Scottish Borders Health & Social Care Integration Joint Board

Meeting Date: 17 February 2021

Report By:	Phillip Lunts, Strategic Planning Lead, NHS Borders Anne Hendry, Director, Scottish hub of the International Foundation for Integrated Care
Contact:	Phillip Lunts, Strategic Planning Lead, NHS Borders
Telephone:	07747 763963 phillip.lunts@borders.scot.nhs.uk
FORMATIVE EVALAUTION OF THE DISCHARGE PROGRAMME	
Purpose of Report:	To present the findings and recommendations of the Evaluation of the Discharge Programme.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the findings of the Discharge Programme Evaluation b) **Consider** the recommendations c) **Advise** on further actions
Personnel:	None (actions arising from recommendations may have staffing implications)
Carers:	None (actions arising from recommendations may have carer implications)
Equalities:	Equity of access and service provision is considered within evaluation
Financial:	None (actions arising from recommendations may have financial implications)
Legal:	None.
Risk Implications:	Not relevant.

Situation

This is an evaluation of the Scottish Borders Health and Social Care Partnership Discharge Programme.

Background

The Discharge Programme consists of 5 projects initiated individually over 4 years from 2017 and brought together as a single programme in 2019.

The projects within the Discharge Programme effectively provide an intermediate care (IC) service for the Scottish Borders: bed-based intermediate care (Waverley and Garden View), home-based intermediate care (Home First) and infrastructure for enabling rapid and seamless access (Strata and Matching Unit).

Assessment

This evaluation has found the following;

Waverley Transitional Care Unit delivers against its objectives of rehabilitating older people to regain independence following hospital discharge. Time to access service averages 1.8 days. Home discharge rates are 79%. However, the service runs at 70% occupancy and does not admit older people with higher levels of need due to restrictions on length of stay and lack of nurse cover. This is an issue for residents of Central Borders, most likely to benefit due to lack of a community hospital in the locality.

Garden View Discharge to Assess offers a facility for older people to leave hospital whilst completing assessment for care or waiting for home care or 24-hour care. Time to access the service averages 3.6 days. Average length of stay and home discharge rates are comparable to benchmarks. Occupancy is 66%. The service does not offer full reablement due to lack of AHP cover and is unable to admit people with higher levels of dependency.

Both services have positive user feedback. Costs are higher than benchmark but would be comparable if occupancy was higher. Neither service offers step-up access from home.

Home First offers a home-based reablement service. 25% of people who use the service are step-up referrals to remain at home and 75% are referrals at discharge from hospital. Time to access the service averages 1 day. The service meets its objective of 80% remaining at home at the end of their Home First episode, with a 57% reduction in their requirement for home care (against 40% target). 57% are fully independent at the end of their Home First episode while those who need ongoing home care have 11% reduction in the level of care required. The high rate of discharge with no ongoing care suggests that people with more chronic care and support needs may not have been referred to the service.

Infrastructure. The Matching Unit has been mainstreamed into SBCares and arranges 180 care packages a month, a 10% increase since 2019, with average time to start of package of 5 days. Strata digital referral system is managing 800 referrals per month to care homes, intermediate care, third sector and Trusted Assessor, with Strata referrals to homecare soon to be launched.

This evaluation concludes that these services make a critical contribution to system performance but their efficiency could be improved by some adjustment of criteria and skill mix.

Recommendations

The evaluation therefore recommends:

- Home First should be the default and should better align with What Matters locality hubs and services to increase the balance of step up IC and enable closer working with local Housing providers and Third sector support

- Bed based IC should be streamlined as a single pathway for older people with post-acute reablement / rehab / nursing care needs that cannot be met by Home First, particularly for residents in Central Borders

- The service budget for these projects should now be mainstreamed to enable strategic commissioning, substantive recruitment and workforce development as part of a comprehensive framework for integrated intermediate care in each locality.

- This will need to be maintained within the existing Transformation Fund limit of £2.2M, and will be included within the overall budget for IJB delegated services, to be agreed for 2021 to 2022. A further report will be provided for the IJB within the first quarter of the year, setting out recommendations for the way in which these budgets will be mainstreamed. Any resource implications arising from changes to staff contracts as a result of this proposal will be addressed through review of IJB budget as required.

Critical to delivering these actions is the need to mainstream the operation and finding of these services to allow the strategic developments outlined in the recommendations.