Item No: 8

Meeting Date: **Monday, 31st October 2016**

Glasgow City Integration Joint Board

Report By: **David Williams, Chief Officer**

Contact: **Stephen Fitzpatrick**

Tel: **0141 576 5596**

CONTINUING AND COMPLEX CARE

Purpose of Report:	To update the Integration Joint Board on the joint work with Acute and other NHS Greater Glasgow and Clyde Health and Social Care Partnerships to manage the transition from Continuing Care.

Recommendations:	The Integration Joint Board is asked to: a) Agree that work begins on testing the transitional model for continuing and complex care in North East Glasgow with immediate effect.

Implications for IJB:

Financial:	This transition programme will require to be underpinned by the transfer of a still to be quantified but significant budget from Acute to the Health and Social Care Partnership. The report identifies a number of associated financial risks that will need to be managed as part of the transition process.

Personnel:	Whilst there are no specific personnel changes arising from this change, it will result in additional workload for social work staff and GPs.

Legal:	There is the potential of legal challenge in respect of the proposed transfer of individual patients to social care from continuing care. However, any such challenge would be to the NHS Board rather than the Health and Social Care Partnership.

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Equalities:	None

Risk Implications:	The financial risks associated with this transition programme are outlined in the report at section 4.

Implications for Glasgow City Council:	None

Implications for NHS Greater Glasgow & Clyde:	The changes to continuing care represent a significant strategic priority for the NHS Board.

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	√
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	

1. Background

1.1 In May 2015 following an independent review the Scottish Government announced that the provision of Continuing Care by the NHS would end and be replaced by the concept of Hospital Based Complex Care, establishing a simple test for eligibility:

'Can the individual's care needs be properly met in any setting other than a hospital?'

1.2 Patients whose needs cannot be properly met in any setting other than a hospital will remain in an acute hospital bed. Other patients who would have previously been admitted to NHS Continuing Care will now be supported by extended community and care home services provided by Health and Social Care Partnerships.

1.3 The number of people in continuing care fluctuates, but historically has been c300 across the Health Board area, just over half of whom generally come from the city of Glasgow.

1.4 A recent audit of the people currently transferred into these beds indicates that:

- approximately 25% die within 2 weeks
- approximately 50% die within 60 days
- over the medium term approximately 20% may be suitable for an alternative placement not requiring access to complex care

- palliative care needs are most frequently identified as the reason for requiring a complex care placement

1.5 Glasgow's continuing care patients have been placed in the following sites, which with one exception are private care homes (localities served in brackets):

- Mearnskirk (South)
- Rodger Park, Rutherglen (South)
- Greenfield Park (North East)
- Fourhills (North West & North East)
- St Margaret's (North West)
- Drumchapel Hospital (North West)

1.6 The programme to transition from continuing care to a new service model is Health Board wide, with an implementation group comprising representatives from Acute and all constituent Health and Social Care Partnership's initially established under the leadership of the Health and Social Care Partnership Change Manager. It continues to meet, with the Chief Officer Operations having taken over as chair. However, this group has looked to the Glasgow Partnership to take the initiative in developing the detailed operational model and accordingly a Glasgow City transition process and plan has been put in place.

2. Glasgow Plan

2.1 Developments in Glasgow to date have centred on three existing continuing care facilities. By necessity this has included Drumchapel Hospital given its closure on 2 October 2016. The lessons from the closure process there have informed the approach taken in North East Glasgow, where there is a plan to test a transition model in Greenfield Park and Fourhills that has been developed in partnership between Health Board planners, Acute Division (North Glasgow) and the Health and Social Care Partnership, including the clinical lead for Older People.

2.2 This model is outlined in Appendix 1 and details the various pathways and potential care destinations for the former continuing care patients in that area. These include remaining in Acute care (Hospital Based Complex Care), going home, entering long term care (all expected to be small numbers), intermediate care (rehabilitation) or intermediate care (non-rehabilitation). This latter category of care will be new and arising directly as a consequence of the changes to continuing care.

2.3 The intention is to test this model in practice once approved by the Integration Joint Board and to apply the learning in its further development and roll out across not only Glasgow, but the wider Health Board area.

2.4 Each individual patient is currently being medically reviewed to establish whether they require to remain under the direct care of a consultant (Hospital Based Complex Care) or whether they can be discharged for a social care assessment, whereby the other pathways and potential care destinations become the focus.

2.5 As per 2.3, the intention is to progressively roll out the new model in each existing continuing care site over time. Each site brings different challenges. In Rodger Park the expectation is that the capacity there will in time transfer to another BUPA unit within the city boundary, potentially Darnley. In Mearnskirk the NHS are tied in to a contract

until 2019, so service changes will need to take place on that site until that time. The Health Board is currently working with St Margaret's and West Dunbartonshire Health and Social Care Partnership to agree a transition date.

2.6 The implications of this work in Glasgow will be addressed with the other Health and Social Care Partnerships through the Board-wide group referenced in 1.6. It may be the case that some of the smaller Health and Social Care Partnerships opt to purchase from the Glasgow Health and Social Care Partnership provision rather than establish their own discrete capacity, given the small numbers involved (e.g. East Renfrewshire, East Dunbartonshire).

3. Implementation Issues

3.1 There are a number of issues to be worked through as the transitional plan to the new model is implemented.

3.2 Primary amongst those is the imperative to put in place a transparent and rigorous financial framework, specifically given the risks identified below. The Glasgow Partnership is currently working with the Health Board and other Partnerships to agree this financial framework which will re-shape the current financial resource between transfer to Health and Social Care Partnerships, identified savings, and a continuing provision for a small number of Health Board Complex Care provision within Acute. There is a need to ensure that the Health and Social Care Partnership, in progressing this proposal, does not come at a financial detriment to the Integration Joint Board.

3.3 Contracts for the former continuing care beds will also require to formally transfer from the Acute Division to the various Health and Social Care Partnerships. This will be effected as an internal NHS transfer of contracts.

3.4 The implications of the changes for GPs and wider primary care will need to be tested and assessed. This work is being jointly led by the Health and Social Care Partnership Clinical Lead for Older People, with the Lead Clinician for Medicine for the Elderly in Acute.

3.5 It is anticipated that the new model will see a significant increase in the numbers of people who require a social work assessment (in contrast to continuing care where this population would not have been referred to social work). The Head of Older People's Services and Primary Care (North East) is currently assessing the implications for social work capacity.

3.6 Many of the former continuing care patients lack capacity and therefore the Adult With Incapacity implications require further consideration, including any registration requirements as the beds transition from NHS to social care, and the Mental Health Officer capacity.

3.7 Other implementation considerations include early engagement with the impacted care home providers and the development of an IT infrastructure to support efficient and effective working within the new model; e.g. network access on site for GPs and geriatricians; GP access to full Clinical Portal etc.

4. Risks

4.1 There are key risks that will need to be managed on an ongoing basis as part of this reform programme.

4.2 There is a reputational risk from families who may have an expectation that continuing care was for life. Those individuals transitioning to social care status will be liable for charges for the first time and the financial implications may be significant for some. Whilst Health and Social Care Partnership staff will be supportive in engaging with patients and families on these issues, it is principally the role of Acute consultants to explain the reasons for the change and the impact on individuals.

4.3 There are a number of financial risks to be managed, some of which have been indicated above. These include failure to agree the required level of resource transfer with the Health Board and/ or Acute; potentially unfunded additional demands on GP, social worker and other Health and Social Care Partnership staff time; and, demand exceeding planning assumptions, reducing the scope to realise budgeted for savings.

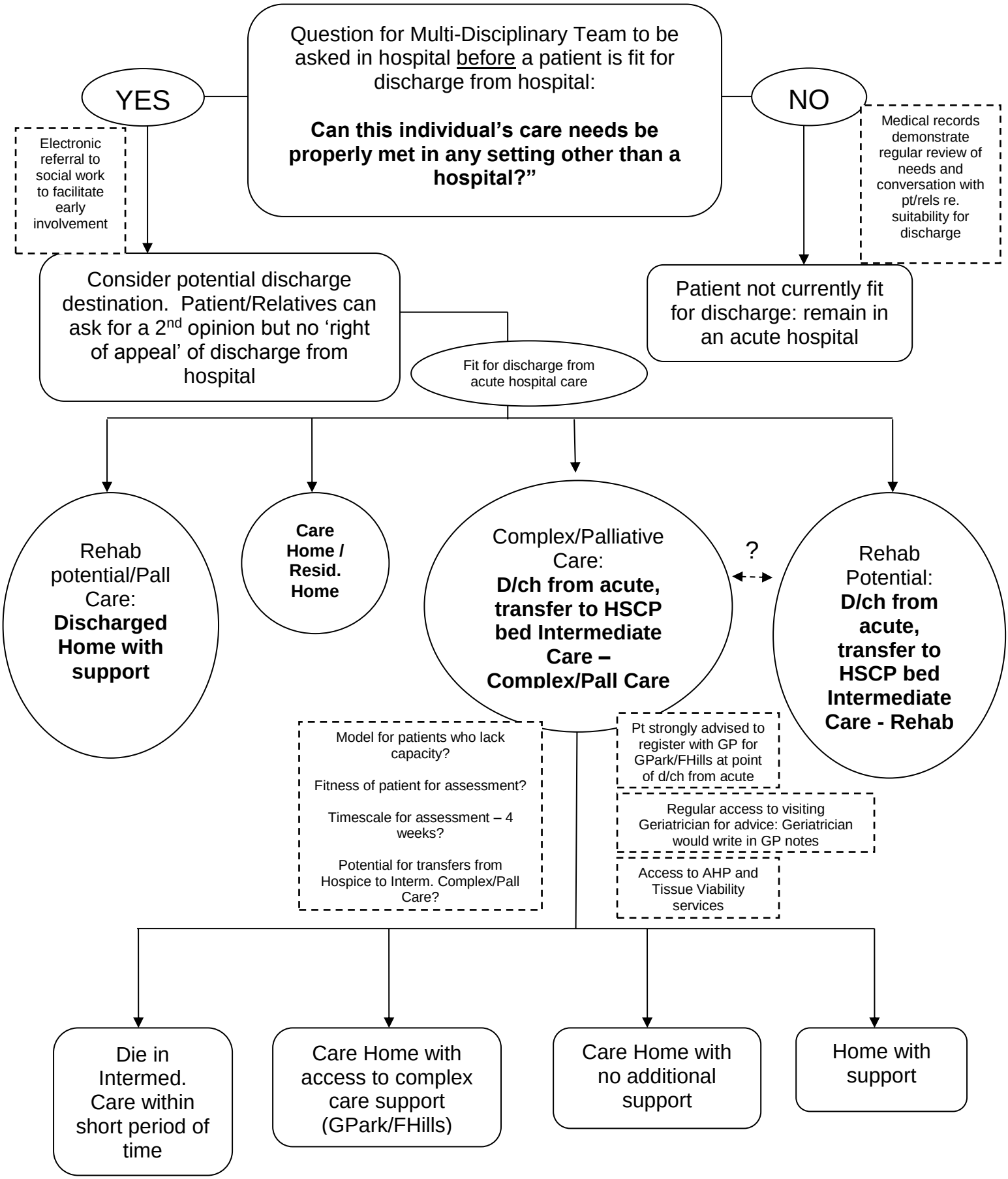
5. Recommendations

5.1 The Integration Joint Board is asked to:

a) Agree that work begins on testing the transitional model for continuing and complex care in North East Glasgow with immediate effect.

Appendix 1: Model for Hospital Based Complex Clinical Care
North East Glasgow

Version 2: 5 Sept 2016



DIRECTION FROM THE GLASGOW CITY INTEGRATION JOINT BOARD

1	**Reference number**	311016-8-a
2	**Date direction issued by Integration Joint Board**	31st October 2016
3	**Date from which direction takes effect**	31st October 2016
4	**Direction to:**	NHS Greater Glasgow and Clyde only
5	**Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)**	No
6	**Functions covered by direction**	All functions associated with the provision of continuing care - acute care (Hospital Based Complex Care), care at home, long term care, intermediate care (rehabilitation) or intermediate care (non-rehabilitation).
7	**Full text of direction**	NHS Greater Glasgow and Clyde are directed to begin work on testing the transitional model for continuing and complex care in North East Glasgow with immediate effect.
8	**Budget allocated by Integration Joint Board to carry out direction**	Direction to be carried out from within existing resource allocation as directed by the Chief Officer: Finance and Resources. A number of financial risks outlined in this report will be kept under review by the Chief Officer: Finance and Resources, and reported to the Integration Joint Board in due course.
9	**Performance monitoring arrangements**	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
10	**Date direction will be reviewed**	30 September 2017.