Shetland NHS Board	Shetland Islands Council

Agenda Item
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Meeting(s):	Shetland NHS Board	25th June 2021
Report Title:	Covid-19 Remobilisation Plan #3	
Reference Number:	Board Paper 2021/22/22	
Author / Job Title:	Elizabeth Robinson Public Health & Planning Principal, NHS Shetland	

1.0 Decisions / Action required:

That the Board:

1.1 APPROVES the third Remobilisation Plan for April 2021 – March 2022.

2.0 High Level Summary:

2.1 The COVID-19: Re-mobilisation: Next phase of Health and Social Care Response to March 2021 was submitted to Scottish Government in May 2020, followed by a second iteration in August 2020. These plans outlined the recovery and remobilisation of services across health and care through winter until the end of the current financial year. The plans were underpinned by the individual operational service recovery planning that had been undertaken by services.

2.2 A subsequent request was received by Scottish Government for an updated Remobilisation Plan to cover the period April 2021 to March 2022. The initial deadline was 5th February 2021, but this was extended to end of February for an initial submission which was then subject to ongoing discussion and development between the partners. Notification of this planning request was to NHS Chief Executives, but there was an expectation that the plan was developed in partnership with other agencies, including IJBs.

2.3 An outline of the plan was presented to the IJB on 18th February 2021. Based on feedback received, the plan was then submitted to Scottish Government at the end of February 2021.

2.4 A letter approving the plan was received on 2nd April 2021 from John Connaghan, NHSScotland Chief Operating Officer. (Appendix 2)

3.0 Corporate Priorities and Joint Working:

3.1 The ability to remobilise the health and care system in Shetland will require joint working across the Health and Social Care Partnership 'HSCP' and working in partnership with other agencies, as well as with our community.

3.2 The remobilisation and recovery process will need to ensure that recovery service planning and delivery are in alignment with the Strategic Plan.

3.3 The Remobilisation Plan update framework has focused on areas like Public Health, inequalities, care in the community and unscheduled care which will draw on partnership working.

4.0 Key Issues:

4.1 The previous two Remobilisation Plans were written in line with the 'Re-mobilise, recover, re-design Framework for NHS Scotland'. The plans set out how the following would be managed:

- The backlog of planned care (to minimise harm).
- The unmet demand (to ensure safety).
- COVID-19 and non COVID-19 unscheduled care demand.
- The increase of whole system working, accelerating transformation and re-design of the system.

4.2 The wider Public Health agenda underpinning the plans was:

- Work to improve population health.
- Increased prevention activity.
- The tackling of inequalities.
- Development of services which promote equality for all.

Remobilisation Plan

4.3 The third Remobilisation Plan is based on the following principles:

We will build and retain resilience
We will minimise excess mortality and morbidity from non-COVID-19 disease
We will re-establish services, prioritised to clinical need and reflecting population demand.
We will focus on approached 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

4.4 The attached plan (Appendix 1) lays out the key elements of work under the following headings:

Living with COVID
Primary and community based care
Whole system approach to mental health and wellbeing
Planned care and clinical prioritisation
Urgent care priorities
Rural general hospital remobilisation requirements
Patient experience
Addressing inequalities and embedding innovation
A sustainable workforce
Staff wellbeing and resilience

4.5 Members are asked to approve the third Remobilisation Plan.	
5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The Remobilisation Plan outlines the operational recovery of services during the pandemic and is designed to ensure that services moving forward meet the needs of service users, patients and the Shetland community, while maintaining safety and financial stability.
6.2 Human Resources and Organisational Development:	The report highlights changes in working patterns as well as redeployment of staff to enable renewal of service delivery during the pandemic. Staff working across the HSCP have been managed in accordance with their own corporate HR policies. Regular consultation and communication with Trade Union colleagues has taken place throughout the pandemic to discuss workforce issues arising as a result of the pandemic.
6.3 Equality, Diversity and Human Rights:	Equality, diversity and human rights are critical issues to be considered as we re-mobilise. There is increasing evidence of an increasing inequality gap as the timeframe to progress through the pandemic lengthens. This has been acknowledged in the framework for the update of the remobilisation plan which prioritises public health and partnership working to address social inequality and the social determinants of health.
6.4 Legal:	The Remobilisation Plan 2021-22 is a requirement of the Scottish Government. Updates to the Plan should be developed and submitted in partnership with the IJB and should reflect national guidance and policy frameworks. There are no direct legal implications related to this. However, consideration of legal implications and compliance with legal requirements may be relevant in relation to taking forward certain aspects of the 2021-22 Remobilisation Plan.
6.5 Finance: 1. Impact against in year budget: 2. Impact against IJB MTFP: 3. Other	The Remobilisation Plan is in the process of being developed in consultation with finance staff from NHS Shetland and Shetland Islands Council. The costs will be submitted to the Scottish Government along with the remobilisation plan.
6.6 Assets and Property:	There are no specific issues in this paper to address with regard to assets and property.
6.7 ICT and new technologies:	Digitisation and telemedicine have been a key enabler for service delivery during the pandemic. In particular, the use of Near Me has been integrated into service delivery and is becoming the new norm for a significant number of face to face consultations. The use of Microsoft Teams has also been a key enabler for HSCP staff to undertake their day to day business and to enable remote working.

6.8 Environmental:	There are no specific environmental implications to highlight.	
6.9 Risk Management:	There have been Corporate and Directorate Risks raised regarding the recovery and remobilisation process. The risk profile has also been considered regarding the potential to manage concurrent risks (e.g. EU Exit/winter planning)	
6.10 Policy and Delegated Authority:	The Chief Officer is responsible for the operational management of Integrated Services which includes operational planning and the delivery of such plans.	
6.11 Previously considered by:	None	

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Appendices:

1) NHS Shetland Remobilisation Plan #3
2) NHS Board Remobilisation Plans – 2021/22 Letter from John Connaghan 2nd Aprill 2021

Background Documents:

Remobilise, Recover, Redesign: the framework for NHS Scotland;
https://www.gov.scot/publications/re-mobilise-recover-re-design-framework-nhs-scotland/pages/1/

NHS Shetland Re-Mobilisation Plan for 2021/22

Developed in partnership with the

- IJB
- Regional partners
- National partners
- ACF/APF

Remobilise, Recover, Redesign

- Reflects aims and principles of Re-mobilise, Recover, Redesign
- Reflects balance between 3 core pillars of safety, delivery & financial sustainability
- Health Inequalities – we recognise the need to address issues of equality of access and outcomes
- Governance via Executive Management Team and relevant Board Committees

The Plan is based on the following objectives:

We will build and retain resilience

We will minimise excess mortality and morbidity from non-COVID-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 (short & medium term priorities)

KEY PRIORITIES

Delivering Essential Services

- Redesign of urgent care
- Key role of primary and community-based care
- A whole system approach to mental health & wellbeing
- Planned care and Clinical Prioritisation
- Patient experience
- Addressing inequalities and embedding innovation
- A sustainable workforce
- Finance and capital

Living with COVID

- Sustainable Longer term vaccination Programme
- Maintaining and extending the testing programme
- Supporting the safe provision of adult social care

Supporting staff wellbeing

We will engage with the people of Shetland to agree the basis of our future Health and Social Care system.

Primary and Community Based Care

General Practices and Community Pharmacies remain open as they have done throughout the pandemic; however, we continue to expand the role of primary care/community-based services as part of our remobilisation. In Shetland, we maintain robust collaboration and joint working across the interface of primary and secondary care. With this is mind, a Clinical Pathways Group was established in March 2020 in order to consider redesigns or new ways of working across the system; for example, to develop a model for Same Day Emergency Care, agree how we will support patients who are shielding, how will we identify patients with long COVID, or agree how we will support a frailty model.

All Care Home residents in Shetland have received their first COVID vaccination and the second round has now started. Nearly 40% of our adult population have received their first vaccination.

The five adult screening programmes all re-started in autumn 2020.

Risks, opportunities and assumptions

Our plan is based on risks from COVID reducing as we move through the phases of vaccination. After a large outbreak during Christmas and New Year, we have experienced a period of stability with very few news cases. We will continue to take advantage of such situations.

We will deliver flexible and responsive Primary & Community Based Care, focused on improving health and reducing inequalities	
Primary Care	
	We will maintain a Community Assessment Centre (CAC) until all adults have been vaccinated
	National screening programmes are fully recommenced and embedded.
	Routine long term condition checks are fully recommenced and embedded.
	Near Me and Ask My GP will be embedded as part of normal daily use within general practice
Community Based Care	
	Continue to support care homes with COVID-19 testing and the management of any resident displaying COVID-19 symptoms;
	Development of a Social Care Support Team, including Training & testing coordinators, to provide support for & assist development of Care Home, Care@Home and Third sector in maintaining and supporting people to remain at home.
	Early identification & mitigation of resilience issues
	Build on strong relationships with Infection Control & Prevention Team to ensure we are proactivity managing and reducing any infection risks
Community Nursing	
	Continue to deliver a full Intermediate Care Team service and General Practice Nurse / Treatment Room service at all Health Centres;
	Continue to provide a shift based 24/7 District Nursing service; 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.
	Development of overnight awake service to decrease GPs on call and maintain patients in the community.

Mental Health and Wellbeing

We recognise the impact that the COVID-19 pandemic has had and will continue to have on population level mental health. At present patients using our mental health service have a choice of Attend Anywhere, telephone or face to face for all therapy appointments. We currently have the shortest wait for a routine assessment by a CPN in Scotland, with people being seen routinely within 3 weeks. Emergencies are seen within 24 hours, 7 days a week.

Risks, opportunities and assumptions

The CMHT is able to operate daily within-hours providing clinical/therapeutic/support services to address routine/urgent/unplanned situations. The Psychiatric Service is currently providing an out of hours service for emergency presentations, but it is fragile as currently reliant on locums who are contracted until end of March 21. The Dementia Assessment Service is delivering a mixture of remote and face to face assessments, depending on level of cognitive function. An appropriate cognitively functioning family member will be included in any remote assessments. Medication reviews/blood tests/urine screening and planned depots are ongoing. Staff attend homes/care homes to see patients if all other options of addressing the issue have been explored. The Substance Misuse Recovery Service continues to facilitate group work i.e Mutual Aid Partnership (MAP), but the CMHT is not yet 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. EMDR is not delivered at present as it is a therapeutic intervention that can trigger historical trauma memories, so it is not appropriate to do it remotely.

Our newly appointed Consultant Psychologist is aiming to have reviewed the clinical psychology waiting list by end of March 21.

The success of this programme is based on our ability to recruit to new posts.

Continue to develop a whole system approach to mental health and wellbeing that recognises the importance of community empowerment and resilience, provides timely and appropriate treatment and supports recovery	
Prevention and community capacity building	
	Roll out of Stress Control programme once training is available
	Review Suicide Prevention strategy and build capacity in training delivery
	Link with NHS Highland Flow Navigation Hub to allow appropriate triage of Mental Health requests
Treatment & support	
	Continue to manage Psychological Therapies waiting list, through merging of primary and secondary care psychological therapies services, provision of teaching, training and consultancy for the wider mental health team with the view to upskilling staff, and potential placements for trainees.
	Recruit Mental Health Officer and Mental Health OT to respond to increased crisis work & help to support the rights of individuals with mental health issues.
	Supplementary staffing to support access to CAMHS and the team bed in, with new clinical staff having been appointed in Jan 2021
	Developing a MDT approach to peri-natal mental health
	Implement same-day prescribing as part of Medically Assisted Treatment Standards
Recovery	
	Continue to develop Substance Use Recovery Hub and Mutual Aid partnerships
	Identify employment opportunities for people on stable methadone programmes

Planned Care and Clinical Prioritisation

This section is based on the Framework for Clinical Prioritisation, and an expectation that by the start of Quarter 2 in 2021 we will be delivering pre COVID levels of activity for local elective and diagnostic routine activity. This is a planning assumption and may flex depending on the position with COVID and availability of visiting specialists.

Planned care and clinical prioritisation	
	Capital projects to support increased diagnostics, ambulatory care and 23 hour elective pathways
	CT scanner replacement in May 2021 and planning for implementation of MRI in 2021-22, increasing local diagnostics capability
	Ambulatory care capital project to increase DSU capacity
	Intention to keep surge capacity ward in situ, to enable increased elective activity in 2021-22 – aiming for near post COVID levels of activity by September 2021 for local services
Using technology to support redesign of planned care	
	Continuing to work with NHS Grampian to deliver tele-health solutions to support children and adults OPD.
	Exploring options for asynchronous appointments for elective care (similar to Ask My GP).
	Developing remote MDTs and reporting for cardiac care, sleep studies and diabetes care – reducing unnecessary travel for patients and clinicians
Workforce	
	Developing assistant practitioner roles to support healthcare science/diagnostics service
	Working with NHS Grampian to redesign pathways for Children accessing Child Health and intended appointment of a Community Consultant Paediatrician to liaise with specialists based at RACH
	Developing specialist nursing roles in OPD to support elective care e.g. Nurse led intraocular injection therapy
	Potential development of specialist outpatient roles in providing pharmacist prescribers to support the off-island consultant rheumatology and dermatology models.

Increasing Elective Care	The tables in Appendices A and B set out the projections for increasing elective/diagnostics activity to March 2022. We have built in a clinical triage process so that all elective patients waiting for surgery have a tele-consultation with the local Consultant to discuss risk factors (e.g. balance of risk for high risk patients) before they are given a date for pre-operative assessment and surgery. This allows patients to continue to make an informed choice about the timing of their procedures in context with their overall clinical/social circumstances. We are actively managing our waiting lists as per the guidance set out in the clinical prioritisation framework[1] and applying the clinical priority matrix. We are also continuing to look at ways in which we can offer local services as an alternative to patients travelling to specialist centres and have made good progress in 2020-21 identifying ways in which we can increase our ability to provide diagnostics locally i.e. replacement of CT scanner, scoping exercise to support procurement of a MRI scanner and increased availability of cardiac physiology. Funding already agreed with SG to redesign our DSU will be allocated in 2021-22 to take forward the build phase of the project to create a 12 bedded, multi-functional DSU, ambulatory care facility. The additional elective bed capacity will also support the phasing of the build project, with reduced impact on elective flow. As noted in the following section, we have increased our elective bed capacity to ensure that we can support increased activity in 2021-22 as visiting services resume or where we use independent providers to help manage gaps in service provision. We also intend to retain our supplementary workforce in theatres, surgical teams and diagnostic services to support remobilisation. To reduce reliance on high cost agency staffing and improve continuity of care, we have offered fixed term appointments to manage our supplementary workforce requirements. The investment provided in 2020-21 in new equipment has enabled us to create a second endoscopy suite which will support increased patient activity and allow us to simultaneously manage local anaesthetic lists in theatre whilst continuing to operate the endoscopy suite.

[1] https://www.gov.scot/publications/supporting-elective-care-clinical-prioritisation-framework/

	However, one of our key risks is the decontamination facilities, where we have experienced numerous technical issues during 2020-21 which has meant that endoscopy activity has had to be reduced and scope reprocessing has had to be undertaken for us by NHS Grampian. The replacement of the decontaminator washers is a key factor in our remobilisation planning and the rate at which we can increase elective procedures – where almost 75% are endoscopy related. We have discussed the provision of visiting services with NHS Grampian during the all phases of remobilisation. Patients requiring urgent care that cannot be delivered via tele-health will need to continue to travel to NHS Grampian for assessment and/or treatment until visiting services resume. 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. We expect that by the end of 2021-22, 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. Our main areas of backlog are shown in Appendix C, which is our operational dashboard which is reviewed on a weekly basis (data current WC15/02/21). 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 need to be completed with NHS Grampian and reflected in their remobilisation plan priorities.
Cancer Care	We have prioritised the maintenance of pathways which support patients with urgent suspected cancers and since its publication in August 2020[2]; we have taken note of the guidance in the COVID 19 Framework for the recovery of cancer surgery. We have also increased our local chemotherapy provision to reduce the impact of patient travel where it has been safe to do so. Given that we would intend to sustain these changes and offer more chemotherapy in Shetland we are reviewing the skill mix of the team to ensure we have resilience and safe staffing levels. The number of referrals for patients with urgent suspected cancer quickly returned to pre-COVID levels following the first wave and we have seen in general a steep increase of referrals through winter months. We have also in We remain confident that we can provide cancer care within 62 days for patients who are eligible for treatment in Shetland. However, we know that there are ongoing challenges in Aberdeen in providing urgent care for patients with suspected colorectal, breast 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.

Remobilisation – Acute & Specialist Services

At NHS Shetland, Infection Control, Diagnostic Services, Children's Services (including CAMHS) and Women's Health sit within the Acute & Specialist Services Directorate

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 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 in 2021-22 so that the additional clinical areas can be used support increased activity in line with the remobilisation plan requirements. How we will utilise the additional 22 beds is described further on in the plan.
Intensive Care (level 3)	We will retain the existing respiratory care unit to maintain COVID 19 resilience[3] and allow us to manage critical care patients safely as adaptations to the layout of the Hospital mean we have a restricted Theatre Recovery area and the RCU is a more appropriate environment in which to provide stabilisation of patients waiting for transfer. This arrangement will remain in place throughout 2021-22, whilst be build a permanent space with negative pressure that can be used flexibly to provide care up to level 3 if required. We expect the negative pressure bay will be located on the acute medical unit. We will also retain additional ODPs in order to ensure we have the necessary resilience and to provide the additional theatre sessions needed to speed up elective care recovery.
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 amber pathway. In addition to this, we have identified a red HDU pathway which is part of the COVID 19 unit and RCU. This is 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. We will maintain these flexible arrangements for as long as they are required during 2021-22.

[3] This in effect reduced or core DSU by 6 beds and hence the need to retain surgery capacity to manage elective care requirements

Utilising the Gilbert Bain Hospital Site for COVID-19 resilience and increasing the delivery of other services	We have put in place red, green and amber pathways for all clinical specialties and will maintain them for as long as is required. This has included zoning the hospital campus which we have achieved by: • Creating a 10 bed COVID 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/or other patients respiratory symptoms. This unit includes isolation rooms that can be used to offer NIV if required and gender segregation. The beds can be used on a sliding scale from 1 to 5 to 10, depending on demand. • Utilising the remaining 30 acute beds across the Hospital for patients who are in the amber pathway (this is 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 green pathway which will be used to provide space for a day case unit (DSU), an endoscopy suite (2 beds) and inpatient beds for post-operative patients in the green pathway. We are actively staffing 7 beds to provide the DSU capacity as additionality (over the 42 acute beds which is our core capacity). Up to nine beds will be staffed on an ad hoc basis to provide post-operative care to patients requiring an overnight stay in the green pathway. We intend to keep the surge capacity beds throughout 2021-22 in order to enable us to increase the level of elective care activity, particularly in order to enable the visiting services to restore services and manage backlog. • Elective ambulatory care is provided from the surge capacity bed complement, and the 3-4 beds allocated are staffed on an ad hoc basis. The beds have been allocated as an amber pathway, in a separate area from the green. • Allocating the two theatres as red and green pathways (for emergency and elective cases). • Outpatients (Adult and Children's) are support patients in amber pathways, with a separate entrance for patients who are higher risk (this will remain in situ for as long as it is required. • Zoning the Maternity Unit to create red and amber pathways and labour wards. • 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, but for medical imaging we have increased ultrasound scanning locations and changed the shift pattern to reduce the impact on waiting times.

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 and resumed face to face services in Q3 of 2020-21. Staffing difficulties during the winter months along with an increase in COVID prevalence, meant that some teams had to revert to clinical prioritisation to sustain services. Health Visiting and CAMHS teams have been the greatest affected. The CAMHS team is very small but has recently appointed to vacancies outstanding in 2020. 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. Whilst we have not seen a significant increase in referrals, we have seen an increase in the acuity of young people accessing services. We are working closely with partners including Schools to provide appropriate support and advice to families and other practitioners. Heath Visitors and School Nurses are supporting the return of children to the school setting in February 2021. Visiting Paediatric clinics are in place and we are in the process of appointing a Community Consultant Paediatrician who will support a review of the provision of clinical care for children in 2021-22 as well as managing a community based caseload. 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 have seen an increase in activity across the obstetric service and an increase in the complexity of issues in high risk women. Additional Midwives will continue to be required in order to support the remobilisation of the service, support increased activity and succession planning. We are also reviewing access to family planning services and managing an existing backlog and improving access to LARC.
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 and primary care. We intend to substantively 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 SG allocation to support care assurance and care home oversight has been used to offset some of the costs but there is a shortfall which will be a cost pressure going into 2021-22. 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 have resilience and to enable us to manage the increased activity and testing requirements associated with remobilisation. The wider BMS team has also revised the pattern of working to provide more core cover 8am-8pm to support clinical decision making and flow through SDEC.

Redesigning Urgent Care

The Redesign of Urgent Care (RUC) programme is ongoing, aiming to reduce the number of patients who access emergency care unnecessarily, but will also aim to prevent any delays in admissions for emergency care patients

Managing Urgent Care (Emergency Department & Same Day Emergency Care)	We have consistently maintained the 4 hour access target during 2020-21. The Emergency Department (ED) has seen a drop in activity between 2019[4] and 2020[5] of 35% overall. Our current activity levels are approximately 30% less than in Q4 of 2019-20 and that is a result of proactively messaging out to the public to access tele-health advice in the first instance and/or using other services available such as the COVID Assessment Centre (CAC) or Primary Care. Patients who are presenting at ED are often now more complex, frail and deconditioned, despite work across the whole system to monitor people in the community with complex co-morbidities. As part of our redesigning urgent care programme, we have undertaken tests of change to provide alternatives to ED including the development of a Same Day Emergency Care (SDEC) unit which is open 7 days per week. SDEC has re-directed/reduced ED activity by 11%[6], in the time that it has been open since October 2020. We have agreed to retain the unit moving into 2021-22 to support remobilisation and increase the range of patients that can be supported by SDEC e.g. urgent outpatients, emergency ambulatory treatments etc. Plans also include working with the NHS Highland Flow Navigation Centre (FNC) which hosts senior decision making for Highland and the Islands; to develop new pathways such as pre-booked appointments for minor injuries where patients can be seen in SDEC. In addition to this, we have been testing an enhanced multi-disciplinary team approach in ED, with the inclusion of primary care clinicians (GPs and ANPs) to ensure that we can offer right time, right clinician approach for patients requiring urgent care, by offering tele-health assessments wherever it is safe and appropriate. Analysis of the data shows that the greatest impact is at weekends and this is where the additional time has been focussed – more work is required to fully integrate the two teams and ensure that the clinical capacity matches the demand as activity has been low. Work with the FNC team also includes reviewing how best to provide first line support to people requiring access to mental health crisis teams and options for delivering this using a tele-health approach. As part of our capital programme for 2021-22, we will also increase the consultation space in ED through minor reconfigurations of the unit to enable greater opportunity for multi-disciplinary team working.

[4] 6550 presentations to ED from April 2019 to February 2020.
[5] 4280 presentations to ED from April 2020 to February 2021.
[6] 200 patients seen in SDEC from a total of 1745 patients seen in ED between October 2020 and February 2021

Living with COVID

The World Health Organisation (WHO) set out 6 steps which need to be met in order to operate a COVID-safe society

1. Surveillance: Disease transmission is under control
2. Health systems are able to detect, trace, isolate and treat every case and trace every contact
3. Hot spot risks are minimised in vulnerable places, such as nursing homes
4. Schools, workplaces and other essential places have established preventive measures
5. The risk of importing new cases can be managed.
6. Communities are fully educated, engaged, and empowered to live under a new normal

Risks, opportunities and assumptions

The NHS remains on an emergency footing. We therefore need to balance retaining sufficient capacity to deal with any resurgence of COVID-19, whilst maximising the safe and effective resumption of planned services. While cases numbers are low, we will continue to remobilise essential urgent and routine health and social care services, but any surge in the number of cases, and subsequent hospitalisations, would put our health service under significant strain and necessarily impact on efforts to remobilise services.

Outcome	Actions
We have effective and resilient surveillance & intelligence systems in place to guide and support our public health effort and health & care systems	
	Maintenance of surveillance systems
	Epidemiology to support management of outbreaks
	Intelligence-led planning, including Research, Data gathering and analysis on impact of social, economic and community impacts of COVID19 e.g. impact of social distancing on community cohesion; social isolation; physical activity; diet; addictions; wider burden of disease and; DALY.
	Research, Data gathering and analysis of specific health harm impact on inequalities: poverty; multiple and complex disadvantage; protected characteristics; public protection and wider burden of disease and; DALY.
We have a fully resourced Test & Protect system in place, in order to identify and respond rapidly to local outbreaks	
	Maintain Test & Protect team, in order to identify & rapidly respond to local outbreaks
	Develop and innovate in order to meet all government testing requirements, and maintain local swabbing and laboratory capacity
	Continue to deliver Satellite UK Gov scheme
	Maintain Contact tracing team
	Provide Health Protection Specialist/Consultant oversight

We are reassured that Carehomes & other vulnerable settings remain COVID safe and that we can respond quickly and proportionately to any risks	
	Enhanced Assurance for Care Homes, Education Services COVID Strategy meeting, Shetland Emergency Planning Forum and SIC Tactical Team Support, support to workplaces to ensure effective preventative and management practices.
Our community is educated and supported to remain COVID safe, and engaged and involved in building back stronger	
	Continue to support schools, workplaces and other settings at risk of outbreaks with developing and reinforcing preventive measures.
	Continued implementation of Communications Plan in line with WHO 6 phases, but also to maintain engagement with community about continuing redesign and development of services
	Continued development of a Shetland / Orkney Comms unit with external / internal and digital comms, and a strong focus on supporting the renewal agenda.
We recognise, support and enable recovery for people living with Long COVID	
	Development and implementation of pathways of support for people with 'long COVID-19', recognising that it is a multi-system disease.
We prevent serious illness, hospitalisation and death through delivery of the COVID vaccination programme	
	Continue to deliver COVID-19 vaccination programme in line with guidance set out in JVCI for the UK
	Build the capacity of the vaccination workforce to plan, manage, coordinate, deliver and evaluate the programme

Patient Experience

We have tried to develop this Remobilisation Plan around and reflecting patient pathways rather than service-focused boundaries; we are determined to ensure that they reflect citizen perspectives and experience across the whole health and social care system.

Remote solutions & digital health	
	Extend Ask My GP to Scalloway, Brae and Levenwick GP Practices in order to increase accessibility of services and increase patient and staff satisfaction levels.
	Facilitate & expand Home blood pressure and cardiac monitoring to allow patients to take ownership of their conditions.
	Work towards having EMIS & Docman access established on a Shetland wide basis for all nursing staff across Community Nursing services to 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.
	Increasing access to cardiac diagnostic testing with remote reporting – reducing the number of vulnerable, high risk patients requiring travel to specialist centres
Engagement & understanding	
	Engagement on Clinical & Care Strategy for Shetland
	Undertake Shetland wide Health survey to inform renewal of Joint Strategic Plan
Supporting & enabling self care	
	Provide an adequate and timely medicines management assessment service for patients - significant risk of medicines misadventure particularly in our older population.
	Continue to build on the support available to unpaid carers, to encourage registration, and build resilient support networks.
	Continue to develop 'Pharmacy First' model; we have plans to enable a prescribing service from one of our community pharmacies in the coming months as part of this service.
	Promotion of NHS Inform & Scotland's Services Directory to enable people to access accurate, helpful and up to date information and self-manage conditions where appropriate.
	Continue the roll out of Community-led support

Addressing Inequalities

The COVID pandemic has both exposed and exacerbated our health inequalities crisis with disproportionate harm caused to minority ethnic groups and people living in greatest deprivation. Addressing inequalities for all citizens and our health workforce is therefore a vital theme which is at the core of our planning.

Risks, opportunities and assumptions

COVID-19 has taken a significant toll on the mental health of young people; there are increased risks of domestic abuse for women and children; there has been growing digital divide and exclusion; and, older people are at greater risk of social isolation. As part of this, we will continue to be mindful of the differing needs across our islands and how we ensure the necessary access to services.

Activity relating to government programmes for health improvement have largely restarted and have been maintained during the most recent outbreak, although some staff continue to be redeployed to support COVID-19 vaccination 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. As nationally driven health improvement programmes are beginning to start again, there is increasing need to find sustainable solutions for health protection work as redeployed staff return to substantive roles.

We have small numbers of people from ethnic minorities living and working in Shetland, which can make it more difficult to tailor services to specific needs; this underlines the need for designing services *with* patients and communities, so that disparate needs can be taken into account.

Tackling determinants of health	
	Develop a revised framework and implementation plan for tackling inequalities in health
	Work as a key partner of the Shetland Partnership to drive forward innovative solutions and support to help people maximise their incomes and minimise their outgoings
	Continue to roll out Community Led support
	Tackling fuel poverty jointly with Shetland Partnership
	Increasing access to services through Attend Anywhere
	Focus on collection of good quality ethnicity data and addressing of negative impacts appropriately.
Prevention, early intervention & system change	
	ANCHOR
	Type II Diabetes Reversal
	Support increase in levels of health literacy, to build confidence, knowledge and ability to increase the wellbeing of individuals and communities.
	Screening and Learning Disabilities Project
	The co-design with communities of services on our remote non-doctor islands
Realistic Medicine	
	Long COVID
	Development of Pain Management pathway

Embedding innovation

New ways of working and innovations we have tested and implemented in 2020 include:

- Rolling out Near Me across specialties (visiting and local)[7]
- 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 tested)
- 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
- Switching to radiofrequency ablation from injection therapy for chronic pain

Risks, assumptions and opportunities

Enablers include investment in the digital infrastructure needed to sustain the changes we have made at pace as part of COVID 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. We are participating in NoS Innovation work streams, including those supporting tests of change using drone technology. Our recently established Project Management Office will act as a central function to support change to occur in NHS Shetland in a way that is safe, effective, supported and meaningful. It will enable individuals and teams to embark on change; often taking forward ideas that they have wanted to pursue for some time - knowing that they have the backing of the organisation even if it doesn't work out as initially intended.

We also need to invest in our Information Governance and Data Protection function to support the rapid changes in ways of working: Internal and external audit identified the need for the IG Team to increase its resilience/capacity/training to address organisational responsibilities arising from changes in information governance (IG) and records management (RM) legislation and NHS Scotland IG standards (ISO27001). This includes the reconfiguration of NHS Shetland records systems for O365.

Innovation
We continue to establish monthly virtual MDTs between social care, GP practice and community pharmacy staff with a view to improving the safety of medicines use in the community.
We are looking to establish electronic MAR sheets as a pilot project in the coming year.
The introduction of HEPMA will bring a revolution in our prescribing and administration in the hospital setting, making patient care safer and more efficient
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
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

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

Sustainable workforce

Access to appropriate workforce resources will be key to the sustainable delivery of all of these services. We will continue to use learning from our COVID response to maintain adaptable and responsive staffing models and are actively succession planning. 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 will continue to invest 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.

In 2021-22 we will also be introducing new ways to manage unscheduled care and putting in place training to support skills acquisition or refresh across the ED team to ensure that we can offer a more integrated MDT approach for urgent care.

Risks, opportunities and assumptions

In order to deliver new ways of working, we have completed workforce professional judgement templates will all Heads of Service in the Acute setting. 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 resilience plans, we have staff identified to support the RCU and surge capacity beds or increases in elective care.

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; this is not sustainable given NHSG recovery planning priorities. During 2020-21 a senior nurse completed the training and is contributing to the resilience of the service. 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 maintain a small increase in 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.

In effort to reduce supplementary workforce we have increased some of the funded establishments to enable fixed term contracts to be offered and this has worked well with nursing teams but recruitment challenges remain within ODP workforce. There will be continued reliance on agency ODPs to support remobilisation and on call configurations for RCU. 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. To continue throughout 2021.

The oncology and palliative care nursing teams are now working across two locations with an increased workload to support chemotherapy care so we will also need to continue to provide supplementary staffing through 2021-22 and agree on a revised skill mix. 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. Now that we have a clearer understanding of the capacity required to support Infection Control requirements in all settings we have increased the ICN and ICD capacity on a substantive basis.

Some additional costs have been identified to enable these changes to take place which are summarised in the separate financial section. These include additional support within the Human Resources Team to support recruitment and retention, and the Employee Relations workload.

Staff Wellbeing and Resilience

Staff wellbeing and welfare is critical to the ability of the NHS to remobilise and recover. We are looking to consolidate and embed systems of physical and psychological support for staff in the longer term, as part of our development of a corporate staff wellbeing plan. This is being developed in conjunction with the Area Partnership Forum, Area Clinical Forum, Employee Director and our Workforce Wellbeing Champion, and is led and monitored through the Staff Governance Committee of the Board.

Risks, opportunities and assumptions

- The capacity of staff to engage in training, development and new ways of working while responding to the phases of the pandemic is a risk
- MS Teams and remote systems have provided opportunities for new ways of engaging and working with staff
- Flexible redeployment opportunities during COVID have helped to fill gaps, build understanding of other roles across the organisation and sharing of skills and knowledge

Staff Governance Standard	
	Continue to implement Staff Governance Standard to ensure a system of corporate accountability for the fair and effective management of all staff
	Continue active staff engagement to involve staff in decisions and enable their voices to be heard
	Continue to support and enable personal and professional development of staff to maintain and develop skills and interests
Wellbeing	
	Confidential contacts
	Development of staff listening and support service
	Winter wellbeing programme
	Implementation of Standards in Spiritual Care
Trauma Risk Management	
	Development of TRiM - a trauma-focused peer support system designed to help people who have experienced traumatic, or potentially traumatic events

NHSScotland Chief Operating Officer

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To:
Michael Dickson
Chief Executive
NHS Shetland
By email

2 April 2021

Dear Michael,

NHS SHETLAND: REMOBILISATION PLAN 2021/22

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

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

Covid-19 Resilience

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

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

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

Person-centred approach

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

Staff Wellbeing & Sustainability

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

Partnership Working and Staff Engagement

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

Supporting Adult Social Care

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

Redesign of Urgent Care

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

Planned Care

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

Mental Health

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

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

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

Supporting the spread of Best Practice and Innovation

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

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

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

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

Addressing Inequalities

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

Finance

We have reviewed your financial plan for 2021/22 and provided detailed feedback on 15/03/2021. We note your financial plan shows a breakeven position for 2021/22 assuming £2 million of savings can be met (3.8% of baseline). However there continues to be significant uncertainty about the financial impact of Covid in both the short and longer-term, and what this will mean both for service delivery and associated financial plans.

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

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

In addition, it was noted in 2020-21, that NHS Shetland is a clear outlier in Covid costs on both a NRAC comparison and cost per case basis. We are grateful for the explanation provided to support these costs. However given the scale of challenge for Health Boards and the wider Portfolio for 2021-22, it is critical that NHS Shetland ensure that strong financial controls and scrutiny are put in place to bring the funding requirement in line with that of other NHS Boards.

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

Plan Approval and Feedback

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

- It was positive to see that your RMP is whole-system, with it being evident that you are working alongside the Third-Sector, NHS Orkney, NHS Western Isles and NHS Highland in implementing Covid-19 response and future planning.
- I welcome the new ways of working and technological innovations, including the rolling out of Near Me and the use of Ask my GP evident in your RMP. I was also pleased to see details of testing of an enhanced multi-disciplinary team approach in ED, with the inclusion of primary care clinicians (GPs and ANPs) to ensure that provision of right time, right clinician approach for patients requiring urgent care by offering tele-health assessments when it is safe and appropriate.
- I note that Mental Health Services have continued to operate throughout the pandemic, with all outpatient service users being offered digital, telephone or face to face appointments. I welcome the collaboration demonstrated with other Boards, which is exemplary, and outlines a way or working which could benefit other rural Boards.

Publication of your RMP

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

Next Steps

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

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

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

Yours sincerely

JOHN CONNAGHAN CBE
NHSScotland Chief Operating Officer