Health and Sport Committee: Health Board Survey 2020

Budget Scrutiny: Health Boards

1. Which Health Board are you responding on behalf of?

   NHS Ayrshire and Arran.

2. Please state your **revenue** budget as at the start of the financial year

   £761.8 million

3. Please confirm any revisions to your **revenue** budget, indicating:

   (a) Changes due to additional COVID-19 funding (split between health and social care)

   (b) Changes for other reasons (please provide details)

	Revenue budget £m
Initial position (as agreed pre-Covid)	761.800
Additional COVID-19 funding – health	0.792
Additional COVID-19 funding – social care	4.199
Other changes (non COVID-19)	3.061
Revised budget position	769.852

4. Please provide details of how additional COVID-19 funds have been used. Please include details of funding transferred to local government for integration authorities and additional health board contributions to integration authorities.

   Scottish Government have allocated funding of £3.605 million as a payment to account for Council expenditure to cover spend on PPE and specific costs in relation to care home and care at home services. A further £0.594 million has been passed to councils to cover the Scottish Living Wage uplift. Funding has also been received to support the Ayrshire Hospice of £0.792 million with loss of income of due to the impact of the COVID-19 pandemic. It has been agreed that health allocations for the first quarter of the year will be made in September as there are no cash flow issues for Boards.

5. As a result of the pandemic, please indicate:

a. The main three areas of additional spending

The main areas of spend in the Health Board are:

Infrastructure

Our acute hospitals increased capacity for COVID-19 patients by quadrupling ITU capacity and opening additional COVID-19 hospital beds. This largely used existing staff as all routine Inpatient/Daycase surgery ceased with planned care surgery restricted to emergency and cancer/very urgent cases only and by creating capacity through maintaining a reduced level of outpatient service through telephone and digital consultations. Theatre nurses and anaesthetists were deployed to ITU while surgical ward staff were deployed to additional COVID-19 wards. The gross cost for additional general hospital beds in the first three months of the year was £2.1 million and for ITU beds was about £2.3 million.

Workforce

Nationally it was decided that student nurses in second and third year should be employed by boards. Ayrshire & Arran engaged about 260 student nurses to cover hospital and community placements. Expected spend is around £0.6 million each month until August. These costs will be met by Scottish Government.

Other additional overtime from April to June was £0.5 million. Other additional temporary staff incurred £0.6 million in the same period.

Testing and Test & Protect

Laboratory testing capacity has had to be significantly increased to test for COVID-19. New equipment with a cost of £161,000 has been procured in the first three months of the year, this includes an analyser that was due to be replaced. Staff from the pathology lab have supported the additional workload in the microbiology lab over April, May and June, however now need to return to pathology lab. Additional staff are being recruited for the microbiology lab to ensure that we have a resilient staff complement to support the increased testing requirement over 7 days. Testing costs have risen in line with the increased response to testing across the population and will continue to be sensitive to changes in testing requirements over the coming months. Increased capacity will cost about £80,000 per month therefore a full year cost for testing of about £0.9 million.

b. The main three areas of reduced spending

The main areas of reduced spend in the Health Board are:

Theatre and Surgical staff previously treating elective patients - £2 million April to June

This results from the cancellation of elective inpatients, day case surgery and hospital outpatient activity. Theatre nurses and anaesthetists were deployed to ITU while surgical ward staff were deployed to additional COVID-19 wards.

Supplies costs in theatre - £1.5 million April to June

Theatre supplies spent £2.2 million in Q1 of 19/20 but has spent only £0.7 million in Q1 of 20/21. It includes prosthesis and general theatre supplies.

Supplies costs in outpatients - £0.5 million April to June

Macular service (ophthalmology) and audiology are the main areas where low activity meant reduced supplies spend.

6. Of the areas identified in Q5, do you anticipate that any changes in service delivery will lead to longer-term changes in spending? Please provide brief details, including details of anticipated annual savings or additional costs associated with each change. (200 words max for each change)

Infrastructure

Until such times as the additional capacity to care for COVID-19 patients in our acute hospitals is no longer required, we anticipate that we will need to maintain additional ITU and ward capacity as set out in our remobilisation plans. To support the expansion of ITU beds 7 additional clinical fellows were employed for 6 months and nursing staff were redeployed from other service areas. The full year gross costs estimated are £6.6 million for additional general beds and £5.7 million for ITU beds.

Workforce

The plan for red/ green COVID-19 pathways, continued surge capacity for COVID-19 patients, elective services re-starting, winter planning and changes to unscheduled and urgent care provision will quickly create pressure points within the system and result in poorer outcomes and potential harm if not supported by the requisite AHP services. People in rehabilitation in-patient areas post COVID-19 are also requiring more intensive therapy in line with documented evidence creating a larger demand on therapeutic time. To meet these increased demands on our AHP services we intend to review our workforce planning requirements.

Testing and Test & Protect

To support the delivery of Testing and Test & Protect through our local teams will require additional staff to maintain extra microbiology laboratory capacity for the next two years at a cost of about £0.35 million per annum. We will also require to spend £0.36 million of capital on labs to increase decontamination and testing capacity. As well as laboratory capacity, the testing process requires a clinical team to take samples, a results team to report results and a contact tracing team to follow-up contacts of positive patients, as well as public health supervision. These teams will cost about £1.5 million per annum for NHS Ayrshire and Arran.

7. Which of your performance indicators have been most negatively impacted by the pandemic, and what is the projected effect on their trajectory for the coming year? Please list **three** indicators, showing their expected performance in 2020-21, compared with pre-Covid plans.

   A number of operational performance measures have been negatively impacted by the COVID-19 pandemic. The three performance indicators most affected are:

   a) Inpatient/Daycases;
   b) Outpatients; and
   c) Imaging & Endoscopy.

   As the health and social care system continues to respond to the challenges of COVID-19 there is also a requirement to move into the next phase of our re-mobilisation and recovery planning. Planning will make use of data and modelling assumptions and projections of the impact of COVID-19 on activity, recognising that these assumptions will continue to evolve over the coming months. NHS Ayrshire & Arran in collaboration with the East, North and South Health and Social Care Partnerships will submit the next phase of our re-mobilisation plans to the Scottish Government on 31st July 2020 which will detail our projections, informed by the Royal College of Surgeons clinical prioritisation approach to ensure that patient and staff safety is maintained. High level plans are described below.

   a) Inpatient/Daycases

   NHS Ayrshire & Arran, like other NHS Boards, were required to significantly increase our Intensive Care capacity to manage critically ill COVID-19 cases over the period of the outbreak. To effectively and safely manage the pressures of COVID-19, all routine Inpatient/Daycase surgery ceased with planned care surgery restricted to emergency and cancer/very urgent cases only. Emergency surgery continued in all specialties, and in some specialties a small number of very urgent cases continued.

A comparison of the number of patients waiting over 12 weeks as at 29 June compared to 24 February is outlined below:

	Number waiting	As at 24 February 2020	As at 29 June 2020
Inpatients / Daycases	> 12 weeks	987	3,905

Source: Weekly MMI Report

For 2020/21, a draft Elective Waiting Times Improvement Plan was submitted as part of the wider Annual Operational Plan and included monthly trajectories on the number of patients waiting over 12 weeks for an Inpatient/Day Case appointment.

Prior to the COVID-19 pandemic, the trajectory by March 2021 was to reduce the number of patients waiting over 12 weeks to 361. As part of our re-mobilisation planning, draft revised trajectories have been developed to March 2021 with a projection of 5,066 patients waiting over 12 weeks by March 2021. This is based on the known service restart plans and assumptions on future demand.

b) Outpatients

To further support the COVIID-19 Pandemic response Outpatient activity was also scaled down to release key clinical staff to assist with emerging pressures, to allow adaptation of some Outpatient areas for other uses, and to reduce the public footfall in the hospital sites.

A significant change in practice was required through the COVID-19 Phase 1. Although significant numbers of face to face appointments were cancelled, with only the most urgent face to face appointments continuing, there was an increase in the use of telephone and NHS Near Me video consultations, and virtual review to support continued delivery of outpatient care in appropriate cases. This change in practice is being continued as part of the service re-mobilisation.

A comparison of the number of patients waiting over 12 weeks as at the end of June 2020 compared to the end of February 2020 is outlined below:

	Number waiting	As at February 2020	As at June 2020
Outpatients	> 12 weeks	3,965	16,155

For 2020/21, a draft Elective Waiting Times Improvement Plan was submitted as part of the wider Annual Operational Plan and included monthly trajectories on the number of patients waiting over 12 weeks for an Outpatient appointment.

Prior to the COVID-19 pandemic, the trajectory by March 2021 was to reduce the number of patients waiting over 12 weeks to 1,475. As part of our re-mobilisation planning, draft revised trajectories have been developed to March 2021 with a projection of 18,095 patients waiting over 12 weeks by March 2021. This is based on the known service restart plans and assumptions on future demand.

c) Imaging & Endoscopy

Like other services, routine diagnostic services including x-rays and scans were suspended from mid-March in order to create additional capacity to support the emerging COVID-19 demand and to reduce the public footfall in the hospitals with the associated risk of increased transmission of the infection. Urgent and Urgent Cancer Suspected (UCS) imaging investigations have continued throughout. This has resulted in an increase in the numbers of people waiting for routine imaging investigations.

Endoscopy services have been significantly impacted during the COVID-19 outbreak. Following initial COVID-19 guidance issued by the British Society of Gastroenterologists (BSG) in March 2020, all routine, urgent and UCS endoscopy investigations were stopped due to the available evidence around heightened risk to staff. Only emergency endoscopy procedures continued.

A comparison of the number of patients waiting over 6 weeks as at the end of June 2020 compared to the end of February 2020 is outlined below:

	Number waiting	As at February 2020	As at June 2020
Endoscopy	> 6 weeks	735	2,317
Imaging	> 6 weeks	1,517	4,272

Source: Monthly DMMI Report

Prior to the COVID-19 pandemic, the trajectory submitted as part of the Annual Operational Plan by March 2021 was to reduce the number of patients waiting > 6 weeks for an endoscopy to 200. Based on the revised trajectories that have been developed as part of re-mobilisation planning, the draft projected number of patients waiting > 6 weeks by March 2021 is currently 3,246.

The projections for endoscopy are based on the known service restart plans and assumptions on future demand at this point in time.

The trajectory submitted as part of the Annual Operational Plan by March 2021 was 1,424 for Imaging. Revised trajectories are being developed as part of the re-mobilisation planning.

8. When would you expect performance in these areas to recover and what action / spending will be required? (Please provide a brief description for each of the indicators listed at Q7.)

Elective inpatient and daycase surgery, and elective endoscopy are being re-mobilised in a safe and incremental manner, but it is widely acknowledged that the revised capacity will be significantly less than was the case pre-COVID-19.

There are a significant number of patients awaiting surgery or endoscopy following the suspension of services as outlined above. Demand for these services is increasing again, although there remains some uncertainty as to whether ongoing demand will reach pre-COVID-19 levels or whether it will remain at a lower level.

Remobilising Outpatient activity will build upon the use of telephone and NHS Near Me video consultations, and virtual review to support continued delivery of outpatient care in appropriate cases. This change in practice is being continued as part of the service re-mobilisation. Early experience has provided teams with a clearer view of what types of patients can be managed in this way, and what proportions of patients do require a face to face appointment. The requirement to continue to support physical distancing and avoid crowded waiting areas is key to the co-ordination of the service re-start process.

Outline costs to support planned actions in relation to restarting services are detailed in full in our Remobilisation Plans. In relation to the indicators described at question 7 expected spending to restart services is:

- Inpatients/day cases around £2.7 million;
- Outpatients £548,000; and
- Imaging & Endoscopy £1,383,000.

With this in mind there is no expectation that performance in these areas can be recovered to pre-COVID-19 performance within the current financial year. The timescale for recovery thereafter remains unclear and would be affected by the impact of any second wave of COVID-19 over winter 2020/21. Actions which are being taken to mitigate the current reduced capacity and to recover as much performance as possible include:

Inpatient/Daycases

- Validation of waiting lists;
- Consideration of weekend operating; and
- Consideration of independent sector surgical capacity in conjunction with SG Access Support Team colleagues.

Outpatients

- Validation of waiting lists
- Extension and roll out of NearMe Video Consultations
- Virtual Review appointments
- Working with regional colleagues to review opportunities to utilise Louisa Jordan capacity.

Imaging

- Mobile MRI van in place July to January to create additional capacity;
- Proposal to staff additional CT sessions;
- Proposal to engage locum sonographer to create additional ultrasound capacity; and
- Involvement in West of Scotland regional discussions regarding potential ‘CT Pods’ to be located at 2 West of Scotland hospitals but accessed by all Boards to create additional capacity.

Endoscopy

- Introduction of new techniques (Colon capsule Endoscopy and Cytosponge) as alternatives to endoscopy;
- Introduction of qFIT testing to reduce demand for colonoscopy and help prioritise those who do require a colonoscopy; and
- Engagement of additional capacity at Golden Jubilee National Hospital.