Lothian NHS Board

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Lewis Macdonald
Convener
Health & Sport Committee
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Date 20 October 2020
Your Ref
Our Ref CC/EW

Dear Mr Macdonald

Thank you for your letter of 7 October where you have raised a few supplementary questions further to our evidence to your Committee on 15 September 2020.

I have attempted to detail below responses to each of the questions asked:

Q: Could you indicate to what extent the suggestion that we could not operate without fewer beds because of moving care into the community suggest a narrative requiring ever increasing funding for the health service:

A: The specific reference I was making was to a suggestion that shifting the balance of care from acute to community/primary care could be financed through the closure of acute beds. I do not believe there is an evidence base to support this. To see a reduction in acute beds you would have to recognise that the UK has one of the lowest rates of acute beds in Europe per 100,000 population. In recent years the occupancy levels within hospitals have been increasing significantly, and are regularly above 90% which is generally regarded as the tolerance level for safety. Therefore, whilst I support more care being provided in primary and community care, it will require additional finance or it will require other alterations in how we deliver health services.

Q: Set aside budgets:

A: I think the comments made by Susan Goldsmith need to be set in the context of this year's activity levels being abnormal due to the Covid pandemic and therefore we need to be careful when examining the activity levels that they are seen in the context of an abnormal period. It doesn't seem wise from my perspective to use this period as a baseline for planning bed occupancy levels over longer periods of time.

In relation to the specific query on operating the set aside budget on activity levels, we have an arrangement with IJBs which allocates set aside budgets and costs on the basis of an NRAC derived model. Our plan for the future is to move to an activity based approach for allocating cost, although NRAC will remain as the principal allocation methodology for budgets. However our modelling on future activity levels indicates that any reduction in activity demand driven by IJBs, is likely to be required for future demand driven by the demographic growth predicted for Lothian.

In addition to the point above you were looking for additional information on my views on the need for more single room accommodation and questioning why we need to utilise all available accommodation to address waiting lists. The reality is single room accommodation is more expensive than 6 bedded bays, it requires more floor area which increases capital and facilities costs, and due to the challenges of line of sight/visibility it incurs higher staffing costs. There are clearly benefits for patients, the most obvious one currently is reducing the risk of infection. That said, the issue of waiting times is important and it is imperative that recognition is given to the fact that NHS Lothian, the second largest Health Board in Scotland, continues to be materially below its NRAC share for resources allocation. The formula itself reduces Lothian's population share due to a relatively young age/sex and morbidity/life circumstances and remoteness adjustments compared to other Boards. Therefore our movement from population to NRAC share is more stark than most Boards, resulting in the Board receiving a lower NRAC share than nearly all other Boards. The direct consequence of this is that NHS Lothian does not have the capacity to meet all the demands upon it and this places a significant pressure on the Board in delivering against waiting time targets.

I agree with the principles behind NRAC which aim to target funding at the most disadvantaged populations, however as there isn't a direct correlation between the level of funding and the healthcare targets that are part of the performance framework for the NHS Board, NHS Lothian is disadvantaged.

Q: Preventative activities within the Health Board:

A: NHS Lothian is similar to other Health Boards in carrying out a full range of preventative activities. These range from traditional health improvement interventions around smoking cessation, child smile, promotion of exercise and weight management through to a wide range of health screening and health education activities. The most important preventative activity that we are taking forward this winter is the flu immunisations as we are concerned about concurrent

episodes of significant challenges such as flu and Covid and we are also planning for what we hope will be a vaccine for Covid later this year or early in 2021.

Q: The need to run services concurrently:

A: The pandemic has resulted in many new and innovative ways of delivering healthcare that would have normally taken us significantly longer to implement. This is positive and we need to do a full evaluation of these to assess the effectiveness of many of these but they have certainly helped mitigate some of the negative effects of the pandemic. That being said, the pandemic has resulted in a massive increase in waiting times across specialties as we have had to clinically prioritise emergency and urgent care during this period; it would therefore only be possible to deliver immediate savings if we were to accept that the waiting times that we now have were to become the new normal and I do not believe that this would be acceptable to the population that we serve. It is therefore inevitable in my opinion that there will have to be a period of double running as we further invest in, and optimise, technology whilst also trying to recover much of the scheduled care work that has been delayed as a result of the pandemic. Even with this, any savings in infrastructure, or staffing levels generated from delivering services differently are likely to be required to support not only recovery but demand generated by the future demographic growth predicted for the Board, as indicated above.

Q: Planning for the return of Universities:

A: The specific question is around how the needs of the student population are factored into our delivery plans. There was significant work involved with the Universities in advance of their return. This included discussion and agreement on respective roles and responsibilities. We were clear that the role of the NHS was around testing and tracing in addition to supporting the Universities around health education, health promotion and infection control measures with the Universities taking a lead on accommodation and social support. The student population therefore were a specific focus in the delivery plans. They were recognised as a high-risk group but the importance or remobilising society, investing in the future and the development of the workforce were all considered to be imperative actions for both the NHS and the Universities to progress.

Q: Community assessment centres and hubs during the pandemic:

A: The arrangements in NHS Lothian for community assessment centres and the staffing of them by GPs is very similar to that provided in Greater Glasgow and Clyde. The GPs who committed to manning the community assessment centre were in receipt of additional payments beyond their existing contractual requirements as independent contractors.

Q: Could you indicate what monitoring arrangements are in place in relation to GP activity and how these are linked to the new GMS contract:

A: The new GP contract introduced in 2018 took a different direction to the previous contract which involved significant monitoring through the "Quality and Outcomes Framework" (QOF).

There were three elements to the pre 2018 contract. QOF which tracked GP activity on a wide range of clinical indicators and paid practices based on this data. "Enhanced Services" which generally involved detailed monitoring and payment to practices for a limited range of specific services. "Core services" where the practice was paid a sum based on a formula for providing core services to its patients but which was not monitored in detail.

The 2018 contract introduced the concept of the GP as "expert medical generalist" overseeing the work of an extended multidisciplinary team, removed QOF and consolidated the funding into core services. Monitoring remains for enhanced services. There is no detailed monitoring of "core services" in the new contract. Practices are expected to produce an annual return on their compliance with the contract but this does not include details of activity provided.

There is a "payment verification" regime managed by National Services Scotland which will look in detail at payments to practices on a sample or exception basis.

Q: Indicate to what extent the Board monitors outcomes from this work to satisfy itself in relation to value for money:

A: Enhanced Services are monitored annually and payments made to practices are determined by the level of participation and activity. Payment verification activity is monitored annually and is reported to the Board's Finance and Resources Committee.

More broadly the new GP Contract involved significant investment in NHS Board managed *services to move workload from general practice. The implementation of these* services, tracking the spend involved and assessing the impact is done through a "GMS Oversight Group" that involves the Board, The HSCPs and the GP Sub Committee. This group reports to the Board's Healthcare Governance Committee. The monitoring involves scrutiny of "trackers" completed by HSCPs for the Scottish Government, oversight of problems with accessing general practice, assessment and problem solving for practices in difficulty and practices that have moved into NHS Board direct management.

Yours sincerely

CALUM CAMPBELL
Chief Executive