line with the position issued nationally during the early stages of the pandemic.

West of Scotland Critical Care Network

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

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

When a strong regional response is required calls are scheduled for 1.30pm daily unless otherwise agreed by the co-chairs in discussion with WoS Board representatives. If occupancy in the 12 general ICUs is less than 140% of baseline and 80 or more staffed beds are available on a Friday

then weekend calls are not be undertaken. However, the information is still collated and shared across the region. The network chairs review the information and contact ICUs if there is a significant deterioration in capacity.

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

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

Regional Cancer Prioritisation, Scheduled Care and Diagnostics

Building on the work undertaken in the early stages of the pandemic by the specialty specific groups through the MCNs and MDTs to review their approaches to treatment and prioritisation to reflect this new and additional risk the local clinical prioritisation groups in NHS Boards will link with the Regional Clinical Prioritisation Group which has been established. This involves both senior clinical leaders and senior manager involved in managing cancer and access programmes in each Board across the region.

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

The purpose of this group is to monitor performance against the approved framework and plan appropriate regional working where a risk has been determined. NHS 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 NHS Boards within the network.

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

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

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

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

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

Summary of Potential Mutual Aid

Table 7 summarising the levels of potential support at each stage

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

Mitigating Risks and Rate Limiting Factors

Recognising we are managing a situation where COVID19 is likely to remain for the foreseeable future it means that we may face a number of ongoing service challenges. This requires us to have the agility and flexibility to support care for the most critical patients at any time and this may require a greater level of cross board working than we have required to date.

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

Key to this are:

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

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

- Ongoing education and training of staff will be required to maintain and enhance the wider team development, working to cope with the increase in clinical activity in the critical care areas, and beyond (e.g. early CPAP in ward areas). Consideration of critical care nursing skills becoming more generic within the workforce would also be beneficial.

- Being clear about the PPE requirement and supplies availability to support acute/ critical care as well as elective activity especially as we increase our endoscopy capacity where there is a heavy requirement for PPE- visors and gowns.

- Recognising the importance of pharmacy and medical supplies to all aspects of patient care covered in this paper it is important that consideration is given to how the pharmacy teams work together to support the necessary input to patient care, particularly in areas where there is a small cohort with specialist knowledge and skills such as for critical care.

To prepare for any further potential surges in COVID-19 activity across the region medicine supplies require to be coordinated centrally as Boards will reintroduce services at varying levels. This needs to consider NHS Boards reporting medicine supply levels and potential related planned activity to a central point. A list of the most commonly used drugs and level of stockpile agreed in terms of quantity, location and access to ensure if scenario 5 comes about there is sufficient stock 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.

SECTION 6: WORKING TOGETHER TO REMOBILISE, RECOVER AND REBUILD A BETTER HEALTH & CARE SYSTEM

Health and social care systems need to be thoughtful about how they play a bigger role as part of a community planning response that integrates economic, social, physical and environmental ambitions whilst using technology to help us do things very differently as we live alongside this virus for the foreseeable future. We acknowledge there is no blueprint we can turn to for answers and we also know the status quo is neither realistic nor viable. Public services that are robust and sustainable with an eye to the National Performance Framework (NPF) outcomes and Best Value will be a key requisite for socio-economic recovery locally, regionally and nationally. NHS Forth Valley is keen to play a key role in: driving transformation with partners to address health inequalities, addressing the backlog in our system and preparing for a winter that is likely to be challenging. The work of NHS Forth Valley and its role within Community Planning Partnerships is central to supporting achievement of these outcomes. This is realised through participation in the development, design and delivery of local improvement plans and locality plans as well as in their review, revision and reporting.

The NHS Board Chair and Chief Executive has set up a series of meetings with Local Authority Leaders and Chief Executives, the first meeting was to explore opportunities to how we created conditions to enhance how we work collaboratively to build sustainable and affordable public sector services to achieve our individual and collective transformation ambitions.

NHS Forth Valley during this period of recovery has recognised the sacrifices and successes of our health and care response to COVID-19 including the significant achievements implemented at pace. There is an opportunity to rebuild our local services to meet the physical, social and

mental health needs of our communities affected by significant economic and social disruption and to reset our future ambitions for what our health and care system should look like in the short, medium and longer term. This Plan builds on the conversation with our staff and partners as we look to ensure that their health and wellbeing is protected as we look resume services safely.