



Supported Discharge across Scottish Borders
A review Summary of 5 Projects Supported by ICF Funding Vers 2

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Identified Project Savings:

STRATA:

NHS savings = £334,050 pa

Social Services = £22,350

Total: £356,400

Annual Savings against cost = £356,400 - £115,000= £241,400*

*excludes the £70,000 one off cost for integration and testing.

Garden View:

Annual potential savings, running at 11 bed capacity estimated at:

Total Savings (NHS) £525,965

Annual Savings against cost = £525,965 - £811,200 = -£285,235

However, Garden View could generate a net saving at higher occupancy levels:

Maximum Capacity	15 beds			
Annual Cost	£811,200			
BGH OBD Cost	£131			
Ave. No. Beds occupied	10	11	12	15
Occupancy %	67%	73%	80%	100%
OBD Saved	3,650	4,015	4,380	5,475
Effect bed cost/day	£222	£202	£185	£148
Cost Saving	£478,150	£525,965	£573,780	£717,225
Benefit	-£333,050	-£285,235	-£237,420	-£93,975

Waverley:

Total Savings (NHS) £210,729 (9 beds)

Annual Savings against cost = £438,064 - £648,793 = - £210,729

Maximum Capacity	16 beds				
Annual Cost	£648,793				
BGH OBD Cost	£131				
Ave. No. Beds occupied	9	10	12	14	16
Occupancy %	56%	63%	75%	88%	100%
OBD Saved	3,344	3,650	4,380	5,110	5,840
Effect bed cost/day	£194	£178	£148	£127	£111
Cost Saving	£438,064	£478,150	£573,780	£669,410	£765,040
Benefit	-£210,729	-£170,643	-£75,013	£20,617	£116,247

As can be seen from the table above, additional savings are possible from Waverley, but this would require very high occupancy levels.

Matching Unit:

NHS: £154,056

Social Care: £27,720

Total savings: £181,776

Annual Savings against cost = £181,776 - £151,000 = £30,776

Hospital to Home:

NHS: £1,124,280

Social Care: £180,000

Total Savings: £1,304,280

Annual Savings against cost = £1,304,280 - £1,092,000 = £213,280

Issues:

- Data received in general has been of poor quality, indicating a lack of compliance across all areas.
- Lack of aggressive targets is reducing the potential level of impact and thus savings realised.
- Inconsistency in approach across the reporting of projects and some double counting, certainly between Matching Unit and Strata.
- Future finances may be insufficient to maintain all of the reported projects, thus realisable savings need to be demonstrated.
- Demographic changes over the next 5-10 years will have a noticeable impact on hospital admissions and occupied bed days, possibly beyond the level of realisable savings that can be achieved.
- Implementation of STRATA has been under resourced, leading to many teething issues and non-compliance.
- Lack of true baseline measurements has made the reporting of benefits difficult (if you do not know where you were, you cannot know where you are going).
- Whilst the various projects have been successful in reducing the number of delayed discharges and occupied bed days in BGH, these are still big issues with the community hospitals.
- Going forward, the biggest impact on OBD could be achieved by greater focus on prevention of admission, particularly in the over 65 age group.

- The target focus of potential beneficiary for each project needs closer scrutiny and adjustments made if maximum savings are to be realised (e.g the overlap between H2H and MU with regards to Palliative and also End of Life Care).

STRATA:

Conclusions:

As experience with STRATA grows it is now possible to demonstrate real time savings in operational performance and better service for the end clients who receive the service request 2-3 days earlier on average.

Whilst there are still compliance issues with some users, new reports and dashboard charts are available to quickly identify non-compliance and take remedial action. The reporting dashboard in Strata IQ has been redesigned to better meet our needs and is now capable of being a valuable management information tool.

Recommendations:

- Better resourcing around implementation to manage compliance issues and ensure the right users have appropriate training.
- Expand the use of STRATA to other users as per proposal being developed elsewhere, in particular Waverley and Garden View to ensure all future referrals into and out of these transitional care homes go via STRATA.
- As found with all the other projects, data quality across all systems is particularly poor and needs to be improved to enable easy and more accurate reporting.

Garden View:

Conclusions:

Thus, whilst Garden View provides a valuable resource and means to remove people from BGH who still need a level of support, it may not be cost effective depending on the cost saving model employed.

Garden View does not impact on Social Care savings, nor has any data to support reduced readmission as a result of care provided which would be a significant cost saving. However, the fact that 12% of the users are admitted to hospital whilst still in Garden View, further analysis could be undertaken going forward as to whether service users discharged home have a reduced readmission rate in a similar way to Hospital to Home. Any effect of Hospital Acquired Infection data has not been considered because with relatively small numbers of users, the data would not be meaningful.

Recommendations:

- Occupancy at Garden View needs to be maintained at near maximum to realise any cost savings.
- Review patient admission data 3/6 months before admission to Garden View and again 3-6 months after Discharge from Garden View to see if there is any additional benefit that could be realised (may only be small due to the limited intervention capability at Garden View).
- Determine if the limited realisable cost benefits justify the ongoing running costs.

Waverley:

Conclusions:

As with Garden View, Waverley provides an invaluable step-down resource, however, the financial benefits that are realisable do not exceed the running costs at current capacity levels. Even at full capacity throughout the year a saving of only 16 beds at BGH would be realised.

The occupancy levels have dropped in the first half of 2019 (but starting to rise again) partly due to the inappropriate referrals and the more intensive needs of some of the more elderly service users.

Improvements need to be made to ensure delays to medications, paperwork or service user equipment that have been encountered from BGH to Waverley, often arriving many hours or sometimes days after the service user, impeding the effective care of the service user.

Recommendations:

- Better use of STRATA for referrals into and out of Waverley would overcome any delays in paperwork.
- The Unit Manager(s) should have more say in which patients are sent to Waverley to ensure appropriate resources are available to provide effective care.
- It could be useful to have representatives of Waverley (and Garden View) involved in any integrated discharge team to provide a 'pull' of patients rather than wait for patients to be 'pushed'. This may improve occupancy and reduce delayed discharges in BGH.
- Consider transferring some patients who have a delayed discharge in one of the Community Hospitals to Waverley as this would improve occupancy in Waverley, reduce delayed discharges in the Community Hospitals (which is a significant issue) and also, may well improve the outcomes and wellbeing for the patient/service users.

Matching Unit:

Conclusions:

The Matching Unit is not only demonstrating success by the criteria set out in the funding proposal, but based on the data provided and evaluated, the financial benefits give a modest ROI.

A big obstacle to the analysis was data quality arising from lack of compliance, mainly within Mosaic. It proved impossible to derive a realistic estimate of time from referral to approval of care plan and also from approved care plan to care package delivery due to poor data quality.

A new reporting and management information dashboard is needed and data quality issues need to be addressed to allow evidence-based decision making to take place.

Recommendations:

- Link with Hospital To Home re Palliative Care and End of Life Care.
- Record Location of patient (Home, BGH, Community Hospital, Care Home etc) at time of assessment/referral to enable better estimation of cost savings.
- Record Mosaic CHI number to enable better tracing of individual service user records.
- Improve data recording / data quality, numerous typos and errors with dates (people born in 2045 for example, misspelling of names and addresses). As most of the data originates in Mosaic, it would be beneficial to create a specific report in Mosaic to avoid retyping the data onto a spreadsheet. This will not only improve accuracy but save time when recording referrals.
- To save costs it would appear that merging the START team and the Matching Unit could realise additional benefits.
- There appears to be overlap between Hospital To Home and Matching Unit regarding Palliative and End of life Care, thus new process pathways need to be developed to eliminate duplication of effort.
- One consideration could be to split out the Hospital Discharge elements and hand over to an 'integrated discharge team' based in BGH and retain the other elements within a more Social care setting.

Hospital to Home:

Hospital to Home, at full capacity, based on current levels supports 15 new service users per week, resulting 71 service users per week in the service. Undeniably the service provided is of great benefit to the service users, however, the current focus of activity does not generate maximum cost savings in its current form.

Where the service is very successful is the prevention of admission / readmission of service users following Hospital To Home service, averaging 9 bed days per year saved per service user, which equates to the ability to close three, six-bed bays in BGH, saving > £1.0M.

The service has had limited effect in generating Social Care savings due to the limited numbers of Service Users where a saving can be demonstrated. It is believed there are potential savings due to cost avoidance for example a service user is able to return home without a care package, whereas without H2H, it is likely that a care package would have been required. However, there is no data available within the current systems that would allow a reliable estimate of what these savings could be.

Recommendations:

- For all H2H patients, review their admission / readmission history 3, or preferable 6, months prior to entry in to H2H care and again 3 /6 months following discharge from

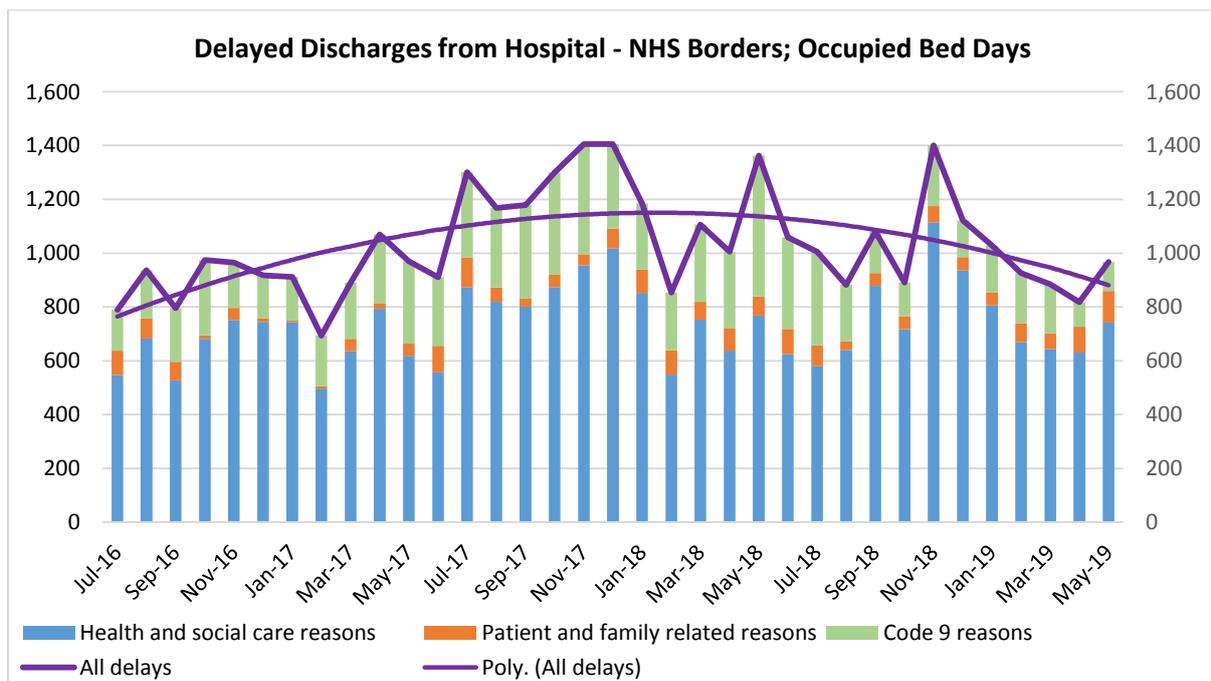
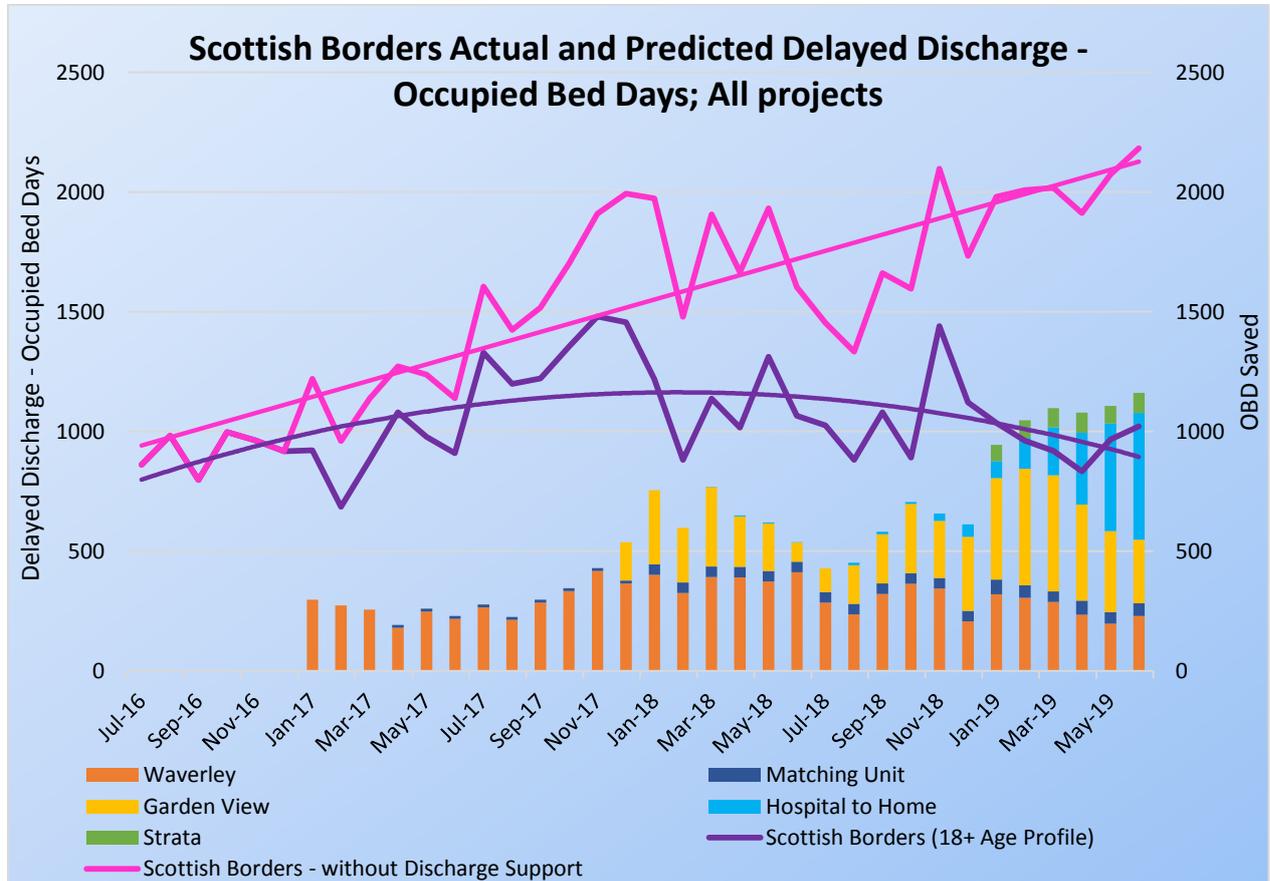
H2H. This will provide better data in which to truly assess a major benefit of the service.

- Realign the focus of the H2H to more address admission prevention than hospital discharge, as this is most likely to have the most beneficial impact on both user health and well-being and also savings generated.
- Hospital delayed discharge, in terms of length of delay is far worse for Community Hospitals than BGH, thus H2H could have a noticeable beneficial effect if it were able to reduce delayed discharges in Community Hospitals, this in turn could ease pressure in BGH due to faster turnaround of patients in the community hospitals.
- Realign project metrics to focus on realisable cost savings such as bed days saved per new user:
 - Prevention / reduction of delayed discharge from hospital (OBD saved)
 - Reduced admission / readmission due to re-ablement
 - Cost savings from reduced Social Care packages for discharged service users
 - Social Care avoidance costs due to independent living capability
- Use STRATA to receive and send any referrals, patient care data etc for consistency with other projects and allow better management information reporting.

Detail:

Scottish Borders/NHS Borders Discharge Analysis

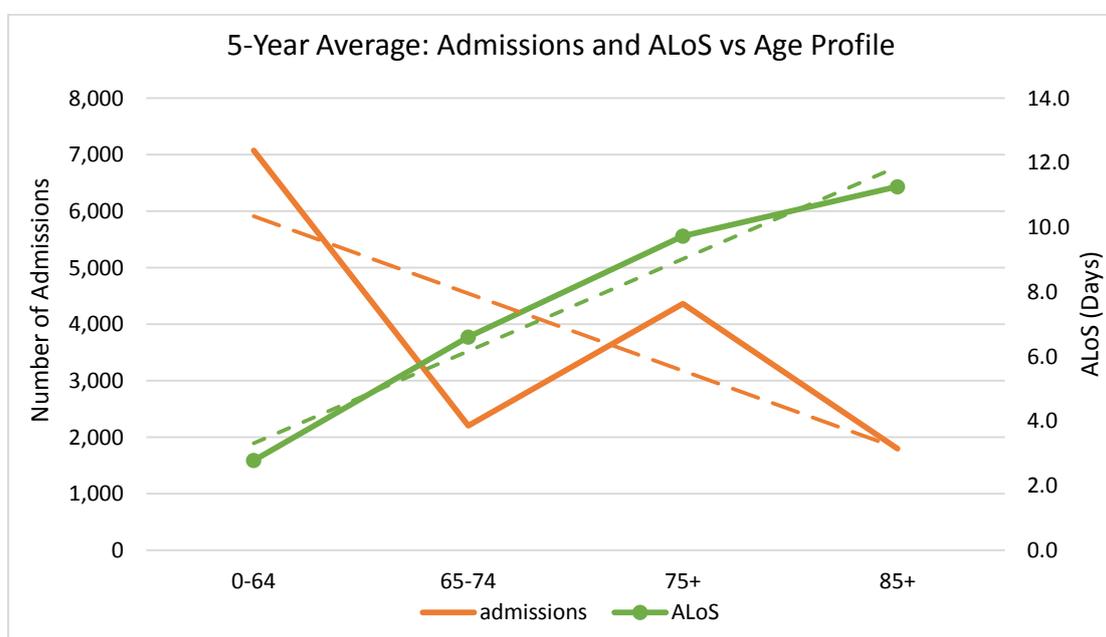
NHS Borders Delayed Discharge Trend



Admissions Data:

Admissions	All Patients	65+	75+	85+
1	6,577	31.7%	20.1%	8.4%
2	1,469	9.5%	6.6%	3.0%
3+	775	5.1%	3.4%	1.4%
Total	8,821	46.2%	30.2%	12.8%

- The 65+ age group account for almost half of all hospital admissions, and a significant number have multiple admissions in any one year.
- Approximately 8.8% of people admitted have 3 or more admissions.
- Approximately 8% of the Scottish Borders population will be admitted to hospital in any one year and as the Borders population demographics change to have a much higher proportion of over 65s, this could be expected to rise to 10-12% within the next 5-10 years. Thus there is unlikely to be sufficient capacity to meet demand in bed space by 2026.



Between 2016 and 2026 the 16-24 age is projected to see the largest percentage decrease (-8.4%) and the 75 and over age group see the largest percentage increase (+33.5%). In terms of size however, the 45-64 age group is projected to remain the largest group, but only just larger than the 65 and over age group.

The 65 and over age group increases by 19% by 2026, but becomes a bigger % of the total population as the under 65 age groups decline (27.8%).

This increase in the >65 age group means an additional 15,000 people, potentially meaning an increase of 55% in hospital admissions for this age group. This equates to an additional ~8,000 OBD based on emergency admission data from ISD, leading to a need for at least 22 additional beds a year. This data is also mirrored by similar data provided by NHS Borders own research into demographic changes and bed demand.