Report on the survey of 2015-16 NHS Board budget plans

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Context
The Health and Sport Committee has undertaken surveys of NHS Board budget plans in 2010-11, 2012-13, 2013-14 and 2014-15. In previous years, the Committee has used the findings from these surveys as the basis for taking evidence from representatives of selected boards to provide a more detailed insight into spending plans. This reflects the fact that, at the time of the draft budget, there is no information available on the spending plans of the boards. The draft budget only provides information on the planned allocations to the boards but no detail below this; meaning that for more than three-quarters of the total health budget, there is no detailed information on its planned use. The budget scrutiny that takes place following the publication of the draft budget cannot therefore provide an in-depth examination of spending plans at local level. The current report is based on a survey conducted with all boards, as outlined in the approach section that follows. The aim is to provide more detailed information on Board spending plans for the Committee to support budget scrutiny.

This report is structured as follows:

1. Approach
2. Performance Budgeting
3. Integration of health and social care
4. Earmarked funding
5. Non-recurring funding
6. Cost pressures
7. Efficiency savings
8. National Performance Framework indicators
   i. Increase the proportion of babies with a healthy birth weight
   ii. Increase the percentage of the last 6 months of life which are spent at home or in a community setting
   iii. Reduce emergency admissions
1. Approach
This year, the Committee agreed to adopt a different approach to the Board survey. Recognising the increasing emphasis placed on performance budgeting, and the challenges in aligning budgets with specific performance measures, the Committee decided to focus on a selected number of performance indicators and gather evidence in relation to these specific areas.

Three indicators were selected from the Scottish Government’s National Performance Framework, chosen to reflect areas of particular interest to the Committee’s wider work programme:

- Increase the proportion of babies with a healthy birth weight
- Improve end of life care
- Reduce emergency admissions

Some specific questions in relation to palliative care were also included to inform the Committee’s forthcoming inquiry in this area. In addition, this year’s survey included some general questions in relation to performance budgeting and questions specific to the integration of health and social care.

Additional financial data and planning assumptions were drawn from the Local Delivery Plans (LDPs) submitted to the Scottish Government. At the time of writing, the Scottish Government had not received LDPs from NHS Fife, NHS Grampian or NHS Greater Glasgow and Clyde so the analysis of LDPs excludes these three boards.

Scottish Government officials and a number of boards were asked for comments on the draft questionnaire before a final version was sent out. The questionnaire (attached as an annexe) was sent out to the 14 territorial boards and 8 special boards on 26 February 2015 for return by 25 March 2015. Responses were received from all boards. The responses are available on the following webpage: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/89277.aspx

Preliminary analysis was undertaken by Nicola Hudson and Andrew Aiton of the Financial Scrutiny Unit, SPICe, with further input from the Committee’s budget adviser, Dr Iris Bosa. Findings from both the analysis of survey responses and analysis of LDPs are summarised below.

2. Performance budgeting
Given that this year’s survey was based around indicators from the Scottish Government’s National Performance Framework, boards were asked to comment generally on aspects of performance budgeting.

First, boards were asked which performance framework has the most influence on their budget decisions. Boards were offered the choice of the National Performance Framework (NPF), the Quality Management Framework (QMF, which incorporates the HEAT targets), or to specify another framework.
In responses to this question, only one board mentioned the NPF in isolation. Five mentioned the NPF in conjunction with the QMF/HEAT, while the majority (12) said that the QMF/HEAT was the main performance framework influencing their budget decisions. Three of the special boards stated that they had their own performance frameworks tailored to their specific role and remit. Healthcare Improvement Scotland noted that the specific targets within the frameworks did not apply directly to it as an organisation. Many of the boards also noted that they would not rely on a single performance framework, but would combine the NPF/QMF/HEAT with indicators and targets designed to reflect local priorities, for example the Single Outcome Agreement of the Community Planning Partnership. The measures set out as part of the Integrated Care Fund were also mentioned by a number of boards. Several special boards highlighted that their work would aim to support boards in meeting HEAT targets.

Overall, it was clear that no single framework was used in isolation. Although the NPF and QMF were generally considered to reflect board priorities, they were often seen as too broad to be used in the absence of other indicators. Two boards commented that the wider frameworks were too focussed on the acute sector, so did not take sufficient account of the needs of the community sector. Workforce issues and infrastructure requirements were also considered to be inadequately reflected in the wider performance frameworks. Some boards also highlighted the importance of policy and legislation in determining resource allocation, while others referred to particular targets linked to ring-fenced allocations.

Boards were asked to describe how performance information influences budgetary decision-making. Most described the use of performance information in regular reporting and management review. Poor performance was often a driver for service redesign. A number of HEAT targets were mentioned by several boards as influencing resource allocation – these were the treatment time guarantee, delayed discharge and the four hour A&E waiting time target. The analysis of specific NPF indicators later in the questionnaire suggested that performance influenced budget decisions more clearly where there was greater scope for improvement. For example, the % of babies with a healthy birth weight varied little across boards, and there was limited evidence of the influence of this performance indicator on budgets. By contrast, performance on the level of emergency admissions per 100,000 population was more varied and had worsened and, in this case, there was stronger evidence of performance influencing budget decisions, with resources being allocated to initiatives designed to improve performance.

**Comment**

It is evident that the performance measures are guidelines for the different Boards. It is interesting to notice the variation in the use of the different frameworks, with the majority of Boards using QMF/HEAT targets, and fewer using NPF. It is also interesting that one Special Board suggested it developed its performance framework based on the NPF and QMF. There seems a rather general acceptance that the main indicators are treatment time guarantee, delayed discharge and the four hour A&E waiting time target. A strategy toward prioritising the indicators to focus on seems to be followed. This aligns with the findings in the Committee’s report published in December, suggesting the need to place more attention on analysing the performance of targets that are more urgent for change, and leaving a
longer period for revision to targets that have a lower priority. This would allow Boards to feel under less pressure to address a large range of targets.

Some Boards indicated that the targets refer to priorities related to the acute services. Given the focus on integration of health and social care, it is important to ensure that indicators are in place to help monitor progress in this area. The survey also highlights the need for analysis of the indicators in relation to local specificities (geographical area, population age, level of deprivation) in order to understand the factors that affect the specific performance and might be out of the control of the Board. The respondents reiterate the strengths and limitations of the indicators: they are useful to provide immediate information but this should not be interpreted in isolation.

3. Integration of health and social care

Boards were asked about their preparations, in terms of budgeting, for the Integrated Joint Boards (IJBs) which will be fully operational from April 2016, but will operate in shadow format during 2015-16. The only exception to the IJB model is in North Highland, where a ‘Lead Agency’ model has been adopted.

The majority explained that shadow budgets for 2015-16 had been determined on the basis of existing budgets for those services that are to be delegated. In future years, an annual budget setting process would be developed.

In addition to the standard delegated functions set out in the regulations, a number of boards have agreed with their local authority partners to delegate a wider range of functions to the IJB. Examples of additional services that a number of boards have decided to delegate, over and above those set out in the regulations, include:

- Additional acute hospital services
- Children’s services
- Health visiting and school nursing
- Criminal justice social work
- Youth justice social work

Territorial boards were asked to provide details of the sums allocated to the integrated joint boards for 2015-16. The majority of boards provided figures (although several noted that the figures were indicative at this stage). Three boards declined to provide figures, stating that they had not yet been agreed.¹ The question was not relevant to North Highland, which has adopted a Lead Agency model.

For those boards that provided information, details are set out in Table 1 below. Where a health board has more than one IJB within its area, the figures represent the total of all IJBs. For Highland, figures relate to the Argyll and Bute IJB. In total,  

¹ NHS Forth Valley; NHS Greater Glasgow and Clyde; NHS Lanarkshire
for the 11 territorial health boards that provided figures, planned IJB budgets total just over £4bn. Overall, health boards account for £2.7bn (66%) of this total. However, this varies considerably between areas. In Orkney and Shetland, planned resources are split roughly equally between the health board and the local authority, while in all other areas, the health board is allocating a larger sum than the local authority. In Dumfries and Galloway, the health board accounts for the largest share (81%) of the total planned budget. This is likely to be a reflection of the decision to include all acute hospital services within the remit of the IJB in this area.

Note that there may be some differences in methodology between boards – in particular, it was not always made clear whether the health board figure includes the ‘set aside’ budget (that proportion of the health board budget that is allocated to the IJB in relation to acute hospital services for unplanned care). Where figures were provided separately, the set aside budget has been included in the health board total.

**Table 1: Indicative allocations to IJBs, 2015-16**

<table>
<thead>
<tr>
<th>Health Board allocation to IJB £m</th>
<th>Local Authority allocation to IJB £m</th>
<th>Total IJB budget £m</th>
<th>Health Board allocation as % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>329.9</td>
<td>233.8</td>
<td>563.7</td>
</tr>
<tr>
<td>Borders</td>
<td>86.0</td>
<td>48.0</td>
<td>134.0</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>224.0</td>
<td>52.0</td>
<td>276.0</td>
</tr>
<tr>
<td>Fife</td>
<td>348.2</td>
<td>144.6</td>
<td>492.8</td>
</tr>
<tr>
<td>Grampian</td>
<td>390.0</td>
<td>230.0</td>
<td>620.0</td>
</tr>
<tr>
<td>Highland (Argyll &amp; Bute)</td>
<td>189.0</td>
<td>62.0</td>
<td>251.0</td>
</tr>
<tr>
<td>Lothian</td>
<td>669.2</td>
<td>342.4</td>
<td>1,011.5</td>
</tr>
<tr>
<td>Orkney</td>
<td>16.4</td>
<td>17.0</td>
<td>33.4</td>
</tr>
<tr>
<td>Shetland</td>
<td>18.1</td>
<td>19.7</td>
<td>37.8</td>
</tr>
<tr>
<td>Tayside</td>
<td>359.0</td>
<td>193.0</td>
<td>552.0</td>
</tr>
<tr>
<td>Western Isles</td>
<td>25.2</td>
<td>20.0</td>
<td>45.2</td>
</tr>
<tr>
<td><strong>Total of above</strong></td>
<td><strong>2,654.9</strong></td>
<td><strong>1,362.5</strong></td>
<td><strong>4,017.4</strong></td>
</tr>
</tbody>
</table>

For Dumfries and Galloway, the planned allocation to the IJB represents 84% of the total health board budget (see Table 2). For the smaller island health boards, their planned allocation to the IJB represents a much smaller share of the total health board budget (in the region of 40%).

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Table 2: Planned health board allocations as % of health board budgets

<table>
<thead>
<tr>
<th>Health Board allocation to IJB £m</th>
<th>Total Health Board budget £m</th>
<th>Health Board IJB allocation as % of health board budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>329.9</td>
<td>635.5</td>
</tr>
<tr>
<td>Borders</td>
<td>86.0</td>
<td>184.2</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>224.0</td>
<td>265.9</td>
</tr>
<tr>
<td>Fife</td>
<td>348.2</td>
<td>574.8</td>
</tr>
<tr>
<td>Grampian</td>
<td>390.0</td>
<td>827.3</td>
</tr>
<tr>
<td>Lothian</td>
<td>669.2</td>
<td>1,225.7</td>
</tr>
<tr>
<td>Orkney</td>
<td>16.4</td>
<td>41.3</td>
</tr>
<tr>
<td>Shetland</td>
<td>18.1</td>
<td>40.7</td>
</tr>
<tr>
<td>Tayside</td>
<td>359.0</td>
<td>660.9</td>
</tr>
<tr>
<td>Western Isles</td>
<td>25.2</td>
<td>63.7</td>
</tr>
<tr>
<td>Total of above</td>
<td>2,465.9</td>
<td>4,520.0</td>
</tr>
</tbody>
</table>

Boards noted a number of perceived challenges in relation to budget planning within the new integrated structure. These included:

- Greater challenges in managing any underspends effectively
- Establishing the scope of the hospital set aside budget

**Comment**

It would be useful to have targets that help direct the IJBs towards efficient and effective operation. With regard to the resource contribution into the IJBs it is evident that there is a variation on the level committed by the different boards. In some IJBs the Health Board is the major funder while in some there is a more equal split of resources transferred to the IJB. The reasons for these differences are worth further exploration, to investigate whether different funding models result in more or less transition towards new models of care delivery. There is also the risk that the current organisation will be simply transferred under the new board. It would be relevant to investigate the level of collaboration and reorganisation taking place under different levels of health board contribution.
4. Earmarked funding

In 2015-16, the boards will, on average, receive 13% of their funding allocation in the form of earmarked funding that is ring-fenced for a specific purpose, such as alcohol or drug treatment programmes. For those boards that have submitted LDPs, this represents a total of £0.8bn in earmarked funding. A higher proportion of earmarked funding implies less flexibility for boards in how they allocate their funds.

The proportion of the revenue resource allocation accounted for by earmarked funding in 2015-16 varies considerably between boards (see Table 3). Across territorial boards, the proportion varies from 7% in Ayrshire and Arran to 30% in Shetland. Across special boards, the range is even wider, from 3% for the State Hospital and NHS Education for Scotland to 45% for the National Waiting Times Centre. This will largely reflect their specific roles and remits.

In the survey, boards were asked whether they felt they were able to spend earmarked funding effectively and in line with the intended purpose. The majority of boards felt that they were able to do so, but made the following comments:

- Spending earmarked funds effectively can be challenging when the allocation comes late in the financial year and/or is non-recurring. For example, if funding is non-recurring, staff may need to be employed on short-term contracts at higher rates of pay.

- Bundling of allocations within broader funding streams e.g. effective prevention / early years, allows for greater flexibility in the use of funds and also reduces bureaucracy which the boards find helpful.

- Smaller boards, such as Orkney and the Western Isles commented that, when allocations are formula-based, this can result in small funding pots that cannot be used effectively to achieve change e.g. where funding is insufficient to allow for the recruitment of a full-time post. The suggestion of a minimum allocation was considered to be a possible solution to this issue.

- NHS Ayrshire and Arran noted some challenges in using earmarked funding effectively e.g. noting the allocations for hepatitis C which can be used to fund extra staff, but not to cover the extra costs of the drugs required.

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2 Analysis excludes NHS Fife, NHS Grampian or NHS Greater Glasgow and Clyde who had not yet submitted LDPs
Table 3: Earmarked funding

<table>
<thead>
<tr>
<th>Territorial Health Boards</th>
<th>Earmarked funding as % of total allocation 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>7%</td>
</tr>
<tr>
<td>Borders</td>
<td>14%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>12%</td>
</tr>
<tr>
<td>Fife</td>
<td>..</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>11%</td>
</tr>
<tr>
<td>Grampian</td>
<td>..</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>..</td>
</tr>
<tr>
<td>Highland</td>
<td>18%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>10%</td>
</tr>
<tr>
<td>Lothian</td>
<td>14%</td>
</tr>
<tr>
<td>Orkney</td>
<td>20%</td>
</tr>
<tr>
<td>Shetland</td>
<td>30%</td>
</tr>
<tr>
<td>Tayside</td>
<td>13%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>24%</td>
</tr>
<tr>
<td>Territorial boards</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Health Boards</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National Waiting Times Centre</td>
<td>45%</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>4%</td>
</tr>
<tr>
<td>National Services Scotland</td>
<td>37%</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>23%</td>
</tr>
<tr>
<td>The State Hospital</td>
<td>3%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>13%</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>3%</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>9%</td>
</tr>
<tr>
<td>Special boards</td>
<td>15%</td>
</tr>
<tr>
<td>All boards</td>
<td>13%</td>
</tr>
</tbody>
</table>

5. Non-recurring funding

Non-recurring funding is a one-off allocation in a financial year and can sometimes be earmarked for a specific purpose. In its annual overviews of NHS financial performance, Audit Scotland has repeatedly raised concerns about boards relying on non-recurring funding to break even.

In 2015-16, boards will, on average, receive 4% of their total allocations in the form of non-recurring funding. This is higher than the equivalent figure of 3% in 2014-15.
Of the territorial boards for which information is available, NHS Lanarkshire has the highest proportion of its allocation (9%) in the form of non-recurring funding. Across special boards, there is much wider variation, from less than 1% in the State Hospital and NHS Education for Scotland to 23% for NHS 24.

Table 4: Non-recurring funding

<table>
<thead>
<tr>
<th>Territorial Health Boards</th>
<th>Non-recurring funding as % of total allocation 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>2%</td>
</tr>
<tr>
<td>Borders</td>
<td>1%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>3%</td>
</tr>
<tr>
<td>Fife</td>
<td>..</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>3%</td>
</tr>
<tr>
<td>Grampian</td>
<td>..</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>..</td>
</tr>
<tr>
<td>Highland</td>
<td>6%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>9%</td>
</tr>
<tr>
<td>Lothian</td>
<td>3%</td>
</tr>
<tr>
<td>Orkney</td>
<td>1%</td>
</tr>
<tr>
<td>Shetland</td>
<td>1%</td>
</tr>
<tr>
<td>Tayside</td>
<td>1%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Territorial boards</strong></td>
<td><strong>4%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Health Boards</th>
<th>Non-recurring funding as % of total allocation 2015-16</th>
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</thead>
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<tr>
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<td>6%</td>
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<td>Scottish Ambulance Service</td>
<td>4%</td>
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<tr>
<td>National Services Scotland</td>
<td>13%</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>19%</td>
</tr>
<tr>
<td>The State Hospital</td>
<td>0%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>23%</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>0%</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Special boards</strong></td>
<td><strong>6%</strong></td>
</tr>
<tr>
<td><strong>All boards</strong></td>
<td><strong>4%</strong></td>
</tr>
</tbody>
</table>
6. Cost pressures
As part of their LDP submissions, boards are asked to set out their planning assumptions in relation to a range of cost areas, including pay, prices, and prescribing costs and volumes.

In respect of pay, the majority of boards were planning on a base uplift of between 1% and 1.2%. Most boards were expecting incremental drift and other factors to add up to a further 1.5% on top of this. Three boards were expecting incremental drift and other factors to add more than 2% to the pay bill (over and above the base uplift): NHS Shetland, NHS Health Scotland and Healthcare Improvement Scotland. It is not clear why these three boards are expecting pay pressures higher than those of other boards.

Wide variation was evident in the boards’ statements of anticipated price and volume pressures in respect of hospital drugs, as shown in Table 5 below which shows data for all the territorial boards and the one special board that provided details for this indicator – the National Waiting Times Centre.

Table 5: Hospital drugs: anticipated price and volume changes 2015-16

<table>
<thead>
<tr>
<th>Territorial Health Boards</th>
<th>Assumed price uplift</th>
<th>Assumed volume uplift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>2.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Borders</td>
<td>13.6%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>8.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Fife</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>10.0%</td>
<td>..</td>
</tr>
<tr>
<td>Grampian</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Highland</td>
<td>0.0%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>0.0%</td>
<td>29.6%</td>
</tr>
<tr>
<td>Lothian</td>
<td>5.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Orkney</td>
<td>1.7%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Shetland</td>
<td>33.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Tayside</td>
<td>3.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>6.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Special Health Boards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Waiting Times Centre</td>
<td>5.6%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

The information suggests that some boards may have taken different approaches to reporting prices and volumes – often, those reporting a low value on one measure report a high value on the other. For example, Shetland reports a 33% assumed price uplift, but no change in hospital drug volumes. Meanwhile, Lanarkshire reports a 29.6% anticipated increase in volume, but no anticipated increase in price.
The LDP evidence is consistent with the information gathered from the survey undertaken. In response to the survey, many of the territorial boards mentioned cost pressures in relation to the budgetary challenges that they face in 2015-16. In particular, drug costs were mentioned by nine of the 14 territorial boards. Pension and workforce costs – including the costs of locums – were also mentioned frequently.

7. Efficiency savings

Eight of the territorial boards and two of the special boards specifically mentioned achievement of efficiency savings target as a particular budgetary challenge for 2015-16.

Boards are asked to provide details of their planned efficiency savings as part of their LDP returns. In total, the boards are reporting planned efficiency savings of £151.5m in 2015-16 (excluding NHS Fife, NHS Grampian and NHS Greater Glasgow and Clyde). This represents 2.4% of board allocations, lower than the 3% efficiency savings target that has been set in previous years.

There is some variation between boards, as shown in Table 6. Of the territorial boards, planned efficiency savings in 2015-16 range from 2.1% in Ayrshire and Arran, up to 3.5% in Shetland. Across the special boards, there is much wider variation in planned efficiency savings (from 0.4% for NHS Education for Scotland to 7.1% for the National Waiting Times Centre).

More detailed analysis of the planned source for efficiency savings highlights that over a third (36%) of savings are expected to come from ‘service productivity’. Other main areas for savings are ‘workforce’ (17%) and ‘drugs and prescribing’ (16%). A tenth of savings have yet to be identified (see Figure 1).

Across territorial boards:

- Forth Valley, Highland and Shetland are planning to achieve half of their savings through service productivity
- Ayrshire and Arran, Dumfries and Galloway and Tayside are planning to achieve around a quarter of their savings from drugs and prescribing
- Forth Valley, Lothian and Tayside are planning to achieve around a quarter of their savings from workforce changes
- In Lanarkshire, the source for one quarter of savings is as yet unidentified; in the Western Isles, the source for one third of savings is as yet unidentified

As highlighted in the Committee’s report on the 2014-15 board budgets, there are growing concerns about the extent to which further efficiency savings can be achieved. It would be interesting to get a more in-depth understanding on the Scottish Government’s approach to setting targets in this area and its future intentions.
Table 6: Planned efficiency savings, 2015-16

<table>
<thead>
<tr>
<th>Territorial Boards</th>
<th>Planned efficiency savings as % of total budget 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>2.1%</td>
</tr>
<tr>
<td>Borders</td>
<td>2.4%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>2.6%</td>
</tr>
<tr>
<td>Fife</td>
<td>..</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>2.8%</td>
</tr>
<tr>
<td>Grampian</td>
<td>..</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>..</td>
</tr>
<tr>
<td>Highland</td>
<td>2.2%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>2.3%</td>
</tr>
<tr>
<td>Lothian</td>
<td>2.7%</td>
</tr>
<tr>
<td>Orkney</td>
<td>2.6%</td>
</tr>
<tr>
<td>Shetland</td>
<td>3.5%</td>
</tr>
<tr>
<td>Tayside</td>
<td>2.4%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Territorial boards</strong></td>
<td><strong>2.5%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Health Boards</th>
<th>Planned efficiency savings as % of total budget 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Waiting Times Centre</td>
<td>7.1%</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>2.6%</td>
</tr>
<tr>
<td>National Services Scotland</td>
<td>3.1%</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>1.5%</td>
</tr>
<tr>
<td>The State Hospital</td>
<td>1.6%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>3.1%</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>0.4%</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>5.8%</td>
</tr>
<tr>
<td><strong>Special health boards</strong></td>
<td><strong>2.2%</strong></td>
</tr>
<tr>
<td><strong>All boards</strong></td>
<td><strong>2.4%</strong></td>
</tr>
</tbody>
</table>
8. National Performance Framework indicators

Boards were asked some specific questions in relation to three indicators from the National Performance Framework:

- Increase the proportion of babies with a healthy birth weight
- Improve end of life care
- Reduce emergency admissions

Responses in relation to each of these areas are considered below. This analysis relates to territorial boards only as the questions were not relevant to special boards.

*Increase the proportion of babies with a healthy birth weight*

Across Scotland as a whole there has been an improvement in this measure over the last five years for which data are available. In 2009, 89.6% of babies had a healthy birth weight; in 2013, the equivalent figure was 90.1.
Figure 2: % of babies with a healthy birth weight, Scotland

There is not a significant variation in this measure across Boards, with most performing at or around the Scottish average (see Figure XXX). In 2013, four boards were more than one percentage point below the Scottish average of 90.1%. These were Forth Valley (88.2%), Western Isles (87.3%), Shetland (86.5%) and Orkney (86.1%).

The smaller island boards noted that very small changes in the numbers of babies above or below a healthy birth weight had a significant impact on the indicator, due to the small overall numbers of births involved. Forth Valley and the Western Isles had been consistently below the Scottish average throughout the period, while the other two boards had occasionally outperformed the Scottish average on this indicator. Both Orkney and Shetland referred to an increase in the proportion of babies born with an above healthy weight, often reflecting maternal obesity or gestational diabetes.

Boards noted the influence of a range of factors on this indicator, including:

- Deprivation levels
- Smoking/drinking/drug use during pregnancy
- Maternal nutrition
- Obesity
- Maternal age
Differences in performance were often felt to reflect differences in the levels of deprivation, which the health board cannot directly address. Boards described the types of activities that they undertook to ensure performance against this measure, including:

- Smoking cessation programmes
- Maternal and infant nutrition programmes
- Family Nurse Partnership activities
- Work with drug and alcohol partnerships
- Targeted community midwifery activities

However, it did not appear that performance against this indicator had a strong influence on budget decisions as most felt that their performance was in line with the national average and that short-term changes in budget allocations would not directly influence performance on this longer-term outcome measure.

Most boards viewed the proportion of babies with a healthy birth weight to be a useful indicator, but not in isolation. A number commented that activity and output measures were more useful in the short-term.

Boards were asked to provide details of spending in 2014-15 and planned spending in 2015-16 on programmes or services aimed at improving performance in this area. With the exception of Forth Valley and Greater Glasgow and Clyde, all boards provided financial information. However, it is difficult to draw comparisons between boards due to the way in which information was reported. For example, some boards gave their total Family Nurse Partnership (FNP) budget, while others noted that it was not possible to disaggregate spending within this budget to the specific issue of healthy birth weight. It was notable that, for those boards providing details of planned budgets in 2015-16, the majority were planning flat cash budgets in this area i.e. no plans to increase spending. The exceptions were:
• Highland – a planned increased in the community midwifery budget

• Lothian – planned increases in the FNP budget as well as increased budgets for PrePare (a specialist service for pregnant women with substance misuse issues) and for smoking cessation activities for pregnant women

• Orkney – an increased budget for its maternal and infant nutrition programme

This area involved widespread partnership working, with all boards noting other partners who would contribute towards performance in this area, including:

• Early years partnerships
• Community Planning Partnerships
• Community Health Partnerships
• Alcohol and drugs partnerships
• Local authority services (including education, social work, housing)
• Other third sector partners

*Increase the percentage of the last 6 months of life which are spent at home or in a community setting*

Scotland-wide performance against this indicator has been improving steadily over the last five years (see Figure XXX). In 2008-09, individuals spent, on average, 90.4% of the last 6 months of life in a home or community setting. This had risen to 91.2% by 2012-13.

**Figure 4: % of last 6 months of life which are spent at home or in a community setting, Scotland**

Across the boards, in 2012-13, performance against this measure ranged from 89% in Greater Glasgow and Clyde to 93.9% in Grampian. In general, rural areas (Grampian, Highland, Dumfries & Galloway) performed better than urban areas. The smaller island boards showed more variable performance, noting that with such small numbers involved, small changes could lead to relatively large changes in the
performance indicator. The limited options in the smaller island boards was also noted – Shetland noted that it has no hospice beds on the island.

Three boards (Grampian, Highland, Dumfries & Galloway) had performed consistently above average throughout the period. Reasons suggested for this included:

- Rural communities having greater experience in managing care outside of hospital facilities (in some cases due to difficulties in accessing acute facilities) – Dumfries and Galloway
- Investment in staff training to support this approach – Dumfries and Galloway, Highland
- Network of community hospitals – Grampian
- Flexible, integrated approach – Grampian, Highland

Tayside, which also showed a stronger performance than other boards, highlighted its rotational approach to nursing posts, giving staff the experience of both hospital and community care so that they can understand the differences between the two settings and the associated challenges e.g. delayed discharges.

Although most boards felt that the indicator was a useful one, it appeared to have limited, if any, direct influence on budgetary decisions. A number of boards noted that it is a crude measure and takes no account of the quality of care or patient preferences. Tayside noted that there were limitations in measuring change against an indicator where the baseline is in excess of 90% and suggested a number of alternative measures, including ‘% achieving preferred place of care’.

When asked to provide details of specific funding in this area, four boards (Forth Valley, Grampian, Greater Glasgow and Clyde and Lanarkshire) declined, with some stating that it was not possible to disaggregate palliative care from other funding streams. Of those that provided details of spending in 2014-15 and planned spending in 2015-16, the majority were planning to increase spending in 2015-16, or at least maintain levels of spending in cash terms. Only one board (Tayside) was planning a small decrease (-0.7%) in planned spending in this area. Orkney and Shetland had the largest proposed increases in funding (in percentage terms). For Orkney, this related to a planned pilot scheme involving Marie Curie nurses providing overnight care to patients. For Shetland, the increase planned spend related to increased spend on anticipatory care planning.

All boards noted the contribution made by other partners in relation to this indicator. In particular, all boards noted the importance of organisations such as Macmillan and Marie Curie and the local authority social work departments.

Palliative care and hospice funding

Boards were also asked to provide details of funding for specialist and general palliative care and for hospices.

A number of boards said that it was not possible for them to separate out general palliative care expenditure from other areas of spending and so did not provide any
information in response to these questions. Only seven boards provided details of spending on general palliative care. For these boards, planned 2015-16 expenditure on general palliative care equated to between 0.02% (Ayrshire and Arran) and 1.5% (Orkney) of the total revenue budget allocation, although from the details provided it is not possible to establish whether all boards have reported according to common definitions. In all seven boards, spending on general palliative care was planned to remain constant or increase in 2015-16.

Nine boards gave details of existing and planned expenditure on specialist palliative care. This represented between 0.2% and 0.9% of total budgets, although again it is not possible to determine whether consistent definitions have been used. Tayside and Fife were planning a reduction in spending in this area in 2015-16, while all other boards were planning to maintain or increase spending on specialist palliative care. The reasons for the planned reductions are unclear from the responses.

Boards were also asked about funding for specialist and end-of-life care in hospices. The Scottish Government guidance recommends that boards should establish long-term commissioning arrangements with hospices and meet 50% of agreed costs. Seven boards provided details of funding agreements and these represented between 41% (Western Isles) and 52.7% (Lanarkshire) of agreed costs. Forth Valley also noted that it provided in-kind support to a hospice in its area (pharmacy support, payroll services, procurement services and laboratory and diagnostic support). A number of boards noted that they did not use hospices, although it was not clear whether this was the reason for not providing data in all cases.

NHS Tayside has responsibility for the co-ordination of funding to support the only independent children’s hospice organisation in Scotland (Children’s Hospice Association Scotland – CHAS). This arrangement was agreed in order to minimise bureaucracy. CHAS operates two hospice facilities – Rachel House in Kinross and Robin House in Balloch.

NHS Tayside provided details for the whole of Scotland as follows:

<table>
<thead>
<tr>
<th>Table 7: Agreed funding for independent children’s hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
</tr>
<tr>
<td>Funding from Territorial Boards</td>
</tr>
<tr>
<td>Funding from Scottish Government (Diana nurse funding)</td>
</tr>
<tr>
<td>Total (£’000)</td>
</tr>
<tr>
<td>as % of total CHAS charitable activities</td>
</tr>
</tbody>
</table>

NHS Tayside note that the requirement for Health Boards is to fund 12.5% of hospice running costs. The current funding arrangement falls below this level. NHS Tayside note that an agreed funding baseline was established in 2009-10, which has been uplifted each year using Health Board percentage uplifts and that CHAS management have been content with this approach. Scottish Government guidance states that jointly, NHS boards and local authorities should meet 25% of children’s hospice running costs. NHS Tayside was not able to provide information on local authority funding for CHAS.
For a service that is of increasing importance given the demographic changes underway, it is important to have more precise information on the cost and usage of this service. Better data and performance indicators need to be identified and collected with regard to this service. It would be useful to understand the rationale for boards planning to reduce the resources for specialised palliative care unit in the coming year, while the other boards plan to increase the resources.

The information provided in relation to highlights that the boards are not meeting the agreement to provide for 12.5% of the running costs. It would be worth further investigation to understand the reasons for this.

**Reduce emergency admissions**

The number of emergency admissions per 100,000 population has increased steadily since 2008-09, from 9,849 to 10,188.

**Figure 5: emergency admissions per 100,000 population, Scotland**

Across Scotland, performance against this measure varied from 7,768 in Lothian and 8,007 in Grampian up to 11,175 in Greater Glasgow and Clyde, 11,570 in Lanarkshire and 13,190 in Ayrshire and Arran.

Performance against this measure has worsened in most areas over the period shown. In Shetland and Ayrshire and Arran, the number of emergency admissions per 100,000 population increased by 10% and 11% respectively between 2008-09 and 2012-13. In five areas, performance improved – Grampian, Greater Glasgow and Clyde, Lothian, Tayside and Western Isles.
Below average performance in this area did appear to have had an influence on resource allocations, with boards developing a wide range of initiatives to tackle this issue. These include:

- Anticipatory care planning
- Local unscheduled care action plans
- Development of Combined Assessment Units
- Joint working with other partners, including GPs, local authorities and the Scottish Ambulance Service
- Hospital at Home services

Some boards mentioned the opportunities offered by the integration of health and social care services to address this issue. Dumfries and Galloway noted their decision to include all hospital services within integration funding reflected the view that improvements in this and other areas can be achieved through a joined up service, avoiding duplication and fragmentation and releasing efficiencies.

All boards felt that it was a useful indicator, although a number noted that it needed to be considered alongside other indicators and that disaggregation e.g. by age, deprivation, reason for admission would provide greater insight.

As with other indicators, boards found it difficult to isolate spending in this specific area. Some provided figures for broader areas of spend e.g. the entire integrated care fund, while others detailed specific capital projects or services. As a result, it is not meaningful to provide any aggregate figures. However, it is interesting to note that, for those boards reporting details of spending, expenditure is planned to increase in 2015-16 for all but one board (Ayrshire and Arran). In Ayrshire and Arran, the reduction reflects lower spending on local unscheduled care action plans in 2015-16.
All boards noted the contribution of other partners in this area, including:

- Local authorities
- GPs
- Scottish Ambulance Service
- NHS 24
- Third sector, including Red Cross

It would be interesting to examine the actions taken to tackle underperformance in this area to identify strategies that have led to success (for example in Greater Glasgow and Clyde and Lothian)

9. Further comments emerging from the survey

The Committee’s report last year on the 2014-15 board budget highlighted the need for more consistency in financial data, as comparative analysis was limited by the different approaches adopted by boards in the provision of information. This situation has not been resolved and it appears that information systems are not designed in such a way as to enable ready access to information linking spend to specific performance indicators. It would be interesting to understand whether any action is underway to address this issue. Early indications suggest that this may receive greater focus in reporting required of the IJBs. There is an opportunity for the Committee to highlight the type of information that would be useful to gather in relation to these new organisations.
Annexe

NHS Board Accounts: 2015-16 questionnaire

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)

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

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

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)

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?

6. What functions will be delegated via the integration plan/scheme? Please explain the rationale for these decisions
7. How much is being allocated to the Integration Joint Board for 2015-16?
   a. by the health board
   b. by local authority partners?

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

Specific challenges

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

<table>
<thead>
<tr>
<th>Board</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>89.6%</td>
</tr>
<tr>
<td>2010</td>
<td>90.0%</td>
</tr>
<tr>
<td>2011</td>
<td>90.1%</td>
</tr>
<tr>
<td>2012</td>
<td>89.9%</td>
</tr>
<tr>
<td>2013</td>
<td>90.1%</td>
</tr>
</tbody>
</table>

Source: [http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/birthweight](http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/birthweight)

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

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

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

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.
<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £'000</th>
<th>Planned expenditure 2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Board</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td></td>
<td>90.4%</td>
</tr>
<tr>
<td>2009-10</td>
<td></td>
<td>90.5%</td>
</tr>
<tr>
<td>2010-11</td>
<td></td>
<td>90.7%</td>
</tr>
<tr>
<td>2011-12</td>
<td></td>
<td>91.1%</td>
</tr>
<tr>
<td>2012-13</td>
<td></td>
<td>91.2%</td>
</tr>
</tbody>
</table>

Source: [http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/endoflifecare](http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/endoflifecare)

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

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

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

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.
<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £’000</th>
<th>Planned expenditure 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. What statutory partners or other partners (if any) contribute towards performance in 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](#))

<table>
<thead>
<tr>
<th></th>
<th>Expenditure 2014-15 £’000</th>
<th>Planned expenditure 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist palliative care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General palliative care services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

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

<table>
<thead>
<tr>
<th>Agreed funding for hospice running costs for specialist PELC (£’000)</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As % of total hospice funding</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Agreed funding for running costs of independent children’s hospices (including local authority funding where relevant)

<table>
<thead>
<tr>
<th>£’000</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>As % of total independent children’s hospice running costs</td>
<td></td>
</tr>
</tbody>
</table>

9. Please provide any further comments on palliative care / hospice funding that you consider to be relevant:
1. How does performance in your area compare with the national performance?

<table>
<thead>
<tr>
<th></th>
<th>Emergency admissions rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board</td>
<td>Scotland</td>
</tr>
<tr>
<td>2009-10</td>
<td>9,849</td>
</tr>
<tr>
<td>2010-11</td>
<td>9,874</td>
</tr>
<tr>
<td>2011-12</td>
<td>10,090</td>
</tr>
<tr>
<td>2012-13</td>
<td>10,130</td>
</tr>
<tr>
<td>2013-14 (p)</td>
<td>10,188</td>
</tr>
</tbody>
</table>

Source: [http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/admissions](http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/admissions)

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

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

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

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
<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £'000</th>
<th>Planned expenditure 2015-16 £'000</th>
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<td></td>
</tr>
</tbody>
</table>

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

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