Agenda Item
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NHS Shetland

Meeting:	NHS Shetland Board
Date:	6 October 2020
Report Title:	Re-Mobilisation Plan
Reference Number:	Board Paper 2020/21/37
Author / Executive Lead/ Job Title:	Elizabeth Robinson: Public Health and Planning Principal

Decisions / Action required:

The Board is asked to note the content and direction of travel described within the attached Remobilisation Plan.

High Level Summary:

NHS Board Chief Executives were written to at the beginning of July 2020 to request the submission of a Remobilisation Plan, covering the period August 2020 - March 2021. This paper is that submission.

It covers public health, acute and community elements of services

It will be subject to further discussion with Scottish Government colleagues over the next few weeks.

Corporate Priorities and Strategic Aims:

The Remobilisation Plan was required to focus on the public health agenda, safety, delivery and financial sustainability as the core pillars of the re-mobilisation process and was developed in line with Remobilise, Recover, Redesign: the framework for NHS Scotland.

Key Issues:

Building the capacity to fully re-mobilise services while at the same time retaining capacity to respond to the continuing threat of COVID-19 is challenging.

This effort requires financial and human resources, which we have tried to describe within this submission.

Great effort has been made to build on the positive changes that took place during the Pandemic, for example, increased use of Near Me technology and blurring of boundaries between acute and community services.

Implications : *Identify any issues or aspects of the report that have implications under the following headings*	
Service Users, Patients and Communities:	The Remobilisation Plan is designed to meet the needs of service users, patients and the Shetland community while maintaining safety and financial stability.
Human Resources and Organisational Development:	The level of recruitment and staff relations issues will have significant issues on Human Resources; this has been recognised and allowance has been made for additional staffing.
Equality, Diversity and Human Rights:	Equality, diversity and human rights are critical issues to be considered as we re-mobilise. Funding has been requested for an Equalities Officer to provide expertise and capacity to ensure that the Board goes above and beyond its duties with regard to compliance.
Partnership Working	Implementation of the Remobilisation plans relies on integrated working with the IJB and community health and social care partnership.
Legal:	There are no legal implications.
Finance:	The financial implications of the plan form a separate submission to government.
Assets and Property:	Allowance for fixed assets is made within the paper.
Environmental:	At present there are few environmental impacts from this plan; however, it is likely that staff continuing to work from home where possible and use of remote consultations where possible will contribute to meeting environmental targets.
Risk Management:	A full risk process is being worked through as the next stage of the Remobilisation Plan.

Policy and Delegated Authority:	No decisions required.	
Previously considered by:	List the committees / working groups or other fora that have considered the matters covered by the report.	Provide dates of the meetings

“Exempt / private” item	NA

COVID-19: Re-mobilisation: Next phase of Health and Social Care Response to March 2021

Our plan is written in line with the 'Re-mobilise, recover, re-design Framework for NHS Scotland', and the seven principles within it. Within the plan we will set out how we will:

- Manage the backlog of planned care (to minimise harm)
- Ensure unmet demand is managed and ensure safety
- Manage COVID-19-19-19 and non COVID-19-19-19 unscheduled care demand
- Increase the focus on whole system working, accelerating transformation and re-design of the system

At the same time we will work to improve population health, committing to prevention and tackling of inequalities and developing services which promote equality for all.

- We will build and retain resilience
- We will minimise excess mortality and morbidity from non-COVID-19-19 disease
- We will re-establish services, prioritised to clinical need and reflecting population demand
- We will focus on approaches that create better population health and wellbeing
- We will support people to recover, including their mental health and wellbeing
- We will embed innovations and digital approaches
- We will ensure the health and social care support system is focused on reducing health inequalities
- We will engage with the people of Shetland to agree the basis of our future Health and Social Care system.

This remobilisation plan is, as of 31st July, in a draft format. It has not been formally agreed by the NHS Shetland Board, and this won't be done until end August 2020. We will, of course, engage with colleagues in SGHSCD on the fine detail before final approval.

Public Health	**Test and Protect** Continue to build the resilience of the system, in order to identify and rapidly respond to localised outbreaks, gradually reducing the rate of transmission. **Health Inequalities** We need to renew the focus on inequalities, with drive and support from the NHS Board. We will develop a revised framework and implementation plan for the Board. **Prevention: Screening** Following Scottish Government guidance, all screening programmes were paused on the 30th March 2020. Screening Recovery Plans have now been agreed at local and national level for the five adult screening programmes. Most of these are recommencing gradually by prioritising symptomatic or high risk patients. This includes cervical screening which recommenced on 29/6, breast screening, and diabetic retinography. Bowel screening is affected by capacity constraints for colonoscopy and its pace of implementation will be influenced by developments in acute services. Contingency arrangements are in place for high risk patients requiring AAA screening until screening sites become operational. **Immunisation** Planning for seasonal flu 2020/21 is well underway in NHS Shetland, taking into account increased uptake and eligibility. Our planning also considers delivery of the potential COVID-19-19 vaccine alongside the seasonal flu programme. This will involve the deployment of mass clinics with immunisation teams involving community/immunisation nurses, trained nurses and health care support workers. **Sexual Health/Blood Borne Viruses** Many of these services continued in a limited way throughout the pandemic and service provision is now extending. This includes Long Acting Reversible Contraception (LARC) for vulnerable groups including those under 25 years; offering alternative methods of and re-establishing STI and Blood Borne Virus Testing (HIV, Hep C and Hep B) and initiating people into effective treatment/therapies and continuation of effective Injecting Equipment Provision (IEP) services.

	Health improvement and wider determinants of health Activity relating to government programmes for health improvement were largely paused during the response phase, with many staff redeployed to support COVID-19-19 testing and health protection. This mainly affected work in communities, particularly locality planning, drugs, alcohol and tobacco control, financial inclusion, healthy weight. Other important aspects of health such as mental well-being and early years have continued in other forms, either through humanitarian efforts, resilience support or research collaborations, particularly in child health. Many of the nationally driven health improvement programmes are beginning to start again, placing increasing emphasis to find sustainable solutions for health protection work as redeployed staff return to substantive roles.

Communications	Continued implementation of Communications Plan (Appendix 4) in line with WHO 6 phases, but also to maintain engagement with community about continuing redesign and development of services. Development of dedicated web resource for COVID-19-19 public information and the development of a Shetland / Orkney Comms unit with external / internal and digital comms people with a strong focus on supporting the renewal agenda.
Re-mobilisation of Primary, Community and Social Care	
Pharmacy	• In many ways we continued to work as usual throughout COVID-19-19 in the hospital/community pharmacy and in primary/social care we were forced to withdraw services that were patient facing but did some of the pharmacotherapy work remotely as we were able according to IT/staff availability. • The implementation of the Hospital Electronic Prescribing and Medicines Administration (HEPMA) project has continued throughout COVID-19-19-19 as far as possible. • Pharmacy First launch – 29th July in Community Pharmacy • Medicines Care and Review service – a partnership between Primary care and Community Pharmacy designed to move responsibility for managing a proportion of the repeat prescription management from the GP practice to Community Pharmacy. Not new but COVID-19-19 has increased understanding of the benefit of promoting this work as the direction of travel. • Increasing use of Near Me technology by pharmacists undertaking consultations in primary care, community pharmacy and secondary care clinics • A pilot study in use of electronic MAR sheets in social care with potential for rolling out across all social care in the future. • Ability of provide an adequate and timely medicines management assessment service for patients needs to be re-introduced as we have significant risk of medicines misadventure particularly in our older population.

Dental	We have started preparations within the independent sector to prepare practices to receive patients during the next phase. NHS Shetland will support all practices to recover capability using the SDCEP Practice recovery toolkit. Patients with oral health problems will be able to contact the practice they are registered with to receive Advise, Analgesic, Antibiotic pathway management. If patient require face to face consultations, this will be facilitated by the PDS in their UDC. The capacity of UDCs will be expanded prior to entering IOC phase. UDCs will be able to deal with red, amber and green pathways as laid down in SDCEP guidance. The guiding principle is that UDCs will provide a single episode of care, avoiding AGPs where possible. UDCs will maintain one red dental surgery for maintenance of red and green pathways through their service. UDCs will be able to link remotely with secondary care partners via Attend Anywhere to jointly assess urgent patients and to ascertain if movement off island is necessitated.
Primary Care	We will be able to provide a green pathway GP service Monday to Friday between 0800 and 1730 We will be able to provide a red pathway COVID-19-19 service 7 days per week from 1000-2000. NB Separate document being developed re red/green/amber pathways, which will be shared as part of this plan]. -We will be able to triage all patients calling GP Practices for an appointment. 1. We need to continue the Community Assessment Centre for the foreseeable future. 2. We need to ensure our buildings can support social distancing in waiting rooms and other areas, e.g. staff rooms. The red/green/amber plan will be key to this. 3. Excellent communication with the public and staff is required to explain how to access services, and where there are changes required in order to comply with social distancing etc, to explain these upfront. 4. There will need to be a digital solution for the sharing of information across all primary care centres.

Community Nursing	Community Nursing Will continue to deliver a full Intermediate Care Team service and a limited General Practice Nurse / Treatment Room service at all Health Centres building on the services that had been maintained during lockdown, namely Immunisations (childhood and adult), Depot injections for Mental Health patients, Vit B12 /Prostap / Nebido / Decapeptyl injections, Monitoring Bloods e.g. warfarin, Lithium, DMARD, Biologics & Pre-chemotherapy blood sampling (as requested); We are preparing to increase range of General Practice Nursing services; Continue to provide a shift based 24/7 District Nursing service; Support care homes with COVID-19-1919 testing and the management of any resident displaying COVID-19-1919 symptoms; Increase ANP activity in managing on the day demand at Lerwick Health Centre; Continue to provide a service to the residents on the non-doctor islands of Fair Isle, Foula, Fetlar and Skerries. Agreement of the future shape of Primary Care services is essential to support the move forward of the new GMS Contract within Primary Care locally. It is also key to enabling Community Nursing services to deliver on the nursing response to the contract and to progressing the role of the District Nurse and General Practice Nurse within integrated teams (as outlined in the Transforming Nursing roles agenda). Having EMIS & Docman access established on a Shetland wide basis for all nursing staff across Community Nursing services will enhance flexibility in staffing across the service as well as ensuring patient safety by nursing staff documenting in a single record that can be viewed and contributed to by all key clinical staff. Maintaining adequate staffing across the workforce with appropriate skills that can respond to patient needs whether these be in red or green patient pathways.

Community Care Resources	Service Delivery Planning will ensure resumption of services in line with easing of restrictions:- We will resume care at home provision for those clients who require support once family carers have returned to work, and resume day care provision within care centres and participation in Stepping Out in Yell. We will prepare to commence enhanced day care provision at ET and Taing with a drop in service available 8am to 6pm Monday to Friday. This project was recruited to with an anticipated start date which conflicted with social distancing/temporary closure of services. We will promote and develop overnight social care support to ensure service users ca be cared for at home in accordance with their wishes with an emphasis on home as the first option for discharge planning. We will continue to facilitate rapid discharge planning/admission to care homes utilising checklist for discharge from hospital where UY not available. Reconfiguration We may need to continue to utilise redeployed/relief staff to ensure safe staffing levels following the introduction of increased testing within care home settings. We will monitor the impact of the leadership and direction provided by TL and the OOH on call system. We will to monitor the impact of senior social care workers providing leadership and direction within residential and care at home to ensure high standards of care are maintained, clinical skills are enhanced and recording is effective and efficient. System of 'Seniors off the floor' ended on 25th May 2020. Increase relief staff complement to ensure that when redeployed staff return to their service areas we can maintain existing commitment to service users and re-open day care facilities when restrictions lifted. Ensure that residential care centres are staffed to safe and appropriate levels through daily monitoring and effective utilisation of skills of senior social care workers to lead and direct care residential clients supporting Team Leaders. In particular for COVID-19-19 19 symptomatic clients; clients requiring end of life care and clients who struggle to understand/comply with social distancing measures e.g. Dementia clients. Continue to develop enhanced multi agency working with Primary Care and DN's in relation to particular cases and from a locality planning perspective. Access additional training in relation to clinical observations.

AHPs	Physiotherapy Core hours for the physiotherapy service will continue to be Monday-Friday 0830-1630 Red, green and clean green wards will continue for minimum 6 months with a likelihood of 12 months. Acute respiratory skills will need to be available 7 days per week Occupational Therapy **Acute Hospital and Intermediate Care Team**: Already providing services to patients in need of acute care and post-discharge rehabilitation **Children's Occupational Therapy:** Continue to offer online/virtual intervention to children and families and urgent face to face appointments. • Continue to signpost families to our online Symbaloo self-help resources. • Review children with complex and exceptional needs, as children will grow and require equipment adjustment (Band7, with shadowing opportunity for Band 5 therapist and Community OT) for approximately 10 children • Develop home programmes for up to 15 children and families, via support from Band 5 and Band 4 OT staff • Review and discharge up to 7 cases where all needs met to allow capacity to take on new referrals pending • Review new referrals and triage as necessary via Near Me • Consider Baby Follow Up alongside overall priorities, for joint assessment with physiotherapy • Develop plans for future service with anticipated Band 7 vacancy **Community OT** • Continue to signpost clients to online and local resources that may enable them to resolve their own identified needs • Continue to provide a Duty OT service during normal office hours • Continue to received referrals from clients or other sources for intervention, which will be prioritised for action on the established priority system, and respond as needed for urgent/critical needs • Provide face to face assessments where they meet the P1 criteria • Provide online clinic with the care homes for routine support and advice (via MT) • Trial the use of Near Me for new assessment (including non-urgent) work and reflect this in the updated referral form

	Orthotics Safely recommence clinical treatments for those patients who still require treatments. Use of the Scottish Orthotic clinical leads traffic light triage algorithm. Currently only seeing inpatients and at risk patients, with domiciliary visits if safe to do so. Telephoning new referrals re shielding, isolation and current health condition including COVID-19-19-19 position. Incorporate new ways of working, especially with new referrals e.g. telemedicine Design new robust protocols for triaging (both existing and new patients) (traffic light triage in place but may need modifying) **SLT** Continue to provide service with a digital first model and explore options for assessment options and therapy. Functional Considerations: In terms of formal assessments investigate the following Digitised assessments Permission to be creative with materials Using document scanner equipment For speech assessments We need to ensure- We can see the service users mouth clearly Audio is clear with no background noise Assess quality of images and audio, as this can impact confidence of assessment results For dysphagia assessments Remote dysphagia assessments require a risk assessment to be done **Podiatry** Safely recommence face to face clinical treatments for those patients who such treatment, using Trakcare PMS to identify, contact and triage existing service users and new referrals. Increase use of “opt-in”. Incorporate new ways of working , especially with new referrals e.g. telemedicine Design new robust protocols for triaging (both existing and new patients) **Dietetics** Write new service delivery processes and review the existing patients from cancelled March/April May/ June clinics. Attend anywhere will be utilised where possible.

Adult services (LD and ASN)	We are still awaiting Scottish Govt. guidance on the re-opening of day support (EGS) and short break/respite (NCL) however critical care need is increasing and being provided for now. This includes critical overnight support at NCL with risk assessment, enhanced infection control and cohorted staff measures in place. To support this, additional staffing will be required. Moving forward Adult Services looking to recruit temp SCWs @ G1 grade as a result of deployed staff going back to substantive posts; backfill required to Supported Living where supported people are not able to fully access day support/day care due to C-19 restrictions and prioritization of people living with carers at higher priority/risk; increased staffing ratio requirements as a result of social distancing measures and enhanced infection control (EGS & NCL). Across Adult Services (LD&ASD) 5 FTEs for up to 12 months split across Financial year 20/21 and 21/22
Mental Health	The CMHT is able to operate a daily within-hours providing clinical/therapeutic/support services to address routine/urgent/unplanned situations. Each one will be risk assessed and only seen face to face if appropriate (red/amber/green) – all other interventions will continue to take place remotely The Psychiatric Service is able to provide an out of hours service for emergency presentations The CMHT is able to carry out all new assessments (DAS at this stage will only if deemed urgent.) The CMHT is able to perform medication reviews/blood tests/urine screening and planned depots. The CMHT is able to attend homes/care homes to see patients if all other options of addressing the issue has been explored. The SMRS is able to provide group work i.e Mutual Aid Partnership (MAP) The CMHT is not able to carry out non-clinical tasks such as facilitating local Dementia champions programme, delivery of training/education, some group work i.e. Survive and Thrive.

Re-mobilisation of Acute and Specialist Care	
Acute General Beds	Our core bed capacity for general acute service provision is 42 beds, plus 2 higher dependency (level 2) beds. The beds are arranged across two acute units (medical ward has 22 beds and the surgical ward has 20). As part of pandemic preparedness, we have increased our general bed capacity by 22 and created a respiratory care unit to stabilise patients who require invasive ventilation, which has a maximum capacity for 5 patients. We will retain 100% of the surge capacity so that the additional clinical areas can be used to maintain COVID-19-19 resilience and support the remobilisation plan requirements. A table top exercise we have undertaken demonstrates that we would be able to revert 15 beds back to surge capacity within 24 hours and the remaining 7 within 48 hours if required.
Intensive Care (level 3)	We will retain the existing respiratory care unit to maintain COVID-19-19 resilience and a shadow rota for staffing has been developed to support patients who require invasive ventilation via the red pathway on an ongoing basis.
Higher Dependency Care (level 2)	As part of our core capacity we have a 2-3 bedded HDU which is situated in the acute surgical unit and we have maintained this area as part of our green pathway. In addition to this, we have identified a red HDU pathway which is part of the COVID-19-19 unit. This will be staffed by our HDU team working on a buddy system with the nurses supporting the acute medical ward. Additional training has been provided to enable us to provide additional HDU nursing capacity across the Hospital site. The RCU will also be used to support level 2 care as needed for patients in the green pathway – if this is considered the most appropriate environment which we wait for patient retrieval.

Utilising the Gilbert Bain Hospital Site for COVID-19-19 resilience and increasing the delivery of other services	We are in the process of building red and green pathways for all clinical specialities, but in terms of zoning the hospital campus the indicative[1] plans are to achieve this by: • Creating a 10-12 bed COVID-19-19 unit for patients, which is part of the acute medical ward. This level of bed capacity will ensure that we have adequate provision for patients presenting with suspected coronavirus and form part of our winter planning requirements as we expect an increase in patients overall who have respiratory symptoms. This unit will include isolation rooms that can be used to offer NIV if required and gender segregation. • Utilising the remaining 30 acute beds across the Hospital for patients who are in the green pathway (this will be a combination of patients requiring acute medical and surgical care, as well as making provision for children and patients with acute mental health crisis). • Utilising the surge capacity beds (22) to provide a 'clean green' pathway which will be used to provide space for a day case unit (DSU), an endoscopy suite and an elective ambulatory care unit for shielding patients. We will actively staff 7 beds to provide the DSU capacity and 5 beds for planned ambulatory care. The remaining 10 beds will be staffed on an ad hoc basis to provide post-operative care to patients requiring an overnight stay and/or surge capacity for elective admissions. • Allocating the two theatres as red and green pathways (for emergency and elective cases). • Outpatients will support patients in green and red pathways, with a separate entrance for patients who are shielding. • Zoning the Maternity Unit to create red and green pathways and labour wards. • Children's Outpatients will continue to be used as a Chemotherapy Unit until September 2020, because it has better access points for shielding patients. Thereafter, it will return to its usual location. Children will be seen in the main Outpatients if a face to face appointment is required and we will continue to use Near Me wherever possible until clinics resume in September 2020. • Diagnostics services (audiology, physiology and medical imaging) have plans in place to decontaminate after each patient and cohort patients according to infection risk profiles. We do not have the means of creating duplex systems for these services.

[1] We are in the process of developing a capital project with Infection Control Team input that will mean that additional fire doors will be added in the acute medical unit to create flexibility to offer RED and GREEN zones

Increasing Elective Care	The tables in Appendix A set out the plan for increasing elective/diagnostics activity from September 2020 to March 2021. We have built in a clinical triage process so that all elective patients waiting for surgery have a tele-consultation with the Consultant to discuss risk factors (e.g. balance of risk for shielding patients) before they are given a date for pre-operative assessment and surgery. This will allow patients to continue to make an informed choice about the timing of their procedures in context with their overall clinical/social circumstances. Patients are being offered appointments in order of clinical priority: 1. Urgent cancer care 2. Non urgent cancer care 3. Soon/routine treatments We have also developed a pre-operative testing strategy to ensure that patients who are in both the red and green pathways can access clinical urgent elective care. This is shown in Appendix B. We have discussed the provision of visiting services with NHS Grampian during the first phase or remobilisation. Patients requiring urgent care that cannot be delivered via tele-health will need to travel to NHS Grampian for assessment and/or treatment. Where possible, we will continue to build on the work already in place to offer a technology based solution to access the multi-disciplinary teams in Aberdeen. Most specialities have continued to offer urgent appointments using Near Me with support from the local team, more detailed plans are being developed for oral surgery and ENT where it has not been possible yet to establish a tele-health approach or reinstate visiting services. We expect that by the end of 2020-21, we will have resumed full operating capacity for local services and worked down the outpatient and treatment time guarantee backlogs. We do not expect that to be the case in respect of services provided by NHS Grampian. This is due to the challenge in managing the number of urgent cancer care patients and other patients with high clinical priority along with the need to consider the total operating capacity available during winter. NHS Grampian is providing an emergency only service for Medical Imaging which means we have had to put in place a local contingency plan, utilising a locum Radiologist to support reporting for planned test requests.

	Our main areas of backlog are shown in Appendix C, which is our operational dashboard which is reviewed on a weekly basis (data current WC 27/07). We will need to consider if it is possible to utilise national capacity via the GJNH and/or the independent sector to bring services back into a steady state in the short term for Shetland residents and the scoping exercise for this will be completed in conjunction with NHS Grampian.
Cancer Care	We have prioritised offering appointments and treatments to patients with urgent suspected cancers and our current waiting list backlog is small (4 patients). The number of referrals for urgent suspected cancer have returned to pre-COVID levels and that has been the case since mid-May 2020. We are confident that we can provide cancer care within 62 days for patients who are eligible for treatment in Shetland. However, we know there will be ongoing challenges in Aberdeen in providing urgent care for patients with suspected colorectal and urological cancers. We are working closely with NHS Grampian to monitor access to diagnostics and treatments to ensure patients do not experience unnecessary delays.

Managing Unscheduled Care	We have seen an incremental increase in Emergency Department (ED) activity from mid May 2020 onwards and activity in July 2020 is at approximately 75% of the usual expected demand. We have put in place a red assessment room, to ensure that patients admitted via ED can be maintained in a red pathway from the first stage of their hospital journey. We are reviewing our ambulatory care pathways in order to ensure that patients who require same day emergency treatment are seen in an appropriate setting. This may include developing an acute ambulatory care area (to offer Same Day Emergency Care) to reduce pressure on emergency care inpatient bed usage and we are looking at data to model whether creating a dedicated space will add value. A test of change will be undertaken in October 2020 for 4-6 weeks (utilising the RCU which only opens to meet patients requiring RCU care) to evaluate how we will build SDEC pathways into our mainstream acute bed base ahead of winter. We are supporting the urgent care priorities that sit across the whole system, including the possibility of hosting the respiratory care referral centre with staffing across primary and secondary care.

Child Health and Women's Health Services	Health Visitors, School Nurses, Children's Nurses, CAMHS and Protection Advisers have continued to provide care throughout the pandemic using a tele-health approach. Face to face clinics/home visit will be in place by the end of July 2020 for the universal pathway and preparation is ongoing to support children to return to Schools in August 2020. The same triage process has been used to ensure that children who require urgent assessment and treatment receive it. Visiting Paediatric clinics resume in September 2020. The CAMHS Department and the Child Health Department require some remedial work before they can re-open (particularly CAMHS) with the removal of carpets, introduction of screens/sanitisation stations. CAMHS is a very small team and additional staffing will be required in the short term to support remobilisation and recovering the backlog of children waiting either for a face to face consultation or a specialist consultation that has not been available during the pandemic. More women are electing to receive all maternity care in Shetland, who would otherwise travel to NHS Grampian for delivery. This means that we are starting to see an increase in local activity across the obstetric service and an increase in the complexity of issues in high risk women. WTE 2.0 Midwives will be needed during the winter months to help support the increased workload and maintain red/green pathways which is also reflected in the workforce plan. Face to face consultations will resume in August 2020 for parent education and the sexual health clinics.
Infection Control	Infection control team expertise has been critical during the pandemic and continues to have a significant role in planning for remobilisation. Our ICT is small and additional resources are required in order to sustain the current level of input, but also recognising the work needed to support other care settings including Care Homes. We intend to increase the Infection Control Nursing capacity and continue to access a Consultant Microbiologist/Infection Control Doctor who is hosted by NHS Grampian, as part of our remobilisation requirements. The Health and Social Care Partnership (H&SCP) is considering increasing infection control resources to support Care Home assurance, but the team will work as an integrated entity.

Laboratory and Microbiology Services	The Microbiology team is small and along with the addition of the Consultant Microbiologist, we have increased the BMS capacity in order to ensure we are resilient during the winter months and to enable us to manage the testing requirements associated with remobilisation. We are also undertaking an options appraisal to look at the testing model that best suits the remote and rural context as there is a capped number of test kits that we can access for cephid analysers in the UK. This is limiting our 'on island' capacity to approximately 350 tests per week and we predict will be insufficient to support both our clinically prioritised patient population in primary and secondary care, as well as quick turnaround of tests for patients identified through the Test and Protect programme if we have a second COVID-19-19 peak and/or to support differential diagnosis for patients with respiratory illness during the winter months.
Shielding	Although the restrictions for people who are high risk will ease during this period of remobilisation; we have put in place entrances to Departments (Diagnostics, OPD) to enable high risk patients to access elective appointments with maximal protection which includes segregation from patients in other waiting areas.
Physical Distancing	We have put plans in place to ensure that all departments have appropriate arrangements in place to allow physical distancing. Strategies include: • Restricting the number of patients that can wait in waiting areas (removing chairs) • Pre-booking patients to be called forward rather than offering drop in clinics • Erecting physical barriers and signage • Where face to face consultations are necessary then we are also reviewing our PPE arrangements to ensure we have appropriate PPE in place across settings.

Training & Staff Development	Our focus is to • support and improve staff wellbeing and engagement via development of programme of staff well being based on the managers reach out conversations • Develop the confidential listening service for staff further • Continue to Facilitate the delivery of e-learning and the use of technology for learning and development Across the clinical workforce our practitioners have generic skillsets already, but we have had to put in place further training in order to ensure that we can support staff to move flexibly between acute medical and surgical settings. In addition to this, we have also invested in developing practitioners to support patients with higher levels of acuity e.g. HDU and critical care skills so that we have some resilience across small teams as we move forward with the remobilisation plan and winter pressures.

Workforce	In order to deliver new ways of working, we have completed workforce professional judgement templates will all Heads of Service. The workforce review has enabled us to look at how we can 'pool' staff and develop in reach models of care to increase nursing and midwifery capacity as it is needed to where it is needed. In addition to this we have put in place a number of virtual on call rosters which means that if we needed to quickly move to COVID-19 resilience plans, we have staff identified to support the RCU and surge capacity beds. We have identified a number of new roles that will need to be develop to support fragile services e.g. Age Related Macular Degeneration (AMD), which is currently provided as a visiting service and this is not sustainable given NHSG recovery planning priorities. We have also identified resources required to support new ways of working e.g. increased capacity required to support patient triage, facilitate Near Me consultations and Patient Focussed Booking. Similarly, we need to retain some of our supplementary workforce (locum nurses, doctors and AHPs) in order that we can staff red and green pathways, with additional on call commitments. We intend to increase our junior doctor cohort by 20% (WTE 1.2) as part of our resilience planning. We also need to retain up to WTE 4 Operating Department Practitioners (ODPs) to enable us to manage the staffing requirements across RCU, Theatres and endoscopy services. We have also identified a need to increase our capacity to support people with long term conditions as the available data suggests that more patients will present with an exacerbation of a long term condition and/or have become de-conditioned during the period of time that they have been shielding. Additional Radiographers and a Radiologist have been put in place to support access to elective medical imaging requirements and work down the backlog of CT requests. Some additional costs have been identified to enable these changes to take place. **Wellbeing** **Microsoft TEAMS** have been set up to enable staff to connect into not only business meetings but also as a way to keep in touch both visibly and verbally. Each manager has set up Teams meetings with staff to ensure that no one

	is feeling isolated or in difficulty. Communication updates will continue to go out to highlight health, safety and wellbeing issues. **Telephone Support Line:** A confidential telephone line has been established to support Health and Care staff responding to the COVID-19 pandemic. Calls are handled by staff and volunteers who have been trained, and are supported, by the Samaritans. The service provides sign-posting to local and national mental health and wellbeing resources, supportive listening and, where appropriate, brief interventions by qualified therapists/coaches. So far there have been few calls to the service. National planning groups anticipate that activity will increase in the coming weeks and months. The quiet period has enabled the Wellbeing Team to test the system in preparation for future demand. The team operate on an on call basis which is currently funded through COVID-19 resources. The national line is being promoted along with Clear Your Head messages and resources. Alongside the telephone support line managers and staff and teams are doing an end of shift/day review to ensure that staff are mentally in a good place to go home. This process will continue. **Wellbeing Hub:** A "staff only" wellbeing space has been established in the Gilbert Bain Hospital. This has been equipped as a welcoming and relaxing environment where staff have access to refreshments, fresh fruit and resources to promote physical, mental, emotional and spiritual wellbeing. The space offers staff the opportunity for quiet reflection and/or supportive conversations with colleagues. Work is in progress to identify other locations across Shetland that could be adapted to give all health and care staff access to this form of support. Funding is via Endowments and the space(s) will continue into Recovery and beyond. **Trauma Risk Management:** TRiM is a trauma-focused peer support system designed to help people who have experienced traumatic, or potentially traumatic events. The use of this tool is currently being explored to support staff and is being tested on the West of Shetland at a Care Home where residents and staff have been impacted by COVID-19. A decision on further development of local TRiM resources will be made on completion of the test and will be picked up as part of operational business within our Health Safety and Wellbeing arena. A strategy group has been established that consists of Health and Social Care staff and all the emergency services; in recognition that Shetland has finite resources and would benefit from a multi-agency response to any traumatic event.

	Endowment Fund: Any staff member can make a bid for Endowment Funds to support a staff wellbeing project. The Fund has recently been supplemented by donations from Captain Tom Moore's "Just Giving" page. Ideas about how to use this additional money are being sought from staff and these will be considered by the Board's Endowment Committee on a regular basis. **Leadership** development is ongoing and the team of staff who were nominated by the Senior Team as part of the succession planning agenda have been contacted and have started their personal development. A quick guide for managers supporting their teams has been developed and managers have been contacted directly for a conversation as part of a wellbeing support plan across the organisation. Links are in place with the corporate team to support and assess wellbeing of staff who are currently working from home and how this may develop over the recovery phase. We will continue to deliver the stepped care model of staff psychological support that was developed and launched for all health and social care staff. Thank you gift bags for health and social care staff have been designed and will be delivered to all teams within by end Sept.

Human Resources	The Personnel Department remained operational throughout COVID-1919 period, providing essential recruitment services; coordinating resourcing of supplementary locum services; coordinating daily staffing availability/ attendance data associated with COVID-19; producing daily reports for EMT; on boarding arrangements and administration of new contracts and variations. More efficient ways of working will need to be maintained to manage backlog of work and anticipated increase in demand for services identified in recovery plans such as recruitment/ change management and also anticipated increase in employee relations issues and return to work support anticipated for high percentage of staff shielding. **Case Management - Employee Relations** It was necessary to delay or adjust arrangements for some necessary ER cases during COVID-19. Remaining cases that have been delayed will be reviewed on an individual basis in conjunction with the relevant service manager, HR and Employee Director to agree the most appropriate and fairest adjustments to take forward to resolve or bring to a close as required. The outcome of review will be communicated as appropriate. In recognition of the requirements of social distancing Teams / video conferencing and other technology will be used for all ER meetings. Increase in guidance / case work anticipated with % staff still to return to the workplace; increased level of anxiety evidenced in sickness absence data • Additional hours required to continue for HR Systems Specialist – Band 6 to support significant system updates planned • On call rota for day time emergency weekend shared by the team • Leave to be planned at regular intervals to maintain resilience and avoid burnout Additional resource anticipated to be required to deliver increase in support requirements indicated in recovery plans plus anticipated increase in workloads for employee relations and change management alongside personnel projects planned for the following 12 months. Review Band 3 to 4 in post Anticipate additional: • HR Advisor Band 7 increase in employee relations support • Administrator Band 4 - Support recruitment & administration • Equality and Diversity support from NHSG E&D Manager required for statutory training delivery 2020 – 21 / virtual alternative to be explored.

ICT	The priorities for ICT are: **Recovery Plans** Support for all recovery plans, most of which have digital at their core **Primary Care Digital Transformation** Standard Desktop Standardised websites Standardised procedures and protocols for use of GPIT Merging of GPIT to facilitate flexible access to primary care Online repeat prescriptions and appointment booking Near Me Appointments Remote BP Monitoring Asynchronous Online Appointments **Infrastructure** Windows Servers Backup System Windows 10 **Business Programme** Website/Intranet refresh Supporting office accommodation changes NHS Mail migration Office 365 **Capital Programme** Echocardiogram replacement Secure Doors Hospital Pager System

	Acute Digital Transformation Trakcare Clinical Notes Digital Dictation cloud migration Telemetry data into Trakcare **Health Intelligence** Modernising Reporting Waiting Times Dashboard Acute Activity Dashboard Modernising Systems Administration **Information Governance and Records Management** Electronic Records – patient and business (RMP) Data restructure and migration to o365 (RMP) Information Security Management System (ISMS) NISR security improvement programme **National Digital Programmes** CHI and Child Health modernisation GPIT replacement Remote Patient Management and Monitoring BP Monitoring Cardiovascular COVID-19 Pre-op Assessment **Regional Digital Programmes** NoS HEPMA NoS Care Portal Phase 2 (GPIT and Social Care) NoS Digital Strategy Development

New Ways of Working, Innovations and other Enablers	New ways of working and innovations we have tested include: • Rolling out Near Me across specialties (visiting and local)[2] • Practitioners working remotely (accessing key clinical systems securely) • Providing virtual multi-disciplinary patient reviews with participants from primary and secondary care (e.g. diabetes and cardiology MDTs are being tests) • Using technology to remotely report on diagnostic tests (e.g. sleep studies and Holters) • qFit testing as part of a redesign to the colonoscopy pathway Further work intend to progress during 2020-21 includes: • Capsule endoscopy • Cytosponge cell collection device as an alternative to OGD • Developing clinical pathways for ophthalmology diagnostics and follow up which are led by the Optometrists in primary care • Switching to radiofrequency ablation from injection therapy for chronic pain • Increasing our telemetry capability so patients in both red and green pathways can receive cardiac care monitoring • Reviewing cross boundary flow of patients to identify if alternatives to referral to specialist care can be identified • Identifying additional tests of change to increase opportunities for using realistic medicine principles and reduce appointments that are not adding value/part of an evidence based pathway Other enablers include investment in eHealth to support the infrastructure needed to sustain the changes we have made at pace as part of COVID-19-19 preparedness. Some of this work needs to be progressed at an intra-Board and/or a regional level and we are developing our QI/Project Management capacity in order to take this work forward.

[2] Between 25 and 50% of all referrals are being seen using Near Me across specialities

Appendices

Appendix A1 forecast of acute activity September 2020 to March 2021

	Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021
TTG Inpatient and Day Case Activity (Definitions as per waiting times data mart)	20	65	65	65
New OP Referrals Received (Definitions as per waiting times data mart)	210	590	690	690
New OP Activity - (including Virtual - telephone, NHS Near Me,...) (Definitions as per waiting times data mart)	200	650	700	700
Elective colonoscopy activity (Definitions as per Diagnostic Monthly Management Information)	40	130	130	130
Elective lower endoscopy activity (Definitions as per Diagnostic Monthly Management Information)	0	0	0	0
Elective upper endoscopy activity (Definitions as per Diagnostic Monthly Management Information)	24	80	80	80
Elective cystoscopy activity (Definitions as per Diagnostic Monthly Management Information)	16	48	48	48
A&E Attendances (Definitions as per Scottish Government Unscheduled Care Datamart)	550	580	610	640
Number of A&E 4-hour breaches (Definitions as per Scottish Government Unscheduled Care Datamart)	5	6	6	6
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	138	145	153	160
Admissions via A&E (Definitions as per Scottish Government Unscheduled Care Datamart)	138	145	153	160
Delayed Discharges (Total Delayed Discharges of Any Reason or Duration, per the Definition for Published Statistics)	3	3	3	3

Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	28	91	91	91
31 Day Cancer - First Treatment Patients Treated (Definitions as per published statistics)	1	4	4	4
CAMHS - First Treatment Patients Treated (Definitions as per published statistics)				
Psychological Therapies - First Treatment Patients Treated (Definitions as per published statistics)				

Appendix A2 forecast of diagnostics activity September 2020 to March 2021

		Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021					
Elective colonoscopy activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	12	39	39	39					
	urgent	6	20	20	20					
	routine	22	72	72	72					
Elective lower endoscopy activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	0	0	0	0					
	urgent	0	0	0	0					
	routine	0	0	0	0					
Elective upper endoscopy activity (Definitions as per Diagnostic Monthly	urgent suspected cancer	8	26	26	26					
	urgent	2	7	7	7					
	routine	14	47	47	47					

Management Information)										
Elective cystoscopy activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	4	13	13	13					
	urgent	0	0	0	0					
	routine	12	36	36	36					
Elective MRI activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	0	0	0	0					
	urgent	0	0	0	0					
	routine	0	0	0	0					
Elective CT activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	47	130	144	75	NB: The final quarter for CT is based on resuming normal staffing levels and working hours				
	urgent	113	310	343	179					
	routine	22	60	67	35					
Elective non-obstetric ultrasound activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	24	83	61	59					
	urgent	64	222	244	237					
	routine	72	250	305	270					
Elective barium studies activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	0	0	0	0					
	urgent	0	0	0	0					
	routine	0	0	0	0					

Appendix A3 forecast of activity by clinical prioritisation category September 2020 to March 2021

P1 Capacity and TTG Total Waiting List (all specialties, on-going waits)					
Clinical Priorities	As at 31/07/2020			Clinical Priorities Key	
P1 (% capacity used)	17.00%			P1a Emergency	Needs operation within 24 hours
P2 (number waiting)	1			P1b Urgent	Needs operation within 72 hours
P3 (number waiting)	4			P2 Requires Surgery	Can be undertaken within 4 weeks
P4 (number waiting)	261			P3 Requires Surgery	Can be undertaken within 3 months
				P4 Requires Surgery	Can be undertaken > 3 months

Appendix B Pre-operative Test Strategy and Clinical Placement Plan

COVID-19/suspected COVID-19: positive tests, awaiting tests, likely false negative tests, clinical likelihood, high community/hospital transmission, other risk factors	Green pathways: likely true negative tests, low clinical likelihood e.g. self isolation, low/no community/hospital transmission, no risk factors
• Level 3 patients RCU (if available) • Level 2 patients requiring NIV Cubicles 3,4,6 Ward 3 • Level 2 patients requiring advanced cardiovascular/neurological monitoring, Ward 3 • Level 2 paediatric patients: Ward 3 • Level 3 paediatric patients – RCU • Neonatal critical care red pathway theatre/maternity	• Elective level 2 surgical patients 'HDU Ward 1* • Emergency Level 2 patients 'HDU Ward 1' • Level 3 patients admitted through A and E – 'HDU Ward 1* (if HDU patient already present and no patients with COVID-19 in hospital, these patients may have to go to RCU) • Level 2 paediatric patients Ward 1or Ward 1 HDU • Neonatal critical care Green pathway theatre/ maternity

Appendix C Current Position (Operational Dashboard Denoting Visiting & Local Services Performance against Waiting Times Targets)

Gilbert Bain Hospital Waiting Times Dashboard

Out Patient Waiting List

Date: 27/07/2020

Specialty	Appt. Within 12 Week Guarantee	Awaiting Appt (Less than 9 weeks)		Awaiting Appt (Between 9 & 12 weeks)		Appt. Greater than 12 Week Guarantee	Total Number Over 16 Weeks	Awaiting Appt (Over 12 weeks)		Total Booked	Total without appt.	% of Patients Without an Appt.	Overall Status of Specialty	Comments
		Available	Unavailable	Available	Unavailable			Available	Unavailable					
Chronic Pain (C31)	3	7				3	7	2	3	6	12	67%		
Clinical Genetics (A3)										0	0			Clinicians using NearMe / Tel where feasable. NHSG visits restarting Oct 2020
Dermatology (A7)		8	2		1		1	1	2	0	14	100%		
Ear, Nose & Throat (C5)		43		7			150	152		0	202	100%		Currently no date for restarting visiting service from NHSG, however consultants using NearMe / Tel where feasable for weekly review clinics - some urgent patients seen in ARI
Fertility								1		0	1	100%		
Gynaecology (F2)	23	14	1		1	3	2	1	1	26	18	41%		
General Medicine (A1):														
Dr Fryer		4						1		0	5	100%		
Dr Armorgianos		8					3	3		0	11	100%		
Dr Wilson		1					1	2		0	3	100%		
Locums	1	4		1				1		1	6	86%		
Nephrology (AG)									1	0	1	100%		Currently no date for restating visiting service from NHSG, however consultants using NearMe / Tel for clinics where appropriate and local medical locum if required for face to face
Ophthalmology (C7)		19		1			76	79		0	99	100%		NHSG visits restarting Sept 2020. 'Virtual' review of glaucoma patients with NHSG implemented & some use of NearMe / Tel where feasable - urgent patients seen in ARI or by local optoms if appropriate
Oral & Maxillofacial (C13)		6		1			40	43		0	50	100%		Currently no date for restarting visiting service from NHSG and local service suspended
Orthodontics (D5)		1					37	38		0	39	100%		Currently no date for restarting visiting service
Orthopaedics (C8) Lower Limb		45		3			67	75		0	123	100%		Currently no date for restating video clinics with GJNH
Paediatrics (AF)	11	17				9	17	12		20	29	59%		Local GPwSI has been using NearMe / tel, however NHSG visiting clinicians are now restarting visits from Aug 2020
Respiratory (AQ)		2								0	2	100%		All currently seen via NearMe / Tel as required
Rheumatology (AR)	2	15		5			14	18		2	38	95%		Potential restating visiting service from NHSG in Oct 2020, however consultant using monthly NearMe / Tel for clinics where appropriate
Rheumatology (GP)							4	4		0	4	100%		Service currently suspended
General Surgery (C1):														
Mr McFarlane	35	3		3		1	2	1		36	7	16%		
Mr Mikolajczak	16	2		1		1	1			17	3	15%		
Ms Weber	13	2		1		10	11	2		23	5	18%		
Dr Lalla (Minor Ops)	7	30		1		24	15			31	31	50%		

Inpatient / Day Case Waiting List

Specialty	Appt. within 9 weeks	Awaiting Appt. (Less than 9 weeks)		Appt. Within 12 Week Guarantee	Awaiting Appt. (Between 9 & 12 weeks)		Appt. Greater than 12 Week Guarantee	Awaiting Appt. (Over 12 weeks)		Total Booked	Total without appt.	% of Patients without an Appt.	Overall Status of Specialty	Comments
		Available	Unavailable		Available	Unavailable		Available	Unavailable					
Chronic Pain (C31)		25			6	1	6	3	9	6	44	88%		
Ear, Nose & Throat (C5)		1			1			11		0	13	100%		Currently no date for restarting visiting service from NHSG
Gynaecology (F2)	6	2	1	1			3	6	3	10	12	55%		
General Medicine (A1):														
Dr Fryer										0	0			
Dr Armorgianos		1								0	1	100%		
Dr Wilson										0	0			
Locums										0	0			
Ophthalmology (C7)		5	1					81		0	87	100%		Possibly restart to service from NHSG / Agency Sept 2020 - still to be confirmed
Oral & Maxillofacial (C13)			1					20		0	21	100%		Also 49 LA procedures all over 12/52 for both local and visiting - Service currently suspended
Oral Surgery (D3)								5		0	5	100%		Service currently suspended
Orthopaedic (C8) - Paediatric										0	0			Mr Barker visit organised for Sept 2020
Paediatric Surgery (CA)		2	1					1		0	4	100%		Mr Driver visit organised for Aug 2020
General Surgery (C1) Not including Endoscopy														
Mr McFarlane	9	7	12	1			3		3	13	22	63%		
Mr Mikolajzcak		13	2		3		4	33	2	4	53	93%		
Ms Weber	1	1	4				3		2	4	7	64%		

Endoscopy	TCI within 4 wks	Waiting under 1 wk	Waiting 1 to 2 wks	Waiting 2 to 3 wks	Waiting 3 to 4 wks	Waiting 4 to 5 wks	Waiting 5 to 6 wks	TCI within 6 wks	Waiting over 6 wks	TCI over 6 wks	Total Booked	Total without TCI	% of pts without TCI	Comments
Mr McFarlane	4	3						2	0 (1)		6	4	40%	
Mr Mikolajzcak	4	4	4	0 (2)					0 (7)	4	8	17	68%	
Ms Weber	7	4 (3)		0 (2)	1		0 (2)		2 (4)	2	9	18	67%	

Appendix D

Mental Health Services

Service	**Detailed Requirement**	NHS Shetland
CAMHS	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity? Prepopulate with latest MMI - patients referred and seen; comparison with same month last year	This information will be available from ISD, however a local tally suggests that we have seen fewer patients compared to the same period last year, and this is not entirely due to COVID-19. We had long term sickness earlier in the year and our Clinical Associate in Applied Psychology has left (a replacement will take up post later this month) and the additional staff member we were able to employ with taskforce money has also left, we are waiting to hear if we will have taskforce money this year. Our referral rate is approximately the same for the month of May - 8 referrals in May 2019 and 9 referrals in May 2020. **NHS Shetland CAMHS establishment is: 2 wte RMN; 1 wte CAAP; 1 PMHW and 1 wte Admin. We also have a visiting psychiatrist, 0.25 wte and a visiting psychologist, 0.25 wte. We have a current open caseload of 9 with 21 on the waiting list of whom 5 have waited longer than 18 weeks. Our longest waits have been waiting for either visiting services or for face to face to carry out assessments such as WISC's. Last year in July we had 10 referrals, this year in July we have had 16 referrals already (at 27 July). Further data will be available from ISD**

	· Have you prioritised access to services that have continued and how? - **Referrals** - how received; assessed; prioritised; seen/ not seen; method of contact? , (for existing caseload, waiting list; cancelling routine work. - **Caseload** - how prioritised; how is risk rating done; who seen/ not seen; contact and method; method and frequency of review. - **waiting list** - current size of list [prepopulate from most recent MMI]; how being managed; if/ how this is different due to COVID-19.	Referrals have been triaged in the usual way i.e. multi-disciplinary screening and then either seen soon, or put onto the waiting list or redirected if not appropriate for CAMHS. For two weeks in March we cancelled routine face to face appointments whilst we familiarised ourselves with Near Me technology and ensured we had up to date and accurate contact information for everyone on the waiting list and the case load, including email addresses. The existing caseload is being seen using Near Me video conferencing and in a small minority of cases using telephone contact. We have continued with routine reviews at the usual rate (including our visiting consultants using Near Me video appointments), and there has been no reduction in frequency of review; in the case or more remote patients there has been an increase in frequency of contact. The waiting list size will be available from ISD, we continue to have long waits due to historical staff shortage, but not due to COVID-19 per se. Patients on the waiting list have been contacted throughout the pandemic period. **Referrals continue to be triaged in the usual way i.e. multi-disciplinary screening and then either seen soon, or put onto the waiting list or redirected if not appropriate for CAMHS. The existing caseload continues to be seen using Near Me video conferencing and in a small minority of cases using telephone contact. We continue with routine reviews at the usual rate (including our visiting consultants using Near Me video appointments), and there has been no reduction in frequency of review; in the case or more remote patients there has been an increase in frequency of contact. Waiting list numbers are currently 21, with 5 waiting longer than 18 weeks. We continue to have long waits due to historical staff shortage, and because of the complex nature of some of the patients referred to us, e.g. neurodevelopmental diversity, mental health problems in patients with a learning disability; we do not have an on isle resource for this level of complexity.**

	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services **completely stopped**? - any **consolidated**, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services - e.g. well being hub? purpose and future impact, for e.g. on Strategic plan?	As above, the service continues to operate in the usual way and no services have been stopped. We have been unable though to carry out some of our assessments e.g. WISCs, that require direct face to face interaction and we have been unable to carry out school observations. Paediatric nursing colleagues have been able to carry out physical observations for eating disordered patients. We are the busiest users of Near Me in our health board and our patients and staff have adapted well to using this technology, however there are some patients for whom the medium is a struggle and they look forward to the return of face to face appointments. We have not developed any new services, but have been proactive in updating our social media (facebook page) with up to date information and self-directed self-help resources for CAMHS. Looking to consolidate team by asking for additional funding for 1 wte development post Band 5 RMN, increasing CAAP hours from 0.7 wte to whole time and for 1 wte CAMHS/LD nurse. **The service continues to operate in the usual way although we have been unable to carry out some of our assessments e.g. WISCs, that require direct face to face interaction and we have been unable so far to carry out school observations. Paediatric nursing colleagues have been able to carry out physical observations for eating disordered patients and for those undergoing treatment trials or initiation of stimulant medicine. Patients and staff have adapted well to using remote technology and for some patients their preference will be to continue to have appointments virtually rather than face to face. We have not developed any new services and we continue to update our social media (facebook page) with up to date information and self-directed self-help resources for CAMHS. We have asked for recovery money to employ a further CAMHS nurse, some visiting consultant LD psychology time and a CAMHS/LD nurse in order to meet the service demands not currently catered for. We have used this year's Programme Board/Taskforce funding to increase our CAAP hours to whole time from 0.7 wte. We are waiting on**

		remedial work in our clinical areas before we can start seeing patients face to face again; this will include uplift of carpeting and replacement with lino, screens, PPE station and ensuring adequate ventilation.
PT	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity? Prepopulate with latest MMI - patients referred and seen; comparison with same month last year	The PT service currently has 1 WTE Consultant Psychologist who is due to retire in Sept 2020 and 2 WTE Talking Therapists. The demand pre COVID-19 for both Psychology and Talking Therapies is greater than the capacity to deliver. There are a number of plans in place to offset the capacity; Survive and Thrive groups have been established; 2 x CPNs will undertake CBT training (they will be trained by Sept 2022. ISD will provide the MMI data, local indications show a reduction in the number of referrals for May 2020 compared to May 2019. This is due to less people attended their local health centres with anything other than COVID-19 related. June**/July** data is showing an upsurge in referrals as an early indicator. There are currently 10 patients being seen by the Consultant Psychologist and 36 by the Talking Therapists.
	· Have you prioritised access to services that have continued and how? - Referrals - how received; assessed; prioritised; seen/ not seen; method of contact? , existing caseload, waiting list; cancelling routine work. - Caseload - how prioritised; how is risk rating done; who seen/ not seen; contact and method; method and frequency of review. - waiting list - current size of list [prepopulate from most recent MMI]; how being managed; if/ how this is different due to COVID-19.	Referrals have been triaged in the usual way; urgent referrals are discussed at the morning risk and safety meeting that is attended by Consultants, nurses (from all the different teams), recovery workers and admin. Routine referrals are discussed at the weekly multi-disciplinary meeting where they are allocated to the different teams and given priority depending on the need. None of the routine work has been cancelled during the pandemic. All patients, both new referrals and existing were prioritised using the RAG system. Those who flagged red have been seen face to face throughout (following the guidelines on PPE etc.), those that were amber and green were reviewed remotely, either via Near Me or telephone. The RAG system has been updated on a weekly basis at the team meetings to ensure any new reds are being seen face to face.

	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services completely stopped? - any consolidated, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services - e.g. well being hub? purpose and future impact, for e.g. on Strategic plan?	No services within PT have stopped, all patients were offered the option of Near Me or telephone therapy. 10% declined due to either issues with poor broadband/telephone signal; no private space in the house; the issues they wanted to discuss were linked to home. These individuals have been contacted every 2 weeks to check if they still wish to wait for face to face, 3 % have agreed to virtual therapy. There is a large historical waiting list for Clinical Psychology due to a gap in service for those with moderate to severe conditions. The longest wait is currently at 130 weeks. The PT service currently has 1 WTE Consultant Psychologist who is due to retire in Sept 2020 and 2 WTE Talking Therapists. The demand pre COVID-19 for both Psychology and Talking Therapies is greater than the capacity to deliver. There are a number of plans in place to offset the capacity; Survive and Thrive groups have been established; 2 x CPNs will undertake CBT training (they will be trained by Sept 2022. We are also planning to roll out Stress Control once facilitators have been trained - this was put on hold due to COVID-19. Shetland receives the highest number of referrals of all the island Boards by a significant increase. From Jan19 - March 20 Shetland received 393 referrals, Orkney 248 and Western Isles 219. In order to continue to meet the demand additional resources have been requested via the remobilisation plans, **via Scottish Government**; 1 x Therapist and 1 x Clinical Psychologist. A staff well-being group has been established as part of the Caring for People Plan. This group has developed a well-being space in the local hospital for Health and Social Care staff to meet up and is looking at other spaces to provide the same. A phone line has been developed although this will step back once the national line is operational. Daily briefings are sent out for staff on self-care and points of contact for additional support within and outwith Shetland.

CMHTs	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	The number of routine referrals has stayed the same for CMHT; 19 in May 2019 and 20 in May 2020. **Routine referrals for June/July have seen an increase of 4%.**Urgent referrals have also stayed at 21 for both May 2019 and May 2020 (although many of the 2020 presentations have been repeat attenders and/or new to CMHT) **June/July urgent referrals and OOHs response has seen an increase of 15%.** 2 x WTE Consultant Psychiatrists and 5.2 FTE CPNs. As part of COVID-19 we have employed 2 x FTE Locum CPNs to support the 24/7 nursing response. These will be in post till end Sept/**Nov**. 2 x FTE have been requested as part of the mobilisation plan **via Scottish Government** to be able to permanently embed the 24/7 model. Additionally 2 x FTE Occupational Therapists were seconded into the CMHT during the pandemic. They proved invaluable delivering care to a caseload each of 10. A request for a FTE has been submitted with the remobilisation plan **via Scottish Government** who will be able to carry a case load of 15 - 20.
	· Have you prioritised access to services that have continued and how? - Referrals - how received; assessed; prioritised; seen/ not seen; method of contact? , existing caseload, waiting list; cancelling routine work. - Caseload - how prioritised; how is risk rating done; who seen/ not seen; contact and method; method and frequency of review. - waiting list - current size of list [prepopulate from most recent MMI]; how being managed; if/ how this is different due to COVID-19.	Individuals have been continually risk assessed; red patients have been seen face to face; the next phase will be amber patients offered face to face appointments; risk assessments will continue as patients' needs can change rapidly. Non urgent CMHT appointments have continued via Near me/phone. Referrals have been triaged in the usual way; urgent referrals are discussed at the morning risk and safety meeting that is attended by Consultants, nurses (from all the different teams), recovery workers and admin. Routine referrals are discussed at the weekly multi-disciplinary meeting where they are allocated to the different teams and given priority depending on the need. None of the routine work has been cancelled during the pandemic. All patients, both new referrals and existing were prioritised using the RAG system. Those who flagged red have been seen face to face throughout (following the guidelines on PPE etc), those that were amber and green were reviewed remotely, either via Near Me or telephone. The RAG system has been updated on a weekly basis at the

		team meetings to ensure any new reds are being seen face to face. There are currently 378/ **405** patients in service **for the CPNs and 496 for the Consultant Psychiatrists - some of these will be seeing both.**
	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services completely stopped? - any consolidated, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services - e.g. well being hub? purpose and future impact, for e.g. on Strategic plan?	No services with CMHT have stopped. As previously mentioned a RAG system was introduced and all referrals have continued to be accepted and assessed appropriately. In order to prevent unnecessary admissions to the local General Hospital a 24/7 nursing service has been established to support the Consultant Psychiatrists who cover the out of hours periods. Mini home treatment packages have been provided for patients who have presented OOHs in order to prevent an admission if not medically needed. 2 x additional FTE CPNs have been requested via the remobilisation plan **Scottish Government** in order for this to continue on a permanent basis
Community LD and ASD	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	MH with LD and ASD are delivered differently in Shetland due to not having specialists on island. MH and LD is delivered virtually with MDTs in Shetland and NHS Grampian through a Service Level Agreement. There is a vacancy for a Specialist Nurse for LD and ASD in Shetland and the recruitment for this was temporarily put on hold due to COVID-19.

	· Have you prioritised access to services that have continued and how? - Referrals - how received; assessed; prioritised; seen/ not seen; method of contact? , existing caseload, waiting list; cancelling routine work. - Caseload - how prioritised; how is risk rating done; who seen/ not seen; contact and method; method and frequency of review. - waiting list - current size of list [prepopulate from most recent MMI]; how being managed; if/ how this is different due to COVID-19.	All referrals are processed via Social Work using the single shared assessment framework With You For You focussing on outcomes and prioritising risk. ASPs have continued if necessary via video link with Sheriff Courts in Grampian as opposed to Courts in Shetland. MDTs have continued throughout the pandemic, albeit with a slightly longer gap in between. ISD will provide MMI. **A Band 7 NHS Shetland SLT is undertaking gap analysis project work in relation to Integrated Adult LD & ASD services, diagnostic pathways and post diagnostic support. Outcomes from this will inform the recovery and renewal plan.**
	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services completely stopped? - any consolidated, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services - e.g. well being hub? purpose and future impact, for e.g. on Strategic plan?	Work has been ongoing for a number of months to establish a new ASD diagnosis pathway for Shetland as we no longer have this speciality on island for adults. This work has temporarily been put on hold. There are currently 13 people waiting for assessment. These have been prioritised and will be seen as soon as a new pathway has been developed. **Currently 13 people waiting for assessment. These have been prioritised and will be seen as soon as a new pathway has been developed. Following Scottish Government Guidance issued on 26th March 2020 instructing closure of day support and short break services for adults with learning disability /ASD, a referral panel has been established where issues of safety in relation to COVID-19 infection are considered with other potential harms for vulnerable people such as the breakdown of living arrangements due to intolerable carer stress. In situations where it is judged essential to provide critical respite and day care to prevent harm, allocation is made supported by risk assessment and action plan, e.g. enhanced hygiene, physical distancing, and exclusion of individuals who are unwell or otherwise displaying symptoms, and through discussion with local Health Protection colleagues. Due to lockdown and C-19 restrictions, there are a number of LD/ASD clients experiencing increased anxiety, including self-injurious**

		behaviour and escalated behaviours that challenge. Integrated Shetland CH&SC are pooling available skills, knowledge and resources to support clients, however management absence is now further impacting on our local response and Adult Services (LD & ASD) are seeking locum cover for essential posts, this will have an associated cost that will require to be met from the C-19 budget
Community Drug and Alcohol Services	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	The Substance Misuse Recovery Service (SMRS) consists of specialist nurses, recovery workers and medical input from a Consultant Psychiatrist and GP with Special Interest in Dual Diagnosis. The level of referrals has remained the same for May 2019 (7) to May 2020 (6), **and has remained the same for June 2019 (6), June 2020 (7) and July 2019 (6), July 202 (3).** However the demand on the team has increased due to an increase in both alcohol and drug use amongst existing patients. There are currently 117 Drugs & 162 Alcohol in service/**284 in service** **156 patients due to alcohol issues** **128 patients due to drug misuse**
	· Have you prioritised access to services that have continued and how? - Referrals - how received; assessed; prioritised; seen/ not seen; method of contact? , existing caseload, waiting list; cancelling routine work. - Caseload - how prioritised; how is risk rating done; who seen/ not seen; contact and method; method and frequency of review. - waiting list - current size of list [prepopulate	Referrals have been triaged in the usual way; urgent referrals are discussed at the morning risk and safety meeting that is attended by Consultants, nurses (from all the different teams), recovery workers and admin. Routine referrals are discussed at the weekly multi-disciplinary meeting where they are allocated to the different teams and given priority depending on the need. None of the routine work has been cancelled during the pandemic. All patients, both new referrals and existing were prioritised using the RAG system. Those who flagged red have been seen face to face throughout (following the guidelines on PPE etc.), those that were amber and green were reviewed remotely, either via Near Me or telephone. The RAG

	from most recent MMI]; how being managed; if/ how this is different due to COVID-19.	system has been updated on a weekly basis at the team meetings to ensure any new reds are being seen face to face.
	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services completely stopped? - any consolidated, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services - e.g. well being hub? purpose and future impact, for e.g. on Strategic plan?	Stopped all face to face contact with patients unless needing depo/blood/urine screen for opioid replacement or are admitted to hospital. Opiate replacement medication is being home delivered to those on the shielding lists or who are deemed locally to be vulnerable. Both nurses and recovery workers have been involved in the deliveries. Group recovery meetings have stopped - a virtual equivalent is being planned to begin mid-July. All other patients are being contacted via Near Me and/or telephone
Community services for Older Adults	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	Older adult services are delivered as part of the CMHT and have continued throughout the pandemic. A separate Dementia Assessment Service is provided by 1.5 WTE Specialist Nurses with Consultant input provided weekly by NHS Grampian under a Service Level Agreement. They have suspended all routine assessments, in line with NHS Grampian, all urgent assessments have been undertaken and any behavioural reviews have taken place using Near Me and/or telephone. The data for functional older adults is incorporated into the CMHT data above. Dementia data can be provided by ISD. There are currently 258/**212** patients on the Dementia register
	· Have you prioritised access to services that have continued and how? - Referrals - how received; assessed; prioritised; seen/ not seen; method of contact? , existing caseload, waiting list; cancelling routine work. - Caseload - how prioritised; how is risk rating done; who seen/ not seen; contact and method;	Referrals have been triaged in the usual way; urgent referrals are discussed at the morning risk and safety meeting that is attended by Consultants, nurses (from all the different teams), recovery workers and admin. Routine referrals are discussed at the weekly multi-disciplinary meeting where they are allocated to the different teams and given priority depending on the need. None of the routine work has been cancelled during the pandemic. All patients, both new referrals and existing were prioritised using the RAG

	method and frequency of review. - waiting list - current size of list [prepopulate from most recent MMI]; how being managed; if/ how this is different due to COVID-19.	system. Those who flagged red have been seen face to face throughout (following the guidelines on PPE etc.), those that were amber and green were reviewed remotely, either via Near Me or telephone. The RAG system has been updated on a weekly basis at the team meetings to ensure any new reds are being seen face to face.
	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services completely stopped? - any consolidated, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services - e.g. well being hub? purpose and future impact, for e.g. on Strategic plan?	Routine dementia assessments have been suspended. Patients deemed to be high risk for assessment and/or behavioural reviews have been seen face to face. Routine assessments will begin face to face over the next 2 months alongside NHS Grampian. All ongoing patients and new referrals will be offered the option to engage with all elements of the service remotely.
Community Specialist & Forensic services	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	Forensic services are delivered via NHS Grampian under Service Level Agreement
OOH/ Crisis	· Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	Crisis work has traditionally been delivered by the CMHT as we do not have specialist crisis teams. The data is captured above in the CMHT data

	· Have you prioritised access to services that have continued and how? - Referrals - how received; assessed; prioritised; seen/ not seen; method of contact? , existing caseload, waiting list; cancelling routine work. - Caseload - how prioritised; how is risk rating done; who seen/ not seen; contact and method; method and frequency of review. - waiting list - current size of list [prepopulate from most recent MMI]; how being managed; if/ how this is different due to COVID-19.	Referrals have been triaged in the usual way; urgent referrals are discussed at the morning risk and safety meeting that is attended by Consultants, nurses (from all the different teams), recovery workers and admin. Routine referrals are discussed at the weekly multi disciplinary meeting where they are allocated to the different teams and given priority depending on the need. None of the routine work has been cancelled during the pandemic. All patients, both new referrals and existing were prioritised using the RAG system. Those who flagged red have been seen face to face throughout (following the guidelines on PPE etc.), those that were amber and green were reviewed remotely, either via Near Me or telephone. The RAG system has been updated on a weekly basis at the team meetings to ensure any new reds are being seen face to face.
	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services completely stopped? - any consolidated, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services - e.g. well being hub? purpose and future impact, for e.g. on Strategic plan?	Crisis work has traditionally been delivered by the CMHT as we do not have specialist crisis teams. A Psychiatric Liaison post is in the process of being recruited to using the Action 15 funding. No services with CMHT have stopped, including crisis work. As previously mentioned a RAG system was introduced and all referrals have continued to be accepted and assessed appropriately. In order to prevent unnecessary admissions to the local General Hospital a 24/7 nursing service has been established to support the Consultant Psychiatrists who cover the out of hours periods. Mini home treatment packages have been provided for patients who have presented OOHs in order to prevent an admission if not medically needed. 2 x additional FTE CPNs have been requested via the remobilisation plan in order for this to continue on a permanent basis

IPUs	· Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way? - have any services completely stopped? - any consolidated, and reason for this? - delivered in a different way? E.g. by Near Me, telephone. - any new services	• No inpatient bed on Island • Service level agreement with Cornhill. Patient detained or needing inpatient service fly 200 miles to Aberdeen. • Low stimulus room in hospital, but staffing it is an issue. Only staff for 24 hrs. Challenging if fog bound. Specialisms come from Grampian or other islands. Medical interventions MH or physical carried out by generalists.