Formative Evaluation

Scottish Borders Discharge Programme

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Exec Summary

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

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.
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

Critical to delivering these actions is the need to mainstream the operation and funding of these services in order to progress the strategic developments outlined in the recommendations.

1. Background

We know that too many older people remain in hospital when they could be cared for more appropriately and achieve better outcomes in a more enabling setting. The Discharge Programme brings together five distinct projects commissioned and funded through the Integrated Care Fund to help address this continuing challenge.

Three projects increased local capacity for specific components of Intermediate Care:

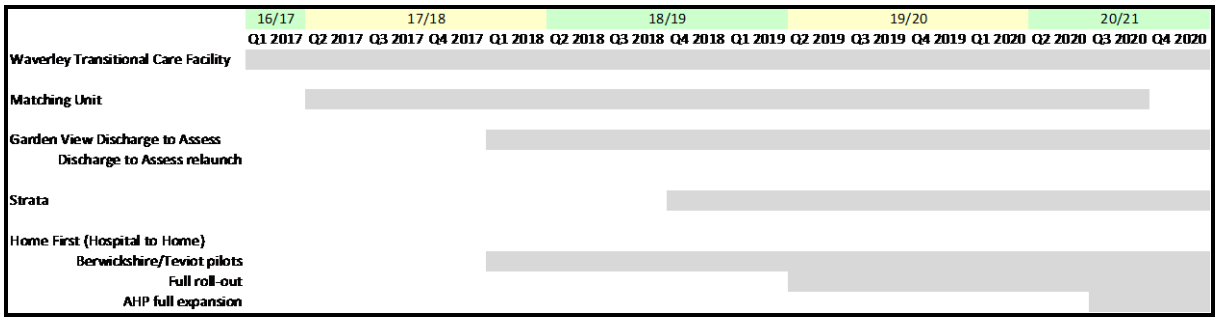
- Bed based Intermediate care in Waverley Transitional Care beds
- Step-down care in Garden View Discharge to Assess facility
- Reablement and crisis response at home in Hospital to Home, now known as Home First

Two projects provided enabling infrastructure to improve discharge processes and flow:

- The Matching Unit for effective allocation of home care support
- Strata electronic referral management system

These projects were established independently at different times since 2017 (figure 1). In recognition that there are significant interdependencies between the projects, they were brought together as a Discharge Programme in 2019, however potential synergies have yet to be fully realised. Further developments in the enabling infrastructure are expected to improve flow through a digitally enabled referral management system supported by an integrated discharge hub, a trusted assessment model and more efficient allocation by the Matching Unit and locality hubs.

Fig 1. Timeline for the 5 projects



This report reviews the progress of the projects to date and considers their individual and collective contribution to the strategic objectives set out in the Scottish Borders Health and Social Care Strategic Plan 2018-2021. It reflects on their limitations and identifies potential to enhance their effectiveness by adjusting the capacity, skill mix and alignment of services to further expand their reach and impact.

An important caveat is the lack of a common dataset for the projects which has limited the ability to compare data on case mix, experience and outcomes. Therefore, routinely collected health and social data have been used, where available, to review the progress of the projects. Although this is an internal evaluation conducted by NHS Borders, the analyses and conclusions have been critically appraised by Prof Anne Hendry, Director of the Scottish hub of the International Foundation for Integrated Care, to provide objectivity and insights from UK and international evidence and current practice in this field.

2. Why These Projects Matter

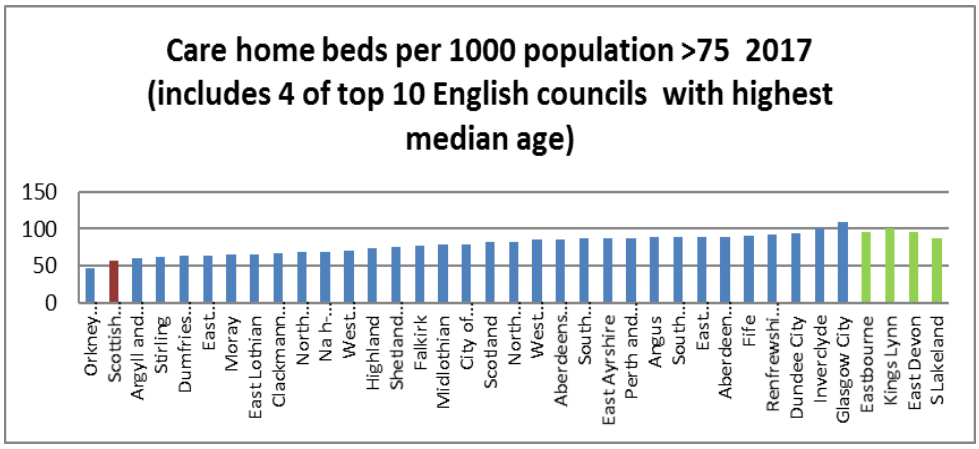
24% of the Scottish Borders population are age 65+, well above the Scottish average of 19% (2019 mid-year population estimates). Projections indicate the population aged 75+ will almost double by 2041 (Table 1). As they age, older people are more likely to live with frailty or long term conditions, associated with increased demand for acute and chronic care, rehabilitation and support.

Table 1 Population projections for Scottish Borders

Year	Age Grouping					Tot Pop
	<18	18-64	65-74	75-84	>85	
2016	21,507	65,780	15,451	8,633	3,159	114,530
2041	21,373	57,700	17,022	14,886	6,337	117,318
% change	-1%	-12%	10%	72%	101%	2%

Scottish Borders has a relatively high number of hospital beds (per 1,000 population) compared to other Scottish Health Boards. Figure 2 shows that the care home capacity is well below the national average, with only Orkney having a lower rate. This leads to delays in accessing long term care from the community and from hospital.

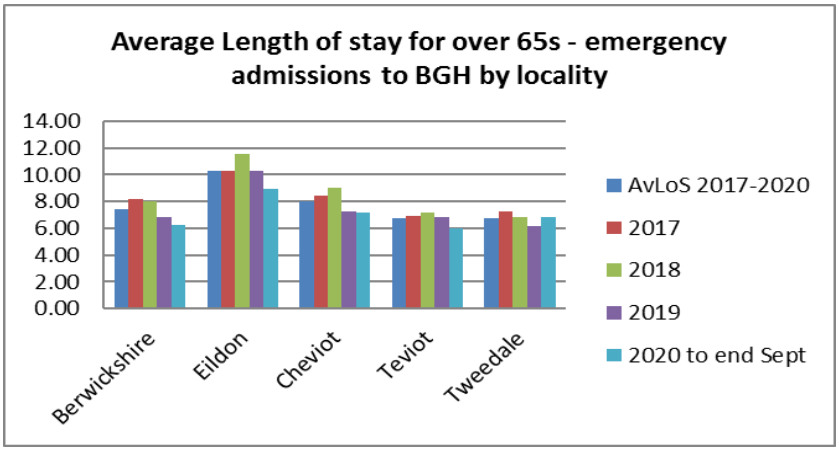
Fig 2. Care home provision by HSCP



Remaining in hospital longer than is necessary increases the risk of harms, particularly for older people who are already at greater risk from deconditioning, falls and hospital acquired infections. Achieving the best outcomes for older people and their carers requires timely discharge and support to recover in an enabling environment in order to regain independence. Delays in discharge following acute care serve to escalate dependency and further increase demand for long term support. This is the rationale for strategic investment in **intermediate care (1) :** a continuum of time limited integrated community services for assessment, treatment, rehabilitation and support for older people and adults with long term conditions at times of transition in their health and support needs.

Scottish Borders already has a bed based intermediate care capacity of 92 Community Hospital beds before commissioning of additional beds at Garden View and Waverley facilities. For a population of 115,510, the community hospital complement alone represents almost four times the average bed based intermediate care capacity reported in the 2018 National Audit of Intermediate Care in England **(2).** However, around a third of the Scottish Borders population live in Central Borders (Eildon locality) which lacks a community hospital. Central Borders residents have traditionally remained in the Borders General Hospital (BGH) for their post-acute care and rehabilitation. This results in a longer Length of Stay (LOS) at BGH for older people from the Eildon locality (Figure 3).

Fig. 3 Average LOS at BGH for over 65s by Locality



The continuing need for physical distancing and strict infection prevention processes in response to Coronavirus will impact on hospital capacity and configuration in the short to medium term. In their recent letter to Chief Executives **(3),** the Scottish Government restated the prime importance of actions to ensure people who are clinically ready for discharge experience minimum delay before being cared for in their own homes or other appropriate settings. The discharge projects were designed to augment intermediate care capacity, particularly but not exclusively for Central Borders, by introducing alternative pathways for supported discharge, reablement and crisis support at home or in community facilities.

But the context in which the five projects were implemented has radically changed. Coronavirus has heightened the need for rehabilitation and recovery for those affected by Covid-19 and by the response to the pandemic. Now more than ever we need dynamic and flexible community support and services that work with people and local communities. Therefore this review is a timely opportunity to reflect on what we have learned from the Discharge Programme and to consider the evidence and experience of reablement and intermediate care beyond our system in order to make the best use of our collective assets, skills and facilities.

The recently published report of the Independent Review of Adult Care in Scotland **(4),** recommends investment in models and approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. In the words of the independent review, this is a time to be bold and ambitious for the future.

3. What Works

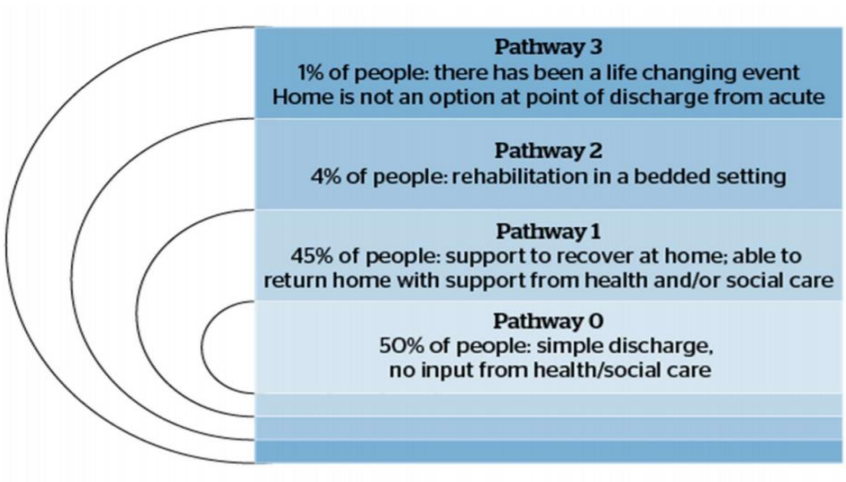
An international consensus study **(5)** agreed that Transitional care services are a subset of a broader continuum of **Intermediate Care**: a range of time-limited services that aim to ensure continuity and quality of care; promote recovery; restore independence and confidence; or prevent a decline in functional ability at the interface between hospital and home, care home, primary care and community services. The approach is based on holistic and person-centred care, the involvement of family and unpaid carers, support for self-management, and use of equipment and simple assistive living technologies to enable independence.

A scoping review of the evidence on Intermediate Care reports a range of positive outcomes **(6)**. Although several interventions reduced hospital utilisation and improved quality of life, impact on function, ED admissions, long-term care and costs critically depends on targeting the right cohort. NICE Guidance from 2017 **(7)** indicates these services particularly benefit people who have complex support needs or circumstances, are vulnerable to a decline in health status or functional ability or are at increased risk of (re)admissions to hospital or institutionalisation.

Services that offer reablement and rehabilitation at home demonstrate improvements in function and a reduction in the need for ongoing support **(8-10**). Therefore a Home First approach promotes Intermediate Care at home where safe and appropriate. However some people, particularly those who are most dependent, live alone or need alternative housing or major adaptations, may benefit from a period of bed based Intermediate Care to provide critical time and the right environment to restore their confidence and independence, and avoid premature long term care. Bed based Intermediate Care can be provided in dedicated capacity within a care home, housing with care, or community hospital setting. This may be as ***step up*** **(**admitted from home for assessment and rehabilitation) or ***step down*** (transfer from hospital).

These concepts are illustrated within the four **Discharge Pathways** developed by Prof John Bolton **(11)** and now widely adopted in the UK.

Fig 4. Discharge Pathways

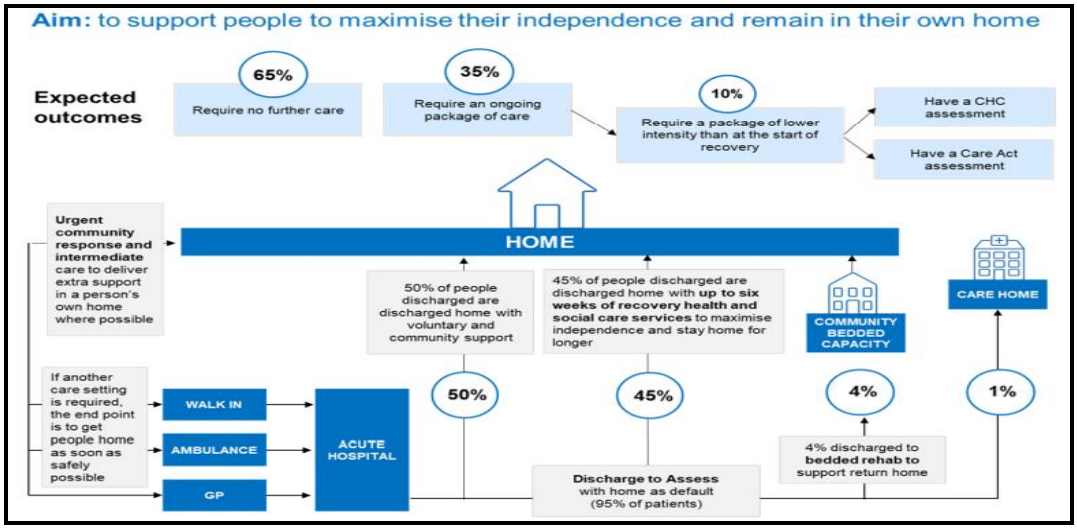


Pathways 1 and 2 are sometimes described as Discharge to Assess (D2A). The Local Government Association (LGA) and Association of Directors of Adult Social Care (ADASS) recommend that the

terms Discharge to Assess (D2A) should be rebranded as '**discharge to support recovery and then assess**' **(12).** They highlight that premature decision making may adversely impact on the balance of care if individuals are not given an opportunity to recover their independence in the right environment. Very few patients should be discharged from acute hospital to permanent residential care without an opportunity for short-term recovery through reablement at home or in bed – based intermediate care. Expert guidance and experience from the National Audit of Intermediate Care **(2)** suggests over **70%** of older people who received bed based intermediate care are able to return to their own homes within 6-8 weeks. As many as **65%** of those receiving reablement based domiciliary care may require no further on-going care and support within 6-8 weeks **(11)**.

Intermediate care is best delivered by an interdisciplinary team with a single point of contact to optimise service access, communication and coordination of care. Services should have sufficient capacity, expertise, clear governance arrangements, and support for team members to work collaboratively and to improve service quality and outcomes for people and care systems. However many intermediate care services have evolved from pilot projects established with time limited funding, often poorly integrated with other services. This makes the landscape increasingly complex to navigate resulting in duplication, inefficiencies and gaps. Effective intermediate care should be an integral part of the wider network of health and community care available in a locality. These principles are now embedded within NHS England's Hospital Discharge Service: Policy and Operating Model **(13)** as illustrated in figure 5.

Fig 5. Discharge Flow



Consolidation and further investment in intermediate care services is a key priority in NHS England's Long Term Plan through the Urgent Community Response element of the Ageing Well programme (14). This aims to achieve 2 hour standards for a crisis response at home and a 2 day standard for transitional care or supported discharge from hospital. Seven accelerator sites are creating the right capacity and infrastructure to optimise their reablement and intermediate care services. The Journal of Integrated Care will publish a special issue of case studies and research on this topic in 2021: https://www.emeraldgrouppublishing.com/journal/jica/intermediate-care-integrated-local-and-personal

4. Review of the Five Projects

4.1 Waverley Transitional Care Unit

16 designated beds within a 26 bed local authority residential care home in Galashiels were commissioned in 2017 to provide up to six weeks of transitional care for adults considered to have rehabilitation needs. The service is managed by SBC and includes support from:

- Care workers: 17 wte
- Occupational Therapy: 2 posts (1 x 18.75 hours per week and 1 x 18hrs)
- Physiotherapist: 30 Hours per week Mon – Thursday 8.30-4.30pm.

Aims

- Facilitate timely discharge from hospital for patients requiring further bed based rehabilitation to enable them to return home
- Remove the requirement to remain in an acute hospital when medically fit to transfer to a community facility, particularly but not exclusively for residents of Central Borders
- Provide rehabilitation support to enable clients to fully achieve their functional potential
- Reduce the demand for long term 24-hour care placements
- Improve staff satisfaction with the management of patients with rehabilitation needs

Referrals

Figure 6 shows source of referrals. All admissions were step down referrals from Borders General Hospital, principally from medical wards. Referrals from MAU are likely to reflect proactive input from the frailty at the front door team. There were few referrals from medicine for the elderly, orthopaedic or stroke wards. Referral to transfer time averaged 1.8 days.

Fig.6 Referral sources

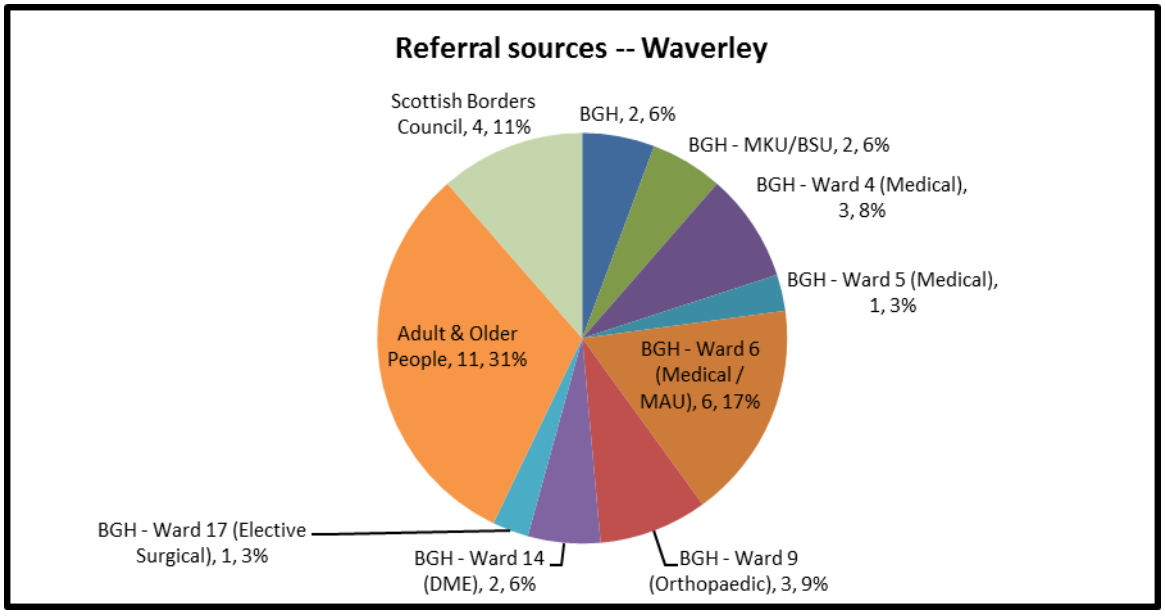
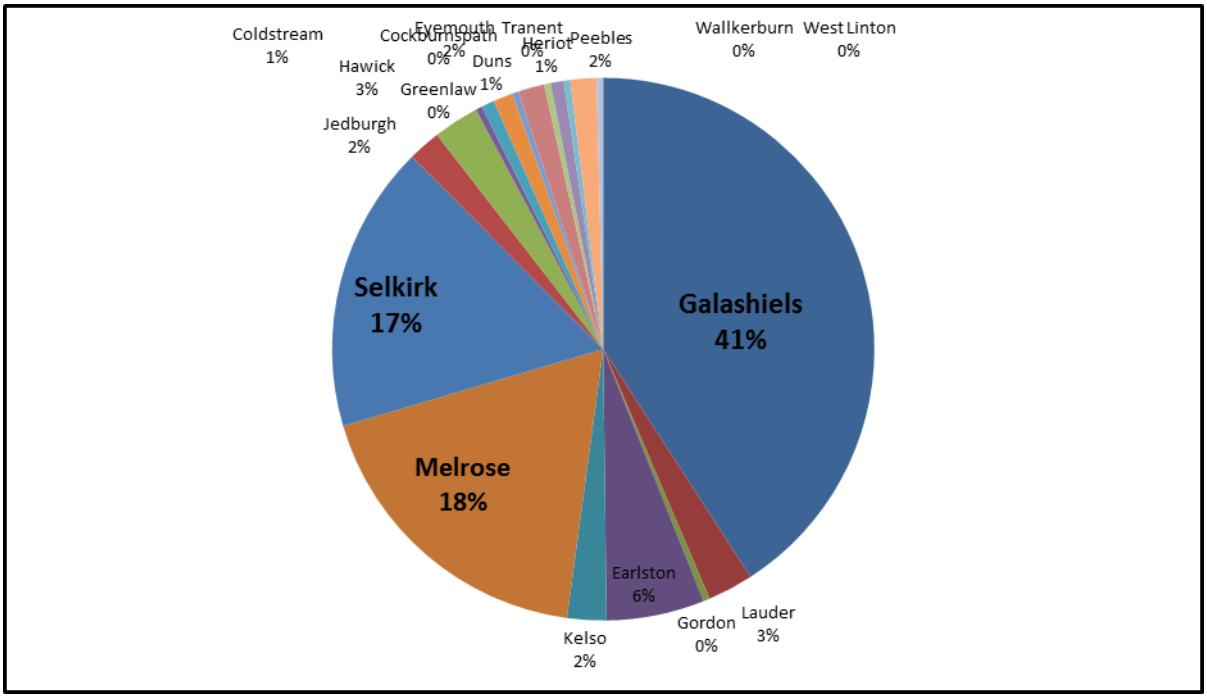


Figure 7 shows 85% of admissions to Waverley lived in Central Borders.

Fig 7. Place of residence of admissions



Casemix

71% of admissions were female. Average age was 84 years (range 51 – 105) with 3% < 65 years. The facility has no registered nursing staff and admission criteria state referrals should have ''no on-going nursing care needs except those ordinarily met by a District Nurse team. '' They should be ''able to mobilise with assistance from equipment and/or a maximum of two staff.'' Therefore the casemix is not comparable to community hospitals as admissions have only mild to moderate dependency:

- 94% had mobility issues or used a mobility aid
- 70% required help for washing and showering
- 35% were incontinent of urine or faeces
- 33% had visual impairment
- 20% had cognitive impairment
- 8% had another mental health illness

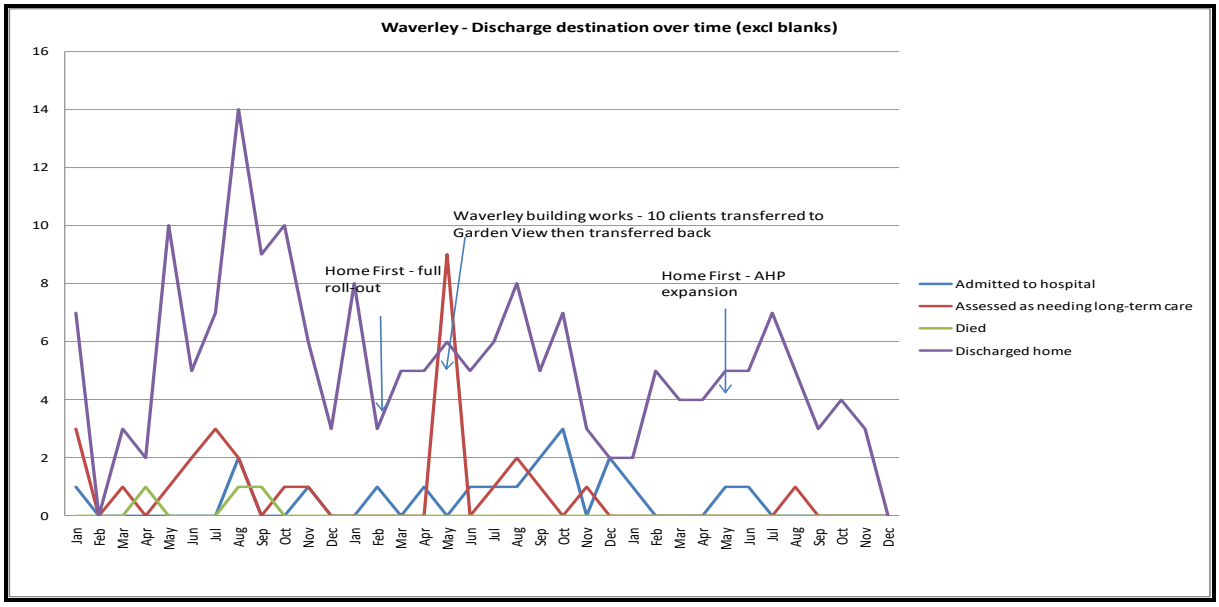
The low levels of cognitive impairment suggests a presumption that those with cognitive impairment have limited potential for rehabilitation, explicit in the admission criteria ''able to understand and be motivated to engage with their rehabilitation plan'' and ''Must be able to engage in a prescribed Programme of Rehabilitation.'' However, this is not an exact science and a significant proportion of people with dementia or recovering from an episode of delirium may be missing a vital opportunity for step down rehabilitation in a more enabling environment. Similarly, the admission criteria ''Able to achieve identified rehabilitation goals within 6 weeks'' may limit inclusion of such patients as well as some older people with neurological disability who may require a longer period of recovery and specialist supervision of therapists who may not

have neurorehabilitation expertise. This criteria may reflect financial rather than functional considerations as charges may apply beyond six weeks.

Outcomes

Overall, 79% of people admitted to the transitional care unit were discharged home. Figure 8 shows numbers being discharged home per month have reduced over time suggesting referrals with lower dependency requiring short term reablement are now more appropriately directed to Home First.

Fig. 8 Trends in discharge destination



Records show few adverse incidents (34 recorded Jan – Dec 2020) and only three deaths. The rate of readmissions to hospital was 6%, comparing favourably with 28 day readmission rates for discharges from BGH (10% for all wards and 19% from geriatric medical wards).

Experience of care

No routine survey of services users experience was available.

The unit has received 22 written compliments and no formal complaints in the past year.

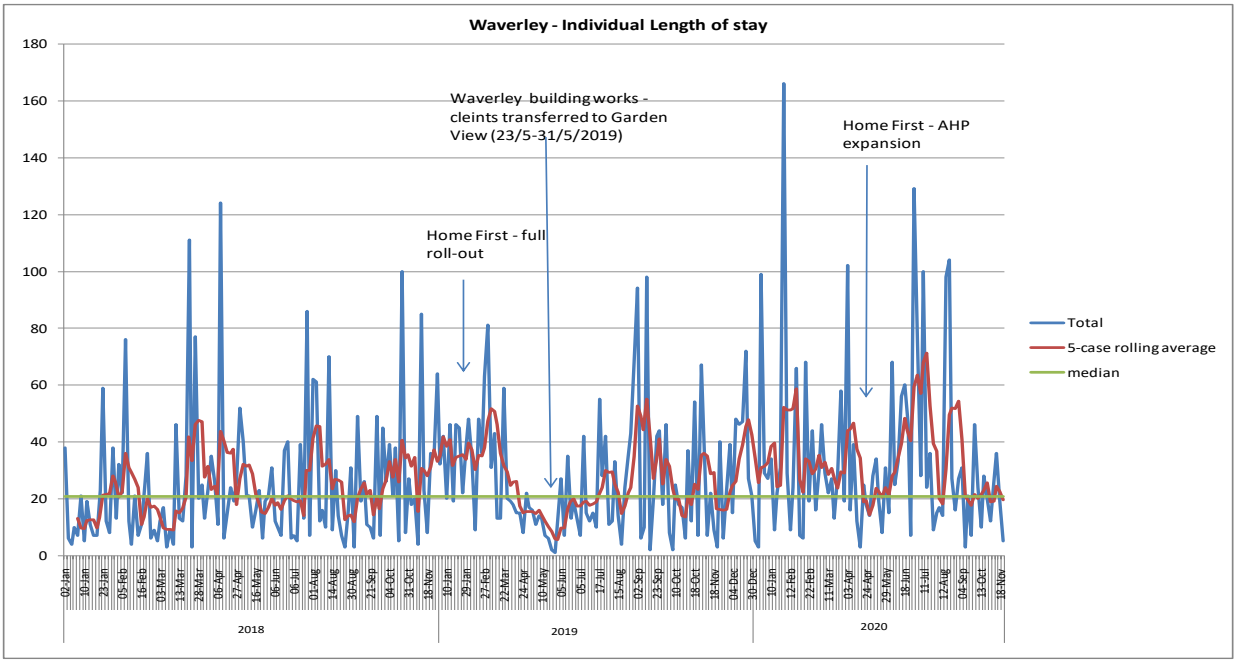
In the latest inspection report by the Care Inspectorate (October 2019), the four residents surveyed felt safe, accepted, treated kindly and satisfied with their care. The six relatives interviewed felt Waverley staff were fair, kind and treated their relatives with dignity. They suggested there could be more activities and more time to communicate any changes in condition or medications.

Throughput

Anticipated throughput per annum was 132 assuming an average LOS of 42 days and 95% occupancy for the 16 beds. The unit achieved an average annual throughput of 124 and a median 10 admissions per month.

Figure 9 shows the LOS for each admission over time. Overall, average LOS was 31 days (median 26 days, range 1-129 days). Average LOS for those discharged to home was 34 days, although a small number of people requiring rehousing or adaptations before discharge home stayed considerably longer. Average LOS was 36 days for those assessed as requiring long term care, reflecting current challenges in accessing care home placements. A small but discernible increase in the 5 case rolling average LOS over time reflects a shift in casemix following the roll out and extension of Home First offering an alternative pathway for short term reablement support at home.

Fig. 9 Individual LOS



Cost per case

Cost per case for 2020/21 budget and projected activity: £6,152. This compares to a benchmark average cost from National Audit of Integrated Care (2018 data) of £5,486 for bed-based intermediate care. If Waverley operated at 90% capacity at current average length of stay, cost per case would be £4,631

Summary of outcomes

Table 2 summarises performance for the project outcomes detailed in the Integrated Care Fund Project Brief (2016):

Table 2

Outcome	*Measure*	Performance Indicator	Benchmark
That individuals admitted to the facility can transition back to their own homes	*% of individuals returning to their own homes within 6 weeks of admission*	79%	NAIC 80%
That individuals who return home, stay at home	*% of transitional unit individuals readmitted to hospital*	At 7 days: 1% At 28 days:6%	Over 65s discharged from BGH 7 day / 28 day All BGH 4.7% / 10% Geriatric Medicine 7.7% / 18.8% General Medicine 7% / 16% (Discovery data)
That individuals remain as independent as they were prior to their admission to hospital	*% requiring more care than prior to their admission to hospital)*	Functional outcomes scoring (AUSTOMS) commenced Dec 2020. Data only available for 4 clients. All 4 clients improved functional scores on discharge	NAIC benchmark – 85% of clients with improved function

4.2 Garden View Discharge to Assess Facility

The Discharge to Assess Unit, based at Garden View in Tweedbank, opened in January 2017 to provide additional capacity of up to 24 residential care home beds to assess the support needs of people in an enabling environment prior to their return home or to long term care in supported accommodation. The facility is managed by SB Cares, closely aligned to the Waverley Transitional unit, but does not have aligned AHPs or HCSW resource. The initial focus was on patients with a goal to return home but from October 2018 admission criteria were extended to accept people who were being assessed for 24 hour care if they had no on-going nursing care needs.

Aims

- Individuals stay in the Facility no longer than 2 weeks (Oct 2018 revised to 6 weeks)
- Individuals are able to be discharged home (or to care home from Oct 2018)
- Individuals who return home, stay at home
- Feedback from people who use the service is positive
- Feedback from staff is positive

Referrals

Figure 10 shows residence of admissions. 48% lived outwith Central Borders, suggesting Garden View offered selected individuals an alternative pathway to their local community hospital.

Fig. 10

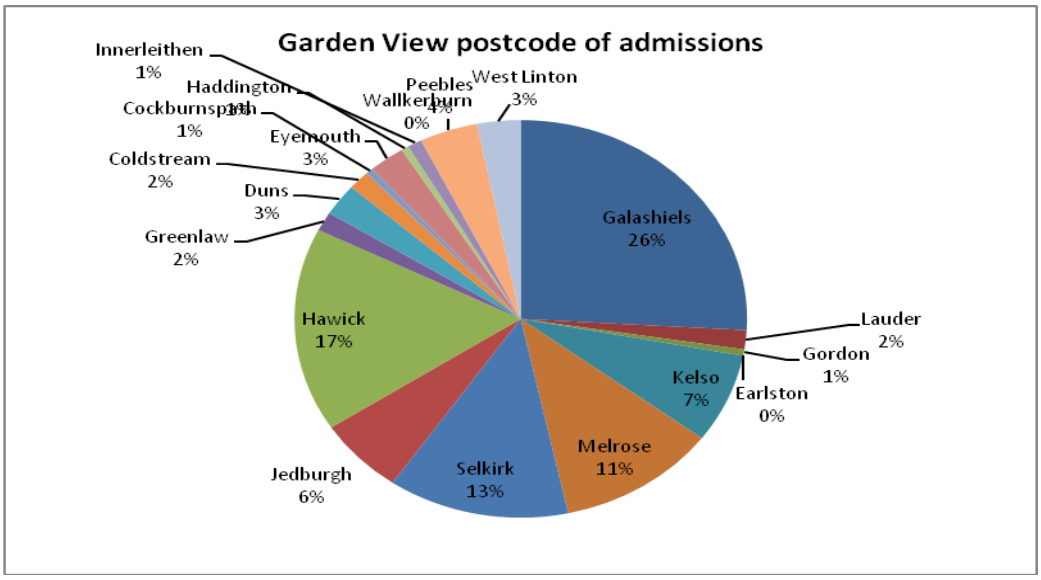
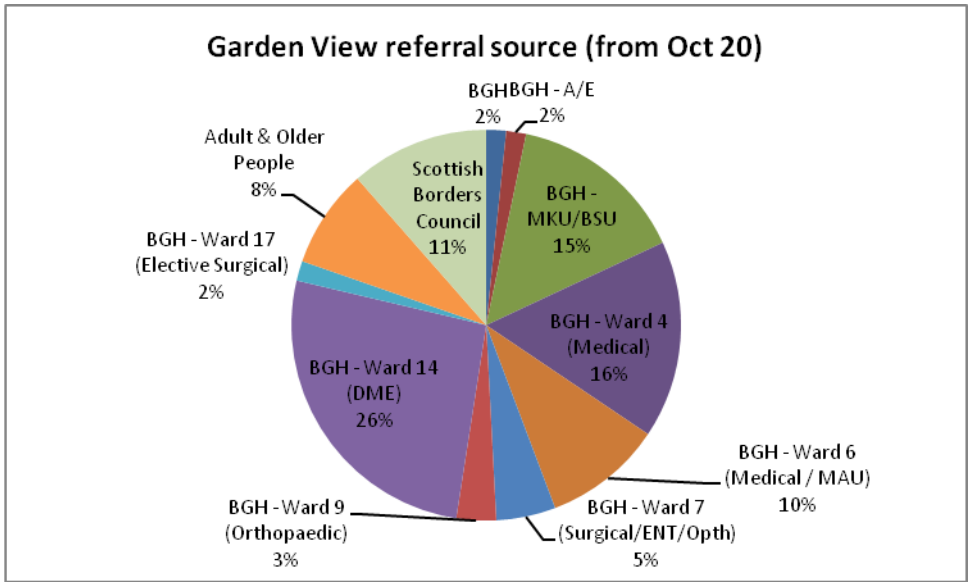


Figure 11 shows the source of referrals. All were step down following an episode of acute care at BGH and no referrals were from community hospitals. Using recent information from Strata, just over half of the admissions were transferred from BGH Medicine for the Elderly wards, Ward 4 or BSU/ MKU. Most were transferred to Garden View within 1 day of receipt of the referral.

Fig. 11 Source of referrals



Casemix

Average age was 83.4 years, range 50 to 99 years with only 4% under 65 years.

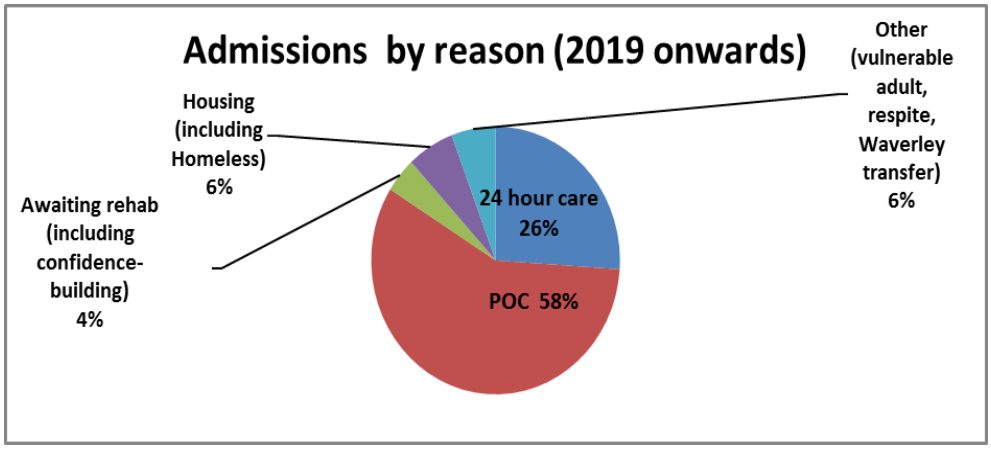
The casemix was broadly similar to Waverley but the Garden View cohort had a higher prevalence of people with cognitive impairment, including Adults with Incapacity, and a slightly lower proportion (75%) who had mobility issues.

Similar to admission criteria for Waverley, referrals should be able to mobilise with assistance from equipment and/ or a maximum of two staff and should have no on-going nursing care needs except those ordinarily met by a District Nurse team. However criteria for admission to Garden View required the identified goals to be achievable within six weeks without access to AHP support.

Figure 12 shows that goals at admission were largely about process rather than function and included:

- Undergoing Social Work assessment
- Waiting for commencement of a Package of Care (POC)
- Waiting for 24hr long term care placement
- Waiting for completion of Home Adaptations/Equipment/ Maintenance work
- Waiting for a new Tenancy
- Waiting for resolution of Delirium
- Waiting for surgery or recovery where there is a nonweight bearing status

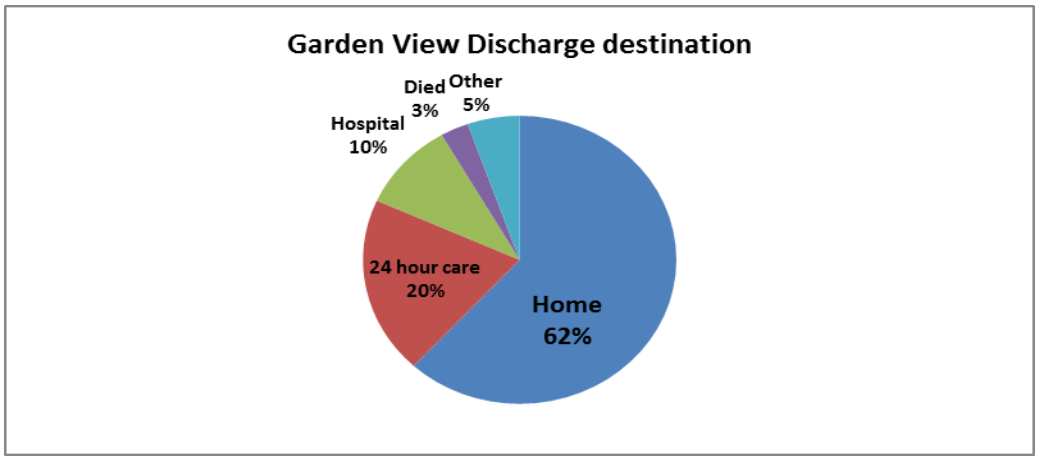
Fig. 12 Admission Goals



Outcomes

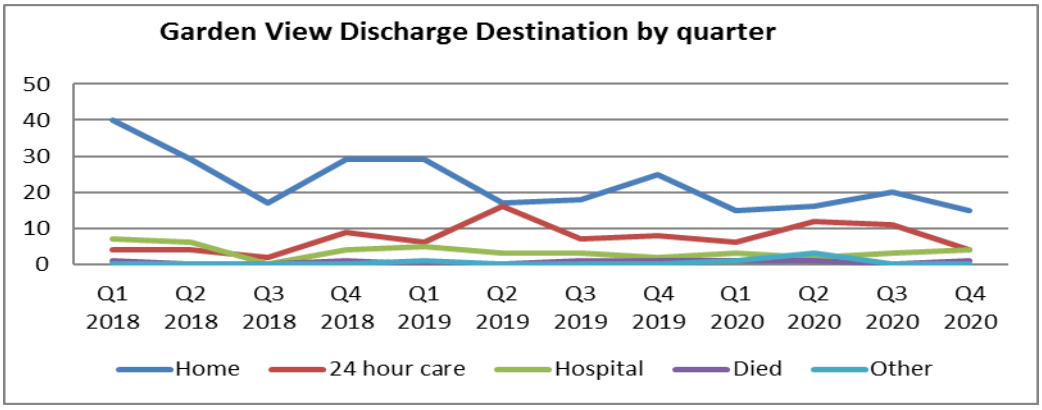
Figure 13 shows that almost two thirds of admissions to Garden View returned home with a Package of care (POC). With one-fifth transferring to residential care. This suggests that clients entering Garden View largely progress to their intended destination of referral.

Fig 13 Discharge Destination



Quarterly rates for discharges to home have decreased over time (Figure 14), in keeping with the increasing capacity for an alternative hospital discharge pathway to assess at home via Home First.

Fig.14 Discharge Destination over time



Records show a total of 96 adverse incidents in 2020, mainly falls. Three percent of admissions died in the Unit. The rate of readmissions to hospital from Garden View was 10%, equivalent to the average 28 day readmission rate for discharges from all BGH wards and significantly lower than the 19% readmission rate for discharges from BGH geriatric medical wards.

Experience of care

No routine survey of services users experience was available.

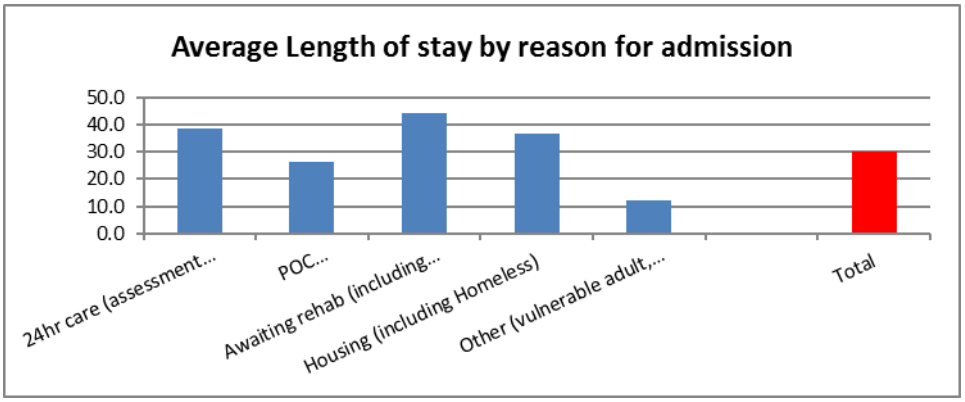
Ad hoc feedback from service users is consistently favourable and Care Inspectorate reports are mostly positive. Three residents surveyed reported feeling safe, accepted, treated kindly and satisfied with the quality of care and with the environment. The only criticism was of a lack of social activities.

Throughput

With a capacity of up to 24 beds, Garden View could be expected to achieve a throughput of at least 198 per annum, assuming an average of 42 days Length of stay (LOS) and 95% occupancy. This is a very conservative assumption for LOS for a cohort with largely process outcomes,

considering the average LOS achieved at Waverley for a cohort considered to have rehabilitation needs. Figure 15 shows how throughput at Garden View critically depends on the balance between the shorter LOS for those awaiting assessment and commencement of a POC to return home and the longer LOS for those being assessed for or awaiting placement in 24 hour care or awaiting housing solutions.

Fig 15 Average LOS by reason for admission



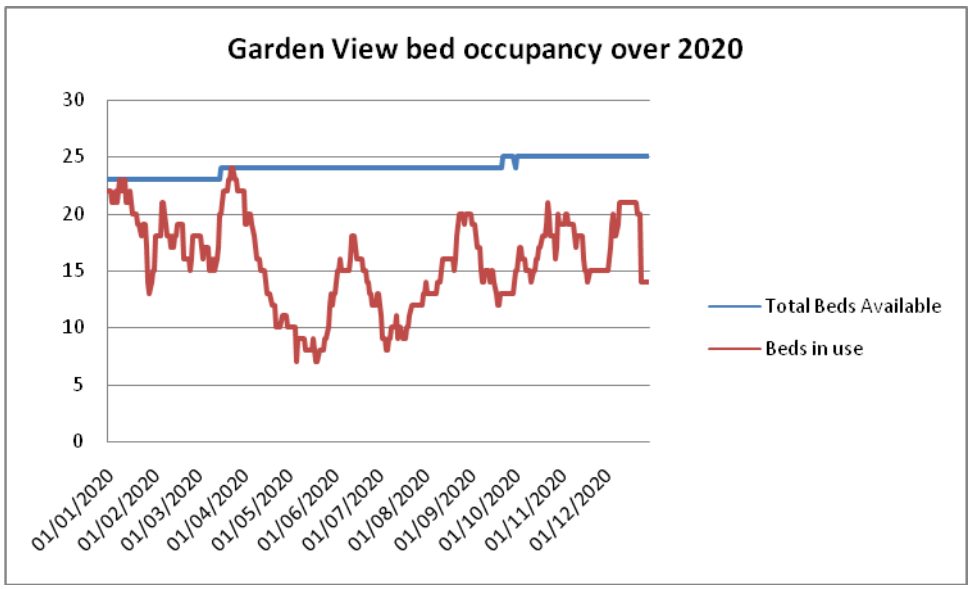
Throughput has been considerably less than anticipated from the outset and has further reduced over time. Table 3 shows the proportion of admissions discharged within 2 weeks halved between 2018 and 2020 and there has been a fourfold increase in the proportion staying longer than 6 weeks.

Table 3

	Admissions per year	Average no. of admissions / month	LOS 14 days or less	LOS > 42 days
2018	153	13	59%	8%
2019	149	12.4	36%	32%
2020	136	11.3	30%	32%

Figure 16 shows low average occupancy but recent increasing occupancy largely reflecting people undergoing assessment for long term 24 hour care as increased capacity for Discharge to assess at home via Home First has reduced the demand for admissions while awaiting a package of care.

Fig.16 Occupancy rates



Costs

Based on total service spend and current activity (145 cases), the cost per case for Garden View is £7,167. This compares to an average cost per case from the English NAIC benchmarking data (2018) of £5,486. If Garden View operated at 90% capacity at current length of stay (207 cases), the cost per case would be approximately £5,038.

Summary of outcomes

Table 3 summarises performance for the project outcomes detailed in the Integrated Care Fund Project Brief:

Table 3

Outcome	Performance Indicator	Benchmark
Individuals stay in Facility no longer than 2 weeks (changed to 6 weeks in Oct 2018)	Length of Stay (LoS): Up to 14 days 112 29% up to 42 days 202 70% >42 days 69 30%	NAIC (2018) average LOS 26 days for bed- based intermediate care
Individuals that stay in the Facility are able to be discharged home	Discharge destination : 62% discharged home 68% of transfer for assessment for package of care discharged home	NAIC (2017) – 69% discharged home from bed-based intermediate care
Individuals who return home, stay at home	Readmission rates: 7 day 28 day number 4 15 total 2% 6%	Readmission rates for over 65s discharged from BGH 7 day 28 day All BGH 4.7% 10%

		Geriatric Medicine General Medicine (Discovery data)	7.7% 7%	18.8% 16%
Service Users Feedback is positive	No routine data Care Inspectorate reports favourable			
Staff Feedback is positive	No data			

4.3 Home First

The service was initially established as *Hospital to Home* (H2H) to provide personalised reablement for individuals who no longer require acute hospital care, but are not yet able to live independently at home. Reablement is provided by HCSW with guidance from a district nurse or AHP. H2H evolved further to form Home First that also supports a crisis response for people who are at high risk of being admitted to hospital if they do not receive support at home. The service started on a small scale in Berwickshire in January 2018, extended to Teviot in March 2018, to Central Borders/Tweeddale in August 2018 and to Cheviot in late 2018. The care element was fully operational across Borders by March 2019. Full AHP/rehabilitation =roll-out was completed in May 2020. Clients were accepted if they were expected to benefit from reablement delivered by HCSW under supervision of a nurse or AHP.

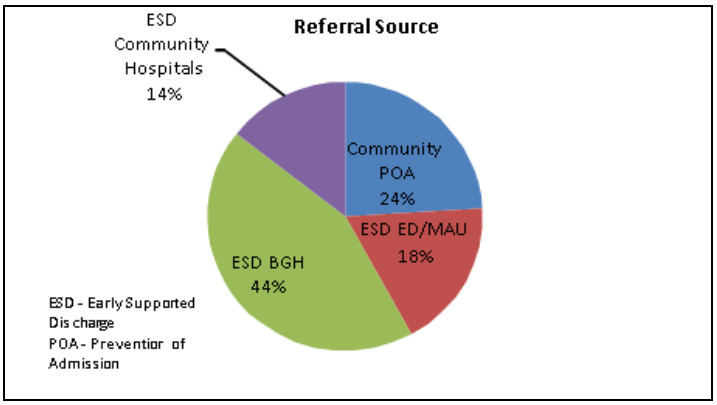
Aims

- Support earlier discharge from hospital
- Maximise rehabilitation potential during the early weeks post discharge
- Support individuals to continue to live at home.
- Increase capacity of homecare provision by reducing care needs by 40%
- Increased engagement with community based services in each locality
- Reduce avoidable attendances / admissions to hospital

Referrals and Casemix

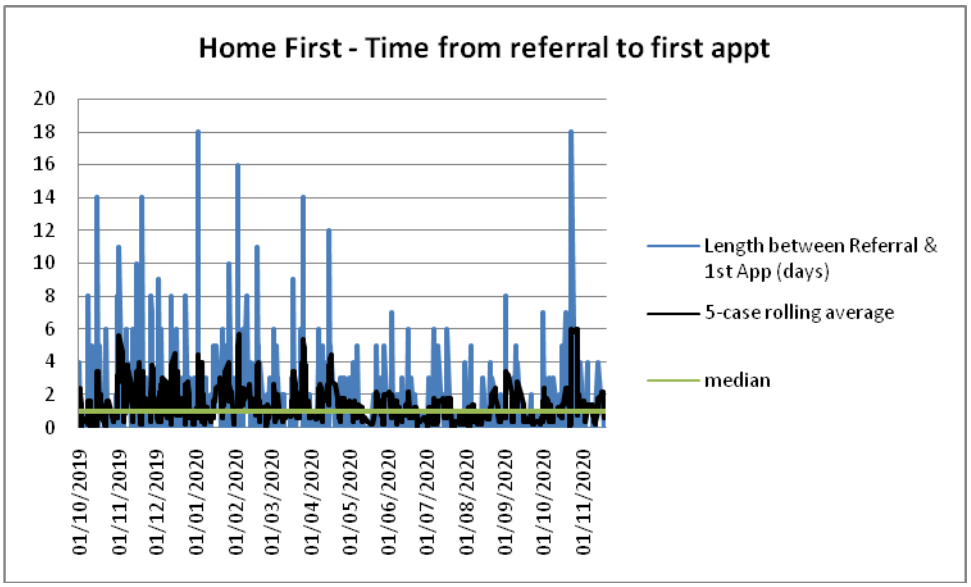
Activity increased by 23% between 2019 and 2020 and Home First managed 1280 people in the year to Nov 2020. 24% of referrals were from the community for an alternative to emergency admission to hospital. Figure 17 shows a further 18% were from the emergency department or medical admissions unit reflecting early intervention and return home.

Fig. 17 Referral Sources



Median time between referral and first visit by home carer was 1 day (Figure 18),

Fig.18 Time from Referral to First visit by Home carer



Overall, 88% of home care clients had visits 7 days per week. Figure 19 shows two thirds of the home care clients had at least two visits per day.

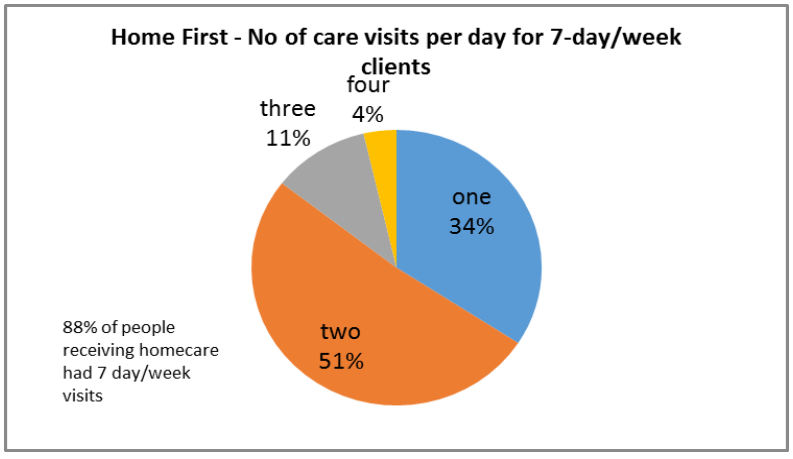


Fig.19

Some 96 clients who had sufficient unpaid carer or family support did not have HCSW visits but had early intervention by AHPs with average time to first visit 2.5 days (Figure 20). 94% of AHP only clients had one visit per day with over 50% of these daily visits occurring at least 5 days per week (figure 21). There may be scope for greater skill mix for follow through sessions under AHP supervision.

Fig. 20

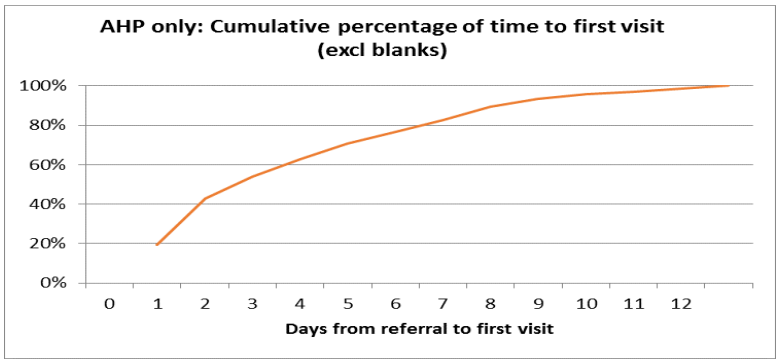
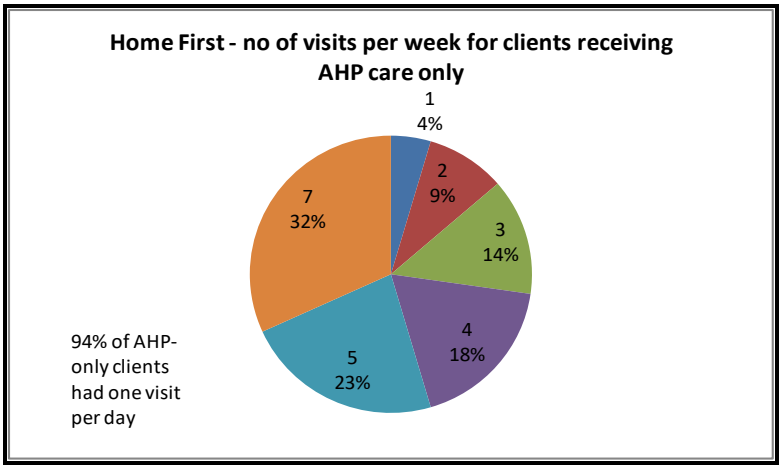


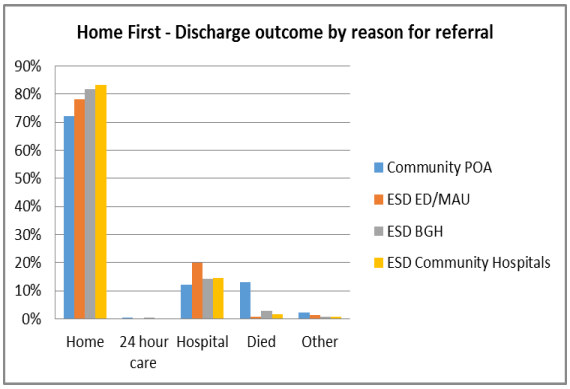
Fig 21



Outcomes

Overall, 80% remained at home. Figures 22 and 23 show the outcomes by source of referral. Around 11% were (re)admitted to hospital. This compares favourably with 19% rate for 28 day readmissions for BGH Geriatric medicine and 16% for General medicine. Mortality was low and includes expected deaths in people for whom Home First enabled their expressed wish to remain at home. Very few clients moved onto 24 hour care.

Fig. 22 Discharge outcome



Fig, 23 Home First LOS

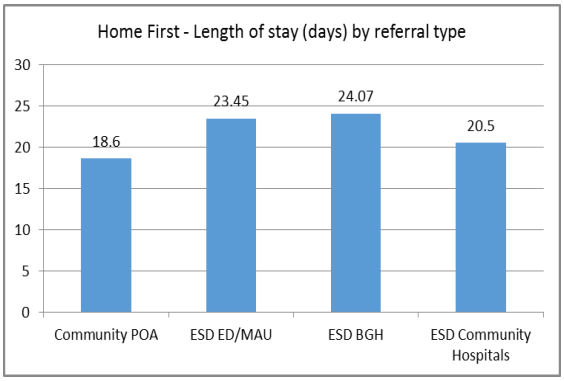


Table 4 shows the reduction in home care hours for those who received HCSW assistance for ADL. Overall, there was a 57% reduction in the intensity of the care packages required at the end of the Home First episodes. This level of reduction in demand for home care is central to the business case for the service and to the sustainability of home care provision for an ageing population with increasing levels of need

Table 4 Change in Home care package

	No. Service Users	**Total Care Minutes Per Week (Start)**	**Total Care Minutes Per Week (End)**	**Average Care minutes per week (start)**	**Average Care minutes per week (end)**	**% change**
Total clients with home care hours recorded	968	300,685	106,715	**310**	110	**57% reduction**
Subset who remained at home	722	208,955	89,600	289	124	**57% reduction**

Interestingly, some people considered to have longer term support needs were accepted onto the caseload to allow them to return home awaiting the availability of their assessed care package. Although there was little expectation of improvement, in fact the package of care required decreased in 23/86 'short term bridging package' cohort and there was an 11% reduction in the total care hours they required after only a short period (average 10 days) of Home First support. This underlines the acknowledged tendency for over prescription of care when assessments are undertaken in hospital settings and the potential benefits of reablement even for individuals considered to have more chronic care and support needs.
AHPs have recently introduced the AusTom tool to assess functional ability in the Home First caseload. The tool considers emotional and psychological wellbeing and levels of social participation as well as physical function. It also considers the level of carer distress.

Table 5 shows that three quarters of the patients assessed with the tool before and after their Home First episode showed improved scores. Carer distress reduced in around half.

Table 5 AusTOM scores

AusTom Scores	**Impairment N = 40**	**Activity Limitation N = 40**	**Participation Restriction N = 40**	**Distress (Patient) N = 40**	**Distress (Carer) N = 21**	**Overall Total scores n=40**
improved	22	27	23	22	10	30
same	15	13	15	17	10	9
deteriorated	3	0	2	1	1	1

The Care Opinion scenarios in Annex 1 give some insight into the improvements experienced and the benefits perceived by patients, carers and families. These are complemented by three scenarios shared by Home First staff to illustrate the added value of the service

Costs
Based on total service spend and activity, the cost per case for Home First is £1,093. This compares well with an average cost per case from the English NAIC benchmarking data (2018) of £839 for home based intermediate care and £1.987 for reablement.

Summary of outcomes

Table 6 summarises performance for the project outcomes detailed in the Integrated Care Fund Project Brief:

Table 6 Project Outcomes

<table>
<tr><th>Outcome</th><th>Performance Indicator</th><th>Benchmark</th></tr>
<tr><td>Personalised re-ablement approach to maximise early rehab potential in the early weeks post discharge</td><td>AUSTOM scores (n = 40): Functional change on discharge:
<table><tr><th></th><th>improved</th><th>same</th><th>deteriorated</th></tr><tr><td>Impairment</td><td>55%</td><td>38%</td><td>8%</td></tr><tr><td>Activity Limitation</td><td>68%</td><td>33%</td><td>0%</td></tr><tr><td>Participation Restriction</td><td>58%</td><td>38%</td><td>5%</td></tr><tr><td>Distress (Patient)</td><td>55%</td><td>43%</td><td>3%</td></tr><tr><td>Distress (Carer)</td><td>48%</td><td>48%</td><td>5%</td></tr><tr><td>Overall</td><td>75%</td><td>23%</td><td>3%</td></tr></table></td><td>NAIC 2018 (reablement): Improved 66%, no change: 27%, decreased: 7%</td></tr>
<tr><td>Increasing capacity of care provision by reducing care needs of this cohort by 40%</td><td>Overall care needs reduced by 57% at end of Home First
57% of clients discharged independent of care</td><td>IPC report (reference 11) suggests up to 65%</td></tr>
<tr><td>Increased engagement with community based services in each locality</td><td>No recorded data

7% of referrals are generated by District Nurses</td><td></td></tr>
<tr><td>It supports individuals to develop their confidence and skills to enable them to continue to live at home.</td><td>80% remained at home

See Austoms scores above

Also qualitative feedback from user stories – Annex 1</td><td>NAIC benchmark (2017) – 81% remained at home after home-based intermediate care</td></tr>
<tr><td>There will be reduction in hospital attendances / admissions</td><td>See section 5 for Programme impact assessment

11% (Re)admissions to hospital</td><td><table><tr><th></th><th>7 day</th><th>28 day</th></tr><tr><td>All BGH</td><td>4.7%</td><td>10%</td></tr><tr><td>Geriatric Medicine</td><td>7.7%</td><td>18.8%</td></tr><tr><td>General Medicine</td><td>7%</td><td>16%</td></tr></table></td></tr>
</table>

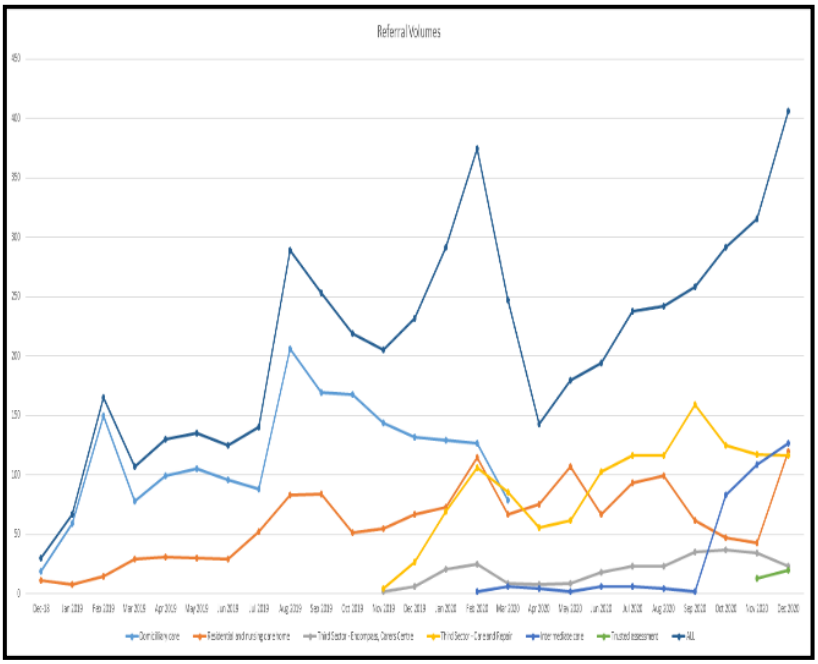
4.4 Enabling Infrastructure

Matching Unit

The Matching Unit was established as a small, central administrative team that ensures the service required by a client is matched with a provider who can meet their care requirements. The Matching Unit team collated and maintained a list of clients waiting for care at home and for end of life care. The unit reduced time previously spent by care managers in trying to secure packages of care and reduced waiting lists for people awaiting assessment and care in their community. 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 5 days. The success of this initiative has led to the approach being mainstreamed within SB Cares with an opportunity to better align with the development of locality What Matters hubs.

Discharge referral Management

STRATA automates and improves the process of discharging patients from hospital to residential care or care at home providers. The system uses a real-time directory of available care home beds, capacity and specialist services allowing these to be matched to patients. The digital system is supported by creation of an integrated discharge 'hub' as a single point of contact multi-disciplinary team with responsibility for coordinating and arranging older people patient transfers and ongoing care.



Strata is now managing around 800 referrals / month in eight pathways across hospital, social care and third sector (figure 24).

Fig 24 Strata Referrals

Figure 25 shows it takes a median time of 10 minutes for staff to submit a referral.

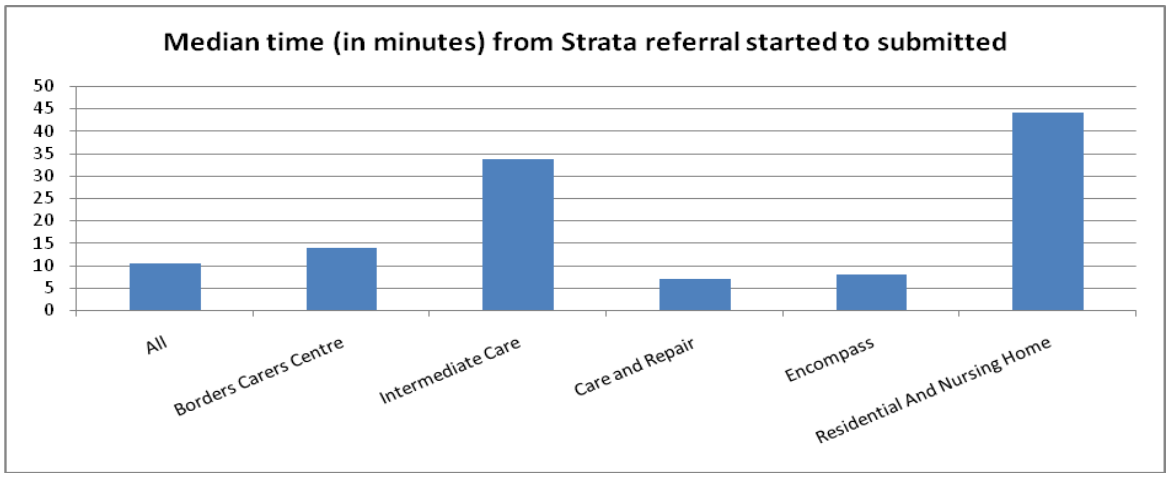


Fig 25 Median time to complete referral (minutes)

The relaunch of the domiciliary care referral pathway is imminent and will be followed by the pathway for referral to Community Hospitals in the next quarter. These are key in enabling BGH and community hospitals staff to directly refer for intermediate care and will be a step towards enabling community teams and GPs to access these through a simple single 'red button' referral process

5. Contribution to System Outcomes

The projects are collectively supporting the IJB to achieve two of their three key strategic aims and related actions (15).

We will improve the health of the population and reduce the number of hospital admissions

- By supporting individuals to improve their health
- By improving the range and quality of community based services and reducing demand for hospital care

We will improve the flow of patients into, through and out of hospital

- By reducing the time that people are delayed in hospital
- By improving care/patient pathways to ensure a more co-ordinated, timely and person-centred experience/approach
- Providing short-term care and reablement to facilitate a safe and timely transition
- Caring for and assessing people in the most appropriate setting
- Providing an integrated approach to facilitating discharge
- Ensuring the reablement and hospital to home service development aligns with housing providers and care and repair services

While attribution of impact is not possible given the complex interdependencies of the projects alongside other actions being implemented within BGH and localities, the three services are

almost certainly contributing to the progress made by Scottish Borders from 2017/18 on key National Outcomes Indicators (16) as illustrated in figures 26- 28.

Fig 26 National Indicator 13 Emergency bed day rate per 100,000 population aged 18+ (to Acute Hospitals, Geriatric Long Stay, and Acute Psychiatric Hospitals)

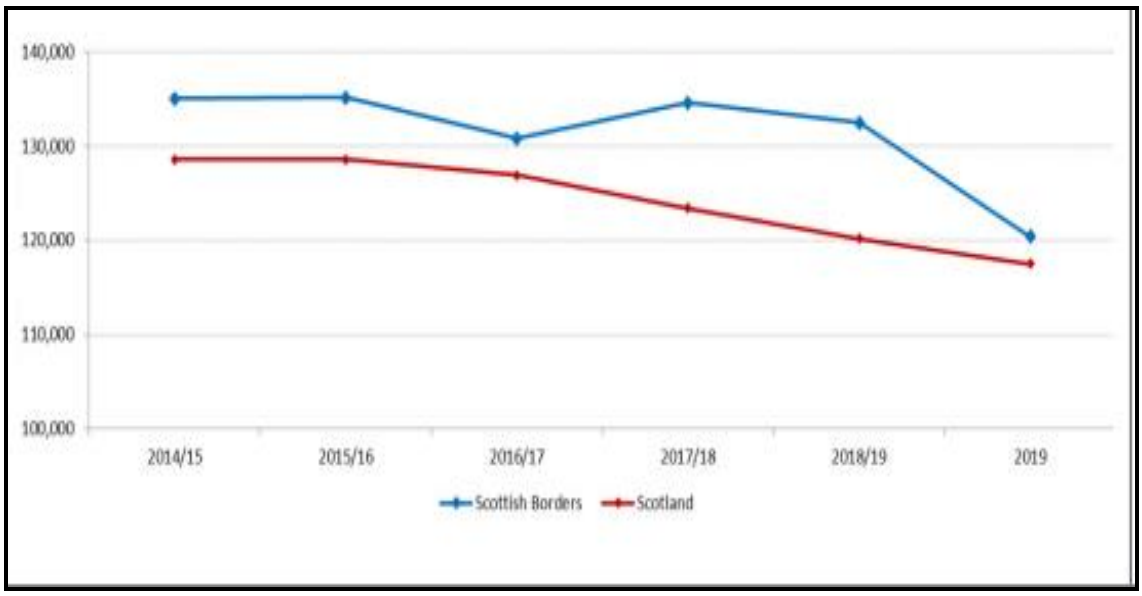


Fig. 27 National Indicator 19 – Number of days people aged 75+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 75+)

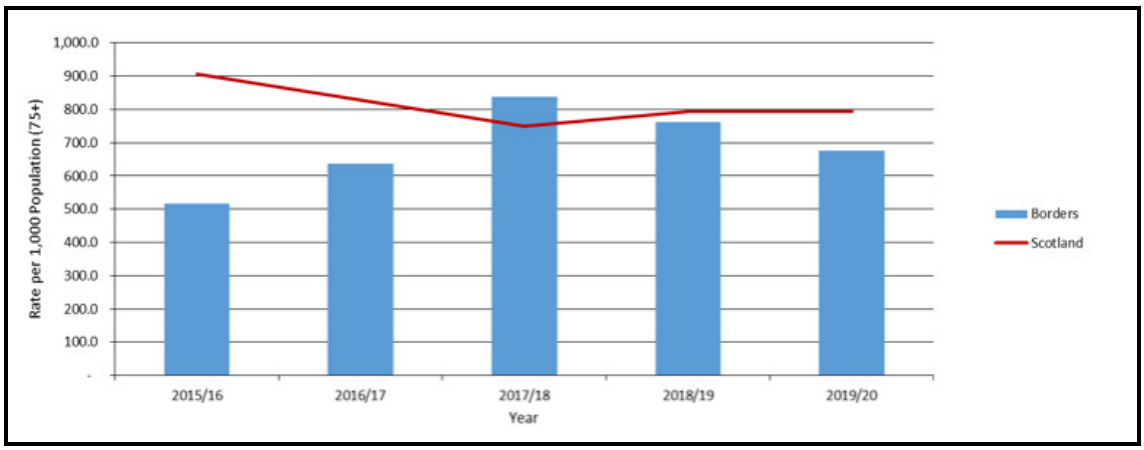


Fig. 28 Number of days people aged 18+ spend in hospital when they are ready to be discharged (rate per 1,000 population aged 18+)

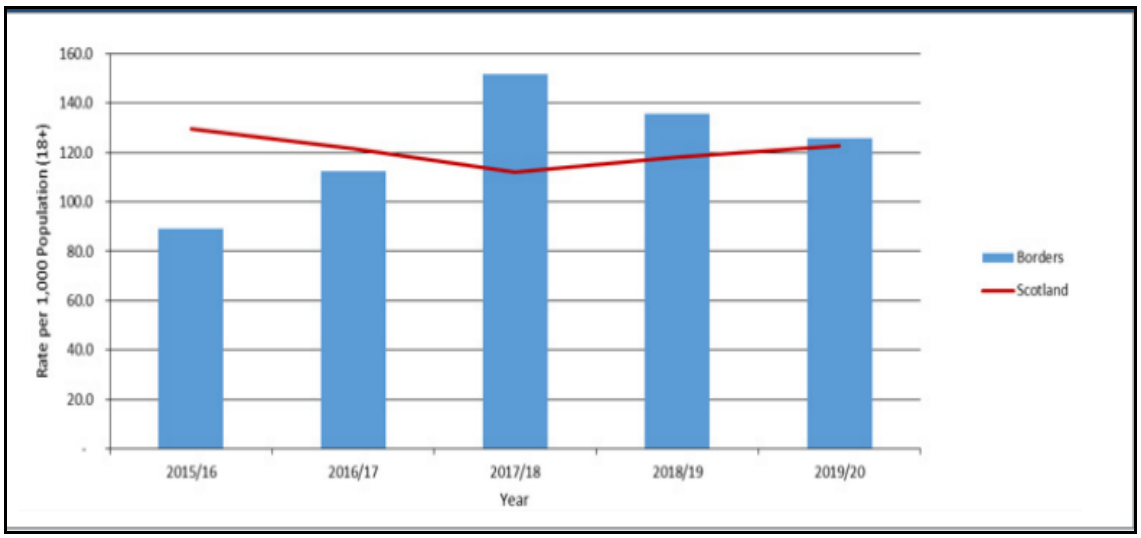


Figure 29 shows quarterly trends in BGH emergency admissions and occupied beddays for the over 65s. The chart has been annotated with the start dates of the new services.

Since 2017, BGH emergency beddays for >65s have decreased by 5% and LOS reduced by 11% despite admissions increasing by 7%.

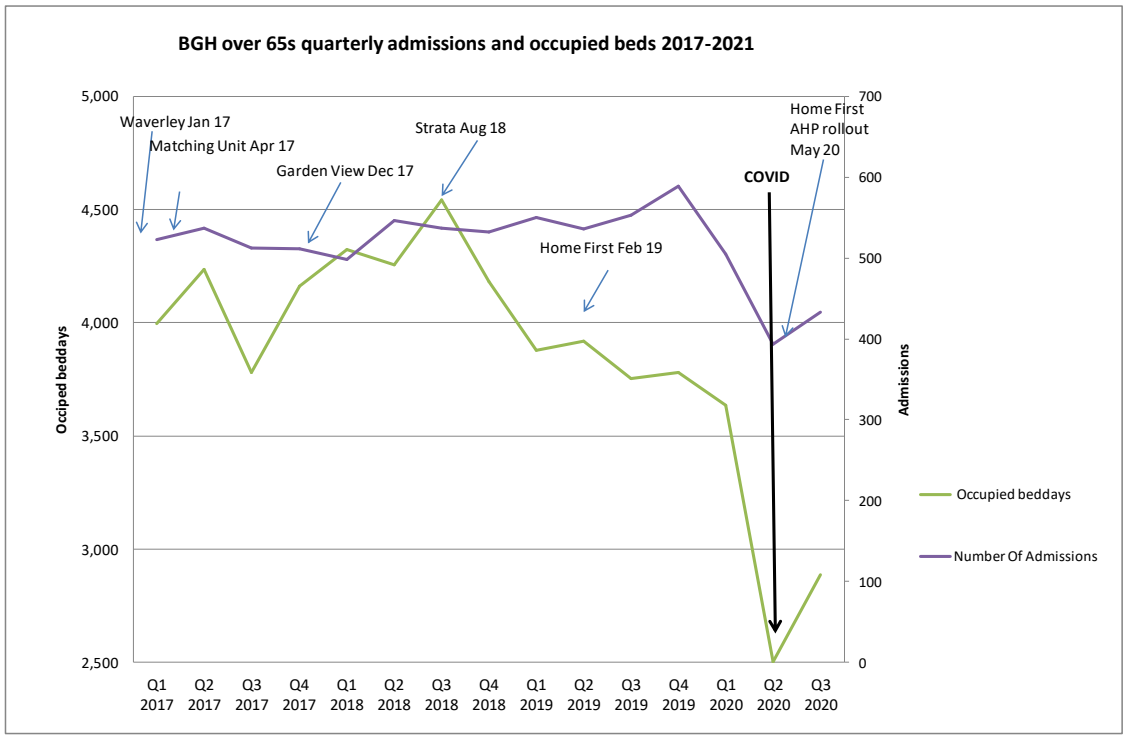


Fig. 29

Value

The lack of a core dataset for the intermediate care services limits the ability to link management information from these services with the wider health and social care information and resource utilisation data available through Source and Tableau.

The financial impact of the programme has therefore been assessed in two ways:

1. Cost per case. The services have been evaluated through a simple cost per case approach. Cost relates to staffing and other non-fixed costs only. This shows (against NAIC 2018 benchmark data)

	Project cost per case	Benchmark
Waverley Transitional Care	£6,152 At 90% occupancy, cost per case would be £4,631	£5,486
Garden View Discharge to Assess	£7,167 At 90% occupancy, cost per case would be £5,038	£5,486
Home First	£1,093	Home-based intermediate care: £ 834 Reablement: £1,987

2. Counterfactual. A counterfactual analysis has been undertaken to assess the potential demand for beds and other resources that would be incurred in the absence of the services provided within the Discharge Programme. This assessment is based on a range of assumptions, largely reflecting actual experience. Details are attached in Annex 2.

   This analysis indicates that, if the services within the Discharge Programme were not available, there would be;

   - an additional demand for hospital beds of between 40 and 57 beds
   - an additional increase in home care hours required of around 26,000 hours per year, representing approximately 5% of current provision

   The Care Opinion feedback is universally positive for Home First but the lack of systematic recording of functional and personal outcomes limits meaningful review of the experience of care in this report.

6. Recommendations

The IJB is invited to consider the following recommended actions that flow from the review:

- Continue to develop the enabling infrastructure: Strata digitally enabled referral management supported by an integrated discharge hub, Trusted assessment model and more efficient allocation of care by the Matching Unit team and locality hubs.

- Merge the two "Step Down" facilities of Waverley and Garden View as soon as possible to create a combined facility with a single set of admission criteria for the combined transitional care unit.

- Commission the required bed capacity for the combined Transitional Care Unit based on the projected impact of scaling up Home First discharge to assess at home

- Provide dedicated nursing expertise to enable the combined Transitional Care Unit to offer a local alternative to community hospital care for the cohort of older residents from Central Borders who have higher levels of dependency and more complex post-acute care needs

- Review the skill mix, leadership and governance of Home First and align the team more closely with locality *What Matters* hubs for greater continuity of care management, better coordination with local assets and housing solutions and to increase access to step up crisis response

- Test a locality integrated team model where the Home First team and community hospitals AHPs rotate / in reach / outreach, building on the lessons from the Neighbourhood Care pilot and work with SAS and out of hours services on urgent response to falls

- Explore opportunities to enhance the integrated locality teams with geriatric medical and palliative care expertise, using remote prof to prof decision support where appropriate

- Develop a core dataset for reablement and intermediate care to enable prospective tracking of service quality and outcomes across these services.

- Consider the use of IoRN within the core dataset to allow measures of dependency and functional ability to be prospectively linked to the Scottish Borders resource utilisation data through the Source returns and Tableau health and social care information dashboard

- Exploit the opportunities from the Older People's Pathway and Joint Digital Strategy

- Develop a route map for the above actions as a strategic framework for intermediate care with nested locality models that are better integrated with the range of locality assets and services including Community Hospitals

7. References

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Annex 1 Care Opinion: feedback of experience of Home First

'' I was concerned about how (my husband) would cope, he is a normally fit 87 and I am 75 but we knew he would be weak when he came home. Then we had a call from the local Home First offering morning and evening support. It was brilliant. Help with showering and dressing in the morning for 2 weeks which was as long as we needed it, evening help for a few days until we didn't need it any more. OT and Physio came and checked what we needed and saw him down the stairs the first time. A handyman came and fixed a grab handle over the bath so he could use that shower. The colo-rectal nurse, the continence pad service, the pharmacist from the health centre and the GP all made contact without us having to do anything and made sure we were alright. The overall service was excellent.''

'' My wife fell & fractured her hip in June. She's been battling with Alzheimers since 2015. Unbelievably she was back home 12 days later & then regularly visited & cared for by Home First care team for the next for two and half weeks. Both the hospital & care staff have been brilliant! Caring, kind, knowledgeable and making us both feel good. She had started to walk with a zimmer before she came home & 3 days ago we were getting back upstairs to our bed. Nothing was too much trouble and they all made us feel positive. Our family is all over the world & under lockdown they couldn't visit anyway. So actually we've had more contact than we would have normally! We're really sad to see them go, but couldn't have had better care.''

'' For myself I only had flu like symptoms and have made a fairly quick return to full health but my wife required hospital treatment. On her eventual release from hospital the local home care team swung into action by visiting morning and evenings, giving us all the support we required with aids, such as a wheeled walker, a commode and a handy wheeled shelved trolley. Physiotherapy and OT persons also visited to assess our everyday living and got a second bannister fitted on our stairs and support rails in the shower. Through this help with assisted showering, confidence boosting support and aids to help with everyday living, both my wife and myself are back to normal living and confident moving around the house and in the outside world again.''

'' The superb team from Home First came in with care for my husband who has a terminal brain tumour and is now receiving palliative care. Every single carer has been professional, skilled and spent time getting to know us and understand our needs. They have cared for both of us in very challenging circumstances. This is an excellent support for families in similar situations''

'' The Home First ladies did an amazing job of providing personal care to my mum, as well as

showing great compassion and assisting her to preserve some dignity when she was completely bed bound. They were so lovely to her and assisted in allowing my mum to stay at home during her last few weeks which is what she really wanted, rather than being confined to a covid ward in the hospital. They also provided immense support, both practical and emotional, to me as I looked after her during her last few weeks and I know I would not have been able to cope without their visits. I am so very grateful to all the lovely ladies in the team and I will never be able to fully express my gratitude to them for everything they did for me and my mum.''

Staff reflections on the impact of Home First

Patient A

An 89 year old lady who had experienced a fall and sustained a fracture to her right wrist and right Neck of Femur was admitted from BGH to Hawick Community Hospital where she underwent a period of rehab in HCH. She progressed to being mobile with a walking aid and transfers with equipment and supervision on the ward but consistently presented as lacking in confidence which impacted on her function. She was referred to Home First for further rehab with aim of regaining independence and returning to preadmission baseline for mobility, personal care and meal prep.

I visited the patient on ward to practice bed transfers which gave me a good picture of her level of function and opportunity to discuss re-ablement plan and purpose of Home First. This allowed seamless transition from hospital to home setting and good rapport established with myself and the Nurse Coordinator at the start of team involvement.

Re-ablement involved OT and PT input with daily visits from HCSW to support initially with personal care and meal prep. PT assessed mobility at home and progressed patient from Zimmer frame to stick for indoor mobility and use of a 4 wheeled walker for outdoor mobility with supervision of family. A home exercise programme was introduced to improve strength, mobility and to improve confidence. HCSW visited daily to supervise mobility and exercise programme. Initially the patient was apprehensive even about walking short distance to answer door, but within a week this was achieved independently with walking aid and eventually to one stick.

Under guidance of PT, HCSW progressed to supervising with outdoor mobility and outdoor step practice. Patient progressed in confidence and to achieve outdoor mobility again, albeit it with walking aid and supervision of family.

The OT provided equipment to assist with bed and toilet transfers and taking a shower. HCSW's initially provided assistance with setting everything up for a shower, elevating her leg and providing reassurance. This progressed to patient being able to perform transfer independently with equipment under supervision with the eventual outcome achieved of independent showering.

A Perching stool enabled a graded return to meal prep and a kitchen trolley enabled independence with transferring items and eliminating dependency on carers for support. Equipment needs were reviewed throughout and withdrawn as transfers and mobility improved.

Hand therapy was provided for fine motor skills, grasp and improving strength- this was reviewed weekly and the goal of returning to knitting was achieved.

HCSW adopted this reablement approach which started with minimal physical assistance to supervisory and this resulted in independence being regained with personal care tasks and meal preparation. The gradual improvement in confidence was significant throughout her time with the team.

At the outset this patient was dependent on care for all aspects of ADL and presented with extreme anxiety. Over a period of seven weeks she returned to independence within the home with no package of care. This was a more positive outcome that had been anticipated in the hospital.

Patient B

The lady, who was previously independent with all activities of daily living (ADL), had a fall on the high street in Peebles when out shopping. Unfortunately she sustained a left neck of femur fracture which was fixed with a dynamic hip screw 2/12/20. She was referred to home first for D2A and the first visit took place on the day of discharge on 14/12/20

She returned home using a large Pulpit frame to mobilise short distances only and required 3 visits per day for the first 3 weeks post d/c. She was initially slow to mobilise and there was marked loss of confidence and balance/fatigue issues evident. Gradually she has progressed from pulpit to 4 wheeled walker indoors. HCSW input has very gradually been reduced with lunch visit being initially reduced followed by the evening visit being discontinued this week. (25/01). She is now washing and dressing independently, making all her meals using the trolley provided and has progressed to practising with 2 sticks indoors, 5 weeks post discharge. The next step in her rehab plan is progression to stair practice (lives in a 1st floor flat).

She is also trying to mobilise to the toilet during the night but due to her urinary urgency she may need to continue to use the commode. She continues to progress with the reablement approach and we are hopeful we will be able to discharge her without a long term package of care. Her rehab has exceeded the 6 weeks but she is still benefiting from Home First input and there is still potential for improvement. There is currently no service in the community to pass this lady on to and we are keen for her to return to full independence if possible.

This example of Discharge 2 Assess shows how Home First can optimise the Fractured Neck of Femur pathway. This lady did NOT go to Haylodge as was originally anticipated, but was able to be discharged straight home with Home First.

Patient C

The patient was discharged from BGH with the request for OT & PT follow up only with no other needs identified. On the 1st visit (24hrs after discharge) she had deteriorated significantly in function and was unable to mobilise, completing transfers only. There was no apparent medical reason for this deterioration. It is possible that the patient was exhausted from travelling home to Berwickshire and the extent of her de-conditioning in hospital only became apparent once home.

Home First provided equipment and linked with the Nurse Coordinator to set up HCSW assistance for personal care and toileting. This managed to prevent a potential hospital re-admission. Her daughter was happy to attend to meals and assisting with toileting out-with our visits. She remained on our caseload while partial weight bearing but is now independently mobile with a zimmer frame, is confidently managing basic personal care and has started to participate in kitchen activities. HCSW calls were reduced to just x2 weekly to assist with full body wash, (daughter continues to assist with meal prep). When her daughter was able to return home we increased her HCSW calls to 1x daily to assist with meal prep/set up and basic domestic assistance. We anticipate, once her weight bearing status changes that she will quickly progress back to full independence and HCSW's will stop.

This example demonstrates Home First's responsiveness and flexibility of support as needs fluctuate, and the confidence and ability of the team to prevent an early re-admission to hospital.

Annex 2: Assumptions underpinning counterfactual analysis

Counterfactual analysis is based on a range of assumptions of alternative pathways for patients and clients. This is not an exact science.

Process

- Overarching assumption that no alternative arrangements for reablement and rehabilitation would be available
- Assumptions are based on data from a number of sources (detailed in list below)
- All Discharge Programme data based on analysis of actual activity 2019-20
- Variable time periods depending on availability of data (see evaluation for details)
- Numbers based on percentage split by discharge destination applied to average activity over time

Counterfactual Hospital bed demand assumptions

Average Length of stay assumptions by client group

	Lower estimate (days)	assumption	Higher estimate (days)	assumption
Home First				
Bridge PoC	10.4	average based on 84 cases - assumes 1:1 ratio - i.e. if PoC not available would be in hospital	10.4	average based on 84 cases - assumes 1:1 ratio - i.e. if PoC not available would be in hospital
PoA	5	based on analysis of average LoS for >65s in BGH as part of Older Peoples Assessment Area planning	5	based on analysis of average LoS for >65s in BGH as part of Older Peoples Assessment Area planning
reablement (discharge and step-up)	5	average time for care package for Hospital Discharge - 2020 (Matching Unit data)	10.4	assumed comparative length of stay to Bridge PoC
Garden View				
Care Home discharges	39	actual average LoS in Garden View - alternative would be hospital	39	actual average LoS in Garden View - alternative would be hospital
PoC discharges	5	average time for care package for Hospital Discharge - 2020 (Matching Unit data)	10.4	as above
House repairs	36.8	actual average LoS in Garden View	36.9	actual average LoS in Garden View
Waverley				
Admitted to hospital	14	average length of stay for DME patient	27	actual Waverley average length of stay
Assessed as needing long-term care	39	average Garden View wait for 24 hr care	56	actual Waverley average length of stay

Died	87	assumes would remain in hospital	87	assumes would remain in hospital
Discharged home	34	actual Waverley average length of stay	34	actual Waverley average length of stay

Counterfactual homecare demand assumptions

The following assumes that the impact of Home First service would not be available and 'saved' home care hours would therefore need to be provided.

- Only Home First activity included
- Waverley/Garden View activity – assumed no impact on home care demand (patients will remain in hospital)
- Average homecare package assumed to be 5.2 hours/week (based on Matching Unit data for Hospital Discharge 2020)

Home First

Bridge PoC	current data indicates 11% reduction in care needs on discharge from Home First
PoA -	
crisis	assume 11% reduction
reablement	care hours saved equivalent to average care package for Discharge patients (5.2 hours/week - 2020 data) for average length of stay in Home First (22 days or 6% of annual)
Reablement (discharge and step-up)	
Patients discharged as independent	care hours saved equivalent to average care package for Discharge patients (5.2 hours/week - 2020 data) for average length of stay in Home First (22 days)
Patients discharged with care package	current data indicates 11% reduction in care needs on discharge from Home First