Dear Duncan,

Draft Budget 2014-15

During the Committee hearing on 29 October 2013 involving myself and the Director for Finance, eHealth and Pharmaceuticals, I offered to provide the committee more information in respect of:

- European Funding for eHealth Projects
- A detailed breakdown of the Nursing Budget
- A briefing on the Integrated Resource Framework
- Evaluation of Change Fund Projects

Annex 1 includes details for each of the points highlighted above.

I would be happy to provide further information if you require it.

ALEX NEIL

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**European Funding for eHealth Projects**

**John Matheson:** The budget line for e-health is flat, but the European investment will mean that, overall, investment in it will increase.

**The Convener:** By how much?

**John Matheson:** I do not have the precise figures, but I can get them for you.

**Action:** The Cabinet Secretary agreed to provide a breakdown in costs relating to European funding.

The European funding received in relation to eHealth projects is:

<table>
<thead>
<tr>
<th></th>
<th>Total Project Budget (£)</th>
<th>European Funding Contribution (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Existing projects</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United4Health</td>
<td>1,556,478</td>
<td>778,239</td>
</tr>
<tr>
<td>SmartCare</td>
<td>1,457,195</td>
<td>728,598</td>
</tr>
<tr>
<td>CASA</td>
<td>155,377</td>
<td>116,533</td>
</tr>
<tr>
<td>Momentum</td>
<td>17,001</td>
<td>17,001</td>
</tr>
<tr>
<td>ACT</td>
<td>68,534</td>
<td>41,120</td>
</tr>
<tr>
<td><strong>Total existing projects</strong></td>
<td>3,254,585</td>
<td>1,681,491</td>
</tr>
<tr>
<td><strong>Upcoming projects (not official yet)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MasterMind</td>
<td>804,632</td>
<td>402,316</td>
</tr>
<tr>
<td>Unwired Health</td>
<td>788,356</td>
<td>611,646</td>
</tr>
<tr>
<td>eSMART</td>
<td>62,451</td>
<td>50,997</td>
</tr>
<tr>
<td><strong>Total upcoming projects</strong></td>
<td>1,655,440</td>
<td>1,064,959</td>
</tr>
<tr>
<td><strong>Total all projects</strong></td>
<td>4,910,025</td>
<td>2,746,450</td>
</tr>
</tbody>
</table>

A brief summary of each of the more significant projects are included below:

**United4Health**

United4Health aims to exploit and further deploy innovative telemedicine services implemented and trialled. All service solutions adopt a patient centred approach, and involve the telemonitoring and the treatment of chronic patients with diabetes, COPD or CVD diseases. Services are designed to give patients a central role in the management of their diseases, fine-tuning the choice and dosage of medications, promoting compliance to treatment, and helping professionals to detect early signs of worsening.

The services to be implemented are: Life-long management of diabetes, Short-term follow-up after hospital discharge for COPD patients, Remote monitoring of Congestive Heart Failure. The Project will operate as a multi-centre clinical trial measuring efficiency and the cost effectiveness of the implemented solutions. This will give scientific validity to the results and will promote adoption of remote patient monitoring and treatment on a large scale.

**Outcomes:** Benefit to 8,000 patients and informal carers with COPD, diabetes or heart failure in the areas of Ayrshire & Arran, Lanarkshire and Greater Glasgow and Clyde.

Results will be analysed to allow for further deployment within the collaborating areas as well as potential for national implementation.
**SmartCare**

SmartCare aims to define a common set of standard functional specifications for an open ICT platform enabling the delivery of integrated care to older European citizens. The pilot will produce and document much needed evidence on the impact of integrated care, developing a common framework suitable for other regions in Europe. The organisational and legal ramifications of integrated care will be analysed to support long term sustainability and upscaling of the services. SmartCare services will provide full support to cooperative delivery of care, integrated with self-care and across organisational silos, including essential coordination tools such as shared data access, care pathway design and execution as well as real time communication support to care teams and multi-organisation access to home platforms.

**Outcomes:** Impact for 10,000 people in the areas of Ayrshire & Arran, Lanarkshire and Greater Glasgow and Clyde (seven health and social care partnerships). 8,000 of these are patients and 2,000 are carers or health professionals.

The aim of SmartCare is to support the wider integrated care agenda in Scotland and to offer integrated services, pathways and ICT support that underpins this ambition in the longer term.

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**CASA**

Consortium for Assistive Solutions Adoption – is about the development of regional policy and the exchange of knowledge around the up scaling of innovative ICT and services for independent living. Demographic changes make it necessary to organize the care and housing of senior citizens and chronically ill in a smarter way including the use of ICT. This also gives opportunities for innovative companies to develop new tools and services.

**Outcomes:** Broadening the understanding of good practices in other countries that can be applied to improve health and social care delivery in Scotland and regions as well as promoting and sharing good practices from Scotland.

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**Mastermind (MA) nagement of mental health diSorders Through advancEd technology and seRvices – telehealth for the MIND)**

MasterMind intends to:

1) Implement at scale evidence based computerised Cognitive Behavioural Therapy (cCBT) services for depressed adults and: identify the barriers and success factors to implement cCBT on a large scale in different political, social, economic and technical health care contexts and from the perspective of different stakeholders such as patients, professionals and health insurances; recommend successful strategies for implementing cCBT in these different contexts/ settings.

2) Implement video conference enabled blended care for patients with depression treated in General Practice where the patient and GP have an interview with a specialist to support diagnosis, treatment planning, follow-up and education of both the patient and the GP. Using the lessons learnt, the Consortium will develop guidelines for promoting and facilitating the broader implementation across Europe of a safe, effective and efficient service supported by relevant stakeholders.

**Outcomes:** 800 people planned to use service across three health board areas. This excludes the number of people already receiving cCBT in some health board areas and new users of those services.

There is the potential for full national service delivery of cCBT to meet the strategic and planned targets for mental health in Scotland.
**Unwired Health**

The objective of this programme is the pre-commercial procurement of mobile services for the management of patients with heart failure and for coaching vaccination programmes.

**Outcomes:** The project will involve users, both patients and health professionals. Their input is used for needs assessment, specifications, user acceptance, evaluation etc. No exact number is set for those who will use the service.

The project focuses on pre-commercial procurement which is used when the goods or services required do not exist in the market. It generally involves the purchase of research to stimulate innovation that we can benefit from at a later stage when goods or services not currently available, are developed within the market from the outcomes of the research.
Nursing Budget

Rhoda Grant: I have that in front of me. It is in table 3.03, which has the heading "More Detailed Spending Plans (Level 3)". Under "Education and Training", the figure for the workforce goes from £31.1 million to £30 million to £33 million over the three years, whereas the figure for nursing, midwifery and AHPs goes from £148.9 million to £137.8 million to £135.8 million.

Alex Neil: I should also emphasise that overall we are not spending less on the training of nurses and midwives. We think that the organisations that you mentioned have misread the budget.

Rhoda Grant: It would be helpful to get a breakdown of those costs and the reasons for them.

Alex Neil: No problem.

Level 4 analysis of Nursing Budget

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursary (Nursing &amp; Midwifery)</td>
<td>67.0</td>
<td>64.0</td>
<td>64.0</td>
</tr>
<tr>
<td>Pre-reg. Nursing &amp; Midwifery Training</td>
<td>62.2</td>
<td>62.2</td>
<td>62.2</td>
</tr>
<tr>
<td>One Year Guarantee</td>
<td>9.4</td>
<td>2.0</td>
<td>0.0</td>
</tr>
<tr>
<td>National Centre for P&amp;Os</td>
<td>2.7</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Workload &amp; Workforce Capacity Bldg.</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Nursing and Midwifery Contribution to the Quality Strategy</td>
<td>1.6</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Rehabilitation Framework</td>
<td>1.4</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Other below £1 million</td>
<td>2.7</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>148.9</strong></td>
<td><strong>137.8</strong></td>
<td><strong>135.8</strong></td>
</tr>
</tbody>
</table>

This demonstrates that the training budget remains unchanged between 2013-14 and 2015-16. The reduction in the overall budget was primarily due to a reduction in the One Year Job Guarantee (£7Am) where there was a non-recurring increase to cover the support that we were giving centrally for the employment of interns on a one-year job guarantee. That responsibility has now been picked up by the individual health boards.

The other main reductions are with the Bursary budget (£3.0m) and the National Centre for Prosthetics and Orthotics (£0.4m). The bursary is a demand led budget and the criteria for receiving a bursary has not changed. The reduction in the National Centre's budget reflects a move to a unit of teaching resource model. All other budget movements are small decreases due to efficiency savings identified which have no adverse impact on the effective delivery of the programmes.
Integrated Resource Framework

Rhoda Grant: That would be helpful. I understand that you currently have integrated resource framework reports that show some of that spending and how it is tracked. Would you be happy to give that information to the committee as well?

Alex Neil: Absolutely—we can give you a full briefing on the integrated resource funding framework.

Integrated Resource Framework

The Health and Sport Committee previously received written information on the Integrated Resource Framework (IRF) in June 2012. The IRF uses routinely recorded activity and cost data to map how health and social care resources are spent. By using individual level data it is possible to report expenditure according to whichever programmes of care are of particular local interest to clinicians and care professionals. For example, joint expenditure for health and social care can be aggregated and reported by GP practice, geography, care group, age, gender, etc. Analysing the data in this way also provides the opportunity to consider expenditure in terms of its preventative/reactive impact, and to report on the balance of care locally across institutional and community based settings.

IRF Output

Outputs from the IRF fall into two categories:

1) Standard mapping reports

Standard mapping reports are produced annually by ISD for all Community Health Partnership areas and consist of aggregate level summary expenditure reports for partnership populations in three age groups: all ages; people aged over 65 years; and people aged over 75 years.

Supplementary information on partnership weighted populations for these age groups is also provided together with a number of analyses, which allows partners to benchmark expenditure per capita for their respective populations. Examples of this standard output are provided at Annex A.

Previously, during the IRF pilots, Community Health Partnership areas produced their own mapping information, but by centralising production through ISD it has been possible to both lessen the burden on Community Health Partnership areas, and to standardise the methodology used, so that data can now be compared between areas.

2) Individual level datasets

The individual level datasets that underpin the aggregate reports are also available for Community Health Partnership areas to carry out more detailed analysis. At present, these consist of activity and cost data for hospital activity and prescribing for all Community Health Partnership areas and social care activity and cost data for a number of areas.

Use of IRF information

Effective planning and commissioning of health and social care services is predicated on Health Boards and Local Authorities understanding how their resources are allocated and used. The IRF enables partnerships to do this effectively. IRF information is currently used by Community Health Partnership areas to inform the development of their Joint Commissioning Strategies for older people.
In addition, Community Health Partnership areas have used IRF individual level datasets not only for the purposes of joint commissioning but also to support service redesign and evaluation. Examples of this are:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute flow and demand for hospital care</td>
<td>NHS Forth Valley and all of its Local Authority partners – Stirling Council, Clackmannanshire Council and Falkirk Council</td>
</tr>
<tr>
<td>Adult mental health</td>
<td>NHS Tayside and Dundee City Council</td>
</tr>
<tr>
<td>Alcohol and drug misuse</td>
<td>NHS Tayside and Dundee City Council</td>
</tr>
<tr>
<td>Anticipatory Care Plans</td>
<td>NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Children’s use of acute health</td>
<td>NHS Tayside and Dundee City Council</td>
</tr>
<tr>
<td>Delayed discharge</td>
<td>NHS Greater Glasgow and Clyde, West Dunbartonshire Council and East Dunbartonshire Council</td>
</tr>
<tr>
<td>Dementia</td>
<td>NHS Lothian and Midlothian Council, NHS Tayside and Perth and Kinross Council, NHS Western Isles and Western Isles Council</td>
</tr>
<tr>
<td>Detailed resource analysis for health and social care</td>
<td>NHS Tayside and all of its Local Authority partners – Dundee City Council, Angus Council and Perth and Kinross Council</td>
</tr>
<tr>
<td>Emergency admissions for older people</td>
<td>NHS Forth Valley and all of its Local Authority partners – Stirling Council, Clackmannanshire Council and Falkirk Council, NHS Western Isles and Western Isles Council</td>
</tr>
<tr>
<td>Re-ablement</td>
<td>NHS Western Isles and Western Isles Council</td>
</tr>
</tbody>
</table>

Two examples of this work (dementia and alcohol and drug misuse) are included at Annex B. I have experienced first-hand how powerful this data can be for clinicians and care professionals. The IRF approach has been used in pilot work with GP practices around Scotland targeting health inequalities. At an event with participating GP practices on 9th October, I heard for myself how important this data is in helping GPs and other professionals to achieve a full understanding of the circumstances in which patients, service users and their families are using services, enabling a truly person-centred approach to care planning and provision.

**Future development of the IRF**

Under the provisions of the Public Bodies (Joint Working) (Scotland) Bill, integrated health and social care partnerships will be required to produce strategic plans. To support this requirement, and to assure the availability of high quality data to local planners, the Scottish Government has commissioned further development work on the IRF from Information Services Division (ISD) of National Services Scotland (NSS). Datasets linked across health and social care, aggregated to the level of individual patients and service users, will be made available to all integrated health and social care partnerships. The Financial Memorandum accompanying the Bill includes estimates for this work at paragraph 67.

This development work will build upon existing Health Board and Local Authority data systems. It is overseen by a steering group whose membership is drawn from partner organisations and stakeholders. I would be happy to share the terms of reference available to the Committee if required.
Annex A – Standard output from the IRF

The chart below demonstrates at the Scotland level hospital based expenditure for people aged over 75. Emergency admissions account for nearly 70% of total resource use.

Scotland -75 plus hospital based resource, 2011/12, £1.4bn

The chart below displays expenditure for health and social care for those aged over 65 in Scotland by splitting this into institutional (hospital based resource use plus care homes) and non-institutional resource use (community health services (for example district nursing), general medical services (GMS) and prescribing by GPs, and social care (excluding care homes)).

Scotland - 65 plus Institutional/Non-institutional Balance of Care - 2010/11, £4.3bn
Annex B – Examples using individual level data for analysis

Dementia – NHS Lothian and Midlothian Council

Midlothian is one of the dementia demonstrator sites in Scotland. Through the IRF, GPs in Midlothian gave NHS Lothian individual level information for those who were diagnosed with dementia in the area and those who were not.

Overall, those with dementia accounted for 5% of the population in Midlothian, yet accounted for 25% of the total health and social care budget for the area.

The charts below display the cost attributable to dementia (that is the difference in resource use for those that have a dementia diagnosis compared to those who do not). A large percentage of the cost for those with dementia in Midlothian is taken up by care homes (62%). This analysis will allow improved planning for the future, by understanding clearly what services those with dementia currently use, the Health Board and Local Authority will be able to improve how they care for those with dementia.

Costs attributable to dementia in Midlothian

![Diagram showing costs attributable to dementia in Midlothian]

Alcohol and drug misuse – NHS Tayside and Dundee City Council

NHS ISD received data for those who were diagnosed with a alcohol and or drug misuse illness for Dundee City Council. Those working in the alcohol and drug partnership in Dundee City were keen to find out what services those with a misuse illness currently used compared to the general population of Dundee City. As Tayside is one of the areas where NHS ISD have linked social care services at individual level, both health and social care were analysed.

As can be seen from the figures (a and b below) a large percentage of spend (72%) for those with a misuse diagnosis is on emergency admissions, compared to 36% for those without a misuse diagnosis. Planned admissions expenditure accounts for 12% for those
with a misuse diagnosis compared to 17% for the group. Prescribing (7%) and social care (5%) account for a far smaller share of resource in the misuse cohort compared to the non misuse cohort where prescribing accounts for 16% and social care 25% of resource.

As with many areas of Scotland, Dundee City is making changes to the care pathway for those with a substance misuse illness, therefore over time it will be possible to revisit the data and see if there has been any change in the pattern of health and social care utilised by these two cohorts.

**Alcohol and Drug Misuse Dundee City - health and social Care resource use for those without and without a substance misuse diagnosis**

**Figure a) Population with a misuse diagnosis**

- Emergency admissions: 72%
- Planned admissions: 12%
- Prescribing: 7%
- Social Care: 5%
- Other Health: 4%

**Figure b) Non substance misuse population**

- Emergency admissions: 36%
- Planned admissions: 17%
- Prescribing: 16%
- Social Care: 25%
- Other Health: 6%
Evaluation of Change Fund Projects

Alex Neil: Some individual projects have been evaluated. I think that we can probably send you details of them.

Evaluation of Change Fund Projects

The Joint Improvement Team invited all partnerships to submit a summary of local progress by the end of September 2013. The main purpose was to share examples of how local partnerships have deployed their Change Fund to make a difference to the lives of older people and their carers across Scotland. Thus each partnership was asked to describe the learning from at least one initiative that they had taken forward under each pillar of the RCOP pathway and to describe the achieved or anticipated outcomes. A report on the analysis of these submissions will be published at the end of this year.

Despite the complexity of demonstrating impact in complex whole system change, the focus of any evaluation has predominantly been through Partnerships local monitoring and evaluation frameworks. Partnerships have developed systems for assessing progress, using the information to drive performance improvement and to inform their Joint Commissioning investment and disinvestment decisions. These frameworks typically allow partnerships to report regularly on a range of reshaping care for older people indicators both national ones as well as project specific indicators relating to their workstreams locally.

For example the Partnerships in North and South Lanarkshire have together established a joint performance framework and electronic dashboard for RCOP and Integration. This uses an application that can be easily accessed, viewed and interrogated across agencies. Their approach includes an evaluation process based on a RCOP logic model. All projects have been mapped to clearly identify which outcomes within the logic model they are contributing to and are now providing evidence to allow contribution analysis to be carried out.

The East Ayrshire Partnership are now provided with performance information through the Covalent system, providing information in relation to both national and local indicators e.g. local Care Home admissions. This system is common across NHS and LA partners, with statutory sector partners being provided with training and data inputting support. This data is used to support the further development of the projects within the Reshaping Care programme, as we discuss the quarterly reporting updates at our partnership meetings.

There are many other examples of local monitoring frameworks used by Partnerships.

Local evaluation of initiatives

The mid-year review submissions from Partnerships highlighted a wide range of local evaluation work around specific initiatives. A few couple of examples outlined below:

In Ayrshire and Arran the Invigor8 programme which was established to improve mobility, strength and balance helping to reduce the risk of falls is being evaluated locally. The Change Fund supported the development of this initiative from the training through to delivery of the classes. An evaluation tool was developed by the NHS to track the improvements made by individuals attending the programme and early indications show that confidence levels are increasing, falls are reducing and strength is improving. A full analysis of the data has still to be completed but the team members delivering the classes have noticed a big difference in participants and they feel that this is most noticeable in the early stages of attending the classes with improvements gained during the first 12 weeks and then maintained throughout the rest of the year with smaller improvements. The classes are planned to continue and a follow up/maintenance classes for those who have completed their 12 months of the programme will be introduced.
Another example is in Edinburgh where they continually review the change fund investments made and information from ongoing evaluation is used to inform future funding decisions. For example an evaluation of the COMPASS (Comprehensive Assessment) is underway. COMPASS is a new way of working which aims to provide more integrated care for frail, older people in Edinburgh by improving the identification of older people in the community at risk of escalation / hospital admission, providing proactive case management for those at risk of admission by the most appropriate service; preventing emergency admission of patients to hospital by facilitating and providing timely access to alternatives; facilitating the discharge and prevent later readmission of patients from hospital following a planned or emergency admission. The COMPASS pilot began in South East Edinburgh in April 2012, and the roll-out to North West began in April 2013. Evaluation of the work so far suggests that significant positive change is being noted amongst participating services. Pro-active case-finding is becoming an established element of COMPASS, with more integrated care planning for patients who have been identified as at risk of hospital admission or re-admission. The model is also achieving improved understanding and communication between services from across the system, leading to better outcomes for individual patients/ service users.

**National evaluation work**

There are also national evaluation work underway for example, evaluation of the 'Smart care partnerships evaluation' - this work involves 7 local health and care partnerships within Ayrshire and Clyde Valley who are enabling choice and control in health, care and wellbeing services through the adoption of innovative ICT solutions, including telehealth and telecare. The initial focus in Falls Prevention and Management, with additional activity on Dementia Care subject to progress. A comprehensive evaluation is planned, the lesson from which will be shared with other Partnerships.

We are also piloting a capacity planning and prioritisation approach to investment and disinvestment – Programme Budgeting and Marginal Analysis (PBMA) - in three areas, Ayrshire, Highland and Perth & Kinross, in conjunction with Glasgow Caledonian University.

Evaluation Support Scotland is also evaluating preventative interventions in their national "Stitch in Time" project, aiming to assess contribution of third sector-delivered interventions to the outcomes of the Reshaping Care for Older People programme.

**Future**

Going forward we will continue to monitor progress throughout the lifespan (till 2014-15) of the Change Fund though partnership submission of progress reports and joint strategic commissioning plans detailing investment plans, progress in shifting spend and impact of interventions.