EAST AYRSHIRE Health & Social Care Partnership

south ayrshire health & social care partnership

NHS Ayrshire & Arran

Appendix 1

Remobilisation Plan 3

April 2021 - March 2022

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

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

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1.0 Introduction

This one year plan has been prepared collaboratively with our partners, to provide Scottish Government with confirmation that we have plans in place to demonstrate how we will safely and incrementally prioritise the resumption of some paused services, whilst maintaining Covid-19 capacity and resilience. The plan covers the period from April 2021 to March 2022 and has been developed and submitted in partnership with Integrated Joint Boards (IJBs) to provide an update from the previous Remobilisation Plan and to set out our key priorities for the year ahead. Whilst being clear about our plans in the next year, this plan should be considered a living document which we will adapt and modify as we move forward through 2021/22.

It sets out our journey in response to Covid-19 and recovering performance in the context of the NHS Scotland Covid-19 Framework for Decision Making of Re-mobilise, Recover and Re-design and the subsequent correspondence received from the Scottish Government regarding remobilisation.

As we move forward into the next phase of remobilisation, we will continue to safeguard robust Covid-19 resilience and support for social care, whilst working on how paused services across the whole system will be safely and incrementally resumed. Patient and staff safety continue to be the overriding priority and ensuring effective prevention and control of infection during the next phase of remobilisation will be critical for the successful restart of services, and the continued safety of our patients, staff and their families. Our Board is committed to embedding our current Staff Wellbeing Programme through the next remobilisation stage and into the winter period.

The response to the pandemic has led to some remarkable and innovative developments in service delivery for the benefit of patients; particularly via the use of digital technology, to enable more services to be delivered at home or in the community. We will want to retain as much good practice as possible in the next phase and in the longer term as part of our wider reform of health and social care.

As a learning organisation we will continue to reflect on the learning as we move through the different phases of remobilisation. Utilising national guidance, professional advice and both local and national modelling to inform our planning. These innovative developments will support the strategic intent for our health and care services over the next 10 years and beyond as set out in our “Caring for Ayrshire” programme. The Covid-19 challenges have, in fact, led to large acceleration in reform in how work is appropriately delivered.

Going forward, we will continue to ensure citizens are supported to get the right care in the right place, developing clear health and care pathways for the people of Ayrshire and Arran.

We will also further develop independent living and self-directed support, instilling an enablement ethos promoted by our professionals (including social work and the Allied Health Professions), collaborating with the third and independent sector to design and commission appropriate models of service and working with housing partners to deliver on this commitment.

2.0 Whole System Approach

2.1 Locality Health and Care Services

Overview

We will continue to maxmise the capacity of our community services to support the whole health and social care system and to put in new ways of supporting individuals, such as outreach and remote/virtual supports for those not able to access traditional day and respite services. This will allow us to respond to the additional demands for new services, support higher levels of frailty and acuity in the community and support our hospital system to faciliate the safe discharge of patients from hospital with the support of our hosptial and community teams.

For 2021-22 there is a requirement for additional resource to continue to meet the additional capacity requirements, it is anticipated this will be required for a 6 month period.

We do have an intention to shift resources across from care homes longer term, however we have a challenge with doing that at the start of the year as we will probably be continuing to make payments to compensate care homes for reduced occupancy at least until the end of June, following which it’s not clear what the ongoing demand and need for care home placements will be. Having the additional CAH capacity funded for 6 months will allow services to stabilise, allow us to continue to review service demand, hospital discharge rates, community referrals and absence levels and the ongoing capacity requirement of Care at Home services, alongside care homes.

Where additional resource is required to support increased demand on a non recurring basis, this is summarised with the Additional Resource table at the end of each sub section.

Priorities

Care at Home
To manage the significant increase in demand for services the Care at Home Service has grown throughout the pandemic with ongoing recruitment campaigns to continually enhance this capacity.

For 2021-22 there is a requirement for additional resource to continue to manage the additional capacity requirements, allowing services to stablise, continue to review service demand, hospital discharge rates and absence levels and management.

Delayed Transfers of Care
We will continue to build capacity in our communities, primarily care at home services to ensure that patients who are clinically ready for discharge experience minimum delay before being cared for in their own homes or other appropriate settings.

A 'home first' mindset will continue to be embedded, ensuring patient transfers are planned jointly with community and acute teams, whilst ensuring a person-centred approach taking account of both clinical assessment and the individual's wishes. We will undertake a self-evaluation, with support from the iHub, to establish a baseline position across the 3 Ayrshire HSCP's and the two acute sites and inform a strategic Ayrshire wide approach which aligns to Caring for Ayrshire.

The core Red Cross Home from Hospital Service provides services of transport, resettlement and follow-on support shifts for people leaving hospital at both UHC and UHA. Additional resource will provide an additional four shifts over 7 days at hospital sites for core transport, resettlement and follow-on support together with safe and well check-calls for those wishing to access this and morning shifts at UHC to support Covid-19 surge capacity.

Day Services
A full review of day services will be undertaken which will include how we address issues of social isolation and loneliness which will have been exacerbated during the pandemic, taking cognisance of any relevant recommendations from the Independent Review of Adult Social Care.

Care Homes
The Professional Care Home Assurance and Support Team (Care Home Liaison Nurses) will support the HSCPs in relation to both management of the ongoing impact of Covid-19 and to support ongoing sustainability in protecting the residents and supporting the longer-term Covid-19 vaccination and seasonal influenza programmes in care homes. We will continue with our Care Home Oversight arrangements.

Community Hospital Provision
Due to the high incidence of Coronavirus outbreaks, affecting both patients and staff, there is a temporary resource requirement to fund the surge capacity provision which requires to be maintained in the Community Hospitals and in partner care homes in order to be in a position to respond to potential future increases in the incidence of Covid-19. These wards are crucial to support down-streaming from acute hospitals and staffing shortages caused by Covid-19 related absence affect the ability to accept transfers creating additional pressures within acute hospitals.

Integrated Island Services
To continue to support an integrated whole island response to the pandemic on Arran there is a requirement for additional resource to support the increased demand with additional nursing capacity, noting a longer-term ambition to develop a similar MDT approach as the model at Lochgilphead. In addition this resource will support the additional GP rota for Arran War Memorial Hospital.

Personal Protective Equipment
Additional PPE continues to be procured for all frontline social care and wider care support staff and infection prevention and control measures applied throughout our services and buildings. If Ayrshire & Arran are to continue to go through the current procurement route in purchasing our own, as per MOU, which is currently in place until June 2021, additional funding is required. The PPE top up supply from NSS would not be sufficient to meet social care needs and in line with the MOU social care providers should source supplies independently.

Community Equipment Store
There has been a requirement to increase capacity of drivers to ensure continuation of service delivery, whilst ensuring adherence to the increased cleaning requirements of vehicles and ensuring equipment is kept separately for decontamination purposes.

Enhanced Intermediate Care Team
The enhanced intermediate care team continue to experience a higher than normal demand for their service, alongside increasing acuity and complexity of patients.

There is a requirement for temporary additional resource to ensure we continue to support an increased number of discharges straight home, thereby further contributing to flow through the system, and acute bed capacity, in addition to managing current waiting lists.

We will continue to further explore capacity and resources required to enhance EICT in line with HIS hospital at home model of care locally. With support from the iHub we will undertake a self-evaluation to establish a baseline position across Ayrshire and Arran which will inform a strategic Ayrshire wide approach aligning to Caring for Ayrshire.

Additional Resource

Description	Cost
Care at Home	
North Ayrshire	£821,077
South Ayrshire	£720,000
East Ayrshire	£880,000
Total	**£2,421,077**

Care Homes	
South Ayrshire	£106,900
Total	**£106,900**
Community Hospitals and Provision	
North Ayrshire	£482,026
South Ayrshire	£545,000
East Ayrshire	£275,000
Total	**£1,302,026**
PPE	
North Ayrshire	£2,000,000
South Ayrshire	£952,000
East Ayrshire	£1,000,000
Total	**£3,952,000**
Integrated Island Services	
North Ayrshire	£156,294
Total	**£156,294**
Community Equipment Store	
South Ayrshire	£49,600
Total	**£49,600**
Enhanced Intermediate Care Team	
South Ayrshire	£210,000
East Ayrshire	£67,558
Total	**£277,558**
Delayed Transfers of Care	
East Ayrshire	£ 94,000
Total	**£ 94,000**

2.2 Community Nursing

Overview

The refocused district nursing role as set out in Transforming Roles Programme describes our future district nurses with the additional level of clinical skill and competency to manage more complex and acute care in the community which will help care for more people in community and reduce demand on GP and acute services.

Under the leadership of the Nurse Director, work has commenced to support the delivery of this plan via the 3 HSCPs, with professional support and leadership being provided by the Associate Nurse Directors.

We are actively reviewing the skill mix across our district nursing teams to ensure we can meet the range of needs of our citizens.

The Scottish Government is committed to expanding our District Nursing workforce and have announced recurring funding totalling £515,064 for financial year 2021/22 to increase the district nursing workforce.
This increase in workforce capacity will be enhanced by the continued investment in education and skills development and by strengthening the established clear career progression pathways for our community nursing staff.

2.3 Rehabilitation

Overview

To meet the significant increase in predicted demand for rehabilitation, the Framework for Supporting People through Recovery and Rehabilitation during and after the Covid-19 Pandemic (2020) highlights the importance of a coordinated and focussed approach to Rehabilitation Services.

Short term
Rapidly determine and plan for the anticipated impact of demand from the three distinct groups of patients. This work will focus on the 6 clinical areas of highest highlighted in work done during the response and recovery phases of the pandemic.

Medium to Long term
Assess the opportunity to retain and/or enhance new ways of working that were essential in the 'Response' phase to the Covid-19. Consolidate and describe the service model for delivery of core and specialist rehabilitation services provided in hospital and community settings in Ayrshire and Arran.

Completion of our local work on data collection will be essential to provide quality data on the impact and value of AHP services. Data modelling will be used to analyse resource and demand to inform workforce planning and convey the detail of any investment, benefits to patients/families/carers and financial savings.

Workforce Planning and Recruitment

We have established an AHP Strategic Workforce Planning Group to lead and direct the organisation's approach to Allied Health Professionals workforce planning and utilisation and ensure the requirements of the Health & Care Staffing Bill (2019) are met. We will look to balance the attractiveness of fixed term contracts and the impact on our ability to recruit as this could impact on our capacity and capability to deliver our mobilisation plan.

Transforming Roles
2021 will bring a renewed focus on this national strategy for AHPs from NES. Locally we plan the development of further non-medical models of care in a variety of clinical areas. These developments include AHP Consultant roles to lead rehabilitation inpatient wards to provide a modernised and effective service. This work will also explore an increased number of Acute Care of the Elderly Practitioners in both acute and community settings to deliver high-quality person-centred assessment and rehabilitation to patients within unscheduled and urgent care settings.

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

Adult Acute Rehab Services
The increased presence of AHPs within Acute Wards are focussed on discharge to assess models and facilitate faster discharge and reduced length of stay for patients. We will look to explore the resource needs in these areas as part of the work of the Rehabilitation Commission in detail.

Trauma and Orthopaedics
Improvements in staffing resource to support reconfiguration of Trauma and Orthopaedic Services will enable consistent timely AHP intervention in line with national performance indicators and improve quality of care for the people in Ayrshire and Arran. Changes to the delivery of elective orthopaedics will increase efficiency of flow and see more operations, in particular arthroplasties, per annum. Amendments to the current staffing model to include a 7 day service will be required to deliver on the national ERAS targets which include reduced length of stay with a shift toward 23 hour cases with performance measured for number of patients' mobilised day 0.

Stroke Services
AHP staff will continue to develop community rehabilitation to support a system wide stroke pathway and will form part of the AHP Rehabilitation Commission, which in turn is focussed on supporting the delivery of our Caring for Ayrshire ambition.

Additional AHP resources with specialist stroke skills would provide earlier acute MDT assessment and intervention to improve flow through rehabilitation pathway and deliver improved outcomes for people following stroke.

Adult Community Hospital Inpatient Services
The wards have seen an increased proportion of patients who require more intensive rehabilitation. In order to provide adequate rehabilitation an increase in resource is required.

This will support people to move on to their home or homely setting more quickly and also allow for increased flow of patients from acute settings where required. We will look to explore the resource needs in these areas as part of the work of the Rehabilitation Commission in detail.

Intermediate Care and Rehabilitation
Previous investment in intermediate care and rehabilitation enhanced the provision within each of the Ayrshire HSCPs. During the pandemic these services have played a pivotal role in supporting the avoidance of acute admission, and promoting rehabilitation and recovery.

The demand on services is high and likely to continue to increase. The long term AHP workforce required within community rehabilitation will be considered through the AHP Rehabilitation Commission. Where immediate additionality is required within the Intermediate Care Teams this has been highlighted within the relevant HSCP section of the mobilisation plan.

Additional Resource

Description	Cost
Adult Acute Rehab Services	
Speech and Language Therapy (UHA)	£25,785
Speech and Language Therapy (UHC)	£60,779
Occupational Therapy (UHA)	£30,390
Occupational Therapy (UHC)	£60,779
Total	**£177,733**
Stroke Services	
Various posts (for additional 6 beds)	£188,000
Total	**£188,000**

2.4 Care Homes

Overview

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

Support to Care Homes
It is recognised that the care home sector continues to have a number of risks and challenges to consider going forward. These include workforce, capacity and financial viability.

The ask of care homes will remain extensive including regular reviewing of visiting models depending on restrictions in place, review of risk assessments, introduction of additional testing regimes, reduced occupancy levels, working with families to manage concerns and maintaining effective communication. Given all of these challenges it is essential that we continue to support our care home sector as a key part of the wider health and care system.

As part of our response to the request for Nurse Directors to have increased professional leadership accountability and to establish enhanced clinical and care professional oversight, our three HSCP Care Home Oversight Groups will continue to provide support to the sector during 2021-22. During this time, we will respond to recommendations and national guidance resulting from the Feeley Review.

Care Home Support & Assurance

The NHS Board Nurse Director is accountable for the provision of professional leadership, support and guidance within the care home sector until June 2021 as described in the Extension of Nurse Director Role letter from Scottish Government on 21 September 2020.

We welcome that funding to support this important role has been made recurring from 2021-22 in the letter to Directors of Finance on 05 February 2021. This will enable A&A to put in place our support substantively for professional leadership and infection prevention and control.

NHS Ayrshire & Arran appointed an Interim Associate Nurse Director for Care Home Support and Assurance reporting directly to the Nurse Director. This has provided additional senior professional whole Ayrshire leadership since the end of May 2020 and will now be recruited to substantively.

We will substantively establish our Professional Care Home Assurance and Support Team which will be accountable to the AND for care home support and assurance and be pan-Ayrshire.

We will also develop a Peripatetic Care Home Support Team. The team will be mobilised to support care homes in crisis when their business continuity plans are exhausted for workforce or if they require additional staff to bolster their workforce in order to ensure the residents have the appropriate standard of care during an outbreak and at end of life.

The Professional Care Home Assurance and Support Team (Care Home Liaison Nurses) will support the HSCPs with the supportive assurance visits and enable these to be carried out regularly (10-12 weekly). Any themes relating to training and education are identified and the Care Home Support and Assurance Team develop as required, and facilitate training across the Care Home sector to meet these needs.

In addition to the routine assurance visits and education, the members of this team will go to a care home when an outbreak is declared to ensure they were supported with IPC measures, adequate supply of PPE, appropriate cohorting of residents in order to assist in minimising transmission. They will also ensure the care of the residents, in particular the Covid-19 positive residents are supported as required.

Additional Resource

Description	3 months (1st April to 30 June 2021)	12 months (1st April to 31 March 2021)
Pan Ayrshire Peripatetic Team		
Senior Charge Nurse	£15,202	£60,808
Senior Staff Nurse	£25,799	£103,196
Staff Nurse	£41,469	£165,876
Healthcare Support worker	£53,188	£212,752
Total	**£135,658**	**£542,632 ***
Professional Care Home Assurance and Support Team		
Interim Associate Nurse Director	£24,868	£99,472
Interim Clinical Nurse Manager	£17,697	£70,786
Care Home Liaison Nurse	£38,699	£154,794
Admin Support	£8,119	£32,476
Total	**£92,383**	**£357,528 ***

** It is anticipated that these costs will be funded by the financial allocation to support the extended role of the Nurse Director function*

2.5 Infection Prevention and Control

Overview

As we exit the second wave of the pandemic we will continue to ensure safe and effective Infection and Prevention Controls across services. To support this we will continue to have enhanced cleaning regimes in place which will require additional expenditure on staff and supplies to continue in to 2021/22.
There will also be increased demand for Infection Prevention and Control Team (IPCT) to provide support across the organisation.

This will include:

- Re-establishment of core activities which have been suspended or reduced as a result of redirecting resources to the Pandemic.

- Preparing for the winter of 2021-2022 which is likely to be challenging with the prospect of re-emergence of Covid-19 combined with increases in influenza and norovirus which have been largely absent to date during the winter of 2020-2021.
- Implementation of the recommendations and requirements arising out of a number of reviews centred on Infection Control in the Built Environment, including those into the events at the Queen Elizabeth University Hospital in Glasgow which is expected to be published in 2021 and will have learning for all NHS Boards across Scotland.
- The establishment this year of the national Centre of Excellence for Healthcare Associated Infection including the Built Environment will also lead to an increased demand on Boards and local IPCTs.
- The continuing requirement for NHS Boards to provide support to Care Homes beyond the end of June 2021.

We welcome the indication in the letter to Directors of Finance on 05 February 2021 that funding to support care homes will be recurring from 2021-22.

Re-establishment of Core IPCT Service
As with the first wave the demands for support from the IPCT during the second wave have escalated rapidly. As a result much of the routine IPCT activity has been paused. As part of our remobilisation we will set out our plan to the Healthcare Governance Committee to assure that the IPC programme of work will see the areas that were paused restarted taking account of priority.

Non-Covid-19 activity was primarily restricted to:

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

Preparations for Winter 2021-22
There is a growing recognition that the SARS-CoV-2 virus will continue to circulate in the UK population for a number of years and will continue to present an ongoing risk to the NHS and Care Homes, especially in the winter months. During the second wave of the pandemic, both influenza and norovirus have been at exceptionally low levels as a result of the wider society lockdown which has reduced close contact between individuals. It has to be assumed that the level of restrictions on society will not be as severe next winter and therefore there is a very high probability that both influenza and norovirus will become re-established. Outbreaks of Covid-19, influenza and norovirus are likely to have a significant impact on both the NHS and the Care Home sector during the winter of 2021-22 and beyond.

A key component of the 2021-22 IPCT work programme will be supporting the organisation in preparing for the winter.

This will include reviewing resources; staff education and visiting wards on an as required basis in the lead up to winter to ensure staff are familiar with the relevant guidelines and supporting documentation.

The outbreaks themselves may be prolonged and complex and will require significant IPCT resource to manage.

Service Structure
During 2021-22 there will be a restructure of the IPCT. There will be 3 teams established:

- Acute Services
- Partnerships and Care Homes
- Technical Services

Acute Services
This activity currently constitutes the bulk of the IPCT activity. The removal of responsibility for the partnerships and the built environment activity will support the re-establishment of core activity within the acute services as well ensuring greater resource to prepare for winter and provide support during the winter months.

Health and Social Care Partnership and Care Homes
The establishment of this dedicated team will enable more pro-active work to be undertaken with integrated services including the community based services such as district nursing teams as well as our care homes.

Technical Services
The increasing ask of IPCTs in relation to the built environment requires not only an additional resource but greater specialisation by IPCTs. The creation of a technical team within the IPCT will allow greater specialisation and consistency of approach as well as ensuring sufficient resource. The Technical team will also cover issues such as environmental and equipment decontamination and health care waste.

Recruitment
The Band 6 posts are unlikely to attract qualified ICNs during 2021-22 therefore there will be a requirement to support new staff in obtaining a suitable post graduate infection control qualification, preferably to diploma level. To attract the best candidates the course fees will be funded. In addition to the 4 new posts there are currently 3 new members of the IPCT who will also require training and qualification support to ensure the IPCT is fit for purpose and sustainable.

Infection Control Doctor
The above assessment does not include the role of the Infection Control Doctor (ICD).

At present 6 sessions are provided from the consultant microbiology complement, with one consultant providing 5 sessions and a second providing 1 session. The role of the ICD is currently being reviewed by the Scottish Government. Any review of the ICD complement should await the outcome of that review.

Administrative Support
Subject to the increase in personnel there may be a requirement to secure additional Band 3 hours to support the expanded workforce and this will be accommodated within the additional allocation received.

Additional Resource

Description	Cost
Expansion of IPCT	
Infection Control Nurses	£206,000
Team Leaders	£187,000
Total	**£393,000 ***
Enhanced Cleaning	
Various Posts	£960,000
Total	**£960,000**

** It is anticipated that these costs will be funded by the financial allocation to support the extended role of the Nurse Director function*

2.6 Public Protection

There is growing recognition, as we move out of lockdown, of the potential impact on connected services such as Sexual Health and Addiction Services. These are referenced in the relevant parts of this plan.

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

Colleagues are undertaking horizon scanning based on evidence from other countries who are further down the journey of releasing lockdown measures than Scotland, to enable a focussed analysis of potential risks and vulnerabilities. This analysis is also enabling consideration of any increased resources that may be required in order to manage and support any increase in public protection activity over the next 6 months. The Covid-19 related risk areas for Public Protection that are being discussed as part of this work are as follows:

- Reduction in prevention activities increases vulnerability to risk of harm;
- Reduction in ability of multi-agency services to detect and respond to risk of harm;
- Increase in public vulnerability to harm; and
- Reduction in visibility of harm

During 2020-21 each of the three Ayrshire and Arran Chief Officer Public Protection Groups has had in place enhanced oversight and governance arrangements with regard to the core public protection strands, and NHS Ayrshire & Arran has participated fully in these arrangements as a key partner and stakeholder. Each of the above multi agency Chief Officer Groups will make an assessment based on their public protection data as to whether that increased oversight is required during 2021-22 and how this will be undertaken. This data will also enable NHS Ayrshire & Arran to make evidence based decisions with regard to any increase in resource required to fulfil our statutory requirements alongside our partners.

Going forward in 2021, we will continue to strengthen our role in identifying those who are abused and enhance capacity to respond to abuse whilst gathering information and evidence on what we can do to prevent interpersonal violence.

Child Protection
There has been a significant increase in Child Protection Supervision which could be partly due to the implementation of a revised Child Protection Supervision Guidance, but also due to the complexity of Child Protection cases and activity that we are currently seeing. It is very difficult at this time to predict if this will continue from the period April 2021 onwards and we are currently prioritising requests for CP Supervision within our existing resource. This increase may also be partly due to staff working remotely and not having the same opportunities for peer support, and so we continue to monitor this and the impact on capacity closely.

2.7 Quality Improvement

Quality Improvement Mobilisation
Our clear aim remains to empower teams to lead their own Quality Improvement priorities in line with NHS Ayrshire & Arran’s strategic direction and using our 4 pillar approach (Service People Quality Finance).

Key areas of work that we will restart are:

- Restart our three year implementation plan for Value Management with improvement activity refocusing clinical areas on the pillars of people, finance, quality and service during remobilisation;
- Integrate QI support with clinical teams supporting remobilisation and build QI capacity through coaching / education; and
- Provide monthly monitoring and reporting, including improvement support for all SPSP and EiC measures, thus providing quality assurance throughout remobilisation.

2.8 Patient Experience

Feedback and Complaints Recovery

We have maintained our local feedback mechanisms, encouraged the use of Care Opinion and responded to complaints in order to learn from what has gone well and what we need to do better.

The complaints team have made significant improvements to our Complaints Handling Process and this places us in a strong position to respond in a timely manner to any increase in complaints and feedback during 2021-22 which may arise due to prolonged waits for treatment or dissatisfaction with decisions made during the pandemic.

NHS Ayrshire & Arran is committed to learning and improving from feedback and complaints. Work has recently been carried out to improve our processes and to develop a more person centred and effective approach to how feedback and complaints are dealt with, and our commitment during 2021-22 is to continue this learning.

Visiting

Not being able to routinely visit and support loved ones in our hospitals has been distressing across our communities during the pandemic. To support the phased reintroduction of visiting in NHS Ayrshire & Arran, a Visiting Bronze team was convened with representatives from Acute and Community hospitals including Infection Control, Health and Safety and Communications. There has been a communication plan put in place and this will be refreshed for each of the next Stages as they are announced.

During 2021-22 we will continue to ensure that we enable a person centred and compassionate visiting approach that takes cognisance of our local community prevalence and complies with any forthcoming national guidance published by Scottish Government.

2.9 Equalities Impact Assessment

Overview

As an NHS Board we have a statutory responsibility to involve people in the design, development and delivery of the healthcare services we provide. We are expected to demonstrate how we are engaging with people, and to evidence the impact of this engagement. For urgent service changes introduced during the initial emergency response, it will be necessary to establish a new starting point for taking forward public involvement and engagement activities. We must be able to demonstrate how:

- Engagement has informed re-mobilisation plans during the early stages and in moving through 2021; and
- Planned engagement informs the development of key renewal objectives in relation to Re-mobilise, Recover, Re-design: The Framework for NHS Scotland, for example - "Engage the people of Scotland to agree the basis of our future health and social care system".

The Covid-19 pandemic has brought about significant changes, not least how we are able to engage and involve people. With social distancing measures restricting traditional face-to-face methods, it will be necessary to engage differently and adopt a 'digital first' approach for the foreseeable future.

We have a statutory responsibility to involve people in developing our health and care services. Legislation set out in the Patients' Rights (Scotland) Act 2011 and the Community Empowerment (Scotland) Act 2015 underpins this. In accordance with equalities legislation we are responsible for:

- Ensuring that the informing, engaging and consulting process is fully accessible to all equality groups; and
- Ensuring that any potential adverse impact of proposed service change on different equality groups has been taken into account by undertaking an Equality Impact Assessment (EQIA) and that this informs the planning and delivery of engagement activity.

3.0 Public Health

Priorities

Covid-19 Immunisation Programme
NHS Ayrshire & Arran is delivering a successful programme of vaccination for all residents in line with JCVI and SG guidance.

At present, the Covid-19 Immunisation Programme is likely to continue throughout 21/22, and may well go on to become a national programme alongside the flu programme. We have committed, with our GP Sub Committee to conclude the Vaccine Transformation Programme by October 2021.

We have started to review how we would deliver a programme for Covid-19 and flu vaccination in readiness for future direction on this. As part of this review we will need to consider what workforce is required to deliver a resilient and sustainable programme.

The Mass Vaccination Programme has been staffed using a mixed supply model for clinical vaccinators – additionality from our substantive workforce working additional hours and/or being deployed to support the programme, sourcing additionality via mechanisms such as NMC re-registrants, NES recruitment portal applicants, returning retirees, speculative employment enquiries and collaboration with our independent contractor colleagues in dentistry, general practice, pharmacy and optometry.

Going forward we will consider and plan our longer term workforce associated with ongoing programme delivery recognising that our reliance on our substantive workforce undertaking additionality needs to be balanced with underpinning staff health and wellbeing, as well as the re-commencement of elective services meaning those deployment to the programme resume their substantive roles fully. As detailed further in the workforce section there is significant national demand from all NHS Boards, both Covid-19 and non-Covid-19 in origin, which means that supply is unable to match demand for our registered clinical staff groups which makes forward planning for our workforce in the vaccination programme context acutely pressing. We will take cognisance and learning from the workforce models deployed by colleagues in other NHS Boards in determining the longer term vaccination programme workforce plan.

Covid-19 Testing Programme

Our testing capacity has increased largely in line with demand to ensure we meet the needs of the citizens of Ayrshire and Arran. Our testing strategy utilises a mixed model and includes utilising our local hospital laboratory, regional laboratory services at Gartnaval, the Lighthouse Regional and Mobile facilities, the Social Care Portal and Employer Portal where most appropriate in order to fully meet projected future need over the next year to 18 months. However, testing capacity in NHS Ayrshire & Arran laboratories remains an area of concern and requires close monitoring.

Testing for Covid-19 on this increased scale requires significant resource to perform the tests, analyse, disseminate results and provide specific information to those who test positive in order to support them to self-isolate, establish close contacts and determine which other individuals require to be tested and self-isolate.

As the pandemic has evolved it has become clear that individuals who are housebound and unable to travel to a Covid-19 assessment centre require access to home testing. This requires an expansion to the existing testing team.

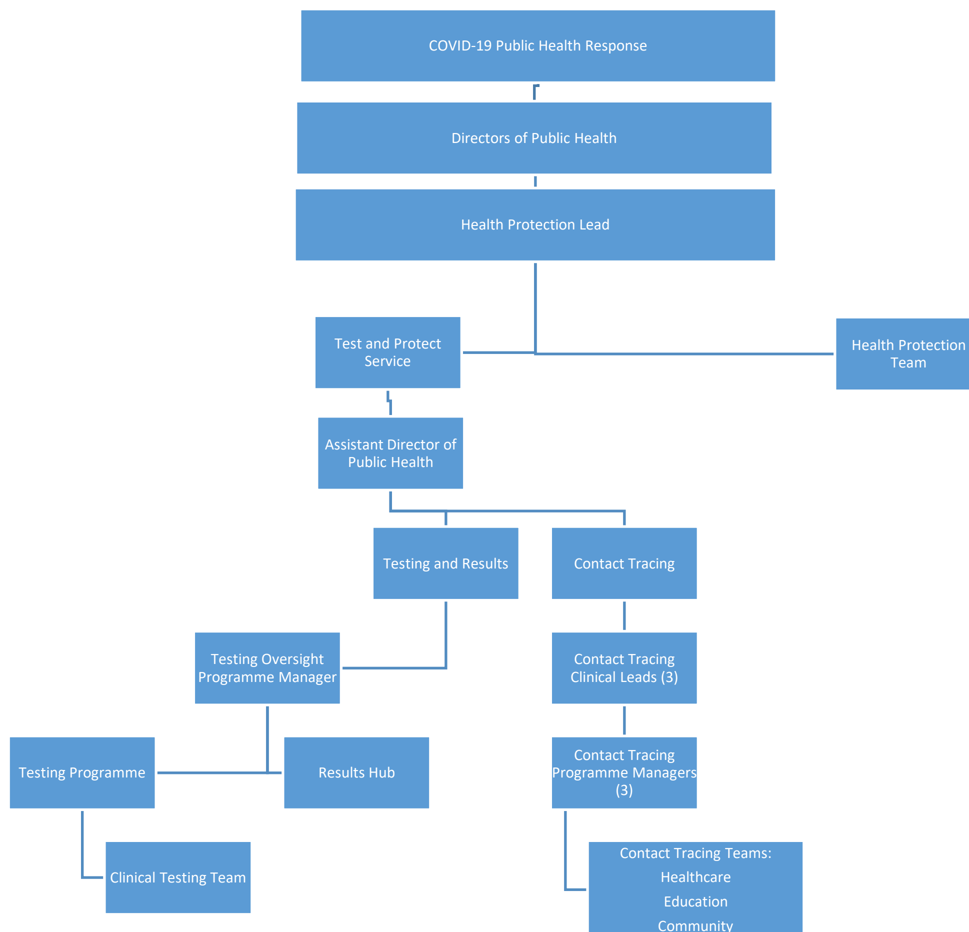
These are predominantly manual processes which continue to be undertaken by staff who have been released from normal duties during the Covid-19 pandemic. As services return to normal, many of these staff will be required to return to their substantive posts therefore additional permanent staff will be required to support this new service.

Test and Protect
The Health Protection Team (HPT) within the Public Health Department of NHS Ayrshire & Arran will provide the central expert resource to support the Contact Tracing function locally.

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

While local contact tracing is one single service, we have built on our practical experience over the pandemic and have developed three interrelating tiers for our Tier 2 provision. Each tier works closely with the Results Hub to ensure efficient identification and follow-up of positive cases.

Test and Protect Structure



The Healthcare Contact Tracing Team deals with all positive cases in a health care setting, providing results and advice to patients at home or in hospital.

The Community Contact Tracing Team undertake contact tracing of cases and contacts in the community.

The Education Contact Tracing Team evolved in Autumn 2020 in response to the rise of cases in education settings, and the resultant workload of associated close contacts. This team consist of two parts: the education triage and risk assessment team (ETRA) and a dedicated contact tracing team. ETRA conducts twice-daily meetings with senior education managers in each of the council areas (North, East and South). The team discusses new cases, conducts risk assessments, and agree isolation dates. Case and contacts are handed to the dedicated contact tracing team who contact and advise them accordingly.

Contact Tracing workforce future requirements are being reviewed in light of the spread of the new variant and increasing incidence in our population and uncertainty relating to the de-escalation of current restrictions. A fundamental challenge remains around the impact on this key function as our services across the NHS return to a post Covid-19 normal.

Screening

Our screening programmes are all progressing with the staged restart in line with national expectations.

Developments

Pregnancy & Newborn Screening (PNBS) will work with colleagues to ensure BadgerNet will facilitate the requirements for screening, and effective reporting against the national KPIs for 2021/22.

Breast Screening continues to be delivered across Ayrshire and Arran, and Dumfries and Galloway, using a combination of the static unit at ACH and two mobile screening vans. We will work with colleagues to plan for the mobile vans being deployed in rural locations until the middle of 2021 and will work with colleagues in offering additional appointments at the static unit at ACH, as longer sessions are possible here. The service will also be able to increase screening appointments significantly when one of the mobile vans returns to Kilmarnock in October 2021 as staff will then be able to deliver 12 hour shifts.

Diabetic Eye Screening (DES) programme have created an additional in-house site at Ayrshire Central Hospital (ACH) which will provide an additional 30 appointments per week, with scope to increase as the service develops. The ACH service will also pilot OCT scanning, a new addition to the service outlined in the CMO letter of January 2021. Following completion of the pilot in April 2021, OCT will be rolled out to the UHA and UHC sites, and procurement of additional OCT equipment has recently been approved for these sites.

Poverty and Health Inequalities

A whole system approach will be taken to the short and medium term activities, many of which are already established and can be further enhanced through collaborative working at both a national and local level.

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

Additional Resource

Description	Cost
Immunisation Programme	£4,295,000
Oversight Team	£270,445
Testing Team	£1,059,796
Results Hub	£440,141
Triage & Health Care Contact Tracing Team	£1,073,510
Community & Schools Contact Team	£1,562,653
Enhanced Health Protection	£667,147
Community Asymptomatic Testing	£2,690,021
Management and Support	£267,437
Supplies costs	£120,000
Total	**£12,446,150***

** A detailed breakdown is provided within Appendix A – C*

4.0 Mental Health

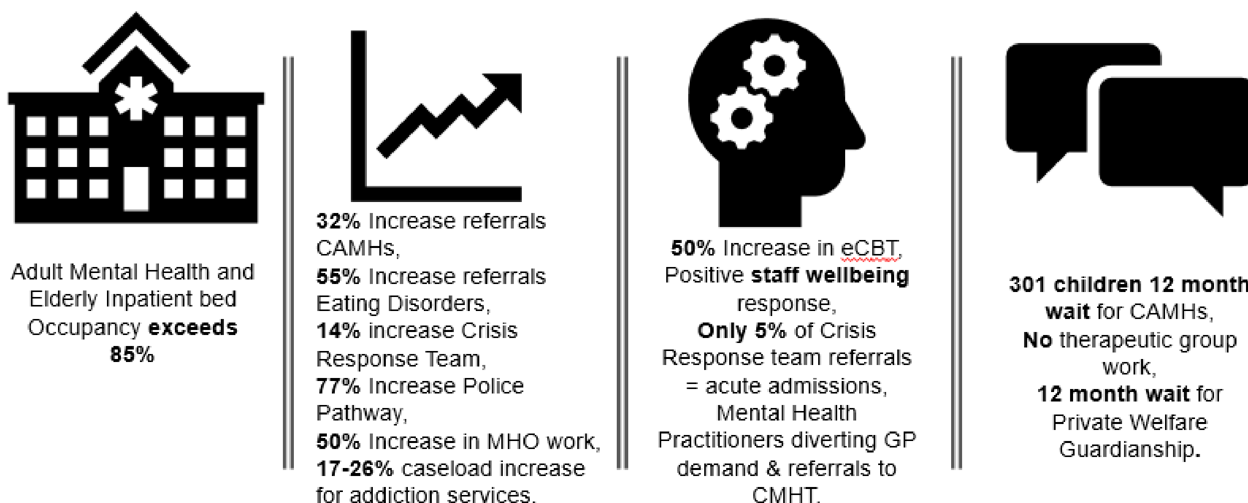
Overview

Mental Health Services continued to deliver both national and local mental health strategic priorities, this section of the plan clearly describes the direct response to the growing demand for mental health services as a result of the pandemic.

The Mental Health Transition and Recovery Plan outlines the Scottish Government's response to the mental health impacts of Covid-19. The announcement of £869m to support Health Boards and Integration Authorities in meeting these challenges will support the actions outlined within this plan.

The additional £120m announced on 16 February, which is planned to be set aside in the Scottish Government budget for mental health recovery, would enable Health Boards and Integration Authorities to identify and take forward further redesign across Mental Health Services to support recovery.

There are elements of the mental health response that will continue and require to be funded, such as levels of absence and enhanced observation requirements for in-patient settings. The plan sets out the increased demand across a number of mental health services including community settings and an assessment has been undertaken of the additional capacity required to meet those increased demands to March 2022, ensuring the increased needs in our communities can be met, limiting any detrimental impact on outcomes and escalation of the acuity of need. The illustration below highlights the growing demands across the breadth of services:



Addressing this growing need will be wholly reliant on additional funding being allocated to enhance our mental health workforce, without this we will inevitably see a back-log and waiting lists for services grow. The additional estimated costs of meeting the areas of demand in the plan are included at the end of the section.

The key themes for recovery continue to be focused on workforce wellbeing, the expansion of digital solutions and service recovery, redesign and reform to enable an effective and innovative whole system responses over this challenging time.

Staff Wellbeing

Staff wellbeing hubs, mindfulness, resilience, coaching, online and offline resources, counselling, safe spaces, the Listening Service, care packages and one to one support in addition to referring to online support services have been implemented and well received during the pandemic. The NHS Corporate Management Team has endorsed a sustainable staff wellbeing service embedded across the health and social care system through a hub and spoke model.

As part of a multi-disciplinary team approach, dedicated Consultant Psychology resource will lead on psychological provision, training, evaluation and research, supported additional psychology resource, to ensure immediate access to psychological support and treatment, as well as reflective practice sessions for wider staff teams.

Trauma Support
Workforce wellbeing is central to psychological training resources and will be used with services to consider better management of secondary traumatic stress, compassionate fatigue and burnout. With the recently appointed Trauma Champions, a broad range of work will continue across the organisation to build on and sustain the initial development of trauma informed and responsive services. Given the growing recognition that adults with Learning Disability (LD) are at increased risk of experiencing psychological trauma, local funding has been approved to extend the trauma focused work in LD for a further year. The work will be embedded within service delivery and supported by the new Trauma Champions.

Digital Enablers
Mental health services will continue to ensure that services are accessible and inclusive and workforce solutions optimised with new innovations and developments. Most services will continue to use telephone and digital technologies (Near Me) for regular client contact with MS Teams being explored as a digital platform to support the delivery the Group interventions. Our Silver Cloud has increased digital referrals for Cognitive Behavioural Therapy (CBT) based approaches by 50%, with further increase expected. A RAG rating system helps to identify the type of assessment and level of support that each patient requires and where necessary will be offered a face to face, in person, assessment. An increase in face to face, in person, contacts is expected in association with the easing of lock down restrictions.

Urgent Care
The unscheduled care mental health service comprises of hospital liaison and community crisis based mental health teams, with the ability to respond urgently within one hour. We are working to re-design the unscheduled mental health care pathway as a priority with a longer term vision of a Mental Health Assessment Centre located at the Ayrshire Central Site alongside our acute Mental Health services. This approach would look to prevent individuals from attending ED in the first place. During 2021-22 we will look to work in partnership with the Scottish Ambulance Service which would see a staff group facilitate a telephone professional line, this test of change would also allow the demand for a mental health assessment centre to be established. This will form part of the redesign of urgent care of which further details are within the Urgent Care section 6.0 of the plan.

Whole System Covid-19 responses
Acceleration of programmes of transformation with secondary care, to ensure a whole system approach to mental healthcare, including the following areas:

- The launch of a Distress Brief Intervention (DBI) Service with a third sector provider has been commissioned to deliver level 2 support across Ayrshire post Covid-19;
- A Pan Ayrshire suicide prevention action plan developed, with key strategic outcomes for Suicide Prevention and as part of this action plan; a training plan has been developed, aiming to reach across all populations as highlighted within the National Strategy; "Everyone's business not just frontline staff";
- Perinatal and Neonatal service development delivering an Ayrshire wide service with an assertive recruitment programme underway;
- Ayrshire wide care pathway co-ordinator role introduced to ensure development of clearer pathways for support and treatment, improving capacity for mental health assessment within primary and community settings and links to secondary care;
  - Key work continues to ensure delivery of:
    - Distress Brief Intervention pathway
    - CAMHs extreme teams and
    - Autism Strategy

Pan Ayrshire Mental Health Services

Child and Adolescent Mental Health Services (CAMHS)
As a result of the pandemic, in the five-month period from August 2020 to December 2020, there was a 32% increase in Routine referrals and a 17% increase in Urgent referrals to CAMHS in comparison to the same period in 2019.

Neurodevelopmental assessments have been subject to two periods of pause and the already significant waiting times for these specialist assessments and diagnosis has grown. As at November 2020 there were 301 children waiting more than a year for a clinical neurodevelopmental diagnosis.

Other approaches and supports are in place including family support, neuro development services commissioned from community providers and opportunities working with education and the alignment with the community mental health framework funding to support young people in the interim period whilst awaiting diagnosis. Work is ongoing to develop a pan-Ayrshire neuro-development service in anticipation of the national specification.

As a result of these extensive waiting times the service anticipate more 'Urgent' referrals to be generated.

Covid-19 has also reduced capacity within the Glasgow based Regional Tier 4 in-patient service, with the impact on visiting, passes and isolation periods after discharge also having a negative impact. This process requires more staff locally to support discharge, particularly for children and young people experiencing eating disorders, where significant face to face contact and mealtime support is necessary.

A model of community care, as described in pathway 3 below will allow for intensive support at times of crisis or mental health deterioration which will reduce the need for hospital admissions.

New pathways of care

Work is ongoing to implement three pathways of care, including a dedicated seven-day service for urgent referrals:

1. CAMHS – Community Locality driven model, Monday to Friday 9am – 5pm triaging and providing care to all referrals which come as Routine.
2. Child and Adolescent Neurodevelopmental Service - Community and Pan-Ayrshire model Monday to Friday 9am – 5pm triaging and providing care to all referrals which are considered to require this specialist assessment and treatment pathway. Developing pre and post diagnostic pathways for children and young people experiencing Neurodevelopmental conditions.
3. Children and Young People's Urgent Care Service – Pan-Ayrshire model, triaging and assessing all Urgent referrals, liaising with in-patient services, providing assertive outreach and increased support to a defined case load. It will be delivered in parallel with the Adult Unscheduled Care services, complementing the already established pathways and services in place and operate Seven Days per week. This pathway recognises no designated CAMHS beds are available within Ayrshire and Arran and this pathway will support the need to prevent hospital admission and intervene earlier in a C&YP's presentation if considered urgent. Preventing hospital admission whilst providing a viable, safe and effective alternative is what is offered to adults via current Crisis Service provision, which whilst offering a supplementary support to CAMHS, it is neither funded nor expert in providing support to C&YP.

At present children and young people are supported by adult liaison and crisis services for interventions required outwith Monday to Friday 9-5. We are currently commencing organisational change with the CAMHS workforce to move to seven day working from August 2021, thereafter from April 2022 extending the hours of the new seven-day service.

The unscheduled care proposal will address the increasing demand in ED and we would expect there to be an impact on reducing waiting times and address follow up, also preventing admission. This could also potentially reduce the level of observations in Woodland view if there is an admission as this additional CAMHS workforce would provide this support instead of supplementary staffing. Waiting times will also be impacted by the investment which has gone to LA'S for community mental health and wellbeing, as a whole system response and the commissioning of follow up supports. The additional CAMHS unscheduled care response will ensure we are targeting the right support at the right time.

Community Eating Disorders Service (CEDS)
Since the onset of the Pandemic, Community Eating Disorders Services (CEDS) has witnessed a significant rise in referrals of 55% on the previous year 2019.

Over 70% of CEDS patients are of CAMHS age range and there are increasingly young children presenting with challenges with regards their eating, the position is exacerbated by the reduction in support from Glasgow based Tier 4 service.

Aligned to CAMHS and in line with the aspiration to develop an unscheduled care pathway for C&YP which provides quicker access to care, assessment and treatment in a crisis situation. C&YP experiencing Eating Disorders would benefit immensely from a crisis intervention pathway which would reduce the pressure to admit to the Tier 4 Regional in-patient facility.

Psychological Therapies
Provision of Psychological Therapies has been maintained, as close to business as usual, from the outset of the pandemic using remote delivery and currently the service achieves an 85% 'Referral to Treatment' standard of referrals to be seen for first treatment within 18 weeks. There is just one area of significant delay and that is for C&YP Neurological assessment within CAMHs. The service is awaiting the new Scottish Government Neurodevelopmental specification and a pilot to enhance support with Speech & Language Therapy and Psychologists is in place enabled by the Extreme team approach.

Further work to enable a culture shift from pain medication towards pain management in Primary Care, is also being implemented to support individuals challenged with persistent pain living in Ayrshire and Arran. The multi-disciplinary team (MDT) have undertaken a skill-mix model, developed digital supports and a pain management service website to signpost individuals to self-management advice, videos, information leaflets and workbooks and a Facebook Group.

The local veteran first point service (V1P) has been funded for a further year and will continue to provide holistic service provision through a blend of remote and face-to-face provision, including psychological and mental health provision, through its multi-disciplinary team led by Psychology. Joint working with the local Prison will be renewed as Covid-19 restrictions allow.

Mental Health Inpatient Services
Inpatient activity is expected to be sustained, given the impact on the mental health of the population of the pandemic, affecting those with a pre-existing condition and causing stress/isolation related episodes in others previously unknown to services.

There is also a pattern of a higher level of acuity of admissions and associated levels of enhanced observations.

Mental Health Inpatient Bed Occupancy

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
W8	81%	71%	81%	70%	50%	52%	43%	34%	54%	70%	**93%**	**99%**
W9	74%	69%	73%	**86%**	**94%**	**96%**	**94%**	**99%**	**99%**	**97%**	**94%**	**97%**
W10	70%	55%	65%	67%	90%	72%	75%	**89%**	**94%**	**90%**	**93%**	**91%**
W11	**90%**	**91%**	50%	31%	27%	78%	80%	**95%**	**93%**	**98%**	**98%**	**97%**

Elderly Mental Health Ward Occupancy

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
W3	**93%**	**97%**	**93%**	79%	81%	84%	82%	**97%**	**94%**	**89%**	**89%**	**100%**
W4	**92%**	**96%**	**94%**	**92%**	**99%**	**98%**	**99%**	**98%**	**98%**	**100%**	**82%**	**100%**

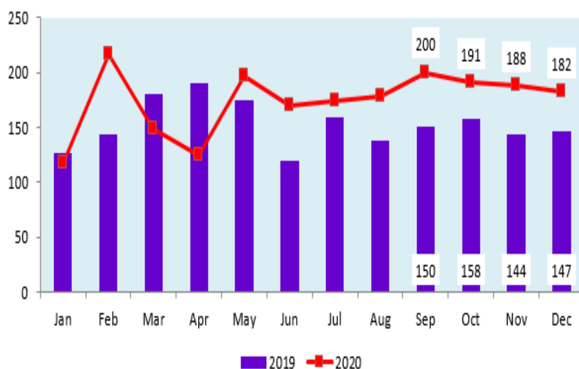
Allied Health Professional (AHP) Services

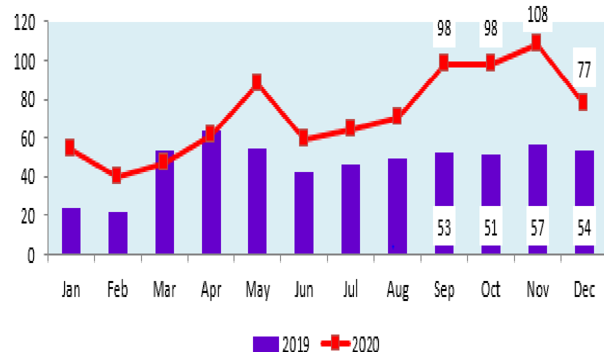
Following increased demand and higher levels of clinical acuity in mental health inpatient wards and the impact of working to meet the needs within the context of social distancing, there has been pressure on continuing to deliver an effective multi-disciplinary approach to mental health services across Ayrshire.

Additional capacity and resource is required to support AHPs at Woodland View alongside community mental health support from Dietetics and Physiotherapy.

Unscheduled Care Mental Health Service

Alongside high occupancy levels in acute wards, referrals to Crisis Response Team (CRT) have increased particularly at the latter part of the year (September – December 2020) where the team has seen a 27% increase in referrals compared to the same period last year. Positively CRT have established efficacy with only 5% of assessments (2020) resulting in admission. The Police Pathway managed by the Crisis Resolution Team, has also seen an increase in activity of 77% (September – December 2020). The sustained increase in referrals is illustrated below:





As acute hospital attendances and admissions increase, so too does the need for prompt response to mental health presentations, to reduce and minimise additional pressures. As we move out of lockdown back into the "new normal" we anticipate an increased number of mental health presentations. As such, it is anticipated that current staffing numbers will not be enough to meet this spike in demand.

Community Mental Health Services

All the community mental health services across Ayrshire have experienced similar Covid-19 pressure points with increasing levels of demand, increased clinical acuity across caseloads and the inability to deliver therapeutic group work. It is crucial that community demand is addressed to avoid an escalation of need which would undoubtedly impact on our crisis and inpatient services.

Mental Health Act

To support acute hospital discharge, care homes and the increased levels of acuity of people already supported by community mental health teams, each area has seen a considerable growth in Social Work and Mental Health Officer legislative work. This work is predicted to increase further as we move out of lockdown with the ongoing impact of the pandemic taking its toll on individual's mental health.

As families have supported their vulnerable relatives during the pandemic, this has created a significant growth in Private Welfare Guardianship requests and applications for Mental Health Officers.

Community Mental Health Teams

All areas have seen an increase in clinical acuity across caseloads as the impact of lockdown and social isolation intensifies existing mental health conditions.

East Ayrshire Community Mental Health Team - in addition to the Wellbeing support for staff, the team has focussed their activity on the following areas:

- **Distress Brief Intervention (DBI)** - in the process of rolling out a DBI service for Ayrshire to ensure those displaying mental distress are supported to manage their levels of distress in a more robust way, therefore reducing the burden on Acute and Primary Care services.
- **Mental Health Practitioners and Self-Help Workers** - expansion with 6 Mental Health Practitioners funded non-recurrently by EAHSCP, the aim is to make these posts permanent and to invest in part funding a local Distressed Brief Intervention (DBI) service. The balance of the cost of the DBI service is provided as an early implementer site by the Scottish Government on a short-term basis and following evaluation, consideration will be given about its sustainability. These investments mean however that no new capacity will be available in 2021-22 for primary and community mental health services to respond to the vulnerabilities arising from Covid-19 without investment from mobilisation. Additional capacity will enable us to respond to an envisaged peak in demand which should, post 2021-22, return to a sustainable level.

Self-help worker interventions can often be provided by third sector organisations. Testing this approach with existing Self-Help Workers from Primary Care Mental Health Team.

- **Mental Health Officers** - during Covid-19 we have already experienced an increase in statutory work through Mental Health (Care and Treatment) Act. Patients known to the Community Mental Health Team are becoming very unwell with increased demands on the service to offer support and treatment. This has resulted in an increase in the volume of statutory work for Mental Health Officers. In the short-term Mental Health Officers have been diverted from part of their normal role as a care management resource. This will be unsustainable in 2021-22 as it is impacting on wider care.

North Ayrshire Community Mental Health Team - in order to respond to the Covid-19 demand pressures, the following areas are identified as the priorities:

- **Mental Health Practitioners** - additional capacity to free up GP time to focus on other areas of work, this will be implemented through Action 15;
- **Mental Health Officers** - increase MHO capacity and administration support to respond to the increase in social work statutory work;
- **Allied Health Professionals** - due to the increase in acuity levels in Community Mental health services, Primary Care based Mental Health Teams and Addictions, additional AHP capacity is required.

South Ayrshire Community Mental Health Team - in order to respond to the Covid-19 demand pressures, the following areas are identified as the priorities:

- **Mental Health Group Work** - prior to the pandemic considerable investment was made in staff training in "Decider skills" with the aim to be able to deliver community based training in large groups within communities, however, as a result of Covid-19 only 1:1 using Near Me and telephone based appointments are available. South Ayrshire remain keen to explore how to increase the opportunities for group work and the ability to roll this out in a larger scale is critical to our plans to respond to the new and emerging number of mental health referrals.
- **Mental Health Practitioners -** Community Mental Health Services commenced a programme of service review and redesign as described within our Mental Health Strategic Plan and are looking to establish Mental Health Practitioners and self-help workers that are based within GP practices.
- **Allied Health Professionals** - due to the increase in acuity across both adult community and Elderly Mental Health teams there is a need to enhance support for dysphagia and communication.

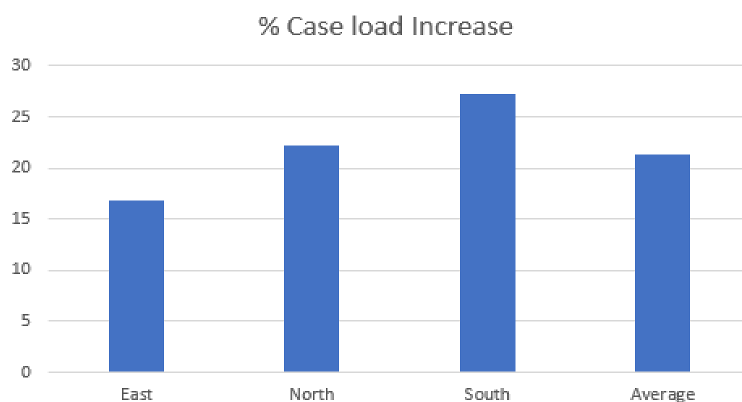
Alcohol and Drug Services

Recent research has indicated that, since Covid-19 restrictions have been put in place sales of alcohol have risen with drinking and drug use patterns changing.

As a result, services are experiencing an increase in demand due to both increased alcohol consumption and changes in poly drug use. This is predicted to further increase as we move out of lockdown back into the “new normal’. This negative impact on physical, social and mental health requires to be assessed and managed.

Each of the areas have experienced the following as a result of the pandemic:

Reduced Discharge from Service
Alcohol and Drug services across Ayrshire continue to retain more individuals in treatment as a protective factor resulting in the active caseloads increasing as described below.



Medication Assistant Treatment (MAT)
Each area is required to implement the new standards. This requires a suitably qualified prescriber and essential wrap around support available for same day prescribing and commencement of treatment. Areas may be able to ‘pilot’ this on a limited basis with existing resources but to offer this intervention in full will require additional resource.

Access to Treatment Time Standards
To continue to deliver a service whilst being compliant of all Covid-19 related guidance, the services have increased the regularity of contact for the most vulnerable clients (Ragged ‘Red’) whilst reducing the type and regularity of contact for other clients open to service (Ragged ‘Amber’ and ‘Green’). If this is continues, there are negative risks associated with client’s substance use, physical and mental health and social care needs alongside the potential of increased deaths associated with drug and alcohol use.

North Ayrshire Services
Due to the service deliberately retaining more individuals in treatment, as a protective factor, this has resulted in the active caseload increasing to over 1,400 (an increase of over 250 individuals). NADARS will pilot a test of change in offering a responsive community-based pathway of support for individuals who have experienced a non-fatal overdose. The service will also support a new multi-agency

integrated Housing First model of support in North Ayrshire and pilot the availability of peer led support within the Service Access Team's response to adult protection concerns (providing early intervention, stability and promoting self-management).

South Ayrshire Services

South Addiction services are planning to pilot new models of same day commencement of treatment to meet MAT Standards. In addition, innovative ways to maintain service provision for those requiring naloxone, injecting equipment and home delivery of medication have been developed during Covid-19 and the service will explore further opportunities to develop these options moving forward.

East Ayrshire Services

Due to remedial works required to support a new base for the addictions services, there has been a delay in redesigning access to services including our ambition to achieve support on the day, with prompter access to Medication Assisted Treatment (MAT). Demand on drugs and alcohol services has increased in more recent months with the understanding that this relates to the impact of isolation, social and economic risk factors related to Covid-19. Additional capacity is required to address the increased demand as we emerge from the social restrictions in 2020-21.

An assessment of the overall capacity increase required in community teams to address the increased demand across mental health and addictions services has been undertaken by each HSCP with an increase in workforce identified to meet this need. This would require to be funded through additional Covid-19 funding investment through mobilisation, otherwise the increase in demand will not be met and there will be delays in support being provided and an impact on individuals' outcome and an increased risk of a crisis response.

Additional Resource

Description	**Cost**
Pan Ayrshire	
Children & Young Peoples Urgent Care Service - Phase 1	£178,000
In-patient Services	£390,000
Unscheduled Care	£70,232
AHPs	£175,580
Total	**£813,812**

North Ayrshire HSCP	
Community Mental Health	£134,000
Addictions - Alcohol and Drugs	£91,000
AHPs	£132,630
Total	**£357,630**

South Ayrshire HSCP	
Community Mental Health	£196,000
Addictions	£44,000
AHPs	£97,000
Total	**£337,000**

East Ayrshire HSCP	
Primary and Community Mental Health	£290,865
Addictions	£50,014
Wellbeing	£50,489
Total	**£391,368**

5.0 Primary Care

Community Pharmacy
Community Pharmacy are committed to continuing to progress with the innovative work with General Practice and the introduction of NHS Pharmacy First Scotland.

Throughout 2021 serial prescribing will continue to be implemented to all GP practices and community pharmacies using remote technology. This is a key enabler to the delivery of the Pharmacotherapy Service, reducing the need for repeat prescription request volume and footfall at GP practices as patients can collect their repeat prescription direct from their chosen pharmacy.

In response to the pandemic a time-limited medicines delivery service has been introduced for those most at risk and will help to alleviate the pressures on the pharmacy network and wider NHS services.

A range of plans are currently being taken forward across community pharmacy in addition to new developments in 2021 to support our citizens as close to home as possible, ensuring community pharmacies are equipped to deliver a wide range of services in the community.

New developments being taken forward into detailed planning include:

- Due to the success in 2020, continue to build on the Ayrshire and Arran mixed model for flu delivery by developing a Community Pharmacy Flu Vaccination Programme to increase access for eligible patients.
- Access to Clinical Portal to further enhance patient care by providing community pharmacists with key information that could reduce patients need to access urgent care.

Community Optometry
There will be ongoing support to Community Optometry practices throughout 2021 to ensure that all appropriate infection control measures are in place to allow general ophthalmic eye care services and domiciliary services to continue to operate. Practices are required to prioritise urgent and essential eye care over more routine care where capacity to meet demand is identified.

Ongoing monitoring will continue to ensure patients can access domiciliary ophthalmic services and that adequate provision is maintained. An update is provide below on the current additional services being provided as well as new initiatives in development that will be taken forward in 2021:

- Use of NHS Near Me for triage and remote consultations is currently being utilised.
- The Diabetic Retinopathy Screening programme within accredited community optometry practices has been re-established.
- The Low Vision Aids service is now fully remobilised within accredited community optometry practices but with the exception of recycling aids. We plan to review the range of aids available through this scheme to ensure that patients have access to the best equipment that the scheme can provide.
- Development initiatives are being progressed which includes a new co management service which would support additional eye disease being managed by non IP Optometrists in conjunction with the Hospital Eye Service and prevent these patients being referred on to Eye Casualty for treatment.
- Following the shift of the Eye Care Ayrshire service to the national Pharmacy First Service, the repeat prescribing request element of the Eye Care Ayrshire will continue to save GP practices receiving repeated requests for scripts.
- Access to the clinical portal (CP) is being actively pursued with Digital Services and Information Governance colleagues for optometry practices. This will support the improvement of patient experience/pathway and clinical care preventing duplication of work, inappropriate referrals and will enhance and streamline the Primary / Secondary Care interface.
- Access to the local website AthenA for optometry practices has been agreed with Digital Service colleagues and will be rolled out early 2021.
- A referral template has been added within SCI Gateway for direct referral to smoking cessation colleagues from community optometrists. This has been achieved as a result of close working between Primary Care and Public Health and it is hoped that there are further areas where such initiatives can be pursued within an Optometry setting.
- A hybrid model of shared care for a cohort of stable glaucoma patients was rolled out in December 2020 as a collaboration between Primary and Secondary care colleagues. Firstly by utilising a cohort of Optometrists on a sessional basis within the hospital eye department to co-manage specific outpatient groups with Ophthalmologist colleagues.

Since this shared care model commenced in December 2020, significant effort has been shown by the Hospital Eye Service to identify suitable patients to further signpost to Optometry practices. Uptake on the service has been limited at this time with Covid-19 also impacting on the service with patients cancelling appointments. The service will continue to develop in 2021.

General Dental Services and Public Dental Service
Urgent Dental Care Centres (UDCC) continue to see patients on referral for treatments. Mask face fitting has taken place to allow staff to see their own patients in these centres and complete the Aerosol Generating procedures (AGPs) themselves.

Dental Practices have now re-opened to provide both urgent and routine care. AGPs Procedures are being performed mainly by General Dental Practitioners (GDPs) within their own Dental Practices rather than referral to the UDCC however the option is still available.

The initial priority in 2021 will be to ensure all dental practices can return to providing a full service to patients in line with national guidance. Plans will be developed throughout 2021 with the Director of Dentistry as set out in the Oral Health Improvement Plan for Scotland aligning to the ambitions of Caring for Ayrshire, with more shared care and skills development of the GDPs and could increase Hospital Dental Services utilising public and general dental services more.

General Medical Services
To monitor the impact across general practice and understand any potential implications early, a number of areas are kept under review in addition to the information shared by individual practices. This includes:

- Reviewing practice activity, returned monthly including the type and numbers of appointments
- Monitoring the urgent care activity through AUCS, the ED and contacts made to NHS24 111

The majority of the Enhanced Services programme delivered through GP practices payment arrangements are paid to practices based on a 3 year average. This arrangement will be reviewed in March 2021 in conjunction with Local Medical Committee/GP Sub Committee members to establish a way forward from 1st April 2021.

Cluster meetings have been re-established along with GP forum and Practice Managers Meetings which allows for a wider discussion on the stability of practices and any wider issues across the system and opportunities to strengthen support to the Cluster meetings from Primary Care during 2021.

Primary Care Improvement Plan

It is recognised that the Covid-19 pandemic and associated remobilisation work has impacted on the original timescales for delivering elements of the 2020-22 Primary Care Improvement Plan (PCIP) and consequently, the implementation of the new GP contract by 2021/22.

Following this recent communication on the endpoint for the new contract, there has been agreement with the Ayrshire and Arran GP Sub Committee that the dates outlined will be 'end dates' and a commitment to continue with the same programme approach to delivery. It is recognised that further work is required to understand and evidence what can be delivered within the current financial envelope for delivery of the contract.

Building on the Community Treatment and Care Service and learning from the Coronavirus pandemic there is a desire to implement new models of service to support both primary and secondary care remobilisation and reduce unnecessary footfall in these locations. As a result a small group of primary and secondary care colleagues have been taking forward the concept of community monitoring and investigation hubs where a range of investigations and procedures could transfer from being delivered in a GP surgery or a hospital outpatient setting and provide a standard approach and equity of access to these types of services.

The group have identified the need to establish physical premises in which this work can be conducted along with initial thoughts on required skill mix of workforce. Embracing digital technology solutions to ensure that clinicians can access the results of the investigations in a reliable and timely manner.

The establishment of Community Investigation and Monitoring Hubs aligns with the organisational Caring for Ayrshire ambition and vision and will require investment in community services to realise benefit. The desire to limit footfall in GP surgeries and hospital premises will be supported and patients will receive the care they require in a timely manner closer to their home.

The next steps to taking this work forward will be to develop a detailed workforce plan along with discussion about physical location of services within community buildings and home visiting services. Further discussion will be taken through the Caring for Ayrshire programme with defined timeframes as we look to deliver a more comprehensive range of services within the community. Any additional funding requests will also be progressed through this route of re-design aligned to our Caring to Ayrshire ambition.

There is now an opportunity to revisit the urgent care area of the contract aligned to the wider Re-design of Urgent Care Programme.

A programme of work has also been agreed locally to understand the various national mental health allocations and links to primary care.

This along with the Redesign of Urgent Care programme will be linked to the requirements within the next iteration of the Primary Care Improvement Plan scheduled to be submitted to the three IJBS, NHS Board and LMC at the end of March 2021.

There is agreement to continue to deliver at pace using the same programme delivery model with the revised timescales issued by the Scottish Government and BMA as final end point.

6.0 Urgent Care

Re-Design of Urgent Care

Much of the focus initially is around patients self-presenting at Emergency Departments or presenting through NHS24. We seek to provide options in the enhanced pathways for patients accessing the system through General Practice to benefit both patients and support safe sustainability of General Practice as well as other primary care contractors, community pharmacy, optometry and dental services. Furthermore we are also ambitious in working towards the development of an Ayrshire wide Mental Health Assessment Centre as part of our new urgent care model.

It is widely accepted that change is required to alleviate pressures from unscheduled presentations across the Health and Care System. The benefit to progressing with the re-design of urgent care services in Ayrshire and Arran is to establish a joined up system to improve patient and workforce experience and support service sustainability.

The intention of the redesign has been to provide safe, person centred urgent care over a 24/7 period to support General Practice and Primary Care out of hours services as well as Emergency Department and Combined Assessment Unit in Ayrshire and Arran.

A significant initial focus for the redesign is patients self-presenting at Emergency Departments or presenting through NHS24, and providing options in enhanced pathways for patients accessing the system through General Practice to benefit both patients and support safe sustainability of General Practice. We are also ambitious in working towards the inclusion of other primary care contractors, community pharmacy, optometry and dental services.

Work is progressing across the Ayrshire Urgent Care Service (AUCS) to establish this as a standalone service between Primary Care and Acute Services supporting patients, services and other partners to ensure a seamless approach to access the right care in the right place. It is noted that this requires to align with the Strategic Plans of our IJBs and Directions from them to the NHS Board and Councils.

A key factor to successful implementation has been the stabilisation of the medical workforce across the Ayrshire Urgent Care Service throughout 2020 and even with the introduction of new pathways maintains good cover provision. Like most systems across Scotland this is built on a sessional volunteer rota. The service is working towards introducing a core multi-disciplinary team led by a senior clinical decision maker to support the various pathways in place with the appropriate management and clinical leadership.

A number of actions summarised in the sections below are now being taken forward as a consequence of the learning captured and aligning to Phase 2 of the national Redesign of Urgent Care (RUC) Programme.

Urgent Care Mental Health Pathway

As a pathway within Ayrshire & Arran's Redesign of urgent care, unscheduled care mental health services have considered the recovery and renewal of mental health pathways. In the spirit of Caring for Ayrshire's doing the right thing, in the right place at the right time we have considered alternatives to hospital attendances where mental health care could be delivered within the person's own home, or as close to it as possible.

As part of our remobilisation phase 3 plans, we plan to build on this, by initially scoping then extending a direct pathway to the Scottish Ambulance Service; initially as a mental health professional to professional line. The anticipated associated costings at this time are approximately £414,825 for 2021-22.

Thereafter we shall scope if any additionality is required, particularly, if there is a future requirement for an alternative mental health assessment centre.

Develop a Professional to Professional model between primary and secondary care services

A second telephone line for both Combined Assessment Units will be supported by acute clinicians for advice to support GP Practices decision making and identify where patients may be able to attend in a more planned way utilising the ambulatory care pathways.

Primary clinicians will be able to seek specialist advice to support patients longer at home, avoiding potential admission or referral to outpatients where possible. It is the aim for this to be either urgent on the day or a short timeframe of 2-3 days for response.

Scottish Ambulance Service

An area that was highlighted during the focussed work with urgent care is the use of ambulances to support patients to attend hospital safely when they have no transport whether via the Ayrshire Urgent Care Service, GP Practices or other care providers.

Ayrshire and Arran has a good working relationship with the Scottish Ambulance Services (SAS) and through the recent implementation of the RUC work engaging on a daily basis with them and NHS 24 identified areas that would benefit from closer joint working to support Paramedics.

A pathway has been introduced to AUCS senior clinical decision maker to support the advanced practitioners who clinically assess all referrals to support alternatives or a scheduled presentation that doesn't require SAS attendance.

This pathway will also prevent patients being conveyed to hospital and therefore treated in their own homes wherever possible. The Flow Navigation Centre can also support and facilitate liaising with GP Practices which can be a time consuming process for SAS just now should a primary care assessment be more appropriate. This will free up time and capacity for crews to attend other patients. This enhanced model has been launched gradually from January 2021, refining and developing the model day to day taking the learning of approach from the RUC programme. The aim is to have this fully implemented by March 2021.

There was also agreement at the end of the pathway finder phase to progress a patient transport service for patients who need to attend hospital for assessment/admission and have no alternative transport. This will facilitate coordinating patient arrival to the hospital in a scheduled manner within an hour from the point of referral to the acute hospital. This will help us significantly to provide timeous care to our patients in the right location, by the right specialist, and do the right test and avoid unnecessary overnight admissions that would otherwise happen if patients arrive late. This would positively change the patient experience.

Interface with other Pathways

There has been close working with the Re-design of Frailty Programme locally and RUC to identify arrangements that can be put in place through the urgent care pathway. Supporting care homes and general practice has been a key area identified from this work. These actions will be progressed through the frailty programme using data and intelligence from the RUC to inform pathways also linking closely with wider arrangements within Acute Services and HSCPs. Working closely with community nursing teams has supported patients being assessed in their own homes where appropriate.

Further work is required to understand how a mental health pathway through the Ayrshire Urgent Service 24/7 could be best utilised to support patients and GP Practices. This will be explored further under the newly commissioned group led by the Associate Medical Director for Primary Care and Associate Medical Director for Mental Health Services, with updates provided through the Primary and Urgent Care Programme Board to connect the models.

Covid-19 Clinical Pathway

As part of the national response to Covid-19 the Scottish Government asked that all Boards in Scotland set up community clinical hubs and assessment centres to support citizens with Covid-19 related queries, providing a comprehensive front line community response to enable rapid pathways for those affected by Covid-19. To have a single pathway in place for patients to seek clinical advice and assessment for Covid-19/Respiratory/Viral symptoms through accessing NHS 24/111 and directed to the local Covid-19 pathway for further assessment if required. This pathway also incorporates the Clinical Assessment Centre for patients to be seen to face to face. Where GP Practices carry out a telephone assessment, particularly those with long term conditions, and suspect Covid-19, they can also refer directly to the Clinical Assessment centre for the patient to be seen safely away from GP Practices. This will remain a requirement throughout 2021/22.

Within Ayrshire and Arran the Covid-19 clinical pathway was integrated as part of AUCS using a clinical triage model providing timely telephone or video consultations to patients, ensuring these are followed with a face to face consultation if required.

This has ensured:

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

We have continuously developed to ensure best use of resources to work flexibly across all part of the urgent care service to support activity. The resource requirements outlined for this pathway have been projected based on the current staffing model to respond to activity and trends throughout 2020/21. This will be reviewed on an ongoing basis and adapted to suit changes in the community position.

Finance

The cost for the RUC service model was developed based on the delivery model of the additional clinical and administration staff for the new pathway within the Ayrshire Urgent Care Service and Minor Injury Units. In addition funding was agreed for programme management time. It was agreed this clinical model would remain in place until March 2021.

Based on the actions outlined within the plan, this would be worst case scenario with the aim that the number of senior clinical decision makers, which is the most expensive element of the model, would be replaced with other MDT professionals. Confirmation of funding for the RUC programme has not been received to date.

Different ways of working across the urgent care service, particularly the out of hours model has resulted in efficiencies across the services and allows opportunity for further re-design and re-investment throughout 2021 to new models, including how we can further invest in our community urgent care response teams such as integrated care teams.

Additional Resource

Description	Cost
Redesign of Urgent Care	
Medical	£879,052
Nursing	£467,960
Mental Health	£415,000
Management	£56,831
Total	**£1,818,843**
Covid-19 Clinical Pathway - Community Clinical Hub	
GP	£1,819,324
Operational Staff	£267,800
Total	**£2,087,124**
Covid-19 Clinical Pathway - Crosshouse Assessment Centre	
GP	£676,884
Nursing	£751,712
Operational Staff	£199,524
Total	**£1,628,120**

7.0 Unscheduled Care – Acute Hospitals

Overview

Pathways to avoid admission within the Emergency Department and Clinical Assessment Units are being developed as part of the wider Re-design of Urgent Care Programme.
In addition to the work undertaken to develop the Flow Navigation Centre Model, there is connected work being taken forward specifically within the Acute hospital setting. This includes:

- Frailty
- Same Day Acute Care through the Combined Assessment Units;
- Clinical Connectedness;
- Management of Delayed Discharges;
- General Surgery Ambulatory Care

Frailty
The ambition for frail older people's services within NHS Ayrshire & Arran is under pinned by the principle of "getting it right for every older person".

As an integral component of our Covid-19 recovery, frail older people whom account for 70% of the acute hospital admissions, require us to target our redesign focus on pathways maximising opportunities of preventing Covid-19 and non Covid-19 harm. Therefore, preventing where appropriate admission to hospital, intervening to ensure any admission is a short stay, and aim to maximise community models of intervention.

Providing early identification of frailty to ensure the appropriate clinical and support interventions are targeted to the level of frailty, thus preventing escalation, and where appropriate prevent hospitalisation. This requires a clinical connected integrated approach across agencies and HSCP partners.

As part of our continuing redesign programme, developing a single system approach, focusing early intervention on entry to the acute care system around front door of the hospital, with a focused direction to prevent hospitalisation, where clinically appropriate and work towards a community integrated, hospital at home model.

This requires clinical leaders within the speciality, both medical and non-medical to provide care and lead this change in practice to acute care being delivered within patients home.

Same Day Acute Care through the Combined Assessment Units

As part of a wider system reform, an Operational Response Centre model will be developed. This will standardise the way in which GP referred patient's access same day acute medicine across Ayrshire. Staff will be able to direct GPs and provide alternatives to admission.

This model will allow an Ayrshire wide approach to care delivery with consideration of speciality referral and individual site capacity and pressure.

Management of Hospital Discharges

Both acute hospitals have historically had consistently high numbers of delayed discharges, which has been directly impacted by Covid-19 pathways. We are working to refocus our HSCP partnership support to provide a collaborative approach to initiate the home first approach. This to ensure, proactive review, early initiation of building a culture across clinical areas and teams to plan transfers of care. We continue to work collaboratively with our partners to ensure patients who do not require acute care, are supported within the right place for their care and support. Both sites now have HSCP representatives on site who work with our clinical and discharge team to where possible prevent delays, and avoid admissions.

Our intent is to work to zero delays, to ensure acute care for those patients that require acute hospital care. To support the management of delayed discharges and promote the home first ethos a weekly multidisciplinary virtual board round has been introduced on both acute sites.

General Surgery Ambulatory Care
An ad hoc Surgical Ambulatory Care Assessment Unit (SACU) was set up in spring 2020 as a response to the Covid-19 outbreak. Over the next year to effectively separate red and green pathways there is requirement to continue with this model. This will support with overcrowding in our ED, surgical GP patients will bypass the ED with full ambulatory assessment and discharge home wherever possible taking place within the unit.

Covid-19 Pathways
NHS Ayrshire & Arran Acute services will take an approach which ensures ongoing provision for the management of Covid-19 related illness, alongside safe delivery of non Covid-19 related emergency care.

Both the Emergency Department and Combined Assessments Units across Ayrshire have had to make significant changes to the flow of patients through each department to ensure that there is clear segregation of Covid-19 suspected and positive patients from non Covid-19 patients.

Whilst it is anticipated that the number of Covid-19 suspected patients will decrease as we move forward, there will still be an ongoing requirement to segregate Covid-19 suspected and positive patients from non Covid-19 patients. As numbers decrease the planning assumptions will be reviewed.

Additional Capacity

There is a need to continue separate low (super-green), medium (green) and high (red) risk pathways with discrete inpatient areas across both Acute sites. Although it is anticipated that the requirement for high risk capacity will reduce in the coming months, both Acute sites require to maintain capacity for medium and high risk patients. There will be an ongoing requirement to manage nosocomial spread of Covid-19 on our Acute sites. Covid-19 outbreaks in Ward areas has resulted in the frequent closure of medium risk beds and wards. Current data shows that patients who have had Covid-19 and recovered in the Acute setting are experiencing on average a length of stay greater than 25 days. This has had a significant impact on site capacity.

To support the mobilisation of Acute Services different bed scenarios have been modelled taking into account both seasonality and community prevalence and the wide internal impact on hospital services associated with Covid-19 including impact on high care beds, capacity for de-escalated patients, separation of red / green pathways and closed beds for infection control. This also aims to take into account a number of other variable factors including the impact of the vaccination programme, new strains of Covid-19 and any lockdown restrictions.

Modelling assumptions have been triangulated with the Covid-19 weekly data issued by Public Health Scotland and using a linear line an overall core capacity requirement of 70 beds by the 9th April 21.

The undernoted provides anticipated range of beds required dependent on the above factors. Our working assumption is to plan for mid-range capacity acknowledging that an agreed workforce plan is required to safely continue to staff the Covid-19 capacity.

The Acute Directorate will review the bed modelling projections on a weekly basis throughout the period of this mobilisation plan.

The detail is summarised below:

Spring (April to June)	A&A	64 - 95 beds
	UHC	44 - 63 beds
	UHA	21 - 42 beds
Summer (July to September)	A&A	32-68 beds
	UHC:	21 - 47 beds
	UHA	11 - 21 beds
Winter*(October to March)	A&A	135 - 196 beds
	UHC	89 - 135 beds
	UHA	46 - 61 beds

**NB This is a reflection of the impact of Covid-19 in winter rather than typical seasonal winter pressures.*

As we mobilise our elective activity we will require patients to be admitted on a low risk pathway and cared for in ring-fenced green beds. This forecloses the possibility of using these beds for patients on a medium risk pathway. This is covered in more detail in the planned care section.

Critical Care

As per mobilisation plan 2, a centralised Ayrshire & Arran Covid-19 ICU was created within a repurposed day surgery unit at UHC. We will maintain our baseline capacity of 10 beds and the ability to increase as the Covid-19 activity rises.
Remobilising elective activity on the UHC site will require a change to the current ICU foot print. Covid-19 ICU will be located within the core ICU unit, ICU 1 and the medium risk ICU would be moved to DSU ICU. The location of medium risk patients in DSU ICU means that we will be able to use the remaining DSU recovery space for elective patients, most likely for endoscopy and local anaesthetic recovery.

Additional Resource

Description	Cost
Same Day Acute Care through the Combined Assessment Units	£405,000
Management of Delayed Discharges	£90,000
General Surgery Ambulatory Care	£258,770
Covid-19 Pathways	£1,049,000
Additional Core Capacity	£5,360,000
Additional Surge Capacity	£3,488,000
Critical Care	£2,820,000
Total	**£13,470,770**

8.0 Routine Elective Care

Overview

Routine and planned care have been significantly impacted over the course of the pandemic, since March 2020. The plan for 2021/22 will focus on beginning to recover routine and planned care services, set against a number of recovery principles:

- There will be a continued requirement to be able to flex, pause and create surge capacity at short notice, in the case of a viral resurgence.
- Patient pathways must remain Covid-19-safe, including Covid-19 testing, pre-procedure isolation and separation of low and medium/high risk pathways for as long as this remains the recommendation of Scottish Government and relevant professional bodies.
- Re-mobilisation and recovery of routine and planned care will continue to follow clinical priority
- Coordination of recovery will continue to be clinically led, building on the effective arrangements developed during the pandemic, and ensuring that new practices which have worked effectively during the pandemic are continued.

This plan includes a request for investment in additional infrastructure, particularly in core staffing for operating theatres and outpatient clinics. This investment in additional staffing will minimise the ask of existing staff to work overtime and additional hours in order to deliver the additional capacity required to begin the planned care recovery, which we anticipate will take several years.

Modernised Approach to Planned Care

The pandemic response provided an opportunity to expedite and benefit from new practices and approaches. The continued development and expansion of these approaches will form a key component of the routine and planned care recovery.

- Waiting List Validation – the implementation programme will be phased across the specialties, having been initiated in Orthopaedics and Endoscopy in February 2021, with a shift from the traditional administrative validation to clinical validation. Clinical time will be assigned to delivery of this critical component.
- Enhanced vetting, Active Clinical Referral Triage (ACRT) and other service specific initiatives
- Patient Initiated Review (PIR)
- Team Service Planning
- Digital Enablers supporting non-face to face, and asynchronous consultations

A 'Bringing It Together' approach is being spearheaded by the Associate Medical Director through 2021/22.

Outpatients

Current position
The outpatient waiting list has grown significantly since the onset of the pandemic due to the impact of social distancing requirements and at times availability of both staff and physical resources.

January 2021			
Waiting Time (weeks)	New UCS	New Urgent	New Routine
0 – 12	1234	2190	7897
12 – 18	8	358	3722
18 – 52	4	340	13220
52 +	0	13	3206
Totals	**1246**	**2901**	**28045**

Re-analysis of outpatient demand and capacity will be undertaken during 2021/22 in order to better understand the changes in referral patterns, and to identify where additional actions will be required to respond to these changes on a more permanent basis. It is noted that referrals for Urgent Suspicion of Cancer are running at 15% above pre-Covid-19 levels nationally, and this same pattern is being noted locally so this is being considered in the planning for 2021/22.

Many specialties have demonstrated significant waiting list increases but there are particular challenges in specialties which rely more on 'hands-on' examination:

- Dermatology
- Diabetes and Endocrinology
- Gastroenterology
- Ophthalmology
- Pain Service

Maintaining new and effective ways of working

Adapting outpatient service delivery during the pandemic expedited a range of changes in service provision as outlined above, and these will be further developed and expanded 2021/22.

Non Face to Face appointments

During the pandemic there was a significant shift in the type of clinic appointments offered.

Appointment Type	January 2020 (%)	January 2021 (%)
Face to Face	97.4	68.3
Telephone	2.2	28.4
NHS Near Me	0	0.9
Virtual	0.4	2.4

Overall there has been a significant shift in the use of non-face to face appointments from 2.6% pre-pandemic, to nearly a third of all consultations being delivered using one of the non-face to face methods.

The local experience by clinicians has been that telephone consultations offer the most pragmatic and accepted alternative.

The re-establishment of more face to face appointments particularly in those specialties where hands on examination is required is expected to result in a slight drop in the overall proportion of non-face to face consultations. However there will continue to be a strong focus on non-face to face consultations through 2021/22 and we have set ourselves the target of continuing to deliver 25% of appointments in this way.

Patient Initiated Review

A number of services have expanded the use of Patient Initiated Review during the pandemic, resulting in fewer patients being automatically re-appointed for follow up appointments. A joint acute and primary care working group are in the process of consolidating this work with a view to ensuring a consistent approach, and an approach which can then be rolled out to a wider range of services during 2021/22. This working group will also be considering how this new activity can be better captured and reported.

Establishing the ‘new normal’

It is assumed that Covid-19 impact on outpatient clinic capacity will continue from March until June 2021, and so outpatient services will continue to operate in a way similar to the autumn 2020.

During this period, and in line with emerging guidance at that time, we will undertake a piece of work to review the current Risk Assessments and whether this lends the opportunity to safely increase the capacity of clinics and waiting areas whilst still observing required physical distancing.

The Covid-19 response included the re-designation of several outpatient clinic areas into Covid-19 testing and assessment hubs, and a staff wellbeing hub. It is anticipated that these areas will return to their former use around June 2021, and this will support the further re-mobilisation of clinics, with a particular focus on those services which are more dependent on face to face examination and so are demonstrating the most significant waiting list pressures.

We also propose to introduce extended delivery of clinics in the evening and at weekends. The delivery of this will require some investment in additional staffing infrastructure in order to avoid an unreasonable ask on existing staff to deliver this in overtime and additional hours.

Operational Plan

A programme of enhanced clinical waiting list validation will be implemented as part of the outpatient recovery programme through 2021/22.

Remobilisation of outpatient activity has enabled NHS Ayrshire and Arran to deliver the following proportions of activity as at January 2021:

- New Outpatients : 53% of pre-Covid-19 levels of activity
- Return Outpatients : 68% of pre-Covid-19 levels of activity

Planning for 2021/22 on the basis of assumptions outlined earlier predicts that we will be able to deliver increase the outpatient activity further, but that this will remain below pre-Covid-19 levels. This will be constrained by ongoing distancing requirements, impact of additional staff leave and absence and the fact that a significant proportion of pre-Covid-19 activity was delivered through overtime which will not be deliverable to the same extent.

	April – June 21	July – Oct 21	Nov 21 – Mar 22
% of pre-Covid-19 activity	55%	70%	65%

The specialty breakdown of this actual predicted activity is detailed in Template 2.

The following outpatient areas will have a particular additional focus:

1. Phased implementation of extended working days and weekend clinics as normal practice, with recurring investment in support staffing in order to move away from the significant use of overtime for the existing workforce. The investment will deliver a further 8% increase in activity.

2. Redesign of the Pain Service* with investment in specialist nursing, pharmacy, physiotherapy and psychology to enable a more holistic service to be provided, re-establishment of a group pain management programme and targeted triage of referrals building on the 23% validation and triage reduction achieved during the pandemic.
3. Redesign of the Breast Cancer* clinic, co-location of the symptomatic and breast screening services in order to maximise team working, service efficiency and service robustness for the future. Further development of extended roles in nursing and mammography. This investment will deliver 800 additional breast cancer consultations and clinical assessments, will ensure recovery of the 31-day and 62 day cancer targets for breast cancer, and will make the breast cancer service more robust.
4. Ophthalmology clinic redesign*, incorporating the principles of shared care, and maximising service capacity through close working with community optometrists and nurse-led clinics. This will deliver an additional 9000 outpatient consultations.
5. Independent Sector insourcing on a non-recurring basis to increase service capacity. This will deliver 4000 outpatient appointments (mix of telephone and face to face consultations).

*separate detailed proposals available

Elective Surgery

Current Position

There have been significant constraints in operating capacity during the pandemic. However the reduced outpatient clinic capacity has also meant fewer patients being added to the inpatient/day case waiting lists.

Overall the elective surgical waiting lists have increased, but with the biggest impact being for the patients awaiting procedures in the less clinically urgent Priority 3 and particularly the priority 4 categories.

	March 2020	December 2020 (Update for January once available)
Number of patients awaiting IP/DC surgery	4,190	4,679
Number waiting > 12 wks	1,238	3,172

The allocation of operating theatre capacity based on clinical priority has affected some surgical specialties more than others.

Number of Inpatients/Day cases waiting > 12 wks

Specialty	March 2020	December 2020 (Update for January once available)
ENT	73	287
General Surgery (incl Vascular)	138	520
Gynaecology	5	122
Ophthalmology	295	432
OMFS	67	222
Plastic	0	26
Trauma & Orthopaedics	624	1,112
Urology	35	356
Other	0	83
Total	**1,238**	**3,172**

The extended waiting list for patients awaiting orthopaedic surgery is a particular focus. Many of these patients' procedures are categorised as being of low clinical urgency however the impact on their quality of life, mobility and ongoing pain can be significant. For this reason, addressing the backlog of patients awaiting orthopaedic surgery will be a priority during 2021/22.

Maintaining New and Effective Ways of Working
Throughout the pandemic, the allocation of the limited operating capacity has been driven by the relative clinical priority of each case. This has been clinically-led, and coordinated by the Theatre Re-Start Groups which have net weekly.

This approach has proven to be effective and will be continued through 2021/22 to ensure that there continues to be a prioritisation which is based on each patient's clinical urgency.

Establishing the 'New Normal'

Operating Facilities
One of the significant constraints during the pandemic has been the re-purposing of the UHC Day Surgery and Endoscopy Recovery Area into a Covid-19 Critical Care Unit.

As the number of Covid-19 ICU patients reduces, it is planned that there will continue to be the requirement to retain a smaller Covid-19 ICU area. This will allow the return of some, but not all Day Surgery recovery capacity at UHC.

It is estimated that the day surgery recovery capacity will be 35-40% of pre-Covid-19 capacity, and so without any mitigation, this would have a significant bearing on surgical activity. It is proposed that this be part-mitigated by funding an additional 12 bedded day case/23hr ward area.

Elective Centre of Excellence for Orthopaedic Surgery
Supporting investment will facilitate the creation of an Elective Centre of Excellence for Orthopaedic Surgery. A separate case has been provided seeking support for this realignment of services to enhance elective capacity.

Optimising Resources
This plan makes a request for investment in additional theatre staffing infrastructure. This will optimise the operating capacity by introduce extended operating days and weekend operating but minimising the ask of existing staff to deliver this in overtime and working extra hours.

Collaborative Working with Independent Sector
Collaborative working with Independent Sector hospitals was effective during the pandemic, and opportunities to continue this should be explored. In particular we plan to continue the commissioning of Local Anaesthetic treatment capacity which frees up NHS capacity to undertake more General Anaesthetic surgery.

We would also value the opportunity to discuss options for ongoing independent sector capacity for elective orthopaedic surgery.

Operational Plan
Planning for 2021/22 on the basis of assumptions outlined earlier predicts that we will be able to re-start inpatient/day case operating, but that this will remain below pre-Covid-19 levels.

2021/22 Planned activity	April – June 21	July – Oct 21	Nov 21 – Mar 22
% of pre-Covid-19 activity	50%	75%	70%

A more detailed specialty breakdown of the planned activity is shown in Template 2.

The following areas of Inpatient and Day case surgery will have a particular additional focus:

1. Increasing capacity through extended working days and weekend. This would deliver an additional 110 cases per month, and represent a further 7% increase on the above predicted activity.

2. Establishing additional bed capacity at UHA and UHC to support additional extended day and weekend operating capacity, and to part mitigate the reduction in Day Surgery recovery capacity at UHC.
3. Implement Centre of Excellence for Orthopaedic Surgery at UHA – this is the subject of a separate paper.
4. Independent Sector collaboration – establishment of regular capacity at BMI Carrick Glen Hospital for the continuation of Local Anaesthetic procedures to release UHA and UHC theatre capacity for general anaesthetic cases. This would deliver an additional 600-900 cases over 2 or 3 days per week.
5. Independent Sector collaboration – orthopaedics backlog.
6. Pre-operative assessment – capital investment to re-locate.

Cancer

Current Position

The continuation of cancer services has been a priority through the pandemic, and significant effort was made to protect services which delivered cancer diagnosis and treatment, and to put in place contingency plans at points of peak Covid-19 pressure.

Nonetheless the impact of reduced capacity has resulted in some cancer pathways being slower, particularly in the diagnostic stages.

	31-day Pathway		62-day Pathway	
Pathway	Quarter 1 2020	Quarter 4 2020	Quarter 1 2020	Quarter 4 2020
Breast	94%	100%	96%	74%
Colorectal	95%	100%	75%	77%
Cervical	25%	100%	25%	67%
Head & Neck	100%	100%	100%	100%
Lung	100%	100%	100%	100%
Lymphoma	92%	100%	67%	60%
Melanoma	100%	100%	100%	90%
Ovarian	0%	100%	100%	100%
Upper GI	100%	100%	84%	87%
Urological	99%	100%	100%	93%
TOTAL	99%	100%	92%	85%

Maintaining New and Effective Ways of Working

The co-location of breast cancer symptomatic and breast screening services on the Ayrshire Central Hospital site from February 2021 has been a response to managing the Covid-19 pressures and keeping patients safe. This also offers the opportunity for a more efficient way of working, and a further integration of the clinical teams.

The Breast surgery service also established a working relationship with GJNH, establishing one day per week of breast surgery at GJNH. This has worked well and it is anticipated that this will continue until at least August 2021.

Establishing the 'New Norm'
GP referral practices have altered notably over the course of the pandemic, and indications are that GP practice is likely to continue with some of these new ways of working. The increased use of telephone consultations appears to be impacting on referrals for suspected cancer investigation and early national analysis has suggested a 15% rise in UCS referrals. Further work is required to understand this, and to plan for any ongoing impact.

NHSAA has been successful in its bid to trial a new 'Vague Symptoms' cancer pathway. Funding has been provided to trial this pathway over a 12 months period through 2021/22 using a virtual multi-disciplinary team approach.

Operational Plan
The West of Scotland Cancer Network has agreed priorities aligned to the Cancer Recovery Plan to support specific areas of service development in pre-habilitation, treatment and data.

Priority Area	Funding from Cancer Monies	Comments
Breast Service Co-location at ACH (capital redevelopment)		Funded from 2019/20 cancer funding. Go-Live and evaluation in 2021/22
Skin Cancer Clinical Nurse Specialist	£57,000	Recurring cost from 2022/23
Enhanced Colorectal Recovery Nurse Specialist	£47,000	Part year cost on 2021/22 and full recurring cost from 2022/23
Systemic Anti-Cancer Treatment (SACT) schedulers	£62,000	Part year cost on 2021/22 and full recurring cost from 2022/23
Urology laparoscopic and endoscopic equipment	£165,000 capital £48,000 revenue	
Dermatology skin biopsy coordinator	£5,000 capital £31,000 revenue	Part year cost on 2021/22 and full recurring cost from 2022/23
Pre-habilitation Service	£250,000	Regional plan

Diagnostics - Imaging Services

Current Position
Imaging services have experienced both the impact of reduced capacity due to social distancing and reduced staffing, but also demand increases particularly from unscheduled care.

Number of patients waiting > 6 weeks	January 2021
MRI	768
CT	1,476
Non-obstetric Ultrasound	111

Recently revised Demand and Capacity modelling has clearly set out a significant shortfall in available CT and MRI capacity, consistent with some of the recently publish UK analysis supporting the need for significant investment in imaging infrastructure.

Maintaining New and Effective Ways of Working

During the pandemic, Scottish Government and UK Government funding supported the provision of additional CT and MRI scanning capacity through a mobile CT pod and mobile MRI scanner. Both of these initiatives worked well. The mobile MRI scanner has remained in place through 2020, with a move to 7-day working from July the impact on activity and waiting list clearly shown in the table above. The mobile CT pod has been in situ since early January 2021 and is expected to show a similar impact.

We plan to continue use of the mobile MRI scanner subject to available funding and would wish to continue the use of the mobile CT pod throughout 2021/22 subject to funding and availability.

Establishing the 'New Norm'

During 2021/22 a case will be produced for the capital and revenue investment in an additional CT scanner and additional MRI scanner in NHS Ayrshire and Arran.

Operational Plan

The key areas of focus will be:

1. Continued use of mobile MRI scanner, 12hrs per day, 7 days
2. Continued use of mobile / CT Pod, 12hrs per day, 7 days
3. Increase CT capacity at UHC by staffing 2 additional days

Diagnostics – Endoscopy

Endoscopy services have been one of the areas most significantly impacted by the pandemic and is an area of ongoing local, regional and national focus for recovery in 2021/22.

Maintaining New and Effective Ways of Working

An approach based on clinical prioritisation was introduced during the pandemic, ensuring that patients deemed to have the highest risk of a cancer diagnosis were appointed first. This has meant that through the pandemic it has only been possible to offer endoscopy procedures to patients in the UCS and Urgent categories. Moving forwards endoscopy capacity will continue to be prioritised based on clinical urgency, however work is underway to clinically review the 'routine' category with a view to identify those patients who will still benefit from an endoscopy procedure, and to make some changes to referring and listing practices which will reduce this going forwards. It is recognised that NHSAA has the highest endoscopy intervention rate in Scotland and we aim to address this through 2021/22.

qFIT testing of patients referred with colorectal symptoms was also introduced during September 2020. This has proved a useful tool supporting the clinical prioritisation of patients, and for some patients avoiding the need for colonoscopy procedure. Thus far the qFIT testing has only been introduced for UCS and Urgent referrals and this will be rolled out to include routine referrals during 2021/22.

Colon Capsule Endoscopy has been introduced on a trial basis from February 2021. This procedure is an alternative to colonoscopy for some patients and so is expected to reduce demand for colonoscopy as well as being a less invasive procedure. This service has been funded until March 2021, and so additional funding will be required to continue this through 2021/22 to allow sufficient time for evaluation.

Cytosponge has similarly been introduced on a trial basis from February 2021. This is an alternative to upper GI endoscopy for some patients. This has also been funded until March 2021 and additional funding will be required to enable full evaluation through 2021/22.

Establishing the 'New Norm'

One of the significant impacts of the Covid-19 pandemic has been the loss of recovery space at UHC, which has been re-designated for Covid-19 critical care.

Whilst the anticipated reduction in Covid-19 numbers through 2021/22 should allow the return of this endoscopy recovery capacity, it is also anticipated that the need to ensure continued Covid-19 'surge' and the possibility of some level of viral resurgence in the autumn/winter will mean that there continues to be a reduced endoscopy capacity and a growing endoscopy backlog.

Operational Plan

The key areas of focus will be:

1. Implement clinical validation of waiting list
2. Implement revised triage criteria for endoscopy
3. Continue pilot and review of qFIT, Colon Capsule Endoscopy and Cytosponge
4. Support more effective booking of GJNH endoscopy capacity through appointment of the required pre-assessment nurses and admin support.
5. Expand use of extended roles and provide succession planning with 3 new Nurse Endoscopist posts (1 already in post non-recurring)
6. Continue to work with regional and national teams to develop a regional recovery plan for endoscopy.

Planned Care Anticipated Funding Requirement

	Priority Area	Reveunue Recurring	Revenue Non-Recurring	Capital Required	Planned Activity	Expected Funding Source	Comments
Outpatients	Pain Clinic Redesign					Access	
	Breast Clinic Redesign	£139,094			800 per annum	Access	
	Ophthalmology Clinic capacity		£419,586		9,000 per annum	Access	Phase 1 of plan
	Independent Sector Outsourcing		£800,000		4,000 per annum	Access	
	Cinical Validation		£65,606			Access	
	Investing in extended working day and weekend working as normal practice		£1,721,121		10,400 per annum	Access	
Elective Surgery	Extended Day and Weekend Operating	£1,686,806	£500,000		1,300 per annum	Access	Sustatianable recovery proposal. If recurring funding not available would require overtime which is not keeping with organisations approach to staff wellbeing
	Ward capacity to support increased operating capacity and day surgery throughput (St2, UHA) + UHC		£1,978,629			Access	Recruitment to fix term posts or exit strategy through non-recruitment of vacant posts at end of 12 months
	Pre-Operative Assessment re-location			£543,000			
	Independent Sector Collaboration – Local Anaesthetic capacity		?		600 per annum		SG to confirm
	Independent Sector Collaboration - Orthopaedics		?				SG to confirm
Cancer	Breast Service Co-location at ACH						Funded from 2019/20 cancer funding. Go-Live and evaluation in 2021/22
	Skin Cancer Clinical Nurse Specialist		£57,000			Cancer Funding	Recurring cost from 2022/23
	Enhanced Colorectal Recovery Nurse Specialist		£47,000			Cancer Funding	Part year cost on 2021/22 and full recurring cost from 2022/23
	Systemic Anti-Cancer Treatment (SACT) schedulers		£62,000			Cancer Funding	Part year cost on 2021/22 and full recurring cost from 2022/23
	Urology laparoscopic and endoscopic			£165,000		Cancer Funding	
	equipment		£48,000			Cancer Funding	
	Dermatology skin biopsy coordinator		£31,000	£5,000		Cancer Funding	Part year cost on 2021/22 and full recurring cost from 2022/23
	Prehabilitation Service		£250,000			Cancer Funding	
	Consultant Colorectal Surgeon - in post		£130,000			Access	
	Consultant Gynaecologist - in post		£130,000			Access	
Diagnostics Imaging	Mobile MRI scanner		£603,000		4320 per annum	Access	Total cost is £843,000 (excluding VAT which is reclaimable). Board has £240,000 budget to contribute
	Mobile CT Pod		£450,000		10,320 per annum	Access	Staffed CT scanner, however availability needs confirmed
	Additional Reporting Costs		£400,000			Access	Medica
	Recurring staffing of unstaffed 2 days of UHC CT scanner	£110,000			3,168 per annum	Board General Allocation Uplift	
Diagnostics Endoscopy	Recurring investment in Pre-op nursing / admin for continuation of GJNH		£177,966			Access	
	Colon Capsule		£221,100		300 per annum	Access	
	Cytosponge		£117,000		360 per annum	Access	
	Expansion of the UHC endoscopy Unit		152987	?	1750 per annum	Access	First outcome of recovery discussions. Plan to be further developed. Significant ongoing work in endoscopy recovery plan
	Nurse Endoscopists x 3 WTE (includes 1 funded non-recurringly in 2020)		£196,311		included in above	Access	
Access Support			£131,000				
		£1,935,900	£8,689,306	£713,000			

Total Non-Recurring figures includes £495,000 which it is anticipated will be funded from a cancer allocation

NB A separate case has been submitted for 1.25 million as described in the above Elective Centre of Excellence for Orthopaedic Surgery section

9.0 Women and Children's Services

Overview

We will continue with new ways of working introduced during 2020-21, including telephone and NHS Near Me consultations, utilising a blended approach to provide women centred care.

Paediatric nursing staff will continue to utilise their enhanced skills to support service delivery across inpatient wards and patient flow within the Emergency Department and to support our vaccination programme through 2021-22.

In addition, the Children's Services which are delegated to the Health and Social Care Partnerships anticipate the following additional costs in 2021-22, in relation to Covid-19.

Additional Resource

Description	Cost
Children's Services	
North Ayrshire HSCP	£105,000
East Ayrshire HSCP	£207,214
Total	**£312,214**

10.0 Laboratory Services

Overview

Moving into remobilisation phase 3, and supporting the ongoing need to manage both Covid-19 and non-Covid-19 demands, there are a number of further plans within the department:

- The Microbiology Laboratory continues to operate 7am-11pm 7 days per week to accommodate Covid-19 testing.
- Four Biomedical Scientist posts have now been appointed and one Medical Laboratory Assistant. An additional Biomedical Scientist post requires to be recruited as well as two administrative support roles. Existing staff continue to cover the additional extended hours of work during the period of new staff training.
- Admin support staff have been redeployed to Microbiology and continue to provide a crucial role in ensuring the continued supply of Covid-19 test collection packs.

<u>Developments</u>
There are now three platforms available for testing and daily capacity for testing has increased from 140 to 470 with a surge capacity of 564.

A new testing platform for acute symptomatic testing should be operation by April 2021 and will further increase testing capacity by around 48-94 tests per day.

Additional Resource

Description	Cost
Staff costs – various posts	£312,000
Total	**£312,000**

11.0 Regional

Overview

The challenge of Covid-19 pandemic will continue to pose a significant risk to the NHS during 2021. While the vaccination programme being rolled out across Scotland and the rest of the UK is expected to impact on the disease spread and health challenges caused by this in a positive manner, Covid-19 and the various emerging new strains will remain endemic in the population and as such will continue to impact on the Health and Care System for the foreseeable future. In addition the impact of the past 12 months on the health of the population in general terms resultant from delays in diagnosis and treatment, the increased inequalities in our population alongside the health and wellbeing of staff and the need for recovery all present significant challenge for NHS Boards, which are likely to take a number of years to recover.

In planning for this, the West of Scotland Boards 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 to meet the challenges now facing the NHS as it starts the next phase in dealing with Covid-19 and recovery.

The Collective Response

In planning for the next 6-12 months, recognising the above and uncertainty around Covid-19, we have set out the areas where we will focus 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 national health service partners particularly NHS GJNH, SAS and NHS 24.

Cancer and Scheduled Care

The management of cancer and scheduled care will be the main area of focus in terms of recovery. During the first wave of the Covid-19 Pandemic specialty specific groups reviewed their pathways and altered their approaches to treatment to reflect this new and additional risk to minimise the risk of preventable harm and optimise outcomes, for patients requiring cancer treatment including surgery, systemic anti-cancer therapies or radiotherapy. Much of this work was facilitated through the regional Managed Clinical Network and Multi-disciplinary teams.

Over the past 6-9months, Boards have adopted prioritisation approaches to manage patient care with local clinical prioritisation groups in place to ensure fair and reasonable access to the limited surgery resource in terms of both hospital beds and elective green-site theatre capacity. This has been supported by a Regional Clinical Prioritisation Group and a Scheduled Care Group, involving both senior clinical leaders and senior managers who manage cancer and access programme in each of the Boards across the West of Scotland, to consider the available capacity; support arrangements; learning from approaches adopted in Boards and by specialties; taking a consistent approach where possible to support patient treatment across the region.

In this next phase of remobilisation we will continue with this approach and to follow the guidance set out in *'Recovery and Redesign: An Action Plan for Cancer Services''* formulated by the Scottish Government National Cancer Recovery Group and from the Scottish Access Collaborative and Modernising Patient Pathways Programme.

Whilst there is an expectation that all boards will upscale their diagnostic and elective surgery capacity in the coming months to support the ongoing priorities within cancer and address the backlog, there needs to be recognition that there will also be demands for surgery and diagnostic tests that go beyond patients requiring cancer treatment and that these specialties will also require access to a theatre and diagnostic capacity at a time when constraints on capacity are likely to continue. This will require cooperative working arrangements to be put in place to ensure patients with greatest priority are treated and patients in Board areas seeing higher levels of demand and ongoing challenge with Covid-19 are not unfairly disadvantaged.

To support this, the Boards within the region are using a prioritisation approach and working together to use available capacity to treat patients with greatest need, ensuring equitability where possible. The initial priority focus of the region will be on priority 2 cases for cancer and orthopaedics with the aim to set out a plan that identifies demand and considers the available capacity; aligning clinical capacity to the needs of the patient groups while considering how to address backlogs beyond these areas of initial focus.

NHS GJNH will be an important partner in this work to ensure the capacity available at the GJNH can be maximised to support the treatment of patients within the region where surgical capacity does not allow this within the board of residence.

It is recognised that this is a challenging task and is likely to need for cross Health Board working and/or national support for some specialties 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.

Recognising that there will be capacity challenges for the foreseeable future it will be important to develop agile and responsive approaches to meet demand. Part of the work will involve sharing and learning from the new approaches implemented across the region over the last year; considering digital approaches to capitalise on the transformation experienced such as near me/ remote consultation. It will also be important to work with primary care teams to align demand to capacity, encouraging dialogue to review and adjust pathways and thresholds, where required, to ensure patients with the greatest needs can be accommodated.

Progressing the Regional Programme
There is an agreed regional work programme in place, which we will continue with and build on through 2021/22. The key components for the programme plan for West of Scotland work streams are summarised below.

Regional Service Models in Implementation
Work will continue to progress key regional programmes including the implementation of the Major Trauma Network within the West of Scotland alongside work to progress the Regional Vascular Service Model and the Regional Sexual Assault and Rape Service agreed in 2020. Work will also continue through the Systemic Anti Cancer Therapy Group and the Ophthalmic Services Programme to revisit challenges and opportunities in relation to demand and capacity and the development of supporting roles.

Emergent Service Models and Strategies
There are a number of programmes underway to develop the strategic direction and emerging service models which are at the detailed planning stage which will also be progressed. This includes work on Interventional Radiology; Thrombectomy; Upper GI Service Model; and OMFS. Work will also continue to conclude the Cardiac Strategy which has been reviewing the following areas: Acute Coronary Syndromes, Cardiac Surgery, Electrophysiology and Devices, Structural Heart Disease Cardiac Imaging, Heart Failure. Similarly the work on to progress the Urology Service models for Female and complex reconstruction, Cancer Surgery and the Core Urology and Out of Hours model will also continue.

Cross Region Enabling Activity
Within the region there are a number of cross regional enabling activities which will also be continued and/ or resumed to support the planning and delivery of future services including:

The Regional Innovation work which has continued and helped progress new approaches during the Covid-19 Pandemic. During 2021/22 we will share learning and consider approaches being piloted for wider application and implementation across the region.

The HR and Workforce Planning Work Programme which is reviewing the medical workforce requirements across the region and developing nurse and advanced practitioner roles to support service provision primarily focused on cystoscopy, endoscopy and ENT.

The further development of the Regional PAMS will resume along with the further development of the whole system service planning and modelling tool to help support service and capital planning.

12.0 Workforce

Workforce planning is intrinsic to the intent set out within this remobilisation plan, ensuring we can effectively balance deployment of our existing staffing resource to meet extant operational need, both substantive and supplemental, and demand and supply arising from natural turnover, new models of care and Covid-19 specific service additionality.

An organisational risk has been identified in relation to workforce supply and capacity:

‘Failure to ensure sufficient workforce supply to deliver heath and care services for patients across extant and Covid-19 specific services will lead to an inability to provide sustainable and sufficient care, increased pressures on existing staff resources resulting in poor patient outcomes, adverse impact on staff health and wellbeing and reputational damage.’

Critically, like all health and care systems, workforce demand, specifically for registered clinicians, is significantly outstripping supply and is further compounded by fixed undergraduate supply outturns on an annual basis. This is acutely problematic specifically in trying to meet nursing and midwifery demand, similar to our position in 2020 our expectation would be to recruit the full complement of undergraduate nursing and midwifery students that will graduate in 2021.

As an organisation we foresee the need to consider our employability schemes more systematically and at scale in order to start to counter national supply issues and develop mechanisms to 'grow our own' staff where possible an appropriate. We will look to further explore the Kickstart scheme during the course of 2021/22.

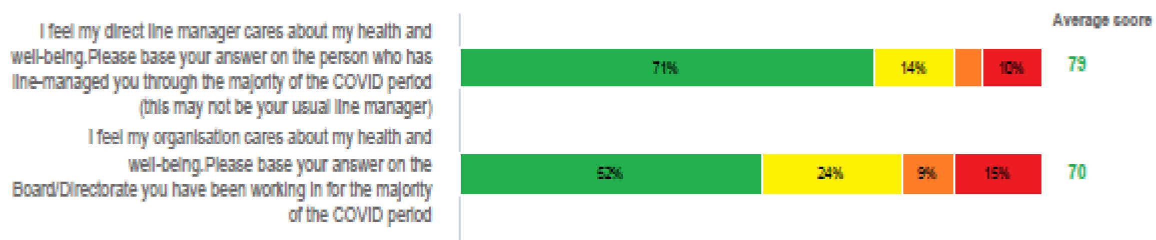
In terms of managing workforce risk, NHS Ayrshire & Arran has invested in expanding the core workforce to support key delivery programmes including Test and Protect and Vaccination. We will review fixed term staffing arrangements and ensure that where essential we provide continuity of staffing to support these programmes on a sustainable basis whist managing the risk of fixed term contracts. Allied to our consideration of both Covid-19 and non-Covid-19 absence is the notable impact upon staff use of annual leave entitlement which is further compounded by the challenging operating environment. With regards to annual leave utilisation specifically the importance of staff being able to utilise this, as means of rest and recuperation away from work is a key concern with regard to workforce wellbeing. We will continue to closely monitor all aspects of staff leave in order to, as far as practicably possible, identify and address critical workforce pinch points which could materially impact on sustainable operational service provision.

Our attendance strategy underpinning Remobilisation will be addressing some of the underlying absence reasons with a focus on supporting staff who experience stress, anxiety or depression and supporting staff with long term chronic health conditions. These areas of focus will be underpinned by ensuring staff wellbeing support is available and line managers are informed and enabled in supporting staff.

Implementation of the Health & Care (Staffing) Scotland Act is currently paused nationally and we anticipate this re-commencing in 2022.

Workforce Wellbeing

The Covid-19 pandemic has brought into sharp focus the staff wellbeing. The iMatter pulse survey undertaken in 2021, with a 49% response rate, provided an indicator of the perception of staff with regard to their health and wellbeing through the Covid-19 period as illustrated below:



This approach has complemented and enhanced the existing Staff Health, Safety & Wellbeing Strategy which sets out the clear need for the organisation to be supportive of and accountable for our staff mental health and wellbeing.

Moving forward our aim is to embed staff health, safety and wellbeing as part of our core infrastructure recognising the model of success prompted by the pandemic, and validated by our staff in their feedback supporting the retention of our wellbeing hubs as part of our organisational fabric.

There is collaborative working across our health and social care system to ensure that all wellbeing models are accessible to staff across all operational areas. Our services, provided from our Wellbeing Hubs and Sanctuaries across our sites, in both Acute and Health & Social Care Partnerships, are focused on the principles of psychological first aid, with a tiered model enabling staff to access services appropriate to their need, both locally and nationally provided (e.g. PRoMIS, national wellbeing telephone support line). We will work with our staff care and wellness teams to support health and care teams to take the action they require to recover from the demands of the last year. This will ensure that we have an agile and targeted approach to support.

We have established a Wellbeing Operational Management group, with wide inclusive representation of stakeholders, that is tasked with developing a comprehensive action plan, budgetary requirements, timescales and performance indicators to be endorsed, through a clear governance and accountability route, by the Staff Wellbeing Sub-Group to the Health, Safety and Wellbeing Committee and ultimately the NHS Board.

The NHS Board is seeking a non-recurring investment for 2021-22 in wellbeing services, with a commitment to make a recurring investment of £515,812 from 2022-23, which reflects the priority we place on these services.

Staff Wellbeing Costings

Role	Banding/wte	Costing	Comments
Staff Wellbeing Connector	Bd 6 1.0 wte	£43,551.00	
Staff care	Bd 7 1.0 wte	£53,773.00	No Backfill (new post)
Staff care ACH	Bd 6 1.0 wte	£43,551.00	No Backfill (new post)
Staff care	Bd 6 1.0 wte	£43,551.00	No Backfill (new post)
Psychiatry	Med/Den 0.4 wte	£55,411.00	Backfill
Medical Peer Support	Med/Den 1.0 wte	£138,529.00	Backfill
Consultant Psychologist	Bd 8c 1.0 wte	£94,818.00	New post
Clinical Psychologist	Bd 8a 1.0 wte	£78,887.00	Funded via SG/NES Board allocation until March 2023
Assistant Psychologist	Bd 4 0.4 wte	£13,051.00	Funded via SG/NES Board allocation until March 2023
Administrator	Bd 4 1.0 wte	£32,628.00	
Non-Pays (Recurring)		£10,000.00	
Less SG/NES funding		(£91,938.00)	2021/22 and 2022/23 only
Additional Funding Required 2021/22	**8.8 wte**	**£515,812.00**	

13.0 Digital

Overview

With the implementation of a distributed working model and effective collaboration tools, this enables the workforce to become agile in their approach to health and social care. The organisation's implementation of Orion Concerto as the Electronic Patient Record (EPR) will enable full visibility of the patient's record irrespective of location or time of day. Our ambition is that access to the EPR will stretch from independent contractor to ICU and everywhere in-between. This whole system approach to digital health and social care is a cornerstone of the organisation's Caring for Ayrshire strategy.

The implementation of the EPR and Office 365 will deliver both operational and financial efficiencies throughout the organisation, enabling real-time collaboration between healthcare professionals and ensuring the healthiest outcomes for the population of Ayrshire.

Public Health

Within the last year there has been a substantial change in the profile of public health as part of the national response to the pandemic.

Several national tools have been developed to support contact tracing as part of the national 'Test and Protect' programme. These national tools have been supplemented by with digital automations to minimise the impact of rising caseloads on the local teams. Patients are being notified by SMS of their test results.

Further TEC projects are being scoped to support public health activities including applications to support the effective signposting of citizens to the appropriate services. At present the use of the Microsoft Office 365 collaboration tools is creating efficiencies between public health teams within NHS Ayrshire & Arran and their Local Authority colleagues. This will be enhanced over the next reporting period.

Mental Health

The implementation of NHS Ayrshire & Arran's EPR (clinical portal) will include mental health services and access to the EPR by mental health clinicians. The mental health system (Care Partner) already provides summary information to the EPR, providing visibility of risks and alerts to all users of the portal. This enhancement will provide the clinicians with a complete view of the patients' health and care interactions and needs. Further enhancements to the Care Partner product will provide additional reporting capability to mental health clinicians. This system has been supplemented with the introduction of TEC solutions supporting patients in the community and providing clinicians with additional information to support the patients in their care.

Primary and Community Based Care

The recent implementation of both Office 365 Teams functionality alongside the Near Me implementation has provided the ability for Primary Care and Community based care to collaborate effectively. The use of Near Me to provide video consultation with patients has proven to be effective giving additional capability over a telephone consultation. The use of Teams has allowed for professional to professional conversations to be had in real time, breaking down the perceived barriers between Primary and Acute care.

The further implementations of EMIS web throughout Community based care will enhance multi-disciplinary team (MDT) working and enabling a distributed working model. These implementations will provide better outcomes for patients while enabling the benefits of a digitally held patient record for community-based care.

Further implementations of Technology Enabled Care (TEC) will enhance patient outcomes while putting the patient in the driving seat of their own care. The integration of this TEC data in to the EPR will further enhance healthcare by providing health and social care professionals' access to this data regardless of location or time of day.

These digital solutions will enhance the existing MDT and Community Treatment and Care (CTAC) models of care.

Routine and Planned Care
The implementation of the latest version of HEPMA covering 93% of all beds throughout NHS Ayrshire & Arran will be completed providing additional capability and safety in the prescribing and administration of medication at the bedside. In addition, a further deployment of Digital Pathology and a replacement Radiology Information System will complement care offered within routine and planned care services.

The implementation of a Radiology home working solution has been completed allowing for consultant radiologists to work flexibly, this will be further enhanced with additional functionality.

Ready access to Trakcare and the implementation of the T2020 version will make active clinical notes functionality available. This combined with the EPR and a distributed working model will allow a flexible approach to vetting, out coming and create efficiencies within this area of care. Completion of Labs order comms will also assist in ensuring timely discharge from hospital and effective results reporting.

Further implementations of Near Me will complement the existing outpatient models and allow for professional to professional discussions to be made using Microsoft Teams. Further advancements with the telephony platform are scheduled for implementation and the additional functionality will include 'softphone' capability. This will enable clinicians to make telephone calls from their laptops regardless of location.

Urgent Care
To support urgent care, NHS Ayrshire & Arran have established an unscheduled care hub. Near Me has been implemented in all areas of urgent care to support the patient and minimise unnecessary attendance. This supplements the existing telephony capability. Microsoft Teams has also been implemented to allow for professional to professional collaboration. Opportunities for integration between systems have been identified and these will be progressed throughout this reporting period.

Bespoke whiteboards are implemented within all areas of the acute estate allowing for Emergency Departments (ED) and Combined Assessment Units (CAU) to identify downstream capacity within wards and allowing for easy identification of patients' medical issues.

14.0 Finance

Overview In addition to the detailed sections within the plan the following areas will require additional resource to support Covid-19 recovery.

Loss of income
In 20/21, income within NHS canteens has reduced significantly due to some staff working from home, the introduction of social distancing within the dining rooms and the introduction of the Staff Hubs where soup and snacks have been provided free of charge. Current income loss on the Dining Rooms is projected to be around £1,000,000 with projected reductions in Salaries and Supplies offsetting this by £520,000 leaving a net loss of income of around £480,000.

Area	Description of cost	Cost
Board	Loss of Income	£480,000
TOTAL		**£480,000**

Council loss of income due to Covid-19 includes income related to Day Care services which have had to close during the pandemic. Projected losses in 2021/22 are shown in the table below.

Area	Description of cost	Cost
East	Loss of Income	£153,000
North	Loss of Income	£100,000
TOTAL		**£253,000**

Provider Sustainability
In 2020/21 care homes were funded to compensate for lower occupancy due to the pandemic. Scottish Government and COSLA continue to work with Scottish Care to ensure the financial sustainability of care homes and estimated costs of this in 20221/22 are shown in the table below:

Area	Description of cost	Cost Apr-Jun only
East	Provider Sustainability	£673,000
North	Provider Sustainability	£1,050,000
South	Provider Sustainability	£1,025,000
TOTAL		**£2,748,000**

Summary

Detailed finance schedules in a format prescribed by Scottish Government will accompany the RMP3, however a summary table showing the totals from each section is shown below.

The costs shown in the table below are the request to Scottish Government for non-recurring funding in 2021/22 for Covid-19 related capacity or recovery costs related to the backlog of elective and mental health services.

Required Resource

Section	Service	Cost	Funding Stream
2.0	Whole System Approach	-	-
2.1	Locality Health and Care Services	£8,359,455	Covid-19
2.2	Community Nursing	-	-
2.3	Rehabilitation	£365,733	Covid-19
2.4	Care Homes	£900,160	Covid-19
2.5	Infection Prevention and Control	£1,353,000	Covid-19
2.6	Public Protection	-	-
2.7	Quality Improvement	-	-
2.8	Patient Experience	-	-
2.9	Equalities Impact Assessment	-	-
3.0	Public Health	£12,446,150	Covid-19
4.0	Mental Health	£1,899,810	Covid-19
5.0	Primary Care	-	-
6.0	Urgent Care	£1,818,843	Re-design of Urgent Care
	Covid-19 Clinical Pathway - Community Clinical Hub	£2,087,124	Re-design of Urgent Care
	Covid-19 Clinical Pathway - Community Clinical Hub	£1,628,120	Re-design of Urgent Care
7.0	Unscheduled Care	£13,470,770	Covid-19
8.0	Routine Elective Care (Revenue)	£10,625,206	Access
	Routine Elective Care (Capital)	£713,000	Access
9.0	Women and Children’s Service	£312,214	Covid-19
10.0	Laboratory Service	£312,000	Covid-19
11.0	Regional	-	-
12.0	Workforce	£515,812	Covid-19
13.0	Digital	-	-
14.0	Finance		
	Loss of Income (Board)	£480,000	Covid-19
	Loss of Income (HSCPs)	£253,000	Covid-19

	Provider Sustainability	£2,748,000	Covid-19
15.0	Governance and Risk	-	-
Total		**£60,288,397**	

15.0 Governance and Risk

Structure of Emergency Management Team

The Chief Executive established the Emergency Management Team and its supporting emergency management structures below on behalf of the Board to ensure that the health and care system was able to respond effectively and deliver services that were safe for patients and staff.
The NHS Board Chair and Chief Executive have kept board governance under review over the last year to ensure that this has been proportionate and flexible whilst ensuring the Board meets it governance obligations.

The aim of the Emergency Management Team:

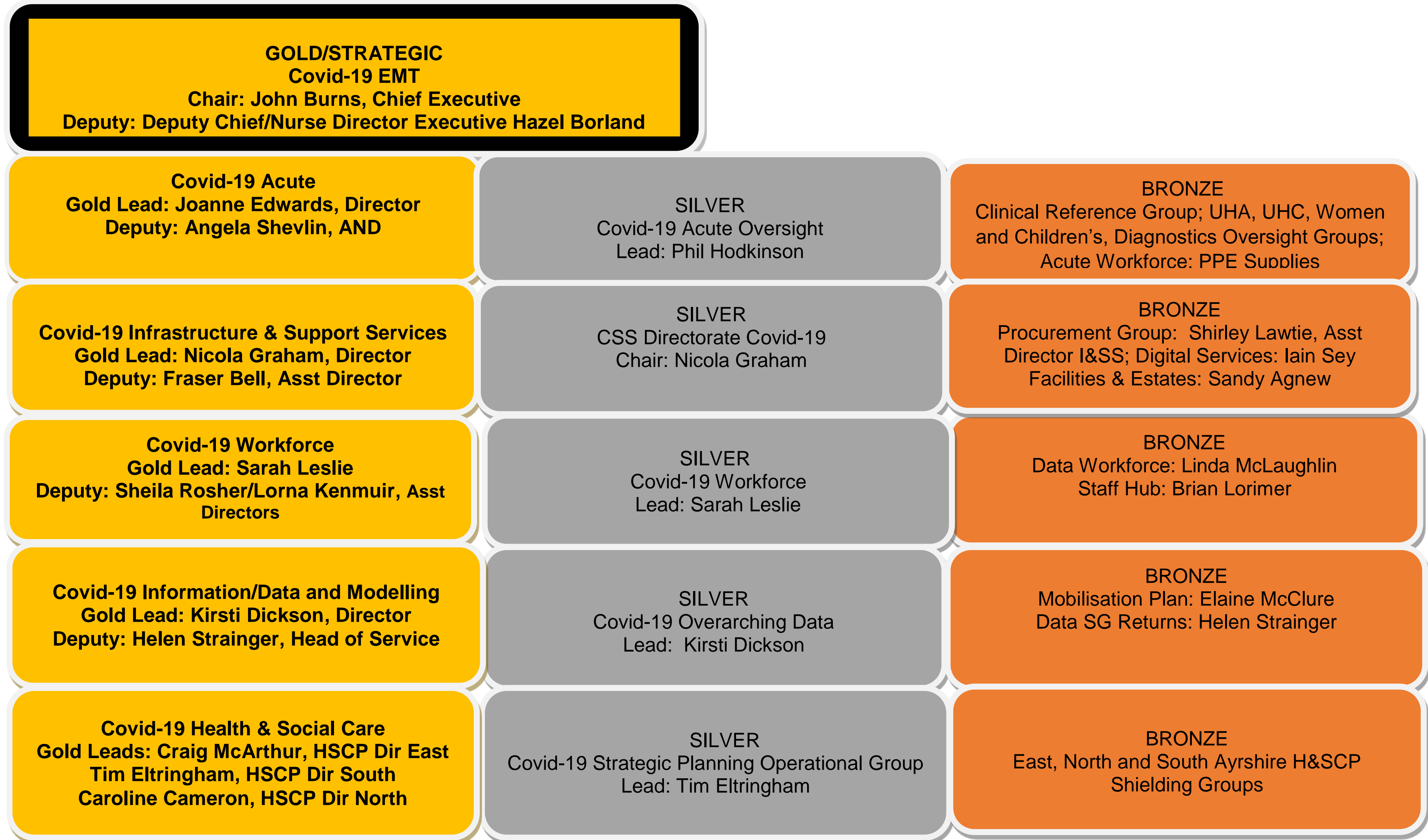
- Collective accountability for delivering on the mobilisation plan; and
- Provide collective leadership and effective response

In doing so will:

- Mobilise services safety for staff, patients and visitors;
- Respond to changing demand flexibly and effectively;
- Ensure a state of readiness;
- Ensure the ability to respond to the added demands of winter;
- Communicate effectively across the Health and Care systems; and
- Maintain an understanding of service response

The EMT will continue to meet as long as needed to provide senior coordination to the pandemic response.

In addition, the Strategic Ayrshire Local Resilience Partnership (SALRP) continues to meet weekly to support and lead the Ayrshire wide response to the pandemic.


EAST AYRSHIRE
Health & Social Care
Partnership
south ayrshire
health & social care
partnership
NHS
Ayrshire
& Arran
GOLD/STRATEGIC
Covid-19 EMT
Chair: John Burns, Chief Executive
Deputy: Deputy Chief/Nurse Director Executive Hazel Borland
Covid-19 Acute
Gold Lead: Joanne Edwards, Director
Deputy: Angela Shevlin, AND
SILVER
Covid-19 Acute Oversight
Lead: Phil Hodkinson
BRONZE
Clinical Reference Group; UHA, UHC, Women and Children's, Diagnostics Oversight Groups; Acute Workforce: PPE Supplies
Covid-19 Infrastructure & Support Services
Gold Lead: Nicola Graham, Director
Deputy: Fraser Bell, Asst Director
SILVER
CSS Directorate Covid-19
Chair: Nicola Graham
BRONZE
Procurement Group: Shirley Lawtie, Asst Director I&SS; Digital Services: Iain Sey
Facilities & Estates: Sandy Agnew
Covid-19 Workforce
Gold Lead: Sarah Leslie
Deputy: Sheila Rosher/Lorna Kenmuir, Asst Directors
SILVER
Covid-19 Workforce
Lead: Sarah Leslie
BRONZE
Data Workforce: Linda McLaughlin
Staff Hub: Brian Lorimer
Covid-19 Information/Data and Modelling
Gold Lead: Kirsti Dickson, Director
Deputy: Helen Strainger, Head of Service
SILVER
Covid-19 Overarching Data
Lead: Kirsti Dickson
BRONZE
Mobilisation Plan: Elaine McClure
Data SG Returns: Helen Strainger
Covid-19 Health & Social Care
Gold Leads: Craig McArthur, HSCP Dir East
Tim Eltringham, HSCP Dir South
Caroline Cameron, HSCP Dir North
SILVER
Covid-19 Strategic Planning Operational Group
Lead: Tim Eltringham
BRONZE
East, North and South Ayrshire H&SCP
Shielding Groups

Gold	Silver	Bronze
Covid-19 Nurse Directorate **Gold Lead: Hazel Borland, Director** **Deputy: Jenny Wilson, AND**	SILVER Care Home Oversight - Lead: Ruth McMurdo Infection Prevention Control Lead: Bob Wilson	BRONZE East, North and South Care Home Oversight Groups
Covid-19 Medical Directorate **Gold Lead: Crawford McGuffie, Director** **Deputy: Phil Hodkinson, AMD**	SILVER Ethical Decision Making Sponsor Director: Crawford McGuffie Chair: Jane Chestnut/Alastair McGowan	BRONZE Incident Management Team: Elvira Garcia, CPHM Data SG Returns: Helen Strainger
Covid-19 Public Health **Gold Lead: Lynne McNiven/ Joy Tomlinson, Directors**	SILVER Covid-19 PH Advice Cell/Health Protection - Lynne McNiven/Joy Tomlinson	BRONZE Bronze Testing Group: Elaine Harrison, AGM Results Hub: Emma Walker, Senior Programme Manager Contact Tracing
Covid-19 Testing **Testing Gold Lead: Hazel Borland**	SILVER Testing (including Contact Tracing) Silver Testing Lead – Lisa Davidson, Asst Director	
Covid-19 Vaccination Programme **Gold Group Chair: John Burns**	SILVER Vaccination Programme Covid-19 Immunisation Operational Delivery Group Lead: Roseanne Neil Covid-19 Immunisation Clinical Governance Group Lead: Crawford McGuffie	
Covid-19 Communications **Gold Lead: Crawford McGuffie** **Deputy: Hazel Borland**		

Immunisation Programme

Appendix A

Cost category	Description of cost	FY Cost £000's
Additional venue costs	Rented venue cost estimate	49.5
Additional venue costs	Tents	25.2
Additional venue costs	Mobile Support Unit	-
GP costs	Payments under the DES PCA(M)17	247.3
Other non-pay costs	Clinical waste	10.3
Other non-pay costs	PPE	6.0
Other non-pay costs	Laptops/IT equipment	-
Other non-pay costs	Staff scheduling system	-
Other non-pay costs	Freephone number	7.2
Other non-pay costs	Printing Costs	4.0
Other non-pay costs	Resus equipment	1.5
Staff costs	Wave 1 - per SG guidance	-
Employed vaccinators	Wave 2 onwards - staff employed	1,885.9
Healthcare support workers	Wave 2 onwards - staff employed	404.3
Domestic and portering	Wave 2 onwards - staff employed	332.3
Admin	Wave 2 onwards - staff employed	330.2
Staff costs	Pharmacy staff	-
Staff costs	Programme delivery costs	299.1
Other PC contractor costs	Use of independent contractors in centres	448.2
Staff costs	IT staff to support local venues	239.7
Other PC contractor costs	Training costs	-
Other non-pay costs	Learn Pro licenses	-
Other non-pay costs	Induction venue costs	2.0
Other non-pay costs	Uniforms	3.0
Storage/cold chain costs	Purchase of cold storage for MVC	
Total Immunisation Programme		**4,295.6**

Community Asymptomatic Testing

Appendix B

Cost category	Description of cost	FY Cost £000's
Scottish Fire and Rescue Service	Staff costs	709.3
Scottish Fire and Rescue Service	PVG	0.6
Scottish Fire and Rescue Service	Uniforms	1.0
Scottish Fire and Rescue Service	Travel	12.0
Traffic Management	Salary	258.0
Traffic Management	Uniforms	0.6
Traffic Management	Travel	3.0
Traffic Management	Temp signage	0.9
Traffic Management	Perm signage	2.5
Oversight Team	Staff costs	68.6
Oversight Team	Staff costs	62.7
Oversight Team	Uniforms	0.3
Oversight Team	Travel	1.4
Oversight Team	IT/Comms	1.9
Delivery of Testing Team (Army first full team from June, 50% until then)	Staff costs	102.7
Delivery of Testing Team (Army first full team from June, 50% until then)	Staff costs	931.6
Delivery of Testing Team (Army first full team from June, 50% until then)	Travel	16.5
Domestic staff	Salary	193.3

Vehicle Hire	Equipment move	15.6
Vehicle Hire	Porter	32.2
Vehicle Hire	Fuel	4.2
Communications/PR	West FM	30.0
Communications/PR	Newspaper coverage	24.0
Communications/PR	Digital billboards	20.0
Other	PPE/sanitising/etc	24.0
Other	Courier Costs	3.6
Other	Business Support kits (including posters/stickers/PPE)	30.0
Other	ATS site costs (HLP etc)	15.0
Other	Contingency	12.0
Other	Speedy Hire - ATS site costs (booth setup/equipment)	18.0
Other	Digital solutions (15 tablets and 6 mobile phones/line rental)	3.8
Other	Signage/pop up banners/SD signage etc (UWS)	6.0
Other	Staff wellbeing	6.0
Other	Support for self-isolation (wrap around care)	78.8
Total Community Asymptomatic Testing		**2,690.0**

Public Health

Appendix C

Post	Grade	WTE	£000
Oversight Team			
Consultant PH or Consultant PH Medicine - interviews arranged)	8D	1.00	119.6
Programme Manager	8A	1.00	65.3
Senior Information Analyst	6	1.00	51.3
Admin (needs to be recruited)	4	1.00	34.2
Sub Total Oversight Team		**4.00**	**270.4**
Testing			
Programme Manager	7	1.00	62.9
Nursing	6	2.60	133.5
Nursing	5	8.00	331.3
Nursing	3	8.00	248.4
Nursing	3	1.00	31.1
Porter	2	3.00	93.2
Admin	3	1.60	49.7
Admin	4	2.00	68.4
Admin Supervisor	5	1.00	41.4
Sub Total Testing		**28.20**	**1,059.8**
Results Hub			
Programme Manager	7	1.00	62.9
Interface Co-ordination Officer	6	0.00	-

Admin Supervisor	5	1.00	41.4
Negative Results Dissemination and Triage	4	8.00	273.8
Admin	3	2.00	62.1
Sub Total Results Hub		**12.00**	**440.1**
Triage & Health Care Contact Tracing Team			
Programme Manager	7	0.80	50.3
Nursing (seconded staff - no recruitment)	5	7.20	298.2
Deputy Managers	5	2.80	116.0
Team Leads	6	4.50	231.0
Admin	4	1.00	34.2
Education Co-ordinator	6	2.20	112.9
Education Triage Nurses	6	2.00	102.7
Education Team Leads	6	2.50	128.3
Sub Total Triage & Health Care Contact Tracing Team		**23.00**	**1,073.5**
Community & Schools Contact Team			
Service Development and Delivery Manager	8A	1.00	-
Programme Manager	7	2.00	125.7
Contact Tracing Leads (not tracing - doing assignment and supporting task)	6	5.00	256.6
Contact Tracers - senior (will be tracing)	5	7.00	289.9
Contact Tracers - senior (will be tracing)	5	10.00	414.1
Contact Tracers (new recruits)	3	9.80	304.3
Contact Tracers (LA)	3	10.00	103.5

Admin/Data Input (CT inbox, 7 days)	4	2.00	68.4
Sub Total Community & Schools Contact Team		**46.80**	**1,562.7**
Enhanced Health Protection			
Consultant PH Medicine	8D	1.00	119.6
Health Protection Nurse Specialist	7	1.00	62.9
Health Protection Nurse	6	4.00	205.3
Admin - (EHP Covid-19 and Imms/HP)	4	2.00	68.4
Data and Surveillance Officer	5	1.00	41.4
Resilience Officer	5	1.00	31.1
Resilience Admin	4	1.00	34.2
Screening Nurse	7	1.00	62.9
Screening Nurse	5	1.00	41.4
Sub Total - Enhanced Health Protection		**13.00**	**667.1**
Management and Support			
IT support Officer (Agency appointment for speed)	5	1.00	41.4
Manager	8c	1.00	106.5
Clinical Lead for T&P	8d	1.00	119.6
Sub Total Management		**3.00**	**267.4**
Total Pay Costs		**130.0**	**5,431.1**
Total Supplies Costs			**120.0**
Total RMP3 Costs			**5,461.1**

NHSScotland Chief Operating Officer

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 2480
E: John.connaghan2@gov.scot

Appendix 2

To:
John Burns
Chief Executive
NHS Ayrshire & Arran
By email

2 April 2021

Dear John,

NHS AYRSHIRE & ARRAN: REMOBILISATION PLAN 2021/22

Thank you for submitting the third iteration of your Board's Remobilisation Plan (RMP) covering the period April 2021 to March 2022.

As detailed in the commissioning letter issued on 14 December, this RMP is intended to provide an update and further iteration of your plans for remobilisation, summarising your work in a number of key areas of activity to the end of March 2022 and building on the process which started with your initial remobilisation plan in May last year.

Covid-19 Resilience

While at present we are seeing a steady decline in Covid-19 hospitalisations and patients in ICU, we are moving into a period of uncertainty as relaxation of restrictions starts to occur. In terms of risk, we can expect some behavioural changes in the population in advance of the time when all eligible people are fully vaccinated. There is also the risk of new variants emerging which may exhibit a level of resistance to the available vaccines.

Whilst the pandemic is ongoing, our key priority is to suppress infection to as low a level as possible which is the best way to ensure the NHS is not overwhelmed, long COVID is minimised and new variants are made less likely. However, alongside this in a clinical setting, Boards should:-

- Have the capability to stand up appropriate bed resources, scaled in proportion to any further waves/outbreaks, including the ability to double their share of the national adult ICU capacity to 360 beds within one week and to treble to 585 beds in two weeks.
- Be prepared to respond to any further guidance issued in this area as more evidence is available.
- Ensure that such preparedness does not impact upon plans for staff leave.
- Maintain an enhanced public health response consistent with extant national guidance, including Test & Protect and the vaccines programme throughout the planning period.
- Be prepared to adapt these programmes to suit changed circumstances including any requirement for boosters and any necessary change to other vaccine programmes.
- Prioritise Infection Prevention & Control, including the ability to rapidly respond to any changes in the national guidance.
- Continue to delivering essential non-Covid services, with a continuing focus on trauma, maternity, cancer, population screening and clinically prioritised elective care.
- Expand the role of primary/community based care, embedding a whole system approach to Mental Health & Wellbeing.

Person-centred approach

Designing patient pathways with the citizen experience at the centre is key to the successful remobilisation and recovery of services. *Re-mobilise, Recover, Re-design: the framework for NHS Scotland* commits Boards to ensuring that the patient experience is included in the design and delivery of high quality care and support. In addressing this as part of your remobilisation planning and delivery, I would encourage you to take account of the ALLIANCE's 'People at the Centre' programme (and report) and Healthcare Improvement Scotland - Citizens' Panel for health and social care on experiences during the COVID-19 pandemic. It will also be important to ensure that hospital visiting is safely resumed, in line with the Strategic Framework, recognising the significant benefits that family presence has for patients and staff.

Staff Wellbeing & Sustainability

The recovery of our services will not be possible without the recovery of our workforce. The ongoing support of staff wellbeing, and embedding sustainability into the workforce, were identified as key priorities in the commissioning of these plans: the process of remobilising services has to be effectively managed alongside ensuring that staff have the opportunity to decompress and heal. That is why Boards were tasked with ensuring that forecasted activity levels are fully informed by this approach. Colleagues in the Scottish Government Health Workforce Directorate will continue to offer appropriate support as you move to the implementation phase of your RMP.

Partnership Working and Staff Engagement

It is clear that your RMP has been developed in collaboration with key strategic partners: the availability of robust and effective mutual aid and partnership working emerged as key themes when reviewing plans from all Boards. I encourage you to continue this approach while implementing your RMP and when developing any further iterations, as well as ensuring that all stakeholders are meaningfully involved. I similarly encourage you to continue to ensure strong and active engagement with your workforce and clinical colleagues, not least via your Area Clinical Forum and Area Partnership Forum, and with third sector interfaces.

Supporting Adult Social Care

Your RMP demonstrated that the Board is aware of its responsibilities in this area and has clear plans in place to fulfil these responsibilities. The Independent Review of Adult Social Care in Scotland, published shortly before Boards submitted their plans, will be a valuable tool and reference point during the implementation phase of your RMP, and as you continue to develop your longer term response in this area. It will be for the new Parliament to decide how to take the review's recommendations forward and we will be in touch further in this regard.

Redesign of Urgent Care

The implementation of a whole system approach under this programme remains a necessary and vital part of the way in which urgent care will be delivered during the period covered by your RMP and beyond. As the delivery models and interfaces are developed and implemented, it is essential that this work is not undertaken in isolation and that whole system pathways are at the core of how systems operate. As Phase 2 of the Redesign of Urgent Care Programme continues across 2021/22 we will work closely with all Boards and delivery partners on all aspects including communications and marketing. The process will be driven forward by an Integrated Unscheduled Care Steering Group, working with key partners to support effective implementation of the whole system unscheduled care programmes of work across primary, secondary, and social care.

Planned Care

Funding for Planned Care activity will be for the new administration to determine, and will be confirmed to you as soon as possible after the election. In the meantime and to ensure that activity can continue at planned levels, please commence implementation of your plans in this area in line with the discussions you have had with our Access Support Team.

Mental Health

It is clear from your RMP, and commendable, that mental health services have continued to be provided throughout the pandemic, prioritised on the basis of need and using remote methods of delivery where possible. We also recognise and appreciate the continued development and embedding of innovations introduced during the pandemic, in particular, digital provision and where appropriate, Mental Health Assessment Services.

Going forward, to meet anticipated increasing demand for mental health services, it will be crucial to continue to develop a whole system approach to care provision, working with partners to support population well-being through to delivering specialist services for people living with mental illness.

To achieve this, it is important that you continue to work closely with colleagues in the Scottish Government Mental Health Directorate on the implementation of the Mental Health Transition and Recovery Plan and associated funding, which should be spent in line with the priorities set out in Ms Haughey's letter of 24 March 2021. In particular, this work should focus in the first instance on: CAMHS improvement; clearing CAMHS and psychological therapies backlogs and improving waiting times; developing primary care and community mental health services; and expanding the workforce.

Supporting the spread of Best Practice and Innovation

The Scottish Government has commissioned the establishment of the Centre for Sustainable Delivery (CfSD), which sits within the Golden Jubilee. As you know, this is a national unit that will build on existing improvement programmes and develop new innovative programmes to support local Boards to deliver national priorities, incorporating new tools and techniques and bespoke assistance to help tackle areas of challenge.

This is very much a collaborative approach with the CfSD working alongside boards and key strategic partners to support remobilisation, recovery and redesign, and the progress and developments that are required in 2021/22. This includes the rapid rollout of new techniques, technology and clinically safe, faster and more efficient pathways for patients. Local boards are asked to work with the CfSD during the development of AOPs to identify how it can support the wide range of programmes and consider what bespoke support may be required to deliver the priorities over the next twelve months.

Research, development and innovation are core to NHS Scotland's role as a person-centred, evidence-based healthcare system, and have played a crucial role in the response to the COVID-19 pandemic. It is critical that NHS Scotland continues to recruit patients into Urgent Public Health (UPH) studies, as designated through the UK-wide prioritisation framework. This research activity is essential to develop approaches that will reduce transmission, reduce the number of patients that require hospitalisation and guide the treatment and care of patients, now and in the future

I should also say that the level to which innovation has already been embedded, particularly in relation to Near Me and other digital solutions is to be maintained. The continued roll-out and consolidation of these innovations will be vital going forward.

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Addressing Inequalities

Another key cross-cutting theme is the need to address inequalities which have arisen or been exacerbated by Covid-19. This has been recognised in your plan and emerged as a key theme nationally. It is vital that implementation of plans, and your longer term strategic thinking retains this aspiration and delivers on your commitments to reduce inequalities across the Health & Care System - including but not limited to those which relate to minority ethnic groups and people living in greatest deprivation.

Finance

We have reviewed your financial plan for 2021/22 and provided detailed feedback on 15/03/2021. We note your financial plan shows an unmet savings target for 2021/22 of £13.3 million (1.7% of baseline) assuming £19.2 million of savings can be met (2.5% of baseline). However there continues to be significant uncertainty about the financial impact of Covid in both the short and longer-term, and what this will mean both for service delivery and associated financial plans.

As in 2020-21, we will therefore look to assess progress against your plan through the formal Quarter 1 review process, when the in-year Covid funding and costs will be clearer. As part of this review we will look for an update as to the revised financial projections for 2021-22 and the progress the Board has made in taking forward savings plans. Further details around the Quarter 1 review process will be provided to NHS Directors of Finance in the coming weeks.

In the interim we expect that the Board continue to develop sufficient– as far as possible- recurring savings options to meet the financial challenge outlined in your financial plan.

As previously indicated, we aim to return to three year financial planning and the next steps on this will be detailed in due course. The timing of this will however depend on the impact of Covid over the coming year.

Escalation Status

As you are aware, the Escalation status of the Board on the NHS Scotland Performance Escalation Framework was considered alongside the review of your RMP.

I can advise you that NHS Ayrshire & Arran will remain escalated at Stage 3 on the Framework in relation to its Financial position. What this means in a practical sense is that existing levels of support and scrutiny will continue, led by the Scottish Government Health Finance team.

Plan Approval and Feedback

I am content to approve your RMP. Your finalised and signed off RMP will be used as the basis for engagement with the Board over the coming year. Feedback has been and will continue to be provided to you by individual policy teams within the Health & Social Care Directorates, as is normal. It is vital that this feedback should be taken on board as you move into the implementation phase of your RMP. On that basis I do not intend to include any significant feedback in this letter, beyond pointing out the following:

- I note that Infection Prevention and Control (IPC) has been identified as a key corporate priority, including Acute, Mental Health and Community Services and would reinforce the view that strict IPC measures and facilities risk assessments should continue in all sectors.
- I was pleased to find a whole-system approach demonstrated throughout the plan evidenced by having been compiled in liaison with a wide range of clinicians and in partnership with your three Integrated Joint Board partners. There was welcome reference to the re-design of patient pathways to reflect the lessons learned and improve quality of access and I am thankful for the pathfinder role played by your Board in relation to the Redesign of Urgent Care.

- I welcome the reflective approach regarding lessons learned from changes in practice during the pandemic and the review of potential new ways of working to further support a whole-system approach.

Publication of your RMP

I am aware that your Board will need to complete its internal governance processes to approve your draft plan and that your finalised plan, incorporating any developments or amendments made to take account of feedback received in the interim, will be published together with this letter in due course. Given the strict requirements in place at this time, I would ask that while we remain in the pre-election period both your RMP and the content of this letter are kept out of the public domain, with publication to take place immediately after the election.

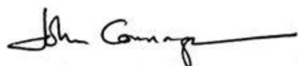
Next Steps

It is our intention to revisit the RMPs for all Boards later in the year once the position on Covid-19 and related matters is clearer, and planning assumptions used in your existing drafts have been validated or amended. As such, we may commission a further iteration of your RMP later in the year, taking account of the foregoing and offering the opportunity for us to update guidance on key areas; this will also be informed by any additional or amended priorities in respect of incoming Ministers.

If you have any questions about this letter, please contact Yvonne Summers, Head of Operational Planning in the first instance (Yvonne.summers@gov.scot).

In the meantime I would like to take this opportunity to thank you, your Board and your entire workforce again for your, and their ongoing extraordinary efforts. Your contribution not just to the nation's response to Covid-19 but to all health & care needs of the population are hugely appreciated by everyone at the Scottish Government.

Yours sincerely



JOHN CONNAGHAN CBE
NHSScotland Chief Operating Officer