NHSGGC COVER PAPER

NHS Greater Glasgow and Clyde	**Paper No. 21/32**
Meeting:	**NHSGGC Board Meeting**
Meeting Date:	**29 June 2021**
Title:	**Remobilisation Plan (RMP3)**
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1. Purpose

The purpose of the attached paper is to: To present the Remobilisation Plan for NHS GGC covering the period from April 2021 to March 2022.

2. Executive Summary

The paper can be summarised as follows:

The Remobilisation Plan (RMP3) is a cross system plan which describes how we will remobilise and redesign clinical services whilst recovering from the impacts of the pandemic. RMP3 builds on previous Remobilisation Plans and acts as our operational plan for the year ahead. It covers the key Scottish Government priorities outlined in the commissioning letter of December 2020:

- Supporting staff wellbeing and developing sustainable workforce planning
- Living with COVID 19
- Delivering essential services
- Addressing inequalities and embedding innovation
- Demonstrating value for money and affordability

RMP3 recognises that Moving Forward Together (MFT) remains our key strategic document describing the medium term vision for clinical services in NHS Greater Glasgow and Clyde. The plan focusses on the next 12 months. A robust project management approach has been developed to support the implementation of RMP3. All the commitments and actions for the plan have been noted on an action tracker with the executive leads, timescales and governance processes. The due dates drive monthly progress reports which can be scrutinised at the appropriate level to ensure that implementation of RMP3 is on track. All actions are aligned to the Board's Corporate Objectives.

The plan has received positive feedback from the Scottish Government.

The detail of the plan identifies specific actions to be progressed during 2021/22:

Workforce: We will continue our commitment to staff mental health and wellbeing and deliver the action plan. We will focus on anticipatory workforce planning to respond to the changing demands of services e.g. testing and vaccination. We will continue to support remote working and maintain social distancing requirements to ensure staff and patient safety. Our workforce plan which was developed alongside RMP3 shows how we will align our workforce with remobilisation activity.

Public Health: We recognise the existing health inequalities exacerbated by the pandemic and will seek to address them with specific actions. We will continue to deliver the local testing and contact tracing processes working with the national contact tracing centre, to deliver the vaccination programme. We will continue to support the wider health improvement agenda with a focus on child poverty, mental health, weight management, smoking cessation and drugs and alcohol. We will develop a more resilient workforce in collaboration with Public Health Scotland.

Social Care: Key priorities to progress with HSCPs include support for care homes and the care at home service. We recognise the need to reduce delayed discharges and to maximise independence for our population, supporting older people to live safely in their own community. We recognise the additional demand for services such as child and adult protection, homelessness and addictions - some of this demand arising as a result of the pandemic and the need to deliver services in different ways.

Planned Care: We aim to step up on our elective programme when COVID-19 levels allow. We will continue to increase our use of virtual patient management (Near Me) and day case procedures, and we will enhance pre op assessment and pre admission management of patients. We will focus on radiology and endoscopy to reduce waiting times, and will work with other providers to deliver additional activity following clinical prioritisation. Detailed activity schedules will accompany RMP3, but activity levels will be substantially less than before due to the impact of COVID-19.

Unscheduled Care: Following the successful implementation of phase 1 of the Redesign of Urgent Care, and the opening of the Flow Navigation Hub, we will be implementing phase 2 during 2021/22. This will include the development of a number of additional care pathways, inclusion of paediatrics in the Flow Navigation Hub and increased utilisation of Consultant Connect. During this year, we will also launch Urgent Care Resource Hubs in Health and Social Care Partnerships (HSCPs), linking them with the wider redesign. We will further develop effective interfaces to support older people to stay in their own community.

Mental Health: We will continue to implement our Mental Health Strategy, including services for older adults, recognising the additional impact the pandemic has had on the mental health of the population. A focus on digital will increase virtual patient management and support new psychological services. Mental Health services will support the wider unscheduled care agenda, building on the Mental Health Assessment Units model and developing Consultant Connect. We will work with partners to reduce social isolation and loneliness. We will focus on the delivery of waiting list challenges for Child and Adolescent Mental Health Services and for Psychological Therapies.

Primary and Community Care: We will continue to develop services focused on supporting people to access the right services at the right time and in the right place, with early intervention and anticipatory care to prevent escalation, in community services and across the four contractor groups. Implementation of Primary Care Improvement Plans is a priority, focused on continued development of extended multi-disciplinary teams and enabling the expert medical generalist role to meet the revised contract implementation timescales. We will focus on maintaining access and flexibility to provide core services, with a particular focus on chronic disease management, interface working and pathway redesign.

Addressing Inequalities: We will continue to practise inequalities sensitive communication for testing, vaccination and service recovery, and implement Fairer NHSGGC 2020-24. We are developing targeted work with Black, Asian and Minority Ethnic (BAME) communities and have established a Workforce Equality Group to oversee addressing inequalities in the workplace. We continue to carry out Equality Impact Assessments on service changes to mitigate any potential inequalities.

Digital and eHealth: Our Digital Team has driven forward significant improvements in virtual outpatient consultations using telephone and Near Me technology in all sectors of the health and care system. We will continue to increase the use of Active Clinical Referral Triage (ACRT) to improve patient care, reduce waiting times and optimise face to face consultations. Work will continue to support the redesign of urgent care, screening and testing policies and the vaccination programme.

Patient Experience: Ongoing engagement with stakeholders is fundamental to remobilisation, and a key part of our drive to reduce inequalities. During 2021/22, we will continue to support Patient Centred Visiting and the implementation of Care Opinion. Public engagement will remain a key focus in service change and improvement,

Finance and Capital: Our plan will be underpinned and intrinsically linked to the Board's Financial Plan which will demonstrate how we will manage within the financial resources available to us. We will evidence the progress we have made in addressing the factors which lead to escalation. Capital planning will continue to be linked to service planning, and will inform the work being progressed to develop a Board-wide Infrastructure Strategy.

3. Recommendations

NHSGGC Board is asked to note the Remobilisation Plan 3 (RMP3).

4. Response Required

This paper is presented for **approval.**

5. Impact Assessment

Actions in the plan have been aligned to corporate aims below:

- **Better Health** **Positive impact**
- **Better Care** **Positive impact**
- **Better Value** **Positive impact**
- **Better Workplace** **Positive impact**
- **Equality & Diversity** **Positive impact**
- **Environment** **Positive impact**

6. Engagement & Communications

Staff partnership have been involved in development of the plan through HSCP and Acute Tactical Groups.

7. Governance Route

- Area Clinical Forum - 11 February 21
- HSCP Tactical - 16 February 21
- Acute Tactical - 17 February21
- SEG - 24 February 21
- Medical and Dental Forum meeting - 18 February 21
- Area Partnership Forum - 18 February 21
- Board Meeting - 23 February 21
- Stakeholder Reference Group - 25 February 21
- Primary Care Programme Board - 4 March 21
- Financial Planning and Performance – 15 June 21

8. Date Prepared & Issued

The paper was prepared and submitted to Scottish Government on 26 February 2021.

Date issued to NHSGGC Board members: 23 June 2021.

NHS
Greater Glasgow and Clyde

NHSGGC Remobilisation Plan (RMP3)

April 2021 to March 2022

Contents

1. Executive Summary

Current position

In NHS Greater Glasgow and Clyde (NHSGGC), we continue to deal with high levels of COVID-19 in our hospital beds, and in ICU. The pandemic has also put pressure on our community and mental health services. In addition, we have maintained a level of elective activity and are dealing with 'normal' winter pressures. Our staff have worked very hard to treat these high numbers of patients and this makes plans for remobilisation, recovery and redesign very challenging. However, our plan demonstrates the considerable achievements to date, and sets ambitious but realistic plans for the year ahead. It highlights the innovative practice which has emerged over the last 12 months.

Approach

Our approach to developing this plan has been cross system, including primary care, secondary care and health and care services in the community. We used the Health & Social Care Partnership (HSCP) and Acute Tactical Groups, and the Strategic Executive Group (SEG) to test the plans and priorities as they were developing. This inclusive process has been supplemented by more formal engagement with a number of the Board's governance groups e.g. Area Medical Committee, Area Partnership Forum, Area Clinical Forum and Stakeholder Reference group.

Strategic Direction

Moving Forward Together (MFT) remains our key strategic document, describing the medium term vision for clinical services in NHS Greater Glasgow and Clyde. Implementation of some MFT recommendations have been accelerated by the need to respond rapidly to the demands of COVID-19. In the twelve months ahead, we will build on this transformational change and embed the innovative practice recently established.

Key Priorities

The detail of the plan builds on the key priorities detailed below, and identifies specific actions to be progressed during 2021/22.

Workforce

We will continue our commitment to staff mental health and wellbeing and deliver the action plan. We will focus on anticipatory workforce planning to respond to the changing demands of services e.g. testing and vaccination. We will continue to support remote working and maintain social distancing requirements to ensure staff and patient safety.

Public Health

We recognise the existing health inequalities exacerbated by the pandemic and will seek to address them with specific actions. We will continue to deliver the local testing and contact tracing processes working with the national contact tracing centre and to deliver the vaccination programme. We will continue to support the wider health improvement agenda with a focus on child poverty, mental health, weight management, smoking cessation and drugs and alcohol. We will develop a more resilient workforce in collaboration with Public Health Scotland (PHS).

Social Care

Key priorities to progress with HSCPs include support for care homes and the care at home service. We recognise the need to reduce delayed discharges and to maximise independence for our population, supporting older people to live safely in their own community. We recognise the additional demand for services such as child and adult protection, homelessness and addictions - some of this demand arising as a result of the pandemic and the need to deliver services in different ways.

Planned Care

We aim to step up on our elective programme when COVID-19 levels allow. We will continue to increase our use of virtual patient management (Near Me) and day case procedures, and we will enhance pre op assessment and pre admission management of patients. We will focus on radiology and endoscopy to reduce waiting times, and will work with other providers to deliver additional activity following clinical prioritisation. Detailed activity schedules will accompany RMP3; activity levels will be lower than before the pandemic due to COVID-19 restrictions.

Unscheduled Care

Following the successful implementation of phase 1 of the Redesign of Urgent Care, and the opening of the Flow Navigation Hub, we will be implementing Phase 2 during 2021/22. This will include the development of a number of additional care pathways, inclusion of paediatrics in the Flow Navigation Hub and increased utilisation of Consultant Connect. During this year, we will also launch Urgent Care Resource Hubs in Health and Social Care Partnerships (HSCPs), linking them with the wider redesign. We will further develop effective interfaces to support older people to stay in their own community.

Mental Health

We will continue to implement our Mental Health Strategy, including services for older adults, recognising the additional impact the pandemic has had on the mental health of the population. A focus on digital will increase virtual patient management and support new psychological services. Mental Health services will support the wider unscheduled care agenda, building on the Mental Health Assessment Units model and developing Consultant Connect. We will work with partners to reduce social isolation and loneliness. We will focus on the delivery of waiting list challenges for Child and Adolescent Mental Health Services and for Psychological Therapies.

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Addressing Inequalities

We will continue to practise inequalities sensitive communication for testing, vaccination and service recovery, and implement Fairer NHSGGC 2020-24. We are developing targeted work with Black, Asian and Minority Ethnic (BAME) communities and have established a Workforce Equality Group to oversee addressing inequalities in the workplace. We continue to carry out Equality Impact Assessments on service changes to mitigate any potential inequalities.

Digital and eHealth

Our Digital Team has driven forward significant improvements in virtual outpatient consultations using telephone and Near Me technology in all sectors of the health and care system. We will continue to increase the use of Active Clinical Referral Triage (ACRT) to improve patient care, reduce waiting times and optimise face to face consultations. Work will continue to support the redesign of urgent care, screening and testing policies and the vaccination programme.

Patient Experience

Ongoing engagement with stakeholders is fundamental to remobilisation, and a key part of our drive to reduce inequalities. During 2021/22, we will continue to support Patient Centred Visiting and the implementation of Care Opinion. Public engagement will remain a key focus in service change and improvement.

Finance and Capital

Our plan will be underpinned and intrinsically linked to the Board's Financial Plan which will demonstrate how we will manage within the financial resources available to us. We will evidence the progress we have made in addressing the factors which lead to escalation. Capital planning will continue to be linked to service planning, and will inform the work being progressed to develop a Board-wide Infrastructure Strategy.

2. Introduction

2.1. Background

This is the third Remobilisation Plan (RMP3) for NHS Greater Glasgow and Clyde, produced in response to the Scottish Government commissioning letter dated 14th December 2020. It covers the period from April 2021 to March 2022, and builds on previous remobilisation activity and plans. This plan does not seek to replicate the detail of other extant plans, but recognises the need to bring together clinical and service plans with Integration Joint Board (IJB) Strategic Plans and other Board strategies.

RMP3 has been developed in partnership with stakeholders across the health and care system in both primary and secondary care and is informed by national policies and guidelines. The plan recognises that we are working in a time of great uncertainty around the impact of COVID-19 in the year ahead. This uncertainty around planning for 2021/22 is compounded by the need to support our staff team who have been working under extreme pressure, often in unfamiliar work areas, for the last 12 months. We have assumed that we will be dealing with high levels of COVID-19 for at least the first six months of this planning period.

2.2. Key Principles

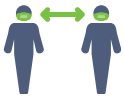
Remobilisation Plan 2 outlined how we would:

- **Deliver as many routine services as possible**, as safely as possible
- **Create and protect the capacity** to deal with the continued presence of COVID-19
- **Prepare health and care services for winter**.

These aims are supported by the principles, agreed by our Strategic Executive Group (SEG), in the diagram below.

Recovery must be flexible to respond to future potential COVID-19 waves

Senior decision makers will triage patient management on agreed system-wide thresholds and critical for care



Social distancing will shape the way we deliver services in the future

Patient and staff safety is paramount (testing and isolating as necessary)

Recovery planning will take an inequalities sensitive approach, recognising the impact of societal changes by the COVID-19 response

We will embrace **new ways of working**

We will continue the cross system working, which has been successful in the COVID-19 response

We must **maximise the opportunities of using digital tools** to enable and sustain recovery

Supporting staff health and wellbeing is critical

2.3. Remobilisation Plan 2

Remobilisation Plan 2 covered the period from August 2020 to March 2021. Progress against the plan is being monitored regularly at Tactical Groups and Strategic Executive Group. An activity monitoring template is reviewed fortnightly, comparing performance to projections in the plan, and mitigating actions are agreed where this is required. The activity monitoring template shows positive progress in remobilising outpatient activity, particularly taking advantage of remote consultations. It also demonstrates positive progress in achieving endoscopy targets and in delivering both Child and Adolescent Mental Health Services (CAMHS) and psychological therapy services. Performance has been more challenging in delayed discharges and in treatment time guarantee (TTG) activity. In addition to monitoring activity, a programme management approach is being taken to monitoring the wider implementation of the plan. An action tracker has been developed identifying clear actions, timescales and leaders for each action. This is reviewed at Tactical Groups and SEG monthly.

2.4. Planning to Meet Demand

As the levels of hospital admission due to COVID-19 have fluctuated over the last 12 months, services in the community and in hospitals have had to flex resources to be able to respond quickly. This changing demand is overlaid on usual unscheduled and urgent care, leaving varying and often unpredictable capacity for the elective programme. The learning over the last 12 months has helped us to develop modelling systems to enable us to predict the likely capacity for elective work, and to match predicted demand for services with our staffing and physical resources. Current COVID-19 projections indicate that it will be difficult to remobilise much of our planned care activity until autumn, and even then, this will be affected by social distancing and infection control guidelines.

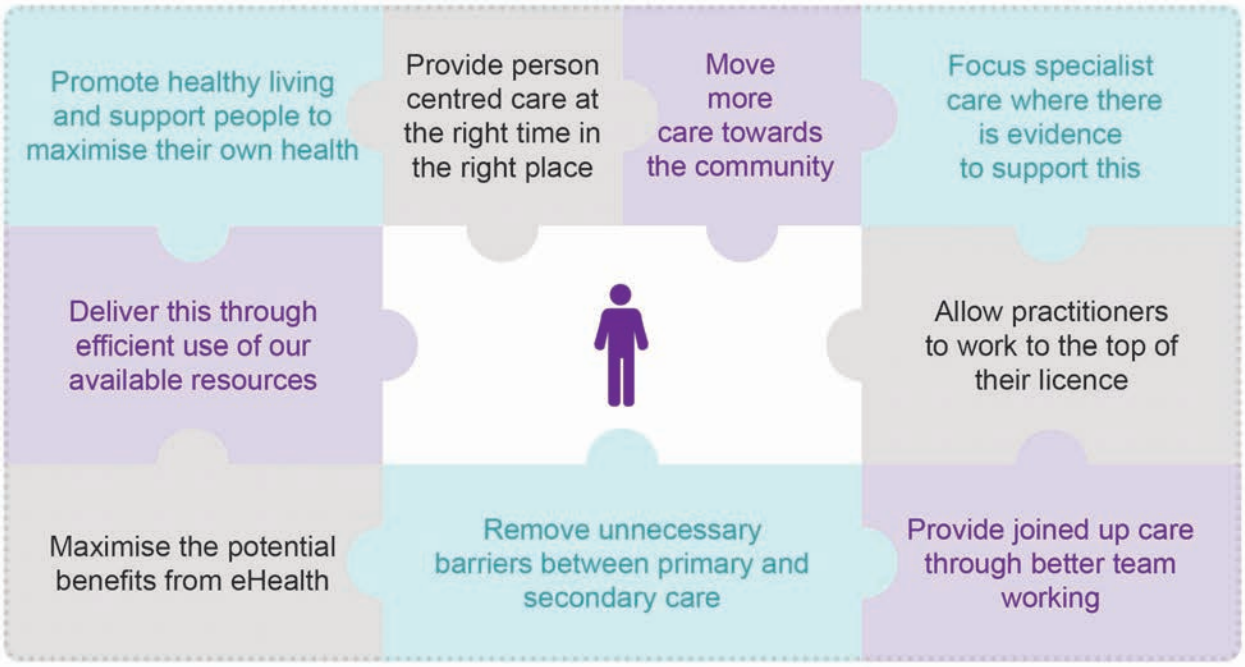
3. Strategic Direction

Key Points

- MFT remains the clinical strategy and vision for NHSGGC
- Our corporate objectives drive priorities for 2021/22
- We will develop a comprehensive infrastructure strategy to underpin our clinical strategy and maximise use of our estate.

3.1. Moving Forward Together (MFT)

MFT remains the strategic document which describes the vision for future clinical and care services in GGC. The key principles established through MFT and the significant work carried out with clinicians, patients and the public are summarised in the diagram below:



Although the formal governance and meeting structure for MFT has been stood down over the period of the pandemic, progress in implementing MFT has continued at pace using the temporary governance arrangements which have been in place over the last ten months. **Maximising the potential benefits from eHealth**, significant progress has been made in implementing ACRT and increasing the number of remote consultations. As part of the drive to **focus specialist care where there is evidence to support this**, planning to implement the West of Scotland Trauma Network has continued throughout the pandemic period, with the recruitment and training of staff and the progression of the required capital work in Clyde. Full implementation of the Trauma Network is expected to be in summer 2021. The redesign of urgent care aims to **provide person centred care at the right time in the right place**. In November 2020, we established the GGC Flow Navigation Hub to direct patients to the most appropriate service first time, and this is now moving into Phase 2.

These achievements are described in more detail throughout this plan, as they form much of the basis for our priorities in the coming year. The Recovery Tactical Group brings together primary, secondary and community services to develop a cross system approach to recovery and remobilisation, **removing unnecessary barriers between primary and secondary care**. The MFT Stakeholder Reference Group has continued to meet, and this group has been able to engage with the development of Remobilisation Plans.

3.2. A Tiered Approach

A key principle which emerged from the MFT work was the agreement to develop a tiered model of service delivery across the entire health and care system. A tiered model of care seeks to deliver the majority of care as near local communities as possible, but recognises that more specialist care is better delivered through a small number of sites with access to specialist staff and other resources. This tiered model is beginning to crystallise with the implementation of the Trauma Network and the establishment of the QEUH as a West of Scotland Trauma Centre (and a Trauma Unit for the local population), supported by two other Trauma Units at the GRI and RAH, and local hospitals with centres of excellence which can focus on rehabilitation, elective work, outpatient/day case activity together with maintaining many emergency services for patients locally.

3.3. Progressing our Clinical Strategy

The rapid changes implemented to respond to the pandemic and to remobilise and redesign our services are continually reviewed against our MFT vision informing our priorities for the year ahead and future years. The tiered approach and the ongoing MFT actions begin to determine the shape of health and care services in GGC. Over the next year, we will develop this model further, informed by the priorities described at 3.5 below and the resources and estate available to us.

3.4. Our Facilities

The physical condition of our buildings and facilities is varied. Our estate comprises new state of the art resources at the QEUH and our ambulatory care hospitals at the Victoria and Stobhill, but also a number of sites which require investment in backlog maintenance. A recent Risks and Needs Assessment of acute sites in NHSGGC ranked the following sites as having the highest risks and needs:

- **Institute of Neurological Sciences at the QEUH** – A programme of work has commenced to look at the options for refurbishing or replacing the 1970s Institute of Neurological Sciences, which has heating, boiler and ventilation systems which are reaching the end of their useful life. The options appraisal will look at the practicalities of undertaking capital works while maintaining services. The Initial Strategic Assessment will be completed by summer 2021.
- **Inverclyde Royal Hospital** – A level of backlog maintenance is required at this site, which serves a local population with high health needs. Inverclyde is part of the Clyde sector, and future plans should include a wider view of Clyde needs and resources.
- **Royal Alexandra Hospital** – This site should be considered along with Inverclyde as key resources for the Clyde population. The site requires improvement and has issues with capacity, layout and co-locations.
- **Glasgow Royal Infirmary** – 50% of the beds on this site (488) are within Victorian buildings with difficult layout and configuration to deliver modern safe care. Future reconfiguration on the site will be challenging but there are some opportunities to develop the site to deliver our clinical strategy.

In HSCPs, a property strategy is being developed, having been tested in Renfrewshire HSCP. This reviewed the local property portfolio, worked with local stakeholders to understand the current and future challenges, identified the gap and set out some options for addressing that gap. The Renfrewshire pilot proposed short, medium and longer term solutions. The lessons learned in Renfrewshire have informed a slightly revised methodology which will now be rolled out across the other HSCPs in GGC. This includes GP owned and leased premises, taking account of issues identified in the GP premises survey, and the national direction of travel away from GPs having to provide their own premises with this work. A prioritisation exercise of HSCP capital bids has been carried out to create a ranking of community and mental health priorities. This will inform the emerging infrastructure strategy.

In mental health, investment is required in inpatient facilities to meet modern mental health standards for single rooms, en suite facilities and enhanced social space. The property portfolio is being reviewed in line with the Board's Mental Health Strategy and this will inform a property strategy for mental health.

The developing, detailed clinical strategy, our existing estate and the requirements for community and mental health facilities will be brought together in a comprehensive infrastructure strategy for the Board. Facilities and Estates teams estimate that this work will take around 12 months to complete with support from Healthcare Planning and Technical expertise. Further detail on the clinical strategies needs to be completed by the end of July 2021 to inform this process.

3.5. Priorities for the Next 12 Months and Beyond

The Board's Corporate Objectives relate to our health and care system and describe what we need to do to achieve our ambition to deliver Better Health, Better Care, Better Value and Better Workplace. The Corporate Objectives drive our more detailed Business Objectives which are outcome focussed, measurable, and time framed and reviewed annually. This process will form part of our overall Governance and Assurance arrangements.

Key priorities for the next 12 months, which are set out in detail in the draft plan include:

National

- **Continue to implement the local Test and Protect Programme and the Vaccination Programme** in line with national guidance
- **Further implementation of Best Start** (Maternity and Neonatal Strategy).

Regional

- **Progress the West of Scotland Thrombectomy business case**
- **Implement the West of Scotland Trauma Network**
- **Commence implementation of our Systemic Anti-Cancer Therapy (SACT) strategy**, subject to resources.

Local Strategies

Many of our local strategies will be implemented over the coming years. We will identify project plans for 2021/22 which will be progressed over the next 12 months. We will continue to progress the implementation of the following local strategies and plans including:

- **Quality Strategy**
- **Workforce Strategy**
- **Stakeholder Communications and Engagement Strategy**
- **Mental Health Strategy**
- **Turning the Tide through Prevention, with a re-phasing of actions to take account of the priority of the pandemic response**
- **Digital Health and Care Workplan**
- **Primary Care Implementation Plans**
- **Realistic Medicine Action Plan**.

Local Service Improvement

- **Progress implementation of our Stroke Strategy**
- **Further develop and co-ordinate services to support people to remain in their own homes**
- **Develop and implement Phase 2 of our redesign of urgent care**.

Local Capital

- **Progress the business case for the re-provision of the INS**
- **Develop an Infrastructure Strategy for the Board**
- **Further progress the business case for the North East Hub**.

Local Business as Usual

- **Maintain red pathways in hospitals and community** as required
- **Remobilise elective activity**, taking account of the national clinical prioritisation process.

Many of these priorities are longer term, but our plan describes what we expect is achievable in the next 12 months.

We will complete the implementation of the key recommendations of the Escalation Oversight Boards for unscheduled care, planned care, GP Out of Hours and leadership and the QEUH final report when received. In addition we will implement the recommendations of the Independent Review and the Case Note Review.

4. Addressing Inequalities

Key Points

- Continuation of COVID-19 related work including equalities sensitive communications about testing, vaccination and service recovery
- Work towards implementing our Turning the Tide public health strategy
- Actions towards implementing the Equalities Act
- Developing targeted work with BAME (Black, Asian and Minority Ethnic), disabled and LGBT+ (Lesbian, Gay, Bisexual and Transgender) communities
- Addressing inequalities caused by poverty.

4.1. Our Vision

The vision for equalities is to eradicate discrimination and promote health justice for all our patients and staff, as well as addressing health inequalities exposed and exacerbated by the pandemic. We will continue to make sure that service planning across all services takes account of local engagement and demographics, and the specific health and wider circumstances of our population.

4.2. Progress to date

Our health and care service in the community have embedded inequalities sensitive practice in all services. The Corporate Inequalities Team support this with targeted interventions. In the last 12 months we have progressed a number of initiatives to mitigate the potential negative impacts of our response to the pandemic. These include:

- **Targeted support to staff groups with higher risk and impact of COVID-19** including BAME staff, but also disability and LGBT+ groups
- **Targeted engagement with South Asian community groups to establish baseline COVID-19 information**. Key messages were produced in a range of community languages and promoted through community BAME organisations including Radio Awaz where a bi-lingual GP delivered an update session on COVID-19. Similar work is underway now with the Roma community and asylum seekers
- **Action to ensure managers discuss risk assessments with BAME staff** as a high risk group and to improve ethnicity data on Human Resources (HR) systems
- **Information disseminated in appropriate formats** to meet the needs of those who cannot read English and disabled people including British Sign easy read in multiple languages for non-English speakers
- **Maintaining social connections for our inpatients with 600 iPads**, each with the Interpreter Now app for deaf people. An additional app (AVA) which is a speech to text app, is also available to assist patients with a hearing loss who lip read to communicate with staff wearing barrier masks. We contract the Lifelink counselling service to ensure provision of a remote service for those with hearing loss.

Six Equality Impact Assessments (EQIAs) were conducted to support the development of Remobilisation Plan 2:

COVID-19 Community Assessment Centres	GP Out of Hours	Virtual Patient Management
Active Clinical Referral Triage/ Patient Initiated Review	Phlebotomy Hubs	Flow Navigation Hub

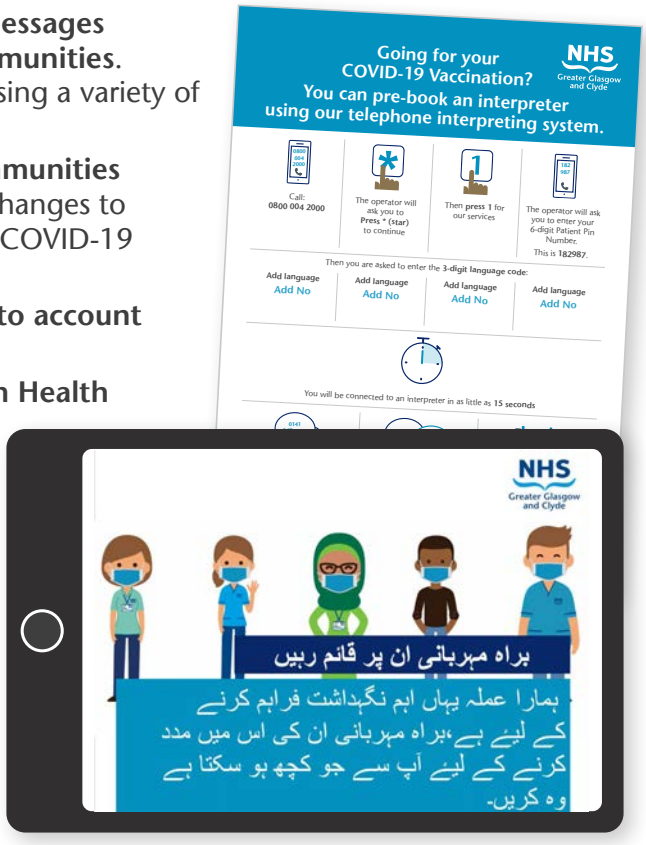
A composite plan has been developed focusing on transport, sensitivity for gender based violence (GBV), inclusion of carers, communication support, and an understanding of additional patient pathways.

NHSGGC has made the ethnicity field mandatory in TrakCare, providing guidance to all Medical Records staff to advise this must be recorded with every interaction with every patient.

4.3. Priorities for 2021/22 will include:

Continuation of COVID-19-related work including equalities sensitive communications about testing, vaccination and service recovery

- **Continue to communicate COVID-19 vaccination messages while challenging myths circulating in specific communities**. Prominent community members will support efforts using a variety of engagement methods
- **Nurture relationships with BAME and disabled communities** to ensure accessible information is provided on local changes to our service provision, vaccination and care due to the COVID-19 pandemic
- **Digital exclusion and literacy levels will be taken into account** when developing tailored information
- **Apply learning from Glasgow Centre for Population Health (GCPH) Glasgow University and other academic partners** who are producing a series of COVID-19 micro briefings. The first was published in January 2021 on the impact of the pandemic on people living with a disability
- **Carry out EQIAs on aspects of RMP3**, building on the learning from RMP2.



Work towards implementing our Turning the Tide public health strategy

Evidence shows that it is likely that the COVID-19 pandemic will widen health inequalities in our population. In remobilising the public health programme, actions will be taken that will aim to offset the wider health consequences for our more vulnerable communities. Basing actions on our published Turning the Tide through Prevention 2018–28 strategy, our remobilisation will consider:

- **Improved access to non COVID-19 health services** for those who are more likely to suffer long terms consequences of COVID-19
- **Improved access to money advice and pathways to employment** for those whose ability to work or access to employment has been restricted by COVID-19
- **The impact on the mental health of our population** for those with underlying mental health problems or poor mental wellbeing exacerbated by isolation and lack of community networks and social capital
- **The potential increase in alcohol and substance misuse**, continuing to gather evidence of the changing patterns of misuse and responding to these through the six Alcohol and Drug Partnerships in Greater Glasgow and Clyde
- **Increased prevalence of GBV due to COVID-19 lockdown** and lack of access to other safer spaces and linked to potential for increased sexual exploitation
- **Support for physical or mental health** particularly for those who require support as a consequence of poverty, disability and for our BAME communities who do not read English, and asylum seekers with no recourse to the public purse
- **Support digital access and inclusion of patients** to support their health and participation in treatment and care.

Actions towards implementing the Equalities Act

NHSGGC continues to demonstrate commitment to addressing discrimination by meeting responsibilities as required by the Equality Act (2010). In 2021/22 we will focus on the following priorities.

- **Support staff to respond to the social issues** affecting health including money worries and housing
- **Assess the impact of changes to services on people with low incomes**
- Use our unique position as healthcare providers **to assist those experiencing all forms of gender-based violence**
- **Implement the British Sign Language (BSL) Act (Scotland) 2015 action plan**, including employing a BSL translator to improve translation of health information for those with hearing loss
- **Deliver an in-depth health and wellbeing survey for LGBT+ people** living in urban central Scotland
- **Develop the NHSGGC Workforce Equality Plan** to ensure staff are treated fairly and deliver EQIAs for key work programmes and service redesign
- **We have also set eight new equality outcomes for 2020-24** based on evidence gathered from extensive research, policy and engagement with patients and staff. These outcomes, covering all protected characteristics, will be implemented in 2021-22.

Developing targeted work with BAME communities

Learning from the impact of COVID-19 NHSGGC is committed to developing a range of work for 2021–2022 to address issues within our BAME communities. These will include:

- **Mandatory ethnicity recording in acute services and improved data recording of ethnicity in mental health and acute services**. As part of national developments, seeking to improve ethnicity recording in primary care
- **A staff focussed campaign on racism** and the impact on health and mental health
- **Engaging BAME communities in reviewing patient pathways** to make improvements and address access issues where required.
- **Engaging with BAME communities, post COVID-19, to capture lived experience** and address any barriers highlighted
- **Provision of accessible community pharmacy services to non-English speakers** by increased provision of telephone interpreting
- **Increased awareness of the needs of patients from faith groups** in relation to their care
- **Engagement to understand the different needs of BAME women**, including asylum seekers who are pregnant, and develop responses to any structural barriers identified
- **Implementation of NHS Scotland Interpreting, Communications Support and Translation National Policy**
- **Population level interventions post COVID-19 for gender-based violence, poverty, digital exclusion and wellbeing are inclusive of BAME communities**.

Addressing inequalities caused by poverty

- **Further work is required to consider the resource impact of meeting the unprecedented demands on public services**, including effects related to Brexit
- **Strategies to mitigate child and family poverty** such as 'Healthier Wealthier Children', Long Term Conditions Financial Inclusion, and HSCP Local Outcome Improvement Plan are being reviewed
- **Work with Money and Debt Advice services** to ensure that patients or families referred are supported promptly by telephone, email or video call
- **Work with Community Planning partners to support the Youth Guarantee scheme** and other employment initiatives designed to mitigate the economic consequences of the pandemic.

5. Patient Experience and Public Engagement

Key Points

- Our Stakeholder Communications and Engagement Strategy will direct our activity and partnership with patients, carers and their families
- We will apply learning from engagement on Near Me, GP out of hours and Community Assessment Centres to these services, and more widely
- We will carry out patient evaluation of further new ways of working including the Flow Navigation Hub
- Person centred care is a focus of our Healthcare Quality Strategy and will drive our priorities for 2021/22.

5.1. Public Engagement Vision

A fundamental aspect of NHSGGCs remobilisation planning will be ongoing engagement and collaboration with our stakeholders. This will help to ensure we are always taking a person centred approach to how we deliver care, and that we are working with our patients, their carers and families in partnership, to capture their experiences, and coproduce new ways of working to improve care across NHSGGC.

5.2. Context

NHS Greater Glasgow and Clyde's Stakeholder Communications and Engagement Strategy which was approved in December 2020 by the Board, sets out how we will build and strengthen relations with our communities and create ongoing, continuous approaches to inform, listen to and involve all of our stakeholders. The core aims and aspirations set out by this strategy are designed to help our Board ensure all communications and engagement activity is person centred. Although the Board's approach to staff communication and engagement is covered by a separate strategy, the views and experiences of our staff will also help to influence and shape how we remobilise services.

Alongside and supporting this strategy will sit the new National Guidance for Community Engagement being developed by Scottish Government, Confederation of Scottish Local Authorities (COSLA), and Healthcare Improvement Scotland (HIS), with contributions from NHSGGC and other key stakeholders helping to shape its development. All engagement activity undertaken by NHSGGC will align with and remain responsive to this developing guidance. NHSGGC will also be playing a key role in the testing of a linked Quality Framework being developed by Healthcare Improvement Scotland, working to ensure we maintain an open and collaborative relationship with them to share all emerging best practice around testing of the framework, as well as ongoing involvement activity.

We have an active Stakeholder Reference Group (SRG), set up to test and support our Moving Forward Together programme. This group has provided useful input to our remobilisation process.

In addition to the overarching Board Strategy, our health and social care partnerships all have Partnership and Engagement Strategies. These set out the approaches to engage with their local communities. For HSCPs a key focus in terms of planning social care services during to 2021/22 will be taking forward the recommendations from the Independent Review of Adult Social Care Services. The Review has sought to focus on developing a deep understanding of the needs, rights, and preferences of people who are using social care services.

The Communications and Public Engagement Directorate continue to offer support and guidance to teams on the most effective communications and engagement approaches for their projects, sharing best practice from earlier remobilisation work and helping teams engage early and effectively. The Patient Experience Public Involvement Team (PEPI) in particular will be working to provide training and support to teams to enable them to listen and involve people in service planning, improvements and developments using a variety of training methods and 1:1 coaching.

5.3. Stakeholder Experience and Engagement – Achievements

Over the last 12 months the PEPI Team have delivered on a programme of stakeholder engagement to evaluate new ways of working implemented during the COVID-19 pandemic. These engagement activities were commissioned by the Recovery Tactical Group, with the PEPI Team gathering the views and experiences of patients and staff in relation to the following work streams:

- **The GP Out of Hours Service**: The PEPI Team were commissioned to undertake a programme of stakeholder engagement to evaluate the new service model from a patient and carer perspective. The report is being used to inform further developments
- **Near Me (online appointments):** The PEPI Team engaged with patients and carers who had a recent experience of using Near Me to access healthcare appointments virtually. The team also worked closely with the Equality and Human Rights Team (EHRT) to support us to engage with protected characteristics groups and capture their experiences
- **Community Assessment Centres and Hub Services**: Due to local restrictions and social distancing measures, the PEPI Team took a remote and digital first approach to engage with 703 people. Engagement methods included the use of social media, Care Opinion, online surveys, the NHSGGC Involving People Network, virtual discussion sessions and telephone interviews to capture stakeholder views and experiences.

Building on the innovative Helping Us Grow Group (HUG) collaborative model developed in neonatal services, the staff at the haemato-oncology unit at the Royal Hospital for Children have developed an integrated family group within the ward. This, together with a range of resources developed enables proactive communication and engagement with patients and families.

5.4. Stakeholder Engagement – Priorities 2021/22

As a result of ongoing social distancing measures, local remobilisation engagement will continue to focus on a digital and remote first approach until it is safe to engage face to face again. Over the next 12 months, the PEPI Team will:

- **Scope and embed a range of innovative digital tools** including encouraging 2-way conversations on our social media platforms
- **Continue to ensure that all engagement activity is responsive** to the needs of our stakeholders
- **Work in partnership with the Equality and Human Rights Team** to ensure we reach all our communities and that our engagement is accessible
- **Carry out further engagement around patient experience of accessing GP Out of Hours (GPOOH)** with a particular focus on those with protected characteristics
- **Engage around the ongoing redesign of urgent care** with a specific focus on access including an analysis of the impact of the changes across the whole system
- **Develop a staff and public campaign to raise awareness of how Near Me** is being used in NHSGGC to deliver healthcare as part of a blended approach and information on how patients can access this
- **In relation to supporting people with chronic diseases, we will support the Managed Clinical Network in the following areas**:

- Approach to self-management of Chronic Obstructive Pulmonary Disease (COPD) utilising COPD-SCOT website
- Development of online classes and self-help resource for Fibromyalgia sufferers
- The Diabetes Managed Clinical Network (MCN) pilot for a blended learning Dose Adjustment For Normal Eating (DAFNE) course (online and self-learning)
- Primary care online version of group education for people newly diagnosed with type 2 diabetes.

As we continue to remobilise services, NHSGGC will work in partnership with communities to shape and embed new models of care, ensuring a person centred approach is adopted. Openness and partnership working are core to this. Therefore, as well as following the legal and national guidance, this approach will ensure any changes or service developments are considered in the context of what matters to patients and service users, and that their voices help influence and shape future service developments.

5.5. Patient Experience – Priorities 2021/22

During 2021/22 we will continue to draw on the lived experiences of our patients and carers to understand what matters most to them through the regular capture of feedback via our corporate systems. Their feedback and experiences will support us to continually measure if care is person centred, high quality, safe and effective, and inform the remobilisation work to ensure the patient's voice is at the centre of service improvement and development.

As part of the delivery of NHSGGCs 'The Pursuit of Healthcare Excellence Quality Strategy,' the PEPI Team continue to support the implementation of Care Opinion across acute and the Board by growing a network of responders who either manage the service or deliver the care. Support includes providing virtual training for new responders in partnership with Care Opinion across the Board to further embed a culture of listening, learning and being responsive to feedback to improve the quality of our care.

To support patient and families to give feedback at the point of care, Care Opinion has been added as an app on the iPads that were procured to facilitate virtual visiting during the pandemic across all adult acute inpatient wards. This provides staff with a regular mechanism to gather feedback from patients and families and enables patients to share their experiences prior to being discharged. Alongside the acute roll out of Care Opinion at service level, East Renfrewshire Health and Social Care Partnership have been working directly with Care Opinion on the local implementation and will officially launch in February 2021. The PEPI Team will continue to work closely with the Leads to facilitate the sharing of learning and good practice to support the ongoing implementation of Care Opinion across the Board over the next 12 months.

Over the next 12 months, we will:

- **Review and improve our approach to collecting, managing and using feedback** across our care settings to continuously improve the quality of our care and services in partnership with patients, carers and the wider public
- **Develop our approach as to how we monitor, listen and respond to comment and feedback** from stakeholders and our communities on our social media channels
- **Increase our communications to raise awareness of the different ways that people can share their experiences** and demonstrate how feedback makes a difference. This will include empowering and encouraging patients and families to raise issues at point of care to support early resolution
- **Raise awareness among staff in relation to the importance of seeking feedback** and provide training to enable them to listen, respond and learn from feedback
- **Continue to report on what we hear from patients and families** in terms of key themes as part of corporate governance processes. The feedback themes will also be used to inform NHSGGC's realistic medicine programme and influence quality improvement initiatives cross the Board.

5.6. Person Centred Care

Person centred visiting

One of NHSGGC's key person centred priorities as set out in the local Healthcare Quality Strategy is to implement a person centred approach to visiting across our inpatient wards. To support the implementation a programme of engagement was undertaken in summer 2019 to listen to the experiences of patients, relatives, carers and staff and to gather their views on what a person centred approach should include. The Equalities and Human Rights Team also engaged with community groups to capture their views and experiences. This engagement approach helped to inform the development of a set of core principles to underpin our approach to person centred visiting. More than 80% of patient areas across NHSGGC had moved to person centred visiting prior to the first lockdown in March 2020.

NHSGGC continue to follow national guidance in relation to visiting arrangements during the pandemic. The national guidance provides a four-stage plan to guide the reintroduction of in-person visiting detailed in a recovery route map. At a national level, each stage of easing of restrictions will be assessed depending on scientific advice and the progress of the infection rates. As visiting is reintroduced this will be aligned to the core principles of person centred visiting already established within NHSGGC with alignment to the additional safety precautions required with a robust remobilisation plan to support this.

Due to the COVID-19 pandemic and visiting restrictions coming into effect, we have had to think differently about how we ensure the core principles of person centred visiting are maintained. To minimise where possible the isolation and loneliness that people can experience when they are separated from those who are most important to them Person Centred Virtual Visiting (PCVV) was introduced in March 2020. All wards have iPads specially set up to enable 'virtual visits' (video call) allowing patients to see and talk to the people who matter to them using FaceTime, Skype or Zoom as well as a range of other apps and icons to support communication, health and wellbeing. Person Centred Virtual Visiting will continue to be an integral part of our person-visiting approach beyond the pandemic. An evaluation approach is well established which includes the experiences of patients, relatives, carers and staff who have used the service.

Person centred care planning

Another priority area for engagement is our person centred care ambitions to work in partnership with patients, families and multi-disciplinary staff, to co-design core principles to ensure 'what matters' to patients and families is central to our person centred approach to planning care. Although this is temporarily suspended due to the pandemic, project planning is well advanced and when safe to do so will commence with the engagement phase and progress to testing core principles in practice before moving to full implementation in all primary and secondary areas of practice. Listening to the views, experiences and feedback of patients, relatives and carers during the testing and implementation phases will be a key part of the measurement and evaluation approach.

Person centred care experience improvement model

Due to COVID-19 the Care Experience Improvement Model and collection of care experience stories from face-to-face conversations with patients and families remains temporarily suspended in all acute clinical teams. When safe to do so the Person Centred Health and Care Team (PCHC) will engage with services in each sector/directorate to re-establish the approach to listen to the experiences of patients, relatives and carers about what matters most to them when being cared for in our hospitals and help to facilitate reflection, learning and improvement from the feedback gathered in real-time.

6. Public Health

Key Points

- We will focus on testing and contact tracing, working with local authorities, to lead the effort to reduce COVID-19 infection rates
- We will lead the planning for a comprehensive vaccination programme to protect our population
- In partnership with hospitals and GPs, we will seek to maintain screening programmes
- New ways of working will be promoted to increase Blood Born Virus (BBV) testing rates
- Our Public Health workforce will be supported and strengthened as they lead efforts to reduce the impact of COVID-19 in our population.

6.1. Introduction

Our priority over the autumn and into the winter period has been to ensure Public Health capacity to respond and support our population and partner services as the progression of the COVID-19 infection rate put pressure on, and continued to disrupt our services and society. Preparations made during the first half of the year to build resilient COVID -19 testing and contact tracing capacity rose to the challenge of the surge that NHSGGC experienced along with the rest of the UK.

The success of the autumn Flu Vaccination Programme saw uptake rates for the over 65 and under 65 at risk priority groups increase on previous years despite the additional constraints of working within the COVID-19 infection control and social distancing requirements.

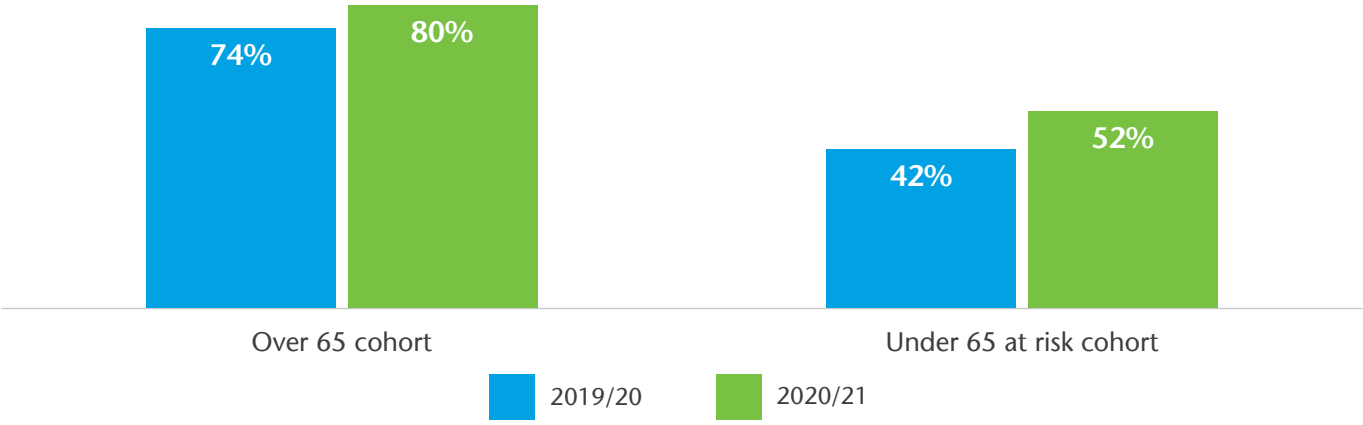


Figure: Flu Immunisation Uptake rates: 2019/20 and 2020/21

The learning from the Flu Immunisation programme, particularly the adoption of Community Vaccination Centres has proved invaluable as we progressed into delivery of the COVID-19 Vaccination Programme which is now one of the key priorities for 2021.

The infrastructure we have put in place to respond to the COVID-19 pandemic will still be required when rates of infection fall and vaccination rates begin to provide population protection. We will consolidate core services to ensure sufficient capacity within 'new normal' conditions and the surveillance capability to respond in the event of future risks.

The continued impact of the pandemic has exacerbated the broader challenges of health improvement and inequality, both with the direct impact of the virus on individuals and indirectly with disruption of core services designed to provide day to day support. We anticipate that as the pandemic recedes, the challenge of addressing its legacy will become more apparent.

There will therefore be a review of the action plan attached to 'Turning the Tide Through Prevention' to prioritise areas of work likely to have maximum impact over this period prioritising actions to minimise the equalities impact of the pandemic.

6.2. Test & Protect

Our Community Assessment Centres (CACs) continue to deliver a responsive service for symptomatic patients who are potentially COVID-19 positive to separate facilities for assessment outside of General Practice and Hospital. Surge planning undertaken in the autumn ensured capacity that could be escalated from a base number of three to five sites in the event of increased prevalence of the virus in the community. Provision for Point of Care (POC) testing for influenza has been in place over the winter period. These services will be maintained as part of our Urgent Care response throughout the year.

Lateral flow testing for NHSGGC Staff commenced on 12th December 2020 and all in scope staff received Lateral Flow Device (LFDs) in line with guidance. The second phase of issue to community based staff through our HSCPs was undertaken from 12th January and is also complete. Ongoing activity relates to supporting vaccinators and additional bank staff. The total kits for distribution was 40,909.

Planning has commenced for the next 12 week distribution period to ensure availability of LFDs from March 2021 onwards with a similar phasing approach. The Board has also ensured all hospice staff, volunteers, health students including those on 15 hour contracts and areas of business continuity have access to kits.

The implementation group are supporting primary care roll out of LFDs to independent contractors and their staff beyond those already receiving kits from CACs, GPOOHs and vaccination centres.

In line with Scottish Government's request to carry out testing within local authorities and communities that continue to have stubbornly high levels or groups in the community that are challenging to engage with, we will finalise our plans to implement this community testing at a number of sites across Greater Glasgow and Clyde using lateral flow devices in community sites.

We will help support local authorities to introduce a number of testing proposals, including:

- **Mobile Testing Units:** Proposals are currently being put forward regarding the use of Mobile Testing Unit (MTUs) on a rotational basis of 6-8 weeks to respond quickly to spikes in infection or outbreaks
- **Students:** Proposals are ongoing around the potential testing of students within sites on University campus (West of Scotland specifically) to allow a large university community to be targeted
- **Workplace sites:** Specifically designed for those with large workforces, covering a wide age range. Expansion of regular testing now includes:
  - Primary care workers such as GPs, dentists, optometrists and pharmacists
  - Staff working in hospices and other healthcare settings such as addiction and mental health services
  - Targeted testing for NHS 24 and emergency control room staff
  - Employment sectors such as food production and distribution
  - Education, with those who work in schools and learning settings as well as all secondary pupils offered at home testing.

We will continue to implement new guidelines as they come out, for example the learning from the pilots of school testing. We will maintain the high uptake rates for staff testing, as above, and we will continue to support care homes to carry out and document staff testing.

Our Contact Tracing has been fully operational since May last year. The workforce model is based on a core team supported by a bank of trained staff capable of responding dynamically to increases in demands.

We continue to maintain a core service to address complex tracing and local outbreaks. This works closely with environmental health colleagues in the Local Authorities and also with the national service. We anticipate that this will continue to manage the bulk of contact tracing within the NHSGGC area assuming current levels of contagion are maintained.

As future circumstances change with the pandemic, we will monitor requirements to ensure best use of our workforce whilst maintaining a flexible and responsive service.

6.3. Vaccination Programme

Our Vaccination Programme has made considerable progress from early December, working responsively to the changing requirements whilst maintaining adherence to the Joint Committee on Vaccination and Immunisation (JCVI) recommendations on priority groups.

The Louisa Jordan is the hub of our vaccination programme and hosts our Vaccine Holding Centre as well as providing the capacity for mass vaccination clinics.

In December, vaccination was rolled out to Care Homes (residents and staff) and frontline Health & Social Care staff. By the first week of January, we had reached every Care Home and provided vaccination to all eligible residents. For frontline Health & Social Care staff, vaccine clinics have been offered daily at the Louisa Jordan and on rolling basis across all hospital sites.

From the beginning of January, General Practice commenced vaccination of the Over 80s population, the Over 75 and Clinically Extremely Vulnerable cohorts, completing them by the 5th and 14th February respectively.

Working in partnership with the Local Authorities, we have located a further 16 locations throughout NHSGGC to operate as large scale vaccination centres in addition to the Louisa Jordan. The Community Vaccination Centres went live on the 1st February, delivering appointments to the 70-74 age cohort initially and the 65 to 69 cohort by the second week of February. Each site has capacity to deliver approximately 1,000 appointments per day, with several having capacity to scale up to considerably more. The Louisa Jordan has led the way with high volume clinics in January, piloting clinics for staff with capacity of 5,000 appointments per day, a volume that is being maintained as the vaccination progresses through the priority cohorts.

Our recruitment drive to build a vaccination workforce has built a bank of 2,199 individuals available to flex to meet the capacity requirements and to establish a firm foundation for the programme as it progresses through the year.

Our pharmacy teams have responded similarly to ensuring that vaccine management, distribution and quality control is maintained. With the programme developing at pace, the complexities of delivering this across so many locations has been challenging. The launch of the Community Vaccination Centres in February allows consideration of requirements to consolidate the dedicated pharmacy expertise and workforce that will be required throughout 2021/22.

Commissioning of the Community Vaccination Centres was undertaken at pace and concurrent to the introduction of new eHealth infrastructure such as the ServiceNow platform for appointments management and the Vaccine Management Tool. Our eHealth team have worked closely with National Services in their development, piloting and launch.

In line with national requirements, we expect to have delivered the Wave 2 requirements for cohorts 2 to 6, including delivery of the 2nd doses commencing from mid-February with Care Homes and frontline Health & Social Care staff.

As we consolidate the infrastructure necessary for mass vaccination, we will strengthen our communications and patient facing requirements to support our public to access the service, identifying and addressing the inequalities issues that make this harder for some parts of our population.

Planning for the continued rollout of the programme to the population through the rest of the year will continue to be responsive to any changing requirements of policy. Plans for 2021/22 will be developed in conjunction with the wider Vaccination Transformation Programme, particularly in relation to next year's flu vaccination programme and specific commitments on travel vaccination and childhood immunisations.

6.4. Adult Screening Programmes

The screening programmes for Abdominal Aortic Aneurysm (AAA), Breast, Bowel, Diabetic Retinopathy and Cervical Cancer recommenced in line with National Policy in the late summer and autumn and will be maintained throughout 2021/22.

The capability to maintain sufficient capacity to address both the backlog that developed during the initial pandemic period and normal levels has been challenging for each screening programme, particularly with respect to patients identified as requiring a second stage investigation delivered by hospital services such as vascular surgery, colonoscopy and colposcopy.

Close working with hospital service and General Practice will continue to ensure capacity planning for each screening programme as demand and supply pressures change during 2021/22.

6.5. Health Improvement

The majority of the Public Health workforce continues to be reassigned to COVID-19 related activity due to the upsurge in cases over the winter period, this includes capacity to support administration activities on acute wards, Test and Protect delivery and health protection support. As a result, the planned remobilisation and development of a number of public health interventions and service improvements have now been delayed.

A smoking cessation campaign has been developed in partnership with Lanarkshire and Lothian Health Boards to promote cessation in the absence of primary care and acute referral activity. Protocols have been redesigned focusing on telephone and Attend Anywhere/Near Me support alongside continuing pharmacy support.

Minimum core service options have been maintained for Weight Management, Diabetes education and supported physical activity interventions including active travel. Further service redevelopment to address digital exclusion has been delayed due to ongoing staff reassignment and current restrictions and will be undertaken when pressures reduce.

Actions to mitigate the impact of the pandemic continue to be delivered largely by HSCP Health Improvement teams and partners with focus on Children and Poverty prioritised. Assistance and crisis support has been prioritised within our hospital Support and Information Services including bereavement support, the distribution of toiletries and clothing as well as emergency funds.

Targeted communication to reduce the impact of COVID-19 on BAME communities has been progressed and includes enhanced messaging on testing, Test and Protect and vaccination through engagement with community groups, local radio programmes and social media.

6.6. HIV

As a result of COVID-19, service models changed to accommodate Government advice which has meant significantly less face to face contact and as a result BBV testing has reduced across key services, however all new referrals have continued to receive a BBV test as part of their assessment. Given the higher prevalence of Hepatitis C in NHS Greater Glasgow and Clyde compared with other Boards, achieving adequate testing is essential to Scotland achieving its targets on the elimination of Hepatitis C as a public health threat by 2024.

Over the course of the pandemic, BBV testing has continued where face to face activity has taken place within key settings, albeit at reduced levels. Teams and partner agencies have continued to provide BBV testing in outreach settings to some of our most vulnerable populations, including through the use of a mobile resource and via a city centre harm reduction initiative. However, overall testing remains suboptimal. In order to recover pre-COVID-19 BBV testing levels the following strategies are being employed:

- **Continue to work with key services/partners** to support recovery/upscaling of testing
- **Continue to utilise and explore how mobile resources can be deployed** to provide testing and treatment services for BBVs
- **Undertake a small pilot to explore the feasibility of home sampling for individuals** within alcohol and drug recovery services who are not currently being seen face to face and therefore have reduced opportunities to be tested for blood borne viruses
- **Review outcomes from harm reduction/testing initiatives** to explore their wider utility in supporting recovery
- **Plans to roll out the WAND initiative** (Wound care, Assessment of injecting risk, Naloxone provision and Dry Blood spot testing) should assist with the increase in three monthly BBV testing across the city.

6.7. Public Health Capacity & Resilience

The Public Health response to the COVID-19 pandemic required the mobilisation of the totality of its clinical expertise and workforce, enabled as non-essential activity was stood down and redeployment of staff. In the autumn, plans for additional staffing were developed and agreed alongside national planning on Test & Protect and the Scottish Directors of Public Health. For 2021/22, the further focus will be required to strengthen health protection resilience and consolidate our Public Health team.

We anticipate these plans to include:

- **Participation in national consultant recruitment**
- **Development of the health protection nurse role**, and support from managerial colleagues across GGC
- **Enhancement of administrative support**
- **Enhanced multidisciplinary working** across the directorate
- **On the job training and development**.

7. Escalation

Key Points

- NHSGGC has implemented and/or progressed all relevant agreed actions on each area
- Our performance was on course to achieve the scheduled care targets set for 31st March 2020
- Work has continued throughout the COVID-19 outbreak and all actions form a major part of the Remobilisation Plan
- Agreed performance targets outlined in the Remobilisation Plans have largely been achieved by the Board, despite the service pressures of COVID-19.

In January 2020, NHSGGC was escalated to Level 4 of the NHS Scotland Performance Escalation Framework in respect of GP Out of Hours, scheduled care, unscheduled care, and management capacity. A Turnaround Director was appointed and an Oversight Board was established.

Prior to the outbreak of COVID-19 and the pausing of the process, NHSGGC had implemented and/or progressed all relevant agreed actions on each area and was on course to achieve the scheduled care targets set for 31st March 2020. This was confirmed at the last meeting of the Oversight Board in March 2020.

NHSGGC co-operated fully and welcomed the additional oversight and support for an extremely complex set of issues. Due to COVID-19 and the time, focus and changes in service delivery, some of the initial actions were changed or amended. However, the Board remained fully committed to addressing the issues identified and working through the recommendations made.

Each of the individual areas are outlined individually below in terms of background, actions and current position.

7.1. GP Out of Hours

Sir Lewis D Ritchie was invited by the Board to review the Primary Care Out of Hours Service, particularly the implementation of the National Review of Out of Hours Services, 'Pulling Together: Transforming Urgent Care for the People of Scotland', published on 30 November 2015, which Sir Lewis had led. During this review, it became clear that strategic and operational issues within the service required immediate attention.

Sir Lewis provided preliminary findings from this review to the Board in late December 2019. The main findings focused around urgent robust actions to underpin resilience, contingency and to secure business continuity. More specifically, these can be summarised as:

- **Improve the administrative and clinical leadership** of the service
- **Draft and implement robust, systematic business continuity plans**
- **Develop a workforce plan** to rapidly increase more diverse multidisciplinary workforce including more salaried GPs and Advanced Nurse Practitioners (ANPs) and deals with recruitment but also retention
- **Consider the introduction of an appointment system** for the benefit of both patients and staff
- **Improve the wellbeing and morale of staff** by improving equipment at sites, and adequate social space and staff amenities
- **A rapid review of the fitness for purpose of existing sites** (priorities RAH Out of Hours (OOH) site)
- **Review and improve the innovation around GPs in training**
- **Accelerate the Urgent Care Resource Hub**.

In response to the review by Sir Lewis Ritchie, and in conjunction with him, an Improvement Plan (Implementation Plan) was developed. In addition, the Board implemented a series of immediate actions. The Scottish Government appointed Board Turnaround Director sanctioned the changes.

The early actions taken included temporarily suspending some Primary Care Emergency Centres to consolidate the service on fewer sites across the Health Board. Previously, that had been done on a reactive, unplanned basis. In addition, the management and leadership arrangements of the service were strengthened by the appointment of a Clinical Director and Lead Nurse, and a plan for improvements in the environment and operational issues was established, including improved security arrangements.

At the time of drafting this document, all the actions in the Implementation Plan have either been implemented, or are in progress for implementation within the 18-24 month target milestone. In terms of the current position, the following are the main highlights (under each Workstream heading):

Leadership

The senior clinical leadership arrangements have been reviewed and a Chief Officer to lead the service and two Associate Clinical Directors have been appointed. Front line delivery has been supported through a short-term increase in team leadership capacity. The management arrangements have been reviewed and agreement reached on a new structure which will ensure more robust management arrangements in support of front-line delivery.

Workforce

A workforce plan for the service was completed and presented to the Escalation Delivery Group on 9th July 2020. A Workforce Short Life Working Group was set up to develop the initial workforce plan and deal with the operational requirements in relation to recruitment and employment practice.

Scottish Ambulance Service (SAS)

A proposal on Advanced Paramedics in Primary Care Out of Hours has been agreed by the Delivery Group. It is anticipated that six Advanced Paramedics will support the OOH workforce. This has been agreed by SAS as part of their strategic and operational staffing plans with plans for implementation in April 2021.

Recruitment

Following a major recruitment drive, the Board now has 35 salaried GPs with interviews for a further six (by mid-February 2021). This has helped create stability in the system as those GPs tend to take set sessions each week. The Board continues with rolling recruitment campaigns for salaried GPs and ANPs. The recruitment of ANPs is a challenge but work continues with the HSCP Chief Nurses to look at widening the experience of OOH for those ANPs working in the HSCP as part of their professional development.

Staff Governance

The Staff Governance arrangements have been reviewed, with revised Terms of Reference and membership.

Environment

The centre spaces have been improved with positive feedback from clinical and administrative staff.

Walk–ins and Appointments

The appointments system was implemented across all sites from 1st June 2020 and is now fully embedded. The system will continue to be reviewed and will be monitored as part of the performance management arrangements.

Near Me

Near Me is available across all sites, with appropriate technology, permissions, clear instructions and training provided. A further survey is planned for summer 2021.

Communication & Engagement

Staff newsletters are now issued monthly from October 2020. An extensive patient and service user survey has been completed and a separate report is provided for the Oversight Board.

One of the key areas which remain in progress relates to the continuity and level of service at the Vale of Leven and Inverclyde. The Vale of Leven is now fully in place and work continues in Inverclyde.

Monitoring and Performance

The implementation of all the actions is monitored through the GPOOH Leadership Group and reported to the Oversight Board and the NHS Board. A performance framework was put in place and has highlighted a significant improvement in performance. This improvement is outlined below.

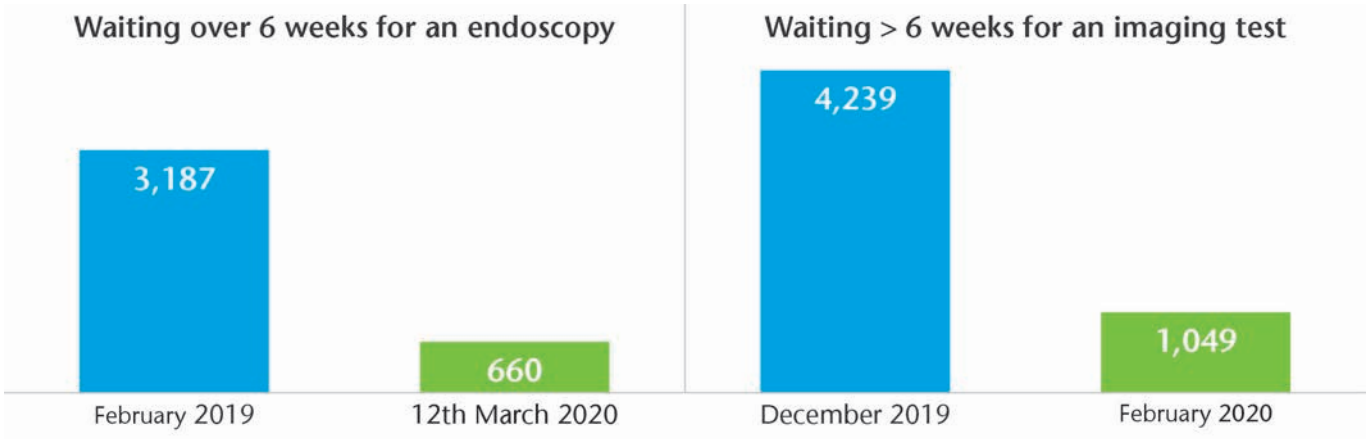
7.2. Scheduled Care

At the time of escalation, there were 10,283 patients waiting over 12 weeks on the inpatient waiting list and 23,403 on the outpatient waiting list.

Under the guidance of the Turnaround Director, and the Oversight Board for Performance, NHSGGC immediately drafted and implemented a Turnaround (Recovery) Plan. One of the main elements, and a key attributor to the early success of the Plan, was the appointment of a new Director of Access and support staff, along with the significant focus from the Senior Management Team. The Plan included a comprehensive review of demand and capacity plans, a review of NHSGGC's Access Policy and reinforcing waiting list validation processes, all of which were underpinned by enhanced performance management and strengthened governance arrangements around the planned care agenda.

As such, there were 9,070 patients waiting over 12 weeks on the inpatient waiting list as at 9th March 2020, and 20,710 patients over 12 weeks waiting on the outpatient waiting list. The Board was on course to meet the agreed targets of 8,500 and 19,800 respectively at the 31st March 2020 before the COVID-19 outbreak and impact. This trajectory was accepted and acknowledged by the Oversight Board at the meeting held in March 2020.

In addition, we consistently achieved the target in relation to the 31 days cancer performance, and the Board had also significantly reduced the length of waits for patients requiring an endoscopy when compared to the same period the previous year.



In common with the NHS across the UK, the elective programme was suspended and subsequently gradually remobilised due to COVID-19. However, in terms of progress against the agreed actions in the Turnaround Plan, the following is a summary:

Capacity Plans

The development of pre-COVID-19 capacity plans is complete for each of the 21 major specialties, with clinical sign off achieved by each specialty. We continue to develop the cross-sector elements of the plans to refine current plans and ensure optimum arrangements for capacity utilisation across the entire organisation.

Anaesthetic Rostering

It was recognised that issues with anaesthetics were contributing to higher than average cancellation rates across the elective programme, particularly in the North Sector. To improve the situation it was agreed, as part of the Turnaround Plan, to implement a new electronic anaesthetic rostering system across GGC, the procurement process is underway.

Plastibell

The Board was experiencing a significant number of long waiting patients with regards to religious and cultural circumcisions. Various actions to resolve this over a number of years had limited impact. As part of the Turnaround Plan it was agreed to establish a Plastibell Service for young children referred for religious or cultural circumcision, and from late 2021/22 to begin to phase out surgical circumcision for religious and cultural purposes for children. Referral in to the new service will continue, as before, via the patient's GP and Maternity/Neonatal staff.

High Volume Orthopaedic Surgery

The Turnaround Plan identified the need for specific action around the Orthopaedic waiting list due to the volume and proportion of long waiters. The initial work in the February/March 2020 period focused on the Gartnavel General Hospital site, and on immediate recovery and managing fluctuating theatre capacity. However, this work was stopped at the outbreak of the COVID-19 pandemic.

Since then, additional analysis highlighted variation in the remobilisation of Orthopaedic theatre sessions across different Sectors in NHSGGC following the first wave. This was shared and discussed with clinical teams. Lessons learnt during 2020 will now inform more rapid remobilisation in 2021, as outlined elsewhere in this document.

All Sectors have completed clinical prioritisation of patients on the inpatient waiting list. Regular cross-sector Orthopaedic meetings have been established to agree allocation of capacity with clinical review at senior level to consider list pressures for priority patients.

In addition, P2 orthopaedic patients are being treated in the Golden Jubilee National Hospital.

High Volume Cataracts

Ophthalmology cases consisted of a large part of the patient waits over 12 weeks. Within that, cataract patients account for 70-80% of Ophthalmology surgery. Whilst NHSGGC's service, including the use of the Golden Jubilee National Hospital (GJNH), measured up well against national statistics, there remained opportunities to introduce greater efficiency into the system. The plan as part of the Recovery Plan focused mainly on developing a high volume cataract service at the Vale of Leven Hospital, aiming to deliver 10-14 patients per session.

This approach was ratified by the Escalation Oversight Board on the 19th March 2020. By the end of March 2020, all cataract surgery had ceased across NHSGGC and the plan was put on hold.

Following the outbreak of COVID-19, remobilisation planning in Ophthalmology has focussed on outpatient capacity to manage the volume of new and return outpatients. With funding recently approved by the Scottish Government, the Ophthalmology team have begun implementation of a new model of virtual clinics to enable more rapid assessment of patients with risk of loss of sight. The service will also establish new ways of working with Community Optometry.

The planning work will now move to focus on inpatient and daycase (IPDC) patient management. The initial remobilisation position in the late summer highlighted a reduction in theatre capacity due to

COVID-19 of approx. 40%. The principles for high volume cataract services have been set out and the key issues to be addressed by future plans are:

- **Agree plans for targeted improvement on cataract lists** and trajectories for the reduction of the waiting list
- **Optimising arrangements for cataract surgery** to enhance opportunities for establishing high volume lists
- **Ensuring the opportunities presented by the developments at the GJNH are maximised**
- **Review site delivery** and look to enhance operative arrangements to increase productivity in key locations.

These are well under way and forms part of the remobilisation projections within this Plan.

Clinical Validation and Prioritisation

The recording of clinical prioritisation information has been taken forward for inpatient/daycase activity across all specialties in the last quarter. Following a significant exercise to complete the required prioritisation information on Trak, mechanisms were implemented to ensure that new patients added to the waiting list had a clinical priority assigned at that time. Review of clinical priority information has been applied in cross-sector discussions to review the management of P2 patients. Regular review has been implemented in specialties compromised by bed availability and theatre allocation, with cross-sector agreement on patient management and a minute of actions.

Currently all theatres in NHSGGC have been undertaking Priority 1 and 2 cases in line with the phased prioritisation framework. Robotics (P3) continues. To maximise resources and ensure the most urgent cases managed the following actions have taken forward:

- **Local and NHSGGC wide clinical and managerial review of available capacity**. This is performed daily
- **Oversight given to Chiefs of Medicine of cancer patients** offered alternative treatment to surgery
- **Chiefs of Medicine guiding Clinical Directors to review P2 patient lists** and prioritise patients
- **Specialty session changes at GJNH, Ross Hall and Nuffield Hospitals** enacted regularly
- **GJNH liaising closely for management of urgent cases**. Rapid response with accommodation of all requested patients in the next two weeks.

Outpatient Waiting Lists remain a challenge in terms of recording clinical prioritisation information. With the need to retain Urgent and Urgent Suspicion of Cancer (USOC) information for cancer reporting an additional field is being progressed with Intersystems to facilitate the inclusion of priority information. National guidance regarding recording for Outpatient Department (OPD) on an ongoing basis is awaited.

Specialty validation has been progressed on the basis of Advanced Clinical Referral Triage review with agreed vetting outcomes. Associated revision of clinical pathways e.g. within Gastro has commenced with the intention of applying new guidance to waiting list patients when pathways are finalised.

Access Policy

One of the cornerstones of the Turnaround Plan was to revise the NHSGGC Access Policy to better manage patient choice, clarify what constitutes a “reasonable offer” and re-introduce the “locational unavailability code”. A revised policy approved by the Scottish Government (SG) Oversight Board in March 2020, and the revised policy was approved by NHSGGC’s Acute Services Committee later in March 2020. By following the key principles set out in this Access Policy and defining responsibilities under those principles, NHSGGC sought to ensure equity of service and reduce variation.

Accompanying the proposed revised Policy was an Implementation Plan with defined tasks, accountabilities and actions, focusing on staff training, communications, performance metrics and monitoring arrangements and an equality impact assessment report.

Again, however, the implementation of the revised policy was suspended due to the impact of COVID-19, and particularly the intended Scottish Government application of the "COVID-19 unavailability code".

Current Position

Whilst the majority of the originally agreed actions above have been implemented or partially implemented (and paused due to COVID-19) each action will be considered as part of the remobilisation actions outlined in this document. The Board has exceeded the outpatient activity targets and delivered close to the TTG activity levels outlined in the initial Remobilisation Plan.

7.3. Unscheduled Care

ED performance has been a challenge for the Board, with a return of 76.6% in December 2019. This growth in demand in terms of the number of attendances contributed to the overall performance.

Following Escalation, the Turnaround Director introduced a number of workstreams to ensure immediate focus to develop a Performance Recovery. At the NHSGGC Performance Oversight Board on the 19th March 2020, the group reviewed the projects identified under the Escalation Recovery Plan to agree priorities for continued progression until further notice as a result of the response to COVID-19.

As with the other elements of the Escalation process, the projects agreed at the Oversight Board were paused due to COVID-19, then reshaped to suit the remobilisation agenda and resultant different ways of working. A number of the projects have also been incorporated into the National Redesign of Urgent Care. Outlined below is the position with the Unscheduled Care actions:

Managing Rising Attendances - Professional to Professional Advice

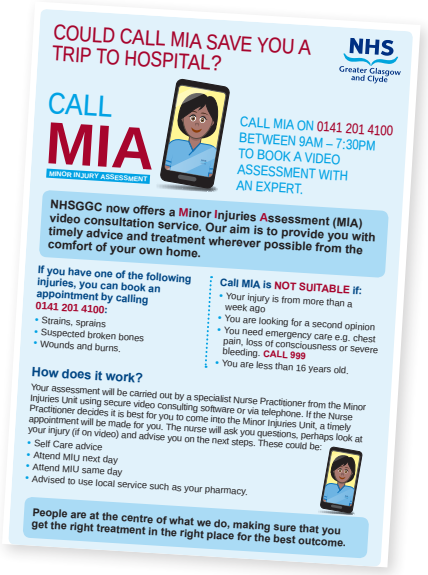
The development of the professional to professional advice service has been delivered from the GRI, RAH, QEUH and RHC. Service provision is delivered via the Consultant Connect software and is now available across a number of specialties and in practice we are delivering direct access routes for GPs using telephone or the mobile app into more than 20 services across NHSGGC. The Board is also in the process of completing the setup of a nurse led service within the Mental Health Assessment Units.

Professional to Professional Written Advice

This service has been developed as an alternative to telephone advice using the planned care Scottish Care Information (SCI) Gateway referral service. The Unscheduled Care Team have worked with eHealth to develop a new referral service that sees written advice from specialties provided within three working days following request from GPs as an alternative to seeking immediate telephone advice. The service was launched at the QEUH with the Department of Medicine for the Elderly on 24th November 2020 as an initial pilot to ensure the functionality and process has been clearly defined. The plan is to produce an initial evaluation paper and develop a roll out plan over the coming weeks to other specialties with sponsorship from the Acute and HSCP Tactical Groups.

Call MIA service expansion - Aligned to Flow Navigation Hub

The initial pilot was established within the North Sector to deliver a virtual service for minor injury patients. As this model was also part of the National Redesign of Urgent Care work it was incorporated into the overall Programme Plan.



Implementation of a designated Virtual Consultation service was delivered in December 2020 with all three Sectors established as potential virtual consultation service providers. The core service is provided directly from Stobhill, Victoria and Vale of Leven MIUs on behalf of their respective Sector and is supported by the Flow Navigation Hub team.

The Board have also now establishing a Flow Navigation Hub to deliver an appointment booking service aligned to a clinical hub to deliver virtual clinical triage and Near Me assessments to provide effective patient streaming and scheduling of urgent care activity.
The aim is to deliver the right care, in the right place, at the right time, for the first time for those who currently self-present at Emergency Departments (EDs). The Centre went live on 1st December 2020, following final agreement by the Scottish Government. Work is now progressing to deliver Phase 2 of the programme focusing specifically on pathway development including Ophthalmology, Gynaecology, Ear, Nose & Throat (ENT), Sexual Health and the Falls Pathway (including care home residents) and Paediatrics.

Signposting and Redirection

The development of a Board wide policy for redirection and signposting at NHSGGC Emergency Departments, to create a consistent message for the public and staff on which conditions we should see and treat at our Emergency Departments has been completed. More broadly, this work was intended to complement the Board and National Redesign of Urgent Care Programme, with the aim of embedding the national and local messaging of right place, right care at the right time.

The purpose of Signposting and Redirection is not to turn attendees away from the ED, but to direct them to another area/service where their healthcare need can be met and minimise the risk to them and others in overcrowded EDs.

The policy is supported by a set of Standard Operating Procedures and a competency framework to complete a comprehensive suite of clinical and operational documentation. Following approval through our internal governance processes, we await further national guidance before implementation can be progressed. We understand that this forms part of Workstream 7 of the 'Building on Strong Foundations' Programme (previously the 6EA Programme) and anticipate progress will be made in the coming months.

Hospital Discharge – Discharge to Assess

Work has continued on the 'Discharge to Assess' (D2A) policy. The policy and Standard Operating Procedure have been developed and approved for implementation and are now live across Acute sites and IJBs. To support implementation a suite of materials has been developed including pop up banners, A4 posters and leaflets.

Adult with Incapacity Peer Review

The proportion of Adults with incapacity (AWI) patients delayed in their discharge who are currently within NHSGGC inpatient beds is disproportionate to the overall number of delayed discharge patients. A project was set up to deliver a peer review process for AWI patients with a view to identify if there is learning and best practice clinical and process guidance that we can establish to ensure our process is as effective and efficient as possible. As there is constant pressure on the system to effectively manage the inpatient capacity across NHSGGC the aim is to ensure that the practice and process adopted is optimised for both patients and the overall health care service.

NHSGGC Unscheduled Care Performance

The Board recorded a sustained improvement between April and September 2020 against the four hour A&E standard across NHSGGC. However it has fluctuated since, specifically as a consequence of the second wave of the COVID-19 pandemic. Winter pressures and the severity of the "2nd wave" have resulted in a decline in performance since December 2020 as hospitals have been challenged to maintain both COVID-19 and non COVID-19 pathways.

Year on year comparisons are difficult within the context of the pandemic however the year to date ED performance to 31st December 2020 was 93.0% compared to 86.0% for the same period to 31st December 2019 for NHSGGC. GGC continues to perform well in comparison to mainland NHS Boards.

Key process changes continue to be adapted, reflecting both the original Escalation related Turnaround Plan, and the more recent Remobilisation Plan, with a constant focus on ensuring flexibility to utilise the resources available across the hospital teams in the most effective and efficient way to maintain safety and continue to deliver high quality care.

There has been a great deal of flexibility demonstrated across the sites and the teams have worked collaboratively to respond to the significant challenges of operating two separate flows to protect patients and staff. As COVID-19 cases remain high, we must continue to find new ways to adapt to the circumstances as the situation develops whilst the vaccination programme rolls out.

7.4. Leadership and Strengthening the Senior Management

In March 2020 the Oversight Board was presented with details of the Board's approach to Collective Leadership and Culture Development in response to escalation and also incorporating learning from the Sturrock Report. Over the last year due to COVID-19 our leadership development priorities shifted to support leaders with their wellbeing and the wellbeing of their staff. All development programmes were also adjusted to online delivery, and some were paused in winter of 2020/21 with the exception of those supporting wellbeing. For example, the Online Half Hour Breakfast Sessions (a series of Emotional Reboot and Sleep Assist sessions) were attended by 340 senior managers and have been highly rated for their practical help.

Many of the activities in the Collective Leadership and Culture plans are progressing, most notably the launch of Investors in People at Inverclyde Royal Hospital, the South Sector Transformation and Engagement Programme and the development of the new Medical Management Programme.

For remobilisation commencing April 2021 the Collective Leadership and Culture Development activities now form part of our new NHSGGC Workforce Strategy. The profile developed in partnership is 'Growing our Great Community'. The Collective Leadership deliverables will be as follows:

- **Following each Sector/Directorate Senior Management Team (SMT) identifying a cohort of emerging leadership talent** at all levels, the development support to these cohorts will follow a tailored programme commencing in May 2021
- **Leadership Visibility**: Director and senior teams will review the most appropriate activities (formal and informal) that enable effective face to face connection and engagement with their staff at all levels and implement any improvements identified. (NHSGGC Sturrock Review Action)
- **The next cohort of Ready to Lead** (NHSGGC Leadership Programme for Middle Managers) will commence in September
- **The new Medical Management Programme** will commence in April and run every quarter thereafter
- **The leadership development programme for the Corporate Management Team** will be reviewed and expanded to Directorate SMTs by end 2021.

With regard to Culture Development:

- **The Investors in People launch at Inverclyde Royal Hospital** will produce a site development plan commencing in March 2021 and the three year roll out across other NHSGGC sites will commence following IRH site accreditation
- **'Civility Saves Lives' and Joy in Work initiatives** will be widened in their application across NHSGGC
- **Our new Head of Staff Experience is leading on cascading collaborative conversations** ensuring that all our staff have a voice
- **An online system for capturing, learning, and spreading improvement** from successful initiatives will be developed and piloted
- **Our Health & Safety Culture** programme be finalised and launched
- **There will be further embedding of Succession & Career Planning** in each Directorate.

The Board had acknowledged the need to strengthen the senior management team in 2019, before Escalation, due to the multiple demands on the team, and in order to ensure the Senior Management team had the ability to address the current challenges in a robust and constructive manner.

Following Escalation, and the establishment of the Turnaround Plan, these proposed changes were documented, reported and accelerated. The progress and position can be summarised as follows:

Service Delivery

A Director of Access post was created, and an appointment made. That individual left the Board in early 2020, and an interim has been appointed and a team established to support scheduled care planning and performance.

Integration

An Interim appointment has been made to the post of Director of Primary Care.

Wider Acute Division

Within the Acute Division, a new Acute Nurse and Medical Director (Deputy Nurse and Medical Director – Acute Services) have been appointed. In light of the very significant challenges within the Acute Division at present, the Acute Medical Director has agreed to reduced his clinical commitments for the next period to ensure enhanced clinical leadership is available. Additional Business Manager support has also been made available to the Chief Operating Officer.

In addition, the Acute Division Directors have been realigned with a senior Director being seconded into the MFT programme and a number of the remaining Directors being moved to alternative Sectors/ Directorates to strengthen operational delivery.

Delivery of Change

Communications/Public Engagement

The process to appoint a substantive Communications and Engagement Director was concluded, followed by a Deputy Director. Additional senior communications support was recruited to assist the current team. External support was also provided from the Board's external training provider.

The team has been further strengthened through the expansion of the press team and the realignment of resource to support internal communications. With regard to public engagement, the Head of Service has moved on and arrangements are underway to recruit to this role. The Consultation Institute are also currently working with the Director on a programme to develop the team and support the delivery of the Board's strategy.

Quality/Person Centred Care

In order to enhance the Board's capacity in this area, a Deputy Director of Nursing has been appointed to increase the management capacity in this important area.

Support Arrangements

Finance and Performance

Three Deputy Directors of Finance have been recruited, together with a new Head of Financial Improvement Programme.

Estates and Facilities Directorate

Within the last few months, the Director of Estates and Facilities has reviewed the structure within the Directorate and a number of senior Estates posts have been advertised and appointments made to strengthen the operational and governance aspects of this Directorate. An Assistant Director of Estates has also been appointed to enhance senior leadership in this area. All posts have been incorporated into the existing Estates and Facilities resource.

Support for the Head of Corporate Governance and Administration

As outlined above, there is a very significant workload associated with the ongoing Reviews, Oversight Board, legal claim and Public Inquiry. In order to ensure this work is addressed timeously and in a responsive manner, a Project Management Office (PMO) has been established under the auspices of the Head of Corporate Governance and Administration. Two staff have been seconded into this office and an additional senior manager has also been seconded to ensure the routine business of the Board is maintained in an effective manner. The Executive Group are currently reviewing this position as further bolstering of the team is required.

Employee Experience

The Board also reviewed its approach to Culture and Collective Leadership through the development of the Culture Framework. To support the delivery of enhancing our employee experience the Human Resources and Organisational Development Team have appointed a Head of Staff Experience.

In summary, NHSGGC continues to face a number of very significant challenges, not least a significantly high number of COVID-19 positive patients.

In order to ensure appropriate senior leadership capacity is available, the above actions have, and are being, implemented at present with a view to ensuring stability and sustainability over the medium and longer term. The changes outlined above relate to the original Escalation Recovery Plan, and as such, COVID-19 related recruitment has been omitted.

The majority of the changes will be absorbed by realigning existing budgets. However, recurring additional resource will be required in relation to a number of the senior posts and, once the precise nature of these posts is finalised, full details of the proposed additional requirement for the senior posts is reported through the Remuneration Committee and Finance, Planning and Performance Committee.

8. Planned Care

Key Points

- Clinical Prioritisation of care will continue to direct use of resources
- Optimum arrangements for service configuration are being progressed
- External capacity essential to address reduction in waits.

8.1. Principles and Assumptions

In May 2020, NHS Scotland published Re-mobilise, Recover, Re-design setting out the framework for recovery of services affected by the COVID-19 pandemic. The essential principles as they relate to acute services are:

- **Maintain surge capacity for COVID-19**
- **Build on and maintain new and effective ways of working**
- **Manage the backlog and minimise harm**, including the impact of unmet need
- **Manage COVID-19 and non-COVID-19** unscheduled care demand.

In November 2020, Scottish Government published its Clinical Prioritisation Framework, which gives further guidance on how clinical prioritisation can be implemented. Key components of this document are:

- **Prioritisation on the basis of nationally-agreed criteria** for surgery, endoscopy and diagnostic imaging
- **Active review of waiting lists**, using ACRT and ensuring realistic medicine applications (such as EQuIP and Patient Initiated Review (PIR)) are applied consistently. This active review would allow for re-prioritisation of patients based on symptoms and length of wait as well as existing clinical criteria.

As we move into 2021/22, we expect capacity will remain below pre-COVID-19 levels for the foreseeable future for the following reasons:

- **Staff absence** due to the need for self-isolation, new infection and long-COVID
- **Backlog of staff leave** and essential rest for staff
- **Need for infection control measures** including social distancing in clinical areas
- **Need for pre-procedure testing**, requiring re-deployment of staff for this purpose
- **Requirement to separate elective and emergency pathways** and staff
- **Restrictions relating to airborne precautions** for Aerosol Generating Procedures (AGPs).

In addition to these known factors, experience from the first recovery phase in 2020 shows there will be increased complexity of emergency presentation with patients seeking attention for conditions that they may otherwise have presented with at an earlier stage.

This and the need for testing and isolation at the front door can be expected to place an additional demand on unscheduled care and hospital capacity. Further loss of hospital capacity will result from the inevitability of outbreaks of COVID-19 in hospital wards, despite universal front door testing, with loss of available beds due to infection control restrictions. These known risks mean that plans for recovery of scheduled (planned) care need to be closely linked to unscheduled care planning.

In September 2020 NHSGGC Acute Division set out more detailed plans for elective care during remobilisation and any subsequent waves of COVID-19 admissions focussed on:

- **Maintaining outpatient activity**
- **Establishing green pathways/sites**
- **Maintaining urgent and essential surgery** including trauma

Urgent and Essential Surgery: Oct 2020
P1 emergency, trauma and cancer - all specialities
P2 cancer patients - all specialities
P2 benign patients - all specialities
Semi-urgent emergency and trauma - all specialities
Transplant surgery - live deceased donor programme working as per National Guidance
Neurosurgery: emergency P2
Spinal and Spinal Injury Trauma
Vascular surgery: emergency cases
Cardiology: emergency cases
Assisted Conception Services

- **Maximising existing capacity for elective surgery** (through use of Ambulatory Care Hospital (ACH) sites, Day Surgery Units and extending NHSGGC activity at GJNH)
- **Developing intermediate surgery** at ACH sites
- **Adopting a consistent, coordinated and flexible approach** across NHSGGC.

Our medium/longer strategy for elective surgical care will build on this approach taking account of a number of challenges unique to the current situation:

- A significant **high volume of patients on all new patient waiting lists**
- A number of **new patients waiting more than 52 weeks**
- **Reduced capacity for management of return outpatients**
- **Continued limitations to service delivery** from managing COVID-19
- **Elective service capacity that is significantly restricted**.

Our elective strategy for NHSGGC will strike a balance between centralised and distributed care whilst making optimum use of the current facilities. In this way NHSGGC will deliver improvements in efficient service delivery.

Proposals for optimal use of facilities will build on the positive improvements seen to date; for example, knee and hip replacement surgery established at Stobhill ACH. We will continue to use models of care with proven results, underpinned by enhanced medical and nursing staffing models that begin to explore extended working days and/or six day working. The key areas of this medium/longer term strategy are:

- **Transforming care through widespread use of clinically agreed patient pathways standardised across NHSGGC**, that make best use of the entire workforce and avoid unnecessary referral into services
- **Continuation of cross-sector arrangements established for COVID-19** and support for cross-sector management of waiting lists, with available capacity focussed towards the highest priority patients and those waiting more than 52 weeks
- **Optimised arrangements for surgical services on GRI, QEUH, RAH and IRH sites** that facilitate green pathways and provide capacity for the highest priority and most complex surgical patients

- **Completion of the Trauma implementation plans** in Clyde Sector
- **Development of designated sites for intermediate surgery**. This requires sustainable staffing models of overnight medical cover and ERAS ward care to be put in place
- **Support for theatre and surgical teams to establish elective surgical hubs** for specific activity where this is relevant and appropriate, e.g. Cataract, some Orthopaedics
- **Further support for increasing day surgery** at designated sites
- **Continuing use of GJNH for Orthopaedics and Ophthalmology** with service-level agreement (SLA) activity increasing for 2021/22
- **Use of Private Sector capacity** when this is available at any point in the year.

This will all be underpinned by strong clinical leadership and cross-sector/specialty collaboration supporting the development and implementation of robust specialty plans.

In recent years the Scottish Government has provided significant non-recurring investment to support improvements in outpatient and inpatient waiting times. NHSGGC will continue to require a significant level of investment in 2021/22 to deliver the levels for elective activity required for recovery, recognising the Board is starting from a challenging position.

8.2. Outpatient Services

Key Points

- All services to maintain 80% pre-COVID-19 activity as a minimum throughout 21/22; use of remote consultation is essential
- Outpatient prioritisation core recording to be implemented to support urgent patient management
- NHSGGC has been at the forefront of many national workstreams to remodel and transform patient pathways; this will continue to be encouraged and supported in 2021/22
- Key pressure areas will have a clinically led recovery plan.

The Outpatient Waiting List and Outpatient Activity:

As at 1st February 2021, there are 93,493 new outpatients on the new outpatient waiting list (OPWL); of these 53,986 new outpatients have been waiting more than12 weeks and 9,617 patients waiting more than 52 weeks.

The current number of patients waiting over 12 weeks is comparable with figure reported in the July 2020 NHSGGC Remobilisation Plan; however, since July 2020 the overall waiting list has risen by 17% and most significantly the number of patients waiting over 52 weeks has risen significantly.

Throughout the last year NHSGGC has delivered a large volume of outpatient activity with many positive changes made by services to maximise activity. For example, Chronic Pain services had already transformed the way services are provided with the introduction of their Early Information Sessions; COVID-19 has seen this programme and the Pain Management Programmes transfer successfully into group on-line sessions.

Another example is the development of centralised supporting arrangements such as the Phlebotomy Hubs supporting all services to manage patients virtually wherever possible. Over the medium term the introduction of 'Results-Plus', where patients may have access to lab or imaging and responsibility for their own follow up arrangements, could build on this principle of reducing unnecessary attendance at hospital, providing more flexible healthcare and giving patients more control of their own care.

Urgent and urgent suspicion of cancer referrals have continued to be seen at all times, with services adapting to meet the demand; for example, Gynaecology services have increased capacity for Colposcopy clinics to manage an increase in demand.

New outpatient activity has steadily increased throughout the year with many services returning to 80% of pre-COVID-19 levels by December 2020. It is predicted most services will remain at 80% of pre-COVID-19 new outpatient monthly base activity during 2021/22, with the exception of a small number of services with particular infection control challenges; for example, ENT and Dental.

Referral rates into services have not yet returned to 2019/20 levels, with 2020/21 total new outpatient referrals predicted to be 30-40% lower than 2019/20. Whilst it can be expected that new outpatient referral rates will continue to rise in 2021/22, it is not predicted they will fully return to levels seen in 2019/20.

Much of the work being led by the national Scottish Access Collaborative and Modernising Patient Pathways Programme is aimed at addressing this capacity/demand mismatch by promoting new ways of working. NHSGGC has, and continues to be, an active participant of these programmes often leading the way in new approaches. The pandemic has seen these principles implemented at pace and there is opportunity to continue to build on these successes.

Remote consultation

The use of remote consultations has become routine within NHSGGC. Telephone consultation has been the most widely employed and appears to have been well accepted by staff and patients. Already approximately 50% of appointments are carried out remotely and building on this level is a key aim, however it is accepted that face to face consultations will continue to be required for some patients. Near Me consultation are also being undertaken.

Patient Initiated Review (PIR)

PIR is an established follow up process in some specialties and there is significant potential to extend this. The process requires administrative systems that allow patients rapid access to clinical teams in the event of deteriorating symptoms or other clinical triggers but can remove the need for routine appointments with limited or no clinical gain. Each specialty will have specific patient groups for whom this approach is best applied.

Active Waiting List Management

Patients on outpatient waiting lists for some months may have symptoms that have now resolved or indeed worsened so that active review (involving patient contact) is required. Different specialty specific models for patient review are being explored. For certain well-defined groups there is the opportunity to develop further the national “EQuIP” model developed in NHSGGC where patients are sent information about the condition involved and offered “opt-in” appointments. This is being actively explored for patients with reflux-predominant dyspepsia as one component of the Gastroenterology ‘Bringing it Together’ programme. This requires a whole of system approach with involvement of primary care and secondary care colleagues in pathway re-design.

Active Clinical Referral Triage

ACRT was devised and initially implemented within NHSGGC and has been widely accepted by clinical teams as the model for management of new referrals into secondary care. Key to widespread implementation of pathway re-design associated with ACRT is the current work underway with eHealth colleagues to update the TrakCare interface to more accurately capture the ACRT options at the point of triage.

Clinical Prioritisation of Patients

Throughout the COVID-19 pandemic clinical teams have regularly reviewed their outpatient waiting lists and prioritised patients in line with national guidance. Recording of outpatient priority on TrakCare remains a manual process which limits use of the data for decision making and performance monitoring. NHSGGC has made representations to the national group involving the TrakCare supplier (Intersystems) to seek a resolution to this manual approach in a way that does not interfere with cancer tracking or Patient Focussed Booking. It is hoped a solution will be found and implemented at the earliest opportunity.

Joint Approaches with Primary Care

The programme of work outlined above describes review and redesign across all acute specialties within NHSGGC. It is essential that this work is taken forward in conjunction with Primary Care services in order that pathway changes work seamlessly for the patient.

Arrangements will continue to be reviewed to ensure structures facilitate active engagement across Primary and Secondary care and support rapid pathway redesign.

Outpatient Plans for 2021/22

The following programmes of work are being progressed to ensure core outpatient capacity is maximised throughout 2021/22:

- **Continue to engage nationally to resolve recording of the outpatient priority on TrakCare**
- **Implement recording of priority during 2021/22** and use for monitoring and performance management of waiting times for the most urgent patients
- **Use prioritisation data** to inform improvement plans with individual specialties
- **Continue to maximise use of ACRT (Active Clinical Referral Triage), PIR (Patient Initiated Review) and Virtual Patient Management (VPM)** across all specialties within NHSGGC services, and undertake targeted work with specialties who have been slower to adopt new practices
- **Use the recently completed specialty capacity plans** to identify where core capacity has traditionally been unable to meet the demand seen, and use to inform discussion with specialties to identify opportunities and plans for redesign
- **Explore solutions and set out robust specialty plans to address the highest volume of long waiting outpatients**, and those with the longest waiting times; an example of this would be Dual-Energy X-ray Absorptiometry (DEXA) redesign between Medicine and Radiology
- **Consider learning from use of the 'Bring it Together' improvement model** in Gastroenterology and agree where this can be adapted for other NHSGGC specialties
- **For Orthopaedics, Urology and General Surgery NHSGGC will progress a cross-sector approach** to addressing the longest waiting patients
- **Develop a plan for ENT**
- **Implementation of an Ophthalmology Hub** from early 2021/22 providing testing to support virtual patient management. Joint working with Community Optometry teams
- **Use our engagement across specialties to identify and progress where extended practitioner roles can further support** typically consultant led activity
- **Continue to strengthen and develop arrangements between Primary and Secondary Care** and ensure all work is inclusive, well-coordinated and appropriately supported
- Supported by non-recurring Scottish Government resource **continue the use of waiting list initiatives for targeted specialties**
- **Explore opportunities in conjunction with the Scottish Government of Insourcing for priority specialties** complementing the agreed specialty delivery plans
- **Work with national teams to ensure national communications complement the new approaches to patient management** and reflect the scale of the challenge ahead.

8.3. Endoscopy

Key Points

- Accessing additional and maintaining maximum capacity is imperative
- Implementing agreed revised patient pathways is essential
- Planning for sustainable increase in provision is necessary
- Aim to maintain 55% activity in Q1 rising to 70% in Q4.

Endoscopy waiting lists have been significantly impacted by COVID-19. During the first wave, all but essential endoscopy was discontinued and capacity has continued to be significantly reduced for infection control reasons and the necessary redeployment of endoscopy nursing staff to support pre-procedure testing.

The Endoscopy Waiting List and Activity

Currently there are approximately 8,700 patients on the new Endoscopy waiting list. The new waiting list has continued to grow at a pace of circa 4% month on month since July 2020; increases are across the various scope types with some slight reductions in patients waiting for double procedure in recent months. Capacity for diagnostic Endoscopy appointments is now circa 59% of pre-COVID core/base capacity.

The key priority for Endoscopy will be to increase provision and also ensure protection as far as possible from any future COVID-19 waves, allowing the service to increase capacity and activity wherever it is safe to do so, in line with social distancing and infection control requirements. Referral rates August 2020-January 2021 are increasing approximately 4% per month.

Clinical Prioritisation

Endoscopy leads across NHSGGC have agreed a prioritisation framework to facilitate triage of new patients. This has involved the co-design of a new lower gastro intestinal (GI) referral pathway with Primary Care using Quantitative Faecal Immunochemical Test (qFIT) to determine the need for and urgency of colonoscopy. Work is ongoing to re-vet the existing colonoscopy waiting list to apply the same principles.

Work on the re-design of the upper GI referral pathway is at an advanced stage. This has potential to appropriately remove many patients from existing waiting lists with a clinical plan and ensure that upper GI endoscopy is used only where is will have clinical benefit.

Additional Sessions: Waiting List Initiatives (WLIs) and External Capacity

WLIs restarted in October 2020 extending the delivery of appointments across NHSGGC to Saturdays. This additional capacity will continue for the foreseeable future.

The Golden Jubilee National Hospital are continuing to support NHSGGC endoscopy lists. The overall patient numbers remain lower than pre-COVID-19 levels.

NHSGGC was dependent on external capacity and WLIs to support endoscopy demand prior to the pandemic and this will require to be continued until capacity is restored and the backlog of patients has been worked through.

New Services

NHSGGC working in conjunction with the Scottish Government began to implement alternative types of investigation during the latter half of 2020:

- **Capsule Colonoscopy (CCE):** A new modality to investigate the colon at present used in around 80 patients per month. NHSGGC is currently closely observing the clinical outcomes following each investigation in order to understand the volume of patients requiring further investigation following CCE
- **Cytosponge:** A validated outpatient procedure for Barrett's screening which can also be used as an alternative to upper GI endoscopy for patients with long-term reflux disease
- **Transnasal Endoscopy (TNE):** An outpatient procedure without sedation where a thin endoscope is used to examine the oesophagus, stomach and duodenum. Biopsies can be taken and no open suctioning is used. The reduced patient recovery time means more patients per sessions are able to be seen.

These services were launched during December 2020 and January 2021. Training will continue for clinicians across NHSGGC to expand the provision, however more widespread utilisation of Cytosponge and CCE will require to be supported by a national IT solution.

Recruitment and Staff Training

Endoscopy services have a clear career structure in place for nurse staffing. Proposals will be put forward by early 2021/22 for a new Training Academy approach that, through new recruitment and accelerated training, will significantly augment the Endoscopy workforce over the medium term.

Maximising Available Facilities

Options for expanding utilisation of the physical capacity over seven days in a sustained way are being explored. Increasing capacity can only be achieved by a step change in base activity. A range of options are being explored including insourcing options, mobile unit and/or modular building options, any other fallow area within NHSGGC.

Endoscopy Plans for 2021/22:

- Continue work on **clinical prioritisation and use of qFIT**
- **Continue to support WLIs** and maximise use of all available capacity at the GJNH
- **Continue to expand** the introduction of the new services
- **Develop proactive recruitment and training programmes**
- **Explore potential** in the following areas:
- Increasing base staffing to support standard use of units out with core hours on a non WLI basis.
- Opportunities to **run Endoscopy activity in fallow theatres**
- **Significant increase in the capacity from GJNH**, with operators from GJNH
- **Additional capacity from modular provision** for an extended period
- **Expanding diagnostic assessment provision** for a range of services through development of centralised unit(s)
- **Other insourcing options and/or use of Private Sector** (e.g. Nuffield, mobile unit).

8.4. Radiology

Key Points

- Additional capacity in US, CT and MRI will be essential
- Service redesign and extended roles will support recovery.

Prior to COVID-19 Radiology Services were experiencing higher demand than the capacity available. This has been compounded by the restrictions in place for social distancing and red/green pathways which reduces the number of patients able to be scanned, particularly for ultrasound. Notwithstanding these challenges NHSGGC has made significant progress in reducing the numbers of patients waiting over six weeks for MRI and CT.

Remobilisation plans in Radiology Services address two key areas: the continuing backlog of patients waiting for the three key modalities (CT/MRI & U/S), and responding to new areas of development as services redesign as a result of the COVID-19 pandemic; for example, new inpatient pathways requiring imaging.

Prioritisation and Core Radiology Capacity

During 2020/21 the radiology service has adopted a range of new approaches in line with national guidance and supported implementation with a comprehensive training programme for all staff. This investment in staff training will continue throughout 2021/22.

Where possible Radiology Services are exploring extended working patterns; for example, Sonographers at West Glasgow Ambulatory Care Hospital (WACH) are currently piloting an extended working day (8.00am-6.00pm) to help reduce waiting times. Where extended working is possible this requires additional staff trained in MRI, backfill of current duties to enable release of staff, and funding to support a Band 6 practise educator role. However there remains a need to increase the core scanning base across NHSGGC for both CT and MRI. This has resource implications in terms of capital, ongoing maintenance, and staffing costs.

There are a number of specialist areas facing particular challenge including Paediatric MRI patients requiring General Anaesthetic, Cardiac scanning and DEXA scanning. Specific plans will be drawn up in conjunction with clinical teams during 2021/22 aiming to put in place longer term sustainable solutions for these issues.

Additional Capacity

Additional capacity has been provided in 2020/21 through waiting list initiatives, clinics at the Louisa Jordan and mobile MRI/CT vans.

At present the Louisa Jordan provides NHSGGC with 68 contrast and 30 non contrast patients per week; from February 2021 this will be expanded to include an additional 80 ultrasound patients per week.

In 2020/21 NHSGGC has been supported with an MRI staffed van at the QEUH and GRI which has assisted in reducing the waiting lists in MRI. In January 2021 the MRI van at GRI was replaced with a staffed CT van which will provide additional capacity through to the end of July 2021. The Scottish Government is considering the placement of the mobile unit in NHS Tayside and the two CT pods in the Louisa Jordan with discussions underway. Any additional capacity would be greatly valued and NHSGGC will continue to work closely with the Scottish Government to explore all possibilities to secure this.

Additional capacity is also being developed through new and extended staffing roles. Throughout 2020/21 Radiology teams, with the support of partnership colleagues, have established a range of approaches to develop staff skills and use Teams in new and innovative ways. Further developing training opportunities across a range of roles during 2021/22 will help to support recruitment of Radiology staff.

Radiology Plans for 2021/22:

- **Continue work with Primary Care to look at patient pathways, guidelines etc**, in particular addressing the category 4 non urgent GP referrals
- **Evaluate the current pilot of Sonographer extended working** for effectiveness and impact on waiting times further rollout would be resource and staffing dependent
- **Consider options to increase the scanning base across NHSGGC for both CT and MRI**. This would require additional scanners based in the ACH and is resource and staffing dependent
- **Develop specialty plans for Paediatric MRI patients requiring General Anaesthetic**, Cardiac scanning and DEXA scanning
- **Continue to make use of the Louisa Jordan facility for as long as it is available** and continue to work closely with the Scottish Government to explore all possibilities for mobile scanning facilities to augment capacity
- **Support the use of waiting list Initiatives** for all modalities whenever possible
- **Increase use of Sonographers in musculoskeletal (MSK) soft tissue ultrasound scanning** supported by a MSK radiologist training programme
- **Build on the successful approach developed in 2020/21 training two Radiographers** to undertake barium fluoroscopy work.

8.5. Cancer

Key Points

- Urgent cancer surgery will continue to be prioritised
- Continued implementation of plans for specialty pathway redesign and local access to SACT
- Developments for robotic surgery will be taken forward.

Current 31/62 Day Cancer Performance

NHSGGC has strived to maintain as much of our cancer services as possible during COVID-19. Since November 2019 NHSGGC has consistently exceeded the 95% 31-day standard. Performance against the 62-day standard has improved in 2020 although the most challenging cancer pathways continue to be Colorectal, Lung, Upper GI and Urology.

The majority of cancer surgery continues to be booked in line with target timescales, as defined by surgical prioritisation categories. Improvements in waiting times for robotic Urology surgery, a tertiary service provided by NHSGGC for the West of Scotland, have been demonstrated with additional weekend sessions from August to November 2020.

USOC referrals rates returned to pre-COVID-19 levels in late 2020. Referrals for some pathways, specifically symptomatic Breast and Colorectal, are now significantly higher than pre-COVID-19 levels. Lung USOC referrals continue to remain around 60% of pre-COVID-19 levels; this is reflected nationally and work will continue into 2021/22 both locally and nationally to raise awareness of symptoms with both Primary Care and the general public.

Systemic Anti-Cancer Therapy (SACT) and radiotherapy activity has continued to increase. By mid-December 2020 overall demand for SACT had returned to pre-COVID-19 levels, with an increase in demand above pre-COVID-19 levels from some tumour types.

Managing the cancer pathway is intrinsically linked to the wider inpatient and daycase capacity across NHSGGC. The plans for cancer outlined below are in addition to the wider actions for inpatient and daycase activity.

Cancer Plans for 2021/22

In addition to maintaining and increasing theatre capacity for cancer services the cancer plans for 2021/22 include:

- **Implementation of prostate cancer diagnostic pathway improvements**, including launch of MRI-fusion biopsy to ensure sustainable provision of targeted biopsy
- **Progress work to significantly shorten time to diagnosis for lung cancer** with the roll out of virtual clinic models across NHSGGC and consolidation of diagnostic pathway
- **Continue the review of cancer pathways**, specifically considering positive innovations that have emerged as a result of COVID-19 pandemic
- **Further develop advanced practice roles across cancer types and specialties** to provide sustainable services fit for future
- **Continue to implement the recommendations of the West of Scotland SACT strategy**, expanding local access to SACT in a tiered care model
- **Work with West of Scotland (WoS) and national partners to plan for and implement Scottish Government policies** around expanding MRI-guided radiotherapy
- **Extend robotic surgery** in NHSGGC.

8.6. Inpatients and Daycases

Key Points

- Clinically urgent patients will continue to take priority
- Maximising available capacity and improving efficiency is essential
- Additional capacity at GJNH and other supporting options will be necessary
- Aim to deliver 50% activity in Q1 moving to 70% in Q4.

Current Waiting List and In-Patient Recovery

Currently there are approximately 25,000 patients on the inpatient waiting list; of around 17,500 patients have been waiting over 12 weeks with a number of patients have been waiting lengthy periods to be seen.

The overall number of people on the waiting list has remained steady since July 2020 and the total numbers of people waiting more than 12 weeks has reduced by 15%, however the number of patients waiting over 52 weeks has increased significantly.

Inpatient waiting times will take many months or years to recover to pre-COVID-19 levels. The biggest impact has been on patients waiting more than 39 weeks which has increased to approximately 35%. Managing this cohort of patients on existing waiting lists will need to be balanced against the need to accommodate new urgent and semi-urgent referrals. The principles we are adopting are set out below:

Clinical Prioritisation

All services are using the nationally agreed criteria to prioritise patients on the waiting list and processes are in place to ensure this is consistently applied. Active waiting list management throughout 2021/22 will take account of re-categorisation of patients depending on length of wait or changing clinical condition; this will be a major challenge for clinical teams and represents an additional workload to monitor that will have to be balanced against other priorities.

Maximising Use of Available Capacity: Theatre Efficiency and Patient Preparation

NHSGGC will maintain its focus on making best use of existing theatre capacity: theatre start and finish times, theatre list planning and avoidance of late cancellations. Matching anaesthetic resource to surgeon availability will be required to avoid unnecessary cancellation and this may involve re-balancing of resource across sectors or new posts where it can be demonstrated that this is justified as part of a team service planning exercise in anaesthetics and surgical specialties.

Theatre activity benchmarks will be agreed with teams and closely monitored to ensure teams are supported where necessary to meet agreed standards.

COVID-19 considerations make effective and efficient pre-operative assessment even more critical to avoid cancellation of surgery, particularly late cancellations. All Sectors are in the process of reviewing how they deliver pre-op assessment. High risk anaesthetic clinical assessment will be reviewed for potential expansion to ensure patients are optimised for their operative intervention, and teams will continue to focus on developing an ERAS approach to care to further optimise pre-op management.

Patient testing will remain in place and it is expected this will this be required for the foreseeable future. As such this requires a sustainable approach to staffing and delivering testing for elective activity in excess of 1,200 cases per week. The solution will need to avoid reliance on elective staffing used for testing in order that capacity is not lost from delivering the elective programme.

Additional Capacity

Additional capacity will be required across all surgical specialties and the need for this is likely to extend into 2022/23. This will be achieved in three ways:

- **Increasing the efficiency of available capacity** (as described above)
- **Extending the use of ACH facilities across NHSGGC** to incorporate six day working and seven day overnight medical and nursing cover
- **External capacity through use of GJNH** (or private sector providers, if available)

The availability of elective beds on acute sites will always be a limiting factor in maximising the use of these facilities or extended day/week working. Non-acute sites and ACHs offer the opportunity to protect these sites as "green" facilities, extend the range of procedures that can be offered on these sites and increase the days when more complex procedures can be undertaken. This will require additional staff to support the extended working week.

During the pandemic the range of procedures undertaken in ACH facilities has grown to include arthroplasties and more intermediate surgery but there is scope for additional progress in this area. NHSGGC was working on improving day surgery rates before the COVID-19 pandemic and recovery will require renewed focus on the use of in-patient beds. It is anticipated that most intermediate surgery could be channelled through ACHs as day case or 23hr procedures. The increased use of local anaesthetic lists where appropriate could free anaesthetic resource to support GA lists. This is relevant to orthopaedics, plastic surgery and general surgery.

Given the volume of patients waiting for surgery in NHSGGC, the capacity available at the GJNH will be essential to recovery.

Protecting 'Green' Pathways

Throughout the third wave of the pandemic, elective surgery continued on non-acute sites within NHSGGC. Green pathways were also maintained within acute sites, until the very high rates of community and hospital infection led to a brief pause in service. Separation of elective and emergency patients will remain essential and some re-organisation of in-patient bed and staffing arrangements may be necessary. Maintaining 'green' High Dependency Units (HDUs) is essential and will require additional resource to support the volume of patients.

EQUiP, Realistic medicine

The EQuIP in surgery was developed and first implemented in NHSGGC and now extends to four surgical conditions. There is considerable scope to extend this work to include other routine conditions across other surgical specialties; this will be explored further in 2021/22 as part of a whole of system pathway re-design alongside the out-patient recovery plan.

Staff Training, Recruitment and Retention

NHSGGC will continue to take a proactive and innovative approach to staff recruitment across all staff groups. Non-recurring funding in 2020/21 has supported a number of proleptic appointments and this proactive approach will continue in 2021/22.

To further develop staff there is an urgency to putting in place new innovative approaches to staff training and recruitment, for example in theatre staffing where an 'Academy' type model has begun to be outlined. This approach will aim to support the development of new and existing roles; for example, Advanced Scrub roles in theatres enabling greater flexibility regarding the type of activity that could be covered in sessions, and Band 4 theatre roles.

In addition there is opportunity to review and, with appropriate resource identified, to extend ERAS and ward based level 1 support with a view to reducing length of inpatient stay and prevent delayed discharge from HDU.

Long Waiting Patients: Orthopaedic Recovery

Orthopaedics has the highest volume of patients on the inpatient waiting list; approximately 7% of Orthopaedic patients waiting are priority 2 and over 60% priority 4. NHSGGC will continue to build on the developments in 2020/21 and further develop the surgical hub approach to optimise surgery. Specific sub specialty plans are being implemented and will be further refined throughout 2021/22; for example, spinal surgery.

Inpatient and Daycase Plans for 2021/22

- **Continue to focus on P1 and highest priority P2 cases** in the early part of 2021/22
- **Re-establish 'green pathways'** and support the rapid recovery of theatre services
- **Focus on theatre efficiency** to help maximise capacity and augment capacity with waiting list initiatives and/or extended working where this is possible
- **Continue to develop specialty specific improvement plans** in areas with high volumes of patients waiting list and/or longest waiting patients, with particular focus on Orthopaedics exploring optimum site delivery and the creation of a protected green site for Orthopaedic surgery
- **Increase day management of patients** and further develop the use of SACH and Victoria Ambulatory Care Hospital (VACH) for intermediate surgery
- **Enhance staffing arrangements**; for example, maximally recruit to theatre nurse staffing posts, use of proleptic anaesthetic appointments, proactive recruitment to limit operative gaps (including Flying Finish), increase base provision for multi-surgeon required operating for complex cancer delivery
- **Redesign of pre-op assessment and pre-admission management** of patients
- **Maximise use of the available activity agreed under the 2021/22 SLA with GJNH** and run additional activity wherever possible (including other Private Sector providers)
- **Ensure appropriate theatre equipment and instrumentation provision** to support increased activity
- **Run additional sessions**: increase of base sessions where physical theatre capacity is available, establish weekend working on chosen sites to generate targeted additional capacity encompassing specific cancer activity and explore insourcing provision
- **Accelerate staff training and staff recruitment** programmes
- **Continue to support cross-sector specialty working**
- **Review specialty capacity plans**.

8.7. Hospital Paediatrics and Neonatology

Key Points

- Clinically urgent patients will continue to take priority
- Capacity will be maximised to help address longest waiting patients.

In 2021/22 the remobilisation of services will continue to focus on the provision of safe and innovative care for children across NHSGGC and the WoS.

Throughout 2020/21 Hospital Paediatrics and Neonatology have gradually remobilised services and are currently delivering the elective programme to a level of weekly theatre sessions and outpatient activity comparable to 2019/20. All current elective capacity is prioritised on patient need.

To support remobilisation clinical teams within RHC, we have developed a website and App providing patients, carers and visitors to RHC with easily accessible information about visiting the hospital for inpatient and outpatient services, local health resources and what to do if your child is unwell. A health professionals' toolkit has been built into the pre-existing guidelines site. This includes information on acute and outpatient referrals, a guide to clinical services within RHC, and patient safety netting and discharge information. The patient information has been developed in collaboration with Primary Care and is available to all health professionals.

Hospital Paediatric and Neonatology Plans for 2021/22

The specific programmes of work and priorities for Paediatrics in 2021/22 include:

- **Implement a paediatric model within the GGC Unscheduled Care Flow Navigation Hub** and continue to prepare Winter Plan for 21/22
- **Implement the West of Scotland Major Trauma Centre**
- **Continue the review of outreach clinics** across Scotland
- **Continue to provide green patient streams and focus on delivering full paediatric theatre complement** extended to MRI and other diagnostic modules as well as Beatson Oncology Unit outreach
- **Continue to respond to COVID-19 through the weekly pandemic planning meeting** led by Immunology Infectious Disease senior medical team
- **Implement a new Plastibell Service** helping to address the longest waiting patients in Paediatric Surgery
- **Develop specific plans in specialties with longest waiting patients**.

8.8. Maternity

Key Points

- New approaches that optimise use of Virtual Patient Management will continue to be supported and developed.

Throughout 2020/21 Maternity Services in NHSGGC have continued to deliver safe care to women across GGC focusing on person centred care. There has been adoption of the use of Near Me and virtual technology across the service, and the introduction of the Outpatient Induction of Labour (OP IOL) has reduced antenatal length of stay by up to 48 hours.

Maternity Service Plans for 2021/22

The key programmes of work and priorities for 2021/22 include:

- **Continue to implement Best Start**
- **Continue to deliver the Home Birth Service, Community Maternity Units (CMUs) and midwife led birthing options** to improve choices for women
- **Continue the roll out of Home Blood Pressure Monitoring**: currently 37% are completed at home; this has potential to increase to 42% in 2021/22
- **Continuing with Outpatient Induction of Labour (OP IOL)**: data suggests that OP IOL is suitable for approx. 20% of all inductions; currently NHSGGC is achieving 3-10%
- **Progressing the use of technology** to deliver the Gestational Diabetes Mellitus (GDM) joint education
- **Review Sonography** and agree the optimum service model
- **Reviewing increase in caesarean section rates** and monitor category types with a view to looking at overall capacity for C-sections
- **Continuing to amalgamate the remote antenatal clinics** based on successful use of a virtual approach at clinically appropriate points in the patient pathway
- **Evaluating the delivery of Parentcraft sessions** through virtual methods and further developing the programme that can be offered in this format.

9. Unscheduled Care

Key Points

- Continued development of our Flow Navigation Hub and associated care pathways will be a priority for us over the next 12 months
- We will maintain COVID-19 pathways in hospital and communities, responding to infection rates
- Our programme of work to improve stroke services, including the development of a Thrombectomy service will be progressed in 2021/22
- We will continue to implement the West of Scotland Trauma Network.

9.1. Redesigning Urgent Care

Our overarching objective is to ensure that patients who need urgent care receive the 'Right Care, Right Place, Right Time, First Time', delivered by the right clinician which minimises disruption and inconvenience for themselves, carers and families. This will ultimately provide a better experience and outcome for the patient. The potential advantages of a more planned approach to unscheduled care attendance include reducing overcrowding and unnecessary face to face contact, improving patient safety through physical distancing, reducing any potential spread of COVID-19, and improving compliance with the four hour ED waiting time target which sees patients spending less time in our Emergency Departments.

Within NHS Greater Glasgow and Clyde, we introduced our Flow Navigation Hub on 1st December 2020 which is the first important step in delivering a model that sees the transition of unplanned care to one where services across our whole system of primary community and secondary care can deliver a planned urgent care response, alongside an acute emergency access route. This, coupled with the ongoing need to manage the impact of COVID-19, continues to influence the future delivery model of unscheduled care across our Health and Care System.

9.2. Redesign Progress

Since submission of the last Remobilisation plan significant progress has been made. Our redesign process has been planned over three phases.

PHASE 1

Phase 1 was fully delivered by the target date of 30th November. Further detail is included in the relevant sections of this document. This key phase involved:

- **Consolidation of the COVID-19 pathways** to prepare for the expected increase in prevalence of COVID-19 and Flu over the winter period
- **Consolidation of Mental Health Assessment Units** as part of a broader redesign of urgent care in mental health (see Mental Health Section)
- **Escalation of the redesign of GPOOHs Service**
- **Planning and preparation of the launch of the Flow Navigation Hub and Minor Injuries pathway**.

PHASE 2

Phase 2 is the current phase of the project and commenced on 1st December 2020 and runs to end March 2021. This includes:

- **Go Live and ongoing review of NHSGGC Flow Navigation Hub**
- **Ongoing review of scheduled minor injury pathway**
- **Open Gartnavel Minor Injuries Unit** which was achieved on 18th January 2021
- **Review and develop new pathways for high volume conditions**
- **Initial conversion of condition specific activity** to scheduled care
- **Assessment of impact across other urgent care pathways**
- **Early work to explore the use of the Flow Navigation Hub for Paediatrics**.

PHASE 3

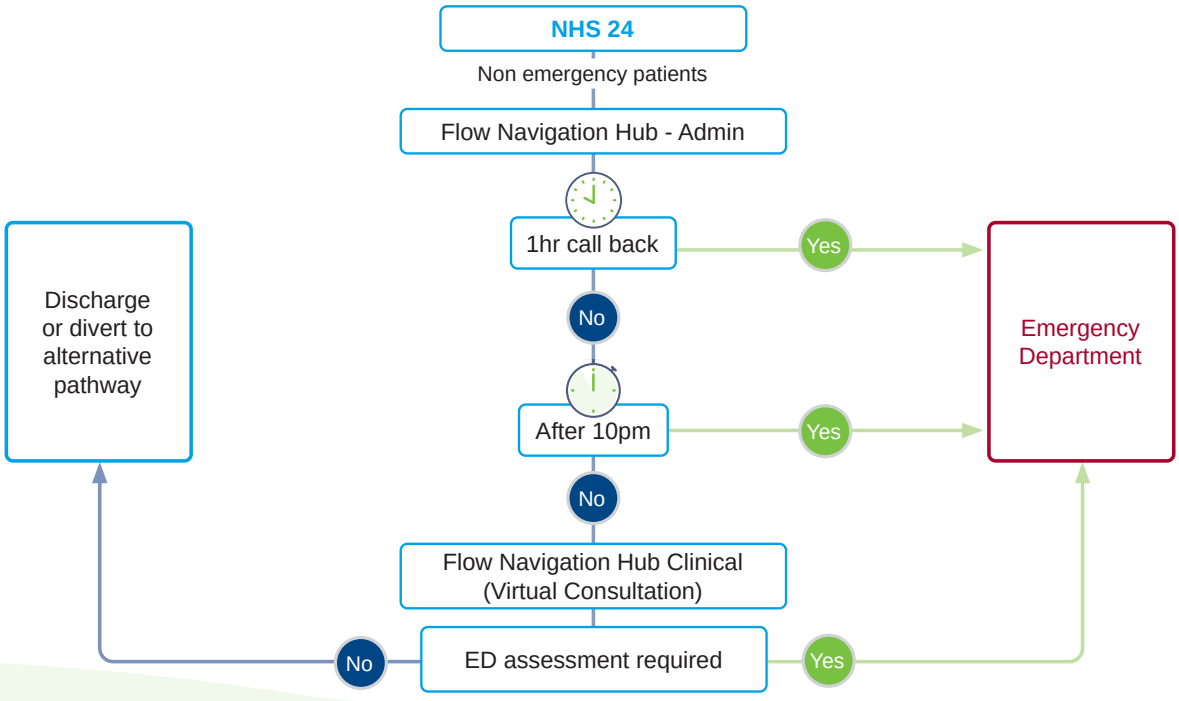
Phase 3 will commence from April 2021 and will deliver:

- **Implementation of the MH urgent care redesign** which will deliver a permanent establishment of the Mental Health Assessment Units (MHAUs)
- **Ongoing conversion of condition specific activity to scheduled care**
- **Ongoing review of new models and further development of an MDT approach** to manage urgent care
- **Development of GP pathway** to Flow Navigation Hub.

9.3. Implementation of the Flow Navigation Hub

On 1st December 2021 NHSGGC's Flow Navigation Hub (FNH) opened, receiving referrals from NHS 24 24/7, 365 days per year for patients who would historically have been directed to emergency departments. The new model has established pathways that will direct patients with urgent care needs to appropriate and safe care without necessarily having to visit Emergency Departments (ED), introducing clinical consultations through telephone and virtual Near Me at an earlier stage in the pathway. This allows the ED workload to be better managed and scheduled.

The clinical arm of our Flow Navigation Hub operates seven days per week currently between 10am and 10pm. The clinicians are supported by the Administration Hub which receives referrals via NHS 24, 24/7. The hub diverts more urgent patients triaged by NHS 24 (1 hour patients) and all of those who present from 10pm directly to the Emergency Department. Between 10am and 10pm all patients triaged as requiring an assessment within four hours are directed to the hub where they receive a virtual consultation. Patients who are assessed as requiring to attend ED are directed accordingly. This pathway is detailed below.



Almost 299,000 people self-referred and attended NHSGGC EDs in 2019. Of those, 109,000 were triaged as flows 2, 3 and 4 and we would expect these patients will still need to attend ED. Our initial planning assumption is that up to 75,000 patients would be directed via our FNH subject to a successful national public messaging campaign that diverts a significant volume of self-attenders to call NHS 24 before attending ED.

A review of activity in December/January2021 saw an average 102 patients per day (714 per week) directed to the Board's Flow Navigation Hub and processed through the admin hub. This is in keeping with the numbers anticipated in the first phase of the roll out of the new model based on a 'soft' launch of the service.

During the reference period an average of:

- **55 patients per day are triaged as 1 hour attendances** and are directed from the Admin Hub straight to their local ED
- **47 patients are directed daily to the Clinical Flow Navigation Hub** for an initial virtual consultation.
- **45% of consultations result in the call being closed with no further action** (21 patients per day)
- **73% of all referrals from NHS 24 (34 patients per day) occur between the hours of 10am-10pm**
- **27% or referrals (13 patients per day) are referred overnight**.

There is potential for the numbers to increase significantly if the new model is supported by a more high profile communication campaign. In 2019 we saw an average of 815 walk in patients per day across our EDs. Current activity is lower due, in part, to the COVID-19 pandemic response supported by new pathways that have diverted attendances away from the hospital Emergency Departments. We will continue to monitor activity and the associated workforce requirements which would be arranged via the Flow Navigation Hub as publicity around the new model increases.

As part of the preparatory work for the launch, and reflecting the potential activity that could be directed via the hub, we have developed an escalation plan. This includes contingencies to address a number of scenarios which includes unsafe staffing levels for functionality; demand exceeding capacity and, the potential impact of the current pandemic on staffing levels across our urgent care system.

In the longer term, as the flow of patients through the hub increases and additional pathways are put in place that bypass ED, NHSGGC would aspire to develop a 24/7 clinical consultation service available supported by a virtual hub overnight. Currently given the extent of the pandemic and disruption to our services, this is not viewed as an optimal use of clinical time as the benefits overnight associated with current demand are minimal.

9.4. Pathway Development

A new minor injuries pathway was initially piloted within GRI and fully rolled out across the Board on 1st December coinciding with the launch of the Flow Navigation Hub. In conjunction with this work, we have established a new pathway to Gartnavel, opening our Minor Injuries Unit (MIU) there on 18th January. Access to this unit is via referral from the flow navigation Hub.

Work is now underway to expand referral routes to other specialty teams, ensuring that patients are signposted and directed without the need for an unnecessary attendance at one of our EDs. Initial speciality areas of focus through the current phase of our redesign project are:

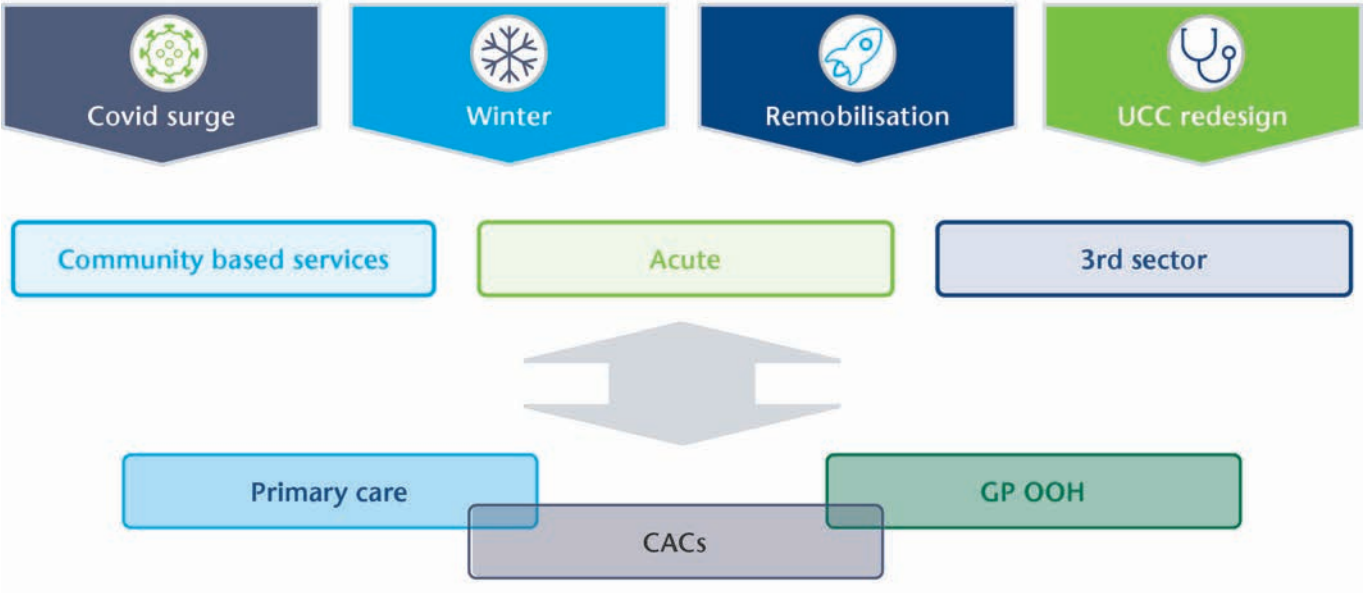
- **ENT**
- **Ophthalmology**
- **Maternity**
- **Nursing Homes referrals**
- **Sexual Health**
- **Head Injury**.

Pathway development work will be progressed with representatives from across the whole system, ensuring that redesign opportunities are optimised across both primary and secondary care. And is essential to ensure that we are assured that other specialities are available to take responsibility for patients streamed as not appropriate for ED.

9.5. Impact Assessment

There are direct dependencies and inter-relationships between the different urgent care services that operate across the Board. As different pressures and/or pathway changes are introduced, the interdependencies become more evident.

Dependencies and Pressures



A performance management matrix has been developed that will let us monitor the impact of the new model and will help inform changes.

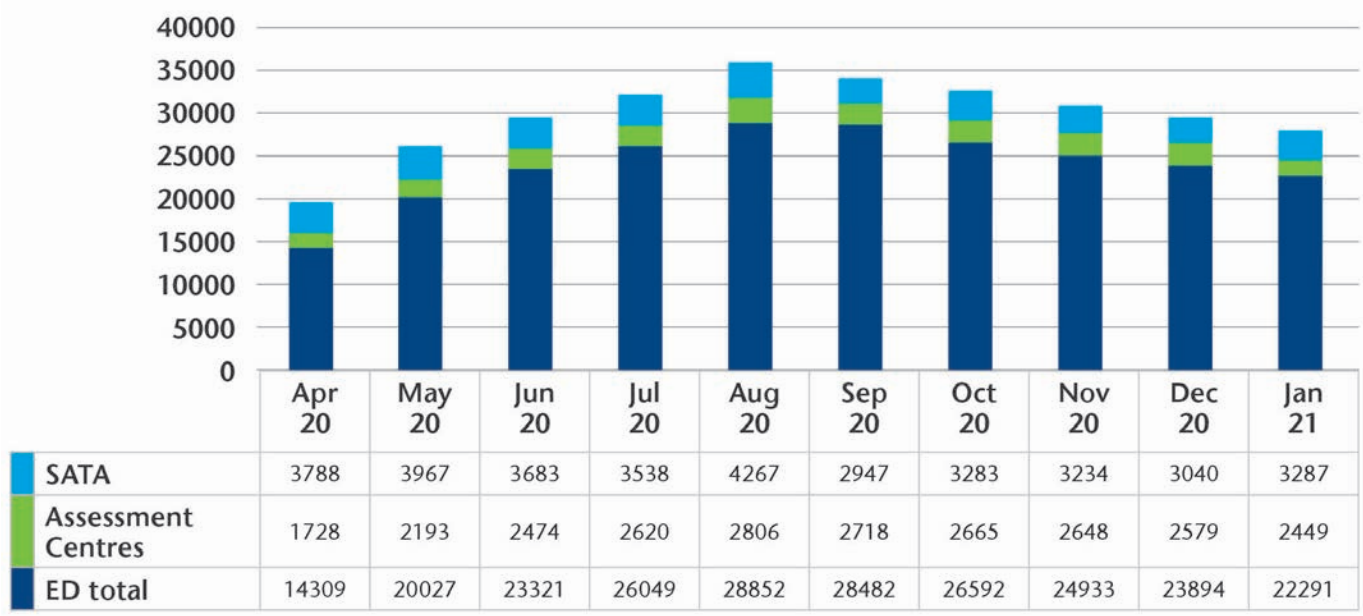
We will need to consider how the Flow Navigation Hubs connects across the HSCP system to GPs, Community Nursing, Community Pharmacy, Allied Health Professionals (AHPs) and other services working in the community to ensure appropriate re-direction.

9.6. Maintaining COVID-19 Pathways in Hospitals

Maintaining COVID-19 pathways including the Specialist Assessment and Treatment Areas (SATAs) for patients with symptoms suggestive of COVID-19 continues to form an essential component of the COVID-19 response.

Departments have been reconfigured to accommodate SATAs and to ensure we have the ability to continue to deliver this pathway as well as manage the predicted increase in emergency attendances as the service returns to near normal levels. Our SATAs have, and will continue to be flexed to meet demand.

GGC Acute Unscheduled Care Activity



	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21
SATA	3788	3967	3683	3538	4267	2947	3283	3234	3040	3287
Assessment Centres	1728	2193	2474	2620	2806	2718	2665	2648	2579	2449
ED total	14309	20027	23321	26049	28852	28482	26592	24933	23894	22291

In order to maintain infection control precautions the red and green pathways described in the Board's earlier plans will remain in place supported by the provision of Personal Protective Equipment (PPE). Additional support has been directed to the SATAs to maintain these pathways throughout winter.

Signposting is in place at all the adult Emergency Departments whereby an experienced nurse undertakes a short assessment and directs patients to Pharmacy, Dentist, Optometrist, GP, GP Out of Hours, Sandyford Centre, Minor Injury Units or NHS 24, as appropriate.

The impact of COVID-19 was first felt in March 2020. Prior to that the number of people attending ED had increased by 2% from the previous year and the number of GP referrals to assessment units by 5%. Pre-COVID-19 emergency admissions to hospital between April 2019 and February 2020 had increased by 2.6 % compared to 2018/19.

9.7. Supporting People to Live at Home

A further development which will deliver on our overarching objective of Right Care, Right Place, Right Time, First Time is the development of an integrated pathway for frail older adults including Hospital @ Home. Glasgow City HSCP is currently working closely with front door (ED & Assessment Unit) and Medicine for the Elderly clinicians at QEUH to develop and test a model which we will look to roll out across Greater Glasgow and Clyde Acute Division and the six HSCPs by the end of 2022.

The tiered model developed comprises of:

- **Enhanced community support**: co-ordination and maximisation of effective interfaces across the unscheduled care pathway will support older people to stay in their community and avoid hospital attendance. This will include GP access to specialist advice through Consultant Connect and development of Frailty & Falls pathways for referrals received at the Flow Navigation Hub and Out of Hours Hub together with access to a range of specialist teams and services in place in the community.
- **Redesign of Front Door Frailty Team**: for patients who present at hospital, enhanced health and social care interventions at the front door will enable early identification of frail adults. In line with the Health Board's Discharge to Assess Policy there will be in-reach from community teams with the ability to signpost to community services together with direct access to specialists through rapid access hot clinics and ambulatory pathways all of which will lead to admission avoidance.
- **Hospital @ Home** which is being developed as part of the integrated pathway will provide co-ordinated, multidisciplinary care and treatment at home where patients have an acute episode of need. The services will provide safe and effective diagnosis and treatment. The core Hospital @ Home team will access specialist services such as the Community Respiratory Team and Heart Failure Team. Again, following the Health Board's Discharge to Assess Policy the team will liaise closely with primary care and community health and social care services in the patient's care planning.

9.8. Maintaining COVID-19 Pathways in the Community

Consolidating the Community Assessment Centres (CAC) model across NHSGGC involved predicting demand, agreeing escalation criteria, securing staff (including standby teams) for the Hub and CACs, and identifying the physical location of centres across all geographic locations covered by the Board.

The pathway will continue to be observed as we move out of winter and will include careful observation of workforce resource. Escalation and implementation of the various phases of the pathway will be implemented should demand require.

Maintaining the COVID-19 Community Pathway is a key part of supporting the sustainability of core services in General Practice and GP Out of Hours by ensuring that suspected COVID-19 patients can be seen out with General Practice, enabling daytime general practice to continue supporting the most vulnerable and complex patients.

9.9. Forward Planning

As we move through 2021 we will continue to evolve and develop the new model, expanding pathways and signposting and directing patients appropriately. This will include:

- **Continuing review of phase 1 of the Flow Navigation Centre**, including oversight of all urgent care activity across the system and development of improved eHealth interfaces
- **Progressing Phase 2 clinical pathways** to provide direct routes to treatment for patients avoiding EDs as appropriate
- **Implementing phase 3 of the Redesign of Urgent Care**
- **Launch of HSCP Urgent Care Resource Hubs** in all six HSCPs to co-ordinate out of hours activity. This is scheduled to be implemented by end January 2021
- **Enhancement of current use of Consultant Connect**, linking with the Flow Navigation Hub
- **Review the Redirection Policy** in line with national guidance
- **Review demand for urgent care**, informed by COVID-19 projections, winter activity and elective demands to assess number of beds and other services required
- **Develop a cross system Winter Plan for 2021/22**
- **Develop consistent interface arrangements for older people** to support them to live safely for longer in their own community, developing a Hospital @ Home model.

In the longer term, we will review existing hubs to ensure that pathways are clear, duplication is avoided and workforce is best deployed. Existing hubs include the Flow Navigation Centre, the GP Out of Hours hub, the GP COVID-19 hub and HSCP Urgent Care Resource Hubs.

9.10. Stroke Care

NHSGGC's Stroke Improvement Programme has continued to drive forward improvement initiatives throughout the course of the COVID-19 pandemic.

There are a number of priority areas of focus within this that will continue through 2021/22 which will impact on the new model of urgent care and will be included in pathway development. These are:

- **Implement an improved pathway to QEUH from Inverclyde**, introducing a SAS by-pass with direct access to thrombolysis and hyperacute care to ensure equal access across GGC
- **Development of a WoS Thrombectomy Service**
- **Development of a tele stroke model for GRI and RAH**
- **Scope the stroke service requirements** to support the development of the Institute of Neurological Sciences capital plan
- **Ongoing review of performance against the National Bundle Target** with remedial actions identified where improvement is required across all our hospital sites.

The planned enhancement to the existing pathway will remove the current inbuilt delay and requirement for a secondary transfer to QEUH for patients who would benefit from hyperacute care including thrombolysis. This equates to 12 patients per month. NHSGGC and SAS are working collectively to implement by June 2021.

West of Scotland Thrombectomy Service

In February 2020, a business case was prepared, setting out the requirements to develop a regional Thrombectomy Service, at the request of the national Thrombectomy Advisory Group (TAG). The initial paper covered the introduction of a thrombectomy service in NHSGGC as a pilot phase, which will provide a 0900-1700 service, Monday – Friday for NHSGGC patients by end of 2021, with initial phasing of costs to roll out to the West of Scotland Health Boards during 2022 (initially on a Monday – Friday, 0900 – 1700 basis).

A final business case will be prepared during 2021 in collaboration with the West of Scotland Boards and will cover requirements to support the final phasing of service implementation. There are a number of component parts to the development of the service, as follows:

Capital Scheme

At end January 2021, the proposal to develop two co-located rooms in the ground floor vacated theatre space of the INS building was confirmed as a feasible option. It is anticipated the design stage should be completed by end March 2021 with an estimated 14 week build period. Procurement of two bi-planar machines is required. Options to secure optimal procurement are being explored with a timeframe to procure and install the equipment estimated at nine months.

It is anticipated that we will seek to move to the pilot phase in late 2021. However this will be dependent on capital and equipment processes achieving the necessary progress.

Diagnostics

National work is in progress to consider the diagnostic pathway, particularly around the required equipment, software and reporting requirements in terms of the general readiness of the spoke hospitals (including NHSGGC).

Telemedicine Pathway

The introduction of a thrombectomy service has put focus on existing thrombolysis pathways within NHSGGC. Work is underway to scope options and requirements for the introduction of a telemedicine response which will support the wider pathway development work ongoing. There are a number of issues related to workforce, estate and the current model which are being worked through and it is anticipated that the service will be phased in through the second half of 2021.

9.11. WoS Major Trauma Network

In August 2019 a paper was presented to NHS Greater Glasgow and Clyde Board which outlined the plans for both the National and West of Scotland Major Trauma Network and described how services would be reconfigured within Greater Glasgow and Clyde to deliver the model. The model is a hub and spoke approach to delivery of care. At the heart of the WoS regional network, is the Major Trauma Centre which will be sited at the Queen Elizabeth University Hospital (QEUH) in Glasgow and will provide care for around 1200 critically and severely injured patients per annum. This activity equates to an additional 700 plus patients per annum attending QEUH compared to current levels. Modelling work has indicated 40 beds are required within QEUH to support Major Trauma/Trauma admissions from across the WoS (24 Major Trauma Ward, 6 Critical Care and 12 Hyper Acute). It also highlighted the need for enhancing provision of Level 2 Rehabilitation Services for the GGC catchment population which will see 4 additional beds being created in Physically Disabled Rehabilitation Unit (PDRU) and a peripatetic rehabilitation service being supported into MT Ward and GGC Trauma Unit. The paper also outlined the significant financial investment by Scottish Government in the West of Scotland to support creating the network i.e., £18m of which £11m is dedicated to the development of the major trauma centre and £7m to support Trauma Units and the specialist rehabilitation service.

The Major Trauma Centre (MTC) will be supported with six standalone Trauma Units (2 of which will be located in GRI and RAH), Local Emergency Hospitals and a range of remote and rural community hospitals. There will also be a MTC for Paediatrics located at the Royal Hospital for Children. Significant redesign of services is required across the WoS to deliver this network model.

Queen Elizabeth University Hospital will be a Trauma Unit/Local Emergency Hospital for its own catchment population. Significant redesign of services within the Clyde Sector is required to deliver the Trauma Unit model and a separate planning group is in place to progress this which links to the NHSGGC Major Trauma Overview Group. The proposed clinical model for delivery also outlines requirements for a Clyde Trauma Unit at RAH and the plans to develop the IRH as an Elective Centre of Excellence as well as being a Local Emergency Hospital.

Supporting all of this will be a specialist rehabilitation service. The focus of this model is on a hub and spoke provision of specialist rehabilitation ensuring complex rehabilitation needs are met for major trauma patients from Day 1. It concentrates specialist services to improve outcomes for patients and to support patients to move along the rehabilitation pathway seamlessly. Evidence strongly supports improved outcomes and, in particular, the impact that this has on social care in terms of reduction in reliance on community services.

The WoS Major Trauma Network will require the MTC to deliver a dedicated major trauma ward, 24/7 hour on-site provision of ED Consultants; major trauma consultant; major trauma co-ordinators, additional theatre capacity and access to diagnostics.

The planning to deliver all of the above is well underway, with much of it completed. To create a major trauma ward requires a number of moves across the QEUH and additional theatre capacity. Recruitment to the majority of diagnostic, pharmacy, practitioner, nursing and AHP posts is progressing well.

The Paediatric programme of work is well advanced and recruitment process has concluded with new staff in post and already making a difference to the management of trauma patients, particularly the role of the Major Trauma Coordinators.

Creating the major trauma network involves a significant redesign of services, recruitment to new roles; changes to pathways and developing new ways of working which requires good clinical commitment input across a range of specialties, management and stakeholders to deliver.

The day to day pressures that both clinicians and managers faced managing the current COVID-19 pandemic alongside the annual winter pressures were unprecedented and this, coupled with growing prevalence of the virus stretched the ability for the key stakeholders to participate in progressing the plans/movement of services during 2020 to deliver the major trauma centre. Similarly within WoS, all of the Boards had similar pressures i.e., reconfiguration of ward areas, staff sickness, winter pressures, which impacted on their ability to deliver the redesign of trauma services that are required to deliver the Trauma Units. As a consequence of this the planned opening for the WoS Major Trauma Network has now been delayed until August 2021 in agreement with the Cabinet Secretary.

10. Mental Health

Key Points

- The impact of COVID-19 on Mental Health services is recognised as a major public health issue with a notable increase in demand across the whole system
- Considerable public mental health work has already been undertaken by our Partnerships and a seminar is being planned for May 2021 to share learning
- We are focused on reviewing and refreshing our extant strategy in light of our response to, and the impact of the pandemic. This includes:
  - Work to ensure the type and number of adult inpatient beds is matched to patient need
  - Review of inpatient and community Out Patient Mental Health (OPMH) services to ensure balance of care is matched to patient need
  - Address CAMHS waiting list challenges.
- First phase implementation of the national Children's and Young Persons Community Mental Health and Well-being Framework is being progressed
- Approaches to tackle trauma, distress and suicidality are being developed and implemented
- We will support the mental wellbeing of our staff and volunteers
- Our redesigned system for unscheduled care will be fully implemented
- We will continue to work with the Forensic Network and Scottish Government to assess the COVID-19 impact across the Forensic Estate and to support the restart of patient flows.

10.1. Vision

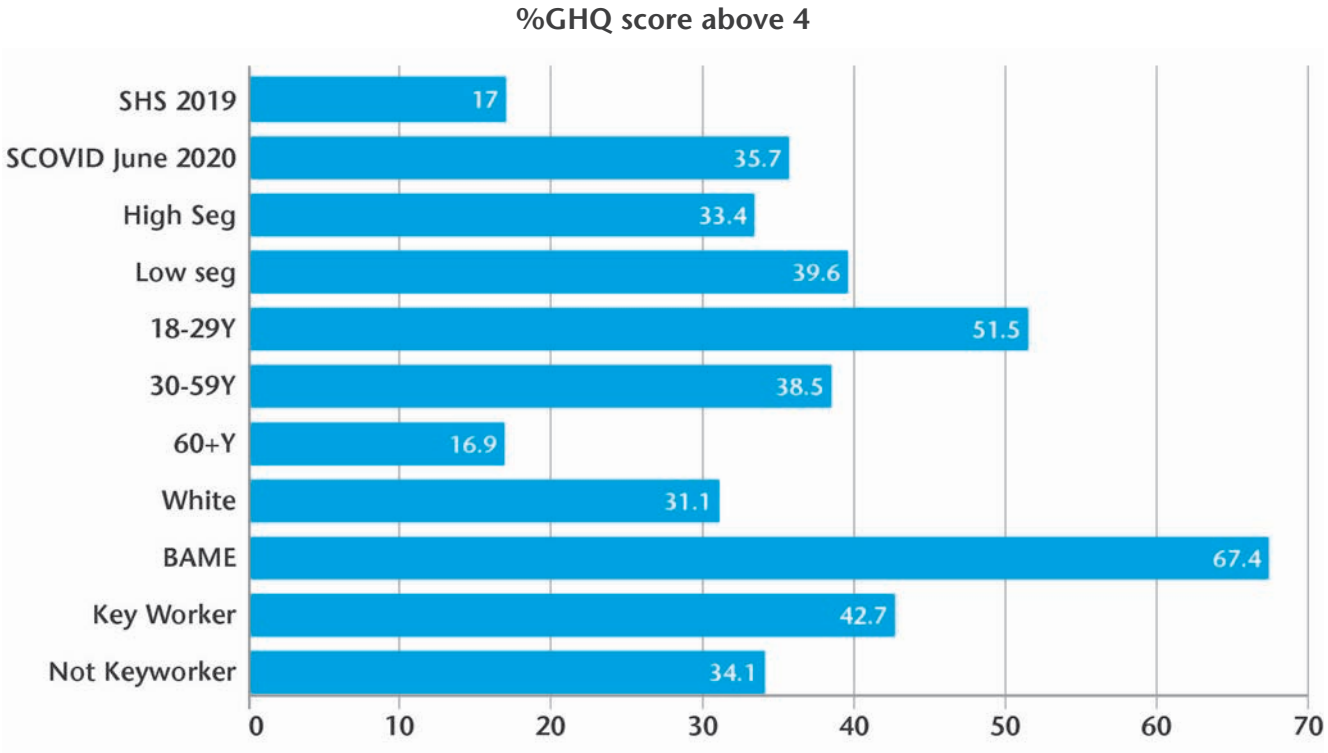
The vision for Mental Health services is to deliver the extant mental health strategy, protecting current investment while investing and redesigning services to meet changing needs. The key programmes in this are:

- **Implementation of a redesigned Board-wide system for unscheduled care**
- **A programme to improve productivity** within mental health teams
- **Digital approaches** to improve mental health
- **Work alongside Health Improvement services and Primary Care** to address and respond to increased distress using non-clinical models of support
- **To develop comprehensive multi-agency programmes** aimed at promoting positive mental health and wellbeing of the population
- **Work alongside HR** to support mental health and wellbeing of all staff and volunteers.

10.2. Predicting Future Demand

In recent months a specific focus has been on reviewing and refreshing the strategy in light of our response to the pandemic and the lessons learned. Service use data shows significant increases in caseloads over the five years to 2019, (with the largest increases amongst people aged 14-29 years).

A review of recent data indicates that demand for unscheduled care has more than doubled compared with the same period last year. In assessing likely future demand, the Scottish Government's mental health tracker highlights the extent of the problem. A General Health Questionnaire (GHQ) score of four or more is considered to represent a significant mental health problem. Compared to the Scottish Health Survey in 2019, the number of people in that category has doubled. It is notable that young people, those from a minority ethnic background, key workers and a previous history of mental health problems are at increased risk than the general population (including those from a lower socio-economic group).



Within GGC we recognise that this presents a major public health issue that will not recede even as infections reduce. We will therefore continue our work to support implementation of the recommendations of the national short life working group for Mental Health in Primary Care which is chaired by the Principal Medical Officer for Mental Health.

A collaborative approach has been taken by Mental Health, Health Improvement and Primary Care teams which are working together to pilot at least two locality integrated teams to offer a prompt and local response to these problems at a GP cluster level. Access to mental health services will continue as before, and we will continue to monitor requirements for a specialist clinical response.

10.3. Public Mental Health Response

Public mental health was a public health priority for NHSGGC prior to the current pandemic. The combined pressures of the pandemic, Brexit-related disruption and the resultant economic impacts are intensifying the effect on mental health. COVID-19 tracking studies in Scotland suggest significant increases in the proportion of people reporting poor mental health, levels of distress and suicidal ideation.

A recent publication from the King's Fund, drawing on learning from other incidents and from the pandemic to date, highlights many of the issues that need to be anticipated and planned for to manage the longer-term aftermath of the pandemic. This includes the need to provide both national responses but also the criticality of enabling and co-ordinating community-based responses, and the longevity of the impacts on staff wellbeing.

Within NHSGGC we have been working to address five public mental health priorities to date (below). Our public mental health responses will continue to be adapted to meet the changing nature of needs. This is anticipated to include:

- **A steep rise in the presentations of distress** related to material hardship and the relational consequences of the conclusion of the furlough scheme which 42,600 of our population are on
- **An increase in exposure of 'hidden' adverse experiences** that children have been exposed to within the home
- **The growing recognition of the social changes generated by prolonged social distancing** and the potential need for resocialisation plans for residents who have overly adapted to shielding/ isolating in a way that diminishes longer term resilience and wellbeing. This requires us to enhance further our mitigation actions and enhance programmes to restore and promote good mental health, without which wider social and economic recovery across GGC will be significantly hindered.

Considerable public mental health work has already been undertaken by our partnerships and Board wide, as described in our previous remobilisation plan. We plan to host a seminar to share the learning from this programme for local and Scottish Government colleagues in May 2021. These developments will be built upon, with our community planning partners, during the next remobilisation phase. Key actions will include:

1. Resilience

- **First phase implementation of the national Children's and Young Persons Community Mental Health and Well-being Framework**. Plans have already been submitted covering early ACES responses, community services and school based services for the £3.155m investment across our six partnerships.
- **Sustain and expand the on-line mental wellbeing training** offer for community planning staff
- **Embed the on-line mental wellbeing group work programme for residents during 2020** (52 courses April-Sept, including building resilience, boosting self-esteem, learning the art of relaxation, coping with change and COVID19 anxiety)
- **Complete (June 2021) the co-produced scoping of a bereavement response service** for those affected by a suicide death, and test a response. This aims to mitigate future trauma for those affected.

2. Social Isolation/Well-being

- **Socially Connected strategic developments will conclude in July** and partnership work plans will be progressed
- **Reporting on the outcomes of the winter social wellbeing investments 2020/21 in May 2021**
- **Continue the digital inclusion work plan in partnerships**, including digital use and inclusion.

3. Trauma/Distress and Suicidality

- **Implement the developing multi-agency team (MAT),** to respond to low mood/anxiety and depression in a selection of General Practices
- **Continue expansion of the brief Intervention range of services** for HSCP/Primary Care referral, complimenting NHS 24 established Distress Brief Intervention (DBI) provision
- **Adoption of the NHSGGC Suicide Prevention Concordat** by all six community planning partnerships
- **Embed the recently established GGC multi-agency Youth and Young Adult Suicide Prevention Group** with intelligence sharing and contagion responses.

4. Underlying drivers (financial and systematic)

- **Publication of Local Child Poverty Action Reports** (LCPAR's) with each of our six Local Authorities in June 2021
- **Sustain and extend financial advice provision in hospital and community setting** (dependent on other Scottish Government funding outcomes)
- **Recruited Youth Employment Guarantee funded employability staff** within receiving services by May 2021
- **The recently established expert panel on ethnicity and mental health** will report in the summer.

5. Mental Well-being of workers (inc. volunteers)

- **Continue the corporate staff welfare planning group and action plan**, including further strengthening aspects of training and awareness raising (delivery contract currently being negotiated), as well as ensuring a regular programme of focused briefings on key mental health topics, manager support and welfare hubs
- **Piloting a Community and Voluntary Service (CVS) led intervention** to provide a range of supports to third sector organisations including piloting an on-line group support programmes for staff affected by the mental wellbeing issues of service users.

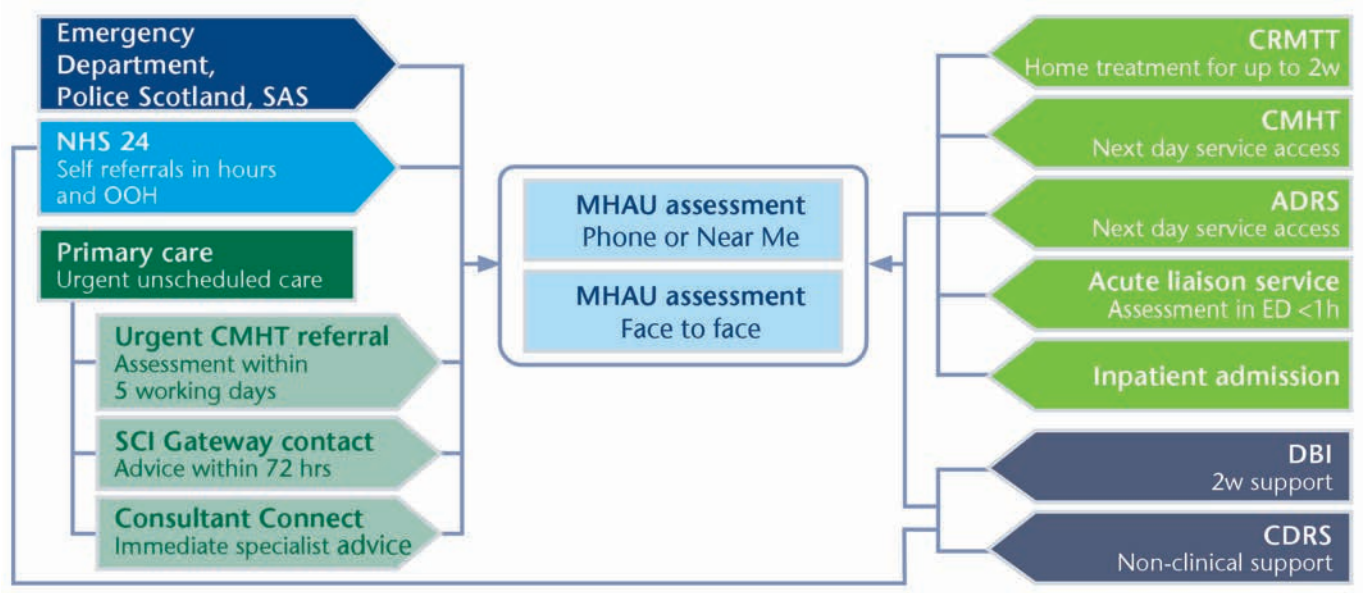
10.4. Core Mental Health Services

Our core Mental Health services have continued to function throughout the pandemic ensuring continuous access to emergency and urgent care response. Fundamentally this has been as a result of the ongoing flexibility of staff who have embraced and adapted to new ways of working including digital and telephone consultation. Face to face emergency and inpatient care continues to be supported by new working practices, use of appropriate PPE and adaption of patient pathways.

Implementation of a redesigned Board-wide system for Unscheduled Care

The aim of work carried out within the Board has been to deliver a single adult mental health Liaison/ Out of Hours service across NHSGGC, consolidating the Mental Health Assessment Units as part of this broader redesign. A Crisis Resolution and Home Treatment/OOH is intended to provide a consistent model of treatment across the Board area as an alternative to hospital admission.

Modelling a post COVID-19 unscheduled care pathway for adult, out patient mental health, learning disability and addictions care groups



Mental Health Assessment Units (MHAUs)

Two Mental Health Assessment Units (MHAUs), established to divert patients away from hospital Emergency Departments as part of the pandemic response, are embedded as part of the system wide urgent care response and pathway re-design noted above. The MHAUs continue to operate to Standard Operating Procedures to improve the way people get a mental health response and reduce footfall through EDs, support Police Scotland, and the Scottish Ambulance Service. The new model has involved investment, significant integration and redesign of unscheduled care and within this the age range has been adjusted to support young people (16 plus) out of hours in the units. A key ambition of the model has been to move from 'unscheduled' to 'scheduled' care as far as possible. This is being progressed with the integration of MHAUs into the redesign of urgent care model and is on course to be fully implemented by end March 2021. Additional work is also planned to consider the urgent care response for younger children.

Productivity within Mental Health Teams

Maximising efficiency and the effectiveness of our Community and Specialist Mental Health Teams (CMHTs) has been driven by the need to manage projected increases in demand. Key areas of focus continue to be the review of eligibility criteria, length of contact and models of support in specialist teams to help create capacity, with the introduction of a 'matched care' approach. This includes:

- **Commencing Group Based Psychological Therapies Service**
- **Testing and rolling out more widely easy out/easy in** (Rapid Access Pathway, Patient Initiated Follow Up) 2021
- **Developing content through 2021 the existing template for MyPsych app** condition based referral guidance
- **Supplemented standardised assessment** (inc. brief assessment)
- **Trialling of Attention Deficit Hyperactive Disorder (ADHD) pathway** for rollout through 2021
- **Commencing proof of concept of Bipolar Hub**
- **BPD (Borderline personality disorder) specialist community network in place**
- **Implementation of Esteem review**
- **Perinatal recruitment**, including the need to meet the new staffing standard.

Digital Approaches to improve Mental Health

In line with other services, throughout the pandemic Mental Health have adopted a digital response to keep core services running and facilitate continuing engagement with service users. In doing so a number of interventions were implemented that continue to be developed and these are noted as follows:

- **Increased remote consultations using phone and NHS Near Me**, recognising the needs of some care groups, e.g. in Older Peoples' mental health
- **Installation of IT in clinical areas and to support remote working** for staff across all community MH services (including all psychiatrists and psychologists in training grades).

Physical Health

Poor physical health can lead to an increased risk of developing mental health problems. Similarly, poor mental health can negatively impact on physical health, leading to an increased risk of some conditions. Therefore, specialist mental health services:

- **Revise and apply the Physical Healthcare and Mental Health Policy**
- **Improve assessment and referral pathways** with the adaptation of an electronic tool for systematic assessment for NHSGGC Egton Medical Information Systems (EMIS)
- **Continue staff training/development** re. Physical Health including proving the concept of a physical healthcare nurse specific to physical wellbeing.

Recovery Orientated Services

Co-production approaches to promoting recovery are important means of supporting and engaging people in their recovery. Recovery peer support programmes have been put in place including:

- **Recruitment of Peer Support Workers** to community mental health teams to support inpatient to community pathways
- **Development of Recovery College** as part of a Recovery Hub.

Social Care Commissioned Services

Our teams working in HSCPs work across health and social work mental health teams and specific work has been undertaken on our social care commissioned mental health services to ensure we have a spectrum of community based supported accommodation which best meets the profile of need. Specialist and mainstream commissioning needs were examined:

- **A further update of the completed baseline understanding of residential and non-residential services** across the HSCPs will be considered
- **Sample review of complex care and challenging behaviour** completed.

10.5. Specialist Adult Mental Health Plans for 2021/22

Specialist mental health secondary care services will also focus on progressing the following areas during 2021/2022:

- **Develop online group work and a Board-wide online psychological therapies service**
- **Work to ensure the type and number of adult inpatient beds is matched to patient need**
- **Review of inpatient and community OPMH services t**o ensure balance of care is matched to patient need
- **Address CAMHS waiting list challenges**
- **Develop consistent tier 2 services across NHSGGC for children and young people** and develop further tier 1 provisions
- **Engagement with communities and other stakeholders** to ensure feedback on these forms of service development.

10.6. Child and Adolescent Mental Health Service (CAMHS)

CAMHS have continued to accept referrals and to make contact with families to offer help. As with other services referrals rates reduced significantly in the early stages of the pandemic, but has subsequently returned to levels commensurate with previous years. It is assumed there will be an uplift in future referrals associated with the effects of the pandemic and as schools and GPs return to seeing children and young people more regularly (either in person or virtually). There are early signs of an increase in more complex cases noted within at least some of the referrals.

Waiting List improvement

Our Waiting List Improvement Delivery Group resumed in August and has recommenced the programme of work which was paused at the outset of the pandemic. Our performance against waiting times standard has gradually increased to 60% by mid-January 21 from a low of 40% noted back in April at the peak of the pandemic. In recovering the position we have and continue to take a number of actions noted as follows:

- **We have contacted children and young people (CYP) who have been waiting longest** and reduced the waiting list size
- **With enhanced understanding of CYP on waiting lists (WLs), we have refined plans based around particular cohorts of children waiting,** including Neurodevelopmental and Anxiety streams for those children awaiting support for these difficulties
- **Additional resource has been agreed for each team and targets set for a 12 month waiting list initiative** to see the CYP who have waited longest and to improve the waiting times standards performance

- **Assumptions made in our original waiting list modelling have been reviewed** and are currently being reworked
- **HSCP's are expanding and enhancing tier 2 and third sector support** for CYP mental health and wellbeing
- **Referral management groups are being established to ensure referrals are routed to the most appropriate supports** based on need.

To underpin this work funding and allocation of resource has been agreed, although recruitment has been challenging, and may potentially impact on our recovery timescales. Previous analysis highlighted demand exceeded capacity prior to the COVID-19 pandemic. It is anticipated that the additional funding secured for Children and Young Peoples mental health will help to reduce future referrals, and the impact of this will continue to be monitored.

Operations Improvement Programme

A number of actions and initiatives have progressed and resumed since submission of the last remobilisation plan and some of these will continue to be developed and progressed throughout 2021.

- **Implementation of revised SG CAMHS referral criteria**
- **Enhanced Caseload Management reports** to ensure transparency of open caseloads and where there is non-engagement/ inactivity
- **Engagement with HSCP and partner agencies to support the development of Tier 2/universal mental health supports** through 2021
- **Documentation, protocol, delivery process and evaluation plan** complete for remote therapy groups via MS Teams. Pilot of Timid to Tiger commenced mid-January 2021 and will be reviewed later this year
- **Planning is underway to support the recommencement of face-to-face and/or virtual Decider Skills group treatment sessions**
- **A working group is to be established to review potential actions to reduce** Did Not Attend (**DNAs**), including revisiting neighbourhood engagement patterns, mechanisms for identifying vulnerable families, and assertive outreach.

Unscheduled Care

CAMHS crisis out of hours presentations are seen by the unscheduled nurse led service currently based in the Mental Health Assessment Unit (details noted above) who will see young people out of hours. Daytime urgent appointments continue to be seen in Tier 3 CAMHS teams.

The CAMHS Choice (assessment) Team is now fully re-established to meet the current demand with capacity available to do so. To support our unscheduled care programme for children and young people we will:

- **Analyse the difference between demand and capacity available** to the service to determine where there are shortfalls in available clinical capacity
- **Revisiting our modelling of the number of first treatment appointments based on previous increased demand** and then enhance for a further COVID-19 affect
- **Analyse reduced/delayed referral rate** against what we would have expected during this period based on historic data and identify any gap in resource to meet this.

A review of these metrics will allow us to properly assess the predicted urgent care capacity requirements.

10.7. Forensic Mental Health

Current Position

Core Forensic Mental Health Services have continued to operate throughout the Pandemic, ensuring continuous access to emergency admission and urgent care which would see individuals transferred to higher levels of security. The service also continues to review the most vulnerable and at risk patients within the community all of which has been supported by staff flexibility, and the adoption of a wide range of new ways of working including the wide scale roll out of Information Technology and telephone consultations. Face to face contacts in the community, with the STAR service and in-patient care continues to be supported by well-developed working practices, the use of PPE and changes in patient pathways. The in-patient services continue to operate under COVID-19 restrictions to admissions, transfers and discharges, with patient testing at every stage of the journey.

At the onset of the Pandemic, all Forensic Community Services were prioritised using "red", "amber" and "green" (RAG) rating, depending on their needs and level of care provision. Red and amber patients continued to have planned contact. From June 2020 work to re-establish care for "green" category patients got underway and the resumption of out-patient clinics has been in place since Mid - June 2020, with initial face to face assessments and clinics resuming at the end of July 2020, both these services continue to date.

The Forensic In-Patient Service continued to admit urgent referrals that required a higher level of security, routine Suspension of Detention has been restricted as per Scottish Governance guidance and will be gradually re-instated in line with the easing of restriction through the Tiers. However, this remains challenging due to social distancing guidance, transport restrictions and infection control measures.

Forensic Future demand

As noted, the socioeconomic impact of the Pandemic is already impacting on demand for mental health services across NHSGGC. The impact on Forensic Mental Health Services has seen an increase in referrals for medium secure care from the Prison Services.

There is an ongoing concern that the Pre-COVID-19 demands on the Forensic Estate will remain and continue to grow as movement between the levels of security restarts. There continues to be a backlog of patients waiting for transfer from The State Hospital to Rowanbank Clinic; from Rowanbank Clinic to Low Secure Services at Leverndale Hospital; and from Rowanbank Clinic and Low Secure Services to the Community. These issues will need to be addressed as Legislation changes. As seen in the 1st wave of the Pandemic it is envisaged that the Forensic Service will continue to see pressure from the Prison Service.

Forensic Estate Issues

In response to the pandemic, the Forensic Network, Scottish Government Mental Health Directorate, NHS and Private Sector representatives have been meeting remotely to assess the COVID-19 impact across the forensic services. The current focus of this stakeholder engagement is in considering the challenges which exist and work required which will assist with the restart of patient flows.

Key priority areas for further consideration across the network throughout the early part of 2021, including within NHSGGC include:

- **Collating current occupancy issues across the Scottish NHS Estate** in High, Medium and Low Secure
- **Identifying and articulating the barriers and opportunities** that support the re-commencement of patient flows
- **Defining the restart process** of the Forensic Estate
- **Adopting a common approach to testing** across the Forensic Estate
- **Assessment of the current bottlenecks** in the system for patients in low secure setting awaiting community placement or discharge to other services.

In common with other Forensic mental health providers this presents a significant issue/risk area for NHSGGC. Current structured community / supported placements remain on hold and referrals for medium secure placements are increasing, all of which is putting stress on the current system. This is turn has the potential for an increase in out of area placements.

There is a need for a sponsored strategic approach to ensure safe, timely and efficient access is achieved across the entire forensic estate in the short to medium term. In the short-term each forensic service will continue to collaborate on a cross service flow map. Although this does not address baseline capacity challenges, it does target a more efficient response to easing and enabling patient flow in the coming six month period. The core bed challenge will be further assessed throughout this period.

Clinical Priority Areas

Key priorities for 2021 would include:

- **Digital Mental Health** – We will continue to operate and Increase remote consultation using phone and NHS Near Me for community patients. We will also continue to support remote patient visiting while current restrictions remain in place
- **Forensic Community Team** – Ongoing assessment and review of RAG rating will remain a key area of focus for all forensic community patients. We will continue to use technology based approach where appropriate and support face to face visits following all relevant infection control and PPE guidance
- **Out-Patient Clinics** - Urgent outpatient clinic assessments will continue to operate
- **Inpatient Care** – We will ensure that our recovery plan fits with the current national planning for Secure Services across Scotland
- **Forensic Service Rehabilitation Recovery Plan** – Our recovery plan is a flexible working document that is reviewed and updated weekly by the operational management team in line with new guidance or new lifting of restrictions by the Scottish Government or NHSGGC Board. Tiers may be introduced gradually over a period of time and we may need to move up or down Tiers dependent on Scottish Government and Board Advice.

11. Primary and Community Care

Key Points

- There will be a focus on services to support those who have been adversely impacted directly and indirectly by the pandemic (Addictions, rehabilitation, domestic abuse)
- We will prioritise maximising independence for our population
- We will continue to support care homes
- We recognise the role of primary care in supporting the priorities above, and will seek to improve and strengthen interface arrangements.

11.1. Joint Approach and Oversight

Over the past 11 months, our HSCPs and Primary Care teams have responded to changes in restrictions and lockdowns, and have adapted their approach based on emerging COVID-19 guidance issued from Scottish Government, Health Protection Scotland and other bodies. These teams continue to face significant demand to support the ongoing response to COVID-19 and to deliver the range of additional services required. This includes the COVID-19 Assessment Centres, Test and Protect, the Flu vaccination programme (which is complete), and more recently, the COVID-19 vaccination roll out which commenced in December 2020.

The oversight, governance arrangements and collaboration across the six Health and Social Care Partnerships has been instrumental in responding to these challenges, sustaining core services, but also in pushing forward with the development and introduction of new services over the same period.

Our community and primary care teams continue to review and update recovery and transition plans that take account of the changing circumstances as restrictions on movement and access continuously change, and are working together to ensure that we deliver a consist approach and best practice. It was previously highlighted that business continuity will continue for many months and this position has not changed. During this period services will continue to evaluate and re-evaluate lessons learned and continue to evolve arrangements through the various phases of recovery.

Externally, an independent review into the future of adult social care has recommended that a National Care Service, similar to the NHS, be set up in Scotland. The full impact of this report and its 53 recommendations have yet to be assessed and agreed. This plan recognises the potential significant impacts of the report but focuses on the next 12 months, and our previously identified priorities.

11.2. Health and Social Care Partnerships Engagement

Third sector organisations, including voluntary organisation and contractors remain key stakeholders and continue to provide invaluable input and resource that delivers support to local communities. Representatives contribute to our planning groups including those co-ordinating the COVID-19 response and third sector representative provide crucial contributions to the Local Response Management Team (LRMT). Within this some will support and be key to coordinating voluntary responses in the community to support the civil contingency efforts.

We noted the significant engagement across all HSCPs with GP sub-committee structures in the last version of our remobilisation plan and this work and engagement continues to be supported. In addition to the Board's Primary Care Programme Board and various sub structures, the Local Medical Committee (LMC) and GP subcommittee representatives continue to be actively engaged supporting the continuing

response to the pandemic which now also includes the vaccination roll out, alongside service and pathway developments that have progressed throughout the period. This level of engagement and involvement will continue through the current reporting period.

11.3. Current Position

Primary Care and community health and social care services have consistently operated an urgent care response throughout the course of the pandemic. General Practice and Community Pharmacy remained open and accessible to patients throughout for a range of services, with some changes to access to encourage telephone first. Community Optometry and Community Dental services have increased activity from the early stages of the pandemic in line with national guidance and the availability of PPE and infection control measures. We were making good progress remobilising services, adopting a phased approach to progress towards the delivery of pre-COVID-19 activity levels, all of which were noted in some detail in the last iteration of our plan. The main exception to this is day care and respite services which, on the whole have remained closed. Different approaches have been adopted to deliver support to affected service users based on individual assessments. The current wave of the pandemic has delayed progress given the current lock down restrictions including the impact of staff absence. It should be stressed that we have not seen the reduction in routine services which was experienced in the initial wave of the pandemic.

Our services continue to face a number of challenges which include demands for services and support, particularly in relation to mental health issues; changing profile of service users; case backlog; responding to increased demands for rehabilitation and workforce issues related to absence, fatigue and the on-going competing demands for resource.

11.4. Strategic Planning

Throughout 2021, our HSCPs will be undertaking a process to review and update their Strategic Plans. This work will provide an opportunity to revisit existing plans, delivering an updated strategy that focuses on the priorities for health and social care services in view of continuing limitations and impact of the pandemic on our communities.

Within the plans there is a commitment to tackle inequalities, achieved by working with localities to address the very different health and wellbeing issues noted across diverse communities. COVID-19 has had a disproportionate impact across our communities. The impact of the virus has been particularly detrimental on people living in areas of high deprivation, on people from Black, Asian and minority ethnic communities (BAME), older people and those with a learning disability. Within these groups, in particular, exposure has been higher and outcomes have been poorer for those who have contracted the virus. It therefore remains a priority of HSCP strategic planning groups to actively consider and agree priority areas to focus resource in response. In this respect there is a commitment to working with communities and groups and directing resource to those who are most affected by the pandemic. This will include supporting critical health and social care, voluntary and community services to prioritise resource.

11.5. Social Care Priorities and Considerations

Care at Home

Care and support services offered to people living in their homes continue to operate. Contracting arrangements differ across our HSCPs, but local services were altered to consistently reflect COVID-19 guidance across all areas. The longer term remobilisation plans within our HSCPs see the service developing to increase support to pre- COVID-19 visiting levels. There continues to be some staffing challenges in some of our local areas and the recovery is being supported by volunteering and community involvement opportunities which are being embedded in practice.

For some time now Care at Home services have been focussed on recovery and transition with teams working collectively to agree and implement a common approach to eligibility and access criteria for re-starts and new referrals for care at home across all HSCP areas. This approach will continue to operate through 2021 with specific focus on preventing hospital admission, supporting hospital discharge and promoting maximum independence. This work will continue to be progressed in partnership through the Board wide Support for Care at Home Group.

Respite and Day Care Services

In line with advice from the Care Inspectorate, in-house centre based day services remain paused, as are all similar services purchased from external providers. Social distancing constraints and the rise of infection rates in care homes has restricted access to residential respite and there has been a continuing reliance on families and informal carers to provide additional support.

Scottish Government guidance was recently issued (January 2021), and we are now looking to remobilise building-based learning disability (LD) services, targeted towards individuals who could benefit most and who are risk-assessed as safe to attend. We will also look to retain subject to resources, an element of the outreach support introduced recognising that some service users may be unable to return to a building-based service at this point in time.

Apart from LD services, other day care services are unlikely to reopen until the vaccine is fully rolled out. Service users have had individual assessments with support packages put in place. There are some continuing gaps in service and through 2021day opportunities, enhanced home and local based community options will be developed and facilitated by Looked After and Accommodated Children's Teams.

Addictions

As with other adult social care services, the addiction service implemented its Business Continuity Plan at the onset of the pandemic, reconfiguring service delivery to minimise face-to-face contacts, retracting non-essential services in order to free up resource for the wider system treating COVID-19 patients, and concentrating services on priority conditions and urgent cases. The service has a developed recovery plan which outline the intention to recover and remobilise services throughout 2021. Some services continue to operate fully including city centre outreach and the enhanced drug treatment service. Our inpatient capacity is currently restricted due to social distancing and control of infection measures.

In the last few weeks the Scottish Government have announced areas where improvements are to be delivered within alcohol and drug services where the aim is to reduce drugs deaths supported by a package of funding. These actions will be considered alongside the current recovery work within the Board to assess where further service development is required.

The current focus of our recovery work through 2021 includes:

- **Alcohol and Drug Recovery Services (ADRS) Care Management** – ensuring that each individual is appropriately reviewed with a RAG status assigned, regardless of the stage of recovery. New service users have continued to be assessed and begin treatment in spite of restrictions.
- **Opiate Replacement Therapy/Medically Assisted Treatment** – Work to resume the pre-COVID-19 service as community transmission decreases and the vaccination programme is rolled out. This work will look to grow our same day prescribing services and broaden the treatment options available across the city. In the interim the current business continuity delivery arrangements will continue.
- **Prescription Management** – Current BC arrangements will continue while face to face clinics are restricted. Discussions are ongoing to include an element of remote service delivery in future service.
- **Acute Addiction Liaison Service** – A blended model has been adopted and will continue to operate through 2021.
- A**HP and Psychology Services** – These services are operating remotely with an urgent face to face provision in place. Remobilisation will be in line with the broader community recovery plans.
- **Day services** – A review of the service is to be carried out in early 2021 with recommendations for future service provision developed.

- **Recovery Communities** – Support is currently provided online seven days per week. A move to tier 3 will allow a limited number of small groups to meet. Most groups will be able to meet once tier 2 is reached. Recovery communities have managed to successfully engage with new people beginning their recovery via assertive outreach and online support.
- **Harm reduction services** – a new harm reduction initiative was launched in the city centre and has engaged with people who inject drugs (PWID) very successfully in Wound care, Assessment of injecting risk, Naloxone provision and Dry Blood spot testing (WAND). This will be rolled out across the city in 2021.
- **Non fatal overdose response team** – currently being developed to enhance the Glasgow Alcohol and Drug Recovery Services (GADR) provision out of hours, offering an immediate, assertive response to those PWID who have suffered a non-fatal overdose and are at significant risk of drug related death.

Learning Disability

The Government announced a community Living Change Fund in February 2021 in response to the recommendations of a short life working group commissioned last year to develop proposals that would enable people with complex needs, usually learning disability and autism and complex mental health, to leave hospital beds and out of area placements and be supported to live back in their communities. The intention is to use the fund as 'bridging' to enable community services to be developed that will allow the closure of hospital beds and reinvestment of funding in community services. The share of the fund for NHSGGC HSCPs is £4.7m over three years. The guidance has not yet been issued, but during 2021/22 the six HSCPs will work together to develop a plan to enable the individuals living in long stay NHS beds and those who are delayed in Assessment and Treatment Units to move to homes in their communities with strengthened community based support.

Child and Adult Protection

Whilst referrals and activity levels reduced across all HSCPs, by up to 35% in some areas visits and direct face to face contact with the most vulnerable children and families has continued, with increased safeguarding contacts utilising technology based solutions. Participation in legal forums has continued, such as children's hearings which are being delivered virtually again due to the current restrictions. As we move through 2021 and restrictions are reduced, face to face hearings will be re-introduced where this can be safely accommodated.

The importance of safeguarding adults who are experiencing domestic abuse has been highlighted during the COVID-19 crisis. The outbreak and lockdown restrictions has made access to support services particularly in the health, social care more difficult although referrals, assessments and reviews of vulnerable adults has continued throughout the COVID-19 period within NHSGGC.

Initial Referral Discussions (IRDs) are now a critical component of the Child Protection Process and National Guidance indicating that they should be held within 48 hrs of a concern being raised NHSGGC works across all six HSCPs. Over the last 12 months we have seen a 48% increase in IRD activity. The following figures show the change in activity over the last four reporting quarters:

Nov 19 – Jan 20	**442**
Feb 20 – April 20	**434**
May 20 – July 20	**563**
Aug 20 – Oct 20	**671**

This increase in activity has delayed the ability of services to respond within the 48 hour period and a significant number of IRDs are being held 5/7 days after concerns being raised.

All organisations have staff working extra hours to alleviate the situation.

Homelessness

The homelessness response to COVID-19 has seen action taken across our local authorities to provide safe accommodation during the pandemic. At the same time the economic impact of reduced income and increased unemployment is increasing pressure on people and changing the profile of homelessness across our communities with an increased number of people experiencing homelessness. During the first few months of the pandemic an increase was driven by those already experiencing homelessness. Towards the second wave of the pandemic, there have been bigger increases from people who are experiencing homelessness for the first time including those who have been furloughed and the newly unemployed. In addition to this homelessness among people with 'No Recourse to Public Funds' has been an issue and is particularly related to the collapse of the hospitality and tourist industry. During the ongoing pandemic, to support public health objectives our HSCPs have provided accommodation, support and food to people who have No Recourse to Public Funds (NRPF). At present we continue to provide this assistance to individuals accommodated within our hotel population.

One of the biggest challenges going forward will be the ability to successfully move those housed in emergency COVID-19 accommodation into permanent and secure housing. The structural barriers that existed before the pandemic, including a lack of housing supply have been exacerbated during the pandemic.

Homelessness Services have worked with a range of stakeholders including Hoteliers, voluntary sector support providers, and private organisations to provide significant levels of support throughout the pandemic period.

A comprehensive range of supports have been put into place for residents within the repurposed hotels. These supports have included:

- **Homeless Addiction Teams (HAT) and Homeless Mental Health Teams (HMHT)** have re positioned themselves providing assertive outreach to our most complex service users, liaising closely with Hotel staff and have also provided regular training
- **Provision of Hot Food to Hotels and bed and breakfast accommodation**
- **On-site support** at repurposed hotels
- **The Physical Health Team has continued to provide a treatment room and outreach service** throughout the lockdown period
- **The Women's Service in Glasgow City moved its clinic base to an all-female site** within the city centre assisting with the increase in city centre homelessness population
- **A Young Person's Team was established during the pandemic** working closely with locality Homeless Casework Team aiming to engage those under 25yrs
- **Additional resource has now been secured longer term via the Drug Death Task Force** (DDTF) investment which will result in recruitment of additional Social Care Staff within the Homeless Addiction outreach team.

HSCP Homelessness Services have also worked with partners to open alternatives to winter night shelters to address social distancing during the pandemic period.

Towards the end of 2020 as the SG social distancing measures eased and mainstream social letting activity recommenced the Homelessness Services started work to move people on from hotel accommodation. We have developed plans to reduce and end our use of hotels to accommodate homeless households. The plan, working through 2021, will involve a gradual reduction in direct response to the increase in supply from Registered Social Landlord (RSL). We are committed to ensure that the people who are currently resident in hotels can access accommodation appropriate to their needs within a supported environment or within a temporary or settled tenancy.

We have identified resource to coordinate the transition of service users to a range of more appropriate accommodation options. Governance arrangements are also in place to manage the step down from the repurposed hotels.

Tackling Delayed Discharge

In response to the pressure on acute services including the increasing delayed discharges, a short term plan has been developed which proposes utilising care home capacity to deliver increased discharge to assess capacity. The action plan and proposal on discharge to assess has been developed across HSCPs, Acute Services and Public Health.

Across the Board there has been a modest week-on-week reduction in delayed discharges across three of our HSCPs including a small reduction in AWI delays. The other three HSCPs are experiencing untypically high levels of delayed discharges at present. The two main barriers to discharge across the HSCPs remain AWI and the ability to discharge to care homes due to a range of COVID-19 restrictions/ Public Health guidance. The volume of delayed discharges not associated with either of these issues is generally very modest across the six HSCPs, hence the focus of the plan is on reducing AWI and COVID-19-related delays.

The proposal is intended to be a short-term intervention of 8-12 weeks to mitigate the pressure on acute hospitals with the assumption being that the immunisation strategy would ease the pressure on bed capacities in acute services. The proposal is set within the framework of the wider GGC Discharge to Assess policy and assumes all of those patients who could be discharged to assess in other care homes have been discharged. It should be noted that this is a specific response given the scale of the current pressure on acute and the impact that care homes closed to admissions has on our ability to discharge patients timeously.

Maximising Independence

Maximising Independence programme for Glasgow City commenced during 2019. In summary the key messages which underpin the programme of work are:

- **There is a continuing long-term inverse relationship between growth in demand for health and social care services and the budgets** available to meet that demand
- **We have reached a point in our transformation journey where we must fundamentally review the 'health and social care contract' with the public** to ensure a sustainable health and care system into the future
- **Any future contract must be guided by maximising independence**, enabling proportionate risk and supporting individuals to remain living at home for as long as possible. This recognises that the best health and care outcomes are associated with the highest possible levels of self-management and independence
- **Arising from that, the time is now right for the HSCP to pursue a step change in individual, family and community independence from statutory HSCP support**, increasingly focusing organisational resources and energies on prevention and early intervention approaches in partnership with local communities, third sector, independent sector, housing sector and community planning partners
- **There are opportunities to develop place and asset-based approaches** in line with the new neighbourhood teams for adult services, older people's services, delivery of the mental health strategy, Primary Care Improvement Plan and review of learning disability services
- **Families, carers and communities will be expected to provide more support at lower levels of need** that do not meet revised eligibility criteria for statutory support. Resources will be reconfigured in recognition of this change
- **The principles of the new GP contract will be applied**, with social workers and other HSCP staff working to 'the top of their licence' and being substantially only engaged in the lives of those with the most complex need
- **The HSCP is actively engaged** with other authorities that face similar challenges.

During the COVID-19 pandemic 'how and when' people accessed statutory and non-statutory services altered. Glasgow City HSCP are therefore leading a programme of work to understand how public behaviours changed throughout the pandemic, and to ensure that we continue to support those who

need help, care and support to access services and are not disadvantaged by changes in access. As part of the research work we will seek to understand psychological behaviour change to help us understand what people need to 'feel better', which will help to inform how we change our responses going forward and in order to meet the key objectives noted above.

There are five key areas of focused work that will structure the transformational activity under Maximising Independence during 2021.

The five areas of focus are:

- **Maximising Well-being for Independent Living**
- **Workforce and Culture**
- **Communities**
- **Changing the Nature of Care Delivery**
- **Communication and Engagement**.

A digitally connected population will be integral to the success of Maximising Independence by supporting continued engagement and participation in our health and social care transformation programme. Given the impact of poverty and wider inequalities the programme will seek to resolve issues around digital exclusion, for example, through the provision of equipment and training opportunities. In addition, a robust digital infrastructure requires to be in place to support evolving digital solutions and connections across the health and social care system. The Maximising Independence programme is therefore proactively engaging with the wider digital infrastructure transformation programmes in the city to ensure due weight is attached to health and social care priorities. The programme will seek to develop a singular approach that coheres all of the above elements of the HSCP's digital infrastructure and inclusion strategy.

11.6. Community Nursing/AHP response

The previous version of our remobilisation plan contained a detailed breakdown of the work and plans for the remobilisation and deployment of our community and primary care nursing teams and our Allied Health Professionals. A current priority of many of these nurses is to support the roll out of the COVID-19 vaccine to residents and staff within Care Homes and across the multiple mass vaccination centres which have been established across NHSGGC. Additionally, the following priorities will continue to be pursued:

Practice Nurses

This group plays a key role in long term condition management within GP practices, and will have an essential role in the recovery phase in ensuring that chronic disease management approaches continue to develop with any backlog and unmet need identified and addressed, alongside the further development of Community Treatment and Care Centres (CTACs) and the overall approach to phlebotomy and monitoring. We will work with practices to support the General Practice Nursing (GPN) workforce with training and development in line with transforming nursing roles and changes to the General Medical Services (GMS) contract.

Treatment Room Nurses

Development of Community Treatment and Care services (CTAC) continues to be impacted by COVID-19 and this work will be picked up and further developed through 2021. Treatment room nurses continue to be a key resource supporting the continuing COVID-19 response with staff quickly mobilised when this is required. This includes provision of ongoing support to CACs, supporting community nursing resource within district nursing and care homes and testing, and supporting the COVID-19 vaccination programme.

Advanced Nurse Practitioner (ANP)

ANPs remain key to the COVID-19 response and have been utilised in different ways. Some of the ANPs have been deployed to support Care Homes focusing on assessment, anticipatory care planning and avoidance of admission to hospital. In some areas ANPs have been working within GP practices which has benefited both practices and patients and is currently being evaluated.

District Nursing (DN)

District nursing services continued to operate throughout the course of the pandemic with over 6300 critical visits per week accounting for around 84% of the normal case load. Within end of life care all services have been maintained. There has been significant input from district nursing and Care Home Liaison Nurses to care homes, with support provided to both residents and staff, in particular via HSCP Senior Nursing teams related to assurance across Care Homes. District nurses have also been crucial to the successful delivery of the COVID-19 vaccination to housebound patients. There are current plans across HSCP's to invest in DN ANP posts which will maximise the contribution to nursing, including impact upon Avoidable Admission and Delayed Discharge.

Health Visiting

Health visiting activity reduced significantly at the outset of the pandemic. Before the current wave activity levels were steadily increasing. Health visitors were involved in CACs in four of the six partnerships during the first wave. Health Visitors are actively participating in the delivery of the COVID-19 vaccines in care homes and vaccination centres across GGC. Participation is enabled through excess and condensed hours to ensure no reduction in core health visiting hours. It is recognised that the delivery of the health visiting 0-5 year universal pathway is a key priority. Through 2021 there will be a continued focus on increasing face to face visits.

We plan to complete introduction of the Universal pathway with plans in place for the introduction of the ante natal visit in early adopter areas from February 2021 with roll out thereafter.

Family Nurse Partnership (FNP)

Family Nurse Partnership is a preventive, intensive, home visiting programme offered to first time young mothers (aged 19 and under) and their families. The programme is voluntary and is designed to tap into the client's intrinsic motivation for change. FNP in NHS Greater Glasgow & Clyde has undergone a rapid expansion and there has been a concurrent model operating since September 2017, meeting the Scottish Government vision of every entitled young woman being offered a place on the programme. There are now seven teams across the board area with a named Supervisor for each team has up to six Family Nurses and associated Data Manager and Administration staff. Over 830 families are supported through the programme and strategic priorities for the year ahead cover:

- **Ensure sustainability, service integration and governance structures for FNP**
- **Client Voice, The Promise, Trauma Response Pilot**
- **Sharing the Learning from Family Nurse Partnership**
- **Quality Improvement**
- **Equalities, Inequalities in Health**
- **Workforce/wellbeing**.

School Nursing

In line with the Scottish Government's Programme for Government NHSGGC will be funded for an overall increase of 56.07 Whole Time Equivalent (WTE) school nurse posts by the end of 2022.

The aim is to support improved child and family health outcomes through the provision of consistent universal services, assessment and evidenced based pathways of care using a Getting it Right for Every Child (GIRFEC) approach The School Nursing service seeks to reduce inequalities and maximise health

improvement opportunities for the school aged population with particular focus on key priority areas such as mental health and wellbeing.

This is a central role for community based children's services, including health visiting, Family Nurse Partnership, and school nursing, to limit immediate societal harms and the wider, longer term impacts of the pandemic on children's health, wellbeing and opportunities.

Allied Health Professions

The phased re-mobilisation of services will continue across all areas including physio, podiatry and speech and language therapy. Before the current wave, services were at different stages of dealing with their backlogs. Service delivery will continue to be scaled up over an extended period of time through to autumn 2021. This will be subject to review and adaptation depending on further outbreaks of COVID-19 within the community and the successful role out of the vaccine.

11.7. Recovery and Rehabilitation During and After the COVID-19 Pandemic

The national Framework for Supporting People through Recovery and Rehabilitation (2020) recognises the potential need for a prolonged period of recovery that encompasses mental health, wellbeing and physical rehabilitation as a result of the coronavirus (COVID-19) pandemic. It acknowledges the challenges for those recovering from the virus as well as the impact of delay or service delivery changes for people with long-term health conditions across all ages, the frail, children and young people, the elderly and carers.

The priority for Allied Health Professions (AHPs) is to ensure that anyone who requires diagnosis, assessment, rehabilitation, or support for recovery will have timely access to the right information and services in the right place. The varied specialist skills across the range of professions (arts therapies, dietetics, occupational therapy, orthoptics, orthotics, physiotherapy, podiatry, prosthetics, diagnostic radiography, therapeutic radiography and speech and language therapy) work collaboratively, across agencies, to enable a return to functional independence, employment, education and leisure activities over the coming months, and years. The AHP impact and added contribution is evidenced across all areas of health and social care delivery and service area, from maternity and child health, public health, planned and unscheduled adult care through to community services offering generalist and specialist intervention at a locality level.

Co-ordination of rehabilitation across this landscape is crucial in ensuring seamless transitions whether this is from critical care through to community or signposting following domiciliary assessment. The availability of specialist rehabilitation across pathways is paramount to ensure the sharing and development of specialist knowledge to a wide range of service providers, across health and social care (including the care home, independent and third sectors). Challenges can be addressed through improvement and transformation of services, with new models of care designed around population physical health, comprehensive frailty and rehabilitation pathways and services, mental health and wellbeing needs. The principles of ease of access in a timely manner to services which are realistic and meaningful to the individual, delivered by a flexible and skilled workforce, who are digitally enabled are key across all ages and needs.

The framework recommends that 3 distinct groups are considered as part of the development of the response to needs in relation to recovery and rehabilitation.

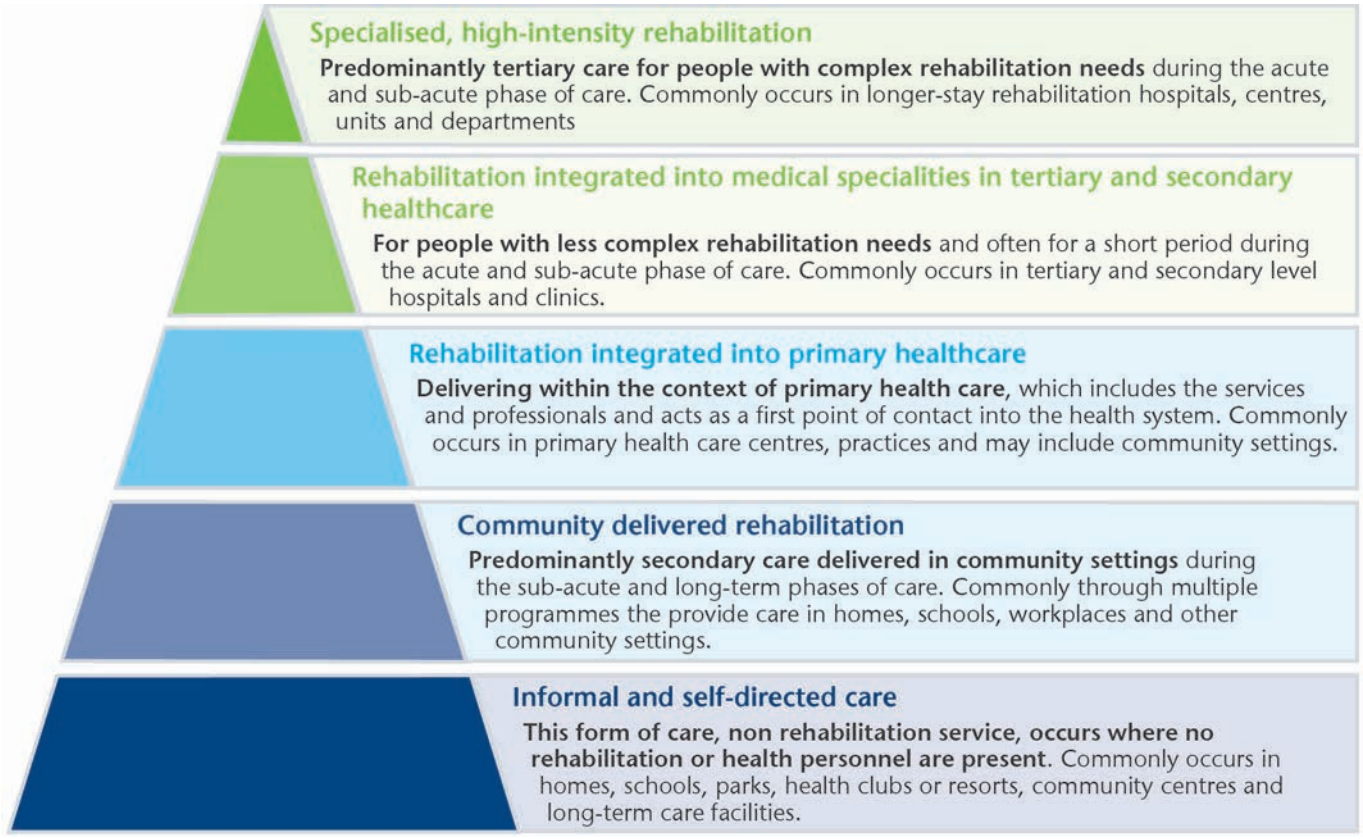
Group 1:

The rehabilitation of people who have had coronavirus (COVID-19) and as a result may present with symptoms such as cardiovascular, pulmonary and musculoskeletal deconditioning, emotional, neurological and cognitive symptoms such as anxiety, post-traumatic stress disorder, post intensive care syndrome, fatigue and pain.

Across GGC, demand has increased for the existing acute and community AHP rehabilitation services, with individuals presenting with increased complexity and chronicity of recovery. Services are being delivered through Active Clinical Referral Triage (ACRT), telephone triage and virtual assessment, maintaining face to face services as clinically indicated. Evidence collected supports concerns around the impacts of an increased wait for people accessing services; suggesting a correlation between the length of wait experienced and the potential risk of complexity and chronicity. Work to sustain and spread the positive learning from this model, as a means of addressing the increased demand across other rehabilitation services in line with the 'Rehabilitation in health framework' (Figure 1) is ongoing.

The diagram below shows the framework which details the need for a focus on informal and community-based resources, further links with primary care and the maintenance of specialist services.

Figure: Rehabilitation in Health Framework



Group 2:

The rehabilitation of those people where emerging evidence points to a negative impact as a consequence of the lockdown restrictions.

This includes people who have been 'shielding'; those not shielding but at risk; those with additional vulnerabilities and their carers; children and young people who are not in school, those with musculoskeletal issues due to deconditioning and a lack of physical activity; those with pre-existing and emergent mental health and wellbeing issues; potential exacerbation of specific conditions, such as Chronic Obstructive Pulmonary Disease, chronic pain and type 2 diabetes.

Various AHP services across child and adult services have developed or expanded online resources, training videos and supports for self-management of their condition. Social media i.e. AHP websites,

Facebook, and Twitter have been successfully utilised to maximise reach and access for the GGC population.

Group 3:

Ongoing and intensive prehabilitation and rehabilitation for people with long-term physical and mental health conditions, multiple comorbidities and those who have been impacted from delayed diagnoses and scheduled treatments due to pausing of non-critical health services.

Where people require specialist rehabilitation services, these have remained available throughout the pandemic, offering remote access or face to face services as clinically indicated. Across GGC the AHP mobilisation plan enabled mutual professional prioritisation and deployment of staff, ensuring essential priority services were maintained across acute and community services, managing patient safety and mitigating risk. These plans ensured AHPs specialist skills were maximised and utilised appropriately in deployment situations, and a wider contribution to the pandemic response within core roles.

11.8. Care Homes

Our aim is to provide advice, support and guidance to Care Homes on nursing requirements and on infection protection and control, aligned to an ongoing schedule of assurance visits. This is to support the full recommencement of social care packages to allow residents to live fulfilling lives in a homely environment. During 2021/22, we will continue to have an enhanced role in professional oversight and mutual aid in Care Homes, including ongoing schedule of assurance visits.

In GGC, we have 196 Care Homes with 9,287 residents and approximately 15,000 staff. 142 of these homes provide services to older people. The governance structure builds on local daily huddles in each HSCP, with escalation to weekly HSCP meetings, and reporting through the Board-wide Care Home Quality Assurance Governance Group to the Strategic Executive Group (SEG). Care homes have experienced significant challenge over the last year. These challenges include:

- **High volume of guidance issues**
- **Variation in quality of care**
- **Availability and resilience of staff**
- **Leadership and management**
- **Standards, inspections and quality assurance visits**
- **Managing COVID-19 outbreaks**
- **Indoor visiting**.

A Care Home Hub Model has been developed in 2020, and will be fully implemented by April 2021. Two hubs will be established – one in Glasgow City HSCP and another covering the other five HSCPs with the boundaries of NHSGGC (East Renfrewshire, Renfrewshire, West Dunbartonshire, East Dunbartonshire and Inverclyde). Inverclyde HSCP will lead on the Care Home Hubs model for the whole system. Each hub will be supported by a multidisciplinary team to ensure there is comprehensive support for care homes both proactively, and in response to issues raised. A Care Home Hub Programme Board, co-chaired by the Director of Nursing and Inverclyde HSCP Chief Officer, has been set up to provide leadership and oversight for the model. The Hub model will ensure consistent communication across the system, oversee resource allocation and will set and monitor outcomes against plans. Local Enhanced Service arrangements for GP practices covering Care Homes will be reviewed and revised to ensure learning and changes from the support provided during COVID-19 are taken into account.

11.9. Primary Care

Current position and strategic objectives

Our primary and community services are focussed on providing and supporting people to access, the right services at the right time and in the right place. There is a drive to promote self-management and independence and enable people to live longer, healthier lives in their own homes and communities. Key to keeping people in their community or in their home is early intervention and having a range of accessible services which provide anticipatory care to prevent escalation to hospital or specialist services.

Key to this is the ongoing implementation of Primary Care Improvement Plans as part of the wider transformation of primary care, focus on enabling the expert medical generalist role and the development of multi-disciplinary teams working together with practice populations, building on the list based system of primary care, to ensure that people can access the right professional at the right time.

GP Practices and Community Pharmacy remained open and accessible to patients throughout the pandemic. Community Dentistry and Optometry faced particular challenges and restrictions in the early phase of the pandemic, and have been building up activity and addressing backlog and unmet need in services in line with national remobilisation guidance and infection control measures. All GP practices have been operating with a telephone first model of triage and telephone or online assessment, with face to face consultation only where required. Many processes have changed across the whole system of care and referral pathways, to take account of new requirements and to reduce patient journeys and paper.

Demand across primary care is related to new concerns and also issues where there may have been a delay to presentation during previous lockdown periods. Particular additional demand has been identified in relation to mental health, financial pressures and isolation, and also patients seeking to understand next steps in relation to referral for other services. Chronic disease management has continued based on clinical priority, and the cervical screening programme was restarted in summer 2020 in line with the national restart.

The COVID-19 community pathway continues to play a key role in ensuring appropriate management of COVID-19 suspected / positive patients. It had a key aim to minimise the exposure of patients using GP practices to COVID-19, enabling the most vulnerable and complex patients to continue being supported by General Practice.

Interface Arrangements

NHSGGC already has well established interface arrangements including a longstanding Primary/ Secondary Interface group including the Deputy Medical Directors (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. Since the last iteration of the plan our joint working arrangements have been strengthened further with whole system planning in place to support ongoing recovery, remobilisation of services and also in the development of new services. Key areas of development are noted as:

- **ACRT** - primary and secondary care collaboration to develop pathways and shared communications
- **Strengthening of sector based interface groups**
- **Whole system approach to the redesign of urgent care and establishment of the Flow Navigation Hub**. This work will continue to develop and redesign urgent care pathways across the whole system over the next 18 months
- **Further developing plans for phlebotomy services** as a further progression from the current acute phlebotomy hub arrangements and the Community Treatment and Care services established within the community as part of Primary Care Improvement Plans, and linking to ongoing development of virtual patient management processes across primary and secondary care
- **Weekly informal meetings** established between the Associate Medical Directors for acute and primary care to identify and address emerging issues and develop shared communications

- **Establishment of clearer processes** to review pathways with cross system clinical engagement
- **Focus on improving communications around the interface** to ensure that information on referral pathways, changes to services and current developments is easily accessible.

These have contributed to the proactive approach that sees a whole system approach to re-design now embedded as standard.

General Practice

It was previously noted that an estimated seven million consultations take place in General Practices in NHSGGC every year. Supporting sustainable recovery within General Practice is therefore critical to whole system recovery and the effective management of patients in a community setting. This includes supporting the following roles as part of the developing expert medical generalist role.

- **Undifferentiated presentations**; those people who may require further assessment, investigation, referral or admission
- **Complex care in the community**; those people who may require more GP/multi-disciplinary team time, particularly for anticipatory care planning
- **Whole system quality improvement and clinical leadership**; continuous quality improvement both within and across GP practices in the cluster and the wider health and social care system.

Through 2021 our work with GP practices will continue to focus on the following priority areas.

Primary Care Improvement Plan (PCIP)

PCIP implementation is the mechanism for delivery of the extended multi disciplinary team working with General Practice to meet the core commitments of the 2018 GMS contract. Implementation in 2020/21 was affected by the pandemic response in terms of planning and implementation capacity, redeployment of staff to support key COVID-19 response role, competing demands on premises and accommodation. It has also been an opportunity to introduce new ways of working which brings in potential for innovation and better ways to ensure equity of provision across practices, including maximising virtual consultations and hub based models. The focus on PCIP implementation in 2021/22 will be to meet the specific revised commitments for the GMS contract agreed in December 2020, and to continue to align next steps in PCIP implementation with wider Board recovery priorities and current and emerging local population needs. Key commitments and priorities here include Vaccination Transformation Programme, including arrangements for transfer of responsibility in line with revised timescales. A particular priority will be planning for the flu vaccination programme alongside next steps in the COVID-19 vaccination programme as part of a sustainable longer term vaccination programme.

- **CTAC services to ensure that chronic disease monitoring and treatment room services are available** to all practices. This includes opportunities to align with acute phlebotomy requests and developments as part of wider outpatient and elective redesign
- **Pharmacotherapy commitment to providing level 1 pharmacotherapy** to all practices by 2022/23
- **Urgent Care Services and Additional Professional Roles**, as part of whole system pathway developments as set out in earlier sections of this document
- **A continued commitment to supporting effective multi disciplinary team working**, and to evaluating the impact of changes for patients, practices and the wider care system.

PCIP Key Enablers include:

- **Premises** – building on work in Renfrewshire, agree primary/community premises strategies as framework for decision making and future developments
- **eHealth** – Continue to support virtual consultations and remote working.

Data

Engage with SG Short Life Working Group (SLWG) on data intelligence to improve information available on activity, outcomes and workforce and to inform evaluation COVID-19 community pathway - Supporting the continuation of the COVID-19 community pathway. This includes the pathways between GP practices, COVID-19 pathway and GP Out of Hours, and support from the primary care workforce across all parts of the system to ensure the COVID-19 pathway remains sustainable. The 'Practice Emergency Contribution' model was developed as a contingency as part of escalation measures.

COVID-19 immunisation programme

Continue to support GP practice delivery of the agreed priority cohorts.

Care Homes

Local Enhanced Service arrangements for GP practices covering Care Homes will be reviewed and revised to ensure learning and changes from the support provided during COVID-19 are taken into account.

Quality improvement and GP Clusters

GP clusters have a key role in quality improvement across Genera Practice working with the wider system of care. This requires ongoing support with data and intelligence to inform priorities, leadership development and QI support, and project support for QI initiatives. Cluster Intelligence Reports will continue to be developed to support this, underpinned by improved data and intelligence.

Chronic Disease Management (CDM)

Chronic Disease Management will be a core part of rebuilding in general practices and a key focus for clusters and QI. CDM for unstable and other priority cases has continued, supported by condition specific advice on prioritisation including close working with Managed Clinical Network (MCNs). There has been a focus on supporting those identified as particularly vulnerable and 'shielding' including individual discussions and Anticipatory Care Planning (ACPs). The scale and pace of routine CDM reviews will be influenced by a range of factors including availability of supporting services, further advice on risk stratification and prioritisation and opportunities for redesign supported by virtual consultations, home monitoring and support for self-management. Engagement in whole system pathway redesign will be key.

Cervical screening

Supporting practices to address any backlog in screening appointments, as part of a wider review of capacity and contingencies.

Staff wellbeing/sustainable workforce

GP workforce and practice sustainability were key national issues prior to the pandemic, and addressing these were among the key aims of the new GMS contract. We will seek to understand any sustainability and workforce risks within General Practice as we move out of pandemic phase, and develop appropriate responses, linking to wider MDT work.

Inequalities

General Practice and the extended MDT has a key role to play in addressing inequalities and working with other parts of the system to address the additional inequalities risks identified in the inequalities section above, particularly in relation to the medium to long term impact of COVID-19 and the consequence of financial uncertainty and poverty for individuals, families and children. We will continue to ensure that PCIPs are developed taking account of local population needs, and work closely with the SG Short Life Working Group on Health Inequalities to take forward any recommendations.

Eye Care Services (Community Optometry)

Community optometry services were remobilised in the second half of 2020 with a number of developments established to support and promote these pathways. Priorities for 2021/22 will include:

- **Continued increase in community optometry activity** up to and beyond pre pandemic levels, increasing routine activity and regular eye examinations as restrictions allow
- **Continue to promote community optometry** as first port of call for eye problems
- **Build on the Glaucoma shared care programme established in December 2020** to increase the number of Glaucoma patients reviewed in community settings, and consider expansion to other conditions where appropriate.
- **Continue to expand and support Independent Prescribing** and increase the number of NES Glaucoma Award Training (NESGAT) trained community optometrists.

Community Dental Services

From 1st Nov 2020, the full range of NHS dental care has been available in high street dental practices, in line with national guidance www.scottishdental.org/wp-content/uploads/2021/02/SOPS_28Jan2021_PHrevision.pdf

Following the release of the Oral Health Improvement Plan in January 2018, engagement with stakeholders continues to progress with the 'New Model of Care' and the aligned financial package which will replace the current Statement of Dental Remuneration.

Public Dental Services (PDS)

PDS continue to remobilise to provide its full range of services. A review of the PDS is currently being undertaken. This is in line with the Oral Health Improvement Plan (OHIP) and the Moving Forward Together programme within NHSGGC. This is to ensure that the services being provided by the PDS are fit for purpose and that the infrastructure is appropriate to support them to allow PDS to provide care to those most in need. The review is focused on four areas:

- **Development of Clinical Offer**
- **Modernisation of Estates and Facilities**
- **e-Dentistry**
- **Workforce.**

Urgent and Emergency Dental Care

Clear guidance is available to ensure the appropriate management of patients with acute dental problems: www.sdcep.org.uk/published-guidance/management-of-acute-dental-problems-madp

11.10. Glasgow North East Hub – Capital Build (Glasgow City HSCP)

Glasgow North East hub is a significant investment proposal to improve services in the North East of Glasgow and deliver key strategies set out in the Board's Moving Forward Together programme. The proposals for the new facility and the integrated services that will work from it are consistent with the five strategic priorities set out within the NHSGGC's Corporate Plan; and the priorities set out within the Strategic Plans for the HSCP and IJB.

The service delivery model includes services for children and adults, across the areas of mental health, addictions, criminal justice, homelessness and health improvement, delivered by a range of public and third sector organisations. The Hub will therefore support a tiered model of care across the entire health and social care system, by enabling health, social care and third sector services to work together to promote early identification of need, early intervention and joined up working to support children, young people, parents/ carers, adults and older people living in the North East.

Building on the existing initiatives that work to reduce poverty across the HSCP, the Hub will facilitate connectivity between health and social care services to deliver a "place-based" approach across a range of public and third sector organisations, and will also include GP practices with multidisciplinary teams, community pharmacists, community spaces, a library and a café. A range of engagement sessions with local residents have been carried out at various sites across the North-East, and elements which are considered important to local residents have informed the design process.

Construction is proposed to commence in September 2021, subject to Full Business Case approval, with an expected completion date of 2024.

12. Enablers

12.1. Digital and Innovation

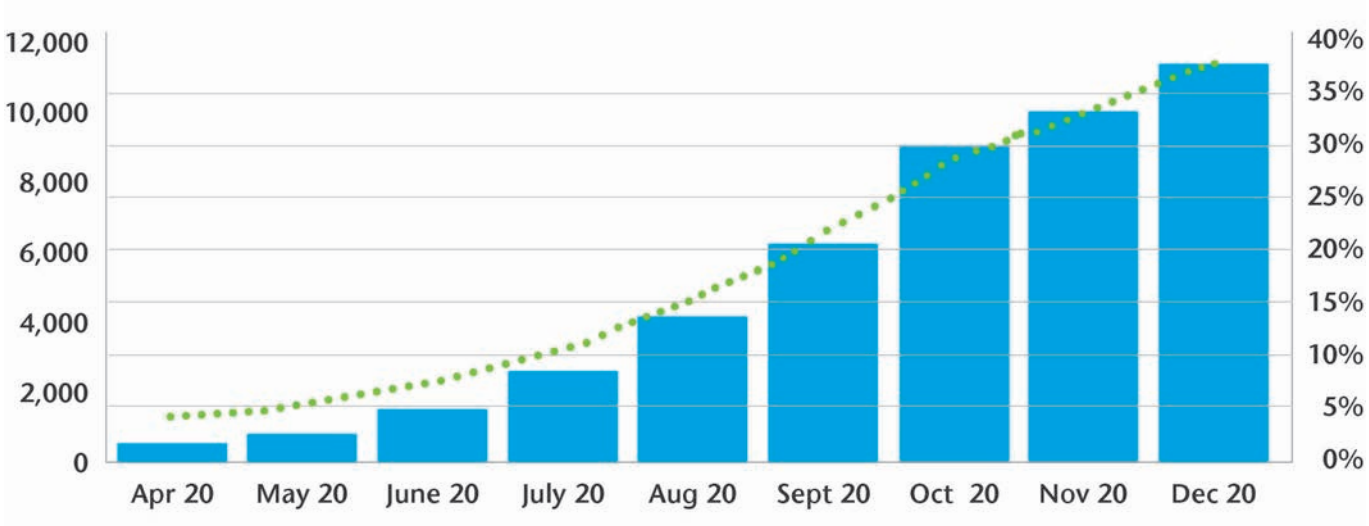
Key Points

- Implementing the Digital Health and Care Workplan will direct our priorities for 2021/22
- We will continue to increase our rates for Virtual Patient Management (VPM) through ACRT and remote consultations, as appropriate
- We will maintain our record of rapid response to demands generated by our COVID-19 workload
- Innovation and learning from new practices will inform our priorities.

An Oversight Group was established in June 2020 to focus on maximising the use of remote and virtual technologies. A multidisciplinary group with eHealth, Health Records, Management, Clinical and Planning representation exists to set out the Board's expectations around service level adoption, provide support and monitor progress of implementation. In addition, Service Improvement Managers have been appointed for Clyde, North & South sectors, working with the Clinical Service Manager, senior Clinical Staff and service support staff to support key areas/sub-specialties for focus and are working together to establish cross-sector agreement, and standardisation of vetting practice and pathways across GGC.

Significant progress has been made. Referrals vetted through ACRT have risen from 4.2% (499) in April 2020 to 38.2% (11,332) in December 2020.

% of Consultant Referrals vetted via ACRT April 20 – December 20



Within Community and Mental Health Services and Community Children's Services the use of virtual patient management has remained consistently above 30%.

This increase has been supported by a significant investment programme of equipment across GGC and dedicated training for clinical staff on the use of the Attend Anywhere/Near Me system. Further programmes of training will continue to be scheduled to include a combination of 'Drop In' Sessions and targeted training for staff in teams/specialties. This includes the roll out to all GPs and Community optometrists to support a telephone/virtual consultation first model.

A review of high volume specialties and subsequent development of trajectories, combined with the introduction of tailored service improvement support, will be the focus for the year ahead. Work is also

underway within the HSCP tactical group to identify further opportunities across community children's services and also community adult mental health services where steady progress is being achieved currently with over 10,000 and 25,000 consultations respectively being carried out virtually – equating to over 30% virtual delivery in these areas across GGC.

77% of clinic templates have been changed. Developments have been made to the TrakCare system for patient correspondence which will allow us to ensure that patients receive tailored communication regarding their appointment appropriate to their mode of contact: Face to Face, Telephone, Video and Written. This will ensure that for video appointments the patients unique URL link will be presented on their letters, and for telephone appointments, the telephone number we will call the patient on is presented which gives an opportunity for patients to contact us to change the number if its incorrect therefore reducing the DNA rate.

Text reminder campaigns have been established within the Netcall system which supports tailored text message appointment reminders to patients, appropriate to the mode of contact.

A programme of work to rationalise vetting outcomes has commenced standardising ACRT vetting outcomes across GGC, safe removal of vetting outcomes no longer applicable, ensuring that vetting outcomes map appropriately to appointment types and clinical services understand ACRT principles.

Redesign of Unscheduled Care

We will continue to support the Board's Unscheduled Care Programme. The Call MIA pilot in Stobhill went live at the beginning of November 2020. The Flow Navigation Hub went live on 1st December 2020 utilising the Board's cornerstone applications such as TrakCare and Clinical portal to provide scheduled virtual consultations utilising Near Me with an aim to prevent ED attendances. A total of 253 Near Me consultations took place during December 2020.

Phase 2 implementation is underway to include the development of Specialty Referral Pathways for ENT, Gynaecology, Sexual Health, Falls/Nursing home residents. It will also include the development of pathway to support Paediatric Flow.

Device replacement and Office 365

During 2021/22 the device replacement programme will be accelerated. To date, approximately 24,000 devices have been replaced with a balance of 14,000 currently in procurement to complete the programme. The pandemic has altered working practices with a significant number of staff working from home and also on a much more mobile basis. This has resulted in many more mobile devices with remote access requirements and changed the balance of laptops to desktops. This was 25:75 previously and it is likely that the future ratio will approach 40:60.

In parallel with device replacement, deployment of MS Office 365 will be scaled up across the organisation to enable further online collaboration, video Teams calls and meetings and the secure sharing of files and documents. The implementation of Office 365 will also enable better digital communication across Boards and external organisations.

Screening and Testing

At the start of the pandemic GGC implemented new technology to support the Board's staff testing programme. This included on-line booking of testing appointments, a text results service and data dashboards and reporting.

Recently the National Notification Service (NNS) for COVID-19 results for patients and staff has been implemented. It is necessary for all NHS Board's to implement the NNS so that the GGC text results service can be switched off. In addition, the new Netcall Hub is being developed to deliver staff test results for the SIREN project and an automated service for both COVID-19 PCR tests and SARS CoV2 IgG will be operational in February 2021.

Vaccinations

The staff vaccination programme was supported by an online booking system called Webropol. This was used to book over 80,000 staff in line with the JCVI prioritisation across NHS and partner organisations. The programme for 1st vaccinations is concluded and staff are now being invited to book their 2nd vaccination appointments. It will be necessary to set up ongoing staff vaccination bookings.

The National Service Now (SNOW) scheduling system is now live and in use in GGC to book appointments for the various cohorts of people for mass vaccination. Cohort files in line with JCVI prioritisation are sent to the GGC Business Intelligence team for validation. GGC have worked closely with National Services Scotland (NSS) to test and implement the SNOW system and Board's currently have a view only access to the system. NSS will hand over a range of functions to Board's to enable rebooking, cancellations and other functions to be carried out as the mass vaccination programme progresses.

A local call centre has been implemented to deal with calls and enquiries passed to GGC from the national contact centre for vaccination bookings. Local issues such as transport requests, requests for home visits and clinical enquiries are passed to GGC to be dealt with.

HEPMA

HEPMA (Hospital Electronic Prescribing and Medicines Administration) will replace the paper drug chart (Kardex) for inpatient areas across NHSGGC. Doctors and other prescribers will use HEPMA to prescribe medicines for inpatients and nurses will use HEPMA to carry out drug rounds and record the administration of medicines to patients. The WellSky HEPMA system is already in use in several other NHS Boards in Scotland.

The COVID-19 pandemic introduced a three-month delay to the planned timescales identified in NHSGGC's HEPMA Full Business Case. Other Boards which already had HEPMA reported benefits in the context of the pandemic, e.g. enabling remote prescribing. The implementation of HEPMA was therefore prioritised and accelerated, to enable the pilot to begin in December 2020. The pilot has commenced and the system is now implemented in Wards 7A, 7B, 7C, 7D and ARU1 in the QEUH.

Following completion of the HEPMA pilot NHSGGC will begin the rollout of HEPMA across the Board area. Rollout is targeted to begin in March/April and will include 330 wards and 115 theatre areas. It is estimated that rollout will take 18 months to complete, ending in autumn 2022. It is expected that rollout to the three largest acute hospital sites (QEUH, Glasgow Royal Infirmary & Royal Alexandra Hospital) will be completed during 2021/22, with rollout to further sites continuing into 2022.

Digital Channels for Heart Failure and COPD Pathways Patient Hub

A new system, the Netcall Patient Hub is currently being deployed to deliver COVID-19 antibody test results to staff members participating in the SIREN study.

A broader programme of work is also being planned for the use of the Patient Hub:

- **Deliver outpatient appointment notifications**, allowing patients to view appointment offers and accept, cancel or request rebooking of offers online. This will start with one specialty with the intention of scaling up to more specialties as the service becomes established. The Board currently sends around 60,000 outpatient letters per month. The objectives of this digital service are to reduce DNAs, reduce the number of paper letters sent and save staff time spent printing and posting letters and responding to re-booking requests.
- **Deliver more test results automatically to patients**. This will initially target notification of HIV viral load results in acute services.
- **Develop workflows that will allow patients to be sent additional information directly from clinical pathways**. The reduction in face to face appointments brought about by the move to remote

consultation means it is no longer possible to hand over leaflets and forms directly to patients. New digital channels such as the Patient Hub will allow clinical staff to initiate a one-way patient communication directly from an existing clinical pathway in TrakCare.

Remote Monitoring of Patients

As part of the respiratory service COVID-19 response, access to the COPD digital service is being scaled up. There are currently 203 active users of the service and a further 118 eligible patients being on-boarded.

Eligibility for the service and management of patients through identification, invitation and sign-up, is now being done using custom, integrated TrakCare waiting lists and a digital dashboard created for this purpose. This has greatly streamlined the eligibility vetting process and there are a further 685 service referrals currently in this workflow.

While patient identification and on-boarding continue, other developments will see the service continuing to integrate with community respiratory teams, as well as signposting for GP and community pharmacy colleagues.

InHealthcare - COVID-19 App

A COVID-19 remote monitoring clinical pathway for high-risk patients has been developed with clinical input as part of the national project using the InHealthcare Application as a pilot. Following assessment, patients are asked to log pulse oximeter readings and other symptoms through their choice of a website, an app, SMS or touchtone phone.

This clinical pathway is currently being tested within NHS Lanarkshire. GGC have engaged with the national Tech Programme and provided feedback to improve the INHealthcare pathway and have provided clinical feedback and await evaluation from Lanarkshire in anticipation of any further rollout.

NHSGGC has a strong track record of delivering at-home monitoring as detailed through our respiratory COPD innovation work, using tools that integrate tightly into our data platforms, feed into our electronic records and our excellent network of Community Respiratory Response Teams. We are therefore in a good state of readiness to contribute to clinical trials and evaluation of home monitoring, but would not necessarily wish to limit this to one particular product.

Our COVID-19 Assessment Centres all use the TURAS platform-based COVID-19 Assessment Tool providing excellent visibility of the clinical assessment to downstream health services. We believe our current pathways are working efficiently and effectively at present. We keenly await the outcome of the initial pilot on NHS Lanarkshire which we understand has recruited around 12 patients to date. This evaluation is still at a very early stage.

InHealthcare – Rapid Heart Failure App

GGC in collaboration with Ayrshire & Arran (A&A) are currently designing a Rapid Heart Failure App using the InHealthcare Application as a pilot.

In addition, two questionnaires are also being developed within the app the ‘Kansas City Cardiomyopathy Questionnaire’ (KCCQ-12) and the ‘Patient Health Questionnaire-4’ (PHQ-4).

Heart Failure Innovation Project

Work is underway with the Heart Failure Service to investigate the use of hand-held echocardiography scanners and the accuracy of AI interpretation of the images produced from them.

The Heart Failure Service commenced an intensive programme of diagnostic clinics at Louisa Jordan in December 2020. Primarily intended to tackle an accumulated backlog of referrals to the Heart Failure Service, these clinics are also being used to provide input to the OPERA study. At these clinics,

consenting patients will have an additional echocardiogram done, using a hand-held device. Images from hand-held scan will be subject to AI analysis and interpretation. The study will then compare the AI derived interpretation with the actual clinical diagnosis from the existing pathway that uses traditional echocardiography machines.

This service makes use of a new web application that will be fully integrated with TrakCare, SCI Store, Clinical Portal and Business Intelligence systems allowing Heart Failure nurses and consultants to view all relevant clinical information, scan results and blood tests in one place. Observations gathered at clinic along with clinic summary reports can then be saved directly into the patients existing electronic health record and sent to the patients GP practice.

By late January 2021, these clinics had seen 131 patients from the Heart Failure diagnostic waiting list, most of those also having consented to participate in the OPERA study.

Other work with the Heart Failure will see redesign of the system used by the heart failure community nurse service. Redesign will bring this system up to date and integrate it with other core clinical systems.

12.2. Workforce and Workplace

Key Points

- Sustained commitment to supporting staff mental health and wellbeing with a focus on delivering our revised Mental Health and Wellbeing Action Plan for 2021/22
- Focused workforce planning to ensure front line services are maintained with Nursing, Midwifery and Dental Students creating additional capacity to support Winter and COVID-19 demands
- Recruitment campaigns for Healthcare Support Workers, and Admin Bank will enable the longer term resourcing of Test and Protect and the Vaccination Programme
- Moving forward, recognising the need for professional recovery. This includes developing and building on new skills required for new roles that are emerging as we redesign services, and regaining our focus on education and continuing professional development.

Since the start of the pandemic response, health and social care staff have shown significant resilience and dedication to delivering high quality care for patients and service users. Many staff have stepped into unfamiliar roles, taking onboard additional training, working from home and, in some areas, fundamentally transformed the way they deliver care.

Vision

NHSGGC have continued to support the mental health and wellbeing of our staff with an evidence based approach which is aligned to the distinct phases of the pandemic (Preparation Phase, Mid Phase, Peak, and Recovery). The vision is for staff to feel enabled to deliver high quality patient care in an environment which is supportive of their mental health and wellbeing in the longer term. Key priorities include:

- **Maintaining sustained commitment to supporting staff mental health and wellbeing** with a focus on delivering our revised Mental Health and Wellbeing Action Plan for 2021/22
- **Anticipatory workforce planning to maintain the level of frontline services** and developing a workforce for additional capacity including Test and Protect and the Vaccination Programme
- **Providing appropriate PPE and maintaining appropriate social distancing** to ensure the health and safety of staff is a key priority.

Progress to Date

Staff Health and Wellbeing

The formal approval of our Mental Health and Wellbeing Action Plan by the Strategic Executive Group has enabled the development of a range of initiatives, with actions implemented to support the mental health and wellbeing of our staff. The first Mental Health Check-In was a success and will be run again in January 2021 with a further follow up in the summer. Additional resource has been provided to Occupational Health in the form of staff psychology support and Cognitive behavioural therapy (CBT).

The plan has been developed with input from the Wellbeing Champions from the six HSCPs and reflects their approaches to sustaining and improving staff wellbeing aligned to the principles of the NHSGGC supported by NHSGGC Staff Health Strategy, NHSGGC Workforce Strategy and NHS Scotland Staff Governance Standards.

- **The Workforce Mental Health and Wellbeing Group** is established to progress implementation of actions this includes a sub group on Peer Support and a sub group on medical staff wellbeing
- **All activity is discussed and agreed in partnership** through members of the Area Partnership Forum
- **The Board's COVID Endowment Committee** has provided funding to continue the Rest and Relaxation Hubs across the Acute and Mental Health Inpatient Areas
- **The plan for 2021/22 includes all the previous support** including links to the nationally available resources and places a key focus on Peer Support rollout and researching more on the impact of Long COVID on staff.

Clinical pathways have been changed and services have been re-designed across all services areas with capacity expanded in key areas, particularly critical care when needed and new services such as Community Assessment Centres introduced.

The importance of staff having the opportunity to fully utilise their leave allowance during this leave year to rest has been recognised and encouraged with the development of an Annual Leave modelling tool to enable planning of leave within all services for the remainder of 2020/21 financial year.

Advanced Practice & Transforming Roles

Following the first phase of the Transforming Roles programme NHSGGC is meeting the turnover requirement of its Advanced Nurse Practitioner (ANP) workforce, and has made significant improvements in the consistency of the ANP role and training. Work is underway to further improve the consistency and sustainability of ANP training as part of the second phase of the Transforming Roles programme, as well as broadening the scope to establish a robust approach to the development of new Clinical Nurse Specialist (CNS) roles, assisting existing CNSs in evidencing their professional development and acquiring any qualifications they need to pursue their role, and ensuring consistency within the Board and as part of a wider approach within Scotland.

In response to the development of new services and Clinical Pathways, such as the Flow Navigation Hub, efforts are continuing to develop the breadth and resilience of the ANP cohort. This will include increased numbers of nurses training to become qualified ANPs, as well as qualified ANPs being supported to become Senior ANPs. These types of developments will allow services to better meet clinical and patient priorities, and provide a robust career path for the development of the Advanced Practice workforce.

Workforce Planning

The Board has demonstrated its ability to recruit staff into key roles, both as backfill for absence and staff turnover, and for additionality in key areas, for example acute nursing.

The staff bank has been key to the successful resourcing of mass vaccination clinics, with over 2000 nursing and midwifery shifts delivered each week, including 1200 vaccinator shifts. The vaccinator resource pool is augmented by over 1200 private contractors, who are available to work additional sessions as and when required. Both of these resource pools will continue to grow in the coming year.

The Test and Protect function is fully resourced with over 100 contact tracers available on every shift. There is a dedicated support and management hierarchy in place to support this operation, and further recruitment can be quickly achieved through a proven, repeatable process.

Administrative staff and redeployed staff have been reassigned to support key activity. This will continue as required during the remobilisation period.

Annualised staff turnover within the Board is relatively constant over the past two years at 7.5%. This equates to approximately 0.7% or 225 WTE leaving each month. There has been no material change to this during the pandemic. This is not expected to change in the coming year due to the expected economic climate.

Allied Health Professional are supporting delivery of acute care whilst recognising that there is a requirement to maintain rehabilitation and community service to prevent the health debt previously evidenced. This is on a prioritised basis, with some AHP staff working in high priority areas such as ICU/HDU to support proning, etc. There are currently 292 AHPs reassigned into front line roles. This is continually reviewed and can be flexed to align with operational demands.

Nursing and midwifery teams have professional systems in place already to monitor and mitigate risk, including twice-daily safety huddles in Acute sectors and daily monitoring of safe staffing levels in HSCPs. Decisions to actively realign staff are made via these professional systems.

Additional nursing staff can be aligned to ICU / HDU units to deliver surge capacity. Safe staffing models have been introduced to allow registered nurses from a non ICU / HDU area to undergo additional training and then to work alongside colleagues experienced in these areas.

Up to 240 medical staff are available to be reassigned to the ICU from across the wider anaesthetic medical workforce. After a skills assessment and appropriate skill refresh or upskill training a total medical workforce of 325 WTE (195 consultants and 130 junior grades) could be available. Planning assumptions have identified the following levels of increased ICU capacity that can be achieved within agreed timeframes: 76 beds (one week), 129 beds (two weeks) and 170 beds (maximum surge capacity).

Healthcare Support Worker (HCSW) recruitment is continuing, and Band 2 HCSW candidates are available within the recruitment pipeline if needed.

Administration Bank recruitment has enabled a total of 87 workers to be added to the staff bank for allocation to shifts to support wards and departments across Acute Services. The recruitment of 1200 Nursing, Midwifery, Medical and Dental Students, working as HCSWs on a six month fixed term contract (15 hours per week) will be delivered in three phases to allow appropriate governance and management to be put in place, and to allow experienced workforce to be deployed adequately to help assist with Winter and COVID-19 demands and pressures.

With regards to Mental Health, contracts have been offered to 100 individuals and all students are being managed in a single phase.

Engagement was held with managers of local services to identify potential staff members who are currently in non-clinical positions that could be reassigned to support with administration tasks in identified wards and this work is ongoing.

A full review of individuals on our redeployment list has been completed, with all individuals contacted and reassessed.

Staff Availability

COVID absence is currently reported seven days per week and reviewed by the Strategic Executive Group. Detailed COVID absence reporting is provided to the COVID-19 HR Support Team to ensure they can provide the appropriate level of support and guidance to the supervisors of anyone absent.

The table below summarises the key results and scenario planning:

	April peak	August low	Current	Scenario A	Scenario B
Self-Isolating (Own Symptoms)	1029	8	32	30	30
Underlying Health Conditions	824	147	600	700	750
Self-Isolating (H/hold)	794	9	95	125	150
Carers/Parental Leave	200	30	33	50	50
Positive Cases Positive Cases	22	26	237	300	400
Long COVID	0	0	192	250	400
Test & Protect Isolating	0	2	57	75	100
Quarantine	0	9	26	20	20
Total Absent (COVID Related)	2869	231	1272	1550	1900
% of workforce absent	7.2	0.6	3.2	3.9	4.7

- Scenario A assumes an increase of COVID positive cases of approximately 25%
- Scenario B assumes an increase of COVID positive cases of approximately 75%
- Each scenario illustrates a knock on effect to Long COVID and Isolating
- Self-Isolating due to own symptoms scenarios are not expected to increase due to the ease of access to testing facilities
- Household isolating is more susceptible to increase and this has been reflected above
- Underlying Health Concerns are not expected to increase to previous levels due to updated government advice.

Scenario A demonstrates a 0.7% increase in COVID related absence, Scenario B demonstrates a 1.5% increase. Neither scenario, nor any reasonably predictable future scenario would see a return to the peak of 7.2%.

The most likely scenario is a small increase from current levels, to approximately 3.5%.

Staff Availability & Absence Scenario Planning (6 months)

The table below shows an updated position including modelling for the next six months:

	Q2 20 Actual	Q3 20 Actual	Jan 21 Actual	Feb 21 Forecast	Mar 21 Forecast	Apr 21 Forecast	May 21 Forecast	Jun 21 Forecast
Staff availability	80.10	80.30	81.40	79.30	78.80	79.5	80.3	80.1
Annual Leave	11.3	9.6	7.7	10	10.5	10.5	10	10.5
Sickness Absence	5.4	6.1	5.8	6.5	6.5	6	6	6
Special Leave (including COVID19)	2.6	3.3	4.6	3.5	3.5	3.3	3	2.7
Other	0.7	0.7	0.5	0.7	0.7	0.7	0.7	0.7

Staff availability for the past 6 months has remained just above 80%. If current absence levels represent the peak of the current wave, the predicted staff availability should be achievable.

12.3. Pharmacy

Key Points

- New pharmacy service delivery models
  - Serial Prescribing: Community Pharmacy management of repeat prescriptions
  - Medicines at Discharge: Community Pharmacy supply of medicines at discharge, enabling hospital pharmacy service transformation
  - Pharmacy First: Community Pharmacy management of minor ailments/common clinical conditions
- A Pharmacy Strategic Framework to provide direction through remobilisation and beyond
- Pharmacy workforce: Review primary care pharmacy service to delivery to ensure appropriate skill mix, leadership and management arrangements.
- Maintain security of medicines supply, including COVID-19 vaccines
- NHSGGC Quality Strategy: Focus on safer use of medicines & person centred care

Introduction

Our response to the pandemic involved significant changes being made quickly and at scale across all settings and services e.g. closer collaboration between critical care & medicine supply teams, access to palliative care medicines in care homes & whole system pharmacy staff deployment in key areas.

This led to greater collaboration between services and demonstrated what is achievable in a complex system, so as we moved into the recovery period over the summer we sought to build on this to replicate behaviours and changes in practice across pharmacy services. We identified three priority change projects as central to our 20/21 remobilisation plan and they remain a core part of our plan for 21/22.

These new models of service delivery form the basis of a longer term plan to develop collaborative, innovative pharmacy services which will transform how we work. To provide direction and inform planning through remobilisation and beyond we have started work on a Pharmacy Strategic Framework and as we move forward we will explore how best to engage staff and put these new ways of working into practice across pharmacy services.

eHealth developments such as HEPMA and sustainable workforce development across all sectors are key enablers for successful remobilisation and new ways of working, so are important elements in the plan for 21/22.

We will continue to balance service development with maintaining a focus on securing the medicine supply chain to meet surges in demand for critical medicines and delivery of the COVID-19 vaccination programme. Clinical governance activities paused during the pandemic are being restarted with a key focus on safer use of medicines and developing a more person centred care approach in the delivery of pharmacy services.

New Service Delivery Models

Serial Prescribing

Serial prescribing enables prescribers to issue prescriptions for suitable patients which are valid for extended periods of time e.g. 48 weeks. This removes the need for GP practices to issue repeat prescriptions every couple of months and patients only need to contact their community pharmacy for ongoing supply. Pharmacy are working with GP practices to rapidly increase the volume of serial prescriptions in order to reduce unnecessary footfall in GP practices and help community pharmacy management of dispensing volumes.

Medicines at Hospital Discharge

Delays at discharge from hospital are a long-standing problem. To help improve this Pharmacy Services have tested the feasibility of supplying patients' discharge medicines via their community pharmacy. Testing in 40 patients discharged from GRI reported a reduction of just over two hrs in time taken to discharge a patient with positive feedback from the patients involved. The Test model is dependent on legal exemptions in medicines regulations during a pandemic, so we are looking at options to develop and test a model of supply and reimbursement in non-pandemic times. This model also has the potential support transformation of hospital pharmacy services.

Pharmacy First

The national 'Pharmacy First' scheme has been implemented across all NHSGGC community pharmacies and is open to all people registered with a GP practice in Scotland. People with minor ailments/common clinical conditions can attend a pharmacy where they will be assessed and offered advice, treatment or a referral. This frees up GP appointments and is more accessible for people. The scheme is supported by a national list of approved medicines for supply and further work is planned to extend the range of common clinical conditions which can be managed this way to build further capacity in primary care.

Pharmacy Strategic Framework

Prior to the COVID-19 pandemic, pharmacy engaged staff in discussions about the strategic direction of pharmacy services and identified five key themes to inform this work.

- **We are empowered to work at the highest level of our practice**
- **We will develop and optimise the use of data and digital solutions**
- **We will work and communicate in an integrated and effective way**
- **We will lead the advancement of innovative pharmacy practice**
- **We will drive a culture of staff empowerment and enablement.**

During the pandemic our staff responded to the challenges by collaborating and making significant changes to our ways of working. We plan to use the learning from our response to the pandemic and develop the themes into a strategic framework which will guide pharmacy forward through remobilisation and beyond.

A Sustainable Workforce

The primary care pharmacy workforce has expanded rapidly in recent years in support of the GMS contract and the pharmacotherapy service delivery priority. Community pharmacy has historically been considered in isolation and needs to now be more closely aligned. We will review, define and standardise primary care pharmacy service delivery including appropriate skill mix and leadership and management arrangements to ensure equity of access to services for patients (and healthcare professionals such as GPs) in all parts of NHSGGC.

We are planning a renewed focus on developing advanced skills across our pharmacy workforce e.g. clinical practice, leadership, education & research. Support structures, including competency linked personal-development plans and mentorship will be put in place. We will launch a pharmacy mini-fellowship scheme to foster leadership skills in the workforce, through the delivery of service improvement projects.

Security of Supply of Medicines

Pharmacy continues to monitor closely the stock levels of medicines (including oxygen), respond to surges in demand and have arrangements in place to mitigate and manage shortages. We will enable delivery of the COVID-19 vaccination programme by increasing our storage and distribution capacity and managing the cold chain to minimise waste. We will continue to assess and prioritise staff resource to deliver this programme through the months ahead, whilst scoping out a sustainable model for the integration of COVID-19 vaccination into delivery of other programmes including flu and childhood vaccinations.

Clinical Governance

We will restart paused clinical governance activities with a focus on two priority areas within the Board's Healthcare Quality Strategy:

- **Safer Use of Medicines**: A strategic framework has been developed and will be implemented via medicines governance groups to inform a rolling programme of activities across acute, mental health and primary care settings.
- **Person Centred Care**: We are developing an action plan which includes staff education & training, seeking feedback from patients and how we can learn from initiatives such as 'What matters to me'.

12.4. Regional

Key Points

- We will continue to support the West of Scotland Regional Planning partnership, building on a mutual aid agreement and working with national partners – NHS 24, SAS and NHS GJNH.

Context

In planning the continual challenges of COVID-19, the West of Scotland Boards have considered and agreed a regional approach to a number of areas outlined below. The regional response is in line with the planning assumptions set out by Scottish Government to optimise what we can do collectively to meet the challenges now facing the NHS as it starts the next phase in dealing with COVID-19 and recovery.

The Collective Response

In planning for the next 6-12 months, recognising the above and uncertainty around COVID-19, colleagues in the West of Scotland have set out the areas where we will focus our collective responses and actions. This work primarily relates to acute care and hospital services.

Our aim is to gradually and safely increase the level of services provided for our population, building on our mutual aid agreement to provide the best level of service across the region whilst continuing to ensure outcomes from other life limiting or life threatening conditions is not impacted. In doing this we will also work with our national health service partners particularly NHS GJNH, SAS and NHS 24.

Cancer and Scheduled Care

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

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

NHS GJNH will be an important partner in this work to ensure the capacity available at the GJNH can be maximised to support the treatment of patients within the region where surgical capacity does not allow this within the Board of residence. It is recognised that this is a challenging task and is likely to need for cross Health Board working and/or national support for some specialties on a temporary basis.

Progressing the Regional Programme

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

Regional Service Models in Implementation

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

Emergent Service Models and Strategies

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

Cross region enabling activity

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

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

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

The further development of the Regional Property Asset Management Strategy (PAMS) will resume along with the further development of the whole system service planning and modelling tool to help support service and capital planning.

12.5. Redevelopment of Institute of Neurological Sciences

Key Points

- We will progress the business case for the redevelopment of the Institute of Neurological Sciences, producing an initial agreement for the business case by summer 2021.

The Institute of Neurological Sciences on the Queen Elizabeth Campus provides Neurosurgery, Neurology, Interventional Neuroradiology, Neurophysiology, Oral and Maxillofacial Surgery [OMFS], Specialist Neurorehabilitation and the Queen Elizabeth National Spinal Injuries Unit. Its regional services cover a population of 2.75 million people, and there are several national services offered to the population of Scotland.

There are six interlinked buildings within the immediate INS campus, with its national and regional mobility centre, WestMARC, situated remotely on the north-east of the QEUH campus. Its eight theatres, Interventional Neuroradiology suite and 13 neuro critical care beds are linked at Level 1 with the QEUH and RHC critical care facilities to ensure the seamless care of children, young people and adults on the campus.

There are 220 beds, supported by neuro pre-assessment, a same-day admissions unit, day surgery unit, a Neurology short-stay treatment and assessment ward, and a full outpatient department with immediately adjacent specialist diagnostics, neurophysiology, neuropsychology and maxillofacial prosthetics laboratory.

Despite ongoing maintenance, which has been limited due to access issues, patient throughput and flow has been compromised repeatedly over recent years by flooding, power outages and lift failures. Wards, theatres and other direct patient care services have been closed or suspended for months at a time.

While four new theatres were commissioned in 2018, the retained INS Theatres and Interventional Neuroradiology facilities require upgrade to meet model standard.

The acuity of INS services necessitates that the majority must remain on the QEUH campus due to vital clinical dependencies, not least of which is supporting the new Major Trauma Centre.

There are a number of national, regional and local strategies which would increase the activity and acuity of patient care within the buildings within 2021/22:

- **Phase I of the West of Scotland mechanical thrombectomy service**
- **The development of a single integrated West of Scotland service for spinal surgery**
- **The addition of Hyperacute and Acute stroke beds** to support both the GGC Stroke Strategy and as part of the ward moves required to implemented the Major Trauma Centre.

There are other planned strategies which will further increase activity and acuity in the next three to five years:

- **The implementation of the GGC Stroke Strategy**, consolidating hyperacute services
- **Phases II and III of the West of Scotland mechanical thrombectomy service** (expanding to full 24/7 service)
- **The transfer of complex and intermediate Oral & Maxillofacial surgery (OMFS) inpatient services**, including all remaining trauma, from NHS Lanarkshire.

The most recent asset management surveys undertaken in 2019/20 indicated that further infrastructure upgrades would take in excess of ten years with multiple and repeated decants of both beds and theatres, with no guarantee that the upheaval and considerable expense would significantly extend the useful lifespan of the older buildings, which date to the early 1970s. In addition, the scoping process for an outline business case to replace the retained theatres (four) and Interventional Neuroradiology suite (one, increasing to two to accommodate the Scottish Government Health Directorate (SGHD)-approved West of Scotland Thrombectomy service) within the Neurosurgical building concluded that the existing floorplate was not capable of providing Scottish Health Technical Manual (SHTM)-compliant replacement facilities.

As a result, all schemes which are not required to meet Healthcare Environment Inspectorate (Scotland) (HEI) requirements or which involve essential maintenance to support ongoing service delivery have been paused and the process for a full Scottish Capital Investment Manual (SCIM)-compliant business cases has been started.

This process is overseen by the Institute of Neurological Sciences Capital Programme.

Board, supported by KD Health as Healthcare Planning partners. An eight-week programme of scoping and clinical engagement was undertaken in October/November 2020 to support the development of an updated Strategic Assessment, which is due to be submitted to the Scottish Capital Investment Group in Q1 of 2021/22.

A further six-month programme is currently underway to develop the necessary output documents for proceeding to Initial Agreement. The development of the facilities to support the West of Scotland Thrombectomy service will also continue in parallel.

12.6. Quality Strategy and Realistic Medicine

Key Points

- Person centred care is a focus of our Healthcare Quality Strategy and will drive our priorities for 2021/22
- We will develop a Realistic Medicine Acute Plan for 2021/22.

The NHS Greater Glasgow and Clyde (NHSGGC) Healthcare Quality Strategy: 'The Pursuit of Healthcare Excellence' expresses our collective commitment to putting quality at the forefront of everything we do. Towards the end of 2020, the Quality Strategy Implementation Group agreed three key corporate priority areas of focus across the organisation, including Acute, Mental Health and Community Services. These are:

- **Person Centred Care**
- **Infection Prevention and Control**
- **Tissue Viability**.

To ensure an open, transparent and collaborative approach is central to how we take forward these objectives, work is progressing to outline how public partners and people with lived experience will be integral to the membership of the key strategic groups to help co-produce and co-design service improvement with a focus on what matters to patients as well as our service providers.

The use of directly-reported patient, carer and staff experience systematically to promote care quality improvement is a key Board priority. At the beginning of each Board meeting the Board Nurse Director shares a patient story to highlight how we listen to patients, families and staff to ensure the correction of any deficiencies brought to our attention are used for reflection, learning and improvement as well as demonstrate best practice. A 'Patient Story' Group has recently been commissioned to collectively engage all the key stakeholders involved in the identification and development of a patient story and ensure uniformity of the approach and focus on current topics and themes emergent through our review of feedback, service development and remobilisation activity.

Realistic medicine puts the person receiving health and social care at the centre of decision making about their care. It encourages our health and care workers to find out what matters most to the people we look after so that their care best fits their needs, situation and personal choices. Realistic medicine recognises that a one size fits all approach to health and social care is not the most effective path for the patient or the NHS. Our planning for realistic medicine is through our Healthcare Quality Strategy. An action plan has been developed for the next 12 month period, covering the following areas:

- **Listen to patients**, understand their problems, preferences and needs
- **Promote shared decision making** between healthcare professionals and patients
- **Ensure that patients have more information** that they may need to make informed decisions about their healthcare
- **Support health and social care professionals** to be more innovative in order to pursue quality improvement and reduce risk to patients
- **Reduce the harm and waste** caused by both over provision and under provision of care.

13. Finance

Under NHSGGC's Corporate Objective Theme of Better Value we remain committed to:

- **Finalising a three year Financial and Capital Plan** and develop detailed plans to return NHSGGC to recurring balance
- **Meeting the key Financial Targets for 2020/21 and 2021/22** within an agreed profile, ensuring services are remobilized in an efficient and affordable way
- **Reducing the underlying recurring deficit**.

Finalising 2020/21

The Board requested, in the formal submission to the Scottish Government, a funding requirement of £176.3m for the Board in relation to direct and indirect COVID-19 costs.

The Board were allocated £102m in the first allocation tranche, equating to 58% of the total requested. Further funding was received in February 2021 in line with the Board's expectations that all direct COVID-19 related costs would be fully funded, including a contribution to unachieved savings.

This, together with underspends from the reduction in the elective programme plus additional funding allocations that were not anticipated when the Board's original financial plan was developed, means that the Board is predicting a breakeven out-turn at 31 March 2021.

However, it should be highlighted that following a previous reduction in the underlying recurrent deficit, the figure has increased to £93m going into 2021/22 (from £55m). This is largely due to all the focus and attention being directed to dealing with the COVID-19 outbreak at the expense of realising savings and efficiencies.

2021-22 Outlook

The outlook for 2021/22 remains uncertain, both in terms of costs, income and Scottish Government funding streams. The costs of managing COVID-19 are very much still part of that uncertainty, particularly the vaccination programme, continued testing and the impact on staffing and service delivery.

The Scottish Government announced their budget on the 28th January 2021, although this may require updating to reflect the UK Government's budget on the 3rd March 2021.

All Boards will receive a baseline uplift of 1.5%. In terms of pay, initial funding has been allocated in line with the Scottish Public Sector Pay Policy for planning purposes. This will be used as an anchor point in the forthcoming Agenda for Change pay settlement and funding arrangements for Boards will be revisited by the Scottish Government in line with the outcome of the pay negotiations. The budgets also included specific allocations for primary care, waiting times, mental health and CAHMS and alcohol and drugs.

An additional £869 million of funding will be provided to support the ongoing response to the pandemic, to be allocated on receipt of remobilisation plans due at the end of February 2021. The Scottish Government also anticipate further COVID-19 funding from the UK Government.

The Finance team have completed a detailed assessment of the projected outlook for 2021/22. Clearly this involves a higher than usual degree of uncertainty (and therefore range of assumptions), particularly around the impact of COVID-19 upon service levels and related costs and funding levels.

This uncertainty means the initial outlook for 2021/22 is subject to change and amendment, however below is the assessment as it currently stands.

	£m	Para
Total new resources	**33.7**	**2**
Carry forward from 2020/21		
Recurring deficit b/f	(93.5)	3
Cost drivers		
Pay cost growth	(50.8)	4
Prescribing - Acute	(23.0)	5
Prescribing - primary care	(8.0)	5
Supplies, PPP & other inflation	(11.6)	6
Cost pressures	(0.3)	7
Investments	(10.9)	7
Cost drivers	**(198.1)**	
Cash efficiency challenge	(164.4)	
Cash efficiency challenge	(6.5%)	
IJB uplift in resources	(13.6)	8
IJB expenditure	20.5	8
Net cash Efficiency challenge	**(157.5)**	**9**
Net cash Efficiency challenge	**(9.7%)**	**9**
Forecast savings achievable (%)	22%	
Forecast savings achievable	35.0	
Recurring deficit c/f	**(122.5)**	
Non recurring deficit outturn	35.0	10
In-year outturn (Acute & corporate)	**(87.5)**	

As outlined above, the initial plan remains subject to amendments based on the final 2020/21 out-turn and the impact of COVID-19 on service delivery. The key messages on the indicative numbers above can be summarised as:

- **The underlying recurring deficit is projected to increase** from £55m to £93m going into 2021/22 (final out-turn dependant). This is largely due to the reduced levels of recurring savings achieved in 2019/20
- **The payroll costs, in year three of the settlement, are expected to increase** by circa £51m, although the final settlement has yet to be agreed (refer above)
- **Prescribing is expected to increase in both price and volume at a similar rate as previous year** – in monetary terms, an increase of £23m across the Acute Division and £8m across Primary Care
- **The elective programme should continue to recover further in the later part of the year**. Whilst costs may reach pre-COVID 19 levels, the patient throughput will remain reduced

- **Investments and future developments have been assessed and costed**, however discussions and negotiations remain on the final programme and final costs
- **A pre-COVID 19 level of recurring and non-recurring savings has been assumed** as the **Financial Improvement Programme** (FIP) is fully remobilised into 2021/22
- **No COVID-19 costs or associated funding have been included in the financial projections**. These are assumed to be fully funded separately
- **The net cash efficiency challenge is £87.5m or 5.4% (2020 - £112m or 7.8%)**.

The cost of COVID-19 including remobilisation in 2021/22 has been estimated at a total of £209m. This is split by Board of £137m and HSCP's of £72m. It has been assumed that these costs will be fully funded by SG in line with 2020/21. This covers the following key areas which are detailed in the Financial Planning templates sent separately to Scottish Government Finance:

- **Continued impact on Hospital Capacity** particularly in Q1 & Q2 estimated at £35m
- **Additional HSCP staff costs** for 21/22 estimated to be £12.3m
- **Estimated costs of £15m for equipment and maintenance** including, deep cleans and four nations cleaning guidance, and continued space requirements for social distancing.
- **The estimated cost of the COVID-19 Vaccination programme continued roll out** of £14.8m (this excludes any Local Authority costs)
- **Costs associated with the Test and Protect programme** for 21/22 £15.7m
- **Digital Transformation** continuing in 21/22 £1.8m.
- C**ontinued use of PPE** £4.2m
- **Primary care services** including Community Assessment Centres will continue in 21/22 estimated costs of £11.2m
- **Mental Health service** costs including the Mental Health Assessment Unit will continue into 21/22 at a cost of £4.6m
- **Planned care** estimated funding requirements of £35m to meet activity trajectories detailed in this paper
- **Estimated costs of £4.5m for the Redesign of Unscheduled Care** with the continued development of the Flow Navigation Hub moving into Phase 2
- **Loss of income** expected to continue in the first two quarters of 21/22 of £9m
- **Winter pressures** for 21/22 estimated at £5.1m
- **Public Health measures** (including flu vaccination programme) remains a key focus for 21/22 with an estimated cost of £4.7m
- **Social Care costs** (payments to third parties) estimated to be £31m.

As highlighted above, NHSGGC is facing another significant financial challenge in 2021/22. The financial planning process started in October 2020 around the following steps:

- **Identification and assessment of the costs, pressures and investment required in 2020/21**, offset against uplifts and identification of the savings target
- **Analysis of the Scottish Government's COVID-19 projection modelling** and an assessment of the related COVID-19 costs for the Board
- **Roll-forward of the organisational-wide** FIP Work streams, including initiatives already underway and a process to identify new ones
- **Cost Reduction Efficiency saving (CRES) to be identified locally** within each Acute Directorate and Corporate Division
- **Identification and quantification of non-recurring sources of income/funding**
- **Initial discussions with the HSCPs** regarding the 2020-21 budget settlement
- **Remobilisation of the Financial Improvement Programme (FIP).**

The FIP Programme has continued in 2020/21 although due to the current COVID-19 position has been less active. The approach remains to deliver where possible all schemes currently identified by the end of March 2021.

A new Head of the FIP was appointed in October 2020 and has reviewed the programme and approach for 2021/22 and is working towards having the 'building blocks in place' for end of March 2021, to enable the Programme to fully remobilise at the start of the financial year. The last few months have involved analysis of the new COVID-19 ways of working, identifying opportunities for medium to longer efficiencies. A number of initiatives have already been identified and are underway.

Non-recurring sources of income and funding

As in recent years, the strategic use of non-recurring funding will be critical if break-even is to be achieved. Senior Finance Management has, and will continue to, identify and analyse all available sources. This involves discussions at national forums such as the Corporate Finance Network, discussions with the Scottish Government, discussions with External Audit and good balance sheet management. However, it should be stressed that the primary financial objective for the Board is to reduce the underlying recurrent deficit. The programme will focus on key Pillars overarching project development:

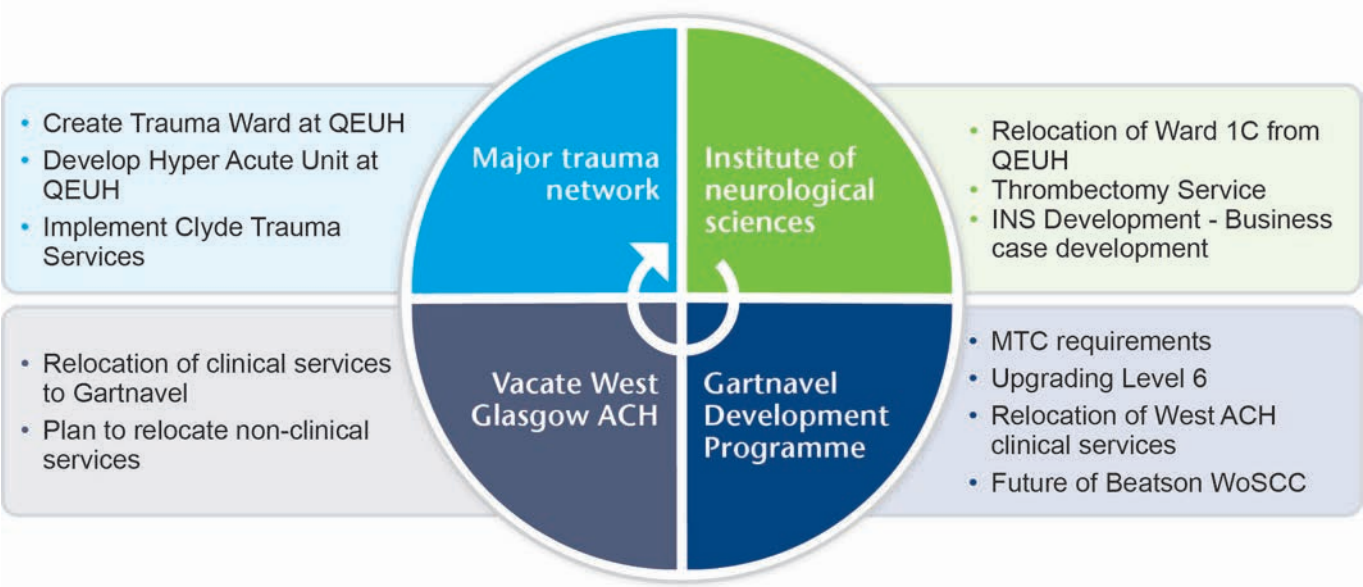
- **Procurement**: National contractual savings, standardisation and rationalisation of the Board's own procurement processes with clear targets for improved performance.
- **Prescribing**: Horizon scan of drug changes, clinical changes and the development of prescribing best practice (elimination of waste). Assessment of benefits and opportunities from HEPMA system.
- **Service redesign**: Priority focus on COVID-19 long term changes, workforce redesign and patient flows and service changes. Active Clinical Referral Triage and Virtual Patient Management (Scheduled and Unscheduled care pathways redesign.) Longer term planning for MFT workstreams/Re mobilisation key priorities.
- **eHealth Digital and Innovation**: Benefits from further virtualisation and the continued use of systems such as teams, and virtual consultations. Opportunities to use technology as an enabler and a control point.
- **Property and asset management**: Review of use of properties, disposals, management of contracts / contractors and energy savings along with the wider sustainability agenda and alignment with clinical strategy.
- **Workforce plans**: alignment of the wider Workforce strategy management of sickness, absence and turnover.
- **Efficiency and Productivity gains**: Whilst recognising that this is not necessarily cash releasing the recognition to improvements to patient experience through the redesign of pathways as a result of the pandemic will have a positive impact on our capacity.

Budget settlement with HSCPs

As in previous years, the Board will seek to agree a budget settlement with IJBs by the 31st March 2021. The settlement is "straight proportionate pass through" of the Boards' funding uplift. The Assistant Director of Finance has met with all the HSCP Chief Finance Officers to discuss the budget process. No issues are anticipated agreeing the settlement.

Capital Plan

The Board has developed a Capital Plan which supports and enables our clinical strategy and priorities for investment. For minor works, the Board will commit capital investment that will target asset condition improvement, backlog maintenance and statutory compliance and the PAMS.



The current Board plans include allocation of capital funding for a number of eHealth projects and the procurement of medical and diagnostic equipment. The current forecast core capital resources available to the Board for investment in 2021/22 are consistent with previous years at circa £49 million.

This figure chiefly comprises a general allocation of £37.4m from Scottish Government Health and Social Care Directorate (SGHSCD) in respect of core capital expenditure plus ring-fenced specific funding amounting to £9m, together with an estimate for Capital Receipts generated through property disposals.

Schemes classified as "ring-fenced" represent specific funding that is provided via a direct allocation from the Scottish Government. For 2020/21 this amount includes £7.5m in respect of the proposed North East Glasgow Health & Social Care Centre, for which a Full Business Case is currently being developed.

An amount of £7.3m has been incorporated within the 2021/22 Plan for investment in eHealth priorities, which includes a general eHealth allocation of £1.5m. Investment includes c£4.9m in respect of the replacement Laboratory Information Management System (LIMS).

The proposed 2021/22 Capital Plan also includes an overall initial allocation of £4m in respect of Medical Equipment replacement, and an amount of £9.4m for local minor works projects in 2021/22.

Backlog Maintenance

In 2019/20 and 2020/21, NHSGGC responded to concerns from various sources (internal and external) regarding the condition of our estate. This resulted in significant spend throughout the year to improve the standard of our estate, particularly on the QEUH campus.

Details of the Board's backlog maintenance requirements are held within the Estates Asset Management System. It highlights a total backlog figure of £377 million, of which £138 million is classed as "high".

Estates management are fully aware of the issues with Estates and the need to manage within the designated financial constraints. Clearly NHSGGC will not be able to address all of its backlog maintenance issue in the near future. The Board are currently finalising the detailed prioritised Plan for 2021/22 split between service contracts, planned maintenance and reactive maintenance. The resultant plan will be finalised, passed through the relevant governance channels and in place for 1st April 2021.

14. Conclusion

To deal with the Global Pandemic of COVID-19, NHSGGC put in place new services and 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. The January 2021 peak of infection has now receded and there is a need to remobilise our services. This involves ensuring that there is retained and flexible capacity both within the community health and social care sector as well as in hospitals to continue to treat patients with COVID-19 as well as ensure any increase in cases is managed. Strict infection control procedures within all sectors are 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.

This plan recognises the impact that COVID-19 has had on patients, staff and the wider population. We have described how we will work with partners to address health inequalities impacted on by COVID-19. The plan has been developed in partnership across the health and care system in NHSGGC and has been tested with representatives of the public and Third Sector through our Stakeholder Reference Group. This cross system working has resulted in effective decision making, informed by the interdependencies and relationships between the different parts of our system. We will continue working with stakeholders as we move to implement the plan, understanding the importance of clear communication with individuals, communities and staff in health and social care.

The pace and scale of change have exceeded anything we have previously experienced. We want to build on the successful new models of care and apply new ways of working to our programme of change and improvement. Importantly, we will review and evaluate new service models and pathways as we progress to ensure that the patient experience is maximised. Patient and staff safety have been paramount during the COVID-19 period, and continues to be so during remobilisation. This plan describes how we will resume activity in a safe way, considering PPE and physical distancing. Staff wellbeing and mental health is a key priority in NHSGGC, and a detailed action plan has been developed to support this.

This plan sets out the way GGC intend to balance all of these factors in order to ensure patient/service users receive timely and safe care whilst maintaining capacity to deal with any surge in COVID-19 patients.

15. Appendix: NHS Board Remobilisation Plan Trajectories

Template 1

Definitions

Indicator	Definitions
A&E Attendances	Definitions as per Core Sites, unplanned attendances only
Total Emergency Admissions	Definitions as per RAPID Data Mart
Total Emergency Admission Mean Length of Stay	Definition as per Discovery indicator, see tab Definition Mean Hospital Stay for example and definitions.
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Definitions as per SG Management Information
31 Day Cancer - First Treatment Patients Treated	Definitions as per published statistics
CAMHS - First Treatment Patients Treated	Definitions as per published statistics
Psychological Therapies - First Treatment Patients Treated	Definitions as per published statistics
Delayed Discharges at Month End (Total delayed discharges of any reason or duration)	Definitions as per published statistics - The data required is the estimated number of people delayed at each census point (the snapshot figure). Baseline figures used are the census point figures as at the end of each month; https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/delayed-discharges/delayed-discharges-in-nhsscotland-monthly/
8 Key Diagnostic Tests - Activity (new elective tests only, excludes planned repeats)	Definitions as per Scottish Government weekly diagnostic Management Information. Only include activity which corresponds to a new diagnostic waiting list entry. Patients who are undergoing regular planned tests should be excluded. The following types of activity should also be excluded: planned repeat/follow up/return; emergency; tests as part of inpatient treatment.

Projections

Projections (Refer to Definitions datasheet)	Quarter ending 30/06/2021	Quarter ending 30/09/2021	Quarter ending 31/12/2021	Quarter ending 31/03/2022
A&E Attendances (Definitions as per Core Sites, unplanned attendances only)	73843	85398	85005	86712
Total Emergency Admissions (Definitions as per RAPID Data Mart)	29889	36137	37271	35297
Total Emergency Admission Mean Length of Stay (Definitions as per Discovery indicator attached)	8.5	7.6	6.8	6.7
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	12149	12271	12393	12517
31 Day Cancer - First Treatment Patients Treated (Definitions as per published statistics)	1701	1777	1814	1890
CAMHS - First Treatment Patients Treated (Definitions as per published statistics)	1620	1680	1680	1680
Psychological Therapies - First Treatment Patients Treated (Definitions as per published statistics)	4350	4650	4650	4650
	Month ending 30/06/2021	Month ending 30/09/2021	Month ending 31/12/2021	Month ending 31/03/2022
Delayed Discharges at Month End (Total Delayed Discharges of Any Reason or Duration, per the Definition for Published Statistics)	202	190	197	195

Historical Diagnostic Activity

8 Key Diagnostic Tests - Activity (new elective tests only, excludes planned repeats) Refer to Definitions datasheet	Quarter ending 30/06/2020	Quarter ending 30/09/2020
Upper Endoscopy	168	1296
Lower Endoscopy (other than colonoscopy)	55	243
Colonoscopy	262	1358
Cystoscopy	194	898

Template 2

Definitions

Indicator	Definitions
8 Key Diagnostic Tests (new patients only, excludes planned repeats)	Definitions as per Scottish Government weekly diagnostic Management Information. Only include activity which corresponds to a new diagnostic waiting list entry. Patients who are undergoing regular planned tests should be excluded. The following types of activity should also be excluded: planned repeat/follow up/return; emergency; tests as part of inpatient treatment.
New Outpatient Activity Projections	New Outpatient activity should only include activity that is measured against the 12 Week New Outpatient Standard. For example, the eight key diagnostic tests should be excluded. All definitions and methodology should the the same as the Public Health Scotland waiting times Data Mart.
TTG Activity Projections	TTG activity should only include activity that is measured against the 12 Week Treatment Time Guarantee. All definitions and methodology should the the same as the Public Health Scotland waiting times Data Mart.

Key Diagnostic Tests: April 21 - September 21

New Elective Diagnostic Test	Urgency	April 2021			May 2021			June 2021			July 2021			August 2021			September 2021		
		Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
All Endoscopy	All Urgencies	1684	0	-1684	1801	0	-1801	1509	0	-1509	1859	0	-1859	1887	0	-1887	1797	0	-1797
	Routine	673	0	-673	719	0	-719	589	0	-589	751	0	-751	743	0	-743	710	0	-710
	Urgent	470	0	-470	504	0	-504	427	0	-427	515	0	-515	533	0	-533	507	0	-507
	Urgent Suspicion Cancer	541	0	-541	578	0	-578	493	0	-493	593	0	-593	611	0	-611	580	0	-580
	Bowel Screening	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Upper Endoscopy	All Urgencies	703	0	-703	810	0	-810	640	0	-640	768	0	-768	774	0	-774	789	0	-789
	Routine	269		-269	310		-310	245		-245	294		-294	296		-296	302		-302
	Urgent	197		-197	227		-227	179		-179	215		-215	217		-217	221		-221
	Urgent Suspicion Cancer	237		-237	273		-273	216		-216	259		-259	261		-261	266		-266
Lower Endoscopy (other than colonoscopy)	All Urgencies	121	0	-121	142	0	-142	114	0	-114	142	0	-142	150	0	-150	149	0	-149
	Routine	68		-68	80		-80	64		-64	80		-80	84		-84	84		-84
	Urgent	35		-35	41		-41	33		-33	41		-41	44		-44	43		-43
	Urgent Suspicion Cancer	18		-18	21		-21	17		-17	21		-21	22		-22	22		-22

New Elective Diagnostic Test	Urgency	April 2021			May 2021			June 2021			July 2021			August 2021			September 2021		
		Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
Colonoscopy	All Urgencies	543	0	-543	542	0	-542	522	0	-522	579	0	-579	646	0	-646	575	0	-575
	Routine	146		-146	145		-145	140		-140	155		-155	173		-173	154		-154
	Urgent	180		-180	180		-180	173		-173	192		-192	214		-214	191		-191
	Urgent Suspicion Cancer	217		-217	217		-217	209		-209	232		-232	259		-259	230		-230
	Bowel Screening			0			0			0			0			0			0
Cystoscopy	All Urgencies	317	0	-317	307	0	-307	233	0	-233	370	0	-370	317	0	-317	284	0	-284
	Routine	190		-190	184		-184	140		-140	222		-222	190		-190	170		-170
	Urgent	58		-58	56		-56	42		-42	67		-67	58		-58	52		-52
	Urgent Suspicion Cancer	69		-69	67		-67	51		-51	81		-81	69		-69	62		-62
All Radiology	All Urgencies	11947	0	-11947	11947	0	-11947	11947	0	-11947	12066	0	-12066	12066	0	-12066	12066	0	-12066
	Routine	7925	0	-7925	7925	0	-7925	7925	0	-7925	8004	0	-8004	8004	0	-8004	8004	0	-8004
	Urgent	2126	0	-2126	2126	0	-2126	2126	0	-2126	2147	0	-2147	2147	0	-2147	2147	0	-2147
	Urgent Suspicion Cancer	1896	0	-1896	1896	0	-1896	1896	0	-1896	1915	0	-1915	1915	0	-1915	1915	0	-1915
Magnetic Resonance Imaging	All Urgencies	3190	0	-3190	3190	0	-3190	3190	0	-3190	3222	0	-3222	3222	0	-3222	3222	0	-3222
	Routine	2553		-2553	2553		-2553	2553		-2553	2579		-2579	2579		-2579	2579		-2579
	Urgent	487		-487	487		-487	487		-487	492		-492	492		-492	492		-492
	Urgent Suspicion Cancer	150		-150	150		-150	150		-150	152		-152	152		-152	152		-152
Computer Tomography	All Urgencies	3912	0	-3912	3912	0	-3912	3912	0	-3912	3951	0	-3951	3951	0	-3951	3951	0	-3951
	Routine	1530		-1530	1530		-1530	1530		-1530	1545		-1545	1545		-1545	1545		-1545
	Urgent	852		-852	852		-852	852		-852	861		-861	861		-861	861		-861
	Urgent Suspicion Cancer	1530		-1530	1530		-1530	1530		-1530	1545		-1545	1545		-1545	1545		-1545
Non-obstetric ultrasound	All Urgencies	4760	0	-4760	4760	0	-4760	4760	0	-4760	4808	0	-4808	4808	0	-4808	4808	0	-4808
	Routine	3774		-3774	3774		-3774	3774		-3774	3812		-3812	3812		-3812	3812		-3812
	Urgent	785		-785	785		-785	785		-785	793		-793	793		-793	793		-793
	Urgent Suspicion Cancer	201		-201	201		-201	201		-201	203		-203	203		-203	203		-203

New Elective Diagnostic Test	Urgency	April 2021			May 2021			June 2021			July 2021			August 2021			September 2021		
		Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
Barium Studies	All Urgencies	85	0	-85	85	0	-85	85	0	-85	86	0	-86	86	0	-86	86	0	-86
	Routine	68		-68	68		-68	68		-68	69		-69	69		-69	69		-69
	Urgent	2		-2	2		-2	2		-2	2		-2	2		-2	2		-2
	Urgent Suspicion Cancer	15		-15	15		-15	15		-15	15		-15	15		-15	15		-15

Key Diagnostic Tests: October 2021 - March 2022

New Elective Diagnostic Test	Urgency	October 2021			November 2021			December 2021			January 2022			February 2022			March 2022		
		Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
All Endoscopy	All Urgencies	2229	0	-2229	1952	0	-1952	1685	0	-1685	2104	0	-2104	2018	0	-2018	1265	0	-1265
	Routine	799	0	-799	772	0	-772	677	0	-677	845	0	-845	807	0	-807	499	0	-499
	Urgent	573	0	-573	548	0	-548	471	0	-471	586	0	-586	563	0	-563	354	0	-354
	Urgent Suspicion Cancer	857	0	-857	632	0	-632	537	0	-537	673	0	-673	648	0	-648	412	0	-412
	Bowel Screening	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Upper Endoscopy	All Urgencies	810	0	-810	868	0	-868	697	0	-697	903	0	-903	878	0	-878	515	0	-515
	Routine	310		-310	332		-332	267		-267	346		-346	336		-336	197		-197
	Urgent	227		-227	243		-243	195		-195	253		-253	246		-246	144		-144
	Urgent Suspicion Cancer	273		-273	293		-293	235		-235	304		-304	296		-296	174		-174
Lower Endoscopy (other than colonoscopy)	All Urgencies	358	0	-358	144	0	-144	148	0	-148	158	0	-158	154	0	-154	76	0	-76
	Routine	89		-89	81		-81	83		-83	89		-89	86		-86	43		-43
	Urgent	46		-46	42		-42	43		-43	46		-46	45		-45	22		-22
	Urgent Suspicion Cancer	223		-223	21		-21	22		-22	23		-23	23		-23	11		-11
Colonoscopy	All Urgencies	712	0	-712	616	0	-616	533	0	-533	652	0	-652	621	0	-621	437	0	-437
	Routine	191		-191	165		-165	143		-143	175		-175	166		-166	117		-117
	Urgent	236		-236	204		-204	177		-177	216		-216	206		-206	145		-145
	Urgent Suspicion Cancer	285		-285	247		-247	213		-213	261		-261	249		-249	175		-175
	Bowel Screening			0			0			0			0			0			0

New Elective Diagnostic Test	Urgency	October 2021			November 2021			December 2021			January 2022			February 2022			March 2022		
		Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
Cystoscopy	All Urgencies	349	0	-349	324	0	-324	307	0	-307	391	0	-391	365	0	-365	237	0	-237
	Routine	209		-209	194		-194	184		-184	235		-235	219		-219	142		-142
	Urgent	64		-64	59		-59	56		-56	71		-71	66		-66	43		-43
	Urgent Suspicion Cancer	76		-76	71		-71	67		-67	85		-85	80		-80	52		-52
All Radiology	All Urgencies	12187	0	-12187	12187	0	-12187	12187	0	-12187	12309	0	-12309	12309	0	-12309	12309	0	-12309
	Routine	8084	0	-8084	8084	0	-8084	8084	0	-8084	8165	0	-8165	8165	0	-8165	8165	0	-8165
	Urgent	2169	0	-2169	2169	0	-2169	2169	0	-2169	2190	0	-2190	2190	0	-2190	2190	0	-2190
	Urgent Suspicion Cancer	1934	0	-1934	1934	0	-1934	1934	0	-1934	1953	0	-1953	1953	0	-1953	1953	0	-1953
Magnetic Resonance Imaging	All Urgencies	3254	0	-3254	3254	0	-3254	3254	0	-3254	3287	0	-3287	3287	0	-3287	3287	0	-3287
	Routine	2604		-2604	2604		-2604	2604		-2604	2630		-2630	2630		-2630	2630		-2630
	Urgent	497		-497	497		-497	497		-497	502		-502	502		-502	502		-502
	Urgent Suspicion Cancer	153		-153	153		-153	153		-153	155		-155	155		-155	155		-155
Computer Tomography	All Urgencies	3991	0	-3991	3991	0	-3991	3991	0	-3991	4031	0	-4031	4031	0	-4031	4031	0	-4031
	Routine	1561		-1561	1561		-1561	1561		-1561	1576		-1576	1576		-1576	1576		-1576
	Urgent	869		-869	869		-869	869		-869	878		-878	878		-878	878		-878
	Urgent Suspicion Cancer	1561		-1561	1561		-1561	1561		-1561	1576		-1576	1576		-1576	1576		-1576
Non-obstetric ultrasound	All Urgencies	4856	0	-4856	4856	0	-4856	4856	0	-4856	4904	0	-4904	4904	0	-4904	4904	0	-4904
	Routine	3850		-3850	3850		-3850	3850		-3850	3888		-3888	3888		-3888	3888		-3888
	Urgent	801		-801	801		-801	801		-801	809		-809	809		-809	809		-809
	Urgent Suspicion Cancer	205		-205	205		-205	205		-205	207		-207	207		-207	207		-207
Barium Studies	All Urgencies	87	0	-87	87	0	-87	87	0	-87	88	0	-88	88	0	-88	88	0	-88
	Routine	69		-69	69		-69	69		-69	70		-70	70		-70	70		-70
	Urgent	2		-2	2		-2	2		-2	2		-2	2		-2	2		-2
	Urgent Suspicion Cancer	15		-15	15		-15	15		-15	15		-15	15		-15	15		-15

NOP by Specialty: April 2021 - September 2021

New Outpatient (12 Week Standard) Activity Projections		30 April 2021			31 May 2021			30 June 2021			31 July 2021			31 August 2021			30 September 2021		
Specialty	Urgency	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
All Specialties	All Urgencies	18475	0	-18475	20231	0	-20231	19351	0	-19351	18267	0	-18267	20026	0	-20026	20010	0	-20010
	Routine	13792	0	-13792	14980	0	-14980	14526	0	-14526	13725	0	-13725	14944	0	-14944	14949	0	-14949
	Urgent	4683	0	-4683	5251	0	-5251	4825	0	-4825	4542	0	-4542	5082	0	-5082	5061	0	-5061
Anaesthetics	All Urgencies	156	0	-156	200	0	-200	173	0	-173	154	0	-154	185	0	-185	142	0	-142
	Routine	151		-151	193		-193	168		-168	142		-142	176		-176	130		-130
	Urgent	5		-5	7		-7	5		-5	12		-12	9		-9	12		-12
Cardiology	All Urgencies	830	0	-830	1024	0	-1024	936	0	-936	842	0	-842	973	0	-973	938	0	-938
	Routine	578		-578	715		-715	663		-663	579		-579	684		-684	688		-688
	Urgent	252		-252	309		-309	273		-273	263		-263	289		-289	250		-250
Dermatology	All Urgencies	2142	0	-2142	2499	0	-2499	2217	0	-2217	2251	0	-2251	2199	0	-2199	2414	0	-2414
	Routine	1394		-1394	1574		-1574	1412		-1412	1442		-1442	1364		-1364	1503		-1503
	Urgent	748		-748	925		-925	805		-805	809		-809	835		-835	911		-911
Diabetes/ Endocrinology	All Urgencies	406	0	-406	452	0	-452	415	0	-415	378	0	-378	419	0	-419	475	0	-475
	Routine	373		-373	413		-413	384		-384	355		-355	391		-391	436		-436
	Urgent	33		-33	39		-39	31		-31	23		-23	28		-28	39		-39
ENT	All Urgencies	1469	0	-1469	1441	0	-1441	1454	0	-1454	1406	0	-1406	1614	0	-1614	1376	0	-1376
	Routine	986		-986	958		-958	955		-955	1007		-1007	979		-979	896		-896
	Urgent	483		-483	483		-483	499		-499	399		-399	635		-635	480		-480
Gastroenterology	All Urgencies	560	0	-560	621	0	-621	465	0	-465	546	0	-546	559	0	-559	541	0	-541
	Routine	365		-365	392		-392	304		-304	363		-363	385		-385	350		-350
	Urgent	195		-195	229		-229	161		-161	183		-183	174		-174	191		-191
General Medicine	All Urgencies	118	0	-118	117	0	-117	110	0	-110	104	0	-104	122	0	-122	98	0	-98
	Routine	100		-100	104		-104	95		-95	97		-97	104		-104	86		-86
	Urgent	18		-18	13		-13	15		-15	7		-7	18		-18	12		-12
General Surgery (inc Vascular)	All Urgencies	1968	0	-1968	2358	0	-2358	2164	0	-2164	1925	0	-1925	2090	0	-2090	2397	0	-2397
	Routine	1186		-1186	1460		-1460	1330		-1330	1202		-1202	1307		-1307	1514		-1514
	Urgent	782		-782	898		-898	834		-834	723		-723	783		-783	883		-883
Gynaecology	All Urgencies	1314	0	-1314	1354	0	-1354	1445	0	-1445	1366	0	-1366	1526	0	-1526	1504	0	-1504
	Routine	847		-847	875		-875	1007		-1007	906		-906	1073		-1073	1000		-1000
	Urgent	467		-467	479		-479	438		-438	460		-460	453		-453	504		-504
Neurology	All Urgencies	530	0	-530	633	0	-633	673	0	-673	616	0	-616	598	0	-598	698	0	-698
	Routine	443		-443	489		-489	511		-511	467		-467	450		-450	512		-512
	Urgent	87		-87	144		-144	162		-162	149		-149	148		-148	186		-186

New Outpatient (12 Week Standard) Activity Projections		30 April 2021			31 May 2021			30 June 2021			31 July 2021			31 August 2021			30 September 2021		
Specialty	**Urgency**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Neurosurgery	All Urgencies	142	0	-142	142	0	-142	132	0	-132	128	0	-128	149	0	-149	139	0	-139
	Routine	97		-97	80		-80	100		-100	89		-89	124		-124	100		-100
	Urgent	45		-45	62		-62	32		-32	39		-39	25		-25	39		-39
Ophthalmology	All Urgencies	2478	0	-2478	2342	0	-2342	2394	0	-2394	2230	0	-2230	2468	0	-2468	2494	0	-2494
	Routine	2053		-2053	1874		-1874	1938		-1938	1814		-1814	2007		-2007	2036		-2036
	Urgent	425		-425	468		-468	456		-456	416		-416	461		-461	458		-458
Oral & Maxillofacial Surgery	All Urgencies	101	0	-101	84	0	-84	142	0	-142	154	0	-154	210	0	-210	146	0	-146
	Routine	99		-99	81		-81	137		-137	142		-142	167		-167	137		-137
	Urgent	2		-2	3		-3	5		-5	12		-12	43		-43	9		-9
Oral Surgery	All Urgencies	280	0	-280	313	0	-313	256	0	-256	278	0	-278	277	0	-277	270	0	-270
	Routine	247		-247	281		-281	220		-220	239		-239	241		-241	231		-231
	Urgent	33		-33	32		-32	36		-36	39		-39	36		-36	39		-39
Orthodontics	All Urgencies	82	0	-82	78	0	-78	51	0	-51	55	0	-55	66	0	-66	54	0	-54
	Routine	82		-82	78		-78	51		-51	55		-55	66		-66	54		-54
	Urgent	0		0	0		0	0		0	0		0	0		0	0		0
Other	All Urgencies	2399	0	-2399	2852	0	-2852	2763	0	-2763	2632	0	-2632	2677	0	-2677	2635	0	-2635
	Routine	2156		-2156	2583		-2583	2502		-2502	2386		-2386	2421		-2421	2366		-2366
	Urgent	243		-243	269		-269	261		-261	246		-246	256		-256	269		-269
Pain Management	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Plastic Surgery	All Urgencies	353	0	-353	413	0	-413	297	0	-297	378	0	-378	329	0	-329	323	0	-323
	Routine	316		-316	360		-360	262		-262	341		-341	294		-294	291		-291
	Urgent	37		-37	53		-53	35		-35	37		-37	35		-35	32		-32
Respiratory Medicine	All Urgencies	674	0	-674	766	0	-766	750	0	-750	631	0	-631	813	0	-813	758	0	-758
	Routine	399		-399	473		-473	488		-488	367		-367	545		-545	500		-500
	Urgent	275		-275	293		-293	262		-262	264		-264	268		-268	258		-258
Restorative Dentistry	All Urgencies	291	0	-291	258	0	-258	306	0	-306	217	0	-217	276	0	-276	267	0	-267
	Routine	291		-291	258		-258	306		-306	217		-217	276		-276	267		-267
	Urgent	0		0	0		0	0		0	0		0	0		0	0		0
Rheumatology	All Urgencies	388	0	-388	441	0	-441	418	0	-418	314	0	-314	480	0	-480	468	0	-468
	Routine	218		-218	257		-257	234		-234	191		-191	285		-285	294		-294
	Urgent	170		-170	184		-184	184		-184	123		-123	195		-195	174		-174

New Outpatient (12 Week Standard) Activity Projections		30 April 2021			31 May 2021			30 June 2021			31 July 2021			31 August 2021			30 September 2021		
Specialty	Urgency	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
Trauma & Orthopaedics	All Urgencies	966	0	-966	1030	0	-1030	1096	0	-1096	946	0	-946	1254	0	-1254	1182	0	-1182
	Routine	890		-890	951		-951	1016		-1016	881		-881	1142		-1142	1096		-1096
	Urgent	76		-76	79		-79	80		-80	65		-65	112		-112	86		-86
Urology	All Urgencies	828	0	-828	813	0	-813	694	0	-694	716	0	-716	742	0	-742	691	0	-691
	Routine	521		-521	531		-531	443		-443	443		-443	463		-463	462		-462
	Urgent	307		-307	282		-282	251		-251	273		-273	279		-279	229		-229

NOP by Specialty: October 2021 - March 2022

New Outpatient (12 Week Standard) Activity Projections		31 October 2021			30 November 2021			31 December 2021			31 January 2022			28 February 2022			31 March 2022		
Specialty	Urgency	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
All Specialties	All Urgencies	21555	0	-21555	20454	0	-20454	18192	0	-18192	20265	0	-20265	18488	0	-18488	15241	0	-15241
	Routine	16050	0	-16050	15174	0	-15174	13389	0	-13389	15097	0	-15097	13618	0	-13618	10809	0	-10809
	Urgent	5505	0	-5505	5280	0	-5280	4803	0	-4803	5168	0	-5168	4870	0	-4870	4432	0	-4432
Anaesthetics	All Urgencies	182	0	-182	198	0	-198	187	0	-187	165	0	-165	166	0	-166	66	0	-66
	Routine	175		-175	193		-193	182		-182	158		-158	158		-158	65		-65
	Urgent	7		-7	5		-5	5		-5	7		-7	8		-8	1		-1
Cardiology	All Urgencies	1117	0	-1117	956	0	-956	812	0	-812	995	0	-995	932	0	-932	695	0	-695
	Routine	823		-823	700		-700	567		-567	731		-731	659		-659	488		-488
	Urgent	294		-294	256		-256	245		-245	264		-264	273		-273	207		-207
Dermatology	All Urgencies	2619	0	-2619	2418	0	-2418	2232	0	-2232	2366	0	-2366	2127	0	-2127	1762	0	-1762
	Routine	1655		-1655	1467		-1467	1387		-1387	1509		-1509	1388		-1388	1110		-1110
	Urgent	964		-964	951		-951	845		-845	857		-857	739		-739	652		-652
Diabetes/ Endocrinology	All Urgencies	480	0	-480	468	0	-468	396	0	-396	492	0	-492	453	0	-453	374	0	-374
	Routine	446		-446	429		-429	360		-360	452		-452	413		-413	313		-313
	Urgent	34		-34	39		-39	36		-36	40		-40	40		-40	61		-61
ENT	All Urgencies	1671	0	-1671	1449	0	-1449	1429	0	-1429	1467	0	-1467	1337	0	-1337	1002	0	-1002
	Routine	1069		-1069	997		-997	931		-931	1003		-1003	886		-886	619		-619
	Urgent	602		-602	452		-452	498		-498	464		-464	451		-451	383		-383
Gastroenterology	All Urgencies	567	0	-567	549	0	-549	496	0	-496	537	0	-537	570	0	-570	416	0	-416
	Routine	341		-341	351		-351	328		-328	366		-366	411		-411	249		-249
	Urgent	226		-226	198		-198	168		-168	171		-171	159		-159	167		-167

New Outpatient (12 Week Standard) Activity Projections		31 October 2021			30 November 2021			31 December 2021			31 January 2022			28 February 2022			31 March 2022		
Specialty	**Urgency**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
General Medicine	All Urgencies	109	0	-109	132	0	-132	96	0	-96	134	0	-134	110	0	-110	103	0	-103
	Routine	98		-98	116		-116	86		-86	125		-125	101		-101	92		-92
	Urgent	11		-11	16		-16	10		-10	9		-9	9		-9	11		-11
General Surgery (inc Vascular)	All Urgencies	2435	0	-2435	2341	0	-2341	2089	0	-2089	2298	0	-2298	2016	0	-2016	1824	0	-1824
	Routine	1488		-1488	1485		-1485	1274		-1274	1453		-1453	1255		-1255	1020		-1020
	Urgent	947		-947	856		-856	815		-815	845		-845	761		-761	804		-804
Gynaecology	All Urgencies	1565	0	-1565	1571	0	-1571	1410	0	-1410	1531	0	-1531	1412	0	-1412	1082	0	-1082
	Routine	1031		-1031	1064		-1064	948		-948	1035		-1035	889		-889	600		-600
	Urgent	534		-534	507		-507	462		-462	496		-496	523		-523	482		-482
Neurology	All Urgencies	742	0	-742	701	0	-701	581	0	-581	752	0	-752	586	0	-586	662	0	-662
	Routine	548		-548	449		-449	371		-371	489		-489	389		-389	409		-409
	Urgent	194		-194	252		-252	210		-210	263		-263	197		-197	253		-253
Neurosurgery	All Urgencies	170	0	-170	154	0	-154	146	0	-146	161	0	-161	149	0	-149	162	0	-162
	Routine	120		-120	110		-110	106		-106	132		-132	110		-110	117		-117
	Urgent	50		-50	44		-44	40		-40	29		-29	39		-39	45		-45
Ophthalmology	All Urgencies	2544	0	-2544	2321	0	-2321	2162	0	-2162	2407	0	-2407	2262	0	-2262	1747	0	-1747
	Routine	2036		-2036	1821		-1821	1771		-1771	1925		-1925	1809		-1809	1378		-1378
	Urgent	508		-508	500		-500	391		-391	482		-482	453		-453	369		-369
Oral & Maxillofacial Surgery	All Urgencies	210	0	-210	175	0	-175	137	0	-137	184	0	-184	141	0	-141	175	0	-175
	Routine	205		-205	170		-170	136		-136	183		-183	134		-134	174		-174
	Urgent	5		-5	5		-5	1		-1	1		-1	7		-7	1		-1
Oral Surgery	All Urgencies	329	0	-329	281	0	-281	253	0	-253	286	0	-286	311	0	-311	119	0	-119
	Routine	291		-291	244		-244	230		-230	252		-252	276		-276	97		-97
	Urgent	38		-38	37		-37	23		-23	34		-34	35		-35	22		-22
Orthodontics	All Urgencies	67	0	-67	82	0	-82	80	0	-80	78	0	-78	41	0	-41	51	0	-51
	Routine	67		-67	82		-82	80		-80	78		-78	41		-41	51		-51
	Urgent	0		0	0		0	0		0	0		0	0		0	0		0
Other	All Urgencies	2880	0	-2880	2718	0	-2718	2375	0	-2375	2644	0	-2644	2368	0	-2368	2141	0	-2141
	Routine	2626		-2626	2453		-2453	2142		-2142	2357		-2357	2146		-2146	1915		-1915
	Urgent	254		-254	265		-265	233		-233	287		-287	222		-222	226		-226
Pain Management	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0

New Outpatient (12 Week Standard) Activity Projections		31 October 2021			30 November 2021			31 December 2021			31 January 2022			28 February 2022			31 March 2022		
Specialty	Urgency	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
Plastic Surgery	All Urgencies	290	0	-290	303	0	-303	227	0	-227	373	0	-373	362	0	-362	259	0	-259
	Routine	267		-267	252		-252	188		-188	288		-288	278		-278	225		-225
	Urgent	23		-23	51		-51	39		-39	85		-85	84		-84	34		-34
Respiratory Medicine	All Urgencies	795	0	-795	844	0	-844	696	0	-696	782	0	-782	775	0	-775	706	0	-706
	Routine	492		-492	541		-541	437		-437	506		-506	474		-474	424		-424
	Urgent	303		-303	303		-303	259		-259	276		-276	301		-301	282		-282
Restorative Dentistry	All Urgencies	314	0	-314	246	0	-246	221	0	-221	229	0	-229	225	0	-225	139	0	-139
	Routine	314		-314	246		-246	221		-221	229		-229	225		-225	139		-139
	Urgent	0		0	0		0	0		0	0		0	0		0	0		0
Rheumatology	All Urgencies	484	0	-484	492	0	-492	426	0	-426	482	0	-482	420	0	-420	296	0	-296
	Routine	297		-297	310		-310	253		-253	282		-282	249		-249	162		-162
	Urgent	187		-187	182		-182	173		-173	200		-200	171		-171	134		-134
Trauma & Orthopaedics	All Urgencies	1280	0	-1280	1290	0	-1290	1038	0	-1038	1210	0	-1210	1019	0	-1019	922	0	-922
	Routine	1200		-1200	1199		-1199	968		-968	1103		-1103	915		-915	842		-842
	Urgent	80		-80	91		-91	70		-70	107		-107	104		-104	80		-80
Urology	All Urgencies	705	0	-705	765	0	-765	703	0	-703	692	0	-692	706	0	-706	538	0	-538
	Routine	461		-461	495		-495	423		-423	441		-441	412		-412	320		-320
	Urgent	244		-244	270		-270	280		-280	251		-251	294		-294	218		-218

TTG by Specialty: April 2021 - September 2021

TTG Activity Projections		30 April 2021			31 May 2021			30 June 2021			31 July 2021			31 August 2021			30 September 2021		
Specialty	Urgency	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
All Specialties	All Urgencies	3230	0	-3230	3516	0	-3516	3273	0	-3273	3846	0	-3846	4148	0	-4148	4004	0	-4004
	Routine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Urgent	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENT	All Urgencies	216		-216	245		-245	228		-228	246		-246	300		-300	277		-277
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Gastroenterology	All Urgencies	69		-69	97		-97	93		-93	103		-103	88		-88	69		-69
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
General Surgery (inc Vascular)	All Urgencies	597		-597	657		-657	618		-618	676		-676	724		-724	773		-773
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0

TTG Activity Projections		30 April 2021			31 May 2021			30 June 2021			31 July 2021			31 August 2021			30 September 2021		
Specialty	**Urgency**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Gynaecology	All Urgencies	294		-294	285		-285	272		-272	311		-311	314		-314	331		-331
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Neurology	All Urgencies	23		-23	17		-17	18		-18	15		-15	17		-17	21		-21
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Ophthalmology	All Urgencies	416		-416	435		-435	433		-433	478		-478	608		-608	617		-617
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Oral & Maxillofacial Surgery	All Urgencies	62		-62	69		-69	64		-64	68		-68	69		-69	52		-52
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Oral Surgery	All Urgencies	18		-18	15		-15	9		-9	9		-9	24		-24	12		-12
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Orthodontics	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Other	All Urgencies	530		-530	611		-611	554		-554	698		-698	752		-752	735		-735
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Plastic Surgery	All Urgencies	196		-196	210		-210	209		-209	320		-320	253		-253	257		-257
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Rheumatology	All Urgencies	6		-6	8		-8	4		-4	4		-4	2		-2	5		-5
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Trauma & Orthopaedics	All Urgencies	486		-486	551		-551	494		-494	575		-575	659		-659	516		-516
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Urology	All Urgencies	317		-317	316		-316	277		-277	343		-343	338		-338	339		-339
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0

TTG by Specialty: October 2021 - March 2022

TTG Activity Projections		31 October 2021			30 November 2021			31 December 2021			31 January 2022			28 February 2022			31 March 2022		
Specialty	**Urgency**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
All Specialties	All Urgencies	4447	0	-4447	4473	0	-4473	3792	0	-3792	5061	0	-5061	5043	0	-5043	3538	0	-3538
	Routine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Urgent	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENT	All Urgencies	295		-295	320		-320	259		-259	364		-364	397		-397	249		-249
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Gastroenterology	All Urgencies	100		-100	99		-99	76		-76	106		-106	110		-110	62		-62
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
General Surgery (inc Vascular)	All Urgencies	814		-814	814		-814	648		-648	901		-901	887		-887	629		-629
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Gynaecology	All Urgencies	333		-333	375		-375	332		-332	469		-469	393		-393	278		-278
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Neurology	All Urgencies	16		-16	17		-17	7		-7	15		-15	15		-15	13		-13
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Ophthalmology	All Urgencies	627		-627	710		-710	607		-607	829		-829	787		-787	553		-553
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Oral & Maxillofacial Surgery	All Urgencies	86		-86	67		-67	52		-52	103		-103	86		-86	50		-50
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Oral Surgery	All Urgencies	18		-18	18		-18	13		-13	22		-22	22		-22	6		-6
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Orthodontics	All Urgencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Other	All Urgencies	769		-769	810		-810	732		-732	952		-952	938		-938	695		-695
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0

TTG Activity Projections		31 October 2021			30 November 2021			31 December 2021			31 January 2022			28 February 2022			31 March 2022		
Specialty	Urgency	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
Plastic Surgery	All Urgencies	305		-305	268		-268	220		-220	268		-268	300		-300	222		-222
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Rheumatology	All Urgencies	2		-2	5		-5	4		-4	6		-6	7		-7	6		-6
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Trauma & Orthopaedics	All Urgencies	673		-673	629		-629	540		-540	642		-642	694		-694	419		-419
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0
Urology	All Urgencies	409		-409	341		-341	302		-302	384		-384	407		-407	356		-356
	Routine			0			0			0			0			0			0
	Urgent			0			0			0			0			0			0

Template 3

P1 Capacity and TTG Total Waiting List (all specialties, on-going waits)

Clinical Priorities	As at 31 Dec 2020
P1 (% capacity used)	43.00%
P2 (number waiting)	2293
P3 (number waiting)	6845
P4 (number waiting)	16303

Clinical Priorities Key	
P1a Emergency	Needs operation within 24 hours
P1b Urgent	Needs operation within 72 hours
P2 Requires Surgery	Can be undertaken within 4 weeks
P3 Requires Surgery	Can be undertaken within 3 months
P4 Requires Surgery	Can be undertaken > 3 months

As per guidance issued with request for remobilisation plans on 21 July 2020 regarding a National approach to clinical prioritisation.

To include waiting list numbers as at 31 December 2020.

16. References & Glossary

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2.1	Scottish Government commissioning letter dated 14th December 2020
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3.1	MFT strategic document: **https://www.nhsggc.org.uk/media/248849/item-9-18-24.pdf**
3.5	Maternity and Neonatal Strategy: **https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland/**
3.5	Primary Care Implementation Plans
4.3	Turning the Tide: **https://www.nhsggc.org.uk/your-health/public-health/turning-the-tide/documents-and-resources/**
4.3	Equality Act (2010): **www.gov.uk/guidance/equality-act-2010-guidance**
4.3	NHS Scotland Interpreting, Communications Support and Translation National Policy: **www.healthscotland.scot/publications/interpreting-communication-support-and-translation-national-policy**
4.3	Healthier Wealthier Children: **www.nhsggc.org.uk/your-health/public-health/maternal-and-child-public-health/healthier-wealthier-children/#:~:text=Healthier%2C%20Wealthier%20Children%20%28HWC%29%20aims%20to%20contribute%20to,child%20poverty%20by%20helping%20families%20with%20money%20worries.**
4.3	Long Term Conditional Financial Inclusion: **http://library.nhsggc.org.uk/mediaAssets/Respiratory Medicine/Long Term Conditions Financial Inclusion Service .pdf**
4.3	HSCP Local Outcome Improvement Plan
4.3	BSL Act (Scotland) 2015: **http://bslscotlandact2015.scot/**
4.3	NHSGGC Workforce Equality Plan: **www.nhsggc.org.uk/working-with-us/hr-connect/equality-diversity-and-human-rights/our-workforce-equality-action-plan/**
5.2	Stakeholder Communications and Engagement Strategy: **www.nhsggc.org.uk/media/264304/nhsggc_board_paper_item-12b-paper-20_70-stakeholder-comms-engagement-strategy.pdf**
5.2	Independent Review of Adult Social Care: **www.gov.scot/groups/independent-review-of-adult-social-care/**
5.3	Care Opinion Scotland: **www.careopinion.org.uk/services/nhs-scotland**
5.5	Quality Strategy: **www.nhsggc.org.uk/media/256774/1-quality-strategy-angela-oneill.pdf**

5.5	NHSGGC's 'The Pursuit of Healthcare Excellence Quality Strategy: **www.nhsggc.org.uk/media/253754/190219-the-pursuit-of-healthcare-excellence-paper_low-res.pdf**
7.1	Transforming Urgent Care for the People of Scotland: **www.nls.uk/scotgov/2015/9781785448782.pdf**
8	Clinical Prioritisation Framework: **www.gov.scot/publications/supporting-elective-care-clinical-prioritisation-framework**
8.1	Scottish Government, 'Re-mobilise, Recover, Re-design: The Framework for NHS Scotland', May 2020: **www.gov.scot/publications/re-mobilise-recover-re-design-framework-nhs-scotland/**
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11.5	GGC Discharge to Assess Policy
11.6	Getting it Right for Every Child (GIRFEC): **www.gov.scot/policies/girfec**
11.7	Figure 1: Rehabilitation in Health Framework: **https://scottish.sharepoint.com/sites/RMP3/Shared Documents/General/Working Draft/(https:/www.who.int/publications/i/item/rehabilitation-in-health-systems-guide-for-action)**
11.7	National Framework for Supporting People through Recovery and Rehabilitation (2020): **www.gov.scot/publications/framework-supporting-people-through-recovery-rehabilitation-during-covid-19-pandemic/**
11.9	Dental Guidance: **www.sdcep.org.uk/published-guidance/management-of-acute-dental-problems-madp**
11.9	Standard Operating Procedures For Dental Teams In Scotland (COVID-19): **www.scottishdental.org/wp-content/uploads/2021/02/SOPS_28Jan2021_PHrevision.pdf**
12.1	Digital Health and Care Workplan

Glossary

A&A	Ayrshire & Arran
ACH	Ambulatory Care Hospital
ACP	Anticipatory Care Planning
ACRT	Active Clinical Referral Triage
ADHD	Attention Deficit Hyperactive Disorder
ADRS	Alcohol and Drug Recovery Services
AGP	Aerosol Generating Procedure
AHP	Allied Health Professional
ANP	Advance Nurse Practitioner
AWI	Adult with Incapacity
AU	Assessment Units
BAME	Black and Minority Ethnic
BBV	Blood Borne Virus
BI	Business Intelligence
BPD	Borderline personality disorder
BSL	British Sign Language
CACs	Community Assessment Centres
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behavioural therapy
CCE	Capsule Colonoscopy
CDM	Chronic Disease Management
CMHTs	Community and Specialist Mental Health Teams
CMUs	Community Maternity Units
COPD	Chronic Obstructive Pulmonary Disease
COSLA	Confederation of Scottish Local Authorities
CRES	Cost Reduction Efficiency saving
CTACs	Community Treatment and Care Centres
CYP	Children and young people
CVS	Community and Voluntary Service
DAFNE	Dose Adjustment For Normal Eating
DDTF	Drug Death Task Force
DEXA	Dual-Energy X-ray Absorptiometry
DMDs	Deputy Medical Directors
DN	District Nursing
DNAs	Did not attend
ED	Emergency Department
EHRT	Equality and Human Rights Team
EMIS	Egton Medical Information Systems
ENT	Ear, Nose & Throat
EQuIP	Effective and Quality Interventions and Pathways
EQIA	Equalities Impact Assessment
EU	European Union
FAQ	Frequently Asked Questions
FFP	Filtering Face Piec
FIP	Financial Improvement Programme
FNH	Flow Navigation Hub
FNP	Family Nurse Partnership
GADR	Glasgow Alcohol and Drug Recovery Services
GBV	Gender based violence
GCPH	Glasgow Centre for Population Health
GDM	Gestational Diabetes Mellitus
GGC	Greater Glasgow & Clyde
GI	Gastro Intestinal
GIRFEC	Getting it Right for Every Child
GJNH	Golden Jubilee National Hospital
GMS	General Medical Services
GP	General Practitioner
GPN	General Practice Nursing

GPOOH	GP Out of Hours
GRI	Glasgow Royal Infirmary
HDU	High Dependency Unit
HEI	Healthcare Environment Inspectorate (Scotland)
HEPMA	Hospital Electronic Prescribing and Medicines Administration
HR	Human Resources
HSCP	Health & Social Care Partnership
ICU	Intensive Care Unit
INS	Institute of Neurological Sciences
IJB	Integration Joint Board
IPDC	Inpatient and daycase
IRDs	Initial Referral Discussions
JCVI	Joint Committee on Vaccination and Immunisation
LCPARs	Local Child Poverty Action Reports
LD	Learning Disability
LFD	Lateral Flow Device
LIMS	Laboratory Information Management System
LMC	Local Medical Committee
LRMT	Local Response management Team
MCN	Managed Clinical Network
MDT	Multi-Disciplinary Team
MH	Mental Health
MHAUs	Mental Health Assessment Units
MIU	Minor Injuries Unit
MSK	Musculoskeletal
MTC	Major Trauma Centre
MTU	Mobile Testing Unit
NES	NHS Education for Scotland
NESGAT	NES Glaucoma Award Training
NNS	National Notification Service
NRPF	No Recourse to Public Funds
NSS	National Services Scotland
OHIP	Oral Health Improvement Plan
OMFS	Oral & maxillofacial surgery
OOH	Out of Hours
OPD	Outpatient department
OP IOL	Outpatient Induction of Labour
OPMH	Out Patient Mental Health
OPWL	Outpatient Waiting List
PAMS	Property Asset Management Strategy
PCHC	Person Centred Health and Care Team
PCIP	Primary Care Improvement Plan
PCR	Polymerase chain reaction
PCVV	Person Centred Virtual Visiting
PDRU	Physically Disabled Rehabilitation Unit
PDS	Public Dental Services
PEPI	Patient Experience Public Involvement Team
PHS	Public Health Scotland
PIR	Patient Initiated Review
PMO	Project Management Office
POC	Point of Care
PPE	Personal Protective Equipment
PWID	People who inject drugs
qFIT	Quantitative Faecal Immunochemical Test
QEUH	Queen Elizabeth University Hospital
RAH	Royal Alexandra Hospital
RSL	Registered social landlord
SAS	Scottish Ambulance Service
SACH	Stobhill Ambulatory Care Hospital
SACT	Systemic Anti-Cancer Therapy

SATA	Specialist Assessment and Treatment Centre
SCI	Scottish Care Information
SCIM	Scottish Capital Investment Manual
SG	Scottish Government
SGHD	Scottish Government Health Directorate
SGHSCD	Scottish Government Health and Social Care Directorate
SHTM	Scottish Health Technical Manual
SLA	Service-level agreement
SLWG	Short Life Working Group
SMT	Senior Management Team
SMR	Scottish Medical Record
SRG	Stake Reference Group
TTG	Treatment time guarantee
TNE	Transnasal Endoscopy
UCC	Should be USC unscheduled care
USOC	Urgent Suspicion of Cancer
VACH	Victoria Ambulatory Care Hospital
vCreate	New video technology system
VOL	Vale of Leven
VPM	Virtual Patient Management
WACH	West Glasgow Ambulatory Care Hospital
WLs	Waiting Lists
WLI	Waiting List Initiative
WoS	West of Scotland
WTE	Whole Time Equivalent

NHSGGC Remobilisation Plan (RMP3)

April 2021 to March 2022