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| **NHS Greater Glasgow & Clyde** | **Paper Number: 20/35** |
| **Meeting:** | **Board Meeting** |
| **Date of Meeting:** | **25 August 2020** |
| **Purpose of Paper:** | **For Noting** |
| **Classification:** | **Board Official** |
| **Sponsoring Director:** | **Mark White, Director of Finance** |

**Paper Title**

Board Performance Summary Report.

**Recommendation**

Board members are asked to:

I. Note the current performance position across NHSGGC in relation to a number of high level key performance indicators.

**Purpose of Paper**

The purpose of this paper is to ensure Board members remain sighted on the ongoing impact of COVID-19 and provide a brief, up to date, high level overview of current performance against key metrics during these unprecedented times. The suite of measures contained within the report reflects some of the key high level priorities across NHSGGC as the Board moves into Remobilisation Phase.

**Key Issues to be Considered**

In light of the COVID-19 Pandemic, this performance summary report has been drafted to reflect current performance using local management information as opposed to the routine monthly validated performance information. The data provided is indicative of current performance levels to give Board members a more up to date view of the performance position during the COVID-19 Pandemic. The data may be subject to change as part of the data validation process.

**Any Patient Safety/Patient Experience Issues**

Yes, all of the performance issues have an impact on patient experience.

**Any Financial Implications from this Paper**

The financial implications are detailed in the Financial Monitoring Report.

**Any Staffing Implications from this Paper**

Outwith the performance on sickness absence, none identified.

**Any Equality Implications from this Paper**

None identified.

**Any Health Inequalities Implications from this Paper**

None identified.

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

No risk assessments per se, although achieving key performance metrics and targets does feature on the Corporate Risk Register and drives the approach to strategic and operational work practices, improvement plans and the strategic direction of the organisation.

**Highlight the Corporate Plan priorities to which your paper relates**

The report is structured around each of the four key themes outlined in the 2019-20 Corporate Objectives.

**Author:** Mark White
**Tel No:** 0141 201 4609
**Date:** 25 August 2020

# NHS Greater Glasgow and Clyde

# NHS GREATER GLASGOW & CLYDE (NHSGGC) BOARD PERFORMANCE SUMMARY REPORT

## August 2020

## 1. INTRODUCTION

In light of the continuing COVID-19 situation, this summary Performance Report provides an overview of current performance against key metrics, including highlighting the significant impact of COVID-19. The suite of measures contained within the report reflects some of the key high level priorities across NHSGGC.

*Board Members should note that often the most recent management information is used to provide Board members with the current position. This data is indicative of current levels of performance (as data has still to be validated).*

Board members are asked to:

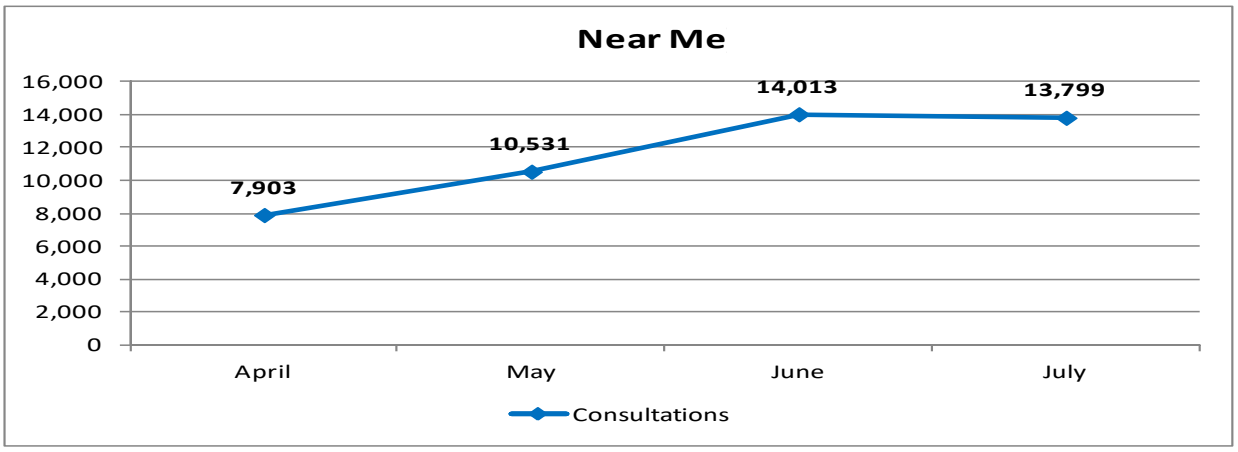
- Note the current performance position across NHSGGC in relation to a number of high level key performance indicators.

## 2. KEY ELECTIVE ACCESS MEASURES

As indicated in previous reports, in order to effectively and safely manage the COVID-19 outbreak across NHS Scotland all routine elective work was temporarily paused on a phased basis from the week beginning 16 March 2020 and planned care surgery was restricted to those requiring emergency and urgent treatment and those referred with a suspicion of cancer or already on the cancer treatment pathway. This change has had a material impact on a range of key performance measures.

Also highlighted previously, the impact of temporarily pausing routine elective work has had a significant impact on the number of people waiting for a planned intervention. Whilst the overall number of referrals has not increased significantly when compared with previous years, the length of wait for patients has, and continues to, increase. As the number of COVID-19 cases continues to reduce, the Board is implementing the Phase Two Remobilisation Plan in addition to implementing the key actions agreed in March 2020 as part of the wider elective recovery programme for scheduled care.

As will be demonstrated in this report, a number of the re-design initiatives and revised patient pathways have been established in response to the COVID-19 pandemic and these will continue as they have assisted NHSGGC in addressing a number of the issues. In addition, as outlined in this report, the use of digital technology continues to be extended further to maximise the potential of the new ways of interacting with patients. By way of example, the number of *Near Me* attendances has increased from approximately 8000 attendances in April 2020 to approximately 14,000 in recent months.




### 2.1 New Outpatients Waiting >12 Weeks

Since mid-March 2020, the total number of patients on the outpatient waiting list has increased from 74,900 in mid-March 2020 to around 82,500 in early August 2020. In addition, during that same period, the number of patients waiting over 12 weeks has increased considerably from around 20,500 in mid-March 2020 to almost 54,800 in early August 2020.

This increase continues to be mirrored across NHS Scotland. The use of digital technology and *Near Me* continues to be utilised and extended for planned care with a move to remote blood testing, ensuring if face to face consultation is required, areas are equipped with social distancing and new clinical pathways are developed.

Detailed work is underway within all specialties as a key element of the Remobilisation Plan to establish a revised capacity plan, taking account of the need to re-profile all clinics in line with the new guidance.

## 2.2 Number of Eligible Treatment Time Guarantee (TTG) Patients Waiting >12 Weeks for an Inpatient/Daycase Procedure

In terms of inpatients/daycases, a similar position exists, with the overall inpatient/daycase list increasing from 21,500 in mid-March 2020 to around 24,500 patients in early August 2020. However, again, the number of eligible TTG patients waiting over 12 weeks has risen to just over 20,000 patients during that period, more than double the number of eligible patients (around 8,850) waiting over 12 weeks in mid-March 2020. Similar capacity planning work is underway with regard to inpatients and daycases taking account of the current PPE, social distancing guidance and air change requirements.

## 2.3 Number of Patients Waiting >6 Weeks for a Key Diagnostic Test

Routine endoscopy procedures also ceased in line with National guidance regarding Aerosol Generating Procedures since mid-March which has led to an increase in those patients waiting over six weeks for endoscopy to around 5,900 patients, from 750 in mid-March 2020. Bowel screening is expected to recommence during August 2020.

In addition, routine radiology examinations have also been suspended which has led to the number of patients waiting over six weeks to increase to 10,285 as at July 2020 (month end). Again work is underway to establish the revised endoscopy capacity.

## 2.4 Clinical Prioritisation

As part of the Recovery Planning process a co-ordinated approach to the re-start of routine elective services is currently being implemented with all services adopting the same approach and applying the same principles in line with Scientific and Technical Advice Committee advised approach.

In line with Scottish Government advice, clinical teams across NHSGGC have been regularly reviewing the priority of patients on their waiting list throughout the COVID-19 pandemic and the recording of this has been locally supported to date.

In April 2020, in response to the COVID-19 pandemic the Royal College of Surgeons produced a *'Clinical Guide To Surgical Prioritisation During the Coronavirus Pandemic'*. This sets out 4 categories of patient prioritisation split across individual specialties:

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| Priority 1a Emergency | Needs operation within 24 hours |
| Priority 1b Urgent | Needs operation within 72 hours |
| Priority 2 Requires Surgery | Can be undertaken within 4 weeks |
| Priority 3 Requires Surgery | Can be undertaken within 3 months |
| Priority 4 Requires Surgery | Can be undertaken in more 3 month |

On Trakcare, the inpatient/daycase waiting list enables entry of clinical priority as urgent, urgent suspicion of cancer and routine. The e-Health Team have been progressing mapping the Royal College codes to the national codes which will provide a means of reporting of the new categories. The technical arrangements can now be made live and agreement for a standardised approach across specialties is being progressed. These guidelines will help inform future capacity planning alongside a new shared approach to urgent waiting lists ensuring that NHSGGC's entire capacity will be used to best effect.

Highlighted below are some of the key actions agreed as part of the Level 4 escalation alongside some of the actions included in the planned care section of the second phase of NHSGGC Remobilisation Plan submitted to the Scottish Government on 31 July 2020. Some of the actions are predicated on significant investment.

In addition to continuing to prioritise cancer and urgent care, key priorities in the recovery of routine elective inpatients/daycases, new outpatients and endoscopy, whilst not exhaustive, includes:

- All services are working towards adopting Active Clinical Referral Triage (ACRT) principles for all new referrals. This will ensure patients access the optimum pathway for their condition, make best use of the entire Multidisciplinary Teams and where appropriate reduce the need for outpatient appointments. The aim is to review all patient pathways and bring them in line with ACRT principles.

- As part of the response to COVID-19 all outpatient services have extended their use of telephone and video appointments as an alternative to 'in person' appointments. Over 500 additional monitors to facilitate the use of video technology were approved are currently being deployed across all outpatient departments. This extension is important as traditional outpatient capacity will be significantly reduced for the foreseeable future. Alternative appointments are also being supported by Acute Phlebotomy Hubs which opened on 10 June and are now being extended to a number of specialities. The purpose is to ensure that blood tests can be undertaken prior to appointments and that results will be ready for the consultation by whatever medium. The Hubs have been receiving over 700 patient requests on a weekly basis and the final phase of extending Hubs to all acute specialties started on 28 July 2020.

- In terms of inpatients and day cases further progress is being made, acknowledging the requirements for patients to self-isolate for 14 days prior to a planned inpatient admission and a pre-admission COVID-19 test to be undertaken 48 hours prior to any planned admission. The focus remains on cancer and urgent patients with robotic surgery for urological cancer also now recommenced.

- Discussions continue with the Golden Jubilee National Hospital and the Nuffield Hospital to secure additional capacity and maximise the opportunities this additional capacity will bring.

- All specialties are in the process of agreeing clinical priorities to inform future re-vetting of inpatient/daycase waiting lists.

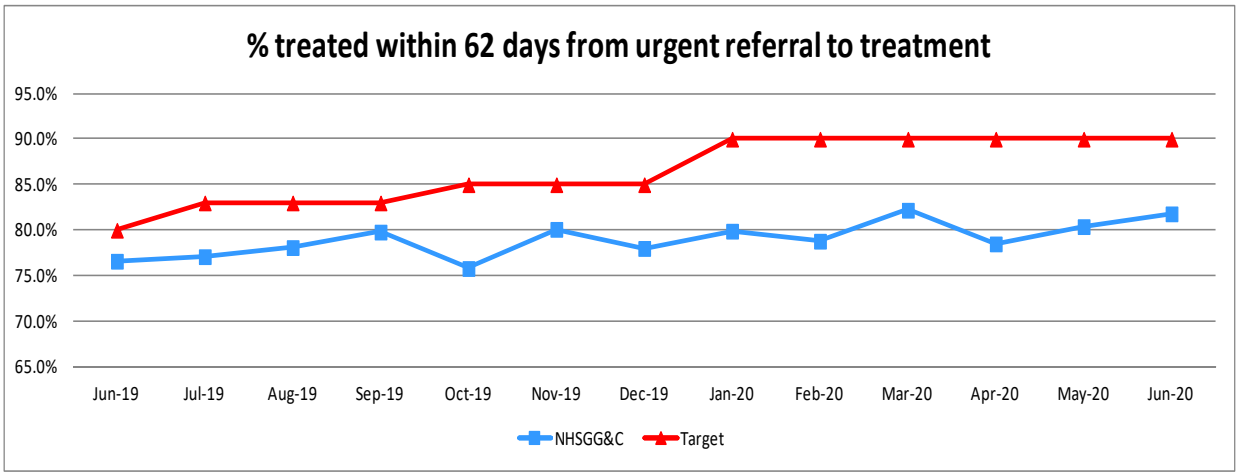
- In terms of endoscopy NHSGGC is currently working with the Scottish Government to potentially begin piloting the use of two alternative types of investigations namely capsule endoscopy and cytosponge.

- A range of other actions are currently being considered as part of the recovery programme including enhancing staffing arrangements and equipment provision, securing additional sessions, new operative approaches, further strengthening cross specialty working, and utilising specialty capacity plans to better match demand and capacity.

Detailed capacity plans are being developed at this time, recognising that they may take several months to be concluded and then agreed with the Scottish Government.

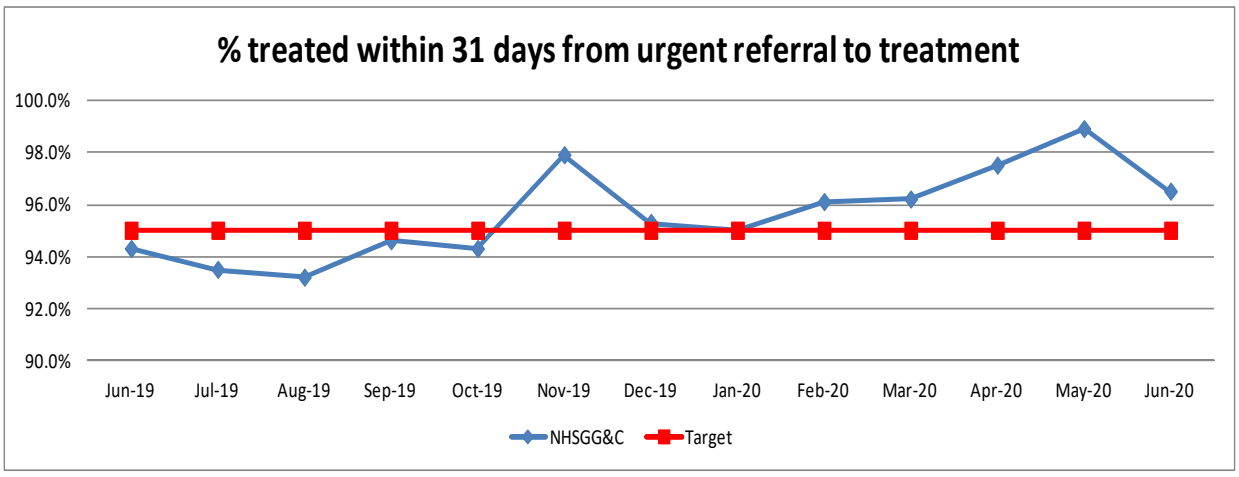
**2.5 Cancer 62 Days – Waiting Time from receipt of an urgent referral with a suspicion of cancer to first cancer treatment**

As at June 2020, 81.8% of patients referred urgently with a suspicion of cancer began treatment within 62 days of receipt of a referral, a further improvement on the position reported the previous two months (78.5% in April and 80.4% in May 2020). A total of six of the 10 cancer types either met or exceeded the original 90% trajectory for the quarter ending June 2020. The four cancer types currently below trajectory are Colorectal (65.5%), Head and Neck (76.5%), Lymphoma (75.0%) and Urology (56.9%).




## 2.6 Cancer 31 Days – Waiting Time from diagnosis with cancer to treatment

As at June 2020, 96.5% of all cancer patients diagnosed with cancer, were treated within 31 days from decision to treat to first treatment, exceeding the 95.0% target. A total of eight of the 10 cancer types exceeded the 95% target for the quarter ending June 2020 with seven reporting 100% compliance. The two cancer types currently below target are Colorectal (90.7%) and Urology (89.0%).




## 2.7 Recovery Planning For Cancer Treatment

The management of cancer patients and vital cancer services remain a clinical priority during the COVID-19 outbreak, although changes to the clinical pathways of patients have been required to ensure all clinical risks are considered. NHSGGC is implementing the national guidance on the management of individual patients who require cancer treatments agreed by the national COVID-19 Treatment Response Group.

The main priority for NHSGGC up to July 2020 was to ensure that those cancer services that were suspended as a result of COVID-19 have, where appropriate, been re-started. To that end, Cancer Multi-Disciplinary Teams hosted within NHSGGC have worked to prioritise service resumption in line with guiding principles and agreed the services that were to be prioritised for re-start pre-July 2020 and those that can wait in the first instance. A full review of all cancer patients awaiting surgery has been completed and patients continue to be 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 within 72 hours
- Priority Level 2 – surgery than can be deferred for up to four weeks
- Priority Level 3 – surgery than can be delayed for up to three months

In July 2020, there were no outstanding Level 1A/1B patients waiting for surgery undated across NHSGGC (this also applies to patients from other Health Boards awaiting surgery within NHSGGC). The treatment for Priority Level 2 patients started during June 2020. At mid-August 2020, of the 99 patients in Priority Level 2, only 31 are still waiting for a dated appointment and of the 69 patients in Priority Level 3, 44 patients are waiting for a dated appointment.

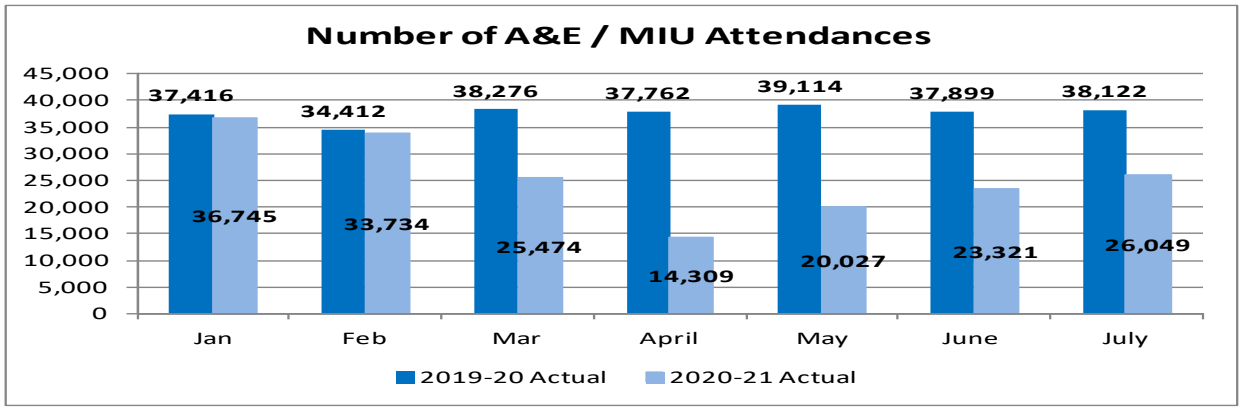
## 2.8 Summary

In summary, considerable changes require to be made to all aspects of the delivery of scheduled care, both urgent and more routine. These changes will have a significant impact on our capacity to deliver routine elective care and detailed revised plans are currently in development. It is anticipated that these plans will be completed during September, assuming agreement with the Scottish Government and confirmation of resources.

## 3 OTHER KEY MEASURES

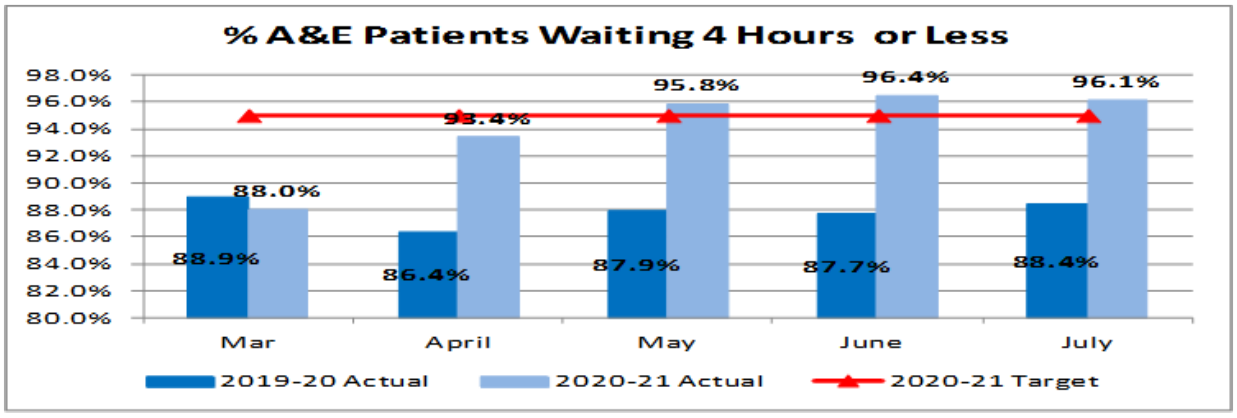
### 3.1 Accident and Emergency 4 Hour Waits and Presentations

In line with national trends, there has been a significant reduction (32%) in the number of patients attending the Emergency Departments and Minor Injuries Units when compared to the same period in 2019/20 (reducing from 38,122 reported in July 2019 to 26,049 reported in July 2020) since national lockdown measures were put in place.




As highlighted in the chart above, A&E/MIU attendances across NHSGGC are beginning to show a month on month increase when compared to the April 2020 position mainly due to the incremental changes in lockdown rules. The July 2020 position represents a 12% increase on the number of attendances reported in June 2020 (82% increase on the April 2020 position).

NHSGGC continues to exceed the monthly target with 96.1% of patients presenting at ED waiting less than four hours either to be admitted, discharged or transferred for treatment in July 2020.




Performance improvements have been sustained and the 95% national waiting times standard target has been exceeded for the third consecutive month despite the complexity of the patient pathway currently in place. Compliance with the target has been assisted by the reduction in number of patients attending, lower levels of bed occupancy across sites and the redesign of emergency access such as the introduction of Specialist Assessment and Treatment areas (SATA). This new SATA model has seen many patients diverted away from EDs to the SATAs on the basis of their presenting condition fitting with COVID-19 symptoms.

Work is underway to further develop the interim emergency care service model developed in response to COVID-19. Precise actions include:

- Supporting GPs by offering a consistent range of electronic advice options as an alternative to admission to Assessment Units.
- Maintaining COVID-19 Pathways in hospitals and communities to protect both patients and staff.

- Delivering COVID-19 and Flu 'point of care' testing through Community Assessment Centres (CACs) and SATA's.
- Continuing the service improvements to the GP Out Of Hours service.
- Ongoing support for successful service changes implemented during COVID-19 e.g. signposting at EDs, SATAs and CACs.
- Providing alternative pathways using 'clinical conversations', Interim Admin Hub booking system and 'Near Me' consultations.
- Optimising digital health where possible and signposting to available local services, such as Pharmacy, Optometry, Dentists, Sandyford, GP's, Minor Injury Unit and ED if required.

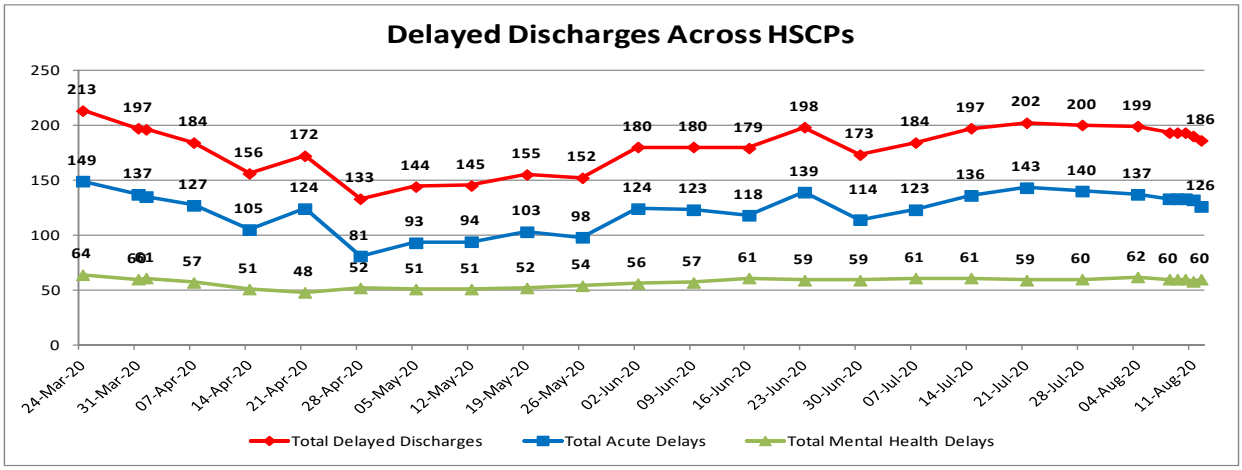
All of the above redesign elements are expected to be in place by the end of October 2020 and underpinned by an NHSGGC public messaging campaign to support pathway redesign that is fully aligned to the National model for urgent care.

During the next few months the Board will remain focused on progressing incremental service changes in a measured and programmed way ensuring that we reflect our capacity to deliver outcomes safely and successfully. Continuing this approach and the ongoing development of these changes will form an integral part of the next phase of our unscheduled care Remobilisation Plans.

### 3.2 Delayed Discharges

Health and Social Care Partnerships (HSCPs) have worked hard to reduce the numbers of patients delayed in their discharge since the beginning of the COVID-19 pandemic. This concerted joint effort resulted in an overall reduction in the number of patients delayed in both Acute and Mental Health.

However, as highlighted in the chart below, since June 2020 there has been a gradual increase in the number of patients delayed across HSCPs, albeit not to the same levels as before the outbreak of the pandemic. The 186 patients delayed in their discharge across HSCPs is a marked reduction (13%) on the 213 delayed patients reported late-March 2020.




HSCPs continue to work on a daily basis to reduce the number of patients delayed across acute hospitals and in mental health and to address the issues relating to the recent increase in the number of delays.
Actions in place across HSCPs include working closely with patients and their families, collaborative working with acute and care home colleagues and the ongoing daily review of performance.

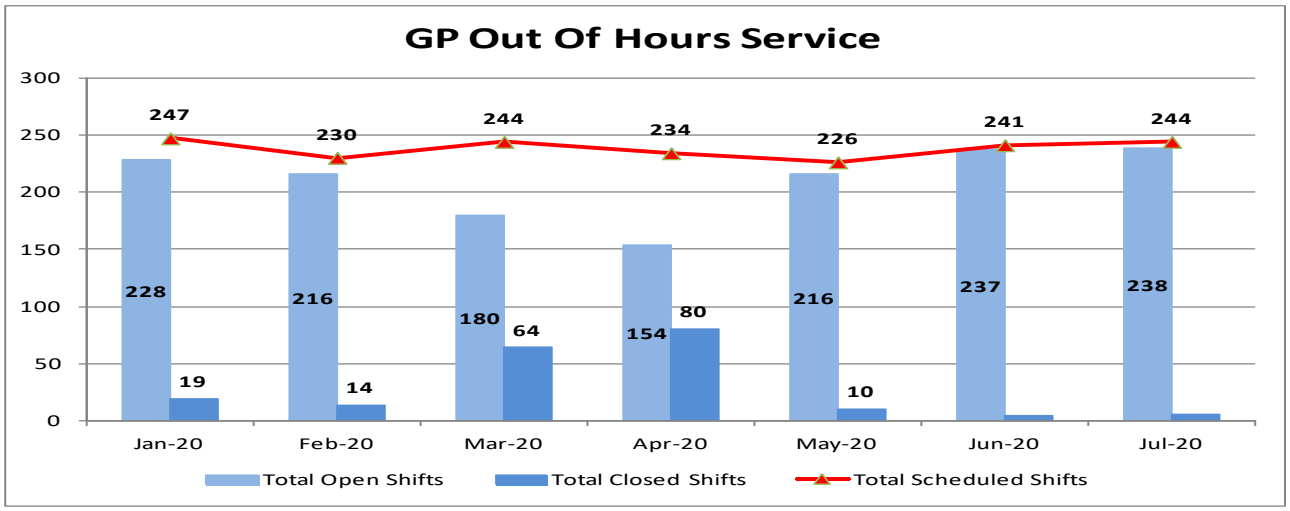
In addition, all HSCPs are working to protect social work input into hospitals, enhance it where possible and to ensure there are no delays to decision making on discharge. HSCP Commissioning Teams and Community Services are supporting care homes to ensure they are

prepared for the care of patients discharged from hospital. Commissioning Teams are also intervening directly to support the discharge of patients with more complex needs to identified placements.

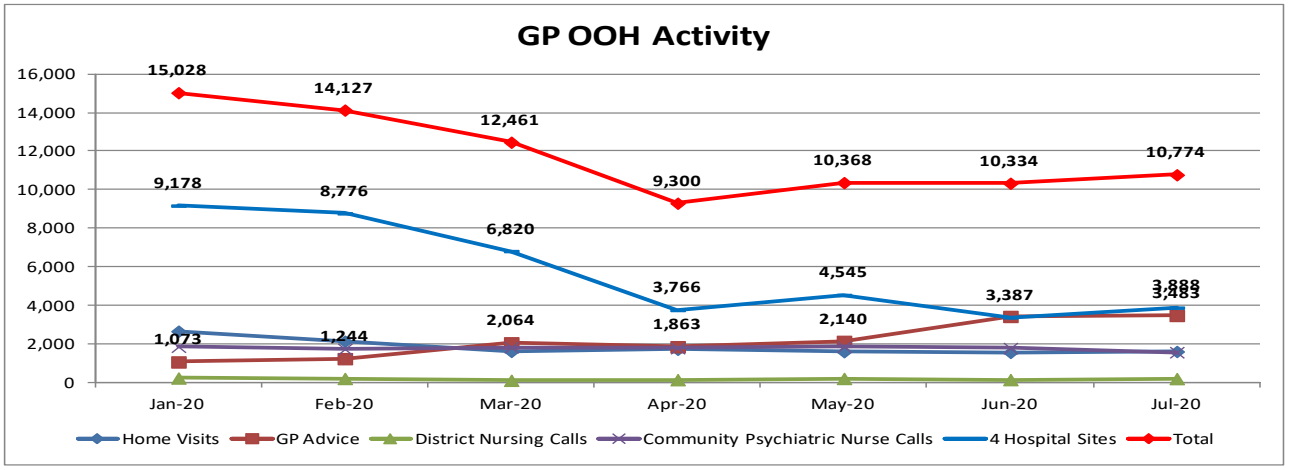
### 3.3 GP Out of Hours (GP OOH)

The implementation of the business continuity model delivering GP OOHs Services from three core sites and the Vale of Leven (VOL) Hospital (which delivers a GP OOHs Service between 11.00pm and 8.00am) has been in place since March 2020. During this period, CACs were also established in response to COVID-19 and, until recently, has had an impact on our ability to staff GP OOHs as a number of GPs opted to work on day shifts at CACs.

The chart below highlights the number of scheduled GP OOHs shifts that have been open and closed since the implementation of the business continuity model. The latest full month's position (July 2020) shows a sustained improvement in the number of GP OOHs shifts that have remained open - 98% compared with the previously reported position. (66% in April 2020; 97% in May and 98% in June 2020).




The table below highlights GP OOH activity levels in July 2020 and shows that activity levels remained fairly static on the previous months' position.




### 3.4 Recovery Planning for GP OOH Service and Building on the Achievements Made to Date

The COVID-19 response has influenced the need to reconsider all ways of working to protect both patients and staff and prioritise infection control. It is no longer appropriate to have waiting areas full of patients and their families due to the risk of spreading the virus. A number of key actions have been put in place that have contributed to the positive progress made including:

- *Walk-Ins* – This practice was stopped at the beginning of the COVID-19 response in order to protect staff and other patients. This is a permanent position for the service. Patients attending are asked to contact NHS24 for triage.

- *Appointment System* – An appointment system in all Primary Care sites went live on 1 June 2020. This has allowed us to successfully maintain patient safety and improved patient care with planned access into the service and effective management of the e GP and Advance Nurse Practitioner workload. The launch of the appointment system was supported by a communications plan for the public to ensure clarity of message to call NHS24 first. The appointment system has been widely welcomed by clinicians in the service and informally there has been positive feedback from patients. During August 2020 there are plans to undertake a thorough and systematic patient engagement survey to further learn and improve on the service provided.

- *Near Me* – linked to the virtual management plans, the OOHs service went live with 'Near Me' on the 15 June and it is now utilised in all sites. Usage has started at a low level but we have plans to maximise the uptake, making it the norm so that, alongside telephone consultations, we expect to see a significant decrease in the numbers of patients who have to come into a site.

- *GP Engagement* – Prior to COVID-19, engagement events had taken place with the GPs who work in the service to assess why fewer GPs were signing up to work for the service. We have listened, made changes and made clear our intent to continue to engage. Webinar sessions with GPs across the service to get feedback on the new models and update on developments have been held. There has also been ongoing engagement with the Local Medical Committee/GP Subcommittee, Clinical Directors and Chief Officers from each of the six HSCPs so the OOHs service is considered as part of the whole system. Informal feedback indicates that OOHs GPs are happier with the new approach and commitments from the service leadership.

As we have moved out of the COVID-19 period, GPs have returned to the OOH services. Improvements in the environment on the sites, the equalisation of pay and the appointment system are actions that have brought some stability to the service but there continue to be challenges.

During the next three to six months we will continue the implementation of agreed actions to further stabilise the service and assess the impact on demand, patient opinion, recruitment and outcomes. We will analyse the data on centre visits and assess the impact of the appointment system and virtual consultations on the patient pathways. This information will help us, in partnership with all our stakeholders, consider the best options to move on from the Business Continuity Arrangements and establish a long term sustainable service.

We have made significant improvements within the service and the advantages of working within the new Urgent Care model from June will provide our colleagues support across the service, a framework to manage workload with the appointment system and technology to deliver an improved and more responsive service for patients.

## 4 MENTAL HEALTH SERVICES

Throughout the COVID-19 pandemic urgent care has continued based on clinical need. Mental Health Assessment Units opened as a response to the service pressures on existing resources within EDs and provide urgent care 24/7. This specialist service provides assessment, diagnosis and management of patients who are presenting in mental health crisis/distress and would have sought assistance through self presenting at ED or accessed assistance via Police Scotland or the Scottish Ambulance Service.

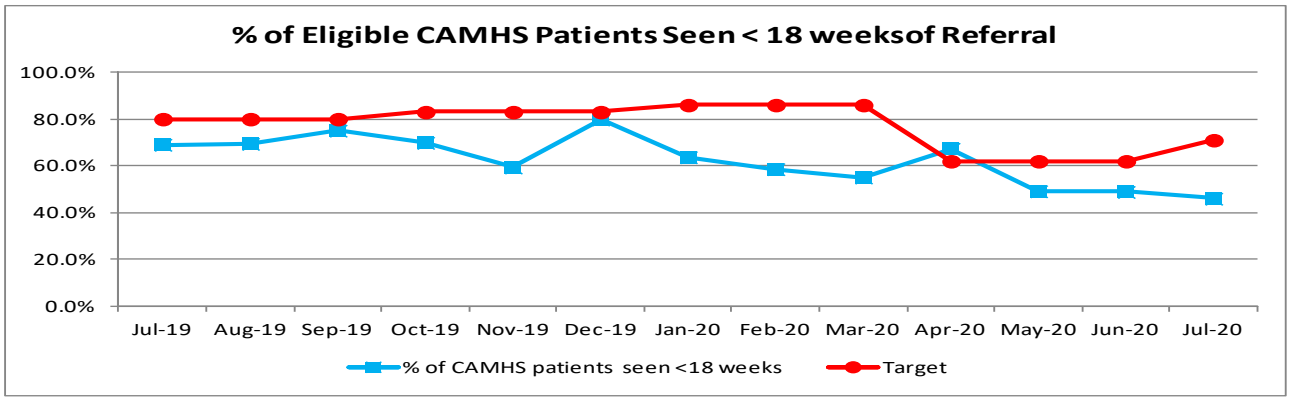
The Units have been a highly effective model of service delivery and remain in operation. An evaluation of the Units will be carried out whilst at the same time patients will continue to be seen and the findings will be considered as part of the recovery planning phase moving forward.

### 4.1 Percentage of Patients Starting First Treatment Within <18 Weeks of Referral for Psychological Therapy

As at June 2020, 78.9% of eligible patients referred for a Psychological Therapy were seen in less than 18 weeks against the 90% standard. Current performance is below the 90% standard. The outbreak of COVID-19 has had an impact in the delivery of psychological therapies in that we have been unable to see as many people to start a Psychological Therapy. The configuration of resources to meet the specific demands of the outbreak resulted in the non-urgent delivery of psychological therapies being less prioritised and the length of time patients waiting increasing. Actions are underway (see below recovery actions) to reduce the length of time patients are waiting and it is anticipated that over the coming months a reduction in the length of wait will be reflected in overall performance along with a return to pre-Covid levels.

### 4.2 Percentage of Eligible Patients Starting Treatment <18 Weeks in Child and Adolescent Mental Health Services (CAMHS)

As at July 2020, 46.0% of eligible CAMHS patients who started treatment in CAMHS had waited less than 18 weeks following referral.




The impact of COVID-19 is a key contributing factors to current performance, as demand for CAMHS continues to outstrip capacity. In addition, the change to national policy in 2019 related to rejected referrals resulting in more children and young people accessing the service which has had a further negative impact on the demand and capacity balance and the waiting list growing.

### 4.3 Mental Health Services Recovery Phase and Improvement Activity

The Recovery Phase will focus on Adult, Child and Adolescent Mental Health Services and Older People, together with the needs of more vulnerable groups. In response to the future provision being delivered in a different way to take account of COVID-19, the recovery phase intends to restore and re-establish services for those who need it, and also manage the transition to new service models.

In terms of psychological therapies key actions to improve performance includes:

- Levelling up capacity by recruiting to current vacancies and newly identified gaps, as well as embracing e-health technologies to maximise virtual face-to-face engagement.
- Increasing flexibility and sharing of resources across geographic boundaries and between care groups.
- Increasing access by establishing a bespoke Board-wide team to co-facilitate group-based interventions with local services and recruiting a cohort of therapists deployed peripatetically to services identified with the longest and highest number of waits.
- The ongoing inplementation of the Psychological Therapies activity management process. HSCP, Locality and Care Groups receive monthly performance data relating to their area. The information is co-ordinated including numbers starting and numbers still waiting, and the local actions identified to address issues specific to the HSCP/Team and service.
- Board-wide waiting list initiatives for Psychological Therapies are also being established, mainly centering aroung Primary Care Mental Health Team activity, through telephone and video conferencing only. Community Mental Health Teams will use assertive Active Clinical Referral Triage and Patient Initiated Review to increase capacity.

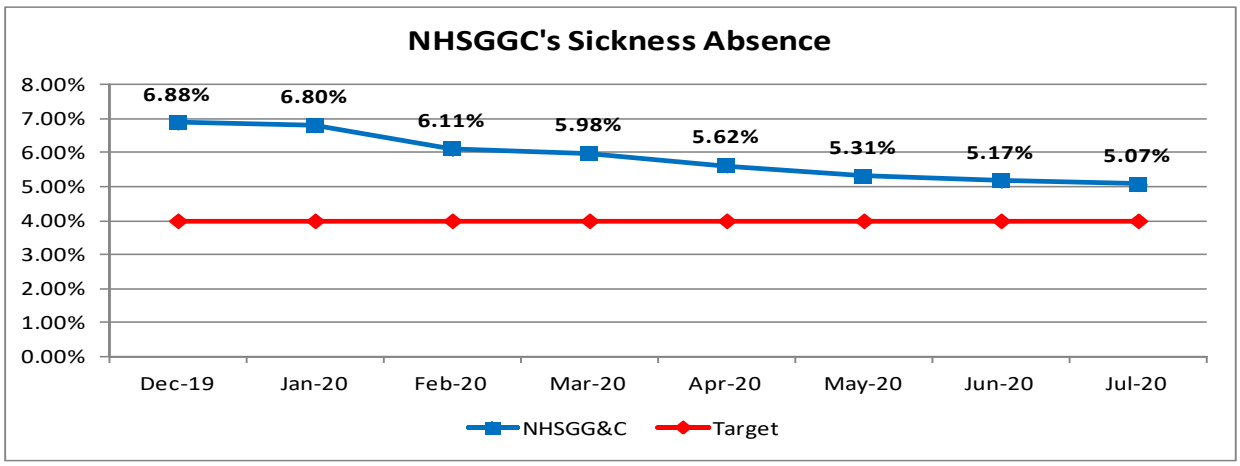
In terms of CAMHS, a Waiting List Initiative has been designed to improve compliance with target with a specific focus on seeing the longest waiting patients first. This initiative is currently being implemented and supported by improvement projections for each HSCP/Team alongside the details of the additional resources to deliver the projected improvement. This process will form a core improvement plan for each HSCP/Team. Individual plans are being further developed, based on analysis of local waiting lists to identify what specific treatment requirements the children on the lists need, based on existing available resource and to include local alternative resources through the wider multiagency system to achieve the required performance levels.

CAMHS will continue to embed the use of Near Me Video Call Appointments as part of the Recovery Plan. Recent national benchmarking results shows GGC CAMHS usage of remote consultations as ahead of the national average.

## 5 HUMAN RESOURCES

### 5.1 Sickness Absence

The current monthly level of sickness absence reported across NHSGGC is the lowest that has been reported during the past two years (in April 2018 overall sickness absence was 2.08%). As at July 2020, overall sickness absence across NHSGGC was 5.07%, a further improvement on the previously reported position. The current position comprises 1.82% short term and 3.25% long term absence.




As seen from the chart above, there has been a month on month sustained improvement in levels of sickness absence since December 2019. This improvement can also be seen in COVID-19 related absences in that 82% of staff absent as a result of COVID-19 have now returned to work and are being supported by the managers through ongoing engagement and application of our

Enhanced Return To Work process and national Occupational Risk Assessment Toolkit. For those requiring more extensive support, this is being made available through Occupational Health. There has also been a slight reduction in long term absence as wider support becomes available again.

## 6 CONCLUSION

The COVID-19 pandemic continues to have a major impact on NHSGGC's performance as outlined in this report. Our draft second-phase Remobilisation Plan, developed in partnership with key stakeholders in line with Scottish Government requirements, was submitted to the Scottish Government at the end of July 2020. Once agreed, this plan will be used as the framework for our prioritised recovery programme going forward recognising the needs of COVID-19 and non COVID-19 patients/service users alongside retaining flexible capacity to address potential future surges.

As outlined, in relation to scheduled care, it is anticipated that further clarity will be available in the next few weeks which will enable more detailed future plans and trajectories to be confirmed.