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Date: 31st July 2018
Your Ref:
Our Ref: NRG /MMc/H&SC0718

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Dear Mr. Macdonald

RE: Health and Sport Committee Follow-up Questions

I refer to your letter emailed to me on the 4th July 2018, raising questions following our evidence provided to the Committee on the 15th May 2018. For convenience I have listed the questions followed by the relevant responses.

Recruitment and retention

Q: We heard in evidence (COL 13) that seven of your consultants and four of your anaesthetists are Polish and the need to be concerned about whether they will stay post-Brexit. Can you advise what anticipatory planning has been undertaken in the event they all leave the Western Isles?

A: We have worked hard to put control measures in place to mitigate the risk of lack of recruitment or retention of consultants. This includes the development of a cohort of physicians, surgeons and anaesthetists who provide regular cost effective locum service. This has the potential to be flexed up should the need arise, in the event that we failed to retain substantive post holders.

NHS Western Isles currently employs 10 substantive consultants and, as of today 25th July 2018, six locum consultants. There are six consultants who have been born in countries which belong to the EU now, of which four of these are Polish. In one speciality, Anaesthetics, we have three out of four Anaesthetists who are Polish.

All of these consultants have resided long enough in the UK to be able to remain after Brexit, and have been encouraged to do so. Some of them are already British citizens. We anticipate that Brexit will not affect their decision to work in the NHS Western Isles.

Health and Social Care Integration

Q: In your submission to the Committee we note many of the strategic aims outlined in the Balanced Scorecard Performance Report 2017/18 are not being met. These include indicators on premature mortality and emergency hospital admission rates. We would be grateful if you could advise:

- *what are the obstacles to meeting the unmet targets?*
- *the extent to which the integration of health and social care is assisting in affecting performance?*

A: Some of the targets not on trajectory are noted below, supported by a rationale statement.

Aim: ***90% patients able to book an appointment with a GP more than 3 days ahead.***

Target: 90% / Actual: 85.2% as at 31.03.18

Reason: Two of the biggest practices in Stornoway are struggling with capacity and have recently changed access models to focus on urgent presentations. Work is ongoing with practice managers to influence access models.

Aim: ***Board must eradicate all waits over 16 weeks (longstop target linked to 12 week target)***

Target: 100% / Actual: 94.3% as at 31.03.18

Reason: It is not possible to eliminate all waits >16 weeks due to combination of

1. the way the Clock Reset rules changed post Treatment Time Guarantee, requirement to take clinical judgement into account before exercising reasonable offer policy; and
2. infrequent clinics for certain locations and specialities.

As clock resets are no longer permitted once a patient goes beyond initial guarantee date, when a patient goes beyond 12 weeks they will not have a clock reset for the rest of the wait regardless of whether they reject multiple reasonable offers, move appointment, make themselves unavailable of Did Not Attend (DNA) multiple times.

The planning officer continues to push for these patients to be discharged after 2 or more reasonable offers if deemed clinically appropriate by the responsible clinician.

We also continue to request extra capacity utilising waiting times monies in specialities where visiting Service Level Agreements does not provide sufficient slots to meet ongoing demand.

Aim: ***80% of women in each SIMD quintile will have booked Ante-Natal clinic by 12 weeks gestation.***

Target: 80% / Actual: 67% as at 31.03.18

Reason: The principal issue relates to coding completed by mainland hospital units where women who have travelled to a mainland unit to give birth do not have the correct date of booking entered. There is a need to work retrospectively with local staff to correct the data submitted by other mainland units to the Information and Statistics Division (ISD).

Work continues to support and encourage women to book prior to 10 weeks gestation. This message is delivered nationally and appears well published and documented. Lack of information does not seem to be the main issue for the Western Isles.

WE are striving to implement an electronic maternity system that will provide more accurate information, which will help with quicker resolution to incorrect data entry by mainland boards. However coding is done at source of birth so the issue with incorrect coding by mainland boards will always require retrospective correction.

Where mothers to be are sent to a mainland unit to give birth are from the Uists and Barra. Staff within the Southern Isles are fully aware of the need to document in the referral letter to the mainland hospital the date of presentation.

Aim: ***Delivery of universal smoking cessation services to achieve a number of successful quits at 12 weeks post-quit in 60% most deprived within-island board SIMD areas.***

Target: 47 quits / Actual: 36 quits as at 31.03.18

Reason: The overall successful quit numbers will not be finalised until the end of June and it is expected several more successful quits to be included in the actual percentage.

One of the main factors in our under performance is the way in which we are measured. (SIMD) postcodes are highly inconsistent as a measure within the Western Isles and many of our successful quitters who are out with the current identified SIMD areas are justified in receiving our specialist support. The number of successful three month quits overall in this period of time in all SIMD areas is 64.

Additional factors include:

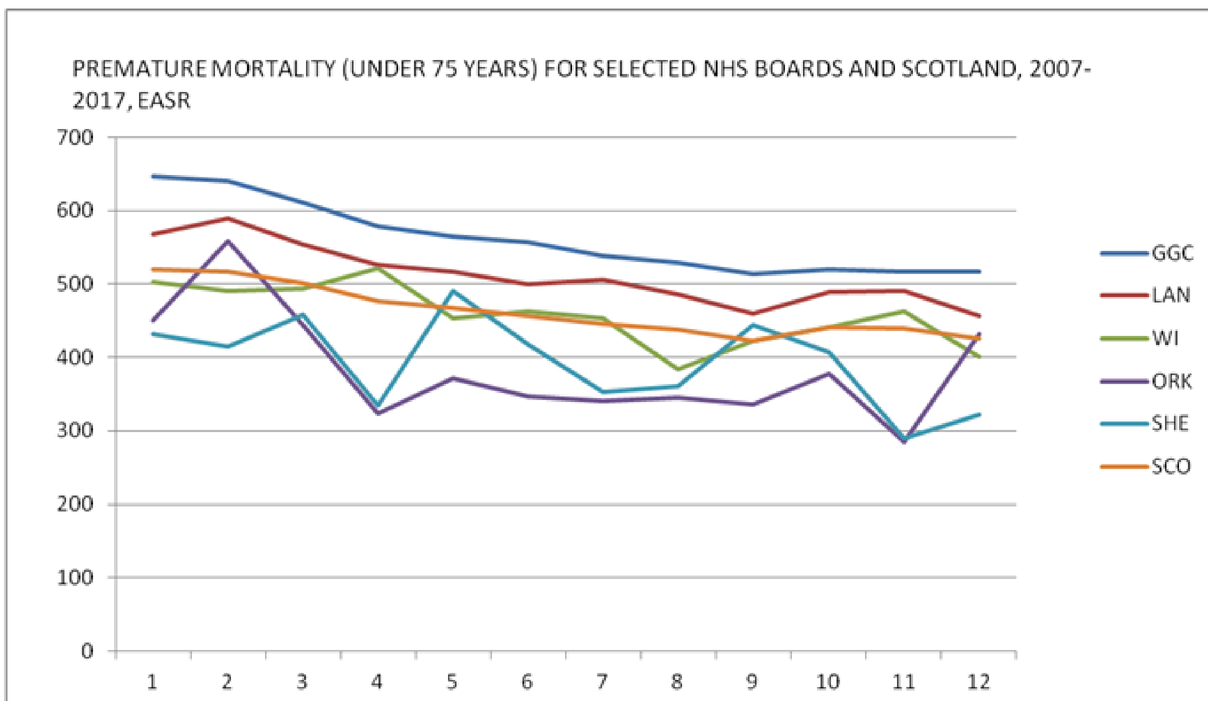
- The increased number of smoker that are using E-cigarettes
- Referral rates lower than in previous years
- New members of staff
- Poor pharmacy support to public

Some actions being taken to mitigate the factors include:

- Providing more training to our partners within the NHS setting and to GP practices in the referral process
- Encouraging Pharmacies to improve their referral process to ensure that they provide a more structured service to the public by improving follow up process and engaging with specialist services to offer more intensive support to client groups.

Premature Mortality

The premature mortality rates in the Western Isles tend to follow the trends of other West Coast Boards, and are around the Scottish national trends, although the small numbers lead to wide year to year variation. Examination of causes of death indicate that there is a lower than national rate of respiratory related deaths (as might be expected) and a slowing of the rate of decline in deaths from circulatory system diseases in the past three years. Other causes (cancer and all other causes) do not vary significantly from the national trends. We will continue to monitor these trends and maintain our activities on healthy living including those around smoking cessation (where we have the highest performance figures in Scotland), alcohol use, diet and physical activity.



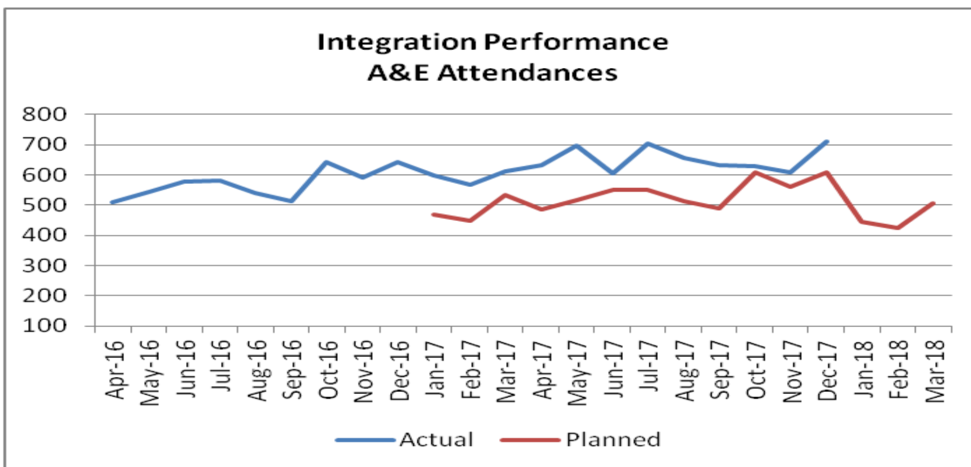
All deaths which occur in our hospitals are reviewed comprehensively and carefully to gather any learning about our care and services provided for patients. Any improvement actions are implemented.
Our recent reviews which focus on deaths occurring in hospital have not raised any issues of concern.

Emergency Admissions / Readmission / Falls

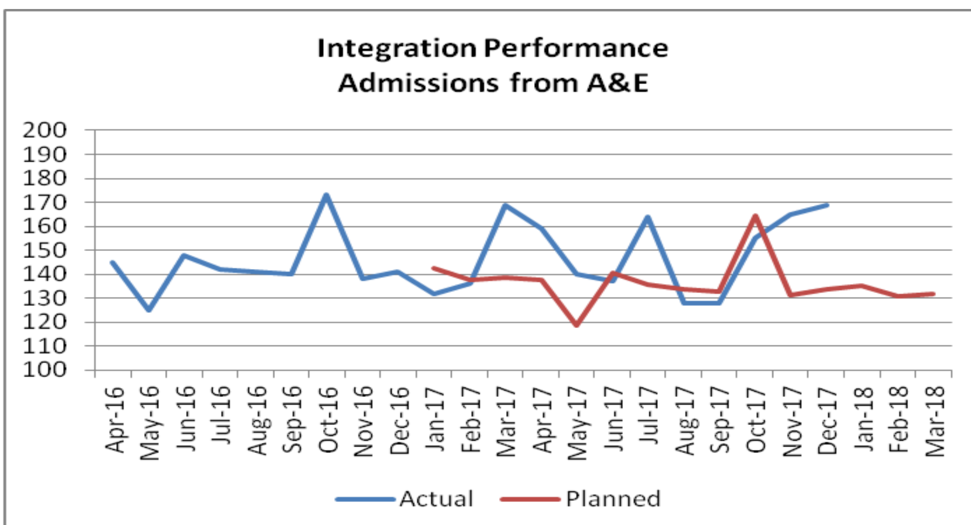
The following series of graphs illistrate in detail our experience of dealing with emegency admissions, re-admissions and falls.

The number of people attending A&E in 2017 exceeded what was expected in that year (graph 1). However the overall conversion rate for admissions from A & E have been below planned trajectory for 2 of the 3 quarters in 2017/18 (graph 2).

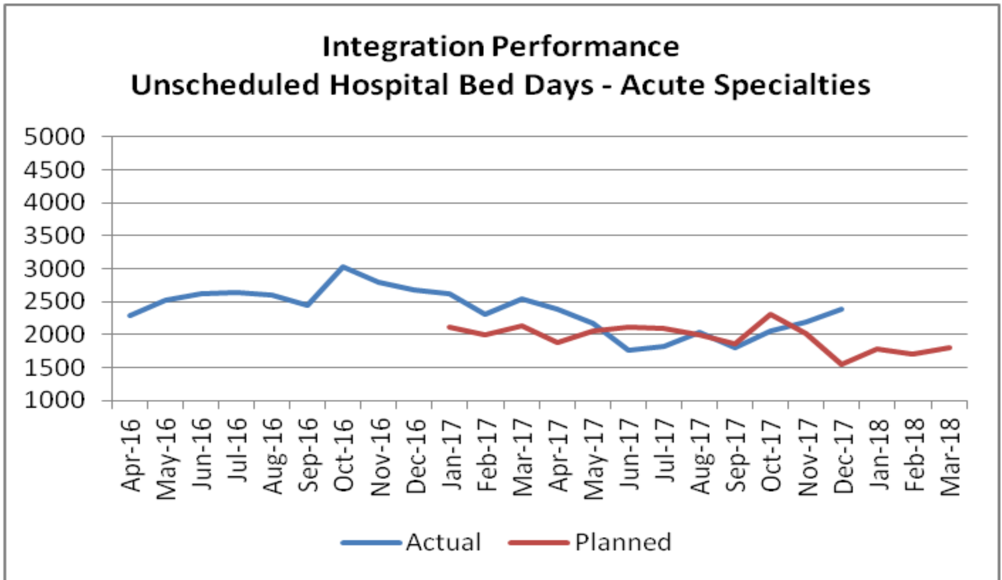
Our unscheduled care bed days, (graph 3), have been on or below target for a 7 month period between May and November 2017. In Q3, we have seen an increase in emergency readmissions within 28 days from 157 in 2016/17 to 174 in 2017/18 (graph 4) (data taken from Source Health & Social care Integration indicators), though this remains significantly below the Scottish average it is a slight increase on the previous year. An increase in the number of falls, (graph 5 & 6), is also seen within Q3 & Q4, leading to a slight overall increase in the falls rate per thousand for the year.



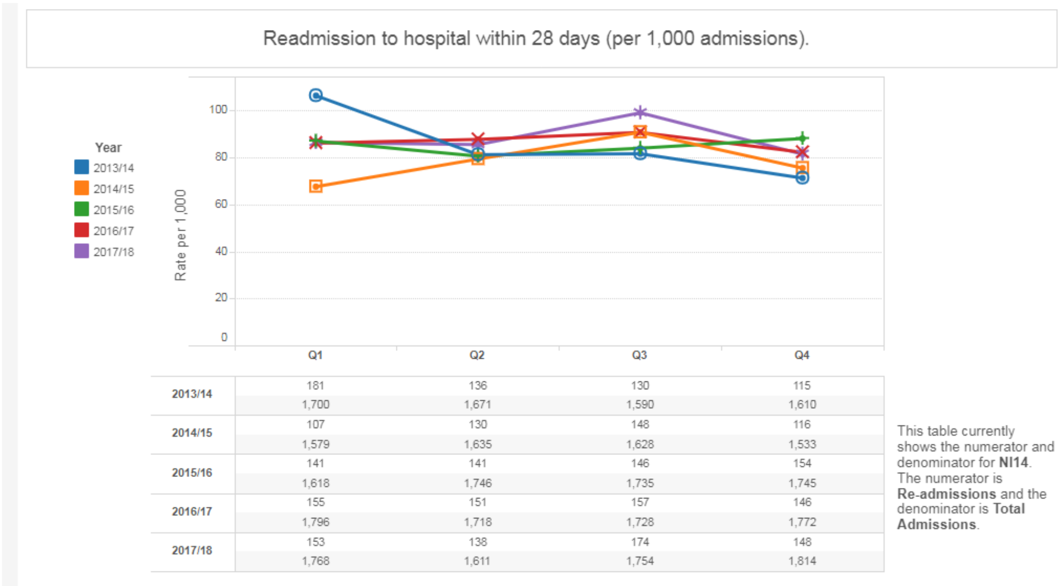
Graph 1



Graph 2



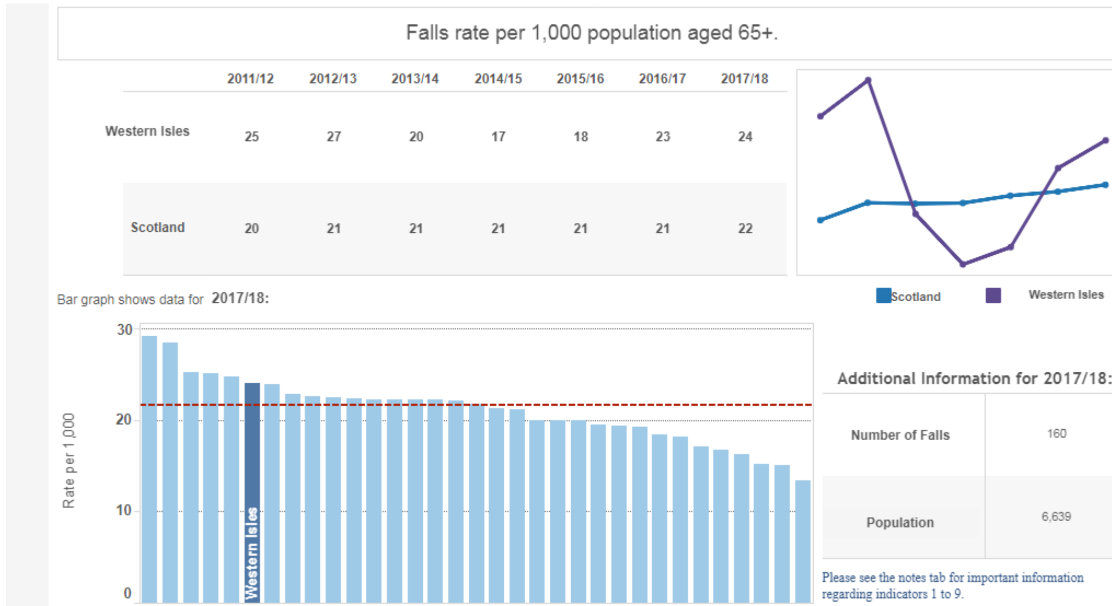
Graph 3



	Q1	Q2	Q3	Q4
2013/14	181	136	130	115
	1,700	1,671	1,590	1,610
2014/15	107	130	148	116
	1,579	1,635	1,628	1,533
2015/16	141	141	146	154
	1,618	1,746	1,735	1,745
2016/17	155	151	157	146
	1,796	1,718	1,728	1,772
2017/18	153	138	174	148
	1,768	1,611	1,754	1,814

This table currently shows the numerator and denominator for **NI14**. The numerator is **Re-admissions** and the denominator is **Total Admissions**.

Graph4

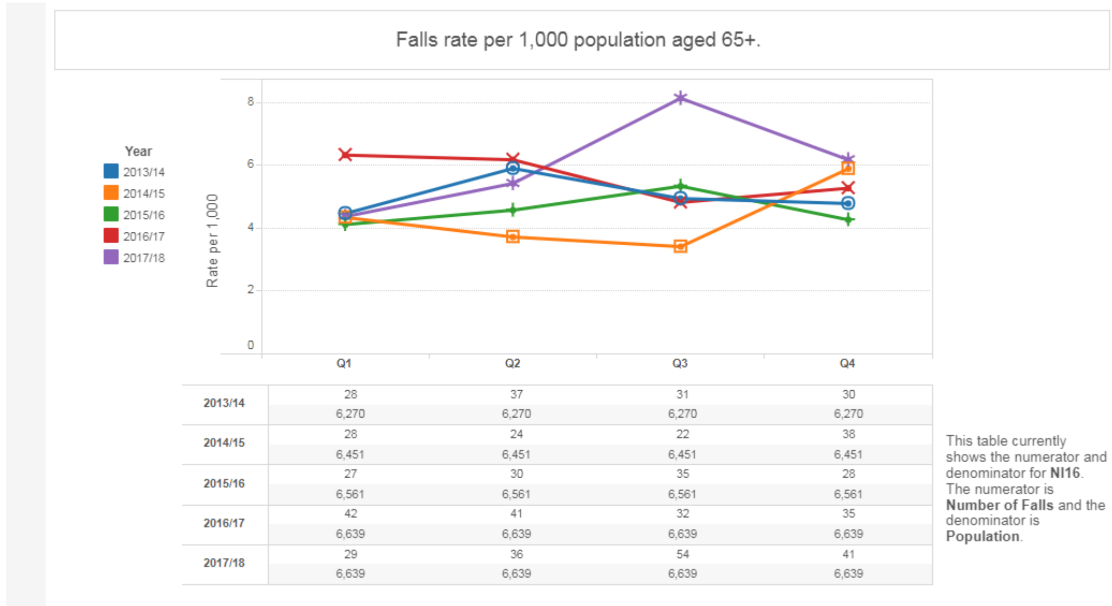


	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Western Isles	25	27	20	17	18	23	24
Scotland	20	21	21	21	21	21	22

Additional Information for 2017/18:

Number of Falls	160
Population	6,639

Graph 5



	Q1	Q2	Q3	Q4
2013/14	28 6,270	37 6,270	31 6,270	30 6,270
2014/15	28 6,451	24 6,451	22 6,451	38 6,451
2015/16	27 6,561	30 6,561	35 6,561	28 6,561
2016/17	42 6,639	41 6,639	32 6,639	35 6,639
2017/18	29 6,639	36 6,639	54 6,639	41 6,639

This table currently shows the numerator and denominator for **NI16**. The numerator is **Number of Falls** and the denominator is **Population**.

Graph 6

To prevent admission, support discharge and consequently reduce re-admission we have produced a reablement services called the START Team (Short Term Assessment Reablement Team). The Team responds to prevent avoidable hospital admissions and the early supported discharge for patients at their optimal pointe. The service includes a building based facility that widens available bed space and enhances the opportunity for reablement approaches to assess and support a person's reablement pathway in a domestic setting.

Redesign of Local Services

Q: The Cabinet Secretary's response to your annual review requested you keep the health directorates informed of progress with redesign of local services. We could not see any detail of this in your submission to the Committee. Can you advise what progress has been made and what baseline information and data you are measuring progress against?

Colleagues within different sections of the Scottish Government Health Department have been kept up to date and providing advice in the design and delivery of many aspects of care.

- **Mental Health**

  The Board in the past undertook a redesign of Mental Health and with the establishment of the IJBs the redesign was moved to the partnership delivery agenda. NHS Western Isles provides a wide range of mental health and learning disability services, although Child and Adolescent Mental Health service is not a delegated function. The functions that are delegated include inpatient, outpatient and community-based support. Mental health covers a range of services, including:
  - general adult psychiatry
  - psychiatry of old age
  - substance misuse (alcohol and drugs), and
  - learning disabilities.

  The existing inpatient and community services have many strengths and we know that our staff provide high quality care and support to service users and their carers and families every day. However, like all Integration Joint Boards in Scotland, we are facing significant challenges, and we cannot keep delivering services the way we have in the past. We need to adapt our services to ensure they are sustainable and meet the future needs of the population. Patient safety is an overriding priority and, to ensure we can continue to deliver a high quality of care to a greater number of people, in order to deliver a sustainable mental health service, it has been necessary to look at the way we provide these services and look at alternative models of care. The service reform will deliver enhanced community mental health service but with short term hospital assessment for those who require it. The consequences of implementing this option will be the closure of the Western Isles Hospital designated Acute Psychiatric Unit and Clisham Ward for the care of people with Dementia, and the services moving into Community. We recognise the importance of consistency for patients and staff and have therefore stated that APU will remain open until assurance can be provided regarding the availability of acute mental health beds on the mainland. Our substantive mainland provider has recently reduced its available beds further in the light of inability to recruit staff for the psychiatric service. Clisham Ward will close once the current patient bed numbers reduce to three. The intention remains that these patients will be transferred into the medical wards for their care and when, as a result of multi-disciplinary assessment, they no longer require hospital based complex clinical care, will await placements in the community.

Research into Community Mental Health Teams across the UK indicates that Community teams should consider components relating to crisis and early interventions in addition to the broader Community Mental Health Teams. However, with the relatively small patient numbers in the Western Isles, it is not sustainable to have individual crisis and early intervention teams. The Mental Health Redesign is investigating having a flexible workforce, with the right skill mix that can be drawn into teams as necessary.

The Crisis and Early Intervention teams are multi-disciplinary teams consisting of CPN, Support Workers, Consultants, Social Workers, Housing, Criminal Justice, Third Sector, Pharmacist, AHPs pulled into the teams as the patient need requires. This will necessitate integration of statutory and non-statutory services staff to enable efficient and effective working practices. Consideration will be given to the co-location of staff to enable a more integrated approach to patient care.

Work continues to make change, including the involvement of colleagues within the Scottish Government.

- **Primary Care Improvement Plan**

Over the next few years, we can expect to see the primary care services provided by GP practices change, as we seek to improve health and wellbeing. Given the profile of our ageing population, increasing levels of frailty and rising demand for services, we need to reform our services if we are to add life to years and years to life. We know that it is particularly difficult to attract GPs into practices in remote and rural parts of Scotland. While some action is being taken nationally to address this shortage, it takes ten years to become a fully qualified GP. So we need to think differently.

We also know that not all people with a health issues need to see a GP. If a person has a sports injury or back problem, often a physiotherapist will be the best person to see. If a person has a long-term condition, a practice nurse may well be able to assist. Indeed, Advanced Nurse Practitioners are able to provide a full range of services similar to a GP, from initial assessment to completion of treatment. What we envisage over time is that the old model of general practice, whereby the patient always sees the GP first, will give way to a new system, where a team of health professionals – including a GP – will provide the support. This team might even identify non-medical issues that are important to the patient – perhaps around benefits advice that impact on health and wellbeing – and refer the patient on to the right person. We envisage the GP actively leading multi-disciplinary teams to ensure that they are fully informed about all active cases.

As part of these reforms, our local health and care system needs to rethink how services are delivered, with a greater focus on preventing ill-health and using technology to bring healthcare professionals into contact with their patients in new ways. This might involve remote monitoring of blood pressure or a video conference over a smart phone or even a telephone conversation. It might also require further collaboration between GP practices and new arrangements to be put in place around local access, to make best use of the

resources we have. While all of these changes are a feature of the reforms we expect to see over the next few years, we also recognise that these will need to be introduced in partnership with communities. We understand that for the new model of primary care to be a success, the people who use or who may come to use the service need to actively shape how they will receive the best possible care and support. If we are to deliver more care in the community; focus more on preventing illness and support those with long-term conditions to self-manage, then we'll need to build on the assets and support arrangements that communities themselves have developed.

The change process will need to be driven through leadership across our primary care system, supported by healthcare management.

We want to build on the reforms within general practice to deliver a new model of care. This will be an iterative process but by the end of our three year transition, the shape and feel of primary care should be different in a number of ways:

Old model →	**New model**
Target based medicine	Holistic medicine
GP as gatekeeper	GP as clinical leader
GP-led service	Multi-professional team
Practice Nursing as Support	Practice Nursing as Empowered Practitioners
Services accessed at practice	Technology based outreach
Referral based onward care	Actively coordinated onward care
Focus on access times	Focus on convenience

As part of this reform we have to look at the work being undertaken by the Scottish Government and British Medical Association (BMA) who have agreed a new GP Contract to support the ongoing development of primary care services in Scotland. The contract will refocus the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on complex care, as well as whole system quality improvement and leadership. The aim is to enable GPs to do the job they train to do and enable patients to have better care.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period through a memorandum of understanding. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health

services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists.

Below are the actions which will be taken forward to implement the necessary changes to make the Primary Care changes including the new GP Contract.

Triple Aim	Outcome	Action		Timeline
Quality of Care	Primary care provides access to a wider range of health and care professionals to ensure patients get the right help at the right time	1	A review of existing multi-disciplinary working is undertaken to identify best practice and then spread across localities through the Locality Planning Groups, including an examination of cost and efficiency. This will be conceptualised and positioned as the Hebrides Care Model.	April 2019
		2	New community mental health workers are funded to support GPs whose patients' mental health needs can be managed by primary care within local communities. This will be a collaborative model developed with third sector partners.	April 2019
		3	The role of rural community link workers will be assessed in the context of existing pilot projects designed to connect patients to different forms of community support and a decision taken about how best to embed these arrangements if successful	April 2019
		4	A pilot project will be funded to explore how and whether the provision of citizens advice in GP surgeries would benefit patient outcomes through the support of a specialist community link worker	April 2020
		5	A review of the physiotherapy service is undertaken to determine how best connections between GP practices and community physiotherapists can be made and a specific MSK pathway put in place, with a view to building community physiotherapy capacity by 2021-22	April 2020 April 2022
		6	Practices will be supported to develop additional Advanced Nurse Practitioner capacity, which is a key element in reducing GP workload. This will be achieved by developing existing practice staff liberated from community treatment and vaccinations.	April 2019
	Patients can access effective urgent care on a 24/7 basis	7	A new programme manager will be appointed to lead our work on the reform of urgent care, to oversee relevant work streams and deliver an agreed implementation plan	April 2018
		8	Work is undertaken with the Scottish Ambulance Service to embed paramedics within local urgent care systems to provide immediate care and determine whether the patient can be best managed in their home environment or requires input from a hospital service	April 2019

		9	A multi-disciplinary team is established to coordinate urgent care during the Out Of Hours period, connecting to the three hospitals within the Western Isles. This will be based on enhanced social and nursing care provision during the out of hour period.	April 2020
	The management of patients' medication is efficient and safe	10	A review of pharmacy governance is undertaken and actions produced to ensure that more effective oversight is in place across primary and secondary care	April 2019
		11	Primary care pharmacy capacity is at least doubled to ensure that practices and social care services are better supported by pharmacy technicians	April 2019-21
		12	A three year programme is established to ensure that pharmacy support delivers core tasks (acute prescribing, repeats, discharge letters, medication compliance reviews); advanced tasks (medication review, resolving high risk medication problems); and specialist tasks (polypharmacy reviews, specialist clinics	2018-21
	Patients are able to access high quality and local community treatment	13	A detailed implementation plan is developed to consider how best community treatment can be provided to local communities, for a range of common conditions and treatment such as minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring. Implementation of this will happen sequentially, using the generic nursing workforce.	December 2019
Health of the Population	Effective and safe vaccination services are developed by the Western Isles Health Board by April 2019 in order to reduce the workload of GP practices	14	A detailed vaccination transformation plan is agreed and implemented, which will focus on sustaining the high levels of vaccination uptake and support capacity attached to general practice. This will be delivered via generic NHS Board nursing capacity, which will also align with the community treatment agenda.	April 2019
	GPs use their skills as expert general medical practitioners to improve the health of the population Our primary care system continues to help people to get well and stay well	15	Quality improvement work is identified and embedded across all practices through participation in the local Quality Cluster. This will build on the GP's leadership role to support a quality improvement agenda that begins with prevention and which is anchored on the national population health priorities.	Ongoing

Value and Sustainability	Our communities are well-informed and understand why primary care services are changing	16	There will be continual engagement with local professionals and communities through regular discussion at Locality Planning Groups about the changes being introduced to primary care. This will be supplemented through a communication strategy that will use a full range of local and social media to explain local reforms.	Ongoing
	Our local practices are sustainable with effective business management and administration arrangements in place	17	Survey work is undertaken to assess practice sustainability and to ensure that plans are in place in terms of succession planning. Work is undertaken with practice managers to determine opportunities to streamline business management	April 2019
		18	Effective representation is made within the Scottish Government's Rural Short-life Working Group around the impact of the new contract on remote and rural practices in the Western Isles	April 2019
	Our local practices attract high quality healthcare professionals into the local primary care system	19	Further work is undertaken to develop and attract a new generation of GPs willing to work in rural practice by innovating at all stages in the training of a GP, from secondary school onwards	Ongoing
		20	Opportunities are taken to examine the physical estate that supports General Practice in the Western Isles, to ensure that we optimise the clinical space available and provide a modern environment for medical practice.	Ongoing

- Delayed discharges ~ noted in a separate section within this letter.

Waiting Times

Q: In your submission to the Committee you pointed out pressures on the waiting times budget resulted in limited options around running extra clinics. However, areas identified in the improvement plan included different scheduling options and a greater use of eHealth support. We would be grateful if you could advise:

- *whether the budgetary constraints continue to restrict progress?*
- *progress on implementing the technological solutions*
- *detail of other solutions being implemented which increase capacity or address demand*

Budget

As a Board we receive access support monies to facilitate waiting times and therefore assume the income and thereby match the expenditure. It became clear in the last few months of 17/18 that costs were exceeding income and that due to the forecast Board overspend we had to reduce waiting list initiatives in the last few months of 2017-18.

The allocation from the Access Support Team for waiting times has increased this year to £328,000 which will allow us more flexibility. This funding is allocated and ring fenced for waiting times.

However, physical clinic space capacity and staff availability are as much of an issue as finance at present. The move to earlier Inverness to Stornoway flights means that visiting Service Level Agreement clinicians are less willing to do Waiting Lists when they are here as their day is then too long and exhausting.

Progress with technology

We are already utilising "Attend Anywhere" for some of our clinics and have now identified an area within the Western Isles Hospital, for clinicians, to dedicate to this. This means a reduction in patients having to travel to the mainland or for a visiting consultant to travel to the Western Isles. One example is of a Respiratory Physician employed by us, receiving clinical governance through NHS Highland but performing his clinics at home in England within a secure system (able to see chest images through radiology PACs system)

Other solutions

We should be able to make progress on long Out Patient Department waits by agreeing more visiting clinics that are not necessarily performed as waiting list initiatives but through matching demand to plan more visits across the year avoiding peaks and troughs of activity. We are also anticipating that some of the monies could be allocated to develop and implement long term sustainable solutions rather than the short term fixes of Waiting List clinics e.g. developing CNS and ENP roles and utilising Attend Anywhere technology as described above.

Cancer Waiting Times

Q: We note from the most recent data from Scotland Performs NHS Western Isles is the fifth lowest performing health board when it comes to the 62 day cancer waiting time target of 95%. We would welcome details of:

- *what work the board is doing to improve the situation; and*
- *the extent to which you are dependent on other board areas in achieving the target*

A: In terms of local Board actions, we continue to promote the national screening programmes (breast, cervical and bowel) and the Detect Cancer early campaign for early attendance at GPs for suspicious symptoms. In 2017/18 we ran a series of roadshows across the islands with the Giant Inflatable Bowel, to coincide with the change from three samples to one sample bowel cancer screening in the autumn. We supported the national breast screening programme triennial visit in the spring and summer of 2017 with information sessions and links to women's groups.

It should be noted that for the cancer 62 day target from urgent referral to treatment, we are fully reliant on other mainland NHS Boards to deliver care for the range of ten cancers assessed through the target.

Our waiting time in the final quarter of 2017/18 reached 88.9%, compared to Greater Glasgow and Clyde of 81.3% and Highland of 81.4%, so we are performing better than our mainland provider Boards. However, this will relate to small numbers of patients and therefore wide variability in achievement is to be expected. We achieved 100% for the 31 day target for decision to treat.

Dementia Post Diagnostic Support

Q: The national target for people newly diagnosed with dementia getting access to a minimum one year's post diagnostic support is 100%. Your submission notes, as of December 2017, only 18% of people in the Western Isles are receiving this service. Can you advise what steps are being taken to meet the target?

A: We did have a significant gap in service due to staffing issues and the service was re-established in September 2016. As at March 2018 progress has been made, albeit small, but the percentage has increased to 22% of those people with a diagnosis have received a year's worth of support.
As at June 2018 further progress has been made with 22 people completed a full year and 51 are currently receiving Post Diagnostic Support.

PDS Outcome	Patients
01 12 Months Finished	22
03 Patient has died	6
04 Patient has moved to another area	1
05 Transferred to Alzheimer's Scotland	1
98 Other	2
Currently Receiving PDS	51
Grand Total	83

The Board has taken a number of actions to support the delivery of the service. Staff are in post, currently on bank hours until the restructuring of the Mental Health Review and its associated resources are finalised. Referrals to Post Diagnostic Support (PDS) were inconsistent and a new pathway was created to improve the process, enabling GPs to refer to the Lead Nurse as well as the Psychiatrist. All GP practices now have their own individual memory clinics taken by our Dementia Specialist Nurse and this has already improved diagnoses and PDS uptake.

Delayed Discharge

Q: In your submission to the Committee you explained delayed discharge has, and continues to be a major challenge for the Western Isles Partnership. You also advised steps were being taken in 2017/18 to help improve the situation. Can you advise?

- *the reasons for NHS Western Isles having the highest proportion of delayed discharge bed days as a % of all bed days*
- *the extent to which the action points to help towards reducing delayed discharge rates been successful*
- *your assessment and expectations as to whether the actions will lead to a permanent sustained improvement*
- *the extent of learning from other health boards such as NHSGGC who have had successes in this area*

A: We are committed to reducing the length of time that older people wait in hospital despite being ready for discharge – this has been one of the major priorities in the first few years of the IJB's existence, working in partnership at strategic level and operational level. The Western isles currently has insufficient care home capacity to serve current and future demand. We have been working hard to improve our performance through the implementation of a delayed discharge action plan. The action plan focuses on capacity issues, as well as issues around culture and practice. As evidenced below (graph 10), delays in hospital have reduced markedly over 18 months. We have applied improvement methodologies to demonstrate that the gains have been sustained.

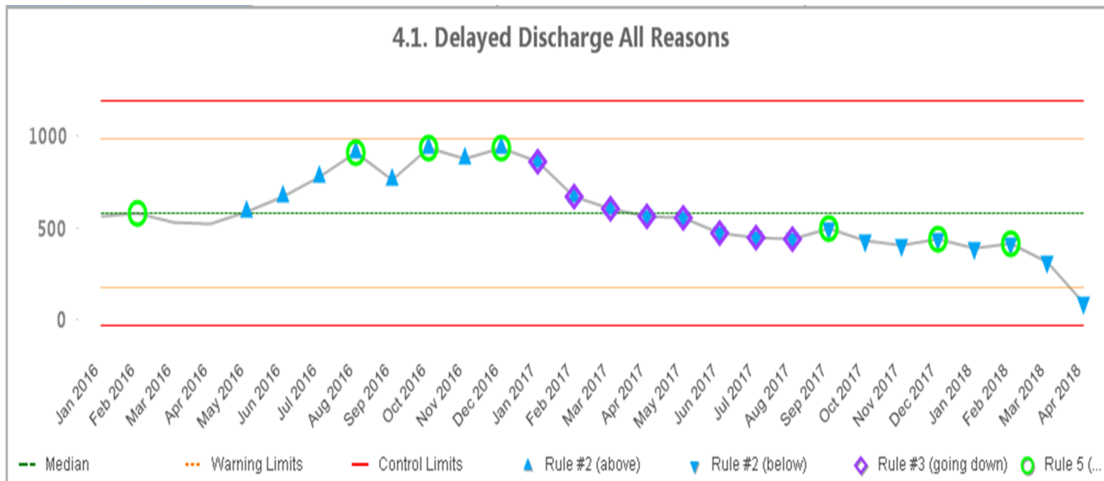
Following the partnership commissioning of additional bed capacity at Bethesda Care Home, there was a short-term reduction in the number of people delayed, but following spikes during the mid-summer and then October (both holiday periods where local community care capacity ~ homecare and residential care was limited), the number of people delayed increased to previous levels.

Prior to those numbers hitting a peak, we devised a delayed discharge action plan, and while that was based on established best practice from across Scotland, it was also grounded on a basic hypothesis about our local system: that improvement will not come simply by thinking about our problem in terms of capacity (e.g. not enough home care) but by tackling culture and practice at an operational level. The hypothesis was based on some early analysis undertaken which showed that capacity across social care services is comparable with Scottish averages.

Since then, under the auspices of the delayed discharge team an action plan was developed in consultation with Scottish Government policy leads and took cognisance of best practice from across Scotland. Significant work has gone into working with the clinical and care leads at an operational level to change culture and practice. While we have managed to maintain our improvements over the course of the last 18 months, this will always be subject to flux month on month as we manage demand for services. Overall, our approach to the management of delays is much improved and under the leadership of the Head of Social and Partnership Services, the weekly discharge planning meeting has shifted from supporting the passive exchange of information to problem solving and risk management. The number of code 9 delays has dropped markedly. The subsequent development of an in-depth analysis of the delayed discharge problem by the Head of Information Services supports the basic assumptions that underpinned the initial

action plan. While capacity within the system is of course an important factor, our hypothesis remains that more effective multi-disciplinary working and streamlined assessment and care management processes is driving better performance.

There have however been increases in recent months as we try to close a long-stay dementia ward, along with increasing staffing challenges in community care (vacancy levels running at 10%). Where we hadn't in the past managed our system as a whole, we are now doing that as a matter of routine. Local community care capacity (homecare and residential) is about average for Scotland but over recent months staffing issues have become more problematic



Graph 10

Finances

Q*: We would welcome:*

- *an update on the position with regards to savings achieved at the end of 2017/18, in particular the balance between recurring and one-off savings;*
- *details of work being undertaken to increase the proportion of annual savings that come from recurring savings;*
- *details of future savings plans; and*
- *what longer term financial planning is being undertaken to ensure that services are designed to meet changing demographics and challenges.*

A: We achieved 100% of our savings, £3,500k - this was split £2,449k recurrent savings (70%) and £1,051k non-recurrent savings (30%)

Below is our current saving plans and we are actively looking an initiatives to reduce the unidentified savings

Ref.	Summary	Lead Manager	Responsible Manager	R/NR	Saving 18/19 £'000	Risk	EQIA / Risk Assessment	Description of Proposal and Associated Risk
NHS2	CNORIS Efficiencies	Debbie Bozkurt	Head of Finance	R	50	H	Not required	Indications are there are efficiencies within the CNORIS budget if % calculations are similar to 17/18
NHS3	Demand Optimisation	Dave Rigby	Medical Director	R	20	H	Not required	The is a work group looking at demand optimisation for example looking at the number of Lab tastes required and whether all these require to be done under clinical guidelines. Work has also been done looking at MRI scans
NHS4	Unidentified Savings	All	All	NR	656	H	Not required	The Corporate Management Team is working to identify further savings to make up the £759k unidentified savings. By month 3 we will have a better idea of the various redesigns of teams that are taking place and there may be an extension of specific vacancies.
NHS1	Reduced sickness absence those working within delegated services	Ron Culley	Chief Officer	NR	182	M	Corporate assessment	In line with wider corporate targets, a more demanding threshold around staff sickness absence has been applied. Generic target to improve sickness absence through deployment of corporate tools like EASY and enforcement of local policy through effective line management. However, this remain a high risk saving proposal given that we are not fully in control of levels of illness and we have an ageing workforce.

NHS5	East side SCN frozen ahead of redesign	Ron Culley	Lead Nurse, Community	R	60	M	Risk assessment in place	This post has already been frozen for several years, with a single SCN managing the two community nursing teams. While this is not without impact, it allows us to think about more permanent restructing and re-allocation of responsibilities across the SCNs in Lewis and Harris.
NHS6	Specialist Nursing Redesign	Ron Culley	Lead Nurse, Community	R	27	M	Risk assessment in place	This is subject to ongoing review. A Band 8b specialist nurse is due to retire mid-year. Proposal to reduce to 0.8FTE plus 3 months freeze. Proposal would have limited impact on overall clinical time but would provide more strategic role around palliative care, in line with Scottish Government policy.
NHS7	Vacancy Efficiencies AHP	Ron Culley	Service Managers, OT and Physiotherapy	NR	30	M	Risk assessment in place	To utilise unallocated resource (due to maternity/part-time working) from Physiotherapy as an in-year efficiency, alongside a £10k contribution from OT. In the short term this absence can be absorbed within the team
NHS8	Mental Health Redesign/Vacancy Management	Ron Culley	SCNs	NR	23	M	Risk assessment in place	To delay transition to new arrangements as we move from Clisham closure to community mental health capacity. Savings associated with a vacancy freeze can only be realised when the ward closes. Mental health redesign requires the transfer of ward based resources into the community to reduce the number of admissions and lengths of stay. Any reduction in the projected work force requirements will impact on the strategic aims of the redesign and

								could result in at risk patients being admitted to hospital because of the unavailability of 24/7 community resource. Additional vacancy management tools will be used to manage this pressure, with the mental health change funds being used as a backstop.
NHS9	Reduced sickness absence	Gordon Jamieson	All	NR	229	M	Corporate assessment	In line with wider corporate targets, a more demanding threshold around staff sickness absence has been applied. Generic target to improve sickness absence through deployment of corporate tools like EASY and enforcement of local policy through effective line management. However, this remain a high risk saving proposal given that we are not fully in control of levels of illness and we have an ageing workforce.
NHS10	Legal Cost Efficiencies	Debbie Bozkurt	Principal Finance Accounta nt	R	20	M	Not required	Ensure we are totally effective in our processes which will enable the Board to claim back all relevant Legal costs from CLO
NHS11	Patient Travel - adherence to Policy and procedures relating to escorts	Debbie Bozkurt/A ngus McKellar	Head of Finance/ Medical Director	R	75	M	Not required	The Board are rolling out new procedures for requesting escorts which will ensure that only the patients that meet the escort criteria have a funded escort. To date two practices in Lewis have been trialling the new procedures and we anticipate a roll out to all practices by mid-summer.

NHS12	Patient Travel - roll out of E Health technologies which will avoid travel to appointments	Debbie Bozkurt/Angus McKellar	Head of Finance/ Medical Director	R	108	M	Not required	The Board have also started rolling out E Health technologies across the specialities which will mean patients do not have to travel to attend short consultation meetings. The patient can be covered VC clinic by attend anyway software or even by telephone for some appointments. We are expecting increases savings over the next few years.
NHS13	Patient Transport including Taxi	Debbie Bozkurt	Chief Executive	R	10	M	Not required	The cost of Patient Transport has increased significantly. There is a need to understand what SAS should provide us with regards to service and the increased cost we are experiencing due to reduced service we appear to be receiving. An analysis of all taxi costs will also be undertaken and whether adherence to patient travel policy is being strictly adhered to.
NHS14	Increase in Catering Income	Karen France	Nurse Director	R	20	M	Not required	Increase promotion of the catering facilities and new service developments will increase the income taken by this service
NHS15	Heat Plate Exchangers installation	DA Stewart	Nurse Director	R	90	M	Not required	We purchased heat plate exchangers last year and they will be installed in 18/19. A report undertaken for NHS Western Isles on the effect of the Heat Plate Exchanges put forward a £90k energy saving
NHS16	Energy Efficiency Schemes	DA Stewart	Nurse Director	R	20	M	Not required	The Board is Insulating lofts in all the clinics and the Western Isles Hospital, LED lights and light sensors will be installed as will new control panels for boilers. This will reduce energy consumption
NHS17	Laundry Efficiencies	Janice MacKay	Nurse Director	R	50	M	Not required	The workload from care homes is increasing plus

								the Board is promoting the Laundry services through various media streams
NHS18	Redesign of school nursing capacity	Ron Culley	Lead Nurse, Community	NR	10	L	Risk assessment in place	Proposal to freeze school nursing Band 5 0.4 wte post for 9 months pending redesign of School Nursing service to comply with the national refocused role of School Nursing. Development of a band 6 role from Jan 2019 complies with government objectives to meet the needs of the school age population in Uist.
NHS19	Prescribing - increase in Rebates	Ron Culley	Associate Medical Director	R	50	L	Assessment suggests that income target can be met.	This efficiency measure is intended to catch all generic drugs, rebates and income generation sources.
NHS20	Efficiencies in Community Dental Services	Ron Culley	Dentistry, Service Manager	R	77	L	Risk assessment in place	This allows for the delivery of oral health objectives within the establishment while continuing to meet core obligations. Risk assessment suggests that saving can be made without adversely affecting oral health outcomes
NHS21	Efficiencies in Central/Local Decontamination	Ron Culley	Dentistry, Service Manager	R	43	L	Corporate assessment	General inter-departmental efficiency measure
NHS22	Rental Income generation within WI Dental Centre	Ron Culley	Dentistry, Service Manager	NR	18	L	Assessment suggests that income target can be met.	Income generation from temporarily accommodating the new independent practice within WI Dental Centre, ahead of a transition to new premises in the summer
NHS23	Vacant Post CN Westside Band 6 Freeze	Ron Culley	Lead Nurse, Community	R	35	L	Risk assessment in place	Existing post-holder is on a career break and proposal is to freeze the post. In the short term this absence can be absorbed within the team with occasional requirement for bank to substitute the vacant hours. In the long term this post requires to

								be prioritised to support the national transforming district nursing role agenda.
NHS24	Disestablish Vacant CHASP PA post	Ron Culley	Chief Officer	R	18	L	Not required	Vacant and not required
NHS25	Freeze AHP Lead Band 6	Ron Culley	Head of Partnership Services	NR	10	L	Risk assessment in place	To allow the new integrated structure to embed, the Head of Partnership Services will spend six months with AHP service managers to discuss and agree AHP lead arrangements
NHS26	Hold Director of Finance Post	Gordon Jamieson	Chief Executive	NR	111	L	Risk Assessment required	Continue with the arrangement that the Head of Finance and Chief Officer of IJB undertakes the workload associated with the Director of Finance post
NHS27	Hybrid Mails savings	Debbie Bozkurt	Procurement Manager	R	18	L	Not required	Once the trial has been completed and software put in place between Cambric systems the hybrid mail system will be rolled out across all services. The saving put forward relates to postage and stationery not release of any staff time.
NHS28	Redesign of Public Health Team	Maggie Watts	Director of Public Health	R	51	L	Risk Assessment required	There are a number of long term vacancy held within Public Health awaiting redesign. We anticipate it will be at least 3 months until plans have been actioned, jobs matched and advertised. Therefore 3 months' worth of vacancies have been put forward as workforce efficiencies
NHS29	Redesign of HR Team	Jenny Porteous/Gordon Jamieson	Director of Human Resources/Chief Executiv	R	26	L	Risk Assessment required	There is a redesign of the HR Team and it is estimated there will be £26k of savings achieved by this redesign

			e					
NHS30	Hold vacant the Resus skills Facilitator	Louise Sullivan	Nurse Director	R	8	L	Risk Assessment required	This post is presently vacant and will not yet be recruited to for the first 3 months of the year
NHS31	Increase take up of residence rooms	Janice MacKay	Nurse Director	R	73	L	Not required	The Board are letting 8 rooms a year within the spare capacity of the residences to the Comhairle for training teachers
	TOTAL Saving Plan				**2,218**			

Although this is not exactly financial planning Mental Health Redesign, IJB Strategic Plan and even the Primary Care Improvement Plan is all about providing services more efficiently, and making the services fit for future growth within the same financial envelope.

The area that will make a big difference with regards to savings and re-investment is the patient pathway work.

Our Patient Centred Care Pathways programme is looking at how we can reduce travel by 1) clinicians and patients 2) to improve the patient experience and also reduce associated costs.

The programme is using rigorous analysis of the data to inform decisions around pathway redesign, and the related implementation of the NHS Near Me / Attend Anywhere platform which will be rolling out in coming months. NHS Near Me / Attend Anywhere is a PC-based video conferencing system. The system is most relevant for return patients, however in some cases this could be used for new. Consultations will often be facilitated by a Healthcare Assistant in the local location, thereby allowing measurements and observation to be taken e.g. weights, blood pressure, bloods etc.

Our eHealth programme has for some years focused on the integration of systems so that data is available to clinicians regardless of location or device, with appropriate safeguards. A notable achievement in this regard has been the Morse system which provides mobile access on a tablet to a single integrated electronic record comprising data from primary and acute care for all community based staff. As we move from eHealth to digital, the strategy will further develop to define and facilitate interagency data flows to Social Care and other partners.

I hope the above responses provide you comfort and understanding that NHS Western Isles continues to review, develop and monitor its delivery of services.

Should you require further information or clarification, please do not hesitate to contact me.

Yours sincerely

Neil Galbraith
Chair
NHS Western Isles