Chief Executive's Office
Eglinton House
Ailsa Hospital
Dalmellington Road
AYR
KA6 6AB

NHS Ayrshire & Arran

Date 25th September 2020

Lewis Macdonald
Convener, Health and Sport Committee

Your Ref
Our Ref JGB/MW

By email only:
healthandsport@parliament.scot

Dear Convener,

I write in response to your letter of 10th September 2020 seeking further information following the evidence session on the 1st September 2020. I shall use the headings in the letter for ease of reference.

Indirect Health Impacts Covid

As set out in the Official Report NHS Ayrshire and Arran identified direct and indirect impacts of responding to the demands of Covid 19. I note the Committee is seeking detail of the assessment made of the potential indirect health impact as a result of reduced elective and diagnostic activity. The Board has undertaken an analysis of our waiting lists and we are able to forecast the increase in numbers waiting notwithstanding the restart of services and hard work of our teams across the health and care system. As we restart we are constantly reassessing the forecast as we seek to maximise our service whilst maintaining safe delivery of services for patients and staff. We have not undertaken a formal public health impact assessment on the wellbeing of those waiting for elective or diagnostic care.

Turning to the second point of balance between responding to the demands of Covid 19 and delaying other services. I believe that NHS Ayrshire and Arran responded in a thoughtful and considered way taking clinical advice on how best to mobilise to respond to Covid 19 whilst maintaining urgent and emergency services. It is also worth noting that in seeking the right balance we quickly deployed digital solutions such as "Near me" to support outpatient services. As we have remobilised we have sought to ensure we remain agile to respond to the ongoing demands of Covid 19 whilst safely restarting elective care. I believe that in the initial mobilisation and subsequent remobilisation planning NHS Ayrshire and Arran has struck the right balance when taking account of Covid 19 readiness and safety and clinical advice.

In response to this Emergency NHS Ayrshire and Arran established an Emergency Management Team and 2 clinically led sub groups for acute care and primary and community care. Clinical leadership and advice was central to our response. Our plans were based on national assumptions about the impact of Covid 19 and locally we set the following objectives;

- To deliver up to 4 times normal critical care capacity
- To deliver surge capacity in inpatient beds
- To continue to safely treat urgent and urgent cancer suspected patients
- To support our teams across the health and care system to mobilise effectively to meet the demands of Covid 19

Throughout the initial response to Covid 19 we sought to maintain services where that could be done safely. By introducing red and green pathways we delivered unscheduled care, cancer and maternity services. Examples of the range of services delivered is set out below;

- Emergency/trauma surgery
- Clinically prioritised surgery for cancer
- Urgent care in Urology, Vascular, Head and Neck, gynaecology and ophthalmology
- Emergency endoscopy
- For adult outpatients we continued with all specialities seeing urgent cancer suspected patients either by telephone or using near me, urgent patients were also reviewed across medical and surgical specialties e.g. Fracture clinics, Urgent and Emergency Ophthalmology, Haematology [including Anti-Coagulant], Oncology, Renal, Rheumatology, Respiratory, Gastroenterology, General Surgery, ENT, Urology
- Imaging services continued to respond to all inpatient referrals across all modalities (MRI, CT, Ultrasound and plain film x-ray). We continued to respond to all urgent suspected cancer and urgent referrals for MRI and CT. All GP urgent activity was transferred to Ayrshire Central to allow radiographers to focus on unscheduled care services e.g. ITU, imaging within Combined Assessment Unit within the acute sites

Turning to staff that were redeployed I can advise the Committee as follows;

A total of 633 staff employed by NHS Ayrshire and Arran either in a substantive role or in a bank capacity were deployed to support the organisation's response to the additional demands placed on the service as a result of the pandemic. These staff deployed were from a number of different disciplines across the service including: medical secretaries, HR staff, medical staff, nurses and midwives, Allied Health Professionals and Dental / Oral Health staff. Examples of redeployment are given below:

- Nurses were redeployed to our Intensive Care and High Dependency Units, our Combined Assessment Units, District Nursing Teams and our specific COVID 19 wards
- Staff from Public Health teams were deployed into our Test and Protect team and the Community Testing Hub
- Administration staff took on roles as Ward Clerks and supported our hospital front doors and reception desks

- Staff in our Occupational Health Team worked in our Staff Hub and took on new roles to assist with Face Fit Testing
- Medical staff were deployed to work across different specialties and support care using their skills in areas such as our Emergency Departments
- In addition, laboratory staff were redeployed from pathology to microbiology to meet increased demand for COVID-19 testing

Turning to the use of the Golden Jubilee and the NHS Louisa Jordan I can advise that we are accessing these facilities as follows;

Golden Jubilee National Hospital

- Breast Surgery : 3-4 patients per week with an anticipated 70 patients by March 2021 (started mid-August)
- Colonoscopy : 16 per week per week with an anticipated 450 patients by March 2021 (started mid-July)

Louisa Jordan Hospital

- Dermatology clinics – 80 patients per week (expected to start from early October)
- Gastroenterology clinics – 40 patients per week (expected to start from early October)
- Orthopaedics (shoulder & hands) – 20 patients per week (expected to start from early October)
- Orthopaedics (general clinics) – details still being worked through

Second Wave

Our plans do not assume a specific second wave but have been prepared to enable our services to flex to meet changes in Covid 19 and suspected Covid 19 demand. We have developed the planning with learning from the initial response, most notably how we will deploy our Critical care. Learning in Phase 1 showed us that maintaining a separate COVID ICU at both University Hospital Ayr (UHA) and University Hospital Crosshouse (UHC) was very challenging and the resource required to do this had a negative impact on the capacity to continue providing planned surgery. As a result we are preparing for future Covid 19 demand by consolidating the COVID ICU onto one hospital site, in an area which can be expanded and contracted as the COVID ICU demand dictates, with 4 distinct stages of expansion possible. This in turn has allowed us to have a more deliberate plan around ongoing delivery of planned surgery. The trigger points for the various red ICU expansion stages are based on the number of COVID ICU patients in the hospital at any given time.

The provision of protected, low risk bed capacity for specific categories of elective patients is also a key consideration in our plan. COVID-19 bed provision has identified 125 acute hospital beds, and although some of this capacity is new, funded bed capacity, some of this will result from the cancellation of some elective surgery. Furthermore, normal seasonal unscheduled care demand is likely to add further pressure to bed availability which may impact on elective surgery.

Learning from Phase 1, and in order to partially mitigate the need to cancel planned operations, the COVID bed-modelling has planned for a greater proportion of the overall COVID beds on the UHC site, and a lesser proportion at UHA. The principle is to focus and protect more of the elective surgery at UHA. Of note in particular is the plan to locate all inpatient elective orthopaedics surgery at UHA.

Detailed bed modelling has been completed, allowing us to more closely follow the demand for inpatient beds, and to understand how much of this demand relates to COVID and how much to non-COVID unscheduled care. The bed model helps to identify when trigger points to open additional COVID capacity have been reached.

Specifically, trigger points will be determined by the use of critical care and inpatient beds which would result in the stepped changes in bed use that have been agreed with our clinical teams.

Cost Benefits and Shifting the balance of care

Turning now to the response provided by Derek Lindsay in Column 7 and the specific matter of costs. An example that would illustrate Derek's answer is not related to Covid 19 but demonstrates costs associated with delivering the right care in the right place. In 2018/19 the Board agreed a case for change that introduced Intermediate Care and Rehabilitation Teams within the Health and Social Care Partnerships. This investment supported care as close to home as possible and also discharge from hospital. The cost of the service was circa £1million but the benefits were avoiding hospital admission where appropriate by providing care at home, reduction in length of stay by supporting effective discharge and contributing to improvement in unscheduled care.

With regard to Hazel Borland's comment about cost benefit analysis in Column 6 I can advise the Committee that we have not undertaken such an analysis. However in relation to Mr Whittle's question I can advise that we understand the costs of acute hospital stays and how they compare to care homes and care at home.

In regard to the discussion at Column 20 we are not able to quantify changes in where care is provided. We have responded flexibly in recent months and seen many different ways of providing care and sought to manage care needs in the most appropriate setting. The increase in the use of digital demonstrates that some hospital consultations can take place in the citizen's home and could be considered as a shift in where care is provided. We will require to review all changes and where clinically sustainable we would want to embed change that may in turn lead to a shift in the balance of care.

Testing Capacity

In response to the question on testing capacity I can advise that at the time of this response NHS Ayrshire and Arran has a laboratory capacity to analyse 3430 samples per week which is sufficient to meet our needs alongside the lighthouse capacity.

Funding

I will now turn to the questions on funding addressing each one in turn;

- The figure of £67million refers to the financial year 2020/21
- Funding received to date includes £8.4 million transferred to Councils, £792k for Ayrshire Hospice and £1.6million for Health Board costs. Other Health Board costs for quarter 1 will be allocated in September. Spend in quarter 1 was circa £9million for our three Health and Social Care Partnerships and circa £9million for other health services costs. It is worth noting that of the £9million for health services costs there is an offset of £5million due to underspend on supplies and staff redeployment All of these additional costs are related to the impact of Covid 19
- The Health and Social Care partnership spend will be approximately 50% of the £67million forecast, with most of this being on social care
- Remobilisation costs included in this forecast include additional elective activity (£4.3million), costs for redesigning urgent care services (£1 million), as well as costs associated with Test and Protect (£2 million)
- The attached spreadsheet details estimated costs for the year

The Committee asks for detail on the arrangements and costs for PPE. Over £5 million of the £67 million estimated cost is for PPE. Almost all of this is under Health and Social Care Partnership costs as PPE supplied to NHS Ayrshire and Arran comes from national procurement with the costs met by Scottish Government. Councils and private care homes are expected to procure their own PPE and only if this supply chain fails would they receive it free of charge from the national supply. Private care homes can seek reimbursement for the additional costs of PPE under sustainability payments.

Restoring services

I shall now address the difference in response in Column 7 and Column 5. Derek Lindsay was referring to the occupancy levels in our hospitals. As we have moved through the summer months we have seen an increase in emergency attendances and in recent weeks we have seen the occupancy levels in our hospitals reach 90%. Hazel Borland in her response was referring to the activity levels in theatres which are approximately 50% of the activity levels pre Covid. This reduction is due to the need to meet the infection control requirements between patients.

Ministerial Steering Group

The last area that the Committee has requested further information relating to is the Ministerial Strategic Group for Health and Community Care – Review of Progress with Integration of Health and Social Care. In response to the proposals within the document Partners were asked to complete a self-evaluation with 4 possible ratings – not yet established, partly established, established, and exemplary. I attach the self-evaluation submissions for the 3 Health and Social Care Partnerships for Ayrshire and Arran which were presented to the Board's Performance Governance Committee in May and August 2019.

Please note the self-evaluation reports have not been updated since last year however I can confirm we have continued to work collectively across all 3 Partnerships to continue to take forward improvements. With a key focus on Directions NHS Ayrshire and Arran have worked with colleagues to support the Scottish Governance Guidance issued in 2019.

I trust this additional information is helpful to the Committee.

Yours sincerely

Mr John G Burns
Chief Executive

Enc. Health and Sport Committee Summary
East Ayrshire HSCP - MSG Self Evaluation Summary
North Ayrshire HSCP - MSG Self Evaluation Summary
South Ayrshire HSCP - MSG Self Evaluation Summary

NORTH AYRSHIRE HSCP – MSG INTEGATION REVIEW LEADERSHIP GROUP SELF EVALUATION SUMMARY				
Feature supporting integration	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
1. Collaborative leadership and building relationships				
1.1: All leadership development will be focused on shared and collaborative practice			√	
1.2: Relationships and collaborative working between partners must improve			√	
1.3: Relationships and partnership working with the third and independent sectors must improve			√	
2. Integrated finances and financial planning				
2.1: Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration			√	
2.2: Delegated budgets for IJBs must be agreed timeously			√	
2.3: Delegated hospital budgets and set aside budget requirements must be fully implemented		√		
2.4: Each IJB must develop a transparent and prudent reserves policy			√	
2.5: Statutory partners must ensure appropriate support is provided to IJB S95 Officers.				√
2.6: IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.		√		
3. Effective strategic planning for improvement				
3.1: Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.			√	
3.4: Improved strategic planning and commissioning arrangements must be put in place.		√		
3.5: Improved capacity for strategic commissioning of delegated hospital services must be in place.		√		
4. Governance and accountability arrangements√				
4.1: The understanding of accountabilities and responsibilities between statutory partners must improve.			√	
4.2: Accountability processes across statutory partners will be streamlined.			√	
4.3: IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.			√	
4.4: Clear directions must be provided by IJB to Health Boards and Local Authorities.		√		
4.5: Effective, coherent and joined up clinical and care governance arrangements must be in place.			√	

NORTH AYRSHIRE HSCP – MSG INTEGATION REVIEW LEADERSHIP GROUP SELF EVALUATION SUMMARY				
Feature supporting integration	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
5. Ability and willingness to share information				
5.1: IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.			√	
5.2: Identifying and implementing good practice will be systematically undertaken by all partnerships.				√
6. Meaningful and sustained engagement				
6.1: Effective approaches for community engagement and participation must be put in place for integration.				√
6.2: Improved understanding of effective working relationships with carers, people using services and local communities is required.				√
6.3: We will support carers and representatives of people using services better to enable their full involvement in integration.				√

SOUTH AYRSHIRE HSCP – MSG INTEGATION REVIEW LEADERSHIP GROUP SELF EVALUATION SUMMARY				
Feature supporting integration	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
1. Collaborative leadership and building relationships				
1.1: All leadership development will be focused on shared and collaborative practice		X		
1.2: Relationships and collaborative working between partners must improve		X		
1.3: Relationships and partnership working with the third and independent sectors must improve			X	
2.1: Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration		X		
2.2: Delegated budgets for IJBs must be agreed timeously		X		
2.3: Delegated hospital budgets and set aside budget requirements must be fully implemented		X		
2.4: Each IJB must develop a transparent and prudent reserves policy		X		
2.5: Statutory partners must ensure appropriate support is provided to IJB S95 Officers.		X		
2.6: IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.		X		
3.1: Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.			X	
3.4: Improved strategic planning and commissioning arrangements must be put in place.		X		
3.5: Improved capacity for strategic commissioning of delegated hospital services must be in place.		X		
4.1: The understanding of accountabilities and responsibilities between statutory partners must improve.		X		
4.2: Accountability processes across statutory partners will be streamlined.		X		
4.3: IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.			X	
4.4: Clear directions must be provided by IJB to Health Boards and Local Authorities.		X		
4.5: Effective, coherent and joined up clinical and care governance arrangements must be in place.			X	

SOUTH AYRSHIRE HSCP – MSG INTEGATION REVIEW LEADERSHIP GROUP SELF EVALUATION SUMMARY				
Feature supporting integration	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
5. Ability and willingness to share information				
5.1: IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.			X	
5.2: Identifying and implementing good practice will be systematically undertaken by all partnerships.			X	
6.1: Effective approaches for community engagement and participation must be put in place for integration.				X
6.2: Improved understanding of effective working relationships with carers, people using services and local communities is required.				X
6.3: We will support carers and representatives of people using services better to enable their full involvement in integration.			X	

APPENDIX I – SUMMARY RATING TABLE

Feature supporting integration	Not yet established	Partly Established	Established	Exemplary
Collaborative leadership and building relationships				
1.1: All leadership development will be focused on shared and collaborative practice				√
1.2: Relationships and collaborative working between partners must improve				√
1.3: Relationships and partnership working with the third and independent sectors must improve				√
Integrated finances and financial planning				
2.1: Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration			√	
2.2: Delegated budgets for IJBs must be agreed timeously		√		
2.3: Delegated hospital budgets and set aside budget requirements must be fully implemented		√		
2.4: Each IJB must develop a transparent and prudent reserves policy			√	
2.5: Statutory partners must ensure appropriate support is provided to IJB S95 Officers.			√	
2.6: IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.			√	
Effective strategic planning for improvement				
3.1: Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.				√
3.4: Improved strategic planning and commissioning arrangements must be put in place.			√	
3.5: Improved capacity for strategic commissioning of delegated hospital services must be in place.		√		
Governance and accountability arrangements				
4.1: The understanding of accountabilities and responsibilities between statutory partners must improve.				√
4.2: Accountability processes across statutory partners will be streamlined.				√
4.3: IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.				√
4.4: Clear directions must be provided by IJB to Health Boards and Local Authorities.			√	
4.5: Effective, coherent and joined up clinical and care governance arrangements must be in place.			√	

Feature supporting integration	Not yet established	Partly Established	Established	Exemplary
Ability and willingness to share information				
5.1: IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.				√
5.2: Identifying and implementing good practice will be systematically undertaken by all partnerships.				√
Meaningful and sustained engagement				
6.1: Effective approaches for community engagement and participation must be put in place for integration.				√
6.2: Improved understanding of effective working relationships with carers, people using services and local communities is required.				√
6.3: We will support carers and representatives of people using services better to enable their full involvement in integration.				√

			Revenue	Capital
Health Board Spend	Apr to Jun Actual £000	Jul to Mar Forecast £000	2020/21 £000	2020/21 £000
Additional Hospital Bed Capacity/Costs - Maintaining Surge Capacity	3,582	7,531	11,113	694
COVID-19 screening and testing for virus	136	1,414	1,550	563
Personal protective equipment	226	90	316	-
Deep cleans	32	787	819	-
Mortuary Costs	-	57	57	-
Equipment & Sundries	64	192	257	-
Digital, IT & Telephony Costs	246	68	314	-
Estates & Facilities cost including impact of physical distancing measures	345	580	925	-
Additional staff overtime and enhancements	476	1,429	1,906	-
Additional temporary staff spend - Returning Staff	20	-	20	-
Additional temporary staff spend - Student Nurses & AHP	824	1,034	1,858	-
Additional Temporary Staff - CNO Care Home Additional Responsibilities	-	269	269	-
Additional temporary staff spend - All Other	592	1,776	2,369	-
Loss of income	-	455	455	-
Cost to 3rd Parties to Protect Services (where services are currently stopped)	-	532	532	-
Contact Tracing Costs	-	733	733	-
Louisa Jordan costs	25	76	102	-
Public Health	136	326	462	-
New ways of working/ Systems transformation	-	1,166	1,166	-
Managing Backlog of Planned Care	-	4,177	4,177	-
Winter Planning	-	355	355	-
HR Staff Hub	26	156	182	-
Ayrshire Hospice	792	471	1,263	-
Medical Staffing	166	-	166	-
Clinical Development Fellows for ITU capacity	-	264	264	-
Public Protection	-	84	84	-
Stroke	-	290	290	-
Rehabilitation	-	1,290	1,290	-

Enhanced Public Health Support Team	-	284	284	-
IPC Team	-	216	216	-
Offsetting savings - Health	(5,090)	(3,200)	(8,290)	-
Total	**2,598**	**22,905**	**25,504**	**1,257**
Expected underachievement of savings (Health)	1,287	6,760	**8,047**	**0**
Total	**3,885**	**29,666**	**33,551**	**1,257**

			Revenue	Capital
H&SCP Costs- Summary	**Apr to Jun actual**		**2020/21**	**2020/21**
Delayed Discharge Reduction- Additional Care Home Beds	419	251	670	-
Delayed Discharge Reduction- Additional Care at Home Packages	97	145	242	-
Delayed Discharge Reduction- other measures	254	657	911	-
Delayed Discharge Reduction- other measures	337	(2)	334	-
Personal protective equipment (Excludes External Provider PPE)	1,818	3,162	4,980	-
Deep cleans	3	73	76	-
Estates & Facilities cost including impact of physical distancing measures	90	96	186	-
Additional staff Overtime and Enhancements	492	1,259	1,751	-
Additional temporary staff spend - Student Nurses & AHP	540	743	1,283	-
Additional temporary staff spend - Health and Support Care Workers	192	675	867	-
Additional temporary staff spend - All Other	-	60	60	-
Additional costs for externally provided services (including PPE)	1,146	2,243	3,389	-
Social Care Support Fund- Costs for Children & Families Services (where delegated to HSCP)	-	20	20	-

Cost to 3rd Parties to Protect Services (where services are currently stopped)	-	199	199	-
Additional costs to support carers	1	9	10	-
Mental Health Services	21	1,764	1,785	-
Additional payments to FHS contractors	1,459	338	1,797	-
Additional FHS Prescribing	-	6,079	6,079	-
Community Hubs	425	1,591	2,016	-
Other community care costs	306	556	862	-
Loss of income	689	767	1,455	-
Additional Travel Costs	6	-	6	-
Digital, IT & Telephony Costs	54	72	126	-
Equipment & Sundries	77	99	176	-
Children and Family Services	60	389	449	-
Prison Healthcare Costs	-	184	184	-
Costs associated with new ways of working- collaborative	-	98	98	-
Winter Planning	-	355	355	-
Additonal Care Home Beds (not delayed discharge)	213	278	490	-
Additional Care at Home Packages (not delayed discharge)	117	843	959	-
Other (EAST)	50	172	221	-
Other- Security Costs PPE Store	24	24	48	-
Additonal Flu Vaccination Costs (Consumables)	-	599	599	-
Additonal Flu Vaccination Costs Staff	-	120	120	-
Offsetting cost reductions - HSCP	(754)	(731)	(1,484)	-
Total	**8,134**	**23,186**	**31,320**	**-**
Expected underachievement of savings (HSCP)	933	1,468	2,401	
Total	**9,067**	**24,654**	**33,721**	**0**