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)

Budget decisions and the allocation of resources are influenced mainly a number of factors including the quality measurement framework for the NHS, local health priorities and changes in legislation or policy. The HEAT targets cover the key areas against which Board’s performance is assessed:

- **Health Improvement for the people of Scotland** - improving life expectancy and healthy life expectancy;
- **Efficiency and Governance Improvements** - continually improve the efficiency and effectiveness of the NHS;
- **Access to Services** - recognising patients' need for quicker and easier use of NHS services; and
- **Treatment Appropriate to Individuals** - ensure patients receive high quality services that meet their needs.

In terms of the budget decisions other key influencing factors have included:

- Changes in the Scottish Medicines Consortium approval processes for new drugs
- Introduction of new legislation, for example Pensions Act 2008 (pension auto-enrolment), Patient Rights (Scotland) Act 2011 (treatment time guarantee) and Children and Young People (Scotland) Act 2014 (introduction of named person)
- Challenges in securing staff necessary to meet changing demands – a shortage of skills in a number of specialties has resulted in higher levels of temporary or contract staff.
- Local decision regarding health provision – this would include investment in services to meet specific needs around healthcare that the Board has supported through its own decision making and resource allocation processes. This would include allocating resources to areas where additional capacity would have a corresponding improvement in quality and safety.
- Capital resources are prioritised towards reduction in backlog maintenance / statutory compliance and replacement of essential medical equipment.
We also consider resource allocation decisions through the Community Planning Partnerships (CPPs) to support delivery of the Single Outcome Agreements (SOAs). These single outcome agreements are aligned to a number of the key areas within the National Performance Framework.

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

We set out within our local delivery plans how we propose to achieve the NHS LDP standards against which our Board performance is measured and monitored. As these are national priorities, Board resources are directed towards achievement of these standards. In instances where additional capacity is required to achieve a required performance standard we will prioritise resources to those areas.

For example; we have invested in the last two financial years in additional consultant and theatre capacity to support delivery of access to elective procedures in line with the treatment time guarantee and to improve performance across the unscheduled care pathway;

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

The Board’s local delivery plan takes of account of the Scottish Government LDP guidance, Quality Measurement Framework and National Performance Framework and forms the basis for the development of a comprehensive NHS Grampian plan which includes all of the actions that need to be taken forward.

The LDP and prioritisation of resources has also been prepared against the background of the Board’s Healthfit 2020 Vision and the significant change that is gathering pace in relation to health and social care integration. The drivers for NHS Grampian are therefore to:

- Support and facilitate the planning, delivery and integration of health and healthcare across the north east of Scotland
- Deliver secondary and tertiary services to the north east and north of Scotland and ensure that good access to such services for the population is maintained
- Be an active partner and leader in north of Scotland working to develop and maintain an effective and efficient network of services
- Train, educate and develop people who will deliver and support health and healthcare in partnership with a range of other organisations
- Be a positive influence in the health and wellbeing of the community in the north east of Scotland.
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)

Examples where we have allocated additional staff resources in the last two financial years to meet performance standards are noted below:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>FTE</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>New theatre investment</td>
<td>74.5</td>
<td>3,348</td>
</tr>
<tr>
<td>Cancer action plan</td>
<td>19.2</td>
<td>980^2</td>
</tr>
<tr>
<td>Critical care nursing</td>
<td>21.0</td>
<td>700</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>12.3</td>
<td>484</td>
</tr>
<tr>
<td>Unscheduled care</td>
<td>23.3</td>
<td>2,000</td>
</tr>
</tbody>
</table>

**New theatre investment**

The Board approved the additional investment in staffing to support the four new theatres for Woodend Hospital and Aberdeen Royal Infirmary. The increase in local capacity was necessary to enable the Board to comply with the Treatment Time Guarantee (TTG) as set out in the Patient Rights (Scotland) Act 2011.

**Critical Care nursing**

Following a review of the service requirements a proposal for additional investment into substantive critical care nursing posts (Intensive Care Unit and High Dependency Unit) was approved. The outcome was approval for an increase in bed capacity within the ICU and an investment in 21 full time equivalent (FTE) nursing staff.

**Endoscopy**

The service developed a proposal with several options to increase capacity to improve performance in terms of access to diagnostic support. The outcome was approval of an investment of c£0.5m to meet a gap in demand for new appointments and to provide additional scoping capacity.

**Cancer action plan**

Additional investment was required within the haematology and oncology units as a result of increasing patient numbers and advances in treatment and supportive care and the need to meet cancer access targets. The service conducted a review of the requirements and a detailed business plan was prepared to support investment in additional staffing.

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1 This is in addition to the commitment of £1.7m made for the recruitment of 39.3 FTE nursing staff in 2013/14
2 This is in addition to the commitment of £0.25m made for the recruitment of c4 FTE staff in 2013/14
Unscheduled care investment

The Board approved a £2m investment in a number of service developments that aim to deliver the greatest impact on the issues associated with the care of patients who present acutely to the ARI ‘front door’. These service developments were:

- Provision of a 7 day (09:00 – 20:00) ambulatory rapid medical assessment clinic
- Provision of a 7 day (12:00 – 20:00) acute care medical consultant to work within the ED department
- Fully support the expansion of the senior medical staff in the HDU to allow a full 24/7 service to be delivered
- The development of an enablement team that is available to see patients within the ED or other ward locations

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?

The integration schemes for each of the three Partnerships in Grampian (Aberdeen City, Aberdeenshire and Moray) have now been approved by the relevant partners and will shortly be submitted to the Scottish Government. Each scheme contains the following provisions with regard to the method under which funding for joint boards will be determined:-

12.1 “Payments to the IJB – 1st Financial Year

12.1.1 Each Party will follow their existing budget setting process in setting budgets for delegated functions for the financial year commencing 1 April 2015, giving due consideration of recent past performance and existing plans. The outcome of this process will be to set a recurring budget for the IJB for delegated functions as at 1 April 2015.

12.1.2 In doing so, the Parties will treat budget setting for delegated functions in a manner which is consistent with their budget setting process for other services provided by the Parties (i.e. the fact that delegated functions will become integrated should not influence the way in which budgets are set for delegated functions). Appropriate due diligence will be carried out by the IJB and Parties. This process will be transparent and the assumptions underlying the budgets must be available to all Parties.
12.1.3 If the IJB becomes formally established part way through the 2015/16 financial year, the Director of Finance of NHS Grampian and the Section 95 Officer of the Council, in consultation with the Chief Finance Officer of the IJB, will agree on a proportionate split of the budget for the year. This would be formally ratified by the Council and NHS Grampian.

12.1.4 Each Party acknowledges that Integration arrangements will still be evolving in 2015/16 and therefore accepts that payment in the first year to the IJB is likely to be indicative in nature. A further due diligence exercise will be carried out at the end of the 2015/16 financial year to assess the adequacy of the payment made in the first year for delegated functions.”

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

The delegation of health services to the Integrated Joint Boards (IJBs) has been considered in detail by the NHS Grampian Executive Team and advice has been taken from senior managers and clinicians in relation to the services that will be delegated which provide a service across partnerships. The principle in the Public Bodies (Scotland) Act is that all services included in the legislation should be delegated but those hospital based services that are embedded within larger hospitals e.g. Aberdeen Royal Infirmary, will remain directly managed by NHS Grampian. The IJBs will, however, be responsible for the strategic planning of those services and for the whole pathway of care.

In relation to delegated services provided across Grampian a condition of the delegation is the requirement for a memorandum of understanding agreed by the IJBs and NHS Grampian to ensure that all parties are satisfied with the management and coordination arrangements that will be put in place. These arrangements will be developed by the NHS Grampian Strategic Change Management Group and the North East Partnership Steering Group for approval by the parent organisation and the shadow IJBs. The aim is that this process will be complete early in 2015/16 to permit the IJBs to start developing the arrangements whilst working in shadow form.

The development of the budgets associated with the delegation of services will continue during 2015 and a process of due diligence will be agreed to ensure that the final budget allocations are fair and reasonable for all parties. The allocation of the delegated budgets and the arrangements for the formal establishment of the IJBs will be submitted to the Board for consideration in due course. The IJBs must be formally established by 31 March 2015 at the latest and the IJB strategic plans must be approved before formal establishment is permitted.

Appendix 1 summarises the services to be delegated.
7. How much is being allocated to the Integration Joint Board for 2015-16?
   a. by the health board
   b. by local authority partners?

   Financial resources will not be allocated to the new Integrated Joint Boards until they become formally established. This is likely to be towards the end of the 2015/16 financial year. Resources will be allocated to meet the costs of services for which responsibility will be delegated to the Integrated Joint Boards. The projected resource that will be allocated from NHS Grampian to the three Integrated Joint Boards is expected to be in the region of £390 million. The projected resource that will be allocated from the three Local Authorities in Grampian to the three Integrated Joint Boards is expected to be in the region of £230 million.

   The development of the budgets associated with the delegation of services will continue during 2015 and a process of due diligence will be agreed to ensure that the final budget allocations are fair and reasonable for all parties. The allocation of the delegated budgets and the arrangements for the formal establishment of the IJBs will be submitted to the NHS Grampian Board for consideration in due course.

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

   The provisions relating to finance contained in the three Integration Schemes are supplemented by more detailed financial guidance which does not form part of the Integration Scheme. The more detailed guidance covers areas like financial governance, budget setting, financial reporting and arrangements for the budgets of large hospital services.

Specific challenges

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

   **Policy and Legislative change**
   The policy and legislative landscape in which Boards operate is continually evolving and requires adjustments to be made in terms of our operating and planning framework. We had the recent enactment of the Patient Rights (Scotland) Act, the Public Bodies (Joint Working) (Scotland) Bill and the Community Empowerment and Renewal Bill. The Board’s local delivery plan acknowledges the new legislation and work is progressing to identify the resource and financial implications (costs and opportunities) of the changes to health and social care integration and in community planning. We are also undertaking preliminary planning for the introduction of the new major trauma centre hub in Aberdeen, the costs and funding for which have not been confirmed nor reflected within our financial plan.
Access to new drugs
The Grampian Medicines Management Group performs a critical role in ensuring that the organisation is effective in its management of prescription drugs in both primary care and hospital settings. The Group’s report to the Budget Steering Group suggests an increase of the annual drugs budget by £7.5m million in 2015/16 (excluding the costs of the new Hepatitis C drugs). During 2014/15 we experienced a significant increase in our primary and secondary care prescribing budgets. Primary care drug costs being influenced by both price and volume increases higher than forecast and secondary care drugs impacted by the approval of a number of high cost drugs under the new Scottish Medicines Consortium approval process. Whilst provision has been made in our financial plans to reflect recurring additional funding for primary and secondary care drugs the full extent of any cost may have to be met from a re-prioritisation of service funding.

Capital
The level of capital funding available to NHS Boards does not fully reflect the investment levels required to ensure that our infrastructure (buildings, equipment and technology) remain fit for purpose and in compliance with required legislation. The Asset Management Group (AMG) advises the NHS Grampian Board on the prioritisation of available capital, and other sources of funding, in line with agreed service strategy and assessed high risk areas for infrastructure replacement and improvement. All capital expenditure proposals are subject to robust scrutiny and challenge by the AMG on an ongoing basis to ensure that all available funding is targeted in the most appropriate manner and phased to maximise impact on reducing known risks.

Managing demand pressures
Changing demographics, with an increasing and aging population, are placing additional pressures on existing health resources. The population of Grampian continues to rise at a faster rate than other parts of Scotland, with new and emerging communities reflected in the local development plans in Aberdeen City and Aberdeenshire in particular. These challenges are reflected in gaps in primary care health provision (current and predicted) and rising levels of activity and patient acuity in our major hospital sites. Our Property and Asset Management Plan will set out the challenges we face in relation to the location of our infrastructure and the need for transformation in relation to the provision of primary and social care. NHS Grampian in conjunction with local authority partners has made very good progress in preventing admission to hospital. This is not only much better for patients but frees up much needed bed space to allow a faster throughput of activity which in turn improves access for new patients. There is growing concern, however, that local authorities will find it difficult in future to allocate sufficient funding to support patients discharging into the community, leading once again to “delayed discharge” difficulties. The establishment of the new Integrated Joint Boards and the introduction of more challenging targets for reducing delayed discharges will further focus attention.
NHS Grampian

Workforce

The employment market within the Grampian area is particularly challenging given the buoyancy of the local market, rising property costs and availability of affordable rental accommodation. In addition we are facing similar challenges to other Boards in Scotland in terms of recruitment of consultants and other clinicians within certain medical specialties and sub-specialties. These challenges have manifested themselves in increases in medical locum costs and higher levels of nursing vacancies.

As a Board we are reviewing all aspects of our recruitment arrangements to ensure that we are maximising the potential to attract and retain staff in the Grampian area. The increasing level of medical locums required to support and sustain clinical services remains a concern both from a financial and clinical service perspective. We do however remain ambitious in our aims for the delivery of healthcare and to building on our position as a high quality teaching and research establishment.

B: Increase the proportion of babies with a healthy birth weight

Indicator measure: The proportion of new born babies with a weight appropriate for gestational age

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

<table>
<thead>
<tr>
<th></th>
<th>% of new born babies with a weight appropriate for gestational age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NHS Grampian</td>
</tr>
<tr>
<td>2009</td>
<td>90.3%</td>
</tr>
<tr>
<td>2010</td>
<td>90.6%</td>
</tr>
<tr>
<td>2011</td>
<td>90.5%</td>
</tr>
<tr>
<td>2012</td>
<td>91.0%</td>
</tr>
<tr>
<td>2013</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

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

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

a. Deprivation – Grampian has fewer areas in the poorest two national SIMD quintiles, and few births are to mothers in the most deprived quintiles
b. Smoking in pregnancy – Grampian has the lowest rate of mothers self-reporting as smokers at the time of booking of the mainland health boards. Also fewer are recorded as smoking at first visit (approx 10 days after delivery).
NHS Grampian

c. Maternal age – Whilst there are more births to ‘older’ (>35 years old), mothers and this is a risk for low birth weight, many of these mothers are in less deprived areas.

d. A high proportion of women book by 12 weeks of pregnancy (98.3% in January 2015, 91.9% in February 2015). This enables community midwives and others to start working with women early on their lifestyle choices promoting the biggest impact possible.

e. Improved working between different health professionals (particularly Midwives and Health Visitors) to identify risks and additional support required

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

For maternity services it is not the indicator that most strongly influences budget decisions however the areas that budgets are committed to such as smoking cessation, healthy maternal weight, substance misuse all contribute to more women having babies of a healthy weight.

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

Healthy birth weight may be most useful as an indicator in the long term, due to improvements being very small from year to year.

Improvements may come from a range of health improvement interventions which result in wider health benefits to the mother and unborn child, such as stopping smoking, avoiding drugs and alcohol. Improvements may also come from factors outwith Health Boards control, such as reduction in deprivation, improved housing, improved finances or financial management, access to appropriate services.

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

<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £000</th>
<th>Planned expenditure 2015-16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal &amp; Infant Nutrition Programme</td>
<td>280</td>
<td>280</td>
</tr>
<tr>
<td>Child Health Weight Programme</td>
<td>178</td>
<td>178</td>
</tr>
<tr>
<td>Maternity Care Quality Improvement Collaborative</td>
<td>38</td>
<td>To be confirmed</td>
</tr>
</tbody>
</table>

6. What statutory partners or other partners (if any) contribute towards performance in this area?
The Community Planning Partnerships have this indicator as part of their Single Outcome Agreements. Through Community Planning Structures, statutory and third sector partners work together to support vulnerable families. The Smoking Advice Service is delivered through a range of community based and independent health professionals.

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

Other areas which may contribute to performance are:

- Sexual health services
- Drug and alcohol services
- Health improvement programmes may lead to positive changes in health generally, and not restricted to pregnancy
- Healthy Start

### C: Improve end of life care

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

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

<table>
<thead>
<tr>
<th></th>
<th>Board</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>92.9%</td>
<td>90.4%</td>
</tr>
<tr>
<td>2009-10</td>
<td>93.5%</td>
<td>90.5%</td>
</tr>
<tr>
<td>2010-11</td>
<td>93.6%</td>
<td>90.7%</td>
</tr>
<tr>
<td>2011-12</td>
<td>94.2%</td>
<td>91.1%</td>
</tr>
<tr>
<td>2012-13</td>
<td>93.9%</td>
<td>91.2%</td>
</tr>
</tbody>
</table>

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

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

There are numerous factors which contribute to our relative performance in supporting end of life support at home or in a community setting:

**Support which NHS Grampian**

- The practice of seeing as many people in an outpatient setting either by clinics or domiciliary visits.
- All measures are taken to avoid inpatient assessment. It is felt that the network of community hospitals across NHS Grampian also helps.
A specialist 24 hour advice line is also provided rather than relying on more general medical help such as GMED.

Commitment to an integrated palliative care plan

The key standards for this integrated palliative care plan are:

- The patient has an initial assessment of performance and symptom status when it is recognised that they are palliative.
- The patient’s care plan reflects their palliative care needs.
- A regular review is undertaken and recorded of the patient’s performance and symptom status and care needs.
- Potentially reversible causes of decline are identified and treated, if appropriate.
- In situations where there are irreversible causes of decline, these are clearly recorded and appropriate comfort measures put in place.

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

We continually keep under review the resource requirements necessary to support the commitments within the Board’s integrated palliative care plan.

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

Yes it is regarded as a very useful indicator as it takes into consideration those patients who change their mind about care towards the very end of life.

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

<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £000</th>
<th>Planned expenditure 2015-16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipatory prescribing</td>
<td>See note below</td>
<td></td>
</tr>
<tr>
<td>Use of Grampian Palliative Strategy</td>
<td>See note below</td>
<td></td>
</tr>
<tr>
<td>MacMillan nurses</td>
<td>See note below</td>
<td></td>
</tr>
</tbody>
</table>

General palliative care services are delivered by a wide range of health professionals across NHS Grampian (e.g. General Practitioners, community nurses, secondary care hospital staff, specialist nurses). Information on what proportion of time these staff spend on palliative care is not gathered and therefore we are unable to quantify expenditure on general palliative care services.
6. What statutory partners or other partners (if any) contribute towards performance in this area?

- MacMillan Nurses
- General Practice Teamwork
- Roxburgh House (which is 100% NHS funded)

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

Grampian Palliative Strategy

Palliative care and hospice funding

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

<table>
<thead>
<tr>
<th></th>
<th>Expenditure 2014-15 £000</th>
<th>Planned expenditure 2015-16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist palliative care services</td>
<td>2,301</td>
<td>2,347</td>
</tr>
<tr>
<td>General palliative care services</td>
<td>See note below</td>
<td>See note below</td>
</tr>
</tbody>
</table>

General palliative care services are delivered by a wide range of health professionals across NHS Grampian (e.g. General Practitioners, community nurses, secondary care hospital staff, specialist nurses). Information on what proportion of time these staff spend on palliative care is not gathered and therefore we are unable to quantify expenditure on general palliative care services.

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:

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

<table>
<thead>
<tr>
<th>Amounts shown are for the whole of NHS Scotland (Note 1)</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed funding for running costs of independent children’s hospices (including local authority funding where relevant) (Note 4)</td>
<td>928</td>
<td>970</td>
</tr>
<tr>
<td>£000s (Note 3)</td>
<td>9.5%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

Notes

1. There is only one independent children's hospice organisation in Scotland, Children's Hospice Association Scotland (CHAS). In order to avoid bureaucracy Health Boards agreed that Tayside Health Board would be the lead funder of CHAS on behalf of NHS Scotland. The figures shown are therefore for the whole of NHS Scotland. CHAS operates two hospice facilities, Rachel House in Kinross and Robin House in Balloch.

2. The requirement for Health Boards is to fund 12.5% of hospice running costs. It is not possible to clearly identify the running costs of the hospices themselves, on which the required funding level of 12.5% is calculated. In order to simplify matters and avoid bureaucracy an agreed funding baseline was established in 2009/10, which has been uplifted each year using Health Board percentage uplifts. CHAS management have been content with this pragmatic approach.

CHAS has provided the total “charitable activities” amount from its accounts as follows:

<table>
<thead>
<tr>
<th>CHAS total charitable activities</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>9,739</td>
<td>10,336</td>
</tr>
</tbody>
</table>

CHAS total charitable activities include not only hospice running costs, but also other charitable activities.
3. The analysis of NHS funding paid and payable to CHAS is as follows:

<table>
<thead>
<tr>
<th>Amounts shown are for the whole of NHS Scotland</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding from Territorial Boards</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Funding from Scottish Government (Diana nurse funding)</td>
<td>672</td>
<td>691</td>
</tr>
<tr>
<td>Totals</td>
<td>928</td>
<td>970</td>
</tr>
</tbody>
</table>

4. Health Boards do not have knowledge of the funding provided by Local Authorities.

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

N/A

**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?

<table>
<thead>
<tr>
<th>Emergency admissions rate (per 100,000 population)</th>
<th>Board</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>8,330</td>
<td>9,849</td>
</tr>
<tr>
<td>2010-11</td>
<td>8,462</td>
<td>9,874</td>
</tr>
<tr>
<td>2011-12</td>
<td>8,588</td>
<td>10,090</td>
</tr>
<tr>
<td>2012-13</td>
<td>8,285</td>
<td>10,130</td>
</tr>
<tr>
<td>2013-14 (p)</td>
<td>8,007</td>
<td>10,188</td>
</tr>
</tbody>
</table>

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

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

NHS Grampian has made a long term commitment to improvements across the unscheduled care pathway and ensuring that we design and implement arrangements to address the challenges around predicted demographic growth. In addition to investment in a purpose built emergency care centre and additional hospital based capacity, we have increased resources and resilience across all elements of the pathway aimed at reduced A&E attendances and the need for hospital admission.
We compare well with the rest of Scotland, despite demographic change and the increase in our over 75 population, particularly in Aberdeenshire. We fare well on a number of complementary indicators including emergency bed days and readmission rates. Some factors include:

- The increased use of anticipatory care planning in primary care
- Our system wide unscheduled care programme, including decision support in the Emergency Department, with many admissions prevented and managed more appropriately elsewhere
- As well as making every effort to reduce inappropriate emergency admissions, we also concentrated on reducing length of stay and readmission rates

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

The Board has made a significant investment in capacity across the unscheduled care pathway given the priority allocated to the redesign of services and the need to establish a new model which would cope with the predicted growth in the over 75 population. This was confirmed several years ago in the NHS Grampian 2020 vision.

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

A useful indicator but needs to be considered alongside a range of other indicators within the pathway eg readmission rates, length of stay and inappropriate emergency admissions.

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

<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £000</th>
<th>Planned expenditure 2015-16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unscheduled Care Action Plan</td>
<td>2,013</td>
<td>887</td>
</tr>
<tr>
<td>Change Fund / Integrated Care Fund</td>
<td>6,763</td>
<td>9,120</td>
</tr>
<tr>
<td>“Front Door” Services Investment Plan</td>
<td>1,500</td>
<td></td>
</tr>
</tbody>
</table>

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

Key statutory partners are the three local authorities (Moray, Aberdeenshire and Aberdeen City) with support from the national emergency services.
7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

We would acknowledge that the delivery of a sustainable position requires an integrated multi-agency approach to the management of unscheduled episodes. This requires integration not only between primary and secondary care but the development of joint plans with other statutory bodies.

Appendix 1

Delegation of Health Services

1. Services as described in the legislation/regulations that will be delegated:

   a) Community Health Services

   District nursing services
   Community substance misuse
   AHP services in an outpatient department, clinic, and community
   Public dental service
   Primary medical services provided under a general medical services contract
   General dental services
   Ophthalmic services
   Pharmaceutical services - community
   Out of hours primary medical services - GMED
   Services provided outwith a hospital in relation to geriatric medicine
   Palliative care services provided outwith a hospital
   Community learning disability services
   Mental health services provided outwith a hospital
   Continence services provided outwith a hospital
   Kidney dialysis provided outwith a hospital
   Services provided by health professionals that aim to promote public health

   b) Hospital Based Services

   Accident and Emergency services provided in a hospital*
   Inpatient hospital services relating to the following branches of medicine—
   • general medicine;*
   • geriatric medicine;*
   • rehabilitation medicine;*
   • respiratory medicine;* and
   • psychiatry of learning disability
   Palliative care services provided in a hospital*
   Inpatient hospital services provided by General Medical Practitioners
   Inpatient addiction or substance misuse services
   Mental health services provided in a hospital, except secure forensic mental health services

   Note: The services marked * will continue to be managed by NHS Grampian as they are integrated with the management of other acute or hospital based services.
2. Existing CHP hosting arrangements to continue to be hosted by IJBs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Current Host</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health Services</td>
<td>Aberdeen City</td>
</tr>
<tr>
<td>Woodend Assessment of the Elderly (including Links Unit at City Hospital)</td>
<td>Aberdeen City</td>
</tr>
<tr>
<td>Woodend Rehabilitation Services (including Stroke Rehab, Neuro Rehab, Horizons, Craig Court and MARS)</td>
<td>Aberdeen City</td>
</tr>
<tr>
<td>Marie Curie Nursing</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>Heart Failure Service</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>Continence Service</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>Diabetes community services</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>Chronic Oedema Service</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>HMP Grampian</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>Police Forensic Examiners</td>
<td>Aberdeenshire</td>
</tr>
</tbody>
</table>

The services identified above will be delegated to the IJBs and the existing hosting arrangement will continue in the short term until a memorandum of understanding is agreed.

For all services that will be operationally managed by an IJB on a Grampian wide basis, or to more than one IJB, a memorandum of understanding will be agreed between the IJBs and NHS Grampian in relation to the hosting and coordination of services before the formal delegation is put in place. The services include:

- All existing hosted services as above
- Inpatient psychiatry of learning disability
- Mental health services provided in a hospital
- GMED Primary Care Out of Hours service (currently managed by the Acute Sector of NHS Grampian)

Supplementary Information – NHS Grampian

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

There is a combination of factors:

Population and location

- The distribution of population is likely to be important: 44.5% of population live in Aberdeenshire, 16.3% in Moray and 39.2% in Aberdeen City.

- Distance from major hospital centres (including travelling times) may result in rural patients, at this time in their lives, preferring to be cared for at home rather than in large secondary care units. Certainly the data for place of death in 2012 would support this -- deaths at home - City 20.2%; Shire 23.7%; Moray 29.4%

- Nursing home/residential deaths appear fairly even across the 3 CHPs - 25.7%, 24.7% and 23.9%
Historically rural primary care teams have demonstrated a great willingness to provide care for people with advancing disease at home or as close to home as possible.

**Palliative and Supportive Care Plan**

The development of an NHSG Palliative and Supportive Care Plan has helped primary and secondary care teams to increase their confidence and skills in caring for patients with advancing disease. In the last 10 years the education department has run 1,085 events for a wide range of professionals attended by 16,582 people. The Plan assists the identification and assessment of patients with advancing disease and the comprehensive, ongoing education and supportive initiative with accompanied the implementation of the plan.

There have been structured educational and supportive interventions with all care homes and community hospitals in Grampian over the last 4 years. We appreciate from work undertaken with care homes between Oct 11 and July 12 that 85% of those residents who died did so in the care home and only 13% died in acute hospital settings.

The availability of a 24 hour palliative care advice line via the specialist palliative care unit affords professionals the opportunity to access advice when required.

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

Continued investment in palliative care in developing services [including education] that improve the quality, preference and type of care provided. With an ageing population investment into more dedicated services will be required in the future. The recommendations from the NHSG Palliative and End of Life Strategy will serve as a framework and vehicle for service development.

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

The indicator is useful if considered alongside quality of care provided, patient preferences, or whether the individual would have preferred to be cared for elsewhere.
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