



SCOTTISH EXECUTIVE

Health Department

Dear Colleague,

FUNDING OF SPECIALIST PALLIATIVE CARE PROVIDED BY INDEPENDENT VOLUNTARY HOSPICES IN SCOTLAND

Summary

This HDL, which relates primarily to independent voluntary hospices providing specialist palliative care for adults, sets within the context of NHS Boards' palliative care strategies the expectation that they will fund 50% of the annual running costs of any such hospice within their area. It also provides guidance on certain aspects of hospices' running costs, in order to promote consistency of approach across Scotland. Although different arrangements apply to the funding of palliative and respite care for children with life-limiting conditions, the underpinning principles and guidance in this HDL apply to independent hospice provision for children.

Action

- Each Board's palliative care strategy, and the palliative care elements in its local health plan, must be drawn up in partnership with any independent hospice in its area.
- Each Board should have a formal mechanism for discussing the service agreement between it and that hospice or hospices.
- Boards which currently do not meet the 50% target should plan to do so, on the basis of the guidance provided in this HDL as a matter of urgency, and by no later than the beginning of financial year 2006-07.

Yours sincerely

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Addresses

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Background

1. This Health Department Letter builds on the arrangements for NHS Boards' funding of the specialist palliative care services provided by Scotland's adult independent voluntary hospices set out in NHS Circular No. 1990(Gen)12 of 23 March 1990, MEL(1993)102 of 12 August 1993 and MEL(1994)104 of 2 November 1994. The original commitment was that Boards should meet 50% of the running costs of hospices providing specialist palliative care for adults. A subsequent commitment was given that Boards and local authorities would jointly meet 25% of the running costs of the independent children's hospice which provides specialist palliative care and respite services for children with life-limiting conditions.

2. 'Palliative care' is defined by the World Health Organisation as 'the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families'. Specialist palliative care requires effective multi-disciplinary working within specialist teams who have undergone recognised specialist training, and also involves co-ordination across a wide range of professions to ensure that all appropriate patients can access this service. This HDL applies to such care when it is provided by a team based on an independent voluntary hospice, as distinct from a specialist palliative care unit based in an NHS Trust. While palliative care and specialist palliative care have traditionally been associated with cancer, it is now well recognised that the benefits of the palliative care approach should be available to everyone suffering from a progressive, incurable condition. The Executive's commitment to this approach is set out in [*Our National Health, a plan for action a plan for change*](#).

3. The Executive values the partnership which exists between the statutory and voluntary sectors in the provision of specialist palliative care. This should be reflected in each NHS Board's palliative care strategy, which should be drawn up in collaboration with all relevant local professional care groups, including primary care and the voluntary sector providers of palliative care services. That strategy should also form part of the local health plan.

4. NHS Boards' funding of the adult independent voluntary hospices is monitored each year on behalf of the Scottish Executive Health Department by the Scottish Partnership for Palliative Care. The most recent monitoring exercise indicated that in the financial year 2001-02 the average funding of Scotland's adult voluntary hospices was 37% overall, with a range of funding between 32% and 50%. There is also a significant shortfall in NHS Boards' and local authorities' funding of the independent hospice for children.

5. In discussions between the Department and the Scottish Hospices' Forum, it has been recognised that this shortfall will be due in part to the introduction by hospices of services which have not been agreed with their local NHS Board. There is general acceptance that the 50% commitment should only apply to the elements of hospices' running costs agreed by both partners, and those should be specified in the service agreement between the Board and the hospice. The Board's palliative care strategy will provide the overall context within which the range of service provision can be determined, and this emphasises the importance of making sure that that strategy, and the palliative care elements in the Board's local health plan, should be drawn up in partnership between the Board and the hospice. Experience suggests that the arrangements work best where there is a formal meeting at least annually

between representatives of the Board and the hospice in order to discuss the service agreement between them.

6. This HDL is therefore intended to clarify the framework within which those discussions should take place, and to provide guidance on certain specific aspects of hospices' running costs in relation to the 50% target. Issuing the HDL is also intended to promote consistency of approach. Where there is any discrepancy between the guidance in this HDL and an existing agreement between a hospice and a Board, the existing agreement should apply unless both parties agree otherwise .

The Framework

7. The 50% target has been set so as not to compromise the essential independence of individual hospices. It is essential as well that the arrangements should not compromise the accountability of NHS Boards in disbursing public funds. The arrangements are also broadly designed to promote partnership without stifling innovation.

8. There is general recognition that running costs could fall into one of 3 categories:
- costs which relate to services and functions which the Board and the hospice are agreed are necessary in line with the palliative care strategy/local health plan and which should therefore be funded by the partners equally. It is expected that these services and functions will comprise most of the work of the hospice. Further information is given below in relation to specific elements of those services and functions;
 - those developments which a hospice wishes to introduce, the costs of which it would be willing to meet in full if the Board felt these developments were not consistent with the palliative care strategy/local health plan; and
 - those developments which the Board wishes to introduce, and would be willing to meet 100% of the cost.

9. Recognition of these categories emphasises the importance of regular discussion between Boards and hospices, in the context of the palliative care strategy, local needs assessment and local health plan. The first round of discussions held after the issuing of this HDL should aim to clarify the position in respect of services which were introduced in the past without the full agreement of the Board. The running costs associated with those services should only be included in the 50% target if both parties now agree to the need for them. In relation to future developments, only by this sort of discussion will there be clarity about which services and functions are recognised by both parties as qualifying for the 50% target. In order to promote the fullest possible mutual understanding of future plans, Boards must be included at the earliest stage in the consideration of any developments which could generate running costs that would be eligible for the 50% target. It is also a condition of 50% funding that Boards may exercise the right to send a representative to any meeting arranged by a hospice at which such developments are to be considered.

10. A list of the adult voluntary hospices in Scotland to which the arrangements set out in this HDL apply is given in the Annex. Where a new hospice is proposed in any NHS Board area, the Board will need to be satisfied that such a development, and the services to be provided, are consistent with its palliative care strategy, if the running costs of the proposed hospice are to attract the 50% funding target.

Individual Elements

11. The contribution of hospices to **education and training** has long been recognised, and stems from their integral role in the overall provision of specialist palliative care services. The costs associated with the educational element of hospices' activities, which includes hospices' role as a general resource and source of advice to other agencies in their area, should therefore come within the 50% arrangement. The calculation should however relate to the running costs net of any income to the hospice generated by this activity.

12. The independent hospices have been concerned about the implications for them of recent changes to the junior doctor contract. It seems reasonable that the hospices should pay for the same elements of the contract as does the NHS. Under the arrangements which apply to the NHS, Specialist Registrars in training in palliative medicine are employed by the Postgraduate Deans, but the out-of-hours element is paid by the Trust in which the hours are worked, since the out-of-hours component is regarded as a service, rather than an educational, period of work. The additional costs of the junior doctors' New Deal arrangements should therefore form part of the annual discussion between the hospice and its NHS Board. The Department is aware of ongoing discussions regarding the core salaries for Specialist Registrars in England, and will keep this issue under consideration, in conjunction with NHS Education for Scotland.

13. Agreement on the appropriate medical establishment, including SHOs where the Post-Graduate Dean has given educational approval, should form part of the basis of the 50% arrangements.

14. **Depreciation.** Where the buildings and services concerned have been agreed as appropriate for inclusion in the 50% calculation, depreciation on the relevant assets should also be covered. Similarly, where new capital investment is not for purposes agreed as appropriate for inclusion in the 50% calculation, depreciation on those assets should not be included in the calculation.

15. **Pharmaceutical Services.** The intention has always been that hospices would receive pharmaceutical services, which is understood as covering advice as well as pharmaceuticals, free of charge. These services are therefore not covered by the 50% arrangement, and should always be identified as a separate element in the agreement between hospices and Boards. Local arrangements for provision/supply can take a variety of forms, but all must ensure that they are as cost-effective as possible.

16. **Fundraising.** This was not an element in the original 50% calculation, but it is now accepted that the basic costs of fundraising should count towards hospices' agreed running costs. These 'basic costs' relate to the employment of an appropriate level of fund-raising staff, but not the costs associated with organising individual fund-raising events. The rationale is that unless this aspect of hospice activity is recognised, hospices' ability to meet their share of the agreed running costs could be put in jeopardy. In relation to the 50% calculation, the 'appropriate level' of staff should be agreed by hospices and Boards.

17. **Out of area transfers.** The 50% agreement relates to the costs of providing the totality of a hospice's specialist palliative care services. It is not calculated on a cost-per-patient basis, which means that hospice should not be sending invoices to Boards outwith

their own area. But where a hospice provides a substantial service to people from more than one NHS Board area, the hospice should agree jointly with the relevant Boards how the 50% contribution should be shared between them.

18. **Relief on water rates.** The increases which hospices faced in their water charges as a result of the withdrawal of relief under the [Water Industry \(Scotland\) Act 2002](#) have been made good by a transfer of funds from Scottish Water to the Health Department in financial year 2002-03, and those arrangements will continue in the present financial year. As no further transfer of funds is expected, any further increases reflected in hospices' running costs will be included in the 50% arrangement.

19. **Charging for inspection by the Scottish Commission for the Regulation of Care.** Hospices have been charged at a lower rate. There are no plans to exempt hospices, as the arrangements cover other bodies which operate on a not-for-profit basis. In view of the importance of ensuring compliance with standards, these charges should form part of the 50% calculation.

Other Issues

20. **Information Provision** [HDL\(2001\)56](#), issued on 6 July 2001, required NHS Boards and Trusts to ensure that information in the form of Scottish Morbidity Records (SMRs) are transmitted to Information and Statistics Division (ISD) for all NHSScotland patients treated in the independent healthcare sector. It is now recognised that this HDL presents practical difficulties for hospices, in terms of both the IT systems available to them and their ability to distinguish those patients who are NHS funded from those who are privately or charitably funded. Hospices have their own information and IT requirements, but this additional responsibility is one imposed by NHSScotland. SMR data, especially if they cover all hospice activity, will be a valuable resource to support financial accountability, palliative care strategy development, epidemiology and local and national service planning. The funding implications stemming from the requirement to provide SMR data, and the IT infrastructure necessary to supply them, should therefore be included in the 50% target. Hospices should agree with Boards the most cost-effective way to meet these needs.

21. **Managed Clinical Networks.** The voluntary hospices have a key role to play in the development of Managed Clinical Networks for palliative care. Paragraph 25 of [HDL\(2002\)69](#) indicates that the Department has pump-priming funding available to assist with the infrastructure costs of developing all types of Managed Clinical Networks, in particular the appointment of a Network Manager. The voluntary hospices have a key role to play in such Networks.

Annex

List of Adult Voluntary Hospices to which this HDL Applies

Accord Hospice, Paisley
Ardgowan Hospice, Greenock
Ayrshire Hospice, Ayr
Bethesda Hospice, Stornoway
Highland Hospice, Inverness
Marie Curie Centre Fairmile, Edinburgh
Marie Curie Centre Hunter's Hill, Glasgow
Princes and Princess of Wales Hospice, Glasgow
Strathcarron Hospice, Denny, by Stirling
St Andrew's Hospice, Airdrie
St Columba's Hospice, Edinburgh
St Margaret's Hospice, Clydebank
St Vincent's Hospice, Johnstone