Greater Glasgow and Clyde NHS Board

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Lewis McDonald
Convener, Health and Sports Committee
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The Scottish Parliament
Edinburgh
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Date: 22nd October 2020
Our Ref: JG/LLPAE

Dear Mr McDonald

Thank you for your letter dated 7th October 2020 regarding myself and our Director of Finance's recent appearance at the Health and Sport Committee. We are pleased you found our submission, and the information presented, helpful.

Please find the following responses to the further questions in your letter:

Funding and Additional Costs

- *Do all of the above figures exclude PPE?*

  The figures quoted in your letter include only the costs of local spending on PPE for both the Board and IJBs. It should be highlighted that the large majority of PPE was supplied directly from the National Distribution Centre, funded directly by the Scottish Government.

- *What other costs are excluded as being met directly by the Scottish Government?*

  The Scottish Government are allocating and distributing COVID-19 and Remobilisation funding on a phased basis. The October 2020 allocation (as referred in your letter) does not include any funding for a number of direct costs, opportunity costs and new initiatives e.g. unachieved savings, winter planning, unscheduled care, an element of social care payments to third parties etc.

  These areas will be discussed on an individual basis with each Board and may form part of funding allocations later in the year. Only then will it be possible to determine what costs are being met directly by the Scottish Government.

- *Do your current estimated costs remain at the levels stated above and how much additional funding are you expecting in the January allocation referred to?*

  Yes, our costs remain as quoted to the Committee at £334m for the Board and IJBs (including Social Care). We are anticipating further funding in the January 2021 allocation, although at this stage of our negotiations with the Scottish Government, it is too early to determine exactly how much.

- *Is all the additional funding required by the HSCPs being routed through the Health Board? If so, at what point are these sums transferred to the HSCP – is the HSCP required to demonstrate expenditure incurred before receiving the funding?*

  All COVID-19 related funding for HSCPs is routed via the Health Board. It is transferred to the HSCPs when the allocation is confirmed in writing (the formal allocation letter) from the Scottish Government.

  There has been no requirement so far to demonstrate that expenditure has actually been incurred as funding received to date has mainly been payments on account for third party providers. The exact costs will be reconciled when the final invoices are received from the external suppliers.

- *Are you anticipating the unachieved saving figure of £70m to be included in the allocations from the Scottish Government?*

  We are in negotiations with the Scottish Government around that issue and that figure. The Board started the year with a savings target of £108m and anticipate achieving £30m to £40m against that. As such, we do anticipate the Scottish Government supporting the Board for at least an element of the remainder.

- *If not what impact will there be on end year balances?*

  If the Board does not receive the £70m unachieved savings, there is a real risk to the Board breaking even in-year. We would be required to revisit certain areas of our Remobilisation Plan to ensure affordability. However, as outlined above, we are continuing our negotiation with the Scottish Government to secure the appropriate level of funding to achieve break-even.

GP Costs

- *The Committee recognise the role of the GP within the community assessment centres and hubs, can you confirm this role was undertaken as part of existing contractual requirements as independent contractors and what if any additional payment was made to them for this.*

  There was, and continues to be, a mixed model of engagement for GPs working in the Community Assessment Centres and the Hub. A number are engaged in the Centres in agreement with their practice and paid via their Practice, with backfill funding provided to the practice. The remainder were engaged via the GP Out of Hours bank contract and associated agreed pay rates. This was to ensure parity across in hours and Out of Hours. The additionality is the GP costs highlighted in the overall COVID-19 costs for the HUBs and the Centres.

- *You also explained monitoring arrangements that are in place and how these linked to the new GMS contract (col 22). To what extent does the Board monitor outcomes from this work to satisfy yourselves in relation to value for money?*

  Outcomes for the new GMS contract and the Primary Care Improvement Plans are assessed in a range of ways to ensure impact and value for money:

  - The National Monitoring and Evaluation framework for the new GP contract which sets out high level indicators tracked over a 10 year period as well as evaluation of specific elements of change. This will consider how the changes brought in by the new contract contribute to the national Primary Care Outcomes as part of the contribution of primary care to the wider health and social care outcomes.
  - Local evaluation framework within NHSGGC focusing on outcomes at patient, practice and wider system level issues.

- Use of improvement methodology as part of the implementation of the new Multi-Disciplinary Team working with practices to gather local data on the impact of change as part of a cycle of continual improvement and to inform the further development of the new models.
- Funding based on submission of activity for certain Enhanced Services.
- Cluster based approach to quality improvement across groups of practices, supported by Cluster Intelligence Reports to enable peer review and sharing of good practice.
- Additional COVID-19 funding to practices was managed through a claims and approvals process in conjunction with Practitioner Services, and all practices opened on the public holidays in April and May, supported by this funding.
- Payment verification for independent contractor services carried out by Practitioner Services (NSS) for all Boards.
- Prescribing Support Pharmacists working with each practice to ensure prescribe efficiency and effectiveness.

- *Could you also advise on respective workloads of GPs before and since the crisis which I think you indicated were covered by the GMS contract (col 22).*

  All 234 GP practices in NHSGGC continue to provide General Medical Services as they have throughout the whole pandemic period. All GP practices have been operating with a telephone first model of triage and telephone or online assessment, with face to face consultation where required. Patient demand for General Medical Services initially reduced in March/April 2020, with the suspension of national screening programmes and reduction in routine attendances; during this period, practices took on additional work to identify and support shielding patients, implement new ways of working, and providing support and advice where other services were not operating, the range of services which GPs could refer to significantly reduced during that time.

  The requirement for Care Home support has been significant, particularly in homes where there have been outbreaks. From June 2020 onwards, demand started to increase again in practices in line with national messaging encouraging patients to attend their GP and remobilisation planning for chronic disease management reviews and the restart of cervical screening from July 2020.

  Practices report levels of demand rising again into the Autumn/Winter with high numbers of phone calls and requests for appointments. Demand for mental health support has been particularly highlighted. There is currently no national routine data collection on workload and activity in GP practices to enable a numerical assessment of changes in workload over this period, however we are regularly in contact with practices about current pressures.

Prioritising Missed Patients

- *Could you elaborate on this (patients prioritised on the basis of clinical need) please and indicate how this assessment is being taken forward including the input of patients and the extent to which their actual current position is taken into account.*

  All patients on the waiting list have been reviewed by a senior Clinician and have been prioritised according to the guidance, issued by Royal College of Physicians and Surgeons in April 2020.

  Patients are prioritised on the basis of P1 to P4 with P1 being the most urgent cases, with treatment required within 3 days. The timescales for the other priorities are:

  - P2 within 4 weeks,
  - P3 within 3 months; and
  - P4 > 3 months.

Each specialty waiting list is kept under regular review by clinical teams.

All patients on the waiting list are contacted by the waiting list team every 12 weeks to advise of the current situation and to keep in contact with patients. Patients are issued advice about what to do if they feel their condition has deteriorated.

When theatre space becomes available patients are listed for surgery on the basis of clinical need and then strict date order.

We trust you find these responses satisfactory. Please do not hesitate to contact me with any further issues or queries.

Yours sincerely

Jane Grant
Chief Executive
NHS Greater Glasgow and Clyde