28 April 2008

Frank McAveety MSP
Convener of the Committee
Public Petitions Committee
TG.01
The Scottish Parliament
Edinburgh
EH99 1SP

Dear Mr McAveety,

Petition Number PE1105

We have been asked to provide our views on the Government response from Ms Nicola Sturgeon. Our views are highlighted in red, following Ms Sturgeon's comments:

Ms Sturgeon's comment:
Thank you for your letter of 25 February 2008 regarding Petition 1105 by Marjorie McCance on behalf of the St Margaret of Scotland Hospice, Clydebank.

You may be aware that I recently visited St Margaret's Hospice and met many of the staff and volunteers involved in the day to day running of the hospice. I also met with representatives of the Board of St Margaret's at which time I stressed the importance of looking to the future and underlined the need for constructive dialogue with NHS Greater Glasgow and Clyde. I also stressed the importance of organisations providing services to the NHS ensuring alignment with NHS strategic priorities.

Hospice response:

We appreciated the opportunity to meet with Ms Sturgeon during her private visit to the Hospice and also to show her the services provided here. During her meeting with the Board representatives, Ms Sturgeon did stress the importance of looking to the future – we believe however that on this occasion it is also important to look at the past. For the past 10 years, the Hospice has been kept in the dark by NHS Greater Glasgow and Clyde over plans to change the type of care provided in the Care of the Older Adult unit for patients with complex medical and nursing needs. No consultation or negotiation has taken place. This was acknowledged by Tom Divers at the NHS Greater Glasgow and Clyde Health Board on 15 April 2008 where Mr Divers stated "at the point when the Health Board and Glasgow City Council agreed jointly in the year 2000 on the development at Blawarthill Hospital, there was not an expected implication for the continuing care provision at St Margaret's, therefore there was no communication around that." We believe we have been very unfairly treated, especially as the Hospice has worked with the Health Board for 58 years.

Ms Sturgeon's comment:
Following this visit, I wrote to the Chair of NHS Greater Glasgow and Clyde indicating my wish for them to urgently engage with St Margaret's and the Hospice Chair. Professor Martin, Chair of St Margaret's Board subsequently met with Andrew Robertson, Chair of NHS Greater Glasgow and Clyde. I look forward to the outcome of that discussion and any subsequent discussions being translated into substantive proposals for the future which will ensure the needs of the population are served.

Hospice response:

The meeting between Professor Martin, Chair of the Board of St Margaret of Scotland Hospice and Andrew Robertson, Chair of NHS Greater Glasgow and Clyde, was arranged following contact made by Professor Martin. The meeting took place in February 2008 and ended on the understanding Mr Robertson would be in contact with dates for a meeting between officers of the Health Board and Hospice.

On 6 March 2008, as no date had been suggested, a letter was sent from the Hospice to Mr Tom Divers, Chief Executive of NHS Greater Glasgow and Clyde, to ask if dates for a meeting were being progressed. On 14 March 2008, Mr Divers' secretary contacted the Hospice to suggest dates for a meeting. On 14 March 2008, an email was received from Mr Divers' office, informing that dates for a meeting were being sent out also Mr Robertson would be sending a letter later in the week with the revised Balance of Care Report.

At 5.05pm on Friday, 14 March 2008, a letter, addressed to Professor Leo Martin at the office address he occupied two years ago dated 13 March 2008, arrived by fax at the Hospice, from Mr Robertson. A copy of the letter did not arrive at Professor Martin's office. It is a seven page letter (copy attached) which states that the Health Board will stop purchasing 30 continuing care beds from the Hospice on 1 April 2009. A postal copy of the letter has never been received.

Ms Sturgeon's comment:
I should stress that NHS Greater Glasgow and Clyde are responsible for planning, providing and securing the provision of NHS services for its population. The St Margaret of Scotland Hospice is a recognised charity and a company limited by guarantee which receives NHS funding for particular services which it provides and the nature of these services determines the type of funding provided. Scotland's health care challenges require a shift in the balance of care towards community-based services and it is important to recognise that, for some people with particularly complex needs, it will be necessary to ensure the availability of the most appropriate services in the right setting with the best support. This is just as important for families and carers. Care of the frail elderly and care for those with palliative care and end-of-life needs are, perhaps, areas that most appropriately reflect our values for the NHS and for society more widely. Implementing the action plan for *Better Health, Better Care* provides an opportunity to reflect our core values in the planning and provision of services for those who are most vulnerable in our society.

Hospice response:

We are aware of the responsibility NHS Greater Glasgow and Clyde has for the "planning, providing and securing the provision of NHS services for its population."

For patients with particularly complex needs, we do not believe "community based services" would be "the most appropriate services in the right setting with the best support."

The Balance of Care Report on which the decision to remove continuing care beds from Glasgow is based, is fundamentally flawed. We are aware there is also a waiting list for patients wishing to access the Care of the Older Adult beds at Blawarthill and the Hospice.

The type of care provided to the patients is Hospice Care – patients at the end of life, who when referred now die between 4 to 6 weeks after admission. These patients deserve the "most appropriate services in the right setting with the best support." Hospice staff are trained to care for patients at the end-of-life. The Hospice is designed to comply with

Hospice Standards, providing patients with a choice of single or twin room. The Hospice is not a Care Home.

Ms Sturgeon's comment:
I have asked to be kept informed of developments and indicated my desire for a constructive conclusion to the outstanding issues. However, the development of services is a matter for NHS Greater Glasgow and Clyde, and it is for the Board to ensure appropriate services are in place. Accordingly, I have no plans to convene a meeting with the NHS Board and St Margaret's.

Hospice response:

A meeting with Hospice and the Health Board took place on Friday 2 May 2008. It was suggested by the Health Board a further meeting should take place within 2 or 3 weeks. It should be noted however, that in the Health Board's letter to the Hospice on 14 March 2008, they advised the decision had been made to withdraw the continuing care provision from the Hospice on 1 April 2009. However, at the NHS Greater Glasgow and Clyde Board meeting on 15 April 2008, the Board did not approve the recommendations of this letter.

Ms Sturgeon's comment:
Turning to the 50% funding agreement, as you know, at present, St Margaret's receive funding from NHS Greater Glasgow and Clyde for the provision of 30 palliative care beds. NHS Boards have been required to meet 50% of agreed palliative care running costs and this is set out in guidance issued to the NHSScotland under HDL(2003)18.

Hospice response:

The baseline funding figure for St Margaret of Scotland Hospice has never reached the same level as other Hospices in Scotland. St Margaret's is effectively providing 15 Palliative Care beds for free.

Ms Sturgeon's comment:
The Committee should be aware that it was the Scottish Hospices Forum, of which St Margaret's is a member, who agreed the funding level be fixed at 50% so as not to compromise the essential independence of individual hospices.

Hospice response:

St Margaret of Scotland Hospice did not agree with the funding level being fixed at 50%. The other members of the Scottish Hospices Forum were content with this figure as they receive a higher level of baseline funding – funding per bed. We do not believe the "essential independence of individual hospices" could be compromised by an increase in the funding level, as the Hospices are so heavily regulated by, for example, by Care Commission and NHS QIS.

Ms Sturgeon's comment:
If the Board of St Margaret's now feel that this formula needs to be amended they should raise their concerns through the appropriate channel, which in this instance is the Scottish Hospices Forum. The Scottish Hospices Forum can then ensure that this issue is raised formally and I would be happy to consider any representations from them.

Hospice response:

The funding formula has been challenged at every Scottish Hospices Forum meeting, however, no formal representation has been made to the Scottish Executive in this regard as all member Hospices did not agree. It was only at the last meeting of the Scottish Hospices Forum, on 1 February 2008, that one other member Hospice comment "Hospices are being taken advantage of" by some Health Boards, as some Hospices received an inflationary uplift this year on the agreed funding, rather than 50% funding and there has been major increases in certain costs in the past year.

For your information, a copy of the minutes of the NHS Greater Glasgow and Clyde Health Board meeting on 15 April 2008 are attached. From these minutes, it is clear the Health Board, by their own admission, did not consult with the Hospice, despite advising the Petitions Committee in their letter of 21 January 2008 that "it is wrong to give the impression that there could have been no inkling prior to 2004 that changes in the provision commissioned by the NHS were coming – indeed, we were trying to engage on this point with St Margaret's prior to this".

Furthermore, the minutes clearly show the lack of information which has been made available to other Board members, which resulted in the Board not being able to accept the recommendations set down by the Chief Executive. This is somewhat surprising given the Health Board Chairman had advised, in his letter of 14 March 2008, that the decision had already been made. Clearly it has not.

Also of particular relevance is that the Health Board Chief Executive stated at the Board meeting "the use that has been made of St Margaret's for elderly care, that is predominantly a city of Glasgow use. The number of residents there currently from East Dunbartonshire and West Dunbartonshire number, I think, only 3." The Chief Executive took this information from a snapshot audit based on one particular day in time. The facts over the last 5 years show that 40% of all patients admitted to the NHS continuing care ward at the Hospice live outwith the city of Glasgow.

Whilst we would in no way seek to advise the Petitions Committee of the next step to take, we would think it important for the Chief Executive of the Health Board to come before the Petitions Committee to explain the decisions made, and why such decisions were made without consulting the Hospice, the public and the NHS Greater Glasgow and Clyde Board members.

I hope this information is helpful and outlines the current position with regard to St Margaret's.

Yours sincerely

Marjorie McCance
Petitioner

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

Thank you Chairman. I would like to introduce this paper, which was written by Anne Harkness, who is the Director of Rehabilitation and Assessment and is the NHS representative on both elderly care and Palliative Care.

I think it is important that I put this paper into its timescale. We are actually coming towards the conclusion of changed programme which has been running for almost 11 years now as part of our modernisation of community care and looking at the change in the balance of care across all the care groups and I'll instance on the way through the paper just by drawing out reference to the extent to which dependence on NHS continuing care has appropriately reduced over the course of the past decade to reflect both policy changes at a national level but also to reflect the wishes of service users that wherever possible, ongoing care should be provided at home or as close to home as can be achieved and you will see that there is a quite dramatic change in the profile of NHS continuing care over that period of time.

This has not been driven by financial considerations and members of the Board who have been in touch with the development of these strategies, be they older people services, or mental health or people with learning/physical difficulties, as part of each of these strategies we have constructed an agreed financial plan that identifies how the resources released from a lessening dependence on NHS continuing care is then freed up and reinvested into other settings. The most recent example of that is how the Clyde Strategy Papers re mental health or older peoples services in Renfrew and in Physical Disabilities Services, you saw what the change in profile of the service would be that allows much more care to be personally tailored and delivered for individuals in a home based or community setting.

So, in essence, we are now in year 11 of a changed programme and are now in the final stages of implementing that change. The paper cuts in to that story so forgive me for the previous bit of history but I think it is not insignificant in terms of just how significant this changed programme has been. It cuts in, in Paragraph 1.1 at 2005. The Health Board and Glasgow City Council had in place at that point a Joint Community Care Committee formally established by both of the parent bodies as a sub-committee within their structures and charged with delegated authority to make decisions on behalf of both organisations. That body agreed the review that is highlighted there in looking at what is called The Balance of Care for Older People and this increasing trend that has seen less of a dependence on institutional care over the course of that period of time.

So what has changed in terms of continuing care over that period of time and that answer to that question will emerge in this paper because a decade ago, the average length of stay of an older person in NHS continuing care would be measured typically in multiples of years. Whereas now, NHS continuing care is very much the specialist care delivered with a lot of medical, nursing and other clinical services in the final months of a person's life and I will draw out those points on the way through. That is the significant shift in the balance which has occurred.

Now, given that the 2005 Joint Community Care Committee Report had identified this continuing move in the Balance of Care, quite properly, that Committee had scheduled a review of the balance of care model in 2008 in order to retest that model, to retest the assumptions that were built into it and then either to be able to confirm that the model remained valid and remains proven or to adjust the model in the light of intervening years'

experience. And therefore another purpose of this paper is to fulfil that commitment given in 2005 to come back and retest the balance of care model which had been developed at that point in time and which had been approved at that Joint Committee.

So, in paragraph 2, the 2005 plan shows at that point an expected reduction in the need for NHS continuing care beds frail older people from 656 to a planned figure at 2007/8 of 312. The three bullet points at paragraph 2.2 just set out the factors that had informed that deduction.

At paragraph 3.1, you will see what has been happening with the continuing care provision over the last 10 years and you will see that from the opening position in 1997, where there were almost 1100 NHS continuing care beds, we stand at a position currently where the figure has been reduced to 402 and where the final changes that were built into the 2005 review and reiterated again in this paper, would see a final reduction to 312.

Paragraph 3.2 makes the point that the final reductions were to close 60 beds in the South of the City and then to change the designation of the current continuing care beds at St Margaret of Scotland Hospice to move away from NHS continuing care to a model of enhanced social care which meets the needs of the West of the City Glasgow most particularly because the utilisation of the beds at St Margaret's in the elderly care ward has a high proportion of residents from Glasgow City with smaller numbers from West and East Dunbartonshire.

The other important point about the development of the model of NHS continuing care, and the aim has been to try to get wherever possible, these continuing care beds organised in clusters of 60 beds or thereby, and we'll come on to that in looking further, in order to give that greater mass for clinical staff cover and most particularly, as part of this, medical staff.

Section 4 of the paper then just works through the review of the major planning assumptions that formed part of the 2005 review and goes back and retests those. And in just looking at them in turn, paragraph 4.2 looks at the level of admission for NHS continuing care and what the pattern has been over the course of the past 5 years and you will see this is a calculated figure because we are still in the position where there are still quite significant numbers elderly people who are being cared for in NHS continuing care beds who do not meet the criteria for NHS continuing care and I will come back to that in another section of the paper.

So, we have retested what we think are ongoing levels of annual admissions in NHS continuing care as outlined in paragraph 4.2. And then paragraph 4.3 best captures the pattern of NHS continuing care over the past decade. You will see in paragraph 4.3 that in 2006/07 the maximum length of stay before death was 14 years. That was a very different kind of model from the model of NHS continuing care now and indeed, the Scottish Executive Health Directive have recently reissued the criteria for NHS continuing care which again reflects the way the model here has been moving over recent years.

And you can see at the top of page 23, the average or mean length of stay (those two mean the same thing) has continued to fall significantly over that period of time in terms of the length of stay through 2000/2001 to 2006/2007.

In paragraph 4.4, shows the difference between the mean and median length of stay before death. The second of those points is taking that group of patients who have been admitted in accordance with the criteria for NHS continuing care and the median is the, if you put all of

the patients in a single analysis, the median is the middle point in that number so you can see that the median length of stay

There is a significant change in the length of stay

Another part of the balance of care review was undertaken in December last year was to ask each of the continuing care providers to complete a point in time audit and the date of admission of the individuals of that group. And you can see the spread there which still reflects the way we are moving through the transition in the redefinition of NHS continuing care. There were 18 patients who had been admitted in the years between 1993 and 1999 and at the other end of the scale at 2007, there were 95 patients who had been admitted. But importantly, the narrative pointing 4.5 following the snapshot audit showed that at that point in time, only 270 of 416 beds were being used appropriately for continuing care and so it shows the significant number of beds still being utilised by patients who do not meet the criteria and reflect the ongoing migration.

There was a further update undertaken in 25 September 2007 and that showed a very similar snapshot of 282 beds in use. And that reflects an average occupancy of 65-68% by patients who meet the criteria of NHS continuing care. Within that particular group, we would expect an average occupancy of 95% - and that is not just plucked from the air. There are already units meeting this average occupancy level. Overall occupancy is in the high 90s per cent and in terms of our future planning arrangements for this particular service, 95% we believe is an appropriate occupancy level.

Very different from the kind of occupancy level you would see in looking at handling emergency care in the context of the business case for Glasgow for where acute medical and surgical specialities, where there is a lot of activity, and there is a lot of turnover, the occupancy levels have been set at around 82%.

One of the challenges that has been made to the Balance of Care report over the course of the past year is the taking proper account of the changing demographics within elderly care if we looked ahead over the course of the next decade and paragraph 5 takes up that issue and shows year by year the key 5 year age band in terms of those older people who will access elderly care and you can see in paragraph 5.1, the very first sentence there says “the average age of admission to NHS continuing care continues to be 82” so working this profile forward for looking at age bands from 80 to 84 and age bands thereon, we believe captures the appropriate population. And you can see that over the course of the next 10 year period, there is an expectation that there will be just under a 25% increase in the number of people over the age of 80 and the analysis is there to show how that builds up year on year.

Turning to page 24 and paragraph 5.2, we have sought to reflect the growing population demand in looking at the robustness of the current model that has been developed and how that moves forward.

What paragraph 6.1 says is if we look upon the current requirement for NHS continuing care, taking each of those planning elements, brings the requirement for 274 beds at 95% level of occupancy. We see growth in the elderly population of 25% but reflecting both current arrangements and what we expect to continue in terms of the way the balance of care is delivered, we don’t think this means a 25% increase in the need for NHS continuing care, rather we believe it reflects an increase of perhaps up to 15% and with continuing

assessments in other parts of the service in order to support those older people who are able to be supported either at home or through other community services.

Paragraph 6.3 is very specific about what we envisage as the key risk involved in this and that is the current numbers of patients awaiting discharge. In essence, what we were hearing from that snapshot in paragraph 4.5 is there that remains a significant number of elderly patients who are in NHS continuing care beds awaiting discharge who do not need to be in those beds as part of their ongoing care and our ability to be able to continue to address and resolve that issue is identified here as a risk and that is one that, as you will see in paragraph 6.3 not least around those who have assessments procedures that involve the Adults With Incapacity legislation. There are significant numbers of those individuals and hence we have allowed some time in terms of our move to implement the remaining part strategy to give us the opportunity to both address that risk but also to give us the opportunity not least to work with St Margaret's over their transition from NHS continuing care preferably to a model of model of enhanced social care.

I want to, just before coming back to the recommendations, just look at Appendix 1. As I said, back in 1997, there were almost 1100 NHS continuing care beds being provided. In the period between 1997 and 2002, that number had already been reduced by something in the order of 400 – almost exactly 400 - and that included the closure, the complete closure of NHS sites including Cowglen, including Knightswood in the West of the City and those sites ceased to provide NHS continuing care altogether and what has happened in the period since 2002 to now is, as you can see, we have moved through to a position where there has been a further reduction from the opening complement there of just under 700 beds to a current complement of just under 400 and if you look down each of the organisations that have been affected, you will see that there has been significant change involved for no fewer than 9 organisations. With each of these organisations, we have been able over that period of time to agree a migration plan from NHS continuing care to enhanced social care. To do that through use of transitional funding in a way which has avoided financial risk to those providers and that is the opportunity which I and the previous Chairman have been endeavouring to move forward with St Margaret's for some time now and which may now need to be able to take on now to complete the final steps of this programme because it is our intention that the rerun Balance of Care has shown that it is robust. If anything in the short term, we might need a slightly smaller complement of NHS continuing care beds but that would then recalibrate up the way and that is the kind of sensitivity that I think we just deal with.

I know one question may be what if in 5-10 years there has been some further change in all of this. And what we have done over the last decade is to change the balance of care, to reflect both policy change, societal change and individuals choice in terms of where services can be provided at home as opposed to in institutions and if at some point in the future it became necessary to recalibrate that, then that I would not see as a material obstacle because as you can see from this page, we have already agreed with almost all of the other service providers involved in providing NHS continuing care a migration creation into an enhanced social care model and if at some future point that needs to be recalibrated then again with notice of the forward planning, it would be possible to do that. There is nothing that has come through from the Balance of Care which suggests the trend which has been a trend that we have tracked for the last 10 years is not going to continue. We continue to require the finalisation of this programme.

Robert, have you anything to add to that.

Robert Calderwood, Chief Operating Officer, Acute Services Division

No, I think you have covered all the main points. The issue going forward looks like flexibility is valid and the Board continues to look at all of this as we go forward with the population but clearly all of these issues are covered and we have talked about the occupancy which is running about 87%. We have looked particularly at catchment areas of our present population and how they can be best served and a significant proportion of the demand in the west of the city is around Knightswood and Yoker. I think all of the other issues are covered.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

There are two points that come to mind. One is that Des McNulty kindly wrote to us outlining the concerns he has as the MSP for his constituency and I have responded to that and I think he knows we have now arranged to meet with representatives of the Hospice on 2 May and Tom and I very much hope there will be an opportunity to meet with Des about these concerns before that meeting. I hope that we can take forward the issues raised here.

The second point is that in 2005 the review was agreed jointly between Glasgow City Council and the NHS and it would just be reassuring to confirm that we have the support of our Local Authority partners in this review.

Jim Coleman, Councillor/Depute Leader Glasgow City Council

Yes, Glasgow is still very much behind it and continue to look forward to the future so we are still very much behind it.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

We'll start with questions around the table. We'll start here and work our way round.
Iain Robertson, Councillor, Leader of West Dunbartonshire Council

Moving towards the social care model. I mean, will there be adequate transfer of resources. We are concerned how that would be for us. I think one of the things that struck me when you talk about St Margaret's is that you are mentioning 11 years in the process but the communication between the 2 organisations have not been too great and I find it difficult to imagine how, after all this time, we are still at loggerheads after 11 years. Perhaps you could comment on that.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

As far as the resources question is concerned Ian, is work we have done, if you look at all the other examples set down in Appendix One there, where there has been a migration from NHS continuing care and social care, we have agreed with the provider what the costs of the enhanced social care model would be. That has been agreed and signed off between us and we have also agreed what the migration process arrangements and what the transitional funding arrangements would be and, I mean, suffice to say I have not personally had to be involved in one of those discussions all I have had to do is sign off the final contract. So I have confidence that the model we have developed around this has been a robust model and I

think the significance of mentioning the 10 years of the programmes of change here around all of the community care groups, and I mention specifically the importance of a financial model, under this proposal and that has been a key element of our ability to make progress. We have not ended up in a position where there have been ongoing spats between the Health Board and individual authorities about whether an appropriate or fair level of resource transfer was put in place and have confidence in that. We have experience with a whole range of different providers of having made that change and we would take that forward in the discussion with Glasgow City, with you, with East Dumbarton and with St Margaret's in that way.

The second point about the longevity of this programme and communication with St Margaret's, and I think it is fair to say that I am on record as having said this and that is that the Balance of Care study in 2005 that took the service model on to this stage, at the point where the Health Board and Glasgow City Council agreed jointly in the year 2000 on the Blawarthill Hospital, at that point in time there was not an expected implication for the continuing care provision at St Margaret's, hence there wasn't any communication around that. It was the 2005 Balance of Care study that had shown that there was a further significant move in the balance of NHS continuing care and suffice to say that in the Autumn of 2004, the previous Chairman and I sought to open a dialogue around that. We have not been able to progress that dialogue and I do not need to rehearse here why it has not been possible to do that and we do now need to be able to identify a way forward that would allow us to be able to enhance the strategy to see St Margaret's continue as the provider of care for older people but one that fits with the strategic model of care. Some sense that has been created that beds are being taking away from St Margaret's to be given to Blawarthill is wrong. This paper shows that that is wrong. The reductions at Blawarthill in that locality at Knightswood have already been made and 60 beds that the Board and the City Council agreed jointly to re-provision at Blawarthill are NHS continuing care beds. The analysis is showing that we now still have 90 more NHS continuing care beds than required.

Amanda Stewart, Councillor, East Dunbartonshire Council

Thank you Chairman and for your comments.

In reading this report in detail and considering the implications and recommendations on page 24, I have to say to the Board at this stage that I am not comfortable with the report being passed today.

Members will be aware that there has been a massive public concern about the removal of these beds at St Margaret's and as a consequence of this, a 90,000 signature petition has been presented to the Scottish Government. I am not suggesting just because of this petition that this Board should not take matters forward as suggested within the review in 2005 but what I am suggesting is that before any decision is made on this very contentious issue, that the full facts are available to this Board.

I draw members' attention to the recommendations in paragraph 6.4 and 6.5. It would appear to me that given the sensitivity of this report and the future provisions at St Margaret's, that before any final recommendations that we not longer purchase the service from St Margaret's, that the recommendations at 6.5 in relation to the likelihood shift in care to a social care model be investigated and a full report presented to ourselves on the findings before a final decision is reached.

Paragraph 6.5 also makes mention of local authorities' input in this process and I want to be assured that their views concurs with that of the Health Board.

In conclusion, I would ask that this report be continued in order that this Board receive a fuller report following the discussion with St Margaret's.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

Thank you Amanda. I think we will just carry on going around the table for comment.

Agnes Stewart MBE, Dixon Community

Well, being from the south side of course, I am looking at the south side provision. First of all, the figures you have given us for the average age over 80, I would have preferred, I know that this might not be done, I would like to know how many people north and south, that perhaps there is some way of splitting the figures so that we know the population that will be involved from both areas. I don't know if you can do it Tom to be honest.

But my second item is in relation to the Mansion House unit, which has currently got 60 beds and plans to have none. Now, in page 3 of the minutes, Helen has itemised that there will be inpatient beds in the new Victoria Hospital. Are you telling us that none of them will be continuing care beds?

Robert Calderwood, Chief Operating Officer, Acute Services Division

If we first of all take the Mansion House Unit – Mansion House unit is a 232 bed operational unit of which 60 beds are NHS continuing care. The balance of beds are NHS rehabilitation covering geriatric/elderly care medicine, stroke and orthopaedic. The Board's position has always been that in the new hospital replacing the Victoria Infirmary there would be 48 what is being referred to as slow stream elderly rehabilitation beds.

[Agnes Stewart interrupts – you just keep on changing the terms?]

It has always been, I can assure you, it has always been slow stream elderly rehabilitation. It has never been in any of those discussions since 2000, any discussion about NHS continuing care beds within the new hospital. The 60 beds within the Mansion House Unit that are NHS continuing care will always be part of the Balance of Care and have always been reflected in this distribution of proposed ongoing.

With regards to the elderly population, I believe we have got ways we can look at splitting of projections by broad postcode areas and could have a high level of north/south split.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

Thank you Agnes.

Dr Barry Williamson, Upper GI Surgeon, Royal Alexandria Hospital

I think this is a very carefully considered paper and I am actually happy to accept its recommendations as they stand at the moment, particularly because of the reassuring flexibility which Tom and Robert have referred to in terms of returning to the planning assumptions to make sure they are correct, that is the most reassuring thing I have heard so far on what is clearly a contentious issue.

I would like to just draw to your attention to a couple of things. Although you have dealt with the raw numbers in the table in 5.1 and the 25% increase in numbers, what is not shown there is data that shows how, as this section of the population increases so the number of people with multiple chronic disease processes will increase. Now if we look at the Public Health Programme, although probably not within the next 10 years, that will offset the increasing dependency of this elderly population which will then reduce the capacity requirements for care. Can I therefore ask you in taking that possible issue into account, to consider measuring readmission rates as it is not the admission rates that matter here for all of this shift to care in the community, it is the readmission rates as if the readmission rates rise, that is an indication that care in the community in its current form is perhaps sub-optimally delivered and it would be a very useful barometer to measure the effectiveness of this.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

There are two or three things come to mind.

I think as far as the definition for NHS continuing care is concerned, there are no readmissions. In future, readmissions will not be part of the phenomenon within NHS continuing care. If we looked at those other parts of the care that Robert was describing in connection with assessment and ongoing rehabilitation, I think your points about how progress in chronic disease management on long term conditions impacts on those requirements is important and one that we would happily take up. It may be the case that in 10 years time some of that profile then starts to shift again which is why I make the point that I did because in essence what we have done in 2008 is come back to review 2 key and fundamental pieces of work in looking at the balance of care within this group. Those of you who were able to be at the Board seminar a fortnight ago will have followed and contributed to a fundamental discussion about the future management of long term conditions and how that plays out in terms of its impact on those future admission arrangements and arrangements for supporting individuals at home. If reasonable, I think what I would say is that with this care group as with each of the other care groups, we will periodically, and periodically is probably no more than every 3-5 years, come back and look again fundamentally at the strategies in place at that point in time remain the right strategies during the development of practice and care that have taken place. I think one of the beauties of the bed modelling work that members of the Board have been exposed to extensively in terms of the development of the business case for north and south Glasgow is that you can see there that we get the opportunity at key checkpoints in the implementation of that strategy to go back and look at what the implications of some of those longer term potential changes are.

So I think some of this is looking forward, with a lack of clarity just now, but the important thing I think is to have the issues registered as part of what will be picked up as part of our ongoing considerations and to make sure that the connection that Barry is drawing between the ongoing management of long term conditions, how that impacts. At this stage I would

think earlier parts might have the potential at some point in the future to begin to have implications on this care group as well. Is that reasonable?

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

Okay, continuing round the table.

John Bannon MBE, NMC Panel

As Tom knows, this goes back to the Knightswood Hospital days and we were given a guarantee when Knightswood was closed that there would be no bed reductions at Blawarthill Hospital. However, that was a bit like the football chairman saying to the manager he had every confidence in him!! It was then the Board closed Blawarthill hospital and there was a bit of a stooshy to say the least and the Board were then minded to keep Blawarthill open.

The various community groups in the west end of the city are happy with the proposal for Blawarthill but I would ask in terms of St Margaret's the decision is deferred until such time as you Chairman have the chance to meet with St Margaret's as otherwise that would be prejudging the outcome of the discussion you will have with Sister Rita and Professor Martin at St Margaret's.

Tom mentioned 60 continuing care beds at Blawarthill. It is my understanding there will be a further 60 beds provided by Glasgow City Council. Glasgow City Council, I understand, have as of last week and I am hearing from two of its elected members, that they are taking a review of residential beds and this is likely to recommend the closure of all residential beds. What implications would this have on continuing care in the west of the city? Again, I would ask in connection with St Margaret's we defer the decision until we have clarity on this and the meeting with St Margaret's.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

I have had no such indication formally or informally and clearly I need to follow that up. What I have set out today is a trail through a set of decision making processes that goes back a decade and more with key touch points at 2000, 2005 and 2008.

In terms of what John has mentioned to me just now, I have to say I am hearing this for the first time.

Peter Hamilton

Just a couple of comments. As a member of the Health Council in 1997, I can well remember when the discussions first started around continuing care so from that point of view I certainly welcome this paper and accept the recommendations made in it.

The only other comment I would make is that maybe it is unfortunate and maybe Tom didn't want to amplify on it but I think that it has been unfortunate there has been an issue around engagement and it is encouraging to hear there will be a meeting on 2 May with Andrew, Tom and St Margaret's. I think it is unfortunate too that the debate in many ways has been through the Letters page of the Herald for so many months now but I think it is encouraging now that at least this meeting is now going to take place.

Douglas Yates, Councillor and Deputy Leader East Renfrewshire Council

Like Agnes, I am more interested in the south side of the city.

I see in Appendix 1 that Mearnskirk is going to be the major site for NHS continuing care beds in south Glasgow and whilst this is vital to the area and there will be people who require them, an audit taken in last December there was about 40 patients occupying NHS continuing care beds which meant there was a significant number of others and with reference to that, it is unlikely this area would require 72 beds. And it is unfortunate that there are such poor transport links to Mearnskirk in fact there is a couple of buses that serve that area that stop quite a bit away short from Mearnskirk and I was just going to ask the Board if they would consider those transport issues in as part of its sustainable transport commitments.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

Happy to do that. Because although there has been a particular process of improved transport efforts around changing the service provisions we have actually sought to encompass all aspects of the services and locations covered and as you know we started this in Glasgow City and have been able to move out now to pick up that work with other Local Authorities and I'm very happy to pick that up and to see if there are some improvements that can be made.

Joseph McIlwee, Councillor, Inverclyde Council

I would like to echo Iain's sentiments regarding the concerns over the transfer of resources.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

I would just re-echo that acting this whole series of service changes across all of the care groups, we have worked to bottom out what would be a fair and equitable distribution of resources and that is a debate that is concerning now then I am happy to take an interest in that and just have a look and understand what the issues are because it has been a founding principle of the way in which this Board and indeed I have operated in other places, I was in Lanarkshire in 2001, that we make sure that we have got not just agreement with service models but have the agreement on funding flows because if you don't have both you don't have a coherent plan.

Rani Dhir

Chairman, I hope you will indulge me as I have a couple of questions.

First of all, it is not clear from this paper whether you are talking about Greater Glasgow and Clyde or just Glasgow City because to me, some of the statistics must be adjusted to cover patients in the Clyde area.

Second of all, although I was not a member of the Board at that stage, but CHPs and CHCPs are still in the quite early stages and I'm therefore curious to know if in that period they have not included the Greater Clyde area, why they have not done it since?

My third point you said you wanted cluster groups of 60 beds and yet in the south side you've got 30 beds in Rowantree, 30 beds in Darnley Court and 72 beds in Mearnskirk. We are not talking about large numbers here, there are only 6 sites so to say you think 60 is optimum I don't think holds any water and I would like you to clarify that disparity.

We're not Greater Glasgow anymore, we are Greater Glasgow and Clyde and I think there needs to be a better piece of work to include the Greater Clyde area and to give the bigger picture.

I am also minded however to see that, for example, to be honest, there is nothing in this paper to tell me why you arrived at this conclusion. There isn't any further information and I can't see how you would then conclude you would no longer purchase a service from St Margaret's. There must have been some other criteria you applied because you said it wasn't about finances.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

I think this is appropriately an update and review of a strategy that previously was for the Greater Glasgow area which reached into parts of West Dunbartonshire and East Renfrewshire. So that's where the numbers come from – they are the previous NHS Greater Glasgow population and I think that that remains a reasonable planning basis for taking this forward. We know that in terms of the work within Clyde, there was unfinished work within Renfrew and that is now the subject of consultation and if there is any further refinement that is required in terms of other aspects of older peoples services provision within Inverclyde locality or in parts of West Dunbartonshire we can take that up. But this is in essence us coming to the final point of the implementation of the strategy, which was kicked off back in 1997.

Regarding the groups of 60, the paper makes the point that where possible we were keen to try and get aggregations of 60 beds. Now there are 72 beds at Mearnskirk that are provided there as part of an ongoing contract. It doesn't make any sense to go and alter that contract in such a way that would leave some of the beds empty and that's why Douglas is saying there are some residents from outwith the local catchment who are cared for there. So we didn't see that it was a material issue there were more than 60 and what we have sought to do in Greenfield and Fourhills in the east and north of the city and then at Blawarthill is get that concentration of 60.

The Blawarthill decision to redevelop 60 NHS continuing care beds was an agreement between Greater Glasgow Health Board and Glasgow City Council in 2000 and as I said in presenting the paper, there wasn't a sense at that point in time that that was going to have implications for beds at St Margaret's or indeed any of the other partners in the west because there are other beds in the west who have also over that period, for example, you will see that in Almond View Nursing home there is no longer any NHS continuing care provision and so that is a further change that has been enacted during this period. The reality is that we have been able to work through with seven other providers these issues of financial migration and change into the new model and are confident we can do that again. There has been a series of decisions that have been taken over a period of time that brought us to a position in 2005 where the Balance of Care study was showing that a further reduction in the level of NHS continuing care was necessary and that is what has been being enacted since 2005 in terms of the subsequent changes there.

The Board has made the decision that it will redevelop 60 continuing care beds at Blawarthill in the west of the city. That was a decision of the Board and a commitment of the Board back in 2000 and so that in terms of this exercise, I take as a given, as a commitment of the negotiations the two organisations entered into and as Jim Coleman has said earlier on in this meeting, that is still a line that the Council is supportive of and in response to John Bannon, I have not heard until he uttered it this morning, that there may be some changes to the thinking and I need to go and understand if there has been some change.

Rani Dhir

You have still not explained to me why you have 2 groups of 30 beds in the south side.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

That is pragmatism. Because we have sites in place there where there are ongoing contracts in place and our ability to step away from those contracts in the short term is constrained. So what we have said in the paper is that we have tried where we can to get concentrations of 60 beds. We have achieved that where possible but we haven't been able to achieve it everywhere but the bottom line is that, and I don't think anyone has challenged this yet, I don't think anyone has challenged this - that this analysis is shown that we still have more NHS continuing care beds than are required. It is this final move to enact those changes in the way it stands as Douglas and Agnes have said in the issues that have still to be implemented.

Rani Dhir

I'm still not quite satisfied that Clyde has not been included just because it is a historic decision. I don't understand why since 2005 you have not looked at the bigger picture in Glasgow and Clyde and I respect you are saying this started 11 years ago but you are actually making changes now so I don't see why you can't look at a strategy for Clyde as well. To be honest, 2 of these areas are actually outwith the Glasgow City Council area. I don't know what the local authorities there think but I think to be fair there has to be a Greater Glasgow and Clyde Strategy.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

We didn't have Clyde in 2005. We have picked up the major piece of unfinished business from Argyll and Clyde on older peoples services in Renfrewshire and as Robert has said, in terms of the use that has been made of St Margaret's for elderly care, that is predominantly a city of Glasgow use. The number of residents there currently from East Dunbartonshire and West Dunbartonshire number, I think, only 3.

Gerald McLaughlin

Can I start of by saying that I think the historical perspective of the analysis is helpful because I think this is a really complicated analysis from the first reading it is quite difficult and I feel quite reassured by that. I guess my point here is that there has been comments made earlier on about the other providers and for me the difficulty there is that I don't know them but understand they are social care and nursing care providers and that of course is very different from St Margaret's. I don't have any problem with the analysis and I am happy to accept the main recommendations of the report. I guess we are concentrating specifically on one provider. However in that context, can you tell me, will the planned meeting with St Margaret's specifically deal with the issues of adjacency questions about how the other patients can be cared for alongside the requirements that these decisions make and plans we may have for them in the future.

And lastly, can you tell us what plans there are going to be if we go ahead with this decision today to report back on the outcome of the discussions with St Margaret's.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

We have been mindful of the adjacencies all the way through this discussion which is why the proposition has never been that we simply take the 30 continuing care beds out of St Margaret's full stop. That has never been the proposition. The proposition always has been what ongoing role, most particularly and I think it is clear the preferred option is around a continuing role in terms of elderly care but one of enhanced social care, but we have also in previous correspondence and in the previous 3 face to face meetings that John Arbuthnott and I had had at St Margaret's over the last 3 years set out an alternative option which was for NHS continuing care for older people with mental illness. And that is our first response in terms of the adjacencies where we have been mindful of that and have sought to create options around that because in one of the discussions we did have which led to us coming back with the option of NHS continuing care for older people with mental health issues was because the view from St Margaret's was because they wanted to continue working in a service agreement or contract with the NHS in preference to working in contract with local authority around the enhanced care model. That was there preference and I can't put it more strongly than that. And the reason why we had put forward that as an option was because we believe there are a lot of commonalities in the care of those groups and indeed we have organised our arrangements here so that the care of older people and the care of older people with mental illness can come together as part of the same area. So I think we have been mindful of the adjacencies of that and that is why we have sought to try and find a way forward.

If I look back and reflect on perhaps how I and the previous Chairman handled some of this, maybe we didn't push to try and make sure that we got into dialogue as early as we might have done but that is only my reflection on that and that wasn't the way we entered into the discussion. We were keen to try and find an agreed way forward that would not involved financial risk for St Margaret's, that would allow the Palliative Care service to continue to be provided and we have been able previously to identify what the costs of NHS continuing care are and what the costs are to the Health Board of Palliative Care. So we have been mindful of that and that is the same line we take into the meeting on 2 May with a commitment on our part to find a way forward. Whatever the vagaries of the previous history may have been and previous decisions taken were, we are in a position where in 2 parts of the city, we still have an excess of NHS continuing care capacity that we need now to be able to work through within an agreed financial framework within an agreed timeframe and hopefully seek an agreed way forward on that basis.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

Okay, I think this will be the last time going around the table.

Dr Catherine Benton

Maybe I'm confused but it is just about the 25% increase in the next 10 years and that that has been pro rata to 15%. Can you explain that?
Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

What I was trying to explain Catherine is that we don't believe based on the current experience of patients in elderly care and how the balance of care has continued to develop

that there would be a straight line relationship between a 25% increase in population and a 25% increase in NHS continuing care. That is the point I was trying to make and in looking at the other parts of the care continually that have been developed, our view is that something like 15% growth in NHS continuing care feels as though that is appropriate. As I was saying in my exchange with Barry, these are matters that were agreed to regularly and periodically review in order to retest whether the assumptions have worked out in the way in which the previous analysis was expected.

Iain Robertson, Councillor, Leader of West Dunbartonshire Council

Like most people around the table, I am fairly comfortable with the report in terms of its logic and I think it is helpful. I would like however to concentrate on the consultation and engagement part of it with St Margaret's. I agree with John [Bannon] there that I think if the Board makes this decision today, it will be seen as prejudging the meeting with St Margaret's and I think this is wrong and I think there is a greater risk to this Board to be seen to be prejudging in that way. At this stage in time, I can't see any reason or any major risk to the Board if we did continue the report until at least the next Board meeting. I understand that there is a timescale there and I think yes, we do need to bring it to a conclusion but I don't see a risk at this particular meeting of continuing. I think there is a greater risk that we may just been seen as a Board who prejudge and to be seen as a Board who are the ones, if you like, damaging St Margaret's and that perception is maybe not the actuality but that's the case. So I am going to agree with John and Amanda here that there is a case for the Board to continue this report pending further information coming back from your discussion.

Donald Sime, NHS Board Director

Thank you Chairman. I think it is quite clear from the paper and from what we have heard here today that we no longer require these continuing care beds. I think both the Chief Executive and yourself working in partnership with St Margaret's and working with them and the discussions with St Margaret's have been commendable and obviously its an extremely emotive subject because it is about people. If this was about the stationery we were buying from WH Smith and we no longer required the stationery, and this had an impact on the business, we might have to consider cancelling it and I don't think there would be quite so much concern and therefore I very much commend the actions of yourself Chairman for the ongoing dialogue with St Margaret's. As for prejudging any consultation with St Margaret's, the evidence is there that we no longer require this provision so I actually propose we accept the recommendations.

Amanda Stewart, Councillor, East Dunbartonshire Council

I would reiterate the comments I already made and therefore would ask the Board to continue this report even until the next Board meeting after the first meeting with St Margaret's has taken place. In fact I would probably like to lodge an amendment to that fact to continue on the basis that I would like to see a further report which would be a further report after the discussions with St Margaret's.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

Now, I wonder if I could leave the amendment just for the moment and we'll come back to you.

Derek McKay, Councillor and Leader Renfrew North

I think we are all agreed in the direction of travel and I don't think there is any doubt about that and I think we've covered that. I suppose the difficult bit is when you get to the detail and I have to say that there is now enough doubt in my mind that I couldn't pass the report as it is and feel confident because what I have picked up and we have had a difficult time with continuing care beds, and we are following quite a controversial strategy and that I know where and know why and know how but there is no detail in the report regarding this and also issues around resource transfer and community infrastructure. I don't see too much of that in this particular report. What I do see is and what concerns me the most and this is not my interpretation but that of my colleagues interpretation of the same report and what may or may not be happening and how it impacts on other authorities, I know that this is mainly a Glasgow issue but it does impact on neighbouring local authorities and what I have heard from other colleagues so I do not think that we have to rush, unless I am told otherwise, this particular decision and a bit more discussion would probably be in order here.

Jim Coleman, Councillor/Depute Leader Glasgow City Council

Just to confirm the city's position – the administration is fully behind this proposal and there is no change in the pipeline either and we'll continue to support it. I would also say I am not in favour of continuation. I agree continuation in some circumstances is normal but facts are facts are facts and nothing is going to change with a continuation of this. We will just be in exactly the same position.

Agnes Stewart MBE, Dixon Community

Well actually I disagree with Jim. I think that in view of what we have heard today that I hope that when the discussion takes place with St Margaret's we can find a decision that suits everyone, I doubt it but I hope so and I feel it won't do any harm to continue this until after the meeting. We don't want versions of this meeting coming out, as they will come out through the media, and therefore I would continue.

John Bannon MBE, NMC Panel

Chairman can I just say that I was not implying Glasgow City Council were walking away from Blawarthill proposal. What I was saying is that Glasgow City Council are considering a review of their residential homes and what impact that could have on Blawarthill, if any.

And the second point I would like to make is, after the 2005 review, why was there no formal public consultation because at that time then the numbers and proposals could have been challenged and tested at that stage?

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

John, I'm confused about what you said this morning. I took a quite different sense from what you said about a material doubt around what might be going forward and I'd thank Jim Coleman for what he has said in response to that.

The Balance of Care work and the work of the Joint Community Care Committee, was itself the subject of a significant debate before the final decisions were taken about that. If you look at the profile of change required between 2005 and the final implementation period in 2008/9, I think history has shown it has been possible through negotiation to reposition the point in the care continuum that individual providers have occupied. This judgement was taken by the partners jointly in 2005.

Peter ??

I support what Jim Coleman has said and I too am against a continuation.

Douglas Yates, Councillor, East Renfrewshire Council

I don't see anything changing from have a continuation of this and therefore I do not support a continue and would support the recommendations.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

This is obviously a very sensitive issue around what is a broadly agreed policy. I have confidence in the key agencies who are responsible and this confidence has been built over an extensive period. Clearly there is a need to address the transport issues as pointed out. It is regrettable within the Board that communications have been much more public than we would have wished. Whatever the outcome of this meeting today, we will provide a report back to this Board following the meeting with the Hospice on 2 May 2008. But we need to make a decision today on the recommendations.

I think looking at the recommendations as they currently stand. The first which is to note the outcome of the review of planning for NHS continuing care for frail older people resident in NHS Glasgow is pretty much agreed. The second, to agree that the implementation of the shift in the balance of care be continued also has broad agreement but there is the issue in relation to St Margaret's. We have to be careful not to allow this to be derailed. I would put it to you that we add a third recommendation and that that recommendation would be that we continue to receive reports and pass these on to the Board as the discussions with St Margaret's progress. We are therefore accepting the thrust of the strategy but taking cognisance of the meeting with St Margaret's. Can I take responses to this proposed amendment.

????

I do not agree. I think we have to consider the reputation of the Board. There is huge public concern regarding this and I do not think this would be sending out the right message so, no I'm not supportive of the amendment.

Ronnie Cleland, North Glasgow University Hospitals Division

Maybe I'm just being a bit pedantic but in the paper in recommendation 6.4, it recommends that the Board no longer continues to purchase a continuing care service from St Margaret's. If we support the recommendations, even the amended recommendations, then we are supporting that so I don't agree.

Donald Sime, NHS Board Director

Maybe I'm just being a bit thick but as a consequence of your amendment, does this mean the Board could come back and revisit it?

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

It is critical that we try to move forward but we do not want to be seen to be pre-empting the meeting with the Hospice.

Gerald McLaughlin

It was originally not urgent and now you are saying it is critical. I don't see the problem here with the continuation. I think you should have the discussion with St Margaret's and then come back to the Board with it.

Jim Handibode, Councillor, South Lanarkshire Council

I have sat here quietly during this and have listened to what has been a very interesting debate. We have however been swamped by information and I really don't need any more information. I ask you Chairman to move to a vote.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

I'm note keen on voting on this. If we defer, we have to clear that ultimately we will still have a difficult decision to made at a later date. I am minded to defer this but only with the knowledge that we cannot procrastinate any more.

Douglas Yates, Councillor, East Renfrewshire Council

Is the discussion capable of influencing the decision.

Andrew Robertson, Chairman Greater Glasgow and Clyde Health Board

We have to be careful not to pre-empt the meeting with St Margaret's and be able to approach St Margaret's with openness.

Donald Sime, NHS Board Director

I accept the Chair's decision to defer.

Amanda Stewart, Councillor, East Dunbartonshire Council

I also accept the Chair's decision to defer.

Jim Coleman, Councillor/Depute Leader Glasgow City Council

I was not happy to continue this and I'm still not happy. Nothing is going to change from discussions with St Margaret's. I am also not happy putting off things because of petitions.

Tom Divers, Chief Executive Greater Glasgow and Clyde Health Board

I think this has been a good discussion. The Board is comfortable with the analysis presented and a date has been set to meet with St Margaret's. However, it is incumbent on St Margaret's to be prepared for that meeting as not moving their position is not helping. There is a gap in the provision of services around enhanced social care.

I am content to have this continued until the next meeting in June and hope to have open discussions with St Margaret's in order to move this forward.

Board agreed to continuation.

Andrew O. Robertson, OBE LLB
Chairman

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PERSONAL

Professor Leo Martin,
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3 Annfield Place,
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Date 13th March, 2008.
Your Ref
Our Ref AOR\FEB

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Dear Leo,

FUTURE PROVISION OF NHS CONTINUING CARE FOR FRAIL ELDERLY PEOPLE WITHIN GREATER GLASGOW

When we met on 4th February I had promised that I would be back in touch with you to resume our discussions about future service options when the "Balance of Care" review had been completed. Previously, Tom Divers had committed to share the output from this updated exercise with you: the work was indeed completed in February and will now be the subject of discussion within the relevant planning groups in the affected Local Authority areas.

The key elements of the study are set out in the short paper which I have attached to this letter. The main conclusions from the updated study reaffirm the conclusions from the 2004 study that the planned reduction in NHS Continuing Care beds – which has substantially now been achieved – has been appropriate and that the complement of 312 NHS Continuing Care beds determined by the 2004 study will provide adequate capacity for the foreseeable future, taking into account the projected rise in the number of people over the age of 80 at 2018.

In the earlier discussions which you had with my predecessor, John Arbuthnott, there were two principal options which St. Margaret's was asked to consider, reflecting the Board's strategy that the number of NHS Continuing Care beds should reduce. The first – and this is very much the Board's and the two Local Authorities' preferred option – would see St. Margaret's move towards a social care model: this would meet an identified gap in the provision of such services in both West Glasgow and West Dunbartonshire. We and the two Local Authorities would want to work with St. Margaret's to achieve that model by April, 2009. The second option would see St. Margaret's move to become a provider to NHS Greater Glasgow and Clyde of services for Older People with Mental Illness. While not the NHS Board's preferred option, that does still remain as an option which could be taken forward over the same kind of timescale.

NHS
Greater
Glasgow

I know that our offices are in touch to arrange a meeting between us in the next two to three weeks. I hope that that meeting will give us an opportunity to consider together how St. Margaret's continues to play a material role in the future delivery of the Board's Strategy on Care for Older People.

Yours sincerely,

Andrew O. Robertson, OBE LLB
Chairman

Enc.

c.c. Sister Rita Dawson
Mr. Tom Divers
Ms. Anne Harkness

Review of NHS Continuing Care for Frail Elderly – former NHS GGHB

1. Background

In early 2005, NHS Greater Glasgow and Glasgow City Council agreed a Review of Provision and Plans for Institutional Care for Older People in the City of Glasgow. This included a section of NHS Continuing Care for the former Health Board area. The purpose of this paper is to present our review of the previous planning assumptions and to inform the implementation of further service change

2. The 2005 Plan

2.1 The plan recommended a reduction in NHS Continuing Care beds from the December, 2004 figure of 656 to a planned figure 312 beds, with the objective of achieving that shift in the balance of care by 2007.

2.2 This reduction was based on a number of factors

- A declining number of admissions to continuing care as a wider range of community services became available
- A declining length of stay in the beds as patients were generally admitted in the last months of their lives
- A reduction in the number of patients awaiting discharge who were inappropriately in continuing care beds

The planned number of beds is shown below, along with the annual changes which have taken place since 1997.

3. The February 2008 Position

The table below shows that the number of beds has been reducing since the late 1990s and shows a reduction of 240 beds since the plan was agreed; but the final phase of reduction has not yet been implemented.

NHS Continuing Care Beds: 1997-2007

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Planned
North sector	658	613	484	435	390	390	390	360	210	210	210	180
South sector	400	400	402	402	372	312	312	282	252	252	192	132
Other	36	20	20	20	14	14	14	14	14	14	14	0
Total	1094	1033	906	857	776	716	716	656	476	476	416	312

The planned final reductions were to close 60 beds in the South of the city and 30 beds at St Margaret's in the West of the city.

4. Review of Planning Assumptions

4.1 The updated "Balance of Care" study has included a review of each of the key elements of the planning assumptions which are relevant to this exercise. In turn, they comprise a review of admissions; of the pattern in average length of stay; and the impact on future service requirements of the changing demographics among the elderly population over the next ten years.

4.2 In order to identify the number of true continuing care admissions the number of discharges has been subtracted from the number of total admissions. The discharges will have been of patients temporarily occupying the beds whilst awaiting a place in another type of care as part of their planned discharge.

	2002/3	2003/4	2004/5	2005/6	2006/7
"True" Admissions	690	598	601	478	509

4.3 The overall length of stay has continued to fall with the average length of stay of patients who died falling in a similar way. The mean length of stay is higher than the median due to the continuing presence of patients who were admitted before the current criteria for the use of continuing care were agreed. In 2006/7 the maximum length of stay before death was 14 years. Notwithstanding this, average length of stay has fallen substantially (by 40%) over the past six years.

Average Length of Stay	
2000/1	201
2002/3	177
2006/7	116

4.4 For completeness, the mean and median lengths of stay before death are shown below:

	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8 to Nov
Mean length of stay before death	138	199	182	215	187	186
Median length of stay before death	47	58	49	39	42	43

4.5 In December 2007 all continuing care providers were asked to complete a 'snapshot audit' of current patients and their date of admission is profiled below.

	1993-1999	2000 - 2005	2006	2007
Number of current patients by year of admission	18	98	58	95

*date of admission not entered for one patient

At the point of this snapshot (17th December, 2007) only 270 of the available 416 beds were being used for continuing care patients. A similar snapshot undertaken on 25th September showed 282 beds in use. This equates to an average occupancy of 65 - 68% by patients meeting the criteria for NHS Continuing Care. We would expect an average occupancy of 95%.

5. Population Profile and Projections

5.1 The average age of admission to NHS continuing care continues to be 82. From 2008 to 2018 a 25% increase in the number of people over the age of 80 can be expected, as the table below sets out.

Year	80-84	85-89	90 & over	total > 80	% incr on 2008
2008	37314	20413	8398	66125	
2009	37951	21092	8285	67328	1.82%
2010	38778	20937	8960	68675	3.86%
2011	39400	21302	9447	70149	6.09%
2012	40459	21491	9832	71782	8.56%
2013	41187	21817	10073	73077	10.51%
2014	41627	22485	10455	74567	12.77%
2015	42402	23251	10808	76461	15.63%
2016	43117	23945	11313	76375	16.53%
2017	43743	24877	11682	80302	21.44%
2018	44,780	25,588	12,029	82,397	24.61%

5.2 For the reasons set out in the final section of this paper, we are confident that the increase in admissions which will flow from this change in demography can be met within the complement of 312 Continuing Care beds.

6. Conclusions

6.1 Each of key data assumptions used in the original review of continuing care has remained valid and the planned reduction in bed numbers will continue to allow sufficient capacity both for the current level of demand at the current average length of stay and for a material, future increase in admissions. From the utilisation pattern seen in 2006\07, the total of annual admissions was 509, with a mean length of stay of 187 days. This gives a total of 95183 bed days, which requires 274 beds at a 95% level of occupancy.

6.2 The planned numbers of 312 beds also allow for a 15% increase in admissions should that occur over the next decade. It is appropriate to assume that there will be an increase in admissions to continuing care as the population over 80 rises although the continued development of community services will mean that there will not be a proportionate 25 % increase. Further, as the patient profile continues to change to reflect the current admission profile this will also generate capacity by reducing the mean average length of stay further .

6.3 There remains a key risk however regarding the current numbers of patients awaiting discharge. Whilst it is planned that there will be no patients waiting over six weeks for discharge from April 2008 there will remain a significant number of patients who are occupying continuing care beds whilst complex procedures regarding Adults with Incapacity are completed. At the last monthly census in January there were 26 of these patients occupying NHS continuing care beds. To close further continuing care beds to the level of para 4.5 in the short term would mean that these patients would stay in rehabilitation beds both blocking access for patients requiring rehabilitation and reducing the overall bed capacity of the acute division.

6.4 It is therefore recommended that the Board no longer purchase a continuing care service from St Margaret's from April 2009 and close 30 beds in South Glasgow in the same timescale. A further 30 beds would close in South Glasgow the following year.

6.5 It is recommended that further discussions be taken forward with St Margaret's to agree an implementation plan for this change and to continue to encourage them to shift the type of care provided there to a social care model in partnership with our local authority colleagues. There is a clear demand for this type of service in that area. It is not intended that current continuing care patients at St Margaret's will be moved to another ward and this will form part of the implementation discussions.