Borders NHS Board

Meeting Date: 3 October 2019

Approved by:	Robert McCulloch-Graham, Chief Officer Health & Social Care
Author:	Robert McCulloch-Graham, Chief Officer Health & Social Care

TRANSFORMATION FUND UPDATE

Purpose of Report:

To inform the NHS Borders Board of the decisions regarding the Integration Joint Board Transformation Fund, taken at the 25 September 2019 meeting.

Recommendations:

The Board is asked to **note** the report.

Approval Pathways:

This report has been agreed by the Integration Joint Board.

Executive Summary:

The purpose of the Integration Joint Board (IJB) Transformation Fund report was to provide the IJB with an update on the position of the fund and to seek approval for further investment in 2019/20; which was agreed.

Impact of item/issues on:

Strategic Context	The IJB report will support the implementation of the Strategic Implementation Plan for the Health & Social Care Partnership.
Patient Safety/Clinical Impact	Covered in the attached IJB paper.
Staffing/Workforce	The Transformation Fund enables the employment staff within each project. The agreement given to continue funding to expand services will require appointment of new posts.
Finance/Resources	No resource implications beyond the financial resource identified within the report.
Risk Implications	Covered in the attached IJB paper.
Equality and Diversity	N/A.
Consultation	This report has been agreed by the Integration Joint Board.
Glossary	N/A.

Scottish Borders Health & Social Care
Integration Joint Board

Meeting Date: 25 September 2019

Report By	Rob McCulloch-Graham, Chief Officer Health & Social Care
Contact	Rob McCulloch-Graham, Chief Officer Health & Social Care
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TRANSFORMATION FUND REVIEW

Purpose of Report:	The purpose of this report is to provide the Integration Joint Board (IJB) with an update on the position of the Transformation Fund and to seek approval for further investment in 2019/20.

Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** the current position of Transformation Fund – Table 1; b) **Approve** the project extensions set out in section 4 and summarised in Table 3; c) **Note** the changes in funding commitments highlighted in Table 4.

Personnel:	The Transformation Fund enables the employment staff within each project. Agreement to continue funding to expand services will require appointment of new posts. Should the IJB not approve the proposal, normal HR processes will apply regarding redundancy and/or redeployment.

Carers:	The Health & Social Care Partnership will continue to liaise with Carers in the Borders around the ongoing development of the initiatives within this paper and the ongoing wider development of the Strategic Implementation Plan.

Equalities:	N/A.

Financial:	No resource implications beyond the financial resource identified within the report.

Legal:	Supports the delivery of the Strategic Plan and is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and any consequential Regulations, Orders, Directions and Guidance.

Risk Implications:	Not supporting the continuation of step down facilities may adversely impact on patient flow and increase demand on acute provision.

1 Background

1.1 The Transformation Fund now supersedes the Integrated Care Fund (ICF) and is a ring fenced budget totalling £2.13m which is available to the IJB to invest in change and shifting the balance of care from acute to community services.

1.2 It has in the past been used to fund a range of small projects over the years, more recent investments however being in larger developments aimed at addressing delayed discharges within the acute and community hospitals.

1.3 The ring fenced nature of the Transformation funding and the approval of commitments against that funding for projects extending over financial years has meant any unspent balance has been carried forward from financial year to financial year.

1.4 The Day of Care Audit (DoCA) undertaken across our mental health wards for the elderly, medicine for the elderly in Borders General Hospital and across all community hospitals, identified a number of patients in excess of 50% who should have been cared for in their own home or within a more homely setting. There is therefore a clear need to introduce a range of services and initiatives within our Discharge Programme which will enable this. As well as providing a much improved provision for 80 plus patients, the DoCA evaluation has highlighted that there is a significant over resource being applied within our hospitals.

1.5 Individually each of the initiatives funded within the Discharge Programme have proven they reduce the length of stay, and therefore the number of occupied bed days caused by delays, (OBDs). This paper has outlined these figures. Collectively their impact will support a significant reduction in demand across our hospitals. The programme, over the next two financial years will support the reduction of the number of patients who are inappropriately placed within our hospitals, and therefore support a significant shift in the balance of care. It will provide the ability to increase resource within our care spend, whilst significantly inable efficiencies across our acute bed base.

2 Update

2.1 The IJB approved a number of commitments in the January 2019 Paper in relation to the funding of the services within the Discharge Programme (H2H, Transitional Care, Garden View, Matching Unit).

2.2 **Table 1** below summarises the funding brought forward from 2018/19 and the current commitments against that funding in 2019/20. Further detail is provided in **Appendix 1.**

Summary Funding and Committments 2019/20			
			£'000
Balance b/fwd from 2018/19			2,013
Annual Allocation			2,130
			4,143
Committed Funding	**Funded End Date**		
Discharge Programme	30/09/2019	1,347	
Community Capacity Building	31/07/2019	42	
Transport Hub	31/11/2019	44	
Community Led Support	31/03/2019	13	
Domestic Abuse Service	30/06/2019	43	
Strata	31/03/2020	115	
CHAT / Social Work	31/03/2020	68	
COPD / Long Term Conditions	30/09/2019	99	
Total Committed Funding			1,771
Uncommitted Funding Available			**2,371**

2.3 The uncommitted balance of £2,371k is available to the IJB for investment.

3 Projects Due to Finish

3.1 A number of projects have ended or are due to finish within this financial year. It is proposed to extend and enhance certain projects and the recommended actions are set out below for each project.

3.2 Transport Hub

3.2.1 The final tranche of funding has been confirmed and made to the Transport Hub. Any further funding bids will be considered as part of the Council's transport strategy work.

3.2.2 The IJB commitment will end on 31 November 2019.

3.3 Domestic Abuse Service

3.3.1 The planned funding has been fully utilised and expectation is that the service will be incorporated into the Public Protection Unit remit.

3.3.2 The IJB commitment has a planned end date of 30th June 2020.

3.4 Community Led Support

3.4.1 The spend against this project slipped into 2019/20 however the allocated funding has now been fully utilised and changes in work practices have been embedded in workplans.

3.4.2 The IJB Commitment ended on 31 March 2019.

3.5 Community Outreach Team / Social Work

3.5.1 The original funding request to the Transformation Fund was for 2 years of funding to invest in additional staffing within the CHAT team and Social Work, with the stated intention that the planned reduction in occupied bed days would

fund the recurring provision within that 2 year period. The CHAT team is working towards full staffing and the work to fully reduce the level of occupied bed days is planned to complete by the end of December 2019.

3.5.2 The assumption is that Transformation funds of £68k (3 months funding) will be required to support the staffing changes until theses costs can be mainstreamed.

3.6 COPD

3.6.1 The work to develop a pulmonary rehabilitation intervention model has been subsumed into a wider programme of work to review support for all main Long Term Conditions.

3.6.2 The utilisation of this funding has been held pending work to assess and prioritise the preferred model of delivery.

4 Projects Recommended for Extension

4.1 Community Capacity Building

4.1.1 The ongoing funding of the Community Capacity Building (CCB) service was due to be mainstreamed in 2019/20. However there has been significant slippage in related pieces of work which have resulted in a requirement to extend funding to 31 March 2020. The extension is key to delivering planned recurring savings of £350k through the Reimaging of Day Services. Funding required totals £214k.

4.2 Discharge Programme

4.2.1 The Discharge Programme comprised several interlinked services focused on preventing admissions, reducing the length of people's stay in hospital and ensuring they are cared for in the most appropriate setting.

4.2.2 Funding was approved for these services to continue to 30 September 2019 at the January IJB.

4.2.3 As part of an independent external review of Delayed Discharges within Scottish Borders an evaluation of the financial and non financial impact of these services on delivering their planned outcomes was obtained. The evaluation considered national and locally produced data and compared and contrasted service provision with other similar regions to evaluate the impact of these services. Reports were produced for each service reviewed and recommendations were made on the ongoing viability of each service. The overarching summary report is attached as **Appendix 2** to this paper.

4.2.4 The key message from the review is that the average length of stay per patient has decreased demonstrating the Discharge Programme is accelerating throughput and reducing occupied bed days (OBD) caused by delay per patient.

4.2.5 For the work moving forward within the discharge programme, we have utilised the number of OBDs as a proxy measure for the effectiveness of each work area. As a group, these programmes are aimed to reduce pressure within the BGH, Community Hospitals and across in patient Mental Health Wards.

4.2.6 We know that if we shorten length of stay and speed up discharge we will reduce the number of OBDs and hence reduce the required number of hospital beds.

4.2.7 By reducing OBDs by 10,950 within a ward area we will be able to close a whole ward, reducing costs by in excess of £1.4M.

4.2.8 You will see from the evaluation of Garden View, Waverley (Transition Service), the Matching Unit and Hospital to Home, that the evaluation identifies an OBD saving for each which equates to 17,115 OBDs, the equivalent of over 1.5 wards. From our day of care audit, we are targeting 76 in-patient beds (2.5 wards) which need to be provided for elsewhere. The collective efforts across these programmes and their expansion in the case of Hospital to Home are essential to meet this target.

4.2.9 The outcomes of the independent review are summarised in **Table 2** below. A comparison of costs and savings was difficult to make due to the compilation of costs within the different Discharge Programme services. Some service costs included indirect costs and overheads whereas others did not. The average direct cost of an OBD for a Medicine of the Elderly bed based on the current ward budgets is £136 per OBD. This represents the releasable saving from removing a full ward of these beds. These budgets are rebased each year so the final release would require to be confirmed. For comparison the full gross cost of a Medicine of the Elderly ward is £3.5m based on the 2017/18 National Cost Book which equates to £291 per OBD.

4.2.10 The table uses the current £136 OBD cost to estimate the savings that could be realised as a result of the work of each of the services to reduce OBD. Summary explanations of the outcomes and recommendations for further investment are set out in the paragraphs following the table.

Discharge Programme	Annual Cost £'000	Step Down Beds Commissioned	Average Beds Utilised	Annualised OBD Saved	Cost per OBD Saved	Saving Health £'000	Saving Social Work £'000
Garden View	811	15	11	4,015	202	546	
Transitional Care	649	16	9	3,344	194	455	
H2H	1,090			8,580	127	1,167	180
Matching Unit	151			1,176	128	160	28

4.3 Garden View

4.3.1
- Average occupancy 73%
- For every acute bed day saved this service cost £202

4.3.2 Further investigation is needed as to the input required from Garden View for the Winter Plan. It is therefore recommended to continue funding Garden View to the end of March 2020. A review will be undertaken in November to ascertain effectiveness following amendment to its admission criteria and operation.

4.4 Waverley Transitional Care

4.4.1
- Service has reduced the readmission rate to BGH by 10%

- 84% of users have returned to their own home or family home.
- Average length of stay has reduced from 6 to 4 weeks
- Average occupancy 56%
- Evidenced reduction in Care packages following discharge (11hrs to 9.4hrs) in small number of cases where information exists.
- For every acute bed day saved this service cost £194 – this reflects the estimated cost including the element commissioned through the block contract with SB Cares.

4.4.2 It is recommended that the service is extended at the current level to the end of the financial year to facilitate further progress in reducing demand for inpatient unscheduled care beds and the level of ongoing care clients require. The service will deliver a saving when capacity of 88% (14 beds) is reached. It is therefore recommended that NHSB and SB Cares work to ensure the appropriateness of referrals to ensure capacity is fully utilised. A final review of the ongoing use of this facility will be made prior to 1 April 2020.

4.5 Hospital to Home

4.5.1

- Saving of 9 bed days per year per service user through prevention of admission / readmission of service users
- Reduction of 61% in overall A&E attendance following discharge from H2H
- Further saving of 30 inpatient OBDs per week
- For every acute bed day saved this service cost £127
- Reduction in care requirements calculated at 9,800 hrs = £180k

4.5.2 This service is already delivering savings and it is recommended that it is expanded to incorporate the provision of additional AHP (Physiotherapy and Occupational Therapy), and additional Healthcare Assistant and Nursing support. This expansion would allow the Central model (which currently includes AHPs) to be rolled out and evaluated across the remaining 4 Localities and enable a fuller assessment of the service prior to 1 April 2020. We expect the expansion of the service to provide an increase in capacity of an additional 40 patients over the current 70 being catered for at any time. Funding for 5 months of the expanded element of the service will cost £254k.

4.6 **Matching Unit**

4.6.1

- Clear links to and potential synergies with the START team
- Potential overlap with H2H regarding Palliative and End of Life care
- Key role in restarting Packages of Care
- Poor data quality impacting on performance assessment
- Introduction of Matching Unit resulted in reduction of 150 outstanding client assessments.
- For every acute bed day saved this service cost £128

4.6.2 It is recommended that the data quality issues are addressed and that funding is continued to allow a more informed evaluation of the service by the 31 March 2020. The Matching Unit is key to the creation of the discharge hub which is expected to complete by November 2019. Synergies are expected to deliver savings which will allow the longer term configuration of the Matching Unit to be presented to the IJB by 1 April 2020.

5 Summary Discharge Programme Investments

5.1 The implications of all of these recommendations are summarised in **Table 3.**

Proposed Discharge Programme Investment 2019/20		Current Annual Costs £'000	Proposed Investment 2019/20 £'000
Garden View		811	406
Transitional Care	*	649	103
H2H		1,090	800
Matching Unit		151	76
		2,701	
Recommended Investment			**1,384**

*The proposed investment relates to the funding required from the Transformation fund. The balance is funded through a block contract agreement with SB Cares.

5.2 An investment of £1,384k is recommended to extend and expand the work to prevent and reduce delayed discharges and ensure patients are supported at home where possible to 31 March 2020. The expansion of the H2H programme and the recommended changes to the commissioned bed capacity will further reduce the demand for unscheduled care inpatient beds. An evaluation of the review of the data input and collection will be undertaken as a priority, addressing the issues raised in the external evaluation, to ensure effective monitoring and evaluation at the next review.

6 Summary

6.1 The review of existing Transformation projects and the external evaluation of the Discharge Programme have identified areas for extended and increased investment in 2019/20. **Table 4** below summarises the financial implications of these investments.

Summary of Funding and Planned Committments	2019/20 £'000	2019/20 £'000
Available Funding		2,371
Community Capacity Building	214	
CHAT	68	
Discharge Programme	1,384	
Recommended Investment		1,666
Uncommitted Balance post investment		**706**

6.2 A balance of £706k remains uncommitted in 2019/20.

7 Further Investment to support the Shift in the Balance of Care

7.1 We are aware from last year's review of patients (Day of Care Audit Plus) that over 50% of patients reviewed did not require hospitalisation and could have been cared for within Care Homes or at Home with Care.

7.2 From national comparisons of the level of commissioned care home beds, the Borders is the lowest with its statistical neighbours. The number of home care hours provided is also significantly below the Scottish Average when compared with 1000 people within the population. These numbers, both within the Borders and nationally, have been falling for a number of years.

7.3 The paucity of these resources has an obvious affect on our ability to move people out of hospital. We know therefore we have a need to increase the availability of care beds and home care hours. We can increase our efficiency further but even with this there will remain a gap, how big a gap is important to determine before entering into a new commissioning round for this care.

7.4 To this end Health Improvement Scotland consultants have been working with Council and NHS Borders staff to determine how much additional care provision is required to cater for the growing demographic and to enable a shift in the balance of care equating to approximately 76 hospital beds.

7.5 This work is nearing completion but needs significant verification. We do expect a final report within this month. It is prudent therefore to withhold a balance of the Transformation Fund to support an increase in the commissioning of these services. This fund would augment additional funding transfers following hospital bed closure and any additional resources through Scottish Borders Council following expected national budget announcements regarding the resource available for care.

Supported Discharge across Scottish Borders

A review Summary of 5 Projects Supported by ICF Funding Vers 2

Dr Kevin Williams

5th September 2019

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 form 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:

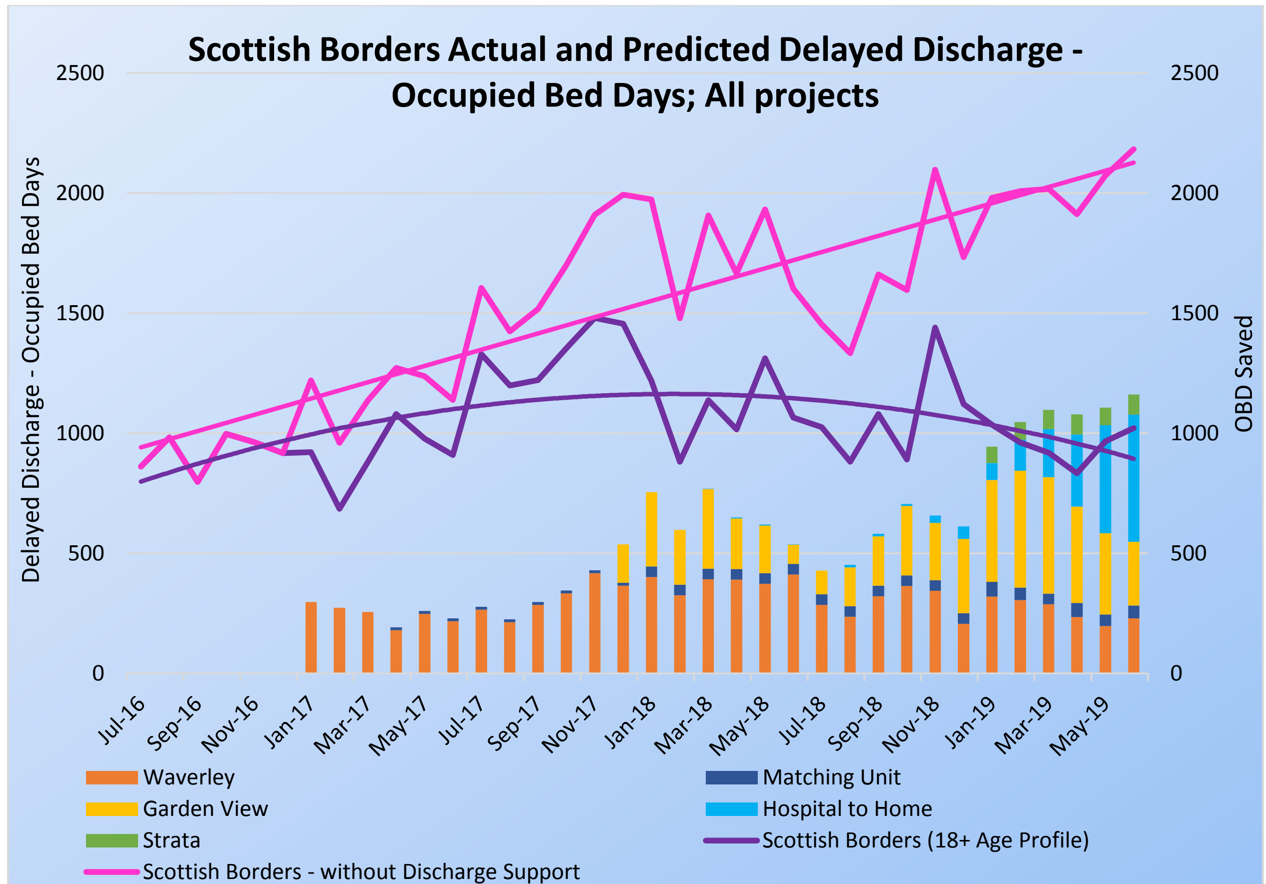
- For all H2H patients, review their admission / readmission history 3, or preferable 6, months prior to entry in to H2H care and again 3 /6 months following discharge from

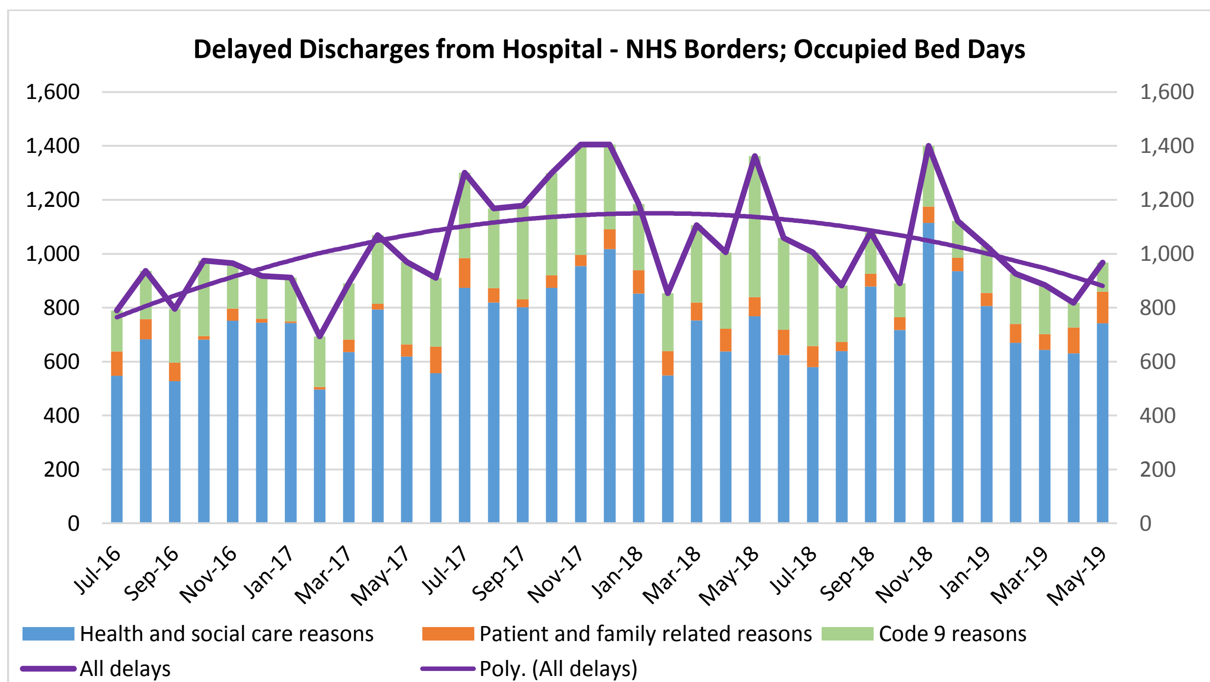
H2H. This will provide better data in which to truly assess a major benefit of the service.
- Realign the focus of the H2H to more address admission prevention than hospital discharge, as this is most likely to have the most beneficial impact on both user health and well-being and also savings generated.
- 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

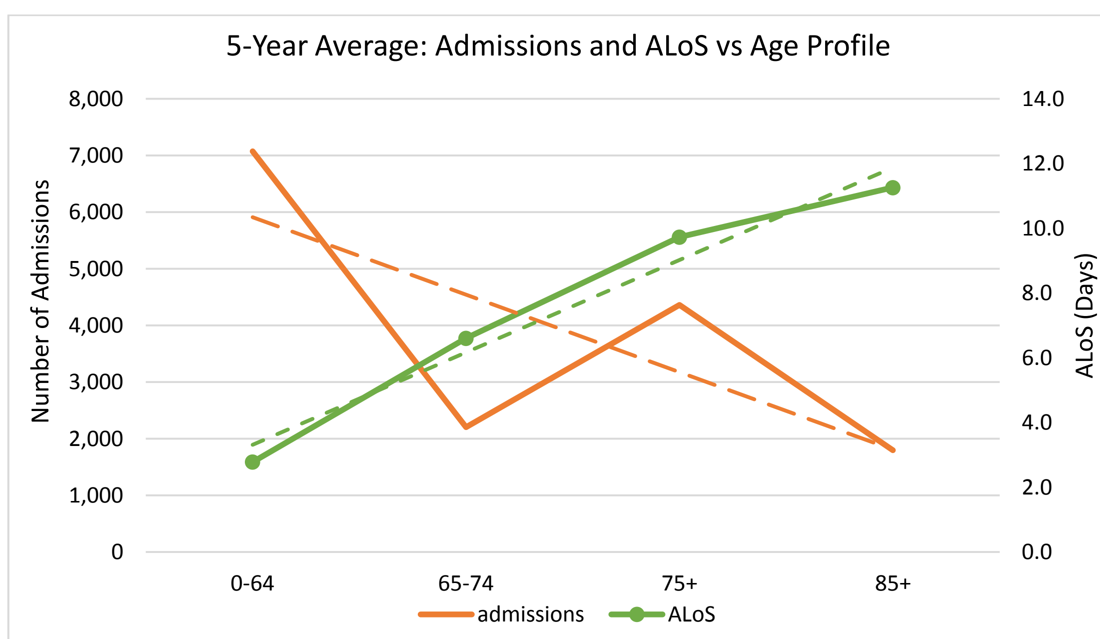




Admissions Data:

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.