THE SCOTTISH OFFICE

NHS
MEL(1993)67

National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG

Dear Colleague

**COMMUNITY CARE IN SCOTLAND:
1993/94 BRIDGING FINANCE SCHEME**

14 May 1993

Summary

I enclose a letter which introduces the third Community Care Bridging Finance scheme in Scotland. It confirms the levels of resource available over the next 3 financial years and sets out the criteria against which bids for Bridging Finance by Health Boards will be judged in future. In particular it seeks requests for Bridging Finance which are focused more on meeting the double running costs associated with the transfer of patients from long-stay hospitals into more appropriate community settings, and which contain proposals directed at particular institutions and which will lead to the closure of complete wards or groups of wards - thereby securing the early release of resources for transfer to Local Authorities.

The letter also announces the introduction of more formal monitoring procedures, directed initially at levels of expenditure and patient transfers achieved.

Action

Health Boards should:

- provide the material requested in Annex D to the appropriate contact within the Management Executive by 14 June 1993;
- submit Bridging Finance applications in accordance with the criteria and format described in the attached;
- copy this Circular and letter to Unit General Managers and all staff involved in Community Care.

Addresses

For action:
General Managers,
Health Boards

For information:
General Manager,
State Hospital
Unit General Managers
Chief Executives,
NHS Trusts
General Manager,
Health Education
Board for Scotland
General Manager,
Common Services
Agency
Chief Executives,
Local Authorities
Directors of Social
Work, Regional
Councils
Directors of Housing,
District Councils
Chief Executive,
Scottish Homes

Enquires to:

Mr C A Naldrett
Strategic Planning and
Performance Review
Division
NHS Management
Executive
Room 275
St Andrew's House
EDINBURGH
EH1 3DE

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Yours sincerely

William Moyes

WILLIAM MOYES

Under Cover of
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THE SCOTTISH OFFICE

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Management Executive

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Health Board General Managers

Copy to: General Manager, State Hospital
General Manager, Common Services Agency
General Manager, Health Education Board For Scotland
Chief Executive, NHS Trusts
Health Board Unit General Managers
Chief Executive, Regional, District and Island Councils
Directors of Social Work, Regional Councils
Directors of Housing, District Councils
Chief Executive, Scottish Homes

14 May 1993

Dear Colleague

COMMUNITY CARE IN SCOTLAND
1993/94 BRIDGING FINANCE SCHEME

1. This letter introduces the third community care bridging finance scheme in Scotland. In particular it:

- reports on the application of bridging finance resources to date and calls for a report on progress made under the previous 2 schemes;
- confirms new resources totalling £28m over the next 3 financial years and invites bids against this provision;
- sets out the criteria against which bids will be judged in future

The 1991 and 1992 Schemes

2. Circulars HHD/DGM (1991)17 and (1992)8 announced bridging finance schemes spanning the period 1991/92 to 1994/95. From an original provision of £33m, supplemented by a further £2m over the period 1991-93, a total of £27m has been allocated to 108 projects allowing nearly 1,900 patients to be placed in the community and, additionally, preventing a considerable number of unnecessary inpatient admissions or readmissions.

3. Both schemes provided health boards with additional financial resources to enable them to work with local authorities in the task of building up community care support facilities which would allow people inappropriately placed in hospital to be transferred to a more appropriate care setting in the community.

4. The resources available could be used to meet either capital or revenue cost of projects. The intention was to enable Boards to meet the

double running costs incurred by running a hospital at a higher level of occupancy than would ultimately be necessary whilst alternative community care facilities were simultaneously being developed for the same client group. In practice the emphasis has been more towards the creation of community based facilities through property acquisition or conversion, or the establishment of care or assessment teams. While we recognise that such expenditure may be required to contribute to initial start-up costs for community care facilities, for the future we wish bridging finance to be concentrated on the financing of double running costs.

The 1993 Scheme: Resources Available

5. On 23 March 1993 the Secretary of State announced an additional £28m provision for bridging finance over the period 1993/94 to 1995/96. Together with the uncommitted balance from the earlier bridging finance schemes the total resources available for this and the next 2 financial years are £8m (1993/94), £13m and £15m respectively.

6. Boards can, in planning and developing bridging finance proposals, assume that provision at the 1995/96 level will continue for the foreseeable future thereafter. But this will be a decision to be taken annually by Ministers in reviewing the level and distribution of public expenditure and will depend in part on how far the scheme is achieving its declared aims.

The 1993 Scheme: Strategic Background

7. There are currently approximately 12,000 people with a mental illness, including elderly people suffering from dementia, or with a mental handicap who have been in long-stay accommodation as patients of the NHS for a period of 1 year or more. In addition there are approximately 7,500 frail elderly people accommodated in the long stay sector. The circular on resource transfers, issued on 15 September 1992 (NHS MEL (1992) 55), made clear that the NHS should not seek to retain responsibility for meeting all the care needs (including social care needs) of patients who do not require continuing specialist medical and nursing supervision. Over time we would expect that this will mean that Health Boards will purchase a significantly fewer number of long-stay places for people with mental handicaps and perhaps also for the frail elderly. Requirements for long-stay accommodation for people with mental illnesses, including the elderly, are more difficult to predict. However, overall we would expect a substantial reduction in the NHS's requirement for in-patient beds, including provision secured under contract from the private sector.

8. We therefore expect Health Boards to devise detailed plans for the elderly, mentally ill and mental handicapped which are designed to achieve, by the end of the decade:

- a significant shift away from institutional-based care towards care in the community;

- a similar shift away from the provision by the NHS of purely social care;

- joint commissioning by the NHS and local authorities of the right mix of health care, social care and housing provision to meet the needs of individual patients, with the financing of that care arranged accordingly.

9. These should be derived from Community Care Plans and Local Health Strategies. The plans are expected to specify a decreasing level of in-patient provision and to set clear targets for the achievement of this in a cost-effective manner. Across Scotland as a whole we would expect around 600 discharges per year in total from long-stay establishments accommodating people with a mental handicap or mental illness, including elderly people with dementia. In addition Boards are likely to require a decreasing volume of in-patient provision for the frail elderly as the plans are progressively implemented. In all cases Boards are expected to focus their plans on particular hospitals and to agree with the NHS provider concerned, and with the Social Work Department and the Housing Department or other housing and care agencies, how the process is to be managed. This should include an agreement on the volume and range of services to be provided in the community, and how these are to be financed, to which all the agencies concerned are firmly committed.

10. Our intention is that bridging finance should be focused primarily, though not exclusively, on meeting the double running costs to the NHS of the process described above. It follows that Boards are most unlikely to receive allocations for bridging finance unless they can point to agreed plans along the lines described, that are consistent with their Local Health Strategies and Community Care Plans, have been agreed with the Management Executive, and for which implementation has been agreed with the other agencies involved.

The Role of Bridging Finance

11. Our intention is that bridging finance should be focused more on meeting the double running costs (revenue) of implementing agreed programmes of transferring patients into the community. Additionally, the emphasis should be on using bridging finance to secure the early and permanent release of revenue resources, while recognising that both capital and revenue finance may be needed initially to set up new community facilities which will allow such a release to take place. A substantial proportion of these released resources will be expected to transfer to local authorities under the arrangements described in MEL(1992)55, and it is appropriate for local authorities, and other social work and housing agencies, to contribute to the establishment of new community facilities. Such contributions may be in kind, eg properties and equipment rather than cash. It may also be appropriate to apply part of the released resources to purchase additional community health care services, notably services that meet the needs of those transferring from the long-stay sector. Conversely, it may be possible to arrange with housing agencies for the provision of "move on" accommodation, for discharged patients who are expected to recover sufficiently in due course to move into main-stream or adapted housing, perhaps with some continuing health or social work support. The balance to be struck between these options will be different for different client groups and areas, and is thus a matter to be settled locally; within the general rule that capital and similar expenditure should be limited to start-up costs.

12. The attached Annex A provides an illustration of a project that links an early release of NHS resources, to help establish alternative community care facilities, with bridging finance to cover a provider unit's double running costs. A key feature of the illustration is that the resources which will be released by planned discharges are withdrawn by the Health Board before any transfers of patients take place.

13. District and Islands Councils have substantial resources for capital investment in housing, and it is open to Councils to allocate resources to special needs housing programmes in the light of locally-determined priorities. Health Boards should therefore co-operate and plan jointly with local housing authorities, and with Scottish Homes, when drawing up strategies and developing bridging finance bids. While a substantial capital contribution is expected to come from housing agencies, bids by Health Boards for capital will, nevertheless, be considered where the scheme clearly merits priority and the capital injection is the only way to get the scheme off the ground.

1993 Scheme: Allocation Criteria and Arrangements

14. This Circular therefore invites Health Boards to submit bridging finance proposals targeted at implementing plans of the kind described above.

15. The minimum information required for each bridging finance application is listed at Annex B. In judging whether or not to approve a particular application we will be looking for the following:-

1. the extent to which the proposal advances the implementation of an agreed strategy for transferring provision into the community;

2. support, in writing, from all the other agencies involved and their firm commitments to provide whatever resources they may have agreed to provide to enable the scheme to be implemented;

3. proposals which are directed at particular institutions or establishments and which will lead to the closure of complete wards or groups of wards and thereby secure the early release of resources;

4. requests for bridging finance which are targeted primarily at meeting double-running costs.

16. The application should be co-signed by the Board and local authority, and by housing authorities and all other agencies who have committed themselves to contributing to the creation and running of the proposed community-based facilities.

17. Health Boards may find it helpful initially to submit provisional applications, to the contact point listed below, containing the information requirements set out at Annex B. This will provide an opportunity for discussion with the Management Executive and the Community Care Implementation Unit to establish whether the proposal and the projected requirement for bridging finance are likely to be acceptable in principle before detailed work is put in hand. This approach may be particularly valuable with requests for significant amounts of bridging finance. The Management Executive would be very happy to discuss provisional applications without commitment on either side. Where the conclusion is that the project should be worked up in detail, it will be important to agree and adhere to a timetable to avoid large sums of bridging finance being effectively "sterilised" and thus unavailable for allocation to other projects.

18. There is no specific deadline for the submission of applications. However, the sooner applications are received the more likely they are to be accommodated within the budget.

19. As with previous schemes, finance for approved projects will be allocated as a supplement to individual Health Board's revenue allocations for the financial years in question. These supplementary allocations cannot be carried forward, in whole or in part, into a subsequent financial year.

Monitoring

20. For the future, and as indicated below, the Management Executive will monitor closely the extent to which individual bridging finance schemes are achieving in practice the objectives originally agreed.

21. In addition, we also wish to satisfy ourselves that schemes which were successful in attracting bridging finance in previous rounds have achieved the claims made for them at the time of approval. I attach at Annex C (Health Board copies only) a summary of your Board's approved bridging finance schemes to date. Annex D lists the information which we would like in respect of each of these projects. Please submit it to the contact point listed below by 14 June 1993. For the future, the information specified in Annex D will be required on 30 November each year in respect of each scheme for which bridging finance was being paid during the previous 12 months. Additional information may also be specified at the time of the approval of a particular scheme and, if so, this will be notified to the Board in writing.

Contact Point

22. Financial review summaries, and any enquiries about the terms of this circular, should be addressed in the first instance to:

Mrs M Beattie (Ext 2396) for Grampian, Highland, Orkney, Shetland and Western Isles Health Boards

Mrs D Evans (Ext 2402) for Fife and Tayside Health Boards

Mr O Kelly (Ext 2401) for Lothian, Borders & Forth Valley Health Boards

Mr C Naldrett (Ext 2530) for Greater Glasgow Health Board

Mr T Lodge (Ext 2276) for Argyll & Clyde, Lanarkshire, Ayr & Arran and Dumfries and Galloway Health Boards.

Yours sincerely,

WILLIAM MOYES

RESOURCE TRANSFER/BRIDGING FINANCE PROJECT ILLUSTRATION

OUTLINE OF PROJECT DETAILS AND BACKGROUND AS AT 1 APRIL 1993

* to discharge 30 patients into agreed community settings;

* phasing of transfers: 10 in September and 20 in December;

* Board's current full year contract with NHS Trust, for Client Group in question, equates to £25,000 per person;

* patients transferring to mixture of sheltered and own home settings;

* voluntary and housing agencies making capital contribution for sheltered accommodation;

* patient transfers create demand for increased resource/day centre facilities and community health care team provision;

* Health Board and Local Authority agree full year resource transfer value of £450,000 as contribution for accommodation costs, and £50,000 for resource/day centre services;

* increased health care team costs assessed at £100,000 per annum.

OUTLINE OF FINANCIAL ARRANGEMENTS

Released Resources - the Health Board:

* reduces contract with Trust by £750,000 (30 x £25,000);

* arranges for transfer of £500,000 to Local Authority as contribution to accommodation/resource centre costs (see Note below);

* contracts with Trust for £100,000 additional community health care services;

* determines application of remaining £150,000 eg as local bridging finance, for other NHS services.

NOTE: Resources transferred from Health Boards to Local Authorities should be for specific purposes, and in relation to the discharge or transfer of responsibility for people who have been in continuous hospital care for a long time.

In general the resource transfer will be a contribution to the annual revenue costs for providing the Community Care Service/facility concerned.

In the above model the Health Board withdraws the 'savings' for the planned bed reductions before the patients begin to transfer ie in advance of the need to meet revenue costs.

In such cases it would be open to the Board to use any balance not required for year one revenue as a contribution (but only where

absolutely necessary) to any capital costs associated with establishing the service/facility in question.

BRIDGING FINANCE

* Health Board has withdrawn full year cost of 30 patients;

* Trust requires funding for 10 patients for 6 months and 20 patients for 9 months (total £500,000) plus continuing overheads ie to cover gradual run down of staff and running expenses - say £40,000 in 1993/94 and £10,000 in 1994/95;

* therefore, bridging bid = £540,000 in 1993/94 and £10,000 in 1994/95.

* Health Board draws sums down (appropriate to need) quarterly in advance from ME for payment to Trust.

ANNEX B

BRIDGING FINANCE: MINIMUM INFORMATION FOR 1993 SCHEME APPLICATION

1. Detail name of hospital(s), client group and:

- current patient numbers;

- current running costs/potential savings once hospital/ward closed;

- approximate number assessed for (a) transfer to community and (b) retention with NHS long-stay care;

- detail of and approximate capital cost for associated community facilities;

- identified/committed sources for above capital figure;

- detailed and approximate revenue costs of associated services/facilities once relocation complete;

- identified/committed sources for the above revenue figure;

- bridging finance requirement and detail ie annual amount and basis of calculation;

- costs associated with reprovision of NHS acute and long-stay services;

- planned application ie amount/timeframe of released resources to:

  * local authority
  * community/primary health provision or care teams
  * retained services

- list all agencies involved with confirmation of their provisional commitment to the proposals and their proposed contribution.

ANNEX D

BRIDGING FINANCE: 1993 REVIEW OF PREVIOUS SCHEME ACTIVITY AND OUTCOME

1. A summary of bridging finance approvals to date is attached as Annex B.

2. For each relocation/patient transfer project detail:

- amount of bridging finance spent in each financial year;
- the capital/revenue analysis of same;
- number of people relocated into the community;
- number of bed closures if different to the above (explained);
- number of relocations/bed closures still planned;
- amount of bridging finance allocation still required;
- timeframe to complete project;
- whether a resource transfer has/is to be made to the local authority (detail amount, timeframe etc).

IMPORTANT: the relocated people/bed closure figures must cover only bridging finance generated reductions and not those resulting from other means.

3. For each community infrastructure/support project detail:

- amount of bridging finance spent in each financial year;

- the capital/revenue analysis of same;

- the operational state of the project;

- demands against any unspent balance from project allocation;

- timeframe to complete the project.