

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)

It is the Quality Measurement Framework which currently has the most influence on our budget decisions. Alongside this is the ongoing monitoring of population health needs.

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

Large variations in performance would trigger consideration of reallocation of budgets.

Information on performance supports any case for service redesign, and often drives it. For instance our high levels of delayed discharges during 2014/15 have provided additional impetus to our work around reducing admissions, unscheduled care, anticipatory care plans and providing more care in the community.

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

Yes to an extent, but they don't completely map to our circumstances – our geography, demography and recruitment and retention issues make delivering on some centrally set performance measures all the more challenging. Our geography presents access challenges in that patients often have to travel by air or ferry for treatment. Our demography currently has a population weighted towards older, including very old, people and considerably fewer people of working age than Scotland overall. In 2013, 13.6% of our population was aged 16-29 years compared with 18.3% of the Scottish population; 20% was aged 60 and over compared with 15.8% in Scotland; 10.4% was aged 75 and over, compared to 8.0%) and by 2037 the Western Isles is predicted to have the highest proportion of people of pensionable age in Scotland, and a 25% reduction in people under the age of sixteen.

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)

In general yes we are able to spend this money effectively, particularly in terms of the bundled allocations. However it can be a challenge as sometimes our pro rata share is a very small sum. This is a particular problem if the expectation is of appointment to a new post, whether short or long term. In addition we are often offered additional funding late in the year on the assumption that we will be able to carry it forward to the following financial

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year (this is something small Boards like us would struggle to achieve). We have, in previous years, had to refuse such offers.

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?

NHS Western Isles has agreed to form an Integrated Joint Board with its co-terminous Local Authority, Comhairle nan Eilean Siar. Funding is being determined for the shadow period based on current budgets provided for the functions that are to be delegated, during which time they will be reviewed.

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

Services currently provided by the Health Board which are to be integrated

Hospital Services – the minimum scope prescribed by Regulations, i.e.:

- (a) accident and emergency services provided in Western Isles hospital;
- (b) inpatient hospital services relating to the following branches of medicine at Western Isles hospital —
 - (i) general medicine;
 - (ii) geriatric medicine;
 - (iii) rehabilitation medicine;
 - (iv) respiratory medicine; and
 - (v) psychiatry of learning disability,
- (c) palliative care services provided in a hospital;
- (d) services provided in Western Isles hospital in relation to an addiction or dependence on any substance;
- (d) inpatient hospital services provided by general medical practitioners;
- (f) mental health services provided in a hospital, except secure forensic mental health services.

Health care services provided outwith hospitals

- (a) district nursing services;
- (b) services provided outwith a hospital in relation to an addiction or dependence on any substance;
- (c) services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital;
 - podiatry
 - dietetics
 - occupational therapy
 - physiotherapy
 - speech & language therapy
- (d) the public dental service;
- (e) primary care services —

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- (i) primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978(a);
 - (ii) general dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978(b);
 - (iii) ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978(c); (iv) pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978(d);
- (f) services provided outwith a hospital in relation to geriatric medicine;
- (g) palliative care services provided outwith a hospital (including at Bethesda Hospice);
- (h) mental health services provided outwith a hospital;
- (i) continence services provided outwith a hospital;
- (j) kidney dialysis services provided outwith a hospital;
- (k) services provided by health professionals that aim to promote public health.

For Local Determination:

The pursuit of single system integrated care should remain the objective. To deliver a safe, effective, sustainable model of integrated care, a whole system approach needs to be maintained and enhanced. Only a whole system focus in terms of strategic planning will ensure the effective inclusion of the acute sector in whole system re design and mitigate against acute sector separation and silo behaviour.

Hospital services provided to certain groups of adults, which will continue to be managed within the hospital but must be included in the joint planning with community services.

In addition, the expanding, enhanced role of e health, telecare and digital applications should achieve efficiencies and optimal system design if a whole system approach is taken.

Mental Health Services are currently undergoing strategic change and is in the implementation phase of a modernisation programme. Significant service change and capital development is key to delivering the agreed enhanced community model. Mental Health services will be delegated.

The work is being taken forward by the Mental Health Project Board, and is driven by the principles and goals of integrated working.

During Summer 2012 NHS WI introduced a new single system model for out of hours covering the community, A & E, and W.I.H. in-patients. The out of hours team is comprised of GPs, Consultants, Clinical Support Nurses and Community Unscheduled Care Nurses. Junior Doctors no longer cover night shift. The single system provides a cohesive team from an in-patient management/now perspective and from the point of view of risk and patient safety. It is not proposed to sub-divide this team.

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7. How much is being allocated to the Integration Joint Board for 2015-16?
 - a. by the health board £25.157 million
 - b. by local authority partners? The Comhairle nan Eilean Siar is currently finalising the total figure; they estimate circa £20 million.
8. Please provide any further comments on budgetary issues associated with integration:

The main financial issues centre around:

- the ability of the IJB to hold reserves, which Health Boards cannot;
- the significant loss of flexibility afforded to the Health Board – it is effectively handing over almost a third of its revenue – to ensure that it can achieve its targets and statutory duties;
- the loss of influence over managing and correcting overspending;
- the as yet unknown additional costs of providing resource to support the IJB's planning and administrative functions.

Specific challenges

9. Please provide details of any specific challenges facing your board in 2015-16 in respect of your budget:

Delivering our savings target of £2.498 million or 3.9% will be extremely challenging, with approximately 40% of this target either deemed high risk or unidentified currently.

Recruitment and retention, in particular of:

- Consultants (physician, surgical and radiology)
- Junior doctors
- Nurses and midwives for Uists and Barra
- ODPs
- Health Visitors

The Highlands & Islands Travel Scheme, pressure on which increases year on year, which is now to be transferred to the Board's baseline budget.

Locum provision for Out of Hours, particularly as there are some key retirements during the year.

Repayment of brokerage of £540k (the penultimate instalment of brokerage received in 2008/09).

Increased employer's superannuation contributions which are estimated to cost an additional £340k.

HMRC have yet to discuss with us their findings in terms of the employment status of GPs providing Out of Hours (OOH) services. The potential for a backdated penalty in terms of national insurance is not known, but there will certainly be increased costs in future.

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	87.3%	89.6%
2010	87.9%	90.0%
2011	89.7%	90.1%
2012	88.9%	89.9%
2013	87.3%	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?
For NHS Western Isles, 1 percentage point equates to approximately 2.5 births, – compared to around 560 for 1% nationally. Therefore the observed % differences above are caused by very small numbers in reality.
3. How does performance against this indicator influence budget decisions?
Given the low number of births annually in NHS Western Isles it is unlikely that budget decisions would be influenced by this indicator alone. If the Board began to see a consistent and significant poor performance it would in the first instance be considering whether there was a need for staff development or other support, along with identifying any additional resource requirements
4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)
The Board views this as an indicator of underlying factors contributing to low birth weight or prematurity rather than a KPI in isolation. We already have a focus on these underlying factors through our work on smoking and alcohol use in pregnancy, promoting healthy weight and addressing good diabetic control. Antenatal care also focuses on early identification of conditions such as pre-eclampsia.
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.

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Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Vulnerability in pregnancy service – provided by Action for children	13	13
Maternal & Infant nutrition - includes payments to young mums groups, healthy start vitamins and other play groups	42	42
Maternity and Children's Quality Improvement Collaborative together with Early Years Collaborative	11	9

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

Health Improvement Scotland
 Scottish Patient Safety Programme
 Perinatal Institute
 Health Promotion
 Sonography services
 Early Years at local council

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

We are currently working on the Growth Assessment Programme (GAP) from the Perinatal institute. This programme is a web based programme which all our midwives have undertaken, supported by the SPSP Scottish patient safety programme. This has not yet been implemented at Western Isles as it is dependent on Sonography workload at the moment and the difficulty in recruiting into posts. There is a potential for increased workload for the sonographers. This situation is similar throughout other areas in Scotland.

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	89.7%	90.4%
2009-10	89.6%	90.5%
2010-11	89.1%	90.7%
2011-12	90.5%	91.1%
2012-13	92.1%	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?
Again the variations in percentage terms relate to small numbers – the Board has been working hard to reduce unnecessary or inappropriate hospital admissions and this is one of the indicators of a small degree of success. Anecdotal evidence locally is consistent with studies that demonstrate the desire of people to live out their lives in familiar surroundings and not in health service premises.
3. How does performance against this indicator influence budget decisions?

This indicator is viewed as a secondary driver for the actions we have been taking to reduce demand on acute admission services and so doesn't currently influence budget decisions.
4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

Yes, although consideration needs to be given to preferred place of death alongside this.
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.

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Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Community unscheduled Care Nurses – Introduction of a twilight shift when pressure is felt by patient and family, we are able to respond in patients home. Unscheduled Care Team also supporting GP Out of Hours and GP on call during the day, all moving towards being non medical prescribers	90	90
MacMillan Nurses	377	382
Marie Curie	5	5

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

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

There is a focus of activity in care at home around vulnerable high need clients thus enabling many to remain at home at later stages of life. This is supported by increased availability of patient facing time within community nursing teams.

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	NIL	NIL
General palliative care services	575	587

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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.

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

	2014-15	2015-16
Agreed funding for hospice running costs for specialist PELC (£'000)		
£'000	187	*still under negotiation
As % of total hospice funding	41**	
Agreed funding for running costs of independent children's hospices (including local authority funding where relevant)		
£'000	Nil	Nil
As % of total independent children's hospice running costs		

** the Board has an SLA with a local hospice. The hospice has elected to use expensive locums to provide medical cover, which reduces the % value of the Board contribution. The Board is working with the hospice with a view to identifying a more cost effective solution.

With regard to independent children's hospices, NHS Tayside take the lead for Scotland and have provided a response.

10. Please provide any further comments on palliative care / hospice funding that you consider to be relevant:

No further comment.

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	10,375	9,849
2010-11	9,819	9,874
2011-12	10,307	10,090
2012-13	10,954	10,130
2013-14 (p)	9,876	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?
There are no obvious reasons for the fluctuation in admissions rates above. However the Fuel Poverty Report 2014 suggests that 71% of households in the Western Isles are living in fuel poverty as opposed to 27% across Scotland, which is likely to have some impact on emergency admissions.

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

Poor performance in this area would cause increased bed occupancy with potential opening of crisis beds and employment of bank staff to cover. If this was sustained it could lead to elective treatments having to be postponed or referred to mainland providers.

This risk has in the past led to decisions to, for example:

- introduce a 23 hour assessment unit in the Western Isles Hospital;
- introduce a unique Out of Hours model which bases the NHS24 GP in the A&E department;
- provide enhanced Out of Hours training in e.g. assessment skills;
- introduce the Key Information Summary; and
- introduce the Emergency Care Summary.

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

Yes we do – it maintains focus on the Local Unscheduled Care Action Plan (LUCAP) and drives any further improvements required.

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

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Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
GP OOH Service within the Western Isles hospital	365	385
Local Unscheduled Care Action Plans	55	55
Mobile Overnight Support Service	141	143

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

Scottish Ambulance Service

Comhairle nan Eilean Siar

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

- The GP Out of Hours (OOH) service has provided experienced clinicians at the front door of the hospital, leading to a reduction in admission rate. It is intended to further strengthen this service in 2015-16
- A number of initiatives are being pursued in liaison with the SAS, including: considering co-location of paramedics in the WIH A and E department, developing an MoU with the SAS which would enable involvement of paramedics in the emergency treatment of patients in the Uist and Barra Hospital, strengthening the see and treat capability of paramedics in tandem with the GP OOH provision. We will continue development of trained paramedics. There has been major work in the development of paramedic practices and increasing decision support in the out of hours period for all age groups, via close working relationship between GPs and paramedics and nurse practitioners. The development of a paramedic practitioner has resulted in greater autonomy of that individual, supported by the on-call GP to increase the see and treat rate to 50 – 60% of 999 calls.
- An innovative COPD pilot project is linking up a specialist respiratory clinician with GPs, and providing proactive anticipatory care of high risk COPD patients.
- There are currently joint discussions, involving Health and Social services, around the development of a step up/step down/Intermediate Care facility in Erisort Ward, Western Isles Hospital (WIH). The overall aim of this new project is to prevent avoidable admissions, reduce the number of delayed discharges within the WIH and to support more patients to remain at home in the community. This so called 'Erisort Project' is looking at the

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concept of a virtual ward, where staff will work between hospital and community, supporting patients to remain at home or providing intermediate care at home or in hospital as appropriate. A Short Life Working Group was set up during 2014/15 with the objective of reducing delayed discharges, facilitating discharge and re-abling patients. We anticipate putting this into operation during the autumn of 2015, and expect the Project to lead to improved anticipatory care and reduced admissions.

- We are exploring ways for community nurses to work on admission prevention and early discharge, including better planning of resource utilisation and IT. This will utilise and enhance skills to provide additional care pathway options as alternatives to admission, supported by GPs. We intend to pilot a trained workforce to care manage with Health Care Assistant dedicated tasks This will involve training up the community nurses and choosing a primary health care team to act as a pilot site. This will be measured by the number of community nurses managing a case load of patients who have been identified as being at high risk of admission. We will utilise Releasing Time to Care Integration worktools.

Other contributory work areas include:

- Establishment of Multi Disciplinary Panels
- Increased access to day care facilities
- Training of homecare workers in medication management
- Extension of Community Unscheduled Care Nursing (CUCN) service by providing a further twilight shift.
- Review of the Medical Assessment Unit
- Review of the TIA and Stroke pathway
- Increasing use of the Key Information Summary
- Day of Care audits
- Improving patient transport options to allow attendees at A&E to return home
- Generic home care workers
- The Mobile Overnight Support Service