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)

   Within the context of the overarching Scottish Government National Performance Framework, Local Delivery Plans including HEAT targets have been the process by which Scottish Government Health Directorate holds Boards to account, and therefore influences budget decisions.

   As Integrated Joint Boards (IJBs) are established during 2015/16 the achievement of the National Health and Wellbeing Outcomes and key indicators being developed to measure progress towards these will influence the strategic commissioning decisions on use of delegated health and social care budgets.

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

   - The requirement to achieve the four hour A&E standard through providing timely emergency assessment has resulted in significant investment at the acute hospital front doors to sustain emergency access performance.
   - Achievement of the legally required Treatment Time Guarantee has influenced significant investment in elective surgical workforce to develop capacity over the last two years.
   - A higher level of staffing has been set up, particularly nursing, in order to sustain patient safety for increasing levels of patient frailty, including dementia.
   - A high level of delayed discharges across the system has resulted in additional beds being opened in order to ensure patient flow within the health system, along with investment in stepdown and alternative care models.
   - Drugs Budgets are reviewed to reflect expenditure trends and include influences for New Medicines arising from SMC Decisions. A key driver in recent increased Acute spend is the policy of promoting access to medicine for end of life treatments especially Cancer. Another influence is the development and use of new, effective but high cost Hepatitis C treatments. A Primary Care example is the use of new Anticoagulant treatments.

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

   The sustainable delivery of care across the health system to meet the needs of our population is the Board's priority. The health performance framework

reflects key priorities for the health system, and these will be increasingly influenced by IJB plans to achieve the national Health and Wellbeing outcomes.

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)

   The following sets out areas where specific funding has been targeted to deliver positive outcomes. It does not take account of the financial impact some of these investments can have on other related services.

   Alcohol and Drug Partnership
   The Scottish Government allocates funding to each Alcohol and Drug Partnership (ADP) within NHS Lothian, to enable the local ADP partners, including NHS Lothian, to deliver nationally agreed core outcomes and local outcomes on alcohol and drugs.

   Funding is conditional on demonstrating progress towards both national and locally relevant alcohol and drugs outcomes. This includes the HEAT Standard for Alcohol Brief Interventions (ABIs). NHS Lothian's target for ABI delivery in 2015/2016 from the Scottish Government is 9757 interventions with 80% delivered in the three priority settings. NHS Lothian has consistently exceeded the target set by the Scottish Government and is a leading Board in Scotland for ABIs.

   The Scottish Government funding enables the training and support of staff in the delivery of ABIs in the three priority settings (Primary Care, Antenatal and A&E). This prevention/early intervention activity contributes to work to reduce health inequalities and promote the health and well being of communities including 'harder to reach' groups where deprivation is greatest. It also funds the delivery of a comprehensive education and training programme for groups of staff in other statutory and voluntary agencies, for example in prisons, police custody suites, criminal justice programmes, youth and sexual health programmes/services and welfare rights teams. This helps to ensure that disadvantaged groups receive a quality service. Staff working in Keep Well, and other specialist projects which have been established to address the needs of people from disadvantaged communities also receive training and support to ensure that they deliver effective ABIs.

   The funding covers the cost of staff to deliver the training and support (Lead Practitioner, GP, Administrator). It is also used to make payments to GPs in line with a LES and it also covers resources and other training costs.

   Detect Cancer Early (DCE)
   NHS Lothian's Detect Cancer Early Programme has benefited from a specific revenue funding allocation of £741k in 12/13, £1.4m in 13/14, and £847k in 14/15.

This dedicated allocation has been used to take forward an early detection strategy and support activities across service settings in NHS Lothian, in order to deliver the Detect Cancer Early HEAT target of a 25% increase in the proportion of lung, breast and bowel cancer detected at stage 1 of disease.

The dedicated nature of the allocation and the annual Detect Cancer Early Funding Evaluation undertaken by the Scottish Government DCE policy team has supported targeted use of allocated funding in Lothian. Strategic Financial Planning for NHS Lothian's DCE programme revenue investment requirement for each year of the DCE programme has been supported by receiving a dedicated funding stream, and local performance measurement against the Local Delivery Plan trajectory for the DCE HEAT target.

Additionally, the allocation of specific DCE capital funding in 13/14 and 14/15 has enabled the local development of a capital programme of investment to support the Lothian DCE programme.

Hepatitis B and C

The Sexual Health and Blood Borne Virus Framework sets out four outcomes relating to hepatitis B and hepatitis C. These are as follows:

- Fewer newly acquired hepatitis B and hepatitis C infections
- A reduction in health inequalities associated with hepatitis B and hepatitis C
- People affected by hepatitis B and hepatitis C lead longer, healthier lives
- A society whereby the attitudes of individuals, the public, professionals and the media in Scotland towards hepatitis B and hepatitis C are positive, non-stigmatising and supportive.

Achievements based on last annual report:

- 25 outlets in Lothian provided clean injecting equipment for people with drug use
- A total of 18,808 hepatitis C antibody tests were performed
- 589 BBV dry blood spot tests were performed
- 235 new hepatitis C diagnoses were reported in calendar year 2013
- 145 people started treatment for hepatitis C, including 34 prisoners
- 66 people started treatment for hepatitis C on the protease inhibitor medications (introduced April 2012)
- 10 patients started treatment for hepatitis C with new medications under trial

- At March 2014, 25 individuals were on the waiting list for hepatitis C treatment and ready to start

- 24 babies born to mothers who had hepatitis B started their course of hepatitis B immunisations (100%) during 2013

- 97 babies born to parents with problem drug use started their course of hepatitis B immunisations during 2013.

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?

   All of the Councils in the Lothian area (Edinburgh City, East Lothian, Midlothian and West Lothian) have agreed to use the Corporate Body model for Integration and will set up Integrated Joint Boards (IJBs).

   These IJBs will receive a payment representing the agreed budgets for Adult Social Care, funding will initially be determined through the normal financial planning process for the Board and Councils. This means that the Community Health Partnership (CHP) Core budgets (including GMS and GP Prescribing), and an appropriate share of the Hosted Services (being services provided on a pan-Lothian basis which are currently managed by the CHPs) will form the joint funding. In addition, the IJB will also have a 'set aside' resource being an appropriate share of the budgets for the agreed delegated Acute services. A list of Hosted and Acute services being delegated is attached.

   The budgets referred to above will be the operational budgets per the NHS Lothian scheme of delegation and similarly the Adult Social Care operational budgets. Overheads and property running costs are (generally) not being delegated to the IJBs at this time.

   A process of due diligence is also being set to assess proposed funding against historic spend and activity and projections going forward. This will be extremely challenging in the current financial environment.

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

   NHS Lothian and the four Councils in Lothian must delegate functions to the Integration Joint Boards as set out in the Public Bodes (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. In addition the Health Board and Councils have elected to delegate the following functions:

   1. The functions in the following list as they relate to the provision of services for people under the age of 18. The rationale for delegation is that

this provision is already integrated with adult service provision and it is advantageous from both a patient and clinical perspective for one organisation to remain responsible for strategic planning of the complete function for the whole population.

- Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
- General Dental Services, Public Dental Services and the Edinburgh Dental Institute
- General Ophthalmic Services
- General Pharmaceutical Services
- Out of Hours Primary Medical Services
- Learning Disabilities.

2. Criminal Justice Social Work has been delegated by Midlothian and East Lothian Councils. The rationale is that that the strategic planning for this function should be integrated with the strategic planning of mental health and substance misuse because of the prevalence of poor mental health and problematic substance misuse of people within the criminal justice system.

3. Youth Justice Social Work has been delegated by East Lothian Council. The rational being that this service should planned together with adult criminal justice social work by one organisation.

4. School Nursing and Health Visiting have been delegated by NHS Lothian to Midlothian and East Lothian IJBs because with the dissolution of CHPs the IJB is the logical organisation to plan these services.

5. Prison Health Care in HMP Addiewell and HMP Edinburgh has been delegated by NHS Lothian to Edinburgh IJB. The rationale for delegation is:

a. The prison health service should remain a single hosted service across the two prison sites

b. The strategic planning for this function should be integrated with the strategic planning of mental health and substance misuse (also delegated) because of the prevalence of poor mental health and problematic substance misuse of people within the criminal justice system

c. Edinburgh IJB is in the strongest position to take on the strategic planning for this function because the majority of prisoners from the Lothians in these two prisons are from Edinburgh.

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

The table below lays out indicative (see note below) IJB budgets (that is both the Payment and the Set Aside resource) for 2015/16.

	£000	£000	£000	£000
	West Lothian	East Lothian	Midlothian	Edinburgh
Health Delegated	147,754	82,124	75,683	363,618
Adult Social Care Delegated	59,500	45,838	36,929	200,100
Total IJB Budget	207,254	127,962	112,612	563,718

Although the budgets for Adult Social Care have now been set by each council, NHS Lothian has not finalised (at the time of writing) its budgetary plans for 2015/16. Also appropriate shares (see above) of the Hosted and Set Aside Acute services have not yet been agreed. However, Lothian are building a financial model to support the IJB budget setting process and an early draft of this has been used to prepare indicative values as above. The final values will inevitably be different however these values should provide a material indication of the resources allocated to the IJBs.

8. Please provide any further comments on budgetary issues associated with integration:
It is clear that Integration will provide challenges in terms of financial management and reporting. Financial management support will continue to be required by the Health Board and the Council, the IJB will also have a set of requirements that (in the case of Health) will not map onto the current Health Board organisation and the operational management teams (the Integrated Management Teams) will require support from both financial management teams (both being the Council and the NHS).

The process of Due Diligence which is a key part of setting up of the initial IJB budget will be challenging given that it is both a new process to our system and also that it will reflect on the financial constraints that both Health and social care systems continue to function under.

There will also be risk to be managed during the period of change from the historic basis of governance and planning into the processes to be managed by the IJB. Transitions are generally challenging for the organisations concerned.

NHS Lothian – Summary of Delegated Functions
Hosted Functions
Dietetics
Art Therapy
LUCS (Lothian Unscheduled Care Service)
Community Complex Care
Sexual Health
SMD (Substance Mis-use Directorate)
SMART (Excl National & Regional) (
CES (Edinburgh, East and Mid) (Community Equipment Store
Clinical Psychology

NHS Lothian – Summary of Delegated Functions
Community Continence (Edinburgh, East and Mid)
Dental
Orthoptics
Podiatry
REAS (Excl. National & Regional) – Royal Edinburgh Hospital
Learning Disabilities
Rehabilitation (Excl National & Regional) – Astley Ainslie Hospital
Acute Set Aside Functions
Emergency Department (RIE & St. John's Hospital)
Emergency Observation Ward (St. John's Hospital)
Medical Assessment (St. John's Hospital)
MoE (WGH, RIE & St. John's Hospital)
Stroke Services (WGH, RIE & St. John's Hospital)
Respiratory (WGH, RIE & St. John's Hospital)
General Medicine (WGH, RIE & St. John's Hospital)
Rehabilitation (St. John's Hospital)
Gastroenterology (RIE, WGH)
Minor Injuries Unit (WGH)
Cardiology (RIE, WGH)
Core Services
GP Prescribing
Personal Medical Services (GMS)
Community Nursing (except Health Visiting and School Nurses in West and Edinburgh)
Community Hospitals (all NHS Lothian hospitals not noted above)
Community AHP Services
West Lothian Mental Health In-patient Wards.
Community Mental Health Services
Other Community Based Services – support to Third Parties etc.
Resource Transfer

Specific challenges

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

Cash Efficiency Programme

The major challenge for the Board is the delivery of cash releasing savings to support financial balance in 2015/16. The delivery of real cash savings has become increasingly difficult over the last year with many of the proposed schemes requiring significant redesign of service, capital investment to support change, and/or resource to pump prime the change. This challenge is reflected in the current risk profile of the Board's Cash Efficiency Programme with £33m identified against a target of £48m, but only £5.7m defined as low risk.

Delivery of plans also requires a reduction in workforce which can only be delivered through turnover. In the areas where workforce reduction is targeted turnover tends to be low.

Month on Month financial balance

There are a number of potential cost pressures which have been assumed as being 'manageable' at an operational budget level. As pressures on the delivery of efficiency continue, the sustainability of this approach presents a risk to the organisation.

Bed Reductions

The efficiency programme within acute services includes a reduction of 114 beds. At the same time, the City of Edinburgh Council, as part of its budget setting in the new financial year, has reduced its total budget for Social Care in the new financial year by £3m, despite an overspend projection of £5m this year. These actions are incompatible as the organisation strives to reduce delays in discharges.

In the ten months of this financial year, NHS Lothian has lost a total of 161,015 days to delayed discharge, compared to 115,621 days over the same period last year. This is an increase of 39%, and with fewer beds and a reduction to the social care budget in Edinburgh, this is a key risk for the health board, and may impact on surgical capacity, acute flow, A+E targets and overall patient care.

Funding Assumptions

In their letter to the health board of the 12 January, The SGHSCD set out the key uplift values in the new financial year. In order to present a balance plan for next year, there are a number of assumptions for the receipt of additional funding which have yet to be confirmed, including anticipated allocations for PPRS (£12.5m, relating to drugs), Waiting Times (£5m), and Capital to Revenue adjustments (£2.689m).

Medicines

Whilst there is significant additional resource being invested into medicines next year, both within acute and in Primary Care, there remain a number of significant risks associated with potential expenditure, particularly around new Hep C drug arrangements.

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

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

	% of new born babies with a weight appropriate for gestational age	
	Board	Scotland
2009	88.6%	89.6%
2010	90.0%	90.0%
2011	90.4%	90.1%
2012	90.1%	89.9%
2013	90.6%	90.1%

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

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

   NHS Lothian performance has remained broadly in line with the national position. The indicator is affected by the wide range of factors which impact on birth weight including maternal nutrition, smoking and alcohol use.

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

   Lothian has put in place a range of initiatives designed to reach women before and during pregnancy in order to support and influence them in making decisions that will lead to a healthy pregnancy. One of the key drivers for this work is to decrease likelihood of their child having a low birth weight which Lothian's strong performance against this indicator demonstrates some success in.

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)
   There are pro and cons. It is an easily recorded measure, which can be adjusted for gestational age. It tells us something about maternal decisions during pregnancy and, potentially, quality of care (e.g. if smoking cessation efforts are successful, or work around maternal nutrition, then we might expect more babies to be born with an age appropriate birth weight). However, there are other influences that impact on birth weight that are outwith the control of the mother or service. It is also, as shown above, no different from national average at NHS Board level. There may well be variation by area, but that is likely to reflect differences in maternal age, smoking, household income. On balance, therefore, it feels like a very crude way to assess performance.
   There are more immediate measures that could be useful, e.g. percentage of eligible women and children receiving Healthy Start vouchers. That is a measure of how well NHS and other services work together to sign up women, and focuses specifically on low income, often vulnerable, families. It is information that we receive across Scotland on a monthly basis, from

Department of Health, broken down by postcode sector. In NHS Lothian we have been able to compare this with process measures (e.g. eligibility, sign up, documentation). Changes with introduction of Universal Credit during 2015 may, however, make this unworkable at present.

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

Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Family Nurse Partnership FNP is now available Lothian wide, targeted at young mothers and most deprived with a primary stated aim of improved antenatal health, including fewer pregnancy related complications.	1,525	2,093
PrePare This is a multi-disciplinary, specialist service for substance misuse which is focused on providing support to pregnant women with significant substance misuse issues. The work of this team focuses on the care of the newborn from a child protection perspective (up to 6-9 months) and the care of the pregnant woman/parents from a substance use perspective. Plans are now in place to continue to roll this service out across Lothian.	97	143
Smoking Cessation Under the auspices of MCQIC, CO2 monitoring is now being offered to all women at booking with subsequent referrals to smoking cessation. Under the Early Years Collaborative further work is being undertaken to look at how to improve take up of the service, with a view to developing a package of measures suitable for scale up across the service.	38	52

6. What statutory partners or other partners (if any) contribute towards performance in this area?
For low birth weight, the work of statutory services such as Health Improvement Team in West Lothian, Community Learning Development in

Edinburgh. The latter work is with Bump Start in North Edinburgh, managed by a voluntary sector organisation (Stepping Stones North Edinburgh). These programmes promote health literacy and provide other support and advice for very vulnerable families. Programmes such as PrePare also work with women at risk of a low birth weight pregnancy (their client group is substance users).

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

Antenatal Booking
Reducing the gestational age by which women attend their antenatal booking appointment allows earlier testing, intervention and education. NHS Lothian have been improving against the HEAT target and local increased targets year on year with a variety of initiatives including the instigation of a central booking line service, information for staff and potential parents to be and working with the GP community. This work continues using the EYC methodology to look in depth at specific issues. Funds to support this work come from the Refreshed Maternity Framework funding among other sources.

Maternal Nutrition
A range of local responses to maternal nutrition issues have been implemented including targeted cooking and food health classes for the newly pregnant, exercise schemes, and access to the Counterweight programme both ante and post natal (with a view to improving subsequent pregnancy outcomes). There is also now a strategic group under the auspices of the Maternal and Infant Nutrition Team, looking at how to develop this further.

Healthy Start and Income Maximisation
Significant improvements have been made in ensuring access to the Healthy Start scheme for those eligible in pregnancy and beyond, improving the nutrition of pregnant women in Lothian. Initially targeting a single midwifery team, the outcomes of this work are being rolled out to other midwifery teams as well as health visiting and other partner groups both in Lothian and beyond via the Early Years Collaborative. Work continues to reduce Health Inequalities through this work.

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

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

	% of last 6 months of life which are spent at home or in a community setting	
	Board	Scotland
2008-09	91.3%	90.4%
2009-10	91.5%	90.5%
2010-11	91.4%	90.7%
2011-12	91.9%	91.1%
2012-13	91.5%	91.2%

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

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

NHS Lothian performs a little better than the All Scotland level on this measure. Our Palliative Care strategy 'Living & Dying Well in Lothian'[1] established strategic priorities aimed at improving care in all settings. Overall, within this quality improvement context, the strategy sets a direction of travel for Lothian increasingly towards earlier identification of palliative care and support needs, and the provision of integrated care. A brief summary of what NHS Lothian's Palliative Care strategy aims to achieve is given in Appendix 1.

We have adopted specific headline indicators locally to assist us in monitoring the balance of place of death in Lothian. We use place of death as a proxy measure of our overall performance, i.e. if our systems of care planning and anticipatory care are working effectively then, in line with evidence on people's preferences for place of care and place of death, we should be seeing a move towards a greater proportion of deaths in community, residential settings over time.

Initiatives such as investment in palliative care training and support for care homes, and redesigning our specialist palliative care models of care with independent hospices and third sector partners (such as the Marie Curie Fast Track nursing service, and the West Lothian Palliative Care Service, which is a partnership between MacMillan Cancer Care, NHS Lothian, and Marie Curie).

In hospital based palliative care we have invested in developing approaches to earlier identification and assessment of palliative care needs, by working across specialist palliative care and acute medicine / front-door areas, and supporting organ specialists (the 'EPIC' project and development of the 'SPICT' tool (www.spict.org.uk) are examples of such approaches).

We have also invested in facilitating use of the KIS. This system is now available and used in all GP surgeries across Lothian, and is the tool via which we are capturing and sharing useful clinical information electronically between GP surgeries and professionals with access to the Emergency Care Summary (ECS). The KIS system is also specifically used as an Anticipatory Care Planning tool for those with palliative and end of life care needs.

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

It is one indicator amongst a number considered locally, with feedback to Boards on this quality strategy indicator relatively infrequent. Overall in NHS Lothian, monitoring movement in place of death (our headline proxy measure) and monitoring process indicators such as uptake and use of the Key Information Summary (KIS) system, Palliative Care DES uptake, and feedback on use of the Supportive and Palliative Care Indicators Tool (SPICT) tool in hospital systems etc. guides decision making on investment and redesign. This, alongside learning from service initiatives ongoing, provides insight into both the overall balance of care and opportunities for service improvement.

[1] http://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/ladwinlothian/Pages/default.aspx

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

It has use, amongst a suite of other indicators. The national indicator a proxy indication of overall how effectively the service has looked after people in the place where they may prefer, and has helped them to die in the place which may be their preference. It assumes however that community residential settings are most often the preference, however we know that for some people needs and preferences change, often rapidly. Whilst we use indicators based around place of care, we are aware that how we care for people with deteriorating health affects how they die and matters more than the ultimate place of death. People can die well and badly in hospitals, care homes, and their own homes. Better indicators of identification of palliative care needs, the quality of anticipatory care given, and patient, carer and family experience in all settings would assist. An indication of well planned personalised care might include for example placement on a palliative care register at an earlier stage than only weeks or days before death, evidence of a well completed Anticipatory Care Plan having been created and shared, and evidence of most care in the last months of life being provided in community settings.

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

Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Palliative Care Fast Track nursing Service & the West Lothian Palliative Care Service (jointly funded by NHS Lothian and Marie Curie)	686	686
NHS Lothian locally enhanced general medical service – care homes anticipatory care planning	981 (based on 13/14 costs)	981 (based on 13/14 costs)
Training for Care Homes (CHCP led and planned Redesign investment)	122	122

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

Lothian independent hospices and charitable companies, Universities in Lothian (the University of Edinburgh, Edinburgh Napier University, and Queen Margaret University all contribute), Lothian Local Authorities particularly social work departments, third sector organisations such as Macmillan Cancer Support, Scottish Ambulance Service, Healthcare Improvement Scotland, NHS Education Scotland, NHS Inform, Independent Care Home providers, Carers organisations, bereavement and spiritual support providers.

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

Palliative care and hospice funding

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

	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
Specialist palliative care services		
• Marie Curie Edinburgh Hospice	2,009	2,009
• West Lothian Palliative Care Service	486	486
• St Columba's Hospice	2,116	2,116
• Lothian Acute Services Specialist Hospital Palliative Care Teams (WGH, RIE)	882	882
• Lothian bereavement services	79	83
General palliative care services		
• Palliative Care MCN	63	63
• Directed Enhanced Service (DES) for palliative care	320	320

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

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

	2014-15	2015-16
Agreed funding for hospice running costs for specialist PELC (£000)		
£000	Marie Curie Edinburgh Hospice: £2,008,879 St. Columba's Hospice:	Marie Curie Edinburgh Hospice: £2,008,879 + pay & prices inflation TBC, - 3% efficiency saving,

	2014-15	2015-16
Agreed funding for hospice running costs for specialist PELC (£000)		
	£2,115,689	TBC St. Columba's Hospice: £2,115,689 + pay & prices inflation TBC, - 3% efficiency saving, TBC
As % of total hospice funding	Marie Curie Edinburgh Hospice: 52% St. Columba's Hospice: 52% of recognised costs.	Marie Curie Edinburgh Hospice: TBC St. Columba's Hospice: TBC
Agreed funding for running costs of independent children's hospices (including local authority funding where relevant)		
£000	97	97
As % of total independent children's hospice running costs	12.5%	12.5%

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

Adult hospices

NHS Lothian has a three year Service Level Agreement in place with each of the two adult independent hospices in the Board area.

For the Marie Curie Edinburgh Hospice the total operating cost for the core Edinburgh hospice services are agreed at £3.9m (rounded cost). NHS Lothian's 2014/15 funding of £2m is 52% of this. Additional costs of £1.6m are agreed to be disregarded from the service funding agreement. These costs relate to corporate management charges attributable to all aspects of the Marie Curie charitable company London Headquarters, additional costs of fundraising (Marie Curie shops etc), and the provision of additional enhanced services not agreed with NHS Lothian.

For St. Columba's Hospice the total operating cost for core hospice services are recognised by NHS Lothian at £4.0m (rounded cost). NHS Lothian's 2014/15 funding of £2.1m is 52% of this cost.

NHS Lothian participates in the Hospice Quality Improvement Forum, a sub-group of the National Advisory Group for Palliative and End of Life Care. The Hospice Quality Improvement Forum is considering independent hospice workforce and workload benchmarking, and standardising activity data capture and reporting, to assist with obtaining better value from hospice care and improving hospice commissioning.

Children's hospice
NHS Tayside provide the details on behalf of NHS Scotland for the funding of children's independent hospices.

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

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

	Emergency admissions rate (per 100,000 population)	
	Board	Scotland
2009-10	8,448	9,849
2010-11	8,502	9,874
2011-12	8,821	10,090
2012-13	8,776	10,130
2013-14 (p)	7,768	10,188

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

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

We are unable to comment on the differences in performance across Scotland. In NHS Lothian we have been taking a number of actions to support care at home and provide alternatives to admission in collaboration with Local Authorities. These include developments in intermediate care, crisis care, hospital at home services, support to care homes, ambulatory care models in hospitals, and enhanced staffing levels including more senior decision makers and medicine of the elderly specialist assessment in emergency departments.

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

Preventing avoidable emergency admissions is aligned to our plans for achievement of the 4 hours Accident and Emergency standard. This has resulted in investment in both hospital based capacity for unscheduled care and in community resources to help people access health and social care support at or close to home. The expected increase in >65 population in Lothian by 30% between 2010 and 2025 has been a driver for investment in services to for adult and older people across the system.

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

This is useful as one of the range of indicators to monitor the progress of the health and care system towards the 2020 vision that everyone is able to live longer healthier lives at home or close to home where possible, and if admission to hospital is necessary, people can get back to a home or

community setting as soon as appropriate. In Lothian the rate of admission is better than Scottish average but our length of stay for older people in hospital is less good, and delayed discharges are a significant barrier to delivering the right care in the right place at the right time.

1. 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

A relatively small number of patients characterised as 'high demand ambulatory care patients' account for a disproportionately large share of acute hospital resources. The 2011 British Household Panel Survey found that 5% of patients account for 42% of inpatient days. The High Demand will ensure access to consultant-led patient-centred care planning for those patients carrying the greatest illness burden (as evidenced by very high Scottish Patients at Risk of Re-admission and Admission (SPARRA) score). Demographic data from SPARRA shows that patients with very high SPARRA scores are more likely to live in deprived areas. Hence by targeting clinical services towards this group the proposal is seen as having a direct impact upon health inequalities. The model we have introduced is based on implementing individualised anticipatory care planning as a means of optimising the care that these patients receive thereby reducing the demands that they place upon acute hospital services while improving individual's ability to manage their health and engage more effectively with non-emergency services.

NHS Lothian has invested in significant service redesign and expansion of capacity at all four of our acute hospitals to better manage the demand from patient presenting for unscheduled care. The aim has been to ensure triage, assessment and treatment in a timely manner, and where possible deliver this on an ambulatory care basis, where admission is not required. This has included additional emergency medicine, general medicine and medicine of the elderly consultant and ANP staff, along with AHP and support resources. Service remodelling has included GP advice lines, urgent appointments – same day/ next day- separate surgical and medical assessment facilities and remodelled environments to improve workflow through receiving departments.

Reducing acute hospital demand through developing alternatives to hospital admission for frail elderly people in their local areas is a major priority for Lothian's four health and care partnerships. All have invested in additional intermediate care capacity and have or are putting in place frailty services which include community focused consultant medicine of the elderly advice and expertise, working alongside nursing and AHP staff to assess, plan and deliver care at home and in care home/ residential settings. This avoids unnecessary admission of a frail elderly person to an acute hospital, with attendant risks of disorientation and distress. The REACT service in West Lothian is the most mature of these models. Partnerships are planning to use Integration Funds to further develop these services in 2015/16.

Programme/service area	Expenditure 2014-15 £000	Planned expenditure 2015-16 £000
High Demand Service	302	475
Investment/redesign of unscheduled care assessment capacity in A+E and acute assessment departments	4696	6822
Development of frailty services in health and care partnerships	1807	2341

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

   Local authorities, GPs, Scottish Ambulance Service, GP Out of Hours Services, NHS 24 and third sector partners.

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

   Other positive contributing factors are:
   - Access to primary care and social support at home
   - Step up/Step down capacity in partnership areas
   - Care home liaison and support from GPs and community nursing.

Appendix 1 – Extract from the summary guide to Lothian's Palliative Care Strategy 2010 – 2015 (developed for public consultation)

What the strategy will aim to do and what's involved

We want to deliver care which includes palliative care and support as early as possible for people who need it and who would benefit.

While previously people would be offered palliative care as they neared the end of life, and when it was no longer possible to actively treat their disease, our vision is for people to be offered a palliative care approach to their care at a much earlier stage.

This does not mean that appropriate treatment of disease or the management of symptoms will stop, but we believe that many people would benefit from starting to discuss earlier with their carers, including health and social care professionals, the life-limiting nature of their illness.

This will help because things such as where you'd like to be looked after, what kind of treatment you want (and don't want), and personal issues such as home, family and care arrangements, can be discussed and planned for and everyone involved in providing care will know where you would prefer to die and what help you will need.

We will aim to support this by breaking down palliative care planning and delivery into three tiers or levels:

- working with people with **Long Term Conditions** to make sure that the need for palliative care is identified as part of routine care at the earliest stage appropriate, helping people to plan, direct and be actively involved in their own care.
- adopting the **Palliative Care Approach** from as early a stage as is agreed appropriate. The palliative care approach seeks to maximise quality of life, by maintaining good symptom control, offering holistic assessment, including family and carers needs, and seeks to agree choices around treatment options, place of care and preferred place of death
- planning for and managing **end of life care** in the last days of life in a tightly co-ordinated and structured manner.