NHS Greater Glasgow & Clyde	**Paper No. 20/29**
Meeting:	**Board Meeting**
Date of Meeting:	**Tuesday 30th June 2020**
Purpose of Paper:	**For Noting**
Classification:	**Board Official**
Sponsoring Director:	**Dr Jennifer Armstrong, Board Medical Director**

NHSGGC Remobilisation Plan

Recommendation

The Board is asked to note the NHSGG&C Remobilisation Plan. The plan was submitted in draft to the Scottish Government on 29th May, and in final form (following engagement with SG officers) on 4th June.

Purpose of Paper

This purpose of this plan is to outline the key priorities for re-mobilisation in the period to the end July 2020.

Key Issues to be considered

- Managing demand by the use of digital solutions
- Maximising capacity whilst complying with physical distancing requirements
- Ensuring staff and patient safety are paramount

Any Patient Safety /Patient Experience Issues Continued monitoring of patient safety issues is ongoing through clinical governance reporting processes.

Any Financial Implications from this Paper

N/A

Any Staffing Implications from this Paper

N/A

Any Equality Implications from this Paper

An Equality Impact Assessment of the recovery plan has/ will be conducted

Any Health Inequalities Implications from this Paper

There are well documented health inequalities associated with COVID-19 which have been taken into account when planning the re-instatement of key services.

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

No

Highlight the Corporate Plan priorities to which your paper relates

Better Care

Author: Fiona MacKay

Tel No: 0141 201 4560

Date: 17/06/2020

Remobilisation Plan

NHS Greater Glasgow and Clyde

June 2020

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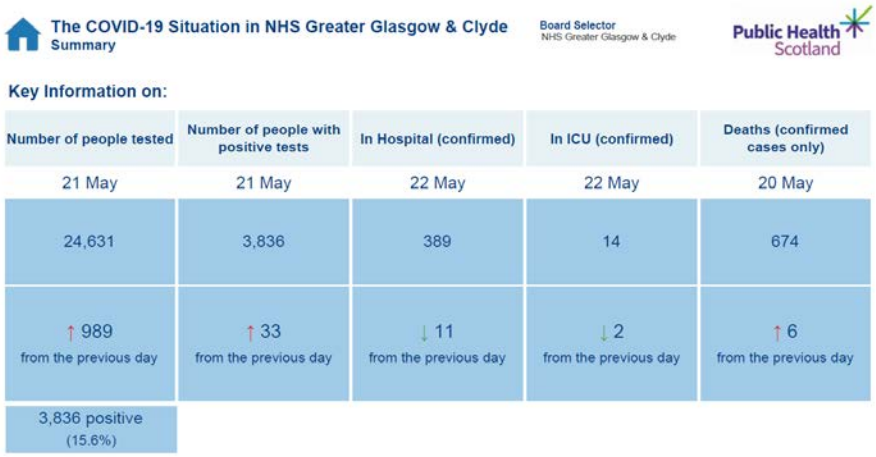
Executive Summary: GGC Next Phase Draft Mobilisation Plan

Current position and approach

- **Current COVID 19 position in GGC is set out in the table below**



The COVID-19 Situation in NHS Greater Glasgow & Clyde
Summary

Board Selector
NHS Greater Glasgow & Clyde

Public Health Scotland

Key Information on:

Number of people tested	Number of people with positive tests	In Hospital (confirmed)	In ICU (confirmed)	Deaths (confirmed cases only)
21 May	21 May	22 May	22 May	20 May
24,631	3,836	389	14	674
↑ 989 from the previous day	↑ 33 from the previous day	↓ 11 from the previous day	↓ 2 from the previous day	↑ 6 from the previous day
3,836 positive (15.6%)				

- **Approach**: the Board has adopted a clinical and social care focus to the plan with involvement of services from across the health and social care sector (HSCS). It has been developed in partnership with H&SC professionals, staff side representatives and has a cross system governance process which reflects this approach at all levels. Clear cross system principles have been jointly developed to ensure a coherent, prioritised recovery programme which recognises the needs of COVID and non COVID patients/service users alongside retaining flexible capacity to address potential future surges.

- **Infection control**: In addition, NHSGGC has maintained urgent and emergency non COVID care based on clinical/social care needs. Strict infection control processes have been implemented to separate urgent COVID and non COVID patients, with any new national guidance or local learning immediately implemented. This includes a clear focus on Personal Protective Equipment (PPE) across HSCS.

- **Health and Social care services: a summary of each of the services including public health, mental health, acute and community services is set out below.**

    a. **Public Health:** the priorities for remobilisation include identifying and addressing inequalities as a consequence of the virus, ensuring childhood and adult vaccination programmes are maintained and the influenza programmes are stepped up, implementing actions to reduce spread of infection in care homes, implementing testing and ensuring staff and services are available to implement the test and protect.

    b. **Mental Health:** throughout the pandemic, urgent care has continued based on clinical need. Mental Health Assessment Units were established and provided emergency care 24/7; this was highly effective and will be reviewed to transition to ensure a more sustainable and integrated approach. The recovery plans are set out for adult mental health, CAMHS and older people together with the specific needs of more vulnerable groups. In addition, the expected increased demand for

mental health services due to COVID are being developed in partnership with community assets to enhance non clinical responses.

c. **Acute services:** there has been ongoing emergency care for non COVID patients, continued provision of urgent cancer care and some urgent elective care. Staff were redeployed from theatres to achieve a 100% increase in critical care capacity and there are detailed plans to treble critical care if required adopting a reservist approach. The key priorities for acute services include: continued provision for COVID patients with flexibility for surges, ensuring backlog of urgent patients addressed for cancer and other specialties and dealing with all emergency care. Outpatient clinics and endoscopy lists will start at the end of May for urgent procedures. We will roll out Attend Anywhere for planned OP care with remote blood tests/imaging, ensuring if face to face consultation is required, areas are equipped with social distancing and new clinical pathways are developed.

d. **Unscheduled care:** the cross system approach taken for COVID patients with a senior GP providing advice directly to patients for self-care or scheduled urgent care has been very effective. It is hoped the national approach will support this to be extended to non COVID unscheduled care. The priorities for NHSGGC include maintenance of the Hubs and Community Assessment Centres with the red COVID services, and ensure this capacity can be flexed to accommodate any further surges. In addition signposting away from ED by senior nurse will be in place for all GGC departments. Attend Anywhere and GP OOH appointments will also be rolled out by June and consultants from a range of specialties will utilise technology to discuss clinical care directly with GPs to enable more planned urgent care.

e. **Primary care and community services:** the plan describes a range of services which will be recommenced starting in June. This will include surge capacity for COVID and securing the digital capability to enhance services. All 235 GP practices are now enabled to use Attend Anywhere and plans are being put in place to resume some services; e.g. chronic disease management and services for vulnerable children and families. There are also detailed plans for dentistry, optometry and community pharmacy.

Summary of the key issues which support the plans

a. **Workforce:** there are 3 issues highlighted for availability of staff: extensive redeployment of staff across all services to support the COVID 19 response, the impact of COVID on staff in terms of sickness and shielding guidance has increased absence rates for staff and the need to prioritise staff wellbeing and ensure staff have the opportunity to take annual leave will significantly constrain service delivery. A number of actions are described to mitigate this e.g. 2,625 new staff recruited and developing Attend Anywhere for shielded staff to deliver service from home. In addition, there are a whole range of actions and services developed to support staff both for physical and mental wellbeing. Finally the plan for the workplace is described to enable more staff to safely work.

b. Digital and innovation: the ability to deliver healthcare digitally will not only reduce COVID spread but enhance patient care. Currently over 500 appointments

a day are conducted in GGC using video technology and the plan is to scale up further. This will also include implementing Active Clinical Referral Triage, Patient Initiated Review and developing capacity for remote/drive through blood tests to enable more appointments to utilise Attend Anywhere. Innovations developed during COVID are described with plans to retain and extend these services.

c. **Other key areas:** Public engagement plans are being developed and patient views sought about the new services. Medicines and oxygen requirements are set out**.**

d. **Finance considerations:** the costs of COVID service provision are set out together with the changes to enable more sustainable services to become embedded. There may also be an opportunity to deliver services in a more productive, patient centred way.

GGC has now gained extensive experience in redesigning care pathways at pace in the provision of health and social care during the pandemic. Staff have been very effective at setting up new ways of delivering care across the whole system. Our staff have been world class in delivering very effective care and GGC is at the forefront of R&D for COVID and non COVID patients. This plan is to ensure services recover safely and put in place changes which will help the NHS and Social care in the months and years to come.

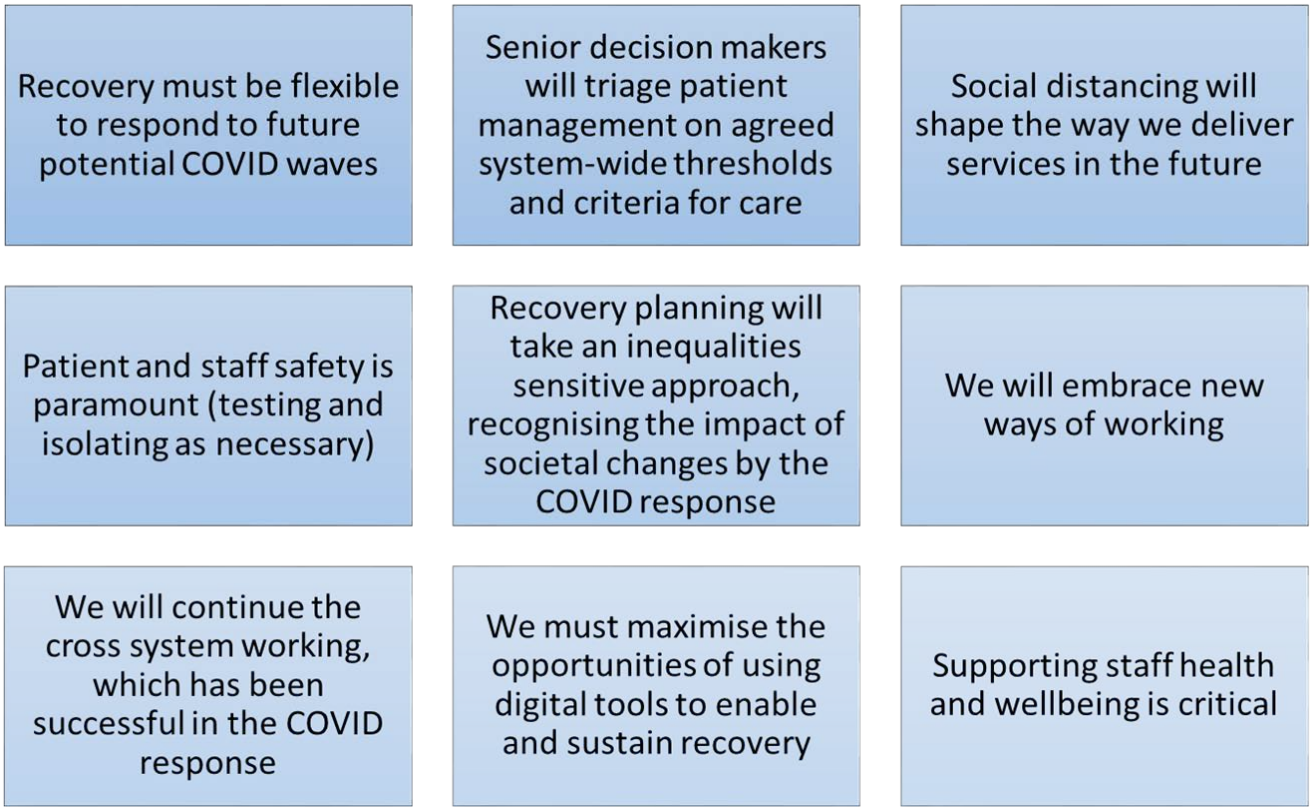
1. Introduction

1.1. Background

This is the draft Remobilisation Plan for NHSGGC covering the initial period to the end of July 2020. It forms part of our wider recovery planning work which extends into 2021.

1.2. Key Principles

The key principle which must guide recovery planning is the need to provide safe and effective services for patients which maximise the health benefits for our population. The Recovery Tactical Group approved the principles below to support this:

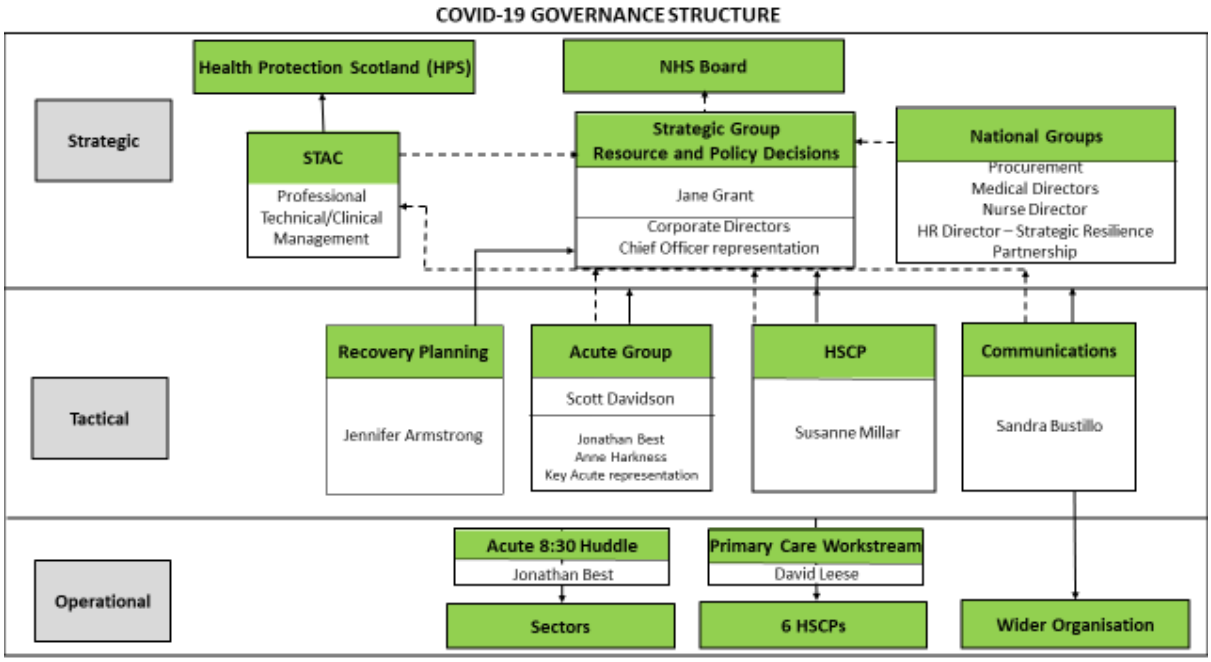


1.1. Governance

NHS Greater Glasgow and Clyde have adopted interim governance arrangements during the COVID-19 pandemic which provide the flexibility required to ensure appropriate governance and oversight, ensure the Board's senior leadership are able to dedicate required time to responding to the pandemic, and protect the health and wellbeing of all those engaged in the Board's governance system.

The Board agreed an interim governance structure centred upon an Interim Board which oversees the functions of the full Board, and which is supported by continuing meetings of the Area Partnership Forum, the Area Clinical Forum, and the Area Medical Committee. It is the intention to review these arrangements in June with a full Board meeting scheduled for the 30th June.

To support the Board specifically in responding to the COVID-19 pandemic, a cross-system 'strategic - tactical – operational' structure was implemented, as set out below.



This cross-system approach supports recovery moving forward, recognising the interdependencies between the component parts of our health and care system. A Recovery Tactical Group has now been established to work with the Acute and HSCP Tactical Groups, and reports to the Strategic Executive Group. The Recovery Tactical Group is supported by a group of clinical advisors which includes representatives from the medical, nursing and the allied health professions. NHS GGC's mobilisation plans have been developed via the governance structures implemented during COVID. Both the Acute and HCSP tactical groups include clinical leadership and there is a separate primary care group with wider clinical engagement of primary care clinicians and the Local Medical Committee. Changes in pathways or referral criteria have been developed jointly prior to agreement at the Strategic Executive Group. A register of all changes has been kept so they can all be reviewed as part of recovery and joint agreement reached on the way forward. The Primary care Lead Clinician for Cancer, who is a GP, has been involved in changes to cancer pathways.

NHSGGC has well established interface arrangements including a longstanding Primary/Secondary Interface group including the DMDs for acute and primary care, GP Sub Committee, COO acute and HSCP Chief Officer. In addition there are a number of joint planning and governance groups including Managed Clinical Networks and the Referral Management Group. These interface arrangements are currently being strengthened to include:

- ACRT: primary and secondary care involvement in developing pathways and shared communications / understanding of pathways
- Strengthening of sector based interface groups
- USOC pathways
  Unscheduled care
- Weekly informal meetings involving the DMDs for acute and primary care to identify and address emerging issues and develop shared communications.

Throughout the COVID 19 pandemic the Board has engaged fully on a weekly basis with its Area Partnership Forum, which is jointly chaired by the Employee Director and the Director of Human Resources. The Forum members have discussed PPE, Staff Testing, Shielding, Mental Health and Wellbeing support to all staff and are now developing and implementing actions with Human Resources on Recovery and Reconfiguration for both workforce and

workplace. This includes continued mental health and wellbeing support, workforce supply and planning, workforce redesign elements to the mobility plans, social distancing, homeworking, contact tracing and the development of local guidance and support relating to all these areas through relevant working groups. The Employee Director is a member of the Strategic Executive Group and Recovery Tactical Group. The Co-Chair of the Acute Partnership Forum is a member of the Acute Tactical Group and the staff side co-chairs are members of the HSCP Recovery Plan groups.

In responding to the pandemic, Forum members have been proactive in bringing forward issues and ideas to support the Board's decision-making, and it is expected that this will continue to support a positive and productive recovery.

The Board's Scientific and Technical Advisory Group has produced guiding principles to ensure that the reintroduction of services is in line with current evidence and infection prevention and control requirements. All plans to restart services are considered by the Acute Tactical Group and must include an estimate of the impact on Level 2/3 care and PPE and take into account the updates given by pharmacy on medicines supply. In addition, there has been significant work to ensure infection control (including PPE) are clearly set out and delivered within HSCP services.

1.2. Risk

As the Board progresses with recovery planning, we are starting to capture information on circumstances which may adversely affect our ability to implement prioritised mobilisation. On this basis, a risk register will be maintained to provide a mechanism to evaluate risks and plan for additional actions to mitigate such risks. The key risks currently identified, and mitigation are set out below:-

Risk Description	Mitigation
There is a risk that a 2nd wave of COVID-19 will lead to significant delays to patient treatment for emergency, cancer and planned care.	Flexible, and new ways of working to continue to treat patients. Continue to use dedicated pathways for emergency patients. Continue to work in partnership with HSCPs to reduce delayed discharges in Acute Services. Ongoing treatment of clinically urgent cases On-going support of independent sector and GJNH.
There is a risk that staff absence due to isolation/shielding/sickness will lead to impact on delivery of patient care.	Continued monitoring of staff absence on SSTS; Ensure ease of access to guidance and support to staff regarding testing; health and wellbeing support; reassignment of staff in non-essential roles in line with agreed partnership approach.
There is a risk that 'New Ways of Working' will lead to increased costs.	All Sectors/Directorates have established tracking processes. Significant additional expenditure was described in initial mobilisation plan, and decisions recorded at local level and escalated to Board level for approval.

There is a risk that the ongoing measures to support the response to COVID-19 will reduce capacity across specialties and increase waiting times for inpatient and outpatient appointments.	New ways of working to continue to treat patients optimally. Development of recovery plans; Support of independent sector and GJNH.
There is a risk of widening health inequalities as a consequence of the pandemic.	Planning for the short, medium and long-term societal impacts and developing evidence based responses to increased poverty and health inequalities; collaboration with the voluntary sector to reach the most vulnerable groups; and monitoring impact in the population and in population sub-groups.

1.3. Clinical Engagement

To provide early structure to the recovery process, NHSGGC has undertaken an exercise with all clinical specialties across the division and HSCP services to capture the important positive changes made during the COVID emergency footing and the main priorities for recovery.

The process to capture this information has utilised the active clinical engagement and effective team working within and across Sectors/Directorates that has been a strong feature of the COVID response in NHSGGC. Specialty teams from across GGC have come together to set out their GGC-wide specialty response focusing on harnessing and expanding the digital approach to recovery and agreeing priorities for how services move forwards. This is all set in the context of maintaining flexibility to respond to any future surges in COVID patient admissions. All services have made significant changes during the COVID response, learning throughout this period. The experience gained means services will be better placed to continue a wider range of service delivery during any further COVID surge.

The output from these recovery templates is being collated into a report and will inform collective action across NHSGGC. This will include a drive to adopt rigorous monitoring of digital activity, a principle of digital first wherever possible for patient interactions and further work to ensure patients who do not have, or are unable to use, digital access are not disadvantaged.

Key Points
• This remobilisation plan is part of our longer term recovery process • The principles underpinning our plan seek to support safe and effective services for patients and staff • We have taken a system wide approach to recovery, involving staff partnership • Clinical engagement has been a strong feature of our remobilisation planning

2. Public Health: poverty and health inequalities

2.1. Context

In developing our response to the COVID 19 context, we recognise that the challenges will aggravate existing issues with regard to poverty and health inequalities, for example, health inequalities will increase, unemployment will rise and more people will experience poverty.

Some health inequalities are as a consequence of the virus but some are as a result of the measures to contain the virus, for example there has been an increase in domestic violence, and we expect there to be short, medium and long term impacts on mental health.

2.2. Mitigation

Mitigation of both short and longer term consequences is a priority within our planning processes. In the current phase of organising a crisis response to COVID-19 a group made up of local child poverty leads, public health, voluntary sector and Glasgow Centre for Population Health identified some key themes which will affect how people access services and also create different demands on our services.

Digital inclusion - Many of our services are moving to a digital first response with uptake of Attend Anywhere and telephone consultations. This will support access to services for some but others without the resources to use technology will require alternative services. Home working has also increased, bringing with it different issues of access and isolation which may impact on our services.

Transport – With limited public transport and concerns by some about using taxis, travel to health services can be a challenge. We have offers of help for drivers who could be redeployed which requires co-ordination and precautionary protocols to protect drivers from infection. The issue of allocating volunteer capacity to need is one that requires further attention. In the medium to longer term the viability of bus companies may inhibit staff and patient travel.

Food – In some areas, access to food is challenging. There can be difficulties getting food deliveries from supermarkets and a lack of transport from food banks. All local areas are working hard to get food to people. Glasgow City has issued food vouchers to 20,000 families, other areas have sent families BACs payment, or delivering food or meals (often with voluntary sector/ home care/ school kitchen support).

Universal credit – Many more people are now applying for UC and experiencing difficulty getting though on the phone, navigation of the system and payment delays. The suspension of sanction triggers (linked to attendance at job centres) is an important support.

The most marginalised people –The most marginal groups include homeless people, prostitutes, asylum seekers, and people with no recourse to public funds, isolated people, gypsy travellers, people who don't speak English well, disabled people, people at risk of homelessness, and people affected by substance abuse. These groups have specific issues affecting them which existed pre-COVID including stigma, access to services and marginalisation. The Board will work in tandem with Carol Tannahill at the Scottish

Government to ensure that these wider issues are addressed as part of the public health response.

There may be consequences of the outbreak which have shown different ways to tackle inequality, for example rapid housing of rough sleepers, which we can maintain or use to tackle heath inequalities more effectively.

2.3. Public Health

The pandemic has highlighted the need for robust public health responses informed by evidence. The programmes of work outlined in the Board's Public Health Strategy 'Turning the Tide through Prevention' are all relevant to tackling the outbreak, protecting the most vulnerable and mitigating the consequences. The recovery will include:-

- Scaling back up health improvement activity and developing innovative ways to work with the public in line with Government guidance.
- Planning for the short, medium and long-term societal impacts and developing evidence based responses to increased poverty and health inequalities.
- Working with Local Authority partners within Local Resilience structures as we move to recovery, utilising existing means of communication and escalation of intelligence between local and national levels.
- Collaboration with the voluntary sector to reach the most vulnerable groups.
- Monitoring impact in the population and in population sub-groups.

Equality Impact Assessments will be a core part of our recovery planning in the immediate short term to July and beyond.

2.4. Vaccination Programme

During this time, services have continued to deliver national immunisation programmes, where safely and practicably possible. This will assist in avoiding outbreaks of vaccine preventable diseases and avoid increasing further, the numbers of patients requiring health services and hospitalisation from vaccine-preventable diseases.

Routine Childhood Immunisations
NHSGGC Pre-School Immunisation Team has, and continues to, work to ensure the continued delivery of the routine childhood immunisation programme, supporting parents/carers to attend child immunisation appointments, emphasising the continuing importance of vaccination programmes whilst helping to allay any concerns prior to attending their child's appointment(s) during the outbreak.

For shielded pre 5s/families the service is now offering a safe and effective bespoke patient centred service and able to deliver routine childhood immunisations at home when appropriate. This has helped ensure timely protection against vaccine preventable diseases. Secondary school immunisation programmes in the 2019/20 academic year were completed in NHSGGC prior to schools being closed.

Planning for this year's primary school flu immunisation programme continues, considering effective ways of working with appropriate PPE and social distancing measures, whilst awaiting further information regarding children returning to school and associated impact on service delivery.

Adult vaccination programmes
Vaccination programmes for pregnant women (pertussis and flu in season) continue to be delivered primarily by maternity services with support from primary care as required.

The routine shingles programme has been suspended temporarily in line with the current COVID-19 advice for adults aged 70 and over. However, if a patient is well and presents for any other scheduled appointment, they can be opportunistically vaccinated.

Pneumococcal vaccination for those in risk groups from 2 to 64 years of age and those aged 65 years continues (subject to supplies of PPV23 and clinical prioritisation). As with the shingles vaccination programme, those aged 70 years and older can be opportunistically vaccinated if presenting for another scheduled appointment (subject to supplies of PPV23 and clinical prioritisation).

Influenza Vaccination Programme 2020/21
The influenza programme 2020-21 will be strategically important in the context of the COVID-19 situation and planning for this commenced May 2020 and continues.

Planning for NHSGGC's Staff Flu Vaccination Programme 2020/21 had commenced prior to the outbreak. In light of physical distancing measures and the impact this will have on the delivery of mass vaccination programmes, efforts to increase peer vaccination will need to be strengthened across all directorates/HSCPs to ensure vaccination uptake is maximised. Planning for the programme will be reinstated in early June.

2.5. Care Homes

Care home residents have emerged as being disproportionately affected by COVID-19 in terms of cases of infection and deaths attributable to the virus.
There are 196 care homes within NHS GGC, 140 of which are for the elderly.

Support

In response to the Scottish Government instruction last month to assess the needs of all care homes, Public Health interviewed every care home by telephone. The analysis of the questionnaires helped Public Health and partners to develop a hierarchy of support for all care homes which include: -

- Establishment of a multi-agency care home group that includes public health GPs, commissioning managers, care inspectorate and Scottish Care, reporting to the tactical group and then to the SEG;
- Advice and support on managing outbreaks from the Board's health protection team;
- Regular discussions with care home managers and the Board's health protection team on guidance about infection prevention and control
- Webinars on PPE and infection prevention and control;
- Advice on COVID – 19 presentations in elderly people
- FAQs on a range of Covid issues which are updated regularly;
- Additional ANP staff for the Care Home liaison teams;
- A managing the media guide which has been shared with care homes;
- The provision of training on best practice on isolation for residents with dementia by specialists in dementia care;
- Additional support for anticipatory care planning

- End of life training and support for care home staff and palliative care medicines provision
- "Medical discussions" being offered to care homes with new cases
- Joint inspection visits being arranged with the Care Inspectorate as necessary
- Joint work with the Director of Nursing to establish a programme of visits to support all care homes using the nationally agreed template. The first visits to the homes with the highest levels of need for support commenced at the end of May.

Weekly review meetings of all the care homes in NHS GGC are held with Care Inspectorate and HSCP partners and public health. This allows the DPH to report to Scottish Government on the ratings of all care homes, highlight areas of concern and describe actions taken or planned.

The announcement on 17th May of additional responsibilities for Board Executive Nurse Directors for the enhanced professional clinical and care oversight within care homes will supplement the support mechanisms for care homes and the reporting systems described. This includes joint daily meetings involving the Director of Nursing and her team, HSCPs and public health. These daily multidisciplinary meeting allow an assessment of support required.

Guidance has been produced for care homes on testing for symptomatic residents and staff, whole home testing for homes with at least one case and testing and isolation on admission for new residents. HSCP testing teams have been established to support care homes in the testing and these will continue to support new guidance on repeat testing and also to undertake surveillance in a sample of care homes. Since the beginning of May, testing in care homes has been expanded to include testing of all residents and staff as part of more detailed investigations of outbreaks. Testing all care homes includes 50% of those with no cases, where weekly testing is offered.

2.6. Testing

We will continue to provide testing for symptomatic staff and household contacts and testing of care home staff and residents in care homes (as set out above). As we implement Test and Protect, we are organising systems to test housebound people or people without transport including contacts who become symptomatic. We anticipate others will use the UKG portal for testing. Testing will continue in hospitals including regular testing of patients over 70 years and patients being discharged to care homes

Support for care homes, testing across the range of eligible groups and implementation of Test and Protect, will take up the majority of our public health resource over coming months. The number of symptomatic staff requiring testing has reduced and we have spare capacity in our drive-thru centres which can also be increased. This will enable additional capacity for sampling to be allocated to Test and Protect.

2.7. Contact Tracing

NHS GGC will mobilise its Contact Tracing service the week of the 25th May with an escalation plan to recruit upwards of 500 staff by the end of June. Our approach has been to source this workforce by reassigning staff from existing positions, possibly where not fully

utilised due to step down of other service, targeting particularly those with appropriate experience and competencies capable of providing support to more junior staff.

We have also been supported by partners within the GG&C Local Resilience Partnership who have contributed staff from within their own workforce and are assisting in the planning of the new service. 120 individuals have already been identified and will have received training and orientation by week commencing Monday 25th of May. Our next phase of recruitment will extend to staff who are shielded but could work from home. We have commissioned Eastbank Community Health and Training Centre to function as the Contact Tracing 'hub', capable of accommodating up to 80 staff within COVID-19 safety requirements. Our plan will equip and facilitate a greater number to work from home.

NHSGGC is liaising closely with the national team to support planning of the National 'Tier 1' Call Handling service and to plan for the ongoing resource that will be required for the ongoing complex case tracing service following commissioning of the National Service.

2.8. Screening Programmes

Screening programmes were temporarily paused in order to minimise the impact on essential NHS services during the response to COVID-19. However, the Pregnancy and Newborn Screening Programmes, including tests offered during pregnancy and just after birth, continued where logistically practical.
Each screening programme carried out a risk assessment to identify the diagnostic and treatment backlog created by the suspension of non-essential services and will agree a prioritisation order when re-mobilising clinical activity.

Priority for re-mobilisation will be given to those aspects of screening programmes that deliver tests that have replaced clinical activity – for example in the case of diabetic retinopathy screening, non-routine follow up smears in cervical screening; follow up test for abdominal aortic aneurysms or delivering assessment and treatment as part of the cancer pathways for breast, bowel and cervical screening. This is picked up in more detail in the cancer section of this plan.

We have assessed and accounted for patients who had been screened and were on the referral to secondary care pathway. The main areas of backlog for these patients are in Colonoscopy and Colposcopy, both of which are part of the Acute Recovery capacity planning. In anticipation of the steer from the National Programme Boards to recommence screening, we are appraising the impact of COVID-19 circumstances on Primary Care capacity. The impact will be a combination of reduced flow of patients in compliance with social distancing and/or loss of access to facilities and sites. Areas for attention include:

- Mobile Breast Screening: Supermarket car parks no longer suitable – Exploring options to relocate to NHS sites within NHSGGC
- Diabetic Retinal Screening: Venues no longer available due to reassignment as COVID Testing centres + reduced flow of patients per clinic – Conducting a stocktake of venues to quantify the shortfall and inform mitigation plans
- Cervical Screening: capacity is delivered within GP premises. Plan to work with HSCPs to establish potential reductions in capacity.

National Programme Boards and Operational Groups have been established to discuss and agree on options and to make recommendations to restart their respective screening

programmes in a safe and effective way. NHSGGC contributed to the discussions regarding plans to recommence the programmes.

Key Points
• We recognise the challenges to inequalities caused by COVID and our national response to the pandemic • Maintaining the vaccination programme is an important priority for our Board • We will work with the 196 care homes in NHSGGC to protect residents and support staff • Preparation for the Test and Protect programme is on track for implementation on 1st June • Patients identified prior to the halting of the screening programme have been prioritised in our clinical services work

3. New ways of working- Digital opportunities

The eHealth response to support services during the COVID period has been significant. This plan focusses on the digital priorities from now until the end of July, which is part of the wider digital strategy.

3.1. Virtual Consultations

Services have initiated a range of solutions to ensure that, where possible, outpatient appointments and GP Practice appointments can continue. This included telephone and also video using the Attend Anywhere (Near Me) system. All GP Practices were enabled with additional equipment (2 x PCs, dual screens, cameras and headsets) and were set up on the Attend Anywhere system with training and support provided. GP Practice staff were also enabled with the ability to use Attend Anywhere to hold patient appointments remotely from home.

IT equipment was also provided to a number of acute specialties either in Outpatient Clinic areas or for clinicians to use remotely at home.

Currently in NHSGGC between 400 – 500 appointments per day are carried out using video technology (Near Me). This includes GP Practices who have adopted the system at scale and > 90% of the 235 practices currently use the system on a daily basis across all HSCP areas.

In addition to acute services other areas that will be scaled up as a priority will include:

- Community mental health services
- Interpreter Services
- Ante-Natal and maternity clinics
- Cancer and Cancer MDT
- Optometrists, Dental Practices and Community Pharmacies

One of the barriers to remote out-patient consultation is the requirement for concurrent clinical investigations, especially blood sampling. Examples of community phlebotomy services in other areas have been reviewed and work is being progressed to develop an interim solution on existing hospital sites.

The recovery plan across all services will increase use of the AttendAnywhere/Near Me system further as services are supported to adopt ACRT. There will be a need for more IT equipment in outpatient and clinic areas which can be booked and used on a flexible basis to ensure virtual consultations are booked to the appropriate clinic area.

In addition, Patient Initiated Review (PIR) is being implemented more widely whereby, if routine follow up is not required, selected patients can be discharged with the opportunity to re-engage directly with the service if circumstances change, i.e. there is no requirement to return to the GP for a further referral for the same condition.

PIR will be used in conjunction with virtual consultations and therefore if patients do choose to re-engage, they may firstly be assessed virtually if this is clinically appropriate and face to face consultation will only be arranged where absolutely necessary. Our recovery templates used a digital first approach and have enabled us to establish targets for improving performance which we will monitor over the recovery period.

3.2. Electronic Health & Care Record (EHCR)

NHSGGC has an integrated Electronic Health & Care Record (EHCR) which delivers a single patient record. There is extended sharing of information to social care practitioners, General Practitioners and Community Pharmacists. Plans to extend this to Optometrists and Community Dentists are in place for end June 2020. GP Practices across GGC are sharing GP summary data into the EHCR. The EHCR is used extensively on a day to day basis to support patient care across NHSGGC and the WoS region and linking to the NoS EHCR and the EoS is planned.

In NHSGGC there are over 25,000 active system users including acute, GPs, HSCP and other community staff. Approx. 2.25 million patient records were accessed in the past year. Access to the NHSGGC Anticipatory Care Plan (ACP) is provided via the EHCR as part of the integrated care record. Use of the ACP has increased during the COVID19 response and will be an important element of the ongoing patient pathway.

The Community Assessment Centres (CACs) which have been opened up across GGC have used the EHCR and also the TrakCare patient management system extensively to support assessment of patients and onward referral to ED/SATA or remote monitoring at home. Where infrastructure has been put in place for COVID Hub and CACs, there are opportunities to consider the GP OOH and in hours Urgent Care Hub plans to support the drive to reduce attendances at ED. There is also potential for the CAC model to be aligned to a community hub going forward.

Ongoing remote monitoring of patients discharged from the CACs and other facilities where they are at risk of deterioration, has been identified as a priority and will be a key part of the recovery plan as set out in the Scottish Government letter in relation to remote monitoring of patients during Response & Recovery. eHealth will be required to support the implementation of the digital tools to support remote monitoring in line with the necessary service models that will be implemented.

Anticipatory Care Plans have continued to be a key part of response and planning during Covid19 with a specific focus on ACPs for patients in care homes, receiving palliative care and those who are shielding. This builds on established processes to enable the wider MDT including ANPs, district nursing and acute services to see, create and add to shared plans. Access to view additional information from the GP record through clinical portal provides additional shared information for decision making.

3.3. Innovations

NHSGGC host the WoS Innovation Hub. During the COVID-19 response a number of ongoing innovation projects have been scaled.

Remote Management of COPD Patients

A number of remote care initiatives have been expanded during the past 2 months including the scale up of the NHSGGC COPD platform, allowing remote management of a cohort of patients. The DYNAMIC (digital innovation with remote data management and machine-learned algorithms to integrate care of high-risk COPD) project commenced September 2018, and is scheduled to complete in August 2020. This is a digital health technology catalyst innovation funded by Innovate UK.

Patient Centred Visiting – VCreate

Implementation of iPad devices across all wards in NHSGGC has allowed patients to stay in contact with their family. For those patients critically ill in ICU additional tablet devices

with VCreate installed were provided under a licence provided by Scottish Government. VCreate is a secure video messaging service, allowing staff to film short messages which can then be securely emailed to a family member.

COVID19 Assessment App

NHSGGC have worked with DHI and NES Digital to develop a new Assessment Tool for use in CACs, ED and SATA. The SBAR styled, structured assessment application can be launched from TrakCare and is currently being rolled out across the CACs and piloted in the EDs and Specialist Assessment and Treatment Areas (SATA) which are located in ED for suspected COVID patients. This dynamic tool will also feed assessment data into the national data warehouse and Test and Protect process.

Extension of Gynaecology PROMS/PREMS project

The GGC Gynaecological Cancer Service had implemented MyClinical Outcomes for Patient PROMS and PREMS within the services. The system was extended to monitor patients whose surgery has been delayed because of COVID-19, monitor patients with cancers other than ovarian cancer and include new question sets.

Key Points
• Progress in extending virtual consultation across the health and care system is now embedded in the recovery process • We are supporting over 25,000 active users of the Electronic Health and Care Record. • Remote patient monitoring is being extended to support virtual consultation and reduce the requirement for patients to attend health facilities • Learning from our innovation projects is being scaled up

4. Workforce and Workplace

4.1. Workforce

Staff across NHSGGC, HSCPs and Primary Care have played a vital role in responding to the COVID-19 pandemic. Services have been re-designed, capacity has been expanded in key areas such as critical care, and across all service areas clinical pathways have been changed. New services have been established in a very short timescale such as the COVID-19 Assessment Centres and Mental Health Assessment Centres. Our staff, supported by volunteers have responded flexibly in extremely challenging circumstances taking on new roles and adopting new ways of working.

The Board is now entering a transition phase and workforce planning, HR and Staff Partners will need to work together to develop a flexible approach that supports the need to safely move towards 'business as usual' which will include continuing to deliver a COVID-19 response.

4.2. Absence Implications

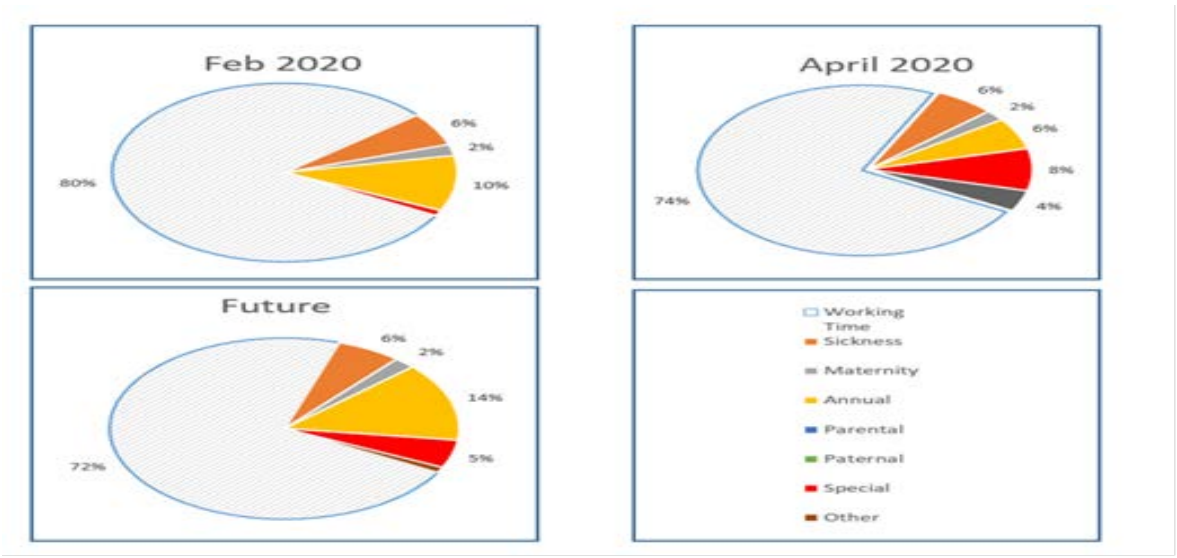
It is anticipated that increased absence levels will continue to impact on available workforce capacity for the foreseeable future and this is a key consideration as part of the recovery

planning. Overall absence in NHSGGC increased significantly as a result of COVID-19 with related drivers including shielding of those staff who are vulnerable, self-isolation due to symptoms or positive diagnosis, and caring responsibilities. The overall absence level of 26% in April 2020 is a significant increase on normal levels, and is artificially depressed by low utilisation levels of annual leave (6% compared to 10% typically for April).

The future projection assumes that annual leave will increase to a rate of around 14% which reflects normal rates and the backlog of accrued leave during the pandemic. COVID-19 related absence is expected to reduce as guidance is updated to reflect changes to restrictions, whilst it is expected that the number of staff isolating with underlying health conditions will remain consistent. As a result a proportionate reduction in special leave is projected. During the recovery period a lower working time % is projected in comparison to a typical month.

There will be an ongoing need to monitor and review absence patterns as the predicted availability of staff is key to planning for recovery and the re-establishment of services.

The Pie Charts below show the changing pattern of staff availability pre, during and post the pandemic. It demonstrates the reasons for staff absence with less staff available for work. This may constrain the ability to deliver services normally.



Immediate Response

Support for the health and wellbeing of our staff remains a very high priority. A Health and Wellbeing Group was established and has delivered a range of additional services to meet the needs of staff. These include recuperation and relaxation hubs, additional psychological support, counselling, pastoral care, a staff support phone line and a money advice service. The Group includes Mental Health and Wellbeing Champions from the HSCPs, Occupational Health, Psychology, and Human Resources.

NHSGGC were involved in establishing the national digital wellbeing hub to enable staff, carers, volunteers and their families to access to a range of self-care and wellbeing resources designed to aid resilience as the whole workforce responds to the impact of Coronavirus.

Recovery Plans

- The Board will continue to work with colleagues, locally and nationally, including psychological and mental health services, on plans to sustain support to look after the mental health and wellbeing of staff at each phase of this pandemic.
- Allocate endowment funds to projects that can support the health and well-being of our staff and patients.

4.3. Workforce Planning

Immediate Response

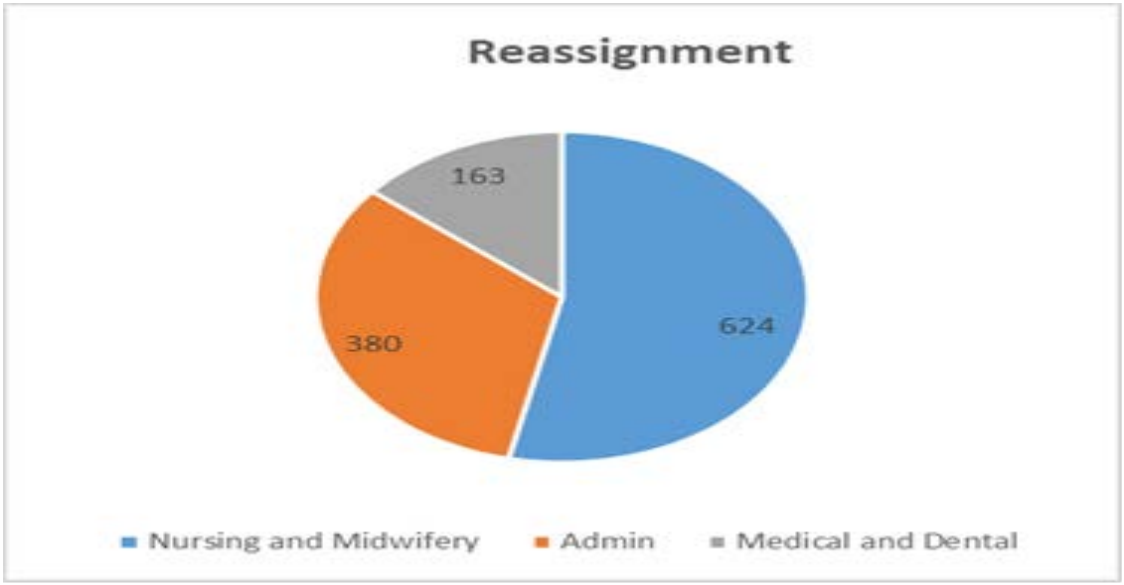
Further modelling will be required to support decision making around the future configuration of services required to continue to deliver a response to COVID-19. Modelling for predicted absence patterns and workforce demographics will continue, identifying staff in high-risk groups in line with guidance from the Scottish Government and internal modelling conducted by NHSGGC's Public Health Directorate.

4.4. Reassignment and Recruitment of Staff

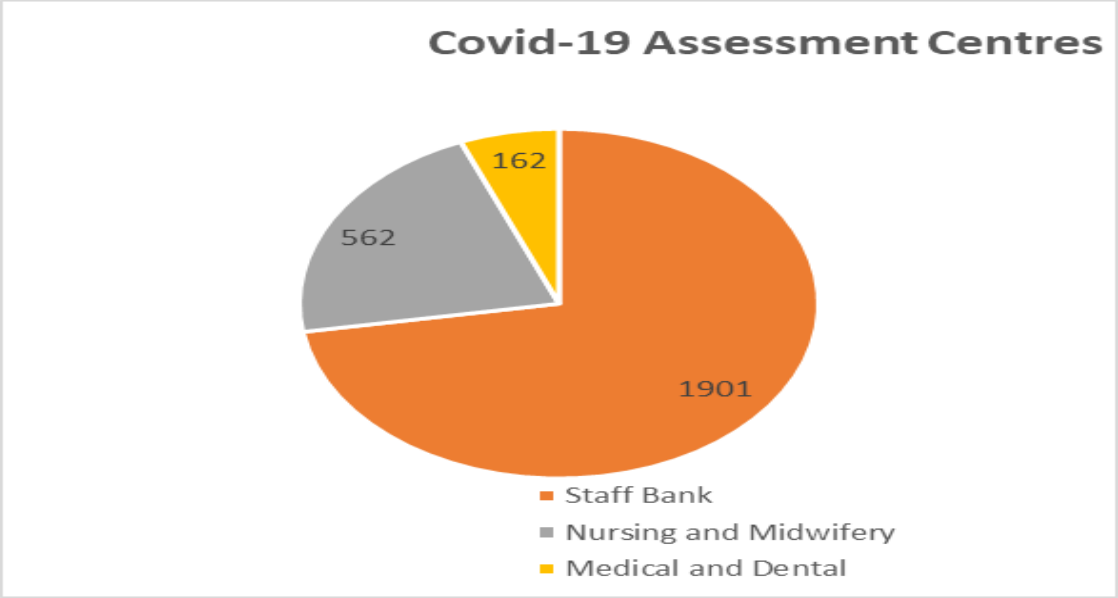
Immediate Response

Reassignment and recruitment have delivered a key response to mitigate the pressures resulting from COVID-19.

- A total of 1167 staff have been reassigned to support the COVID-19 response as illustrated below.



- In addition, 2625 staff have been recruited which has included resource for testing centres and assessment hubs and care homes as illustrated below.



- Some GPs have been working flexibly between their practice and the COVID-19 Assessment centres.
- A number of staff have been reassigned from non-essential services to support areas of demand including 'Rest and Recuperation' (R&R) hubs.
- GGC has engaged a number of additional staff from a wide range of areas including newly qualified junior doctors (FY1s) and recent retirees and others returning to practice.
- Nurses from clinical areas have been upskilled across GGC to meet the additional demands of ICU.
- Health Visitors and Health visiting students are providing support in the COVID-19 Assessment Centres and Community Mental Health Nurses have been deployed to the Mental Health Assessment Hubs.
- Recruitment of Healthcare Support Workers through Staff Bank will enable continual provision of resources to support future demands.

It has been assumed that a significant proportion of these staff will continue to be reassigned for next 6 months in order to respond to potential resurgence of COVID-19 and this will impact on the staff capacity available in the wider system to support recovery. Therefore many of the changes will continue in the near future.

Recovery Plans:

- Work is underway within the medical professional governance structure, with the support of HR&OD to map actions planned and taken to date to develop a detailed contingency plan for medical staff workforce reassignment.
- Workforce plans will be developed and agreed with regards to substantive employment of students who will complete registration in October 2020, as part of the newly qualified campaign and they have been assumed in the future projections.

- Develop plans to provide a flexible workforce that can respond to surges in activity and quickly mobilise additional staff to support increased capacity requirements in critical care and the COVID-19 Assessment Hubs.
- Deliver workforce planning support to help develop workforce models for Mental Health Assessment Units and the COVID-19 Assessment Centres to support the future configuration of the models (currently being reviewed).
- NHSGGC are developing a local model to deliver the Test and Protect approach. Projections of a workforce up to 500 people.

- With 120 required by end May 2020 who have been identified to deliver an effective service and work is underway to seek volunteers from those.

4.5. Ways of Working

The COVID response, lockdown conditions, social distancing and shielding for some staff has required novel ways of working to be adopted across the whole organisation for both clinical, key workers and 'non-essential' staff.

Immediate response

- Key workers on the front line have generally continued to attend their place of work to deliver services
- Risk assessments were carried out across all clinical areas and new pathways adopted and introduced to reduce risk to staff and patients
- New working arrangements were introduced for all 'key' social care staff with office accommodation consolidated and/or closed completely across HSCPs
- PPE requirements assessed and issued across all clinical areas and non-clinical teams as required
- A large number of non-clinical support staff and those self-isolating and shielding have continued to work at home supported by the IT infrastructure that was quickly put in place (e.g. finance, planning, HR)
- Microsoft Teams and teleconferencing has been adopted for most meetings.

Recovery Plans

- Continued provision and adoption of appropriate PPE in clinical and non-clinical areas supported by needs assessments
- Early planning to return some support staff and teams to the workplace safely supported by risk assessments and health and safety considerations
- Adoption of a longer term flexible/agile approach to work
- An assessment of buildings and facilities will be underway to review options to retain social distancing in the workplace and assess the capacity
- Establish new processes for those returning to work to maintain social distancing and avoid overcrowding in clinical and non-clinical office accommodation
- Review of staff social facilities with new processes established or maintained for safe use introduced
- Continue to maximise the use of MS teams and teleconferencing reducing the requirement to travel
- A mental health wellbeing plan for staff will be agreed by start of June.

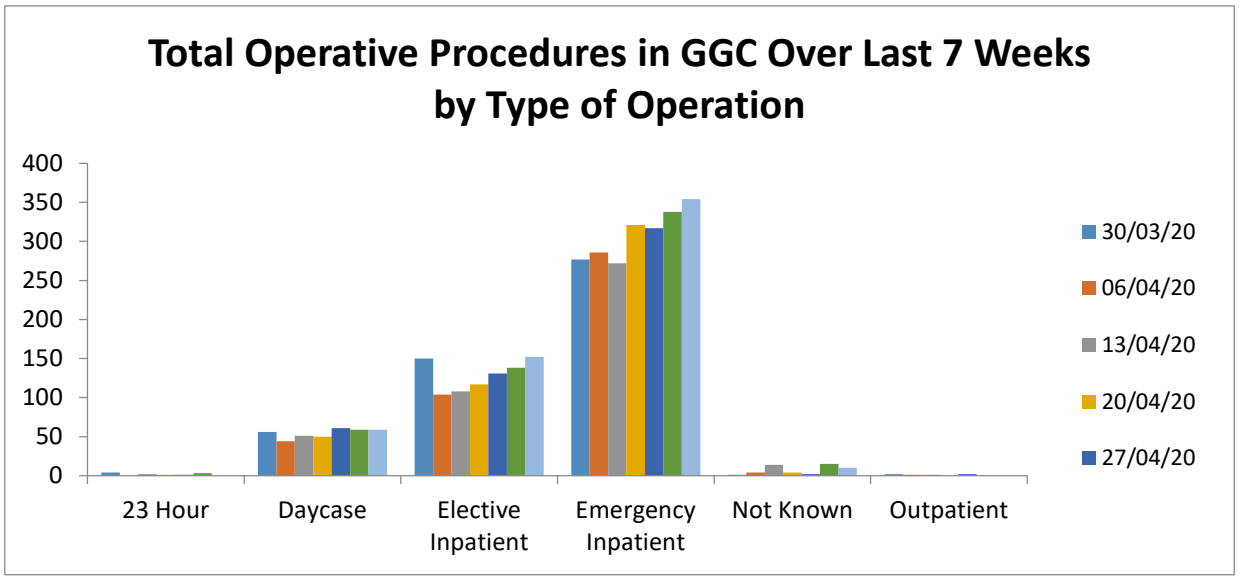
Key Points
• We expect current high absence levels to continue over the early summer as staff take annual leave • A significant proportion of the 1167 staff who have been reassigned, and the 2625 staff who have been recruited to support the COVID effort will be required in the immediate recovery period • We will work with teams to develop a safe and flexible approach to work, respecting social distancing requirements

5. Acute Priorities

The Acute Division has responded to the pandemic by flexing its resource to prioritise the needs of patients with COVID19, those patients requiring emergency and urgent treatment and to those referred with a suspicion of Cancer or already on a cancer treatment pathway.

At its peak there were 86 patients in ICU beds in NHS GGC, 74 of whom had COVID19 and 545 in acute hospital beds with a positive COVID19 test. There was further demand from patients awaiting the results of their tests, the demand via the SATAS can be seen in Section 8.

In the seven weeks from 30th March to 11th May 900 elective operations have been undertaken.



The cessation of routine planned activity has allowed an expansion in critical care beds. The workforce have responded flexibly and been supported by the returning staff and new employees described in Section 4.

Should a further wave of COVID19 be experienced a similar approach will be taken to allow staff and beds to be made available. A review of individual theatre nurse staffing is being progressed to adopt a planned reservist approach to accommodate any further spikes in critical care demand.

The impact of this response on the number of people waiting for a planned intervention has been significant A reduction in referrals has meant that, whilst the overall number of patients waiting, has not increased significantly the length of the wait for patients has risen dramatically:

	16/3/20	**18/5/20**
TTG Inpatients / Day case (available)	22060	23235
Inpatients / daycases over 12 weeks	7594	16364
New Out Patients	70702	74017
Out Patients over 12 weeks	20457	42489
Endoscopy	3880	5175
	696	4206

5.1. Principles and assumptions

A coordinated approach to the re-start of services is being implemented with all services adopting the same approach and applying the same principles.

All services are being reviewed in the context of the advice from STAC which includes the need for patients to self-isolate for 14 days prior to a planned inpatient admission and a pre-admission test to be undertaken 48 hours prior to any planned admission.

The impact on Level 2 /3 care, the need for PPE and the demand for medicines is also assessed.

This new pre-admission process will lead to a different pattern of late cancellations should patients receive a positive test result and, given the need for self-isolation and testing, – short notice admissions will not be possible but this will be reviewed.

Given public anxiety it is anticipated patient initiated cancellations will increase.

Defined patient pathways for all services require to be developed in light of the risks from COVID19 for staff and other patients and maintaining the balance between elective and emergency pathways will be key.

All interventions involving an Aerosol Generating Procedure will require staff to use full PPE including respirators which requires down time and additional cleaning between cases. This will impact on theatre throughput and also on investigative and diagnostic capacity.

Attend Anywhere and virtual consultations along with telephone triage will reduce attendance at hospital sites. The need for physical distancing in out-patient and diagnostic waiting areas will require review , additional precautions to be put in place and is likely to reduce the number of patients able to be seen at each session . For example previously a CT Colongraphy took 20 minutes with the new precautions necessary it is estimated it will require 45-60 minutes.

5.2. Cancer Treatment

Restarting Services

The main priority between now and July 2020 will be to ensure that those cancer services suspended as a result of COVID19 are, where appropriate, re-started.

To that end, cancer MDTs hosted within NHSGGC have worked to prioritise service resumption in line with the guiding principles and agreed which services are to be prioritised for re-start pre-July 2020 and which can wait in the first instance.

Prioritising Surgery

Within NHSGGC a full review of all cancer patients awaiting surgery has been completed and patients are being dated for surgery in line with the urgency categories detailed below:

Priority level 1a Emergency - operation needed within 24 hours
Priority level 1b Urgent - operation needed with 72 hours
Priority level 2 Surgery that can be deferred for up to 4 weeks
Priority level 3 Surgery that can be delayed for up to 3 months

As of 18th May 2020 there are no outstanding Level 1a/1b patients waiting for surgery undated within NHSGGC – this also applies to patients from other Health Boards awaiting surgery within NHSGGC.

The undernoted table shows the number of Priority 2 and 3 patients waiting on 18th May. During June treatment for Priority 2 patients will be underway

	Category 2	Category 3	MDT Review	Total
Brain			2	2
Breast		55	18	73
Colorectal	6	27	1	34
Gynae	18	9	16	43
Head and Neck	3			3
Sarcoma	3		1	4
Skin		3	9	12
UGI		6	5	11
Urology	32	86	1	119
Total	62	186	53	301

Imaging and theatre capacity is being prioritised within the NHSGGC to support cancer patients and in particular to support Category 2 patients awaiting surgery.

To further support our cancer position:

Theatre lists have been protected within the Institute of Neurological Sciences throughout COVID19 to treat urgent Head and Neck cases and the ICU kept free of patients with COVID19.

Screening

Each screening programme carried out a risk assessment to identify the diagnostic and treatment backlog created by the suspension of non-essential services and to agree a

prioritisation order when re-mobilising clinical activity. The associated risks and current backlog of patients has been assessed for each programme.

The SMT for West of Scotland **Breast screening** have started to plan for the re-start of the service. Some of the challenges include template changes to support social distancing within the screening units and a revision of the national letters for appointment to the service. The previous locations for the mobile units may need to be re-negotiated and agreed within areas. The service will require staff currently redeployed to re-establish the service.

Sequencing remobilisation:

1. Complete biopsies and surgery for all outstanding women (11)
2. Complete assessments for women who were shielding (7)
3. Start appointing new women for screening

NSD have set up an operational group to address how the cervical screening programme can be restarted safely with a particular emphasis on prioritisation of women who are classed as Non-Routine.

Sequencing remobilisation:

1. Deal with the 380 outpatients appointments that were cancelled
2. Provide training for Colposcopists to ensure that they are familiar with new pathways.
3. Appoint to Colposcopy the 538 women who have been paused
4. Call recall on non-routine to be ahead of other samples
5. Full reminders for screening to commence in line with national guidance

For bowel screening, we are prioritising those patients on symptomatic pathways who have had CT suggesting cancer and need a diagnosis.

Sequencing remobilisation:

1. Clear backlog of 311 patients for pre-assessment
2. Identify and appoint numbers waiting for Colonoscopy
3. Restart sending kits for testing as part of national programme

Abdominal Aortic Aneurysm invitations for screening were paused and all scheduled clinics were cancelled. The risks with pausing are a delay to diagnosis and the possible rupture of an AAA for not having AAA identified in the next 3 months and the likelihood of this happening is statistically very small.

Sequencing remobilisation:

1. Appoint the 237 patients that were paused for surveillance
2. Appoint the 2813 patients due by end of May
3. Provide surgery for the patients put on hold and/or awaiting scans
4. Restart screening process

Diabetic Retinopathy Screening (DRS) Programme invitations were paused. The risk of pausing screening is possible delay to diagnosis of retinopathy or sight loss but the likelihood of sight loss happening is statistically very small.

Sequencing remobilisation:

1. Appoint the 1393 patients that were paused and deal with the outstanding patients on recall for each month

2. Implement the new IT system (Optimize) and new frequency of screening
3. Appoint the newly diagnosed patients with diabetes (407)
4. Restart screening appointments

Imaging Support to Cancer
All imaging work has been prioritised during COVID19. This is set out in the chart below;

COVID Book		COVID On Hold			
Urgent	**Routine**	**Cat 1**	**Cat 2**	**Cat 3**	**Cat 4**
Cancer staging examinations where treatment is being considered New suspicion of cancer where treatment is being considered	Examinations to assess treatment response where treatment may change as a result of imaging	Examinations where there is suspicion of malignancy that were not performed during COVID crisis	Examinations to assess treatment response that were not performed during COVID crisis Examinations to diagnose and/or treat significant disease or injury and/or alter treatment plan	Further investigations after a positive screening exam (e.g. CT aorta, CT colon) Routine surveillance of patients on a cancer pathway	Examinations to diagnose and/or treat minor disease or injury, where delay unlikely to be harmful Low risk lesion follow up (nodules, etc) Screening exams

As can be seen from the chart above, the scan types noted in the first two columns on the left have not stopped being processed/booked during COVID19. This includes the vast majority of scans relating to cancer services. In the first phase of our COIVD19 response, those scans detailed in the next four columns (Cat 1 to Cat 4) were paused.

In April 2020, NHSGGC approved calling in those patients in Cat 1 in the above chart – these are deemed as semi-urgent patients, some of whom have a suspicion of cancer. With the inclusion of this group, all patients within cancer pathways are being called/dated for scans.

Cat 2 patients will start to be called once there is some relaxation of lockdown principles. Out of circa 30,000 patients waiting for scans at present, 25,000 sit within Cat 2 to Cat 4 as detailed above.

5.3. Urgent Emergency and Semi - Elective Surgery

The operative capacity across the Board in the initial phase of increasing ICU demand was directed to CEPOD and trauma care. With economies of scale, skilled teams from day surgery locations were incorporated into key inpatient sites to accommodate the increasing duration of operative intervention due to the extended infection control measures during and between cases.

As the staffing base within critical care was stabilised with nursing staff from wider staff groups across the acute sites, a phased expansion of operative capacity has been progressed. With varying demands relative to specialty pathways e.g. spinal, major trauma, renal transplant and vascular patient pathways featuring in QEUH, gyn oncology, complex cancer and regional plastics impacting at GRI together with colorectal and urology cancer prioritisation across RAH and IRH, planned urgent care was reprovided in a flexible arrangement on a day to day basis with shared specialty lists.

To optimise available anaesthetic and nursing provision, extended urgent operating time has been supported to facilitate, in particular, timely trauma patient care. This also protected planned urgent specialty sessions. Transfer of urgent patient management across the sectors has been undertaken to balance demands. Subspecialty patient transfers and exchanges have taken place with dual operating to reduce operative time wherever possible. Surgical cancer and urgent care planning meetings with specialty representation have taken place on a weekly basis to ensure appropriate allocation of theatre time.

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Service provision across all theatre areas has been compared to ensure standardisation of practices has been maintained particularly related to use and monitoring of PPE. Plans for additional session are being agreed by facilities colleagues for instrumentation.

Urgent complex cancer surgery has recommenced with HPB and Oesophageal procedures being prioritised for week commencing 18th and 25th May. Streamed elective HDU pathways have been established to support the gradual increase in activity. An additional 2 theatres are planned for urgent Paediatrics during June.

With review of specialty specific national guidance, cross sector specialty group meetings are being conducted led by Clinical Directors to ensure consistency of approach and exploring support arrangements as necessary to maintain similar service provision across the board. Clinical review of waiting lists to prioritise patient management has been instigated with this being a varying undertaking by specialty. A 1st June target date has been set for initial categorisation to enable further planning review to be conducted considering options for protected pathways for elective care.

High risk anaesthetic clinical assessment is being reviewed for potential expansion to ensure patients are optimised for their operative intervention.

Opportunities to limit AGP risk are under review with consideration of Aerosol devices supporting the return of Laparoscopic surgical management in general surgery and gynaecology.

5.4. Endoscopy Services

All non-emergency Endoscopy services were stopped in line with BSG guidance regarding Aerosol Generating Procedures. Only high risk upper GI endoscopy, bronchoscopy and EUS

procedures are being performed and with full AGP precautions. With national consultation local colorectal pathways have been adapted to assess and investigate only those patients at highest risk, and of lowest frailty, at the peak of the outbreak. Bowel screening and surveillance has been paused in line with clinical prioritisation of patients.

An additional 6 lists will start in week beginning 25th May with a further 4 planned for the week of 1st June.

A range of proposals are currently being worked through to guide future service delivery, including:

- Review of all patients currently on the Endoscopy waiting list with enhanced clinical vetting in line with these new pathways.
- For less urgent patients, telephone consultations, Attend Anywhere review and limited face to face appointments will be deployed to ensure appropriate management.
- Revised pathways for patient investigation including stratification of higher priority and intermediate priority patients utilising QFIT assessment and radiological review. Primary and secondary care teams will consider revised colorectal referral pathways that may mandate the application of QFIT testing in both primary and secondary care settings.
- Limited colonoscopy sessions have recommenced in all sectors.
- The feasibility of capsule colonoscopy as an alternative colonic investigation is being considered.

5.5. Outpatient Services

In addition to patients who have been referred with an urgent suspicion of cancer a number of other clinics have continued and over the period to the end of July this will continue and expand. The support from external providers has continued. Initially a number of patients declined to attend face to face appointments but this has started to reduce in May.

Every service is reviewing their service model to ensure that it is adapted to the Board's guiding principles and ensures safe clinical care for patients and a safe working environment for patients. The aim is to ensure that the opportunities for digital working described in Section 3 are maximised and face to face appointments are reduced significantly.

From 18 May, it is proposed to expand the temporary timetable of specialty-based ophthalmology clinics, using the Victoria and Stobhill eye clinics to provide additional urgent Glaucoma, Macular, Diabetic and Uveitis clinics, plus urgent injections. Clinics will start at the three Clyde hospitals in week of 25th May.

Additional clinics are also being established for patients referred with an Urgent Suspicion Of Cancer request as the public are responding to the public messaging encouraging them to seek referral.

5.6. Renal Transplant

Deceased organ donation has continued within NHS GGC during the COVID-19 pandemic, following the guidance issued by NHSBT in April 2020 – with transplants only proceeding after both the donor and recipient have tested negative for COVID-19 and ensuring we follow a 'clean' operating pathway from ward-to-theatre-to ward. 7 successful transplants have been

safely achieved (6 adult and 1 paediatric) at the time of writing without nosocomial COVID19 infection

The clinical teams have worked with their wider colleagues in theatres and critical care to develop green pathways for this surgery and there have been no recorded complications or hospital-acquired infections for the cases undertaken to date.

In light of the national guidance issued on 18th May clinical teams are developing a plan to start living donor transplantation in phases over the coming weeks. From June 2020 this will commence initially for those donor recipient pairs who have completed their work up. Apart from the renal service this will impact mainly on theatres and anaesthetics. There are currently 9 fully worked up living donor pairs in GGC.

We will then consider restarting the investigations for those donor recipient pairs currently in the work up process. This will be dependent on the restart of routine radiological services and then theatre and anaesthetic availability. There are currently 20 living donor pairs along the work up pathway in GGC.

Thereafter as capacity allows, we will commence the assessment of new living donor referrals. This will be dependent on the ongoing capacity of routine radiological services and theatre and anaesthetics.

5.7. AHP services

Since 23 March, AHP services across NHSGG&C have continued to provide care for all urgent and emergency cases in each service, there has also been a focused approach to target activity towards preventing unnecessary admissions, and maintaining mobility and function within the community. This has been achieved in spite of reassigning significant resources to support testing and the delivery of acute care, supporting COVID rehabilitation and inpatient care during the pandemic.

Waiting times for non-emergency and non-urgent referrals have increased commensurate with these measures. By the end of July, waiting times will have increased by up to four months for some services, with these likely to extend further beyond July due to the phased approach to recovery, particularly with regards to reduced capacity and social distancing.

It is anticipated that outpatient and community clinic activity will recommence in a phased approach with each AHP service producing its own recovery plan. A key element of these plans will include the development and integration of Attend Anywhere / Near Me capacity into service delivery wherever clinically appropriate, and contingent on network internet and IT hardware capacity. Implementation of recovery plans will be consistent with prioritised need within service specifications, and according to local service delivery capacity. Any major changes to historic working patterns will fully involve partnership discussions. This will vary considerably by base and service, and will be contingent on the need to maintain staff health and wellbeing and patient/client social distancing and appropriate infection control measures for each type of intervention delivered. Other considerations are:

- Type of activity carried out (some activities necessitate a face to face intervention whilst other professions have more flexibility and less dependence on geographical locations being available)
- Reintegrating AHP staff who have been reassigned

- Staff availability, including the challenge of reintegrating AHP staff who have been reassigned – the % of the AHP workforce reassigned to other duties varies considerably between services
- AHP services' recovery planning will be based on each individual clinical service prioritising its waiting and 'on hold' lists
- AHP services will require detailed liaison with local health and care delivery units and other services to ensure a bespoke approach by location thereby supporting the need for social distancing and infection control measures.

These plans will be agreed in partnership and subject to approval by local management structures and the relevant tactical recovery group at Board level.

5.8. IVF/Fertility – NHS Assisted Conception Services

The planned introduction of GGC IVF services was agreed in principle at a National level. NHSGGC are currently awaiting approval from HFEA at which point we can confirm a commencement date for services.

The service will require support from Anaesthetics and genetics and the availability of this will impact on the treatments that can restart. Initially those treatments that do not require anaesthetic cover will start in June and plans thereafter will be incorporated into the broader review of clinical priorities.

5.9. Maternity and paediatric Services

Maternity Services continue to provide safe care for all pregnant women although the availability of some services remains restricted. The service has ensured the safe provision and adequate staffing of three Maternity Units to support births however in order to ensure staffing levels were sufficient we have temporarily ceased birthing services at the CMU's at RAH, IRH and VoL and are not providing Home Births. These arrangements are under constant review as part of recovery planning and when staffing levels permit and once it is safe to do so then a date for recommencement will be determined. Antenatal and Postnatal clinic appointments have been adapted using technology to reduce numbers required to attend clinic locations. The Maternity Service were already using Attend Anywhere as part of their clinic options and have increased the availability during the pandemic.

Hospital Paediatrics and Neonatal Services have fortunately not had the same impact from the Pandemic and have continued to function although at a reduced level as hospital staff were deployed to assist the Adult Sector. The main impact on RHC is related to loss of surgical activity despite running up to 5 theatres on weekdays, reduction in inpatient and day case planned procedures, loss of new outpatient slots and return patients and diagnostic tests. Recovery planning is well underway and the hospital has introduced a clinical priority criteria to determine the access to theatres for surgeons whilst we determine when additional theatres can safely recommence. All outpatient clinics are being reviewed to ensure where clinically appropriate optimum use of technology and reduce volume of patients required to attend in person.

Key Points
• All priority levels 1a and 1b for cancer have been treated, and during June priority level 2 patients will be seen

- Elective waiting lists have been reviewed and cross sector specialty groups have met to ensure consistent prioritisation
- Capacity to treat is significantly impacted on by infection control guidelines and the need for physical distancing
- Over the next week, an additional 10 endoscopy lists will start
- Outpatient services for urgent suspicion of cancer have continued throughout the pandemic period, and some urgent ophthalmology clinics have commenced

6. Acute bed capacity

6.1. General bed usage and capacity

The demand for beds will come from the following sources:

- Patients with COVID 19
- Emergency admissions
- Urgent/ USOC admissions
- Elective admissions

The expected number of beds required for patients with COVID has been reviewed in light of the actual experience in NHS Greater Glasgow and Clyde and the modelling data supplied by NHS Scotland. It has been assumed that an additional 50% of beds may be required for COVID 19 patients above the modelled numbers.

Escalation plans for an increased number of beds remain in place dependent on similar actions from phase 1 of the pandemic with limiting activity and reassigning staff.
The number of beds occupied by adult patients who have not tested positive for COVID has remained relatively static over the last three weeks, averaging at 2752.

With the more gradual resumption of planned urgent surgery, the impact on inpatient beds will be limited. The actual numbers of patients will be relatively small given the constraints on theatre throughput and evolving experience in operating in an

to be undertaken will be completed during June. Workforce will be key to this, as described in section 4 whilst the number of people self isolating will reduce this will be offset by increased annual leave. The additional steps taken by the Board to secure additional workforce will ensure that capacity can be staffed. It is not yet known what environment with ongoing risk from COVID19 infection

Planning longer term capacity as more routine elective surgery is able the plan is for people who have received a shielding letter at the end of the initial 12 week period and workforce plans will be reviewed in light of that position.

By the end of July it is anticipated that the pattern of inpatient bed use will be:

	End July
COVID	171
Emergency	3338
Urgent / Planned	175

Total	3684
Bed Complement	4336 85% occupancy

The demand from COVID19 will continue to be reviewed and if actual requirement increases above the numbers predicted the elective demand will be reviewed. The emergency demand will also be reviewed as this has been considerably lower during the COVID pandemic and the figures will be reviewed to determine if they return to pre COVID levels.

Further considerations

The Infection Prevention and Control Team have issued advice to services on the patient pathways necessary for patients with confirmed or possible COVID19 and for those who require to be shielded. The requirement to use single room accommodation for patients requiring isolation makes patient placement complex. Currently c 10% of acute adult beds are occupied by patients who have received a letter advising them to be shielded. For example on 21st May 2020 there were 432 shielding patients in the wards across GGC acute hospital sites.

In future this may require patient pathways to be altered across NHS GGC given the varying numbers of single rooms across sites.

187 people were waiting to be discharged from acute hospitals on 16th March at the start of the pandemic. This has fallen to 112 on Monday 18th May which has created additional capacity within the acute hospital setting.

There has also been a small impact on bed occupancy from the requirement to ensure people being discharged to care homes have received 2 negative test results prior to discharge and from the additional steps being taken to ensure care home residents are receiving the best possible care and can be isolated if required. Currently this is not significant but will be kept under close review by the Board and the Health and Social Care Partnerships.

6.2. Private/GJNH

In addition to NHS GGC capacity there continues to be a small number of patients being admitted to the GJNH and the Nuffield for urgent cancer surgery

Breast and Skin Cancer surgery has been undertaken at The Nuffield (60 cases to date). This arrangement will continue over the next three months.

At the GJNH, over 30 colorectal patients have been treated with 15 Clyde patients are also scheduled for surgery. An additional 30 cases are expected to be treated over the next three months at GJNH with more cases under discussion.

6.3. Intensive care beds

GGC opened an additional 55 ICU beds from its base complement of 45 in order to create capacity for the impact of COVID19. In week beginning 18th May this had reduced to an additional 31.

Plans were prepared to increase this to a total of 170 beds and these plans remain in place.

It is recognised that there will be an ongoing requirement for Intensive Care Beds given the impact of COVID19 and the prolonged length of stay that these patients require. The number of non COVID patients in ICU over recent weeks has been an average of 18. National modelling has indicated a need to maintain access to 9 beds for potential COVID surge.

Given the impact of physical distancing on trauma and other emergency activity it is not likely that demand will return to usual levels by the end of July.

Review of previous years activity and occupancy in ICU has shown that there will be sufficient beds available to accommodate up to 9 beds for COVID 19 from within the base capacity of 45. This includes an allowance of 50% above likely number of COVID patients

ICU base	45
ICU beds 25/5	76
ICU patients 23/5	35
ICU COVID patients 23/5	15
ICU beds 31/7	45
COVID ICU	9
Other	36

Given the seasonal demands on ICU, the challenges of keeping separate patient pathways and the likely longer term increase in complex elective operating a capacity plan for ICU and HDU capacity will be developed during June.

Key Points

- COVID demand for beds is projected to be 171 by the end of July (including the potential for 50% surge)
- At 85% occupancy, this leaves adequate bed numbers to deal with urgent/planned activity and emergencies
- The ICU bed base will return to base level during July, which allows for ongoing management of COVID patients with projected levels of emergency and urgent activity

7. Unscheduled Care

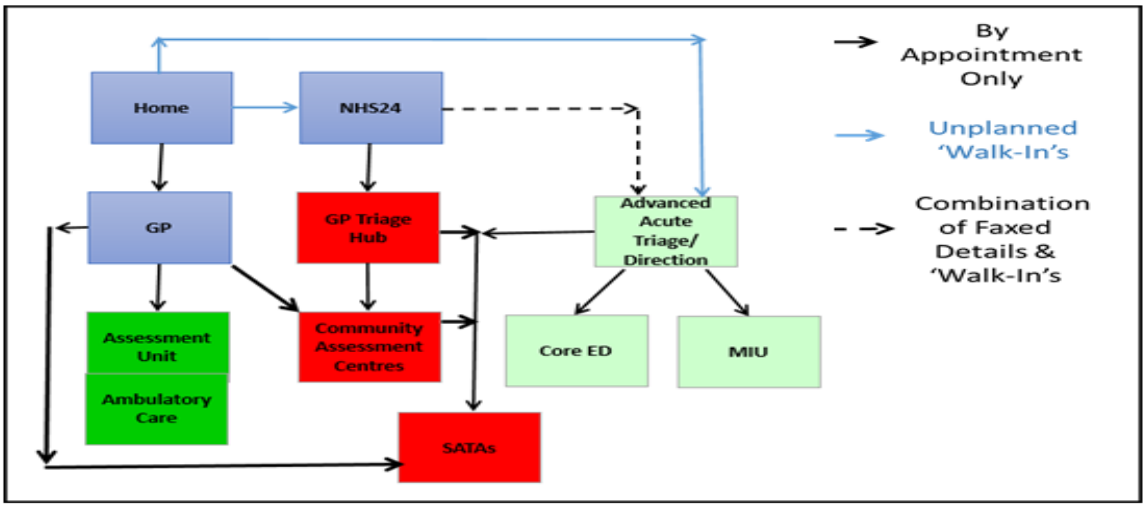
7.1. Activity and performance levels

Unscheduled care activity in NHS GGC has seen a significant reduction, in line with national trends. Between 1st April 2020 and 17th May 2020 our core Emergency Departments have seen 45% of attendances reported for the same period last year. The trend across NHSGGC has now started to move in an upwards direction in line with the 'NHS is open' campaign and further growth is anticipated in the next few weeks.

Performance against the 4 hour A&E standard across NHSGGC has shown a sustained improvement since the social distancing measures were introduced in mid-March. The year to date position at 17th May 2020 was 94.4% compared to 86.6% for the same period last year.

7.2. COVID-19 Pathways

COVID-19 has presented a number of challenges in relation to patient streaming and we have introduced a number of incremental changes to ensure we continue to deliver safe and effective emergency care within the context of the pandemic. To respond to COVID-19 all hospitals have developed new processes to ensure patients are directed to the most appropriate care provider. We must also ensure that patients with and without symptoms can be isolated and managed accordingly and therefore we have developed new Red and Green pathways across emergency care services. We are focused on continuing this approach. The model shown below provides an overview of the 'in hours' service model with further details briefly outlined below. The ongoing development of these changes will form a key part of the next phase of our unscheduled care mobilisation plans.



7.3. Developing and learning from this model

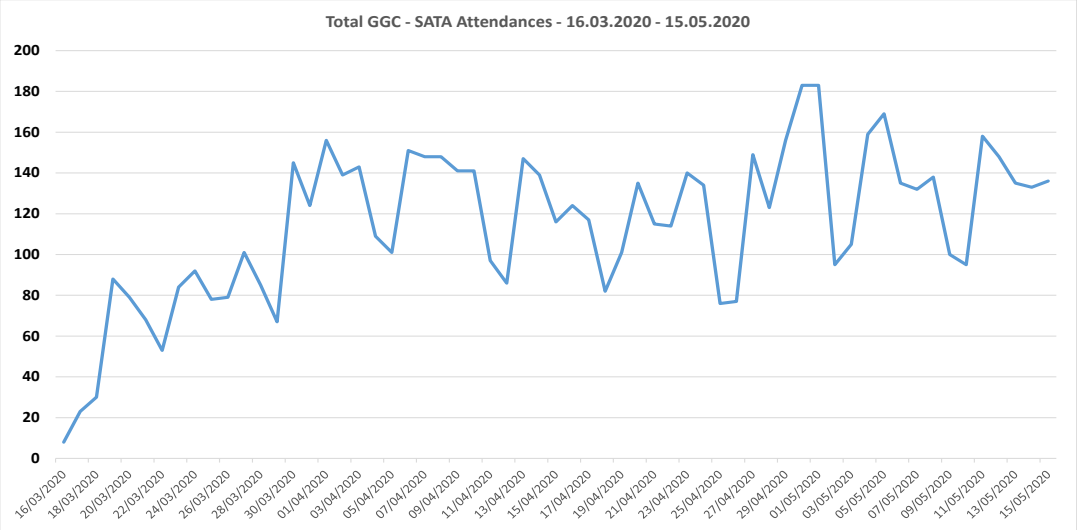
Red Pathway – Suspected COVID-19

- Implementation of GP triage process at the COVID hub to ensure the right patients are escalated through the pathway according to their clinical needs whilst others are provided with advice and follow up where necessary. Further work to see how this aligns to the future model and the ability to create advanced direction to the most appropriate care provider will be progressed.

- Establishment of 6 Community Assessment Centres forming the isolated response to COVID at a point closest to home to reduce and minimise spread. Further work will be done to ensure we have the flexibility to retain some of these to reduce increased demand at EDs and a plan to upscale in response to any further peaks will be developed.

- Introduction of Specialist Assessment and Treatment Areas (SATAs) within the core Emergency Department Complex to isolate patients and stream to the appropriate areas at the point of arrival. As departments have been reconfigured to accommodate SATAs further work will be required to ensure physical space is optimised and we have the ability to manage the predicted increase in emergency attendances as the service returns to near normal levels.

- Real Time patient monitoring dashboards have been developed to ensure there is visibility of all patients going through the Community Assessment Centres and the SATAs to limit transmission, ensuring pathways reflect safety protocols that protect both patients and staff



Green Pathway – non COVID-19

- Active signposting and direction at the front door of the Emergency Department by Senior Nurses has been introduced to ensure patients are seen by the right care provider. This process is not based on triage or further clinical screening therefore our mobilisation plan will focus on the development of a multi-disciplinary direction process in collaboration with clinical teams and incorporating learning from other Boards.

- Appointment only for GP OOH services has been introduced and further work continues to develop the service model to incorporate GP Triage and Attend Anywhere in mid-June to complete consultations whilst reducing face to face attendances.

- Professional to professional advice and guidance lines have been expanded across all Sectors within NHSGGC offering direct access to Acute Medicine, Acute Surgery, Cardiology, DVT, Elderly Care, GP Admissions and Dermatology. This has occurred over a short period of time and further work is required to optimise this across all Sectors with the aim of converting unplanned GP activity to a more planned urgent specialty response.

7.4. Other Considerations

Our response to COVID-19 has meant that the emergency complex and cubicle space within core sites have been redesigned to facilitate streaming through two distinct pathways and therefore available physical space has been reduced to accommodate. As activity increases we must continue to spread urgent care demand across all services including self-care, pharmacy, community specialty teams, dentistry and GPs in an effort to reduce the dependency on EDs. Clinical and operational teams have taken a system wide approach and in collaboration have introduced significant process changes over a short period of time to optimise patient care and clinical outcomes. The next phase of our mobilisation plan will ensure we remain focused on this approach and wherever possible explore options that will enable us to move towards more planned, appointed based urgent care.

Key Points
• Our Hub and Community Assessment Centre model will continue with the ability to flex for future demand surges • Active signposting will be extended to all our Emergency Departments • Learning from the red pathway, with senior clinical triage and more planned, appointed urgent care is being explored for all unscheduled care

8. Mental Health

8.1. Current position

Mental health services have continued to operate throughout the pandemic with a focus on delivering an urgent care response. Across all areas of mental health, services have re-designed and adapted their response to support on-going demand. Clinicians and managers have moved to remote working and MS Teams for management activities. Two new Mental Health Assessment Units staffed by reassigned staff, were quickly established to deliver support across the Board by diverting activity from the Board's Emergency Departments. Changes to this emergency pathway have been supported by both SAS and Police Scotland.

8.2. Planning recovery

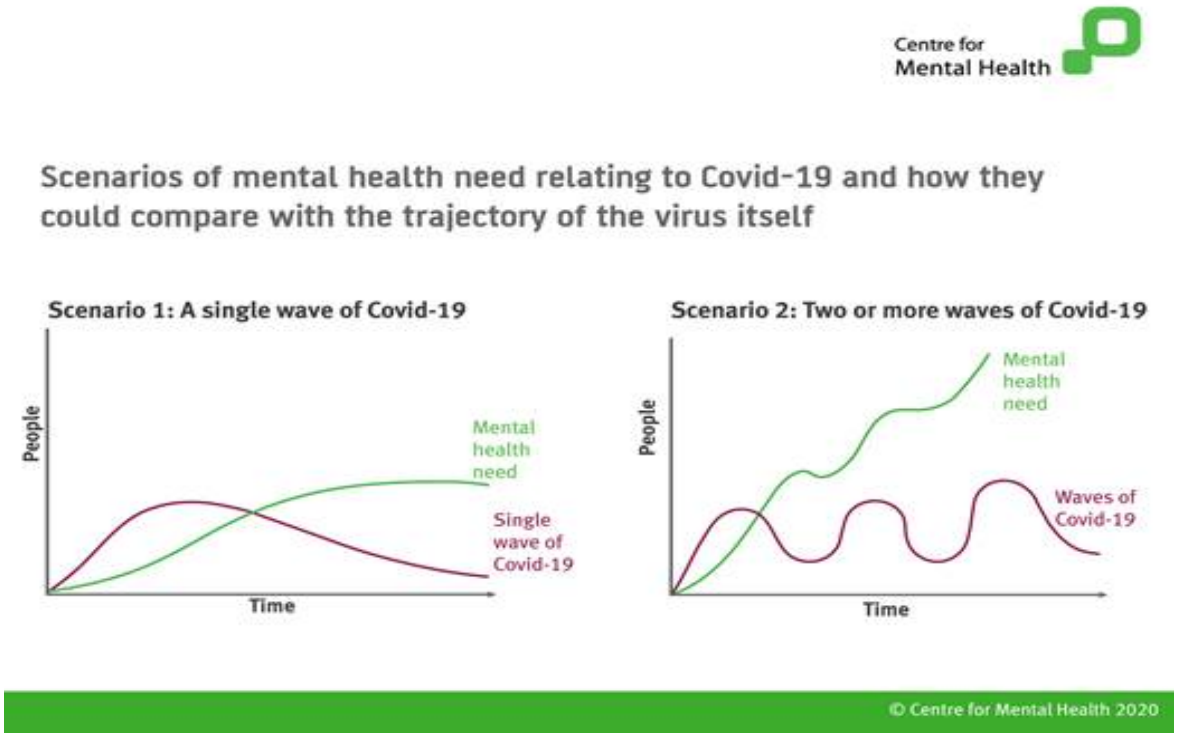
The service is now focused on planning for recovery and transition. It is inevitable that future provision will be delivered differently, and the recovery phase is intended both to restore care and re-establish services for those who need it, and also to manage the transition to new service models.

There are common considerations across the whole system which are a feature of the recovery planning. These would include an assessment of the impact of disrupted services, available workforce, social distancing requirements and impact on estates and facilities, availability of equipment and kit including adequate PPE, and new technology enabled practices which have been adopted to respond to the crisis. Additionally there are factors specific to mental health services which will have a significant impact on future demands and therefore need to be considered as part of this planning. These include the impact of social isolation, bereavement, unemployment, traumatic experiences and anxiety about becoming unwell. The economic consequences of the pandemic, particularly the associated impact on rates of depression, anxiety and suicide need to be considered too. Detailed recovery plans have been developed for Adult Mental Health. Older People's Mental Health and Child and Adolescent Mental Health.

8.3. Demand profile

It is anticipated that as a direct result of the pandemic there will be an increase in demand for mental health services. To prepare for this stakeholders are already working to enhance community resilience, access to local resources and availability of peer support and other non-clinical responses to distress. Examples would include the Thriving Places initiative, and

a new “Safe Haven” service commissioned from the Glasgow Association for Mental Health. Additionally MH information has been made available through a range of websites, including the HeadsUp.scot GGC resource. Plans are in place to publicise suitable mental health



specific social media accounts. This is already in place for CAMHS.

In considering anticipated future demand, it is noted that demand for services has increased significantly amongst young people (15-29) in GG&C over the last five years. This trend is expected to continue. The MH Strategy as part of the Board’s Moving Forward Together plans will have a focus on younger people, particularly in relation to suicide prevention.

8.4. Vulnerable Groups

In considering the Mental Health recovery response it is vital to give due consideration to vulnerable groups. Specific groups recognised as part of the planning will include:

- People with a Learning Disability who are particularly vulnerable due to restrictions on some forms of community support.
- Neurodevelopmental disorders - pathways are being updated by CAMHS and Adult services in recognition of the particular needs of people in this group.
- BAME - The differential impact of COVID-19 on people from BAME backgrounds has been recognised. Prior to the pandemic, the Board committed to improving recording of ethnicity on care records. A working group on BAME mental health will be set up with a range of stakeholders.
- Severe and enduring mental illness - Physical health is often significantly compromised, and services are aware of their particular needs.
- People living in the poorest quintile of GGC areas comprised nearly 60% of all attendances at MHAUs, reflecting the differential impact of COVID-19 on people living in deprivation, and the importance of maintaining equitable access to services.
- Home visits are taking place (with full PPE) for patients who are shielding or self-isolating.

- After a brief pause for all but those in the "red" priority groups (see below), transitions between care groups (CAMHS, Adult, OPMH and specialist services like Perinatal MH) are now operating as usual.

8.5. Clinical Priority Areas to July 2020

At the onset of the pandemic services were immediately prioritised and are now consolidating through a recovery phase. All patients have been contacted by telephone or letter to ensure they are aware of current arrangements, and have been offered advice on how to contact services. This approach will continue. In terms of recovery and transition a number of common action areas feature across all Mental Health service areas these include:

- Explore opportunities to extend the use of digital technologies including Attend Anywhere.
- Review and redesign of pathways.
- Development of range of options to delivery group work remotely.
- Development of self-help materials and on line classes.
- Development of online decision-making aids using the MyPsych app.
- Exploratory work to implement referrer guidance, e.g. using Consultant Connect or equivalent.

Actions specific to each area are detailed in the following table which identifies key priorities and associated actions being progressed between now and end July to support the initial phase of recovery.

Key Points
• An urgent care response has been maintained throughout the pandemic period and all patients have been contacted • Vulnerable patient groups have been identified for priority during recovery • Mental health services for children and young people will be prioritised to address waiting list backlog • The mental health assessment unit model will be continued and developed to support patients to the right service • Digital opportunities such as on line services, Apps and remote consulting are key to new ways of delivering services

	Urgent and emergency care (4 hours/5 days)	Red category (regular scheduled care – fortnightly)	Amber Category (Regular scheduled care – monthly)	Green Category & other responses
Current position				
CAMHS	Services maintained - adaptations to service provision as required.	Patients continued to be seen. "Cohorting" of inpatient care by COVID-19 status.	All CAMHS teams remained open. Teams continued to accept all referrals that meet the referral criteria, though not all patients were seen.	
Adult MH	GP referral to CMHTs, Crisis, Out of Hours and Home Treatment Team (Renfrewshire) continued unchanged. Two Mental Health Assessment Units (MHAUs) established.	Prioritised by CMHTs for scheduled care. Depot injections, clozapine monitoring, and follow-up post-discharge continued as before.	Mainly postponed.	Affects almost all Primary Care MH Team (PCMHT) activity. Mainly postponed as staff activity diverted into other areas.
OPMH	Urgent and/ or crisis visit only being undertaken.	All caseload being prioritised by category of risk. Nurse staff supporting Care Homes via telephone and visits visiting.	People informed of care response. Limited prevention work being undertaken.	As above Routine clinics/ appointments cancelled although some appointments are going ahead.
Recovery – By end July 2020				
CAMHS	Prioritise resource for Crisis Nursing team to ensure rapid assessment and community support is available.	Prioritisation of intensive nursing support Merger of inpatient units and provision of cross-service cover through the development of a hub model.	Cross-covering across professional groups to match capacity to demand Contact with all children and young people on waiting lists.	Develop an enhanced online presence including: online health and wellbeing resources. social media Develop mental health care videos and sound files.
	Actions to end July: • RAG patient status to prioritise new referrals and existing waiting list. Those children and young people waiting longest are being contacted to validate the referrals. • Joint work with Children and Young People's Mental Health Programme Board. Performance Team to agree process to reduce the waiting list backlog. • Implement of Attend Anywhere and virtual CBT clinics. • Increase the time available for clinicians to provide help and treatment at first contact. Work with partners and local authorities to support pathways in to and out of CAMH			

	services utilising Tier 2 funding. • Develop locality-based Tier 2 information resources to assist clinicians to identify and sign post patients to suitable support. • Develop locality-based Tier 2 information resources to assist clinicians to identify and sign post patients to suitable support. • Review the CAMHS delivery model taking into account the impact of COVID 19, and identify all options for responding to increasing service demands within the available resource.		
Adult MH	Maintain MHAUs on an interim basis Adjustment of medical rotas and skill mix to ensure sustainability Evaluate MHAU model Integration with national DBI programme when becomes available in June.	Maintain "cohorting" of inpatient care by COVID-19 status Telephone and video consultations with community patients PPE deployed where clinic or home visits are required.	Initial telephone triage of all new referrals. Catch up with initial assessments. Attend Anywhere/telephone/face to face consultations arranged. Routine contacts with amber category patients Assessment of routine new patient referrals. Recommence psychology input to high risk patients in treatment via AA. Undertake routine new patient assessments of patients on psychology waiting list via AA. Recommence Lithium monitoring Routine transfers of care across services. Electronic brief assessment tool and brief GP communications created as templates within EMIS. All Green category patients should have a planned review within 8 weeks. Recommencing of PCMHT activity including assessments of new patient referrals and provision of therapy for existing patients using remote working and digital resources.
OPMH	Plan for commencement of admissions for Older Peoples' Mental Health to some non-Glasgow locations. Review consolidation move of OPMH beds to available capacity.	Evaluation for revoking cohorting of wards with functional and dementia clinical activity. Contacts with community patients using telephone and video consultations.	Develop initial plans on ways to change and implement safe working practices in line with guidance to reinstate clinics. Escalation of Care Home Liaison activity.

9. Primary and Community Care

9.1. Health and Social Care partnerships

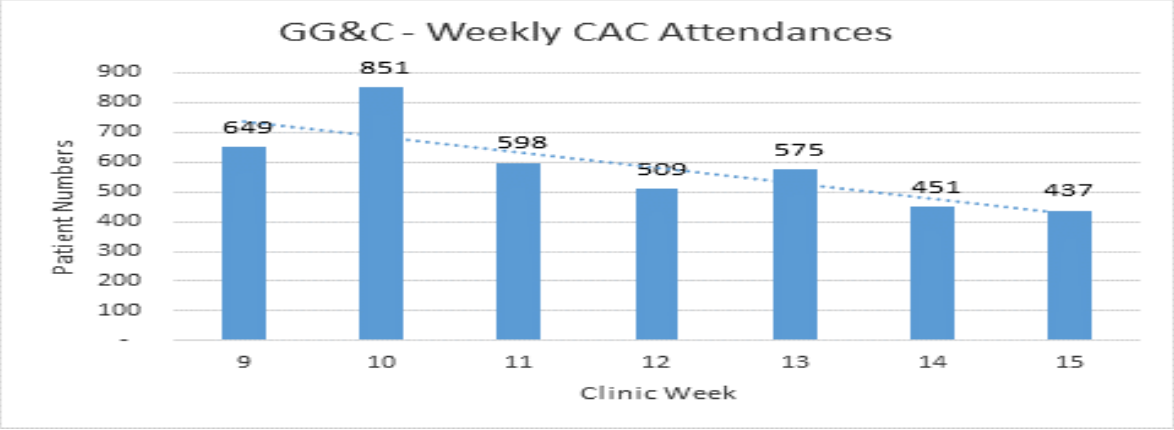
Referral activity has dropped significantly across areas of the Health and Social Care system and this is likely to have longer term consequences. As patients recover from COVID and backlog referrals emerge, there is likely to be increased demand for community based services which will bring additional complexity into the transition/recovery planning. Voluntary and 3rd Sector services will have a key role in the recovery response but have also been impacted. Recovery planning across the Health and Social Care Partnerships and Primary Care is being progressed in consideration of the Scottish Government's Assessment Framework giving due consideration to:

- Options for physical distancing measures
- Potential options are assessed for their viability
- Broader considerations include equality impacts and consideration of tailoring measures, for example to specific geographies and sectors.

Detailed recovery plans for community nursing have been developed.

Phased Transition

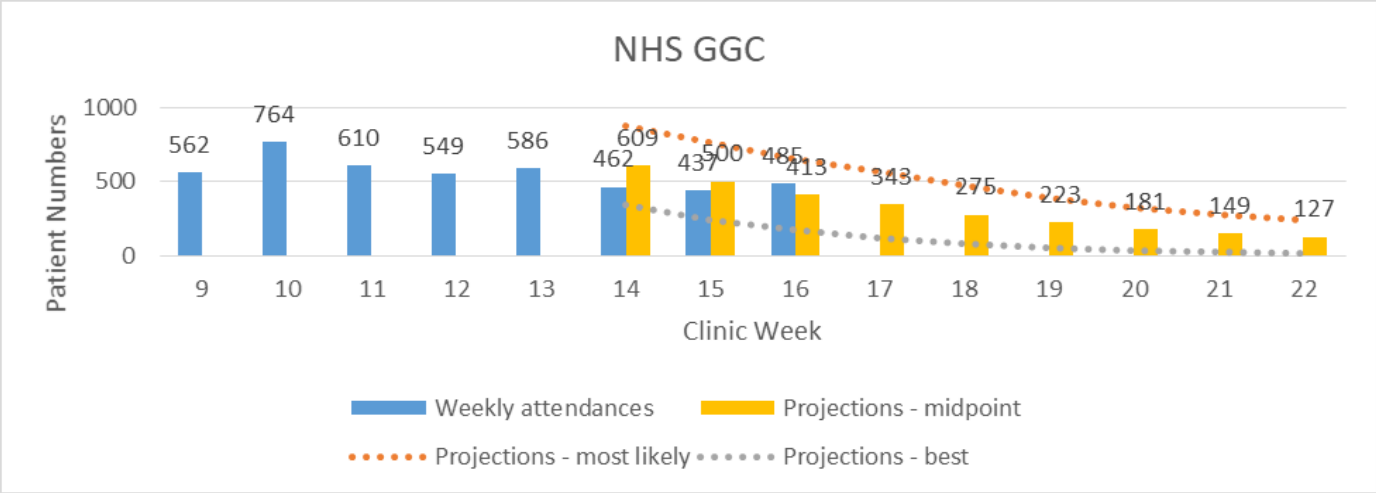
Throughout the COVID-19 crisis, Primary Care and community health and social care services have continued to deliver an urgent care response. Innovative ways of working have been put in place to maintain services and reduce risk to staff, patients and clients. In primary, community health and social care some routine activity has continued, where possible, by adopting new working practices. Inevitably some activity has been suspended. 6 COVID Assessment Centres were rapidly established across NHSGGC as part of the system wide response and elements of the GPOOH modernisation plan have been progressed. These centres deliver urgent assessment of deteriorating, symptomatic patients and the total activity across the 6 centres is noted below. Activity has decreased over the last 5 weeks and staff re-assigned to the centres are now required to return to their substantive role to support recovery.



NHSGGC continues to deliver enhanced community support through established Covid-19 Assessment Centres (CAC). From 8th June there will be 4 centres. Attendances through the centres have fluctuated but are generally on a downward trajectory. Staffing capacity has, and will continue to be adjusted based on demands across the GGC centres and flexible staffing approaches are being adopted to support this.

Scottish Government predicted activity levels have been used to model the future CAC activity levels to develop a workforce capacity model. The predicted activity is detailed below.

Note: At time of writing we are in week 18 (w/c 01/06). The below projections take use through to the 29th June, week 22.



A uniform staffing model has been applied and is detailed below. The optimised staff model is based on, and correlated with activity levels predicted at week 17. The model delivers some flexibility to respond to future peaks in activity and establishes a baseline of staff across 4 centres to support the mobilisation and extension of capacity in the event this is required.

CAC Future Model
Worfkforce implications(25/05)

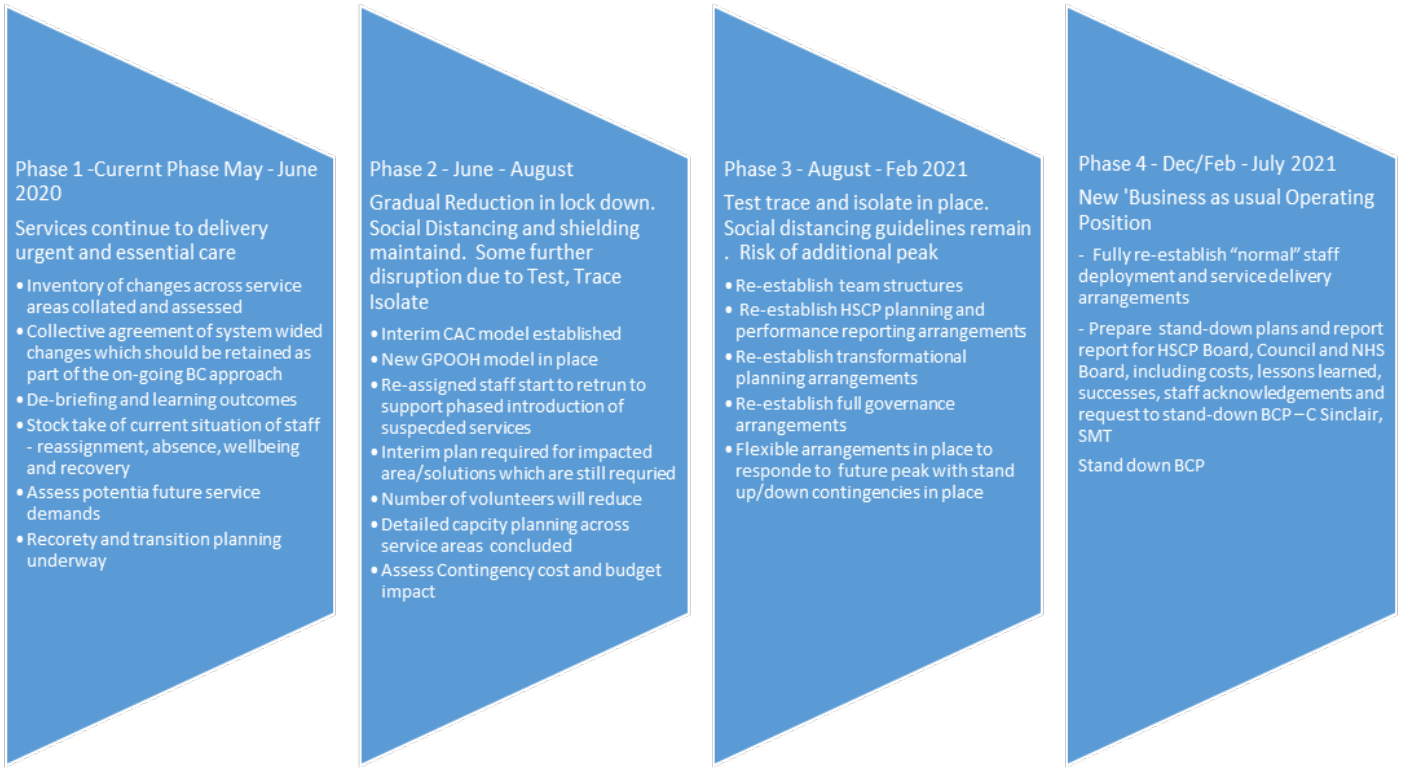
	Projected weekly attendances	GP/ANP	Nurses	HCSW	Admin	Clinical Co-ord	Domestic	Parking Attendant
Barr Street	243	3.6	3.8	3.8	1.2	1.2	0.13	0
Linwood	79	1.5	1.6	1.6	1.2	1.2	0.13	0
Inverclyde	24	0.5	0.6	0.6	0.6	0.6	0.07	0.6
West Dun	27	0.6	0.6	0.6	0.6	0.6	0.07	0
Totals	**373**	**6.2**	**6.6**	**6.6**	**3.6**	**3.6**	**0.4**	**0.6**

Note – parking attendant included only where this is indicated in the current model

There are significant implications for primary, community and social care services which need to be considered as part of the planning for the next phase of transition recognising the

current demand and the growing backlog of care that will need to be addressed. In considering a response it is recognised that a phased approach to transition will be required supporting an appropriately planned scale up of service access. There is no prospect of services fully returning to previous arrangements in the short to medium term. The response to COVID-19 will continue to impact on capacity and the way in which services are delivered for some time.

Figure 1 – Phased approach to Transition across Primary, Community and Social Care Services



Initial Priorities to July 2020 (Transition Plan Phase1 -2)

An initial focus of work being carried out by primary care and HSCPs is considering options and priorities for resuming services suspended during the initial emergency response. Staff whose services have been either suspended or reduced have been deployed to other areas to support the COVID-19 response. Some HSCPs have responsibility for homelessness services, and these will be considered as part of the prioritisation for restarting. Planning is required to ensure that there is a managed approach that balances the need to resume services alongside the on-going COVID response which includes delivery of a workforce to support the COVID Assessment Centres and other initiatives introduced. Estates issues and the need to ensure appropriate social distancing are also a feature of the planning work underway, as are opportunities to extend the digital and telephone response where this is appropriate. Public protection continues to be a key focus collaboratively across health and social care services focussing not just on what has traditionally been seen as 'protection' functions but also work to support the early release of prisoners and those designated as 'shielded'.

There are a number of priorities for primary and community health and social care to be progressed and/or delivered between now and the end July and these are further expanded in the table below. The first section of the table deals with services either scaled back or suspended and the immediate priorities, with the second section focussing on changes, re-designs and developments to be put in place to support transition to a new model of business as usual.

Service	Immediate Priorities – to July 2020
Routine/planned work Delivery of some routine planned services has stalled. This would include Rehabilitation and Enablement Services, screening programmes' Chronic Disease Management.	*Sustain the urgent and routine care provided throughout the crisis* *Identify opportunities to extend new ways of working to support re-introduction of appropriate suspended services* *Increase performance in meeting statutory requirements in key areas.* *Prioritise risk management with consideration of where clients now sit in terms of risk stratification. (This is predicted to lead to higher demands for support and services across all HSCPs)* *Develop of detailed plans at service level identifying issues, risks and interdependencies.*
Group Work Group work suspended across all service areas.	*Identify opportunities and options to run groups digitally and launch where appropriate.* *Establish Platform for some chronic conditions for education /self-management classes and launch.*
Face to Face consultations/interactions In person face to face interactions have largely been suspended where possible across all primary/community based services. Exceptions would include Essential GP consultations including home visits, Immunisations, high risk children and families and adults.	*Continue to maximise interactions using telephone and 'near me' capability where appropriate.* *Design new pathways that will support a scale up of 'face to face' consultations.* *Agree prioritisation for social work interactions based on risk assessments and start to gradually re-introduce.* *Phase in consultations for highest risk patients with long term conditions.*
Initial Frailty Assessments Face to face consultations for identification of Frailty Score and development of care plan suspended. Infrastructure of voluntary: and statutory services ceased or significantly reduced.	*Progress work to build screening into contacts from social and health care practitioners engaging with older adults.*
Day Care Services All day care services have been suspended during the crisis.	*Assess the impact of those who require service.* *Review purpose and function.* *Not feasible to re-introduce in the short term due to risks to staff and clients.*
Respite Services Respite services suspended across all areas.	*Assess the impact of those who require service.* *Development of plan phase back in at scale given on-going restrictions, social distancing requirements all of which will reduced capacity.*
Palliative care in Care Homes Support provided by Acute Palliative Care Team and Medicine for the Elderly Consultants across GG&C.	*Continued delivery of Acute Workforce support, advice and training to Care Home teams.* *Continued delivery of workforce/staffing support through Agency and NHSGGC Bank services.* *Ongoing Screening of patients from hospital prior to discharge to care homes and screening in care homes to continue.* *Screening of care home staff.*

Service	Immediate Priorities – to July 2020
Community Assessment Centres 'CAC' Centres established for symptomatic patient referral where COVID-19 suspected and require medical assessment.	***Continuing requirement for foreseeable future*** *Finalise capacity planning and cost benefit analysis of various options based on updated projections.* *Agree and implement new model with reduced centres/capacity and opening hours in some areas.* *Agree workforce delivery model to support new configurations (staff are re-assigned).* *Review pilot of the Assessment App (on-going) and roll out.*
GPOOH Re-design of GPOOH services underway. Walk in's stopped. Will better control urgent demand ad.	*Agree new patient pathways to include GP triage.* *Introduce appointment system by 1st June.* *Demand and capacity assessment required to assess impact of new model.* *Introduce Attend Anywhere.* *Finalise workforce plan.* *Ongoing recruitment.*
Pharmacy Delivery Service Previously was in place but on a far smaller scale and run by community pharmacists.	*Pursue workforce options to support in medium term need/demand remains high.* *Develop Plan for phased return to previous model as social distancing /isolating reduces.* *Work with community pharmacy to consider longer term potential.*
E Prescribing and Electronic Transfer of Prescriptions	*Review model and develop learning.* *Develop plan to establish as continuing improvement opportunity.* *Review of community pharmacy capacity to support longer term.*
Volunteer Services Volunteers have been key in maintaining contact with clients who are perhaps isolating alone and/or vulnerable through phone call 'check-ins'.	*Pursue options for Third Sector to mobilise and co-ordinate a community-based response to volunteering.*
Practice Buddying/Support Arrangements GP practices working together to support staff absences to ensure business continuity.	*Review learning with clusters and CQLs.* *Identify longer term sustainability issues.*
Digital Technology Virtual consultations/ telephone consultations/ Microsoft teams Adopted system wide.	*Continue to build on successes and extend use to support re-introduction of some 'paused' services.* *Continued roll out and implementation of 'Attend anywhere' and 'Near Me' across GGC.* *Assessment of unmet need based on those digitally excluded.* *Identify alternative response to those who are digitally excluded.*

Key Points
• Our redesign of GP out of hours services, with extended use of Attend Anywhere and increased appointed care continues • Our first cohort of 50 dental practices providing urgent dental care is now being doubled • Optometry services are being supported by eHealth to implement Attend Anywhere and access the Emergency Care Summary • GPs will continue to use remote consultation to treat patients

9.2. General Practice

All 235 practices in NHSGGC have remained open throughout the pandemic period providing essential General Medical Services, under level 1 of escalation which reflects a number of Board wide or national changes including suspension of screening programmes. 9 practices have been at level 2 escalation, all of which are temporary closures of branch surgeries with services being retained at the practice's main site.

Chronic disease management continued in practices as part of core GMS provision, with a focus on patients clinically unstable CDM or urgent needs. NHSGGC has a well-established Local Enhanced Service specification for additional CDM activity supported by advice from the MCNs. Ongoing planning for CDM includes;

- CQL event on 11 June on lessons learned and next steps for CDM,
- Review of components of CDM reviews to identify what can best be done remotely
- Linking to MCNs and specialist services on priorities, risk stratification and whole system pathways
- Learning from House of Care approaches and wider innovation
- Community phlebotomy access and expansion as part of the Memorandum of understanding, continuing to review pathways for monitoring and management to ensure best use of the MDT and patient centred approaches
- Review of availability of wider community supports for a 'more than medicine' approach

Primary Care colleagues are committed to collaboration on patient pathways to ensure services are appropriate, effective and efficient and ensure that General Practice can respond flexibly to changing demand and patient needs. Key actions and priorities for June and July include:

- Continuation of Telephone triage and telephone/video assessment.

- Continued use of NHS Near Me, with expansion of capacity for this supported by roll out of further equipment to equip all consulting rooms (end May).

- Use of remote access to enable staff to work from home if required – established for all practices.

- Ensuring access to GMS services for those patients who may be digitally excluded or require face to face care.

- Buddying arrangements with other practices, supported by facility for remote IT access.

- Continued review of the range of flexibilities agreed as part of level 1 escalation, including reinstatement of screening programmes when directed by national agreement.

- Review of branch surgery temporary closures (all have review dates in June 2020).

- Rapid review of Primary Care Improvement Plan priority areas, supporting deployment of staff back to practices and making the most of new ways of working to enable the extended Multi-Disciplinary Team to work in the most effective way with practices. We will re-establish the Primary Care Programme Board at the end of May 2020 to oversee the approach to renewing our contract work and continue close collaboration with the GP Subcommittee and Local Medical Committee.

- Continued support to Care Homes including testing pathways and provision of GMS services to care homes, including through Local Enhanced Services arrangements.

- Identification and support to shielding patients including Anticipatory Care Planning and eKIS.

- Working with wider community services on ongoing support to patients recovering from COVID19.

- Managing the backlog of issues which have not presented or not been able to be addressed during the pandemic peak period: this will include mental health concerns and vulnerable children and families as well as chronic disease management and liaison with other services for onward referral.

- Joint working with acute colleagues on Urgent Suspicion of Cancer pathways and ACRT.

- Establishing effective ways of working with appropriate PPE and social distancing measures within practices, which will impact on face to face capacity.

- Continued support for practice with reduced capacity due to staff shielding, high risk groups or requirement to self-isolate.

The next steps as we move into recover phase are:

- Timetable for reintroduction of Multi-Disciplinary Team members as part of Primary Care Improvement Plans, where these were redeployed to support the Covid response.
- Review of branch surgery closures (June).
- Review and rebuilding of chronic disease management response in accordance with clinical priority and risk – further guidance being developed in June with clusters and engagement with GP subcommittee.
- Reviewing support and best practice for service provision with appropriate social distancing and PPE.
- Working with acute and wider community services on effective patient pathways.

The continued function of the COVID19 Community Pathway for patients with symptoms of COVID19 will support practices to continue to safely provide general medical services for patients as demand increases.

General practice works as a whole system with acute, mental health and community services. Alignment and communication of changes to other services as part of recovery will be critical to ensure that patients can follow the appropriate pathways.

9.3. Dental Services

PDS Urgent dental care centres
To increase our capacity to deliver care within the PDS urgent dental care centres, we previously completed induction and orientation for our first cohort of 50 high street dentists and many of these dentists are now working alongside PDS colleagues to assist in the delivery of emergency dental services.

We are now bringing on-board a second cohort of 50 high street dentists to provide this service, releasing capacity within our PDS dentists to focus on recovery planning for their own patients and services. This additional cohort of dentist will allow for expansion of the service to deliver occasional treatment, not only emergency dental care. Availability of these dentists of course will be dependent on the Recovery Roadmap set out by CDO.

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Aerosol generating procedures have been getting delivered within NHS GGC on a risk assessed basis and will continue moving forward, these are currently being delivered by HDS colleagues but planning is underway to move delivery of this out to the PDS UDCCs. This will allow our HDS colleagues to focus on recovery planning for their patients and services. Continued supplies of PPE, particularly FFP3 masks remains critical to continue to deliver these urgent treatments and increase delivery of occasional care.

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Following release of Recovery Roadmap from Chief Dental Officer, we will liaise with GDS colleagues to plan how to re-establish emergency and occasional treatment and services to their registered patients, within their own practices, ensuring adherence to social distancing. Dentists are receiving payment of 80% of NHS fees, and clarification from CDO in relation to longer term financial support arrangements will also be required to ensure engagement with dentists in delivering care within the UDCCs.

Service delivery, where clinically appropriate, should be via telephone and digital consultations; Boards have a responsibility in ensuring that practices have the appropriate hardware, software and connectivity infrastructure to maximise the use of digital technology.

In order to ensure a supported return to work, to include virtual consultations it would be useful for dental practices, public dental service and hospital dental service to be considered in relation to provision of hardware and software to maximise digital technology. This will be particularly significant to hospital dental services given infrastructure issues that make social distancing problematic.

Oral health is working towards a mobilisation date of 31st July 2020, when it is expected that all NHS dental practices will have safely reopened and seeing their own patients for urgent and emergency care that does not involve aerosol generating procedures.

9.4. Optometry

The recovery plan for community optometry sets out three phases in line with national guidance

Phase 1 (now) Continuation of the EETC model at the Acute Referral Centres combined with resumption of urgent specialist eye clinics. The successful management of emergencies within

the community without referral to ARCs will be further supported through the roll out of Attend Anywhere and access to Emergency Care Summary and Clinical Portal, which is currently being deployed across all optometry practices.
Scoping exercise taking place early June of all community optometry practices to assess readiness to provide face to face urgent and essential eye care, as soon as national guidance supports this.

Phase 2 Community optometry practices will resume face to face contact for urgent and essential eye problems. Support for this will be through provision of guidance and sharing of good practice, and through established arrangements with the Board Optometric Advisor and Lead Optometrists in each HSCP. Telephone and video triage and assessment, supported by access to NHS Near Me, will continue for all practices as a method of minimising the requirement for face to face assessment in any setting.

Phase 3 At this stage all community optometry practices would begin seeing patients face to face again and recommence routine eye care as national guidance allows. Models of telephone assessment and triage may continue in order to support reduced footfall and manage social distancing requirements.

Through the existing eye care interface arrangements, we are explore the potential for different pathways across a range of subspecialties and conditions including Paediatrics. The scoping of community optometry as part of the phase 1 and phase 2 arrangements set out above will include an assessment of readiness in terms of skills and equipment, for example. The priority would be to agree:

- Clinical conditions which could safely and appropriate be managed as shared care or within the community
- Skills and training requirements, in conjunction with NES
- Funding arrangements, in discussion with Scottish Government review of fees claimable through General Opthalmic Services. The agreement of GOS fees was key to unlocking the Cataract changes
- Tele-opthalmology options and IT enablers across the interface.

9.5. Pharmacy

NHS Pharmacy First Scotland will harness the skills and expertise inherent within each of our 291 community pharmacies, by providing access to treatments for common clinical conditions. The new national Pharmacy First service was due to commence on the 20th April however due to COVID pandemic this has been re-scheduled for the end of July in line with the national launch. In the interim GGC are working with the local community pharmacy contractors committee to develop local services under the Pharmacy First banner where patients could attend the community pharmacy for treatment of a range of conditions to build capacity in primary care.

Community pharmacy will return to normal core model hours by the end of July. Pharmacy teams will begin to restart work directly with GP practices, rather than remote working.

With the support of NHSGGC eHealth colleagues we are progressing the roll-out of ‘Attend Anywhere’ capabilities to our community pharmacy network, which supports the reduction in patient footfall to GP practices and OOH services and improves patient experience.

NHSGGC has started implementation of an enhanced programme for roll out of serial prescribing ensuring that primary care pharmacy staff work closely with GP practices, community pharmacies and patients. This has four main benefits:

- In terms of public health, a reduction in footfall at GP practices and community pharmacies and reduction in generation of paper prescriptions will reduce the potential for transmission of virus during the pandemic.
- A more manageable workload which should smooth peaks in activity for both GP practices and community pharmacies while providing a predictable one stop route for access to medicines for patients.
- Improved patient management by review at the start of the serial prescription and clarity over professional responsibility for supply of medicines within that period lying with the community pharmacy contractor.
- Decreased waste.

Key Points
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10. Enablers

10.1. Public Engagement

The Board's Director of Communications and Public Engagement is working with the Recovery Planning Tactical Group to deliver a programme of stakeholder engagement on new ways of working, including experience of Near Me Attend Anywhere digital technology and unscheduled care signposting/redirection and triage. This will enable views of stakeholders to be gathered to inform ongoing service development, improvement and ensure services meet the needs of stakeholders.
An experience based discovery approach will be utilised, allowing us to draw out what matters to stakeholders during their experience. A stakeholder evaluation report will be produced for each of the above areas.

10.2. Personal Protective Equipment (PPE)

Work continues both locally and nationally to ensure staff have the right Personal Protective Equipment (PPE) at the right time. The Procurement Team and the PPE Sub Group continue to work to ensure a steady supply of PPE which includes working with National Procurement, other Boards and IJBs and a small number of independent suppliers to ideally create that 5 day local buffer stock and ensure continued stability across the Organisation.

The Procurement Team, working closely with our Military Assistance colleagues, have developed a demand and usage model of PPE. This now underpins the management of PPE, informing sourcing, ordering and distribution.

Attention has now turned to working closely with clinical colleagues to understand the potential PPE requirement around restarting the elective programme, and resuming "business as usual" around unscheduled care, pending professional bodies and National guidance. This current work is examining; baseline and projected theatre activity based on a range of activity scenarios, attendance in theatres at the point of intubation, analysis of all elective, non-theatre (GA) procedures that involve Aerosol Generating Procedures and potential demand and staff numbers through unscheduled care.

10.3. Medicines availability

Supplies of a number of critical medicines have been in short supply during the COVID-19 pandemic. There is recognition at UK and SG level that use of some of these critical medicines will also increase as services recover. NHSGGC Pharmacy Services continue to monitor closely the stock levels of medicines on the critical 'watch list'. These medicines are commonly used in ICU areas but some are also used during surgery, endoscopy and colonoscopy. There are a number of interdependency and it is extremely challenging to project usage; reports have been produced to review previous usage of these medicines within these services. Additional supplies are being sought to meet demand across the UK. In addition a core group of Pharmacy Services staff meet regularly to review usage and agree communication to the wider multidisciplinary team. In addition work is underway with Chiefs of Medicine to consider protocols that discourage the practice of drawing up these medicines in advance of procedures to ensure that waste is minimised.

Oxygen was a key treatment for patients with COVI19 and work undertaken by Health Facilities Scotland ensured that the supply available to all sites was increased. The oxygen capability of wards was assessed and likely demand modelled based on the national modelling for likely COVID19 admissions and likely ICU admissions. This indicated that the available oxygen would have been able to meet the demand at peak. NSS are completing a national review of the demand experienced and the results of this are expected in the week of 25th May. This will allow the Board to review its assumptions and plan for any further waves. Consideration of electronic systems to support medicines supply issues including a pilot of prescribing info which provides visibility of stockholdings across NHS Boards.

10.4. Financial Considerations

The above plans and initiatives outline NHSGGC's direction through the remainder of 2020/21 and beyond. In terms of the financial position of NHSGGC, the initial 2020/21 Financial Plan highlighted the Board's £55m underlying deficit and the initial requirement for £112m of recurring savings in-year to achieve break-even. The Financial Improvement Programme (FIP or "the Programme"), which has delivered circa £70m of savings since its inception in February 2018, was the vehicle to try and deliver these savings. However, the Programme was paused at the outset of the Covid outbreak.

In terms of the current position, the Board's current projections for the cost of Covid for 2020/21 are £127m and the IJBs £121m, albeit these costs are reducing every week (£42m reduction mid-April to mid-May) as the expected late May/early June 2020 peak did not materialise. For the Board, a significant element of those costs relate to unachieved savings.

There continues to be review of 'off set' savings which will reduce the overall costs identified on the LMP finance return. Spend areas that have been impacted as a result of reductions in the elective programme is under review. However that will need to be considered alongside the remobilisation of the elective capacity.

The actual COVID spend for Quarter one will form the basis of cost projections on the LMP finance return for the remaining months ahead.

This document coincides with the relaunch of the FIP. In addition, the plans and initiatives within this document will underpin the transformational change and revised ways of working to move the Organisation towards medium to longer term financial sustainability. Whilst detailed financial projections remain under development, every project and initiative must deliver a saving or reduced cost and these will be presented in future drafts of this Plan.

Examples are noted below:-

- The use of ACRT, Attend Anywhere, telephone consultations, virtual clinics and PIR will allow resources to be used in a different way.

- The workforce requirement for traditional Outpatient clinics will require re modelling in light of remote clinic provision.

- Further benefits of the use of remote clinics being explored is the impact on productivity gains. Review of the clinic templates will be undertaken and additional slots added where appropriate.

- The use of PIR will impact on the number of return clinic slots which could be converted to new slots supporting waiting list pressures.

- Further investment in digital infrastructure across hospital sites and community to build on the progress made in remote consultations.

- Expanding the use of homecare pharmacy delivery services will save the time dispensing from hospital and reduce patients attending hospital. Services considering this are clinical Haematology and Specialist Oncology where currently drugs are being constituted in GGC pharmacy and couriered to patients.

- Consideration of changing work patterns from 5 days to 6/7 day working will have a financial impact on workforce resources. However this will need to be balanced against provision of increase capacity and supporting waiting list pressures.

- Consideration of capacity planning to meet social distancing and staff/patient safety across primary and secondary care will have a financial impact.

- Maintaining the COVID 19 community assessment centre approach for the foreseeable future will impact on resource requirements as staff are re-assigned.

Plans for change will be developed through the Boards Recovery Tactical Group which has joint membership from HSCP's and Acute Care. This group will develop service change plans which will consider the impact on changes across primary and secondary care as detailed in this paper. Where service provision is transferring between Acute and HSCP's the financial impact on budget provision will be agreed and budget re- directed where required.

11. Conclusion

The Global Pandemic of COVID 19 led to one of the greatest challenges in the history of the NHS. GGC put in place new services together with greatly increased capacity to treat and care for a very large number of patients with COVID 19 both in the community and the acute sector. As the peak of infection recedes, there is a need to move to the next phase of the mobilisation plan. This involves ensuring that there is retained and flexible capacity both within the community health and social care sector as well as hospitals to continue to treat patients with COVID as well as ensure any increase in cases is managed. Strict infection control procedures within all sectors is required and services need to ensure social distancing measures are employed to protect both patients/service users and staff. This will have an impact on the productivity of services as well as their mode of delivery.

There have been many very positive changes which have led to better patient care: digital delivery of healthcare at scale and changes to unscheduled care putting senior clinicians early on the pathway has led to quicker and more appropriate care. This plan sets out the way GGC intend to balance all of these factors in order to ensure patients/service users receive timely and safe care whilst maintaining capacity to deal with any surge in COVID patients.