A: Budget setting process

Performance budgeting

1. Which of the following performance frameworks has the most influence on your budget decisions:
   - National Performance Framework
   - Quality Measurement Framework (including HEAT targets)
   - Other (please specify)

   The primary influence on budget decisions was the quality measurement framework which included those set out in the HEAT targets

   In addition to this framework, NHS Shetland was also influenced by the Board's vision, values and objectives to deliver our local 20:20 vision.

2. Please describe how information on performance influences your budget decisions:

   The information aided the Board in identifying some priorities for potential investment and also identifying potential pressure points in service delivery that required further scrutiny to understand the root cause and explore sustainable solutions

3. Do you consider the performance framework(s) to reflect priorities in your area?

   Broadly, although the Quality Measurement framework remains skewed to Acute Services measures. This could distort investment decisions away from the overall 20:20 vision for the Scottish health service.

4. Where allocations are made in relation to specific targets, are you able to spend this effectively in the required areas? (please provide examples where relevant)

   Generally we are able to use targeted allocations effectively, although the method of delivering these objectives is not uniform. For example, in many cases these are delivered in Partnership and the NHS is not solely responsible for delivering the services.

   A number of examples are given below:
   Shetland Alcohol and Drug Partnership (SADP) is a partnership arrangement responsible for the local commissioning of services.

   An example of two of the services SADP supports are:
   a. Community Alcohol & Drugs Services Shetland (CADSS)
   b. Community bike project

CADSS is an independent voluntary organisation that provides a range of free confidential services to those affected by alcohol/drug use in Shetland. They offer support, information, practical help and training and work alongside partner agencies to help people rebuild their lives and create healthier futures.

The Community Bike Project works with people affected by alcohol/drugs to learn new skills, re-integrate into society, re-establish a daily routine and get back into work.

The Health Improvement Team leads on the Effective Prevention Bundle but works in partnership with local independent practitioners, third sector organisations and communities themselves, for instance utilising the Shetland Communities portal to highlight public health campaigns. One of the popular schemes at improving physical exercise has been the walking groups.

Integration of health and social care

5. Please set out, as per your integration plans/schemes with each of your partner local authorities, the method under which funding for the joint boards will be determined?

   Shetland Health Board has a single local authority partner, Shetland Island Council.

   The development of the model for integration and the scheme has been developed in partnership with and approved by the elected members of the council and directors of the health board in February 2015.

   The core services involved within the partnership are primarily the council and health board services that were within the Community Health Partnership with the hospital services identified in the legislation added to this.

   The entire draft budgets for 2015-16 for both respective organisations were agreed in December 2014. During the process a joint budget setting session was held were elected members and NHS board members met to hear presentations on the budget proposals for services covered by integration and ask questions in respect of the proposal.

   For the first year of the Integrated Joint Board, the budgets have been primarily based on historical patterns of service delivery, adjusted for relevant priorities, efficiencies and agreed Service development and change.
   In future years the budget will be influenced by the jointly developed Commissioning plan and strategic plans of both the NHS board and Shetland island council.

   It is expected in the future that this will also be influenced by joint participatory budgeting arrangements.

6. What functions will be delegated via the integration plan/scheme? Please explain the rationale for these decisions

   Guidance issued nationally to aid the correct interpretation of the regulation has been utilised to understand the underlying principles.

   However in addition to this there has been some local pragmatism that reflects both the unitary nature of the Health Board and local authority boundaries and balancing this with the practicalities of the diseconomies of scale of providing sustainable quality services in a remote and rural setting.

7. How much is being allocated to the Integration Joint Board for 2015-16?
   a. by the health board £18.1m
   b. by local authority partners £19.7m

   Details of this are set out in the accompanying spreadsheet.

8. Please provide any further comments on budgetary issues associated with integration:

   The philosophy behind setting the integration scheme budget has been viewed as evolutionary and pragmatic in nature as this will develop flexibly over time rather than be fixed at this moment in time.

   The health board and local authority have entered the process as a positive partnership for developing in partnership strategies to focus on and meet the needs of local population in Shetland

Specific challenges

9. Please provide details of any specific challenges facing your board in 2015-16 in respect of your budget:
   Ongoing delivery of efficiencies, due in part to the diseconomies of scale of delivering health care in a remote and rural settings and where a number of services run at a de-minimus level to ensure equity of access to services.

   Ongoing delivery of efficiencies set against high level of performance targets and increasing demand.

   Increased cost of medicines / high cost drugs

B: Increase the proportion of babies with a healthy birth weight
Indicator measure: The proportion of new born babies with a weight appropriate for gestational age

1. How does performance in your area compare with the national performance?

	% of new born babies with a weight appropriate for gestational age	
	Board	Scotland
2009	90.2%	89.6%
2010	91.2%	90.0%
2011	89.7%	90.1%
2012	87.5%	89.9%
2013	86.5%	90.1%

Source: http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/birthweight

2. What factors can help to explain any observed differences in performance?

   Shetland's numbers are small, and so one or two births of low (or high) birth weight babies in a year makes a difference to the % equivalent to the difference to Scotland. In recent years we have seen an increase in overweight women presenting in pregnancy.

3. How does performance against this indicator influence budget decisions?

   The underlying reasons for low and high birth weight drive local programmes for prevention and early intervention, specifically the local focus within the Early Years Collaborative (EYC) on vulnerable women in early pregnancy to address the wider social factors linked to deprivation and substance misuse, and work on obesity and smoking both pre-pregnancy and in early pregnancy. In Shetland, we do not have programme budgeting linked to separate programmes within health improvement or maternity services – targeted programmes within these services are undertaken by staff within the generic teams working collaboratively, with the exception of the midwife linked to the EYC working with vulnerable women in pregnancy.

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)
   Yes, though difficult to interpret in relation to the small population numbers of the Island Boards, it is difficult to separate out the effect of year on year variation due to small numbers, and genuine trends due to causative factors. The alternative for us is to look at some of the interim measures including indicators of need – numbers of women smoking etc, and outputs – numbers quitting, alongside the outcome measures.

5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the **three** main areas of activity in the table below.

Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Obesity and active weight management through Counterweight	63	63
Early Years Collaborative work with vulnerable women in pregnancy including antenatal parenting and intensive work with families with substance misuse issues		
Improving Maternal and Infant Nutrition	54	54

In Shetland, we do not have programme budgeting linked to separate programmes within health improvement or maternity services – targeted programmes within these services are undertaken by staff within the generic teams working collaboratively, with the exception of some specific midwifery time linked to the EYC working with vulnerable women in pregnancy.

6. What statutory partners or other partners (if any) contribute towards performance in this area?

   All of our local programmes have components worked in partnership with both Local Authority and the voluntary sector – for instance work in schools and with local third sector substance misuse services, with community organisations on physical activity to support work on obesity. The Early Years Collaborative has a range of public and third sector partners on parenting programmes, collaboration with social work, children's services, housing.

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

   Other areas that contribute to performance include:

   - Fairer Shetland anti-poverty work particularly on minimising the impact of welfare reform
   - Healthy Start – we have refocused the local programme to improve uptake, particularly in remote rural areas.
   - The Alcohol Brief Intervention programme with pregnant women and for pre-pregnancy via sexual health services.

C: Improve end of life care
Indicator measure: Percentage of the last 6 months of life which are spent at home or in a community setting

1. How does performance in your area compare with the national performance?

	% of last 6 months of life which are spent at home or in a community setting	
	Board	Scotland
2008-09	92.1%	90.4%
2009-10	90.4%	90.5%
2010-11	91.3%	90.7%
2011-12	91.6%	91.1%
2012-13	89.1%	91.2%

Source: http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/endoflifecare

2. What factors can help to explain any observed differences in performance?

   Although performance in 12-13 is slightly lower than over the previous 4 years, the numbers of deaths per year are relatively low in Shetland. At service level every effort is made by staff to support an individual's choice. There are individuals who choose to die in hospital- we have no hospice beds in Shetland.

3. How does performance against this indicator influence budget decisions?

   There is a commitment to support delivery of care including end of life care in community settings.

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

   Yes, however the indicator does not recognise what the individuals choice was.

5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the **three** main areas of activity in the table below.

Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Accelerate anticipatory care planning	20	30
Overnight Community Nursing Service	50	50

6. What statutory partners or other partners (if any) contribute towards performance in this area?

   The local authority care at home and care centre services support end of life care. Third sector partners providing home support also contribute to this area.

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

Palliative care and hospice funding

8. Please provide an estimate of spending on palliative care services (as defined by the Scottish Partnership for Palliative Care, here)

	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Specialist palliative care services	147	150
General palliative care services	See note below	See note below

The general palliative care services in a community setting in Shetland are delivered primarily by the community nursing team. The delivery of general palliative care service is part of the holistic care that the team provides in mostly rural setting. At present all the activity that the service undertakes is not recorded so it is not possible to currently allocate a robust proportion of the service costs general palliative care. However the expansion of overnight community nursing service has increased the resilience of this service.

In May 2012, the Scottish Government published new guidance for NHS Boards and independent adult hospices on establishing long-term commissioning arrangements. It stated that funding of agreed specialist palliative and end-of-life care (PELC) should be reached by NHS Boards and independent adult hospices on a 50% calculation of agreed costs. Funding should be agreed for a 3 year period, though this could be longer if appropriate. In addition it indicated intent for NHS Boards and local authorities to jointly meet 25% of the running costs of the independent children's hospices which provide specialist palliative care and respite services for children with life-limiting conditions.

NHS BOARD BUDGET SURVEY

SECTION C Improve end of life care

9. Please provide details of funding agreed by your Board for hospices;

Amounts shown are for the whole of NHS Scotland (Note 1)	2014-15	2015-16
Agreed funding for running costs of independent children's hospices (including local authority funding where relevant) (Note 4)		
£000s (Note 3)	928	970
As % of total CHAS charitable activities (Note 2)	9.5%	9.4%

Notes

1. There is only one independent children's hospice organisation in Scotland, Children's Hospice Association Scotland (CHAS). In order to avoid bureaucracy Health Boards agreed that Tayside Health Board would be the lead funder of CHAS on behalf of NHS Scotland. The figures shown are therefore for the whole of NHS Scotland. CHAS operates two hospice facilities, Rachel House in Kinross and Robin House in Balloch. All fourteen territorial boards contributed to the above cost on an allocation bases and Shetland Health Board currently contributes 0.48% of the NHS contribution.

2. The requirement for Health Boards is to fund 12.5% of hospice running costs. It is not possible to clearly identify the running costs of the hospices themselves, on which the required funding level of 12.5% is calculated. In order to simplify matters and avoid bureaucracy an agreed funding baseline was established in 2009/10, which has been uplifted each year using Health Board percentage uplifts. CHAS management have been content with this pragmatic approach.

   CHAS has provided the total "charitable activities" amount from its accounts as follows:

	2014-15	2015-16
	£000s	£000s
CHAS total charitable activities	9,739	10,336

   CHAS total charitable activities include not only hospice running costs, but also other charitable activities.

3. The analysis of NHS funding paid and payable to CHAS is as follows:

	2014-15	2015-16
Amounts shown are for the whole of NHS Scotland	£000s	£000s
Funding from Territorial Boards	672	691
Funding from Scottish Government (Diana nurse funding)	256	279
Totals	**928**	**970**

4. Health Boards do not have knowledge of the funding provided by Local Authorities.

D: Reduce emergency admissions
Indicator measure: Emergency admissions rate (per 100,000 population)

1. How does performance in your area compare with the national performance?

	Emergency admissions rate (per 100,000 population)	
	Board	Scotland
2009-10	8,157	9,849
2010-11	8,448	9,874
2011-12	9,733	10,090
2012-13	9,914	10,130
2013-14 (p)	8,970	10,188

Source: http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/admissions

2. What factors can help to explain any observed differences in performance?

The admission rate at NHS Shetland is slightly lower that the national figures because a proportion of patients are transferred to mainland specialist centres for tertiary care (and this will account as an observable difference in our data). The trend analysis over the five years shows that the age profile of patients admitted to hospital is aligned to the national picture, particularly the overall trend of increasing admission rate due to demographic changes, increasing patient complexity/frailty and increasing numbers of people presenting with acute psychiatric needs. We have fewer admissions in younger age groups and this could be again explained by the fact that we transfer some of these patients to children's services in mainland Scotland to access specialist input.

3. How does performance against this indicator influence budget decisions?

Admission rates form part of the overall assessment of inpatient utilisation and provision/shape of service development, which influences budget decisions

about investment and disinvestment in models. Admission rates were a key indicator included in the strategic plans for Acute and Specialist Services at NHS Shetland in 2014-15.

The strategic plans can be accessed via the following link (paper 2014/77): http://www.shb.scot.nhs.uk/board/meetings/2014/201412-Boardpack.pdf

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

   Yes

5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the **three** main areas of activity in the table below

Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Developing medical ambulatory care services	£20 (primarily on capital works)	£100
Developing intermediate care services	£341	£300
Enhancing Day Surgical Unit capacity	£50	£126 (In total over two years this capital project is £1,100)

6. What statutory partners or other partners (if any) contribute towards performance in this area?

   NHS 24, Scottish Ambulance Service, NHS Grampian, Shetland Islands Council

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

   The availability of community based services at locality level, effective anticipatory care planning and early supported discharge all contribute to the rate of admission, the appropriateness of hospital admission the length of stay and the quality of patient experience whilst in hospital.

   Performance against delayed discharge target, 4 hour A&E target and theatre cancellations provide good proxy markers for predicting emergency admission rate increases and performance of the whole system.

HEALTH AND SOCIAL CARE INTEGRATION BUDGETS 2015-16		
REVENUE EXPENDITURE BY SERVICE SHETLAND ISLAND COUNCIL	**Annual Budget Total £**	**FTEs**
DELEGATED BUDGET	**19,742,844**	**623.39**
Social Work for All Care Groups	**949,329**	**14.07**
Direct Payments	4,590	0.00
Fieldwork Preventative Services	900	0.00
Social Work	633,350	14.07
Commissioned Services	310,489	0.00
Carers	**86,640**	**0.00**
Respite Care at Home	86,640	0.00
Criminal Justice	**9,834**	**7.49**
Offender Services	-5,899	6.99
Youth Crime	15,733	0.50
Learning Disabilities & Autistic Spectrum Conditions	**4,827,525**	**139.16**
Residential Short Breaks (Respite)	702,266	18.28
Supported Living & Outreach	2,563,340	80.53
Supported Vocational Activity	1,468,974	39.36
Management Costs	92,945	1.00
Physical Disabilities	**1,373,102**	**17.81**
Occupational Therapy		
Specialist Aids	193,792	0.00
Adaptations	355,000	0.00
Community Alarm	18,000	0.00
OT Staffing including Management & Admin	699,446	16.81
Operational Costs	100,334	0.00
Telecare	6,530	1.00
Sensory Impairment	**1,500**	**0.00**
Specialist Equipment	1,500	0.00
Mental Health	**1,748,319**	**56.79**
Mental Health Officer Services	147,159	2.72
Community Mental Health Support Service	1,324,400	39.17
Dementia Services	194,410	13.90
Mental Health Services Management	81,350	1.00
MHO Preventative Services	1,000	0.00
Older People	**10,332,647**	**383.72**
Care Services at Home:		
Personal Care Service	3,560,331	98.83
Domestic Tasks	587,686	33.02
Local Placements	5,458,523	232.64
Mainland Placements	223,505	
Day Care	427,790	18.23
Management Costs	74,813	1.00

HEALTH AND SOCIAL CARE INTEGRATION BUDGETS 2015-16		
REVENUE EXPENDITURE BY SERVICE SHETLAND ISLAND COUNCIL	**Annual Budget Total £**	**FTEs**
Substance Misuse	**177,205**	**1.00**
Rehabilitation Placements	54,500	0.00
Specialist Social Worker	1,505	1.00
Community Alcohol & Drugs Services Shetland	121,200	0.00
Other	**236,743**	**3.35**
Management Costs	236,743	3.35
TOTAL INTEGRATED BUDGET	**19,742,844**	**623.39**

Shetland Islands Health and Social Care Partnership

Summary Financial Funding 2015-16

		Annual Budget £000's	FTEs
1. Resources from Shetland Island Council	Note 1	19,742.8	623.39
2. Resources from Shetland Health Board	Note 2	18,066.1	210.04
Overall Resources		**37,808.9**	**833.43**

Note 3: NHS hospital based healthcare budget amounts for inclusion still to be finalised.