Report to: Health & Sport Committee

Title: Additional Information Requested

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1. Introduction

Following attendance at the Committee meeting on 4th June 2019, the Committee asked for further detail around a number of issues and this paper aims to answer some of the outstanding points including:

- Budget Setting Process
- The use of Intermediate Care (noted as Step-Down care) within Glasgow City
    - Detail of metrics for Intermediate Care
    - Cost comparison of Hospital, Intermediate Care and Social Care
- Set Aside Budget
- Leadership & Culture of the IJB

In addition, we would like to provide further detail regarding important partnership working with Care Home Providers.

2. Budget Setting

Financial Information for Partnership

Links are provided for reports from Partnership IJB meetings noting the status of Partnership Budget Setting

- **June IJB report on financial allocations for 2019-20 -**

  https://glasgowcity.hscp.scot/sites/default/files/publications/ITEM%20No%2010%20-%20Update%20on%20Financial%20Allocations%20and%20Budget%20for%202019-20_0.pdf

- **In relation to the latest financial monitoring report, the last report to the IJB was in March for Month 10 / Period 11 -**
  https://glasgowcity.hscp.scot/sites/default/files/publications/ITEM%20No%2018%20-%20Glasgow%20City%20IJB%20Budget%20Monitoring%20for%20M10%20and%20P11%202018-19.pdf

- **The Budget Monitoring report for Month 11 / Period 12 went to the IJB Finance, Audit and Scrutiny Committee in April -**
  https://glasgowcity.hscp.scot/sites/default/files/publications/ITEM%20No%2010%20-

%20Glasgow%20City%20IJB%20Budget%20Monitoring%20for%20Month%2011%20and%20Period%2012.pdf

Outcome Based Budgeting

"Another matter we have addressed in previous years is outcome-based budgeting. What support is being provided by the Scottish Government in helping integration authorities develop reporting of budgets against outcomes?"

There can be clear advantages from developing an outcome based budgeting model, if it can be used to ensure resources are directed to the services which contribute the most to the delivery of our objectives. However there are many challenges in implementing these models including:-

- The risk that any modelling developed is not sophisticated enough to reflect the complexity of the services delivered and also the true impact they have on the delivery of outcomes
- Insufficient data available to support the modelling which can result in the use of judgement or proxy data which could then undermine the model
- Single budgets have a tendency to contribute to the delivery of multiple objectives making it tricky to find a direct correlation between resources deployed and outcomes achieved
- Many Health and Social Work services are rooted in statutory obligations which can inhibit resource re-prioritisation and also flexibility over some outcomes

From a practitioners perspective it is resource intensive and extremely complicated to develop a modelling tool which will accurately reflect which budgets contribute to the delivery of which outcomes and if not done properly results in a mechanistic model which delivers an output which cannot be used to inform the delivery of services.

This is only one tool available to IA's and decisions in relation to the prioritisation of services, how they contribute to the delivery of objectives and the re-direction of resources are considered by IA's through a number of other routes including the budget process, regular reviews of performance, service reviews and proposals for transformation.

The Scottish Government has been in discussion with the Chief Finance Officers in relation to this subject.

3. Intermediate Care

Glasgow City has a robust home care provision with the use of GCHSCP Home Care (previously Cordia). The aim is to ensure that patients discharged from hospital, where possible, return to their own home. Packages of care can range from short term low level packages of support to high level frequent visits and / or overnight support. This is further supported by an extensive home based Telecare service and an equipment and aids service (EquipU) which provides further opportunity to focus on an appropriate and safe return home.

However, for some individuals, a return home is not possible due to the level of support required at that time of discharge, the housing circumstances which may not support discharge, or a requirement to undertake further assessment in order to ensure effective decision making about the longer term needs of the individual. Previously, this assessment would be undertaken within the hospital environment, with the risk of delays up to and beyond four to six weeks. For some

individuals, this assessment can be completed as part of a home care package whereas for others, a 24 hour care environment is the most appropriate location.

There are 90 beds commissioned within 6 x 15 bed units across Glasgow City which act as a step down facility for residents of Glasgow City from hospital. The focus of this service is to provide an opportunity to provide rehabilitation support to an individual to ensure the best opportunity to return home, as well as enabling an effective assessment of need. The criteria for this service is implicit in the sense that where a person can go home – including with support – they will go home. If they require an additional level of support to improve their health status or they require additional assessment to understand their longer term needs, then step down facilities will be considered. Because of this, those who require Intermediate Care consist of some of the most frail and complex individuals. The average age of our residents within step down is 85 years of age and they present with complex co-morbidities or physical care needs.

The 6 discrete units are separate from the mainstream care home environment and have specific staffing and multi disciplinary support which provides a distinct environment to support the rehabilitation and assessment process. This multi disciplinary team consists of general practitioners, physiotherapists, occupational therapists, social workers, social care workers and nursing and care staff from the Intermediate Care Unit provider. In addition wider support comes from housing support specialists and community workers.

The patient, their family and carers are key partners in decision making and involved through an individual stay within Intermediate Care in decisions relating to their own and family members long term care.

The Committee expressed concern that step down Intermediate Care could be seen as purely shifting the challenges with delayed discharges from hospital to a separate care location. We reinforced the rehabilitation focus of Intermediate Care and also the opportunity to provide this outwith a hospital environment, where there is a significant evidence base to suggest that discharge from hospital at the earliest opportunity is preferable due to risks of creating dependency, infection risk and choice of units closer to family, to support access and visiting. In addition, the individual is deemed to no longer require the care within an acute hospital location, so alternative provision supports the wider priority of effective use of acute service capacity. It will be seen from the evidence below in the response to metrics, that the Partnership aims to maximise home as an outcome and minimising length of stay as indicators of success of the service.

Costs of Care

The following describes the range of daily costs for each care environment:

	From	To	Average
Cost of Hospital	£335 Long Stay	£350 Short Stay	£342.50
Cost of Intermediate Care	£119.71	£119.71	£119.71
Cost of Home Care	£8.84	£170.77	£24.33

Cost of Care Home	£102.13	£102.13	£102.13

Metrics for Intermediate Care – Qualitative and Quantitative

Figure 1 below shows the length of stay of Intermediate Care residents by discharge. This reflects that the majority are discharged following a four week assessment and / or rehabilitation programme. This previously would have occurred within a hospital environment and as noted earlier, deemed as not the most appropriate location. For some individuals, there are factors which may reduce or extend the length of stay (person becomes unwell and length of stay is increased, or decisions can be made earlier)

Figure 1 – Discharge and Length of Stay

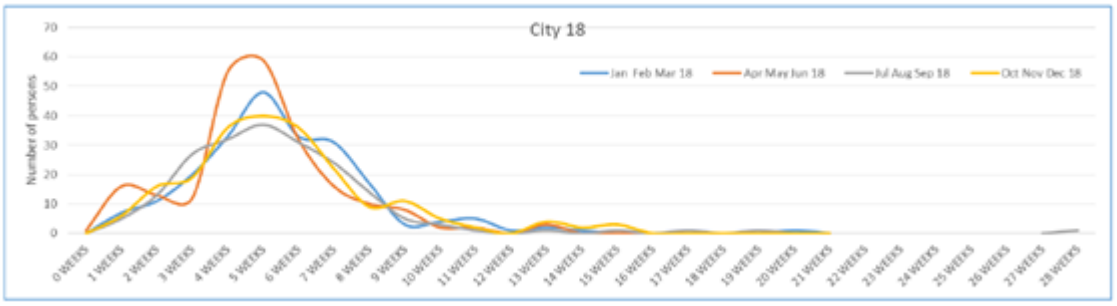
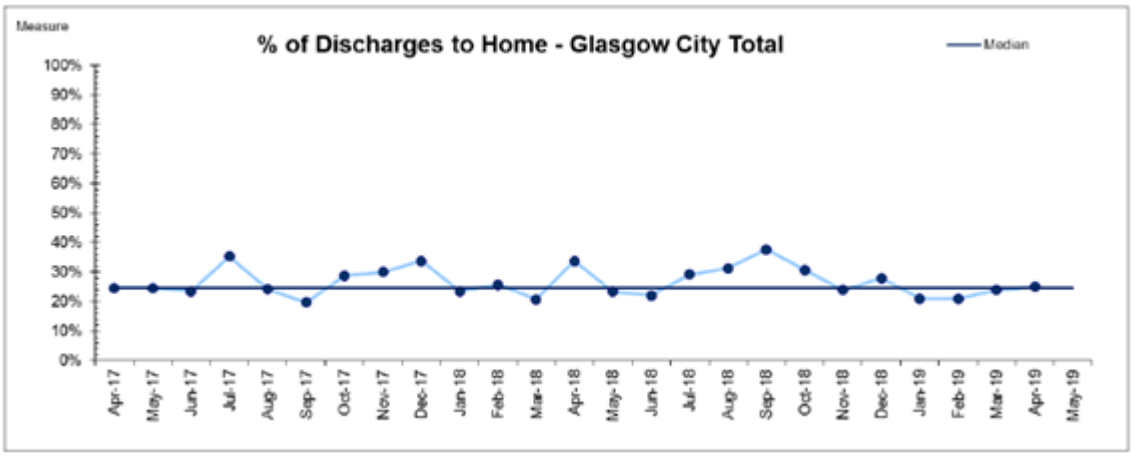


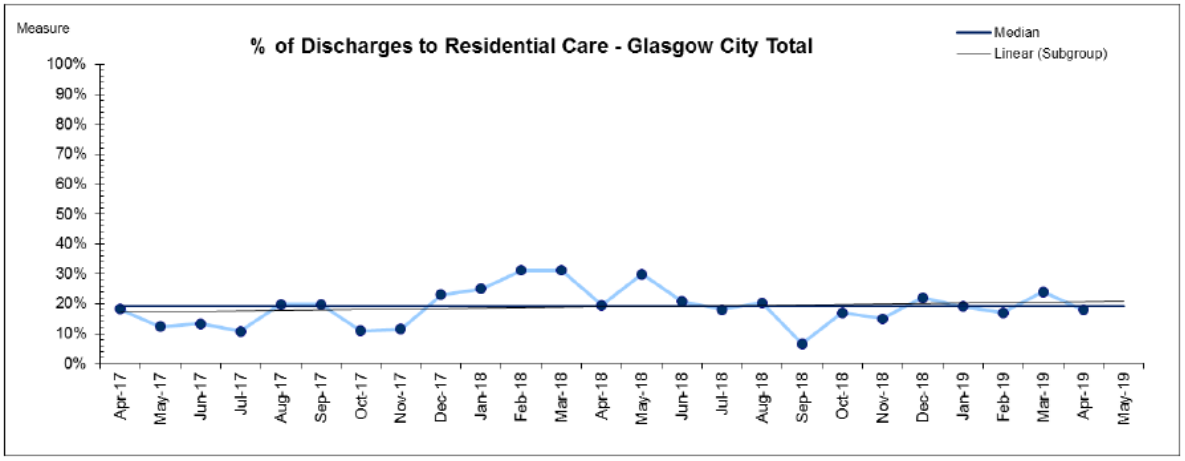
Figure 2 below shows the monthly discharge rate to home from Intermediate Care. The median level since April 2017 has been 25% of all discharges (average 70 per month). Given that this group represents some of the most complex and frail individuals, this is a significant success of the programme of rehabilitation, and partnership working with home care provision, residents, families and carers. Home as a location also includes the persons own home or use of Clustered Supported Living, where an associated package of care is provided.

Figure 2 – Outcome – Home as Discharge Location



A further element of success of the Intermediate Care rehabilitation and assessment programme is in the number of people who move to a lower tariff residential placement rather than into Nursing Care. Figure 3 below, notes the median of 20% of all discharges moving to residential care.

Figure 3 – Discharge Outcome Residential Care



There is also ongoing qualitative review of services which has included surveys and focus groups with clients in Intermediate Care. This has identified how well the process was explained to them, the experience of transfer, the role of the Multi-Disciplinary Team and potential improvement opportunities. Feedback has identified very positive experience of the process and the people involved and a significant focus on returning the individual back to their home where possible, with the focus on rehabilitation. A number of areas have been highlighted for improvement, which includes how we communicate with clients and families and how we could better emphasise rehabilitation and manage length of stay.

4. Set Aside Budget

In the evidence session, we discussed the set aside budget and if it is being used effectively across each IJB. (Official Report, Col, 30). Do you consider that the set aside budget is operating as intended in your IJB? Please can you provide further details of how a "whole-system approach", as referred to in the evidence session, can help ensure that the set aside budget works as intended

Activity to date has been focused on collection of historic activity and cost data. However there has been limited discussion on the mechanism which would be developed to enable set aside to operate as the legislation intended. This has been as a result of the practical difficulties in identifying the specific budgets and costs which are defined as set aside. Often these activities are part of larger services which means that the isolation of costs cannot be easily done. The existence of 6 IA's in Greater Glasgow and Clyde and the difficulty in identifying the impact of the action of one IA on the wider system is also an issue. To resolve this Glasgow City is leading on the development of a commissioning plan which will seek to determine the services which require to be commissioned within the set aside arrangements and how this will shift over time. This will be used to support the strategic planning of the services by both the IA and the Health Board and will support a whole system approach to delivering on the commitments within the legislation.

Set aside budgets continue to be indicative for 2019/20.

5. Leadership and Culture of the IJB

"The Committee's 2019-20 pre-budget report highlighted the importance of relationships and leadership in determining progress towards integration. The report noted that "..a number of integration authorities do not appear to be exerting a challenge function and ultimately their authority and control over the budget is being dictated by individual partners." Audit Scotland also found that a "lack of collaboration leadership and cultural differences are affecting the pace of change".

The Committee has also heard evidence to suggest that partners tend to view their budget contributions as money that should be allocated to "their" services.
Can you provide examples where money has lost its 'social care' or 'health' identity in your IJB?
Is the lack of progress in this area due to leadership and/or cultural issues and if so what steps are being taken to resolve this issue?
How does your IJB share good practice and is enough being done to learn from other IJBs?"

Both sets of Partners remain vested in the budget allocation which they delegate to the IJB and expect this to be used to fund services within their respective services. As an example Glasgow City Council's budget report stated 'It is anticipated that the contribution from the IJB to the Council will be in line with the Council's approved budget.' This is contrary to the spirit of integration and the IA's statutory responsibility to determine how funding is directed. In Glasgow we do exert a challenge function in relation to budgets however this occurs when the budget is set by the IA and delegated back to Partners or when the IA reviews/transforms services and direct the Partner Bodies to deliver services in a different way.

However the IA is not in a position to control the level of funding which is delegated to it to support service delivery and this can undermine the IA's authority and can also undermine their ability to challenge further down the process. This requires clear collaborative leadership and partnership working to manage this process and does represent a challenge. Integration requires all three parties to work together to assess what is required to deliver integration in its local area, which includes the budget. The IA is required to operate in this way, however to date the Partner Bodies budget process continues to operate in isolation which results in budget decisions being taken by one partner which can have implications for the wider health and social care system and therefore the other Partner Body and the IA. A good example of this is the £13m savings taken from Social Care budgets in 2019/20 some of which will impact on direct service delivery and our ability to respond to demand coming from within the Acute System.

As an IA we have developed a financial performance framework which reflects the totality of the resources available to the IA and does not differentiate between where services sit within the Partner Bodies. However whilst we continue to record our costs in Partner ledgers and are also asked to report individual financial performance to Partner Bodies, the ability for funding to really lose its identity is limited.

There are many examples of where the Partnership networks across other Partnerships or services to benchmark services and to understand opportunities to improve practice. This is a core element of the culture that is encouraged and supported. Examples of this include recent visits to Sheffield,

Coventry and an ongoing relationship with Greater Manchester services. At a local level we have reviewed and adopted a number of practices from neighbouring Partnerships, which have led to improvements, including reviewing the Inverclyde delay model, single point of access services.

With the establishment of the HSCP an Organisational Development Strategy was developed with a focus on effective teams, collaborative leadership, continuous improvement and the development of the GCHSCP culture based on the vision and values. The vision was developed in collaboration with locality teams.

From the start it was clear that the work within the partnership was about relationships and collaboration with a foundation of a clear evidence base to inform future decisions. This has been a strong part of the development of the HSCP identify. It is reinforced by regular "time out to reflect " sessions for the Senior Groups to review and reflect on leadership impact and the vision for integration. This includes being able to describe an HSCP identity and a distributive leadership approach.

The Integration Joint Board has its own timeouts for members to reflect on the role of an IJB member and the attributes that all members bring to the formal discussion. These sessions also include an educational role and an opportunity to explore some of the service change proposals in development in more depth than time allows at a formal meeting.

In addition the leadership cohort is brought together regularly across the HSCP to provide a forum to explore leadership challenges and opportunities in integration and to provide a model for further local discussion.

Through these mechanisms and through a close working relationship across the six IA's within NHSGG&C area, there is significant commitment to taking forward the Leadership Group Proposals from the recent MSG report "Review of progress with Integration of Health & Social Care. This includes:

- Collaborative leadership and building relationships
- Integrated finances and planning
- Effective strategic planning for improvement
- Governance and accountability arrangements
- Ability and willingness to share info
- Meaningful and sustained engagement

6. Further Evidence of Working in Partnership with Care Home Providers

The Committee asked what work Partnerships were involved in to support Care Homes and to reduce the impact onto the acute system. Opportunity was given to provide some evidence of this, but we also wanted to highlight some other key pieces of work underway within the Partnership and the impact of these.

There was a recognition within the Partnership of the level of Care Home attendances at acute ED and Assessment Units, admissions to acute and also concern around the length of stay for care home residents. The Partnership commissioned a series of surveys and focus groups with care homes and

other stakeholders which provided a wealth of information to allow us to understand the challenges faced and also to identify a number of programmes to take forward to provide additional support.

Glasgow City led the development of a system known as the *Red Bag Scheme* within NHSGG&C. This is a simple process to bring together all information, property, medication for a care home resident in the event of an unplanned care journey. The system is used in many areas across the UK but limited in Scotland at present. A process is followed within the care home, by Scottish Ambulance Service and also through the acute pathway. This enables the correct information to be available to support decision making, to limit medicine waste, to provide appropriate clothing (both for wearing on the ward and also for discharge) and also to support the effective discharge process. This was introduced in July 2018 to Glasgow City and subsequently across all other Partnerships in NHSGG&C from November 2018. Further information can be found from RedBagEnquiries@ggc.scot.nhs.uk

Other programmes of work have been around supporting the palliative care journey within care homes, improving communication to prevent attendance, provision of anticipatory care planning and the provision of focussed clinical support through GPs or Advanced Nurse Practitioners (ANPs).

The result of this has shown a significant reduction in attendance (Reduction of average of 380 – 306 attendances per month) and admission (reduction of average of 241 admissions to 190 per month). Further work is underway to assess the impact of length of stay, but stakeholders have also reported significant qualitative benefits of the work.