Scottish Borders

Integrated Care Fund Project Brief

2015 – 2018

Project Name	Discharge to Assess – Hospital to Home		
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Guidance on Project Brief

The purpose of this form is to give a brief outline on the key aspects of the proposal to the Integrated Care Fund.

1 Outline project description

Please summarise the project in no more than 250 words

This paper provides an update on the progress and impact of the Hospital to Home pilots in Teviot and Berwickshire. This also presents the case for expanding the Hospital to Home service across all five localities.

The care provision in some areas in the Borders has resulted in people delayed to discharge due to waiting for care to be in put in place. A prolonged hospital stay leads to reduction in function in older people which can in consequence lead to an increase in dependency on care provision post discharge.

The two pilot areas have made a significant impact:

- 44 patients in the cohort, saving a minimum of 1,434 occupied bed days (over 10 months), (Average length of stay in a community hospital being 32.6 days.)
- 14 admissions prevented by providing timely intervention in patients' homes saving a minimum of 456 occupied bed days, (Together saving 1,890 obds)
- 40% reduction of care packages for those who have been in the pilot on discharge

This proposal is to expand Hospital to Home across all 5 localities and put an enhanced model in place in the Eildon Locality, therefore targeting all four Community Hospitals and the Medicine for the Elderly wards within BGH.

This is an integrated model led by District Nurses which is transforming care for our older people as they transition home after a period of illness. Without this service in place Borders will remain an outlier by not having an early supported discharge model and demand on in-patient beds will continue to grow, due to the lack of alternatives.

If the parameters of this model are extrapolated across all localities, we anticipate having a significant system level impact. If this proposal is successful, the staff teams be recruited and processes implemented in the same way as the pilot. It would be fair therefore, to base the proposed first year's impact of the expansion on the data collected from the first pilot.

Proposed Costs

The proposal provides expected costs and savings for the first year of expansion and in appendix 2 it provides full costs and expected saving when operating at full capacity for a complete year.

First year of H2H model expansion

- Hospital to Home for four localities linking with the four Community Hospitals = £708,272,
- Central Discharge to Assess, linking with BGH = £276,473

£984,745

Using the data and experience from the pilot, and extrapolating across 12 months rather than 10, and five localities rather than 2, and building to a full staff compliment within three months, we would expect;

- To save a minimum of 5,670 occupied beds days annually, (equivalent to closing 16 beds.)
- At an average cost of £131 for a bed for a patient over the age of 65 this could release £742,770 in the first year of operation

This not only leads to improved outcomes for older people, but will also reduce occupied bed days in the over 65 age group, leading to increased capacity in our in-patient facilities.

In addition to bed saving, we have experienced a 40% reduction in the level of care packages from the pilot. If we assume an hourly rate of care as £22/hr and extrapolate these figures over five localities for a full initial year, costs avoided would be for 132 patients per year, with collectively 48,180 care hours per year, costing in total £1,059,960.

The 40% reduction would then equate to £423,984.

Savings Summary

Occupied bed day saving	= £ 742,770
Care costs avoided	= £ 423,984
Total	= £1,366,754
Programme Cost	= £ 984,745
Final Saving	= £ 382,009 within the first year

Operating at full capacity for a full year, the programme expects to make a potential saving of £2,640,960 in reducing OBDs by 20,160, equivalent to closing 56 beds. The impact on reducing demand on care packages by 40% for 720 patients in a full year, would equate to £2,312,640.

£984,745 is the full programme cost so the potential overall saving/costs avoided would be £3,968,855

(Appendix 2. gives the rationale for these potential savings from the model operating at full capacity for a full year.)

2	**Project's strategic fit** (see guidance notes section 2) *Which Strategic objectives will it meet?*

IJB Strategic Plan Objectives

Improve the health of the population and reduce the number of hospital admission
The trial in Berwickshire and Hawick has already proven the ability of this work to cater for patients who normally would have been admitted to hospital. This is also been evidenced within East and Mid Lothian.

Improve the flow of patients into, through and out of hospital
The work targets patients who are already delayed within the Community Hospitals, the addition of AHP support within the Eildon Locality will target patients delayed within the DME wards within the Borders General Hospital.

Improve the capacity for people to better manage their own conditions and support those who care for them
The rehabilitation nature of the work reduces the need for continued care by approximately 40%, enabling people to better look after themselves, and consequently better enables family and carers to cope better with individuals needing support, keeping them healthier and less likely to need re-admission.

3	**ICF Conditions** *Please give a description of how the project meets each condition for ICF?*
1.	Investment of the resource must be in line with the strategic commissioning plan and weight given within that to the key priority areas of reducing delayed discharges and unscheduled admissions

The pilot teams have primarily focused on the discharge of patients waiting for care packages in Hawick Community Hospital and the Knoll. There are no delayed discharges now in either of these hospitals for people waiting for care packages. This is reviewed regularly by the MDTs to ensure people who meet the criteria of the pilot teams are discharged when clinically ready.

In the 10 months (6 months in Berwickshire, 4 months in Teviot) of the pilot teams 44 people have been discharged who would have continued to wait in hospital for packages of care, saving 1434 bed days. The teams have also prevented unscheduled admission of 14 people, saving at least 456 bed days. Of these people, none of them were re-admitted to hospital within 28 days.

It is anticipated, if H2H is rolled out across all localities it will save a minimum of 5,670 occupied bed days, in its first year of operation. This will rise significantly over a further year, operating at full capacity the expected reduction of OBDs is 20,160.

Data shows that the average re-admission rate from Community Hospitals is 11.2%. The re-admission rate of people who have been in the service is at a lower rate of 7%.

Over a longer period of time the outcomes of these patients will be able to be compared to the longer term outcomes of other patient groups to better understand long term benefits.

2.	Projects must have a positive measurable impact on delayed discharge numbers and occupied bed days

This work will target patients who, currently we would expect to be delayed, waiting for further support to allow them to go home from hospital. There will therefore be a direct impact on the rate of delays. At full capacity we expect the programme to take 60 people out of hospital every month.

3.	Projects must deliver change which result in reduced costs

See response to question 1 for the first year savings based on the start-up costs and savings of the pilot and appendix 2 for the full year costs and saving when operating at full capacity.

4.	Projects must be evidenced based

The Borders is an outlier in the provision of this type of service. All other Health and Social Care Partnership areas have similar models that support early discharge. There is a shared evidence base that using this re-ablement approach on discharge, improves outcomes for this patient cohort. In addition, we now have an evidence base from the pilot work from which we have drawn our predictions for this proposal.

5.	Funding for each project will be non-recurring and each project must have a clear exit strategy

The improved outcomes for individuals have already been proven both in the Borders and elsewhere. The financial savings are also evident here and across a range of Health and Social Care Partnerships, for both the NHS and to Council Services. The ICF will offer pump priming however this invest to save programme can accrue sufficient savings to mainstream the programme and continue reduce overall costs.

4 Project Aims/ Achievements

Please give a high level description of what will success look like?

The investment will enable Scottish Borders:

1. To deliver a Borders-wide Hospital to Home service with enhanced AHP support in the Eildon locality.
2. To promote a reduction in dependence on care provision by optimising function of older people post discharge
3. To deliver a redesigned pathway of care that promotes timely discharge of older people in our hospital settings
4. Improve patient flow into and out of hospital, by having robust community support in place.

5 Project outcomes and benefits (see guidance notes section 3)

Please be specific about project benefits and outcomes – outcomes should be measurable

The benefits of this model include:

- Personalised re-ablement approach with the aim to maximise the early rehabilitation potential of the person during the early weeks post discharge
- Increasing the capacity of care provision by reducing the care needs of this cohort by 40%
- Increased engagement with community based services in each locality
- It supports individuals to develop their confidence and skills to enable them to continue to live at home.
- There will be a reduction in attendances / admissions to hospital
- Support early discharge from hospital

Qualitative Impact – During the pilot phase, feedback has been sought and offered from service users, staff and other professionals.

"Over the past few weeks the input from your team has been invaluable in preventing admission, and improving his mobility, confidence and self care, including recognising problems with medication compliance and helping him to get into a better routine." – GP, Newcastleton

"Since the new health care support workers started to go in, it's like seeing a different man " – HCSW, Newcastleton

"I have found each HCSW in Hawick to be very enthusiastic and keen to be hands on/help. On the evening service we are lone workers and have found to have the HCSW working with us very beneficial". – Evening Nurse, Hawick

"The caring team who visited during the 'Hospital to Home' period were very patient focused and attentive. Thank you very much for the excellent service." – Service User Berwickshire

6	**What areas of the Borders will the project cover** *Will the project affect the whole of the Borders or a specific locality, if so please state?*

H2H will be delivered across all five Borders localities within the costs identified

7	**Which care groups will the project affect?** (see guidance notes section 4)

This will focus on early supported discharge of older people to promote independence and optimise function on discharge home.
It will also provide support to prevent admissions of older people.

8	**Estimated duration of project** *Please provide high level milestones and including planning and evaluation time*

The project will be delivered over a 12 month period to further develop and embed robust pathways of care from hospital to home for older people. It is anticipated that this work will be mainstreamed in 19/20.

9	**How much funding would the project need and how would it be spent?** (see guidance notes section 5) *Please break down into individual costs*

In order to further develop and embed a Hospital to Home model across the five localities funding of £984,745 (see appendix 2).

10	**What would happen if ICF didn't invest in the project?**

- Continued rise in delayed discharges due to waits for packages of care
- Increase of inappropriate use of inpatient capacity for people who are clinically ready for discharge
- Growing pressure on in-patient flow to be able to accommodate the demand for admission
- Complex systems of care would remain for older people with few options other than continued in-patient care
- Financial and workforce pressures would remain
- The level of admissions & re-admissions would increase
- The cost of creating surge capacity for in-patient care will continue to grow

11	**How would the project release resources in order to sustain the project?** *What services would longer be provided or would be provided in different ways*

Two areas of savings are provided for within this work.

1. Reducing the need for hospital beds.

   Operating at full capacity, over all localities, the work will release 20,160 occupied bed days. If we assume that we do not need a bed for 365 days we therefore will no longer need that bed. This work has the potential of releasing 56 beds. Ward 12 and 14 together have 59 beds, our Community Hospitals each have 23 beds.

   The calculations on the cost of bed days used in this application are based on minimum costs of nursing and care, £131 per bed day. The NHS costings for bed days, including all costs, is £744. This cost could only be realised if all the beds in a single ward were closed. This proposal will give the ability for NHS Borders to rationalise its bed base.

   This saving would complement the costs of this programme several times over.

2. Reducing demand on home care services

   There is a rising demographic of the over 65yrs in our population, we know the demand for care services will be increasing, we expect to pay more every year to keep up with this pressure unless we can slow the demand.

   We need to help people stay well enough to live their lives for longer without the need for care. Through the re-ablement aspect of this work we have already seen an impressive 40% reduction from the intended packages of care to those required at the end of the four week programme.

   On this area alone the work returns more than 100% of its costs as a saving.

12	**How would you identify/ recruit staff to support the project?**

Local / external advertisement and a discussion and internal secondments. Close work with Borders College, offering an access route to a career within the Health or Social Care Professions.

13	**Would the project require dedicated project support from the programme team** (see guidance notes section 6)

Project support would continue to be provided by the Better Borders (NHSB) and Scottish Borders transformational change teams.

Please return this form to the Programme Team
Email: IntegratedCareFund@scotborders.gov.uk
Phone: 01835 82 5080

Appendix 1:

Costs

To operate the Hospital to Home Service via the four Locality Hospitals

Four Localities Hospitals to Home Annual Resource Cost		
Role	**Staffing Level**	**Total**
Band 2 HCSW	20	£456,000.00
Travel	20	£120,000.00
Band 5 Co-ordinator	4	£132,272.00
TOTAL		**£708,272.00**

To operate the Hospital to Home Service via the General Hospital – Central Model

Central Locality Hospital to Home Annual Resource Cost		
Role	**Staffing Level**	**Total**
Band 2 HCSW	5	£114,000.00
Travel	5	£30,000.00
Band 7 Co-ordinator	1	£46,473.00
Band 6 OT	1.2	£40,000.00
OT Travel	1	£3,000.00
Band 6 Physio	1.2	£40,000.00
Physio Travel	1	£3,000.00
TOTAL		**£276,473.00**

Appendix 2

Savings for a full year operating at full capacity

Occupied Bed Days Savings for a full year assuming full capacity

5 staff working with 12 patients for 4 weeks in each locality

5 localities therefore 60 patients every 4 weeks = 720 in a year

Targeting both Community Hospitals and DME wards within the BGH
Community Hospitals average length of stay = 32.6 days, DME average length of stay = 19.6days.
Assuming therefore, a fair average between the two as 28 days, average length of stay.
Total bed days saved in the year therefore;

720*28 = 20,160 OBDs

Cost of a Community Hospital Bed is £137/day a DME Bed £125/day, taking the mid point as £131/day, and operating at full capacity for the year the potential saving is;

£131 * 20,160 OBDs = £2,640,960

Savings due to the reduction in packages of care for a full year at full capacity

Number of Patients in a year = 720

Assuming 3 visits a day of 20minute duration, so each patient receives 7hours per week. Cost of an hour of care through SBCares is £22/hour.

Full anticipated costs for home care without H2H re-ablement = 720*£22*365 = £5,781,600

H2H operating at full capacity expect to reduce packages by 40% as experienced through the pilot. Maximum saving would therefore be;

40% of £5,781,600 = £2,312,640

Hospital to Home Programme for full year Costs

5 Localities = £708,272
Additional support in Eildon Locality for BGH DME discharges = £276,473

Total = £984,745

Final savings

OBDs	= £2,640,960
Home Care Hours	= £2,312,640
Combined saving	= £4,953,600
Programme Cost	= £ - 984,745
Saving	= £3,968,855

Appendix 3: Central Process