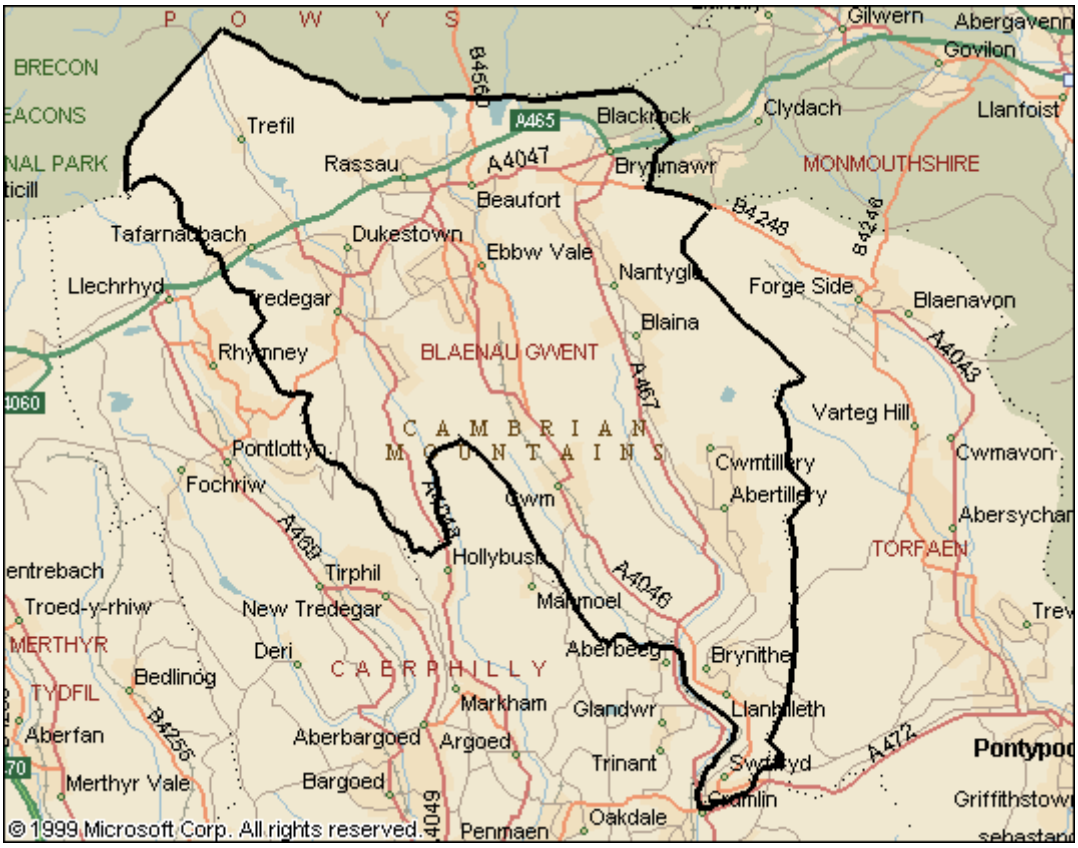
Blaenau Gwent

Whole Systems Project – Delayed Transfers of Care

DRAFT Final Report – May 2003



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1 Introduction

This report summarises the outcomes from a facilitated process to explore ways of developing and spreading a whole systems way of working to better serve the residents of Blaenau Gwent and to identify new ways of working using a specific example – namely delayed transfers of care.

The report brings together individual workshop outputs and supporting material, contained in the appendices. It is hoped that the record will serve to support the subsequent development of new strategic initiatives to improve services and that it will also illustrate the benefits of such an approach for application in other areas.

2 Workshop 1 (12th February 2003)

2.1 Introduction and approach

2.1.1 Introduction

This was the first of three workshops sponsored by the Elderly Care Group (Blaenau Gwent) to explore a whole systems approach to developing services. It was recognised that much had been done in recent years to innovate in service development. However, it was now felt to be time to take a step back and consider new approaches to facilitating service development to maximise benefit to the service user. There remained significant challenges within the system of care and a need to develop a way of working that more fully reflected the ideals of whole system working, that is:

- An ability to develop an appreciation of the whole, rather than focus on the part;
- An ability to develop an understanding of the impact of changes in one part of a system on other, sometimes hidden parts.***Approach***

The approach adopted would be a facilitated process of identifying a key challenge, describing and bringing together a single whole system 'map' of that issue with contributions from each stakeholder and the development of a simulation model to explore different strategies to address this issue. The first workshop would concentrate on the initial issue identification and description of the system identified.

This report outlines the answer to three questions posed in an initial 'break-out' discussion:

1. How should one understand the purpose and objective of the project;
2. What key challenges are faced by the system at present;
3. What boundaries should be set for the work.

2.2 Framework

2.2.1 Purpose and objective for the project

The suggested project objective was:

To identify key areas of action that will enhance whole systems working within services for older people.

This was discussed in four breakout groups with the following comment:

- Whilst older people required specific and specialist treatment services were rarely solely for older people. With the local population also susceptible to chronic conditions at a relatively young age it was suggested that there be no artificial cut-off for the project in respect of age;
- It was felt that 'action' should not necessarily be the focus of the project as we should be encouraging whole new ways of working and understanding the system before launching into specific projects;
- It was commented that the presence of whole systems working was debatable and that there to 'develop and enhance' such working would be a preferable objective;
- There was a need to reflect continuous improvement in the objective;
- It was suggested that we ensure a focus on process and the dynamics of the system rather than just look to identify action that could be taken at one point;
- The project should be about championing the whole system approach, verbalising/modelling the approach and cascading it to others.

As a result of these comments the following is offered as an alternative development of the project objective:

'To explore ways of developing and spreading a whole systems way of working to better serve the residents of Blaenau Gwent and to identify new ways of working using a specific example.'

2.2.2 Key challenges

The following key challenges were identified by the group:

- Interface issues between health and social care including funding;
- Managing expectations and people's understanding of services;
- Ensuring patient and public involvement;
- Human resource issues including recruitment and the flexible/innovative use of staff;
- Capacity within the system of care not always fully utilised or used to best advantage;
- The system seems to be driven by acute pressures, particularly emergency care;
- The need for true partnership working with the Independent Sector;
- Unified assessment;
- Delayed transfers of care;
- Developing a common language;
- Challenging ageism;
- Care management and the co-ordination of services;
- Poor management information;
- The need to define services outcomes;
- Responding to the national agenda;
- Working within current resources and in a way that keeps different pots of money very separate;
- Developing trust and knowing when to compromise;

- Engagement with primary care and GP's;
- Risk management.

2.2.3 Boundaries for the project

In the absence of a specific and targeted issue discussion concerning the project boundaries were inevitably fairly broad. Discussion focussed on ensuring a focus on the people of Blaenau Gwent rather than on services accessed and particularly on the needs of people with chronic conditions. It was considered appropriate to ensure that health, social and independent sector provision were reflected in the system as they all contributed to meeting the needs of the local population.

Discussion also focused on boundaries within the system that could present challenges, for example professional, political and financial boundaries.

2.2.4 Issue identification

Once a framework had been developed and a range of challenges identified it was agreed that the work should proceed focussed on one of these according to the following criteria:

- That each agency present would have a stake and a contribution to make;
- That the issue would reflect a key target set at a political level;
- That the issue would be suitable for identifying both short and longer term strategies and considering the interplay of these – challenging quick-fix solutions with a broader, more sensitive whole system understanding and strategy option.

The issues suggested during the initial session were:

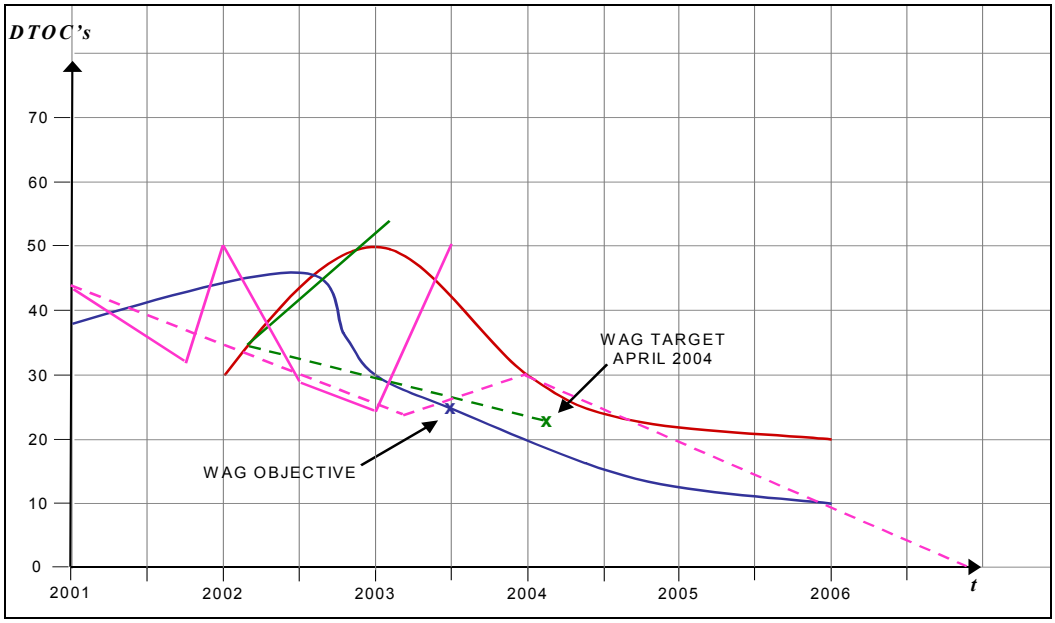
1. Rising emergency admissions and the need to moderate these;
2. Continued experience of delayed transfers of care and the need to reduce them;
3. Lengthy waits for elective orthopaedic procedures and the need to shorten them;
4. Assessment processes that did not always result in speedy outcomes and the need to streamline them.

It was suggested that the 3rd issue had recently been the subject of a piece of work with implementation of action proceeding and that the 4th issue would be part of either the 1st or 2nd. Finally the subject of delayed transfers of care was chosen as best meeting the set criteria.

2.3 Development of a qualitative map of the system

2.3.1 Identifying the performance of the system

Discussion groups were asked to explore how they viewed recent performance of the system in respect of delayed transfers of care. The composite output from their discussion is reflected in the following diagram.



The diagram suggests a degree of consensus about recent performance and forecast behaviour. Differences in perception in what is such a key indicator does, however, suggest that there is the need for greater clarity and joint ownership of the target.

2.3.2 Describing the system

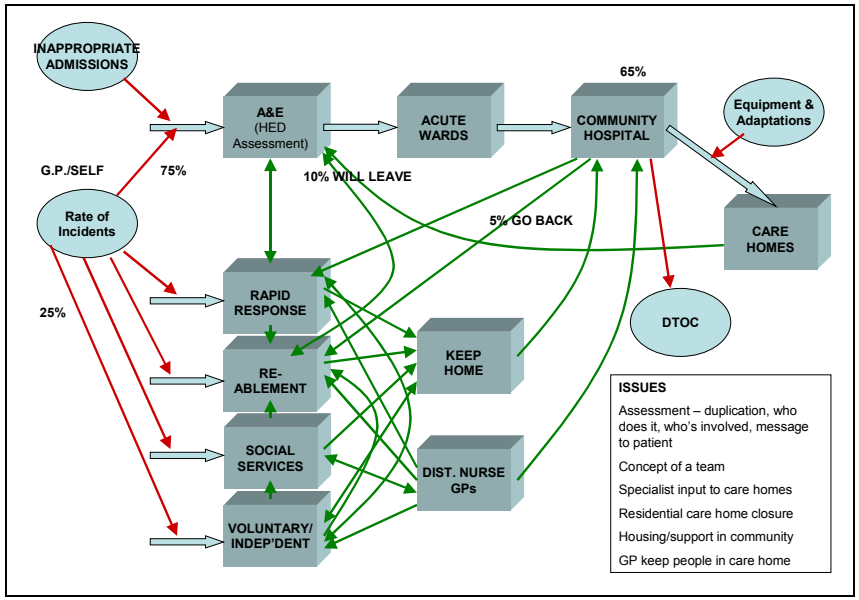
The second task given to the discussion groups was to begin to described the system that produced this behaviour. Four illustrations are provided as the output of this exercise. They reflect:

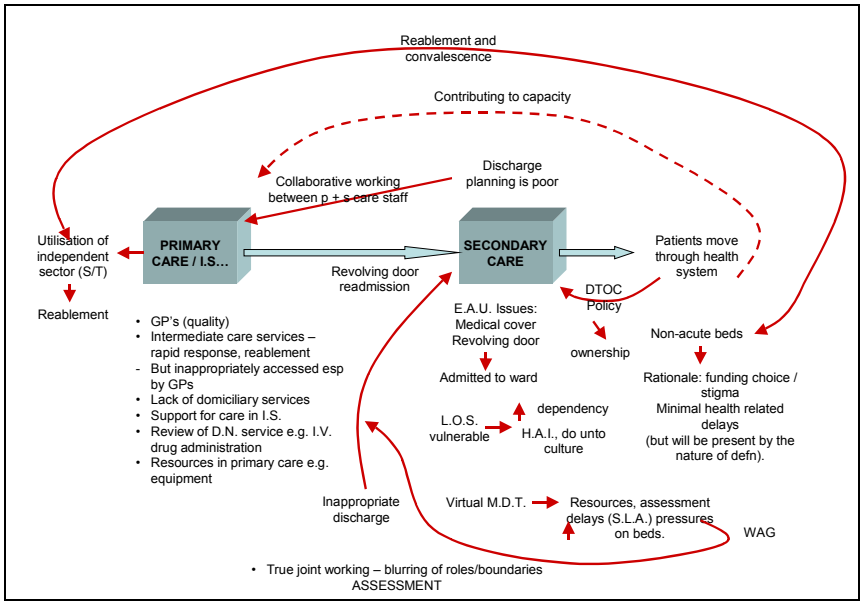
- The key relationship between primary and secondary care at the point of crisis that could result in an admission to hospital;
- The relationship between acute and community hospitals, particularly for 'step-down' services;
- The interventions available to minimise admission to hospital, particularly rapid response and re-ablement;
- A wide range of 'softer issues' that influence the system behaviour including choice, ownership and policy adherence.

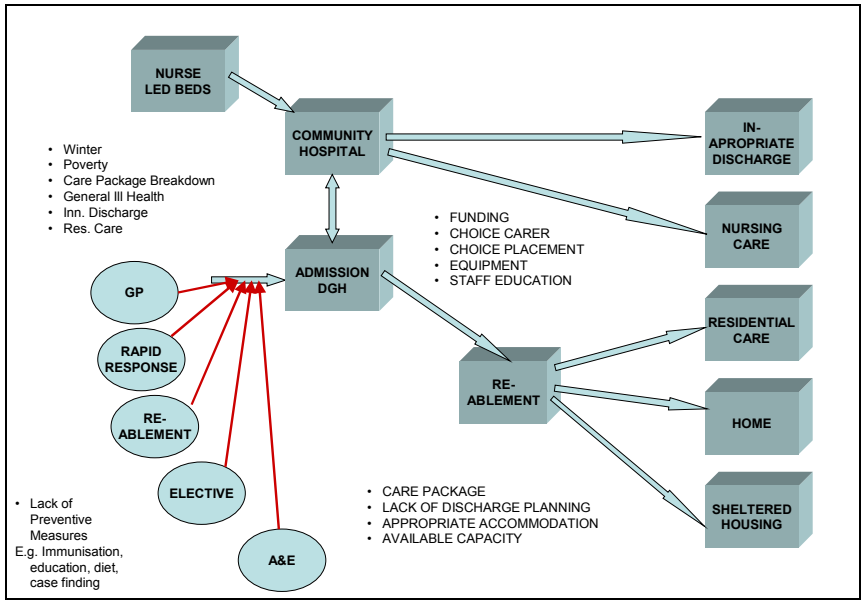
The diagrams produced by the teams are reproduced on page 5.

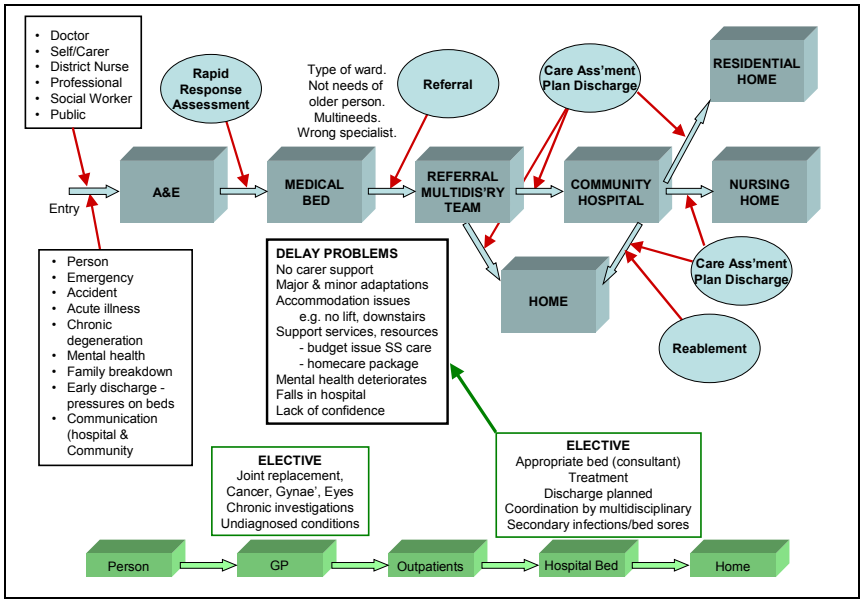
2.3.3 An initial qualitative map

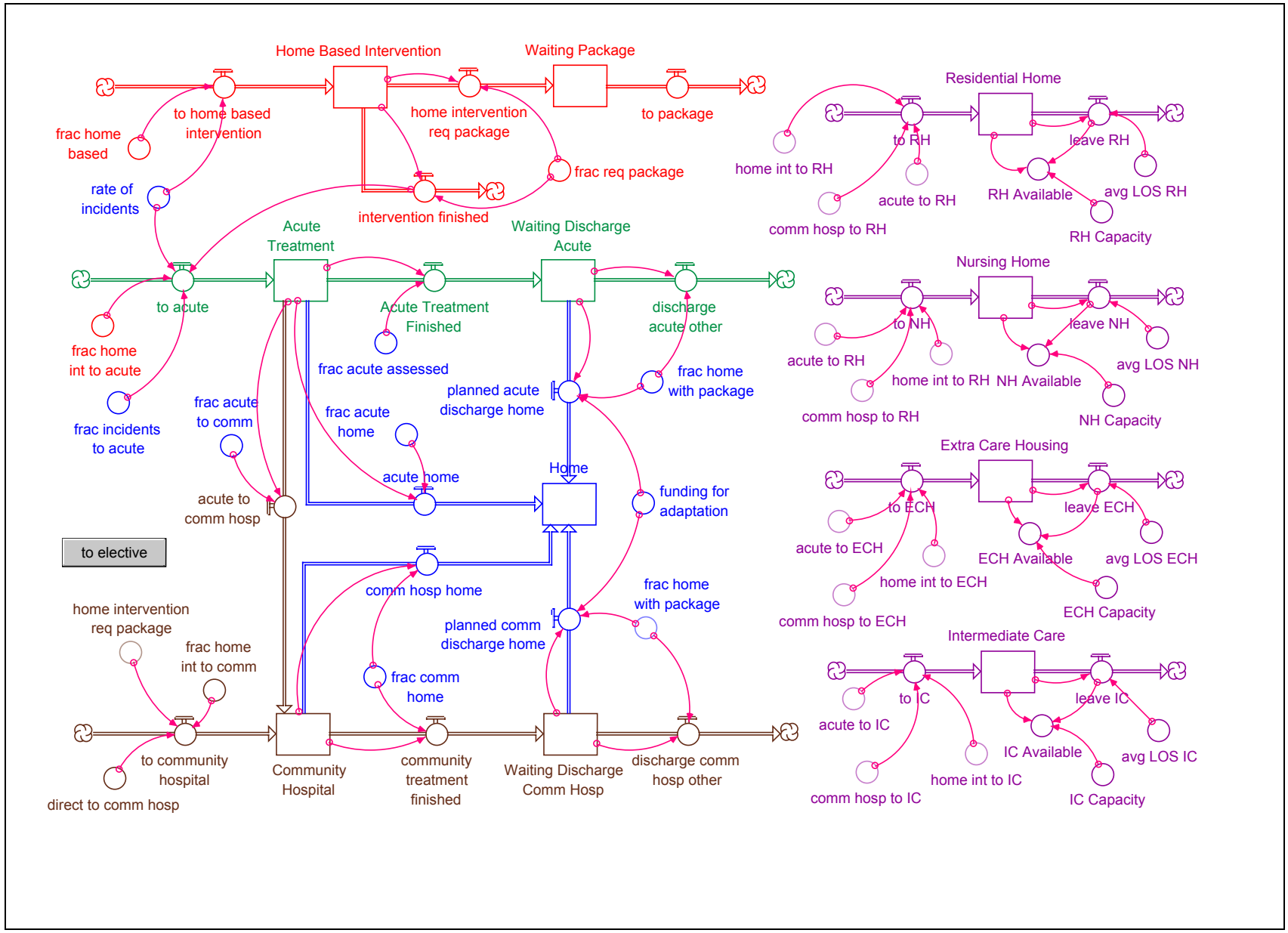
The four approaches were combined to produce a single, first draft, qualitative map that could subsequently be quantified and whose behaviour could be explored. This is reproduced on page 6.











2.4 Conclusion and next steps

Alongside developing the model and reflecting the views of the workshop participants in this report planning was being undertaken to prepare for the second workshop on the 12th March. The purpose of the second workshop would be:

- To review outcomes from first workshop:
  - Project objective;
  - Project 'boundaries and issue identification.
- To present and discuss an initial qualitative map of the system under investigation;
- To discuss anticipated system behaviour.

In addition data collection was initiated, in particular the identification of:

- DTOC for B Gwent residents by reason for delay from 1st April 2001 (weekly data) with location i.e. at Neville Hall or community hospital;
- Number of people waiting for same reasons as in hospital but in the community (may not be broken down but total still useful;
- Non elective and elective admissions to Neville Hall (and to community hospital if possible) by GP practice and split for 18-64 and 65+ by month since April 2001;
- GP code, post code/address and list sizes for 18-64 and 65+;
- Average length of stay for elective/non-elective and 18-64/65+ for B Gwent residents (if possible - average for hospital will do otherwise) at both N Hall and community hospital;
- Information on source, throughput/caseload and destination of people who access either rapid response, reablement or intermediate care;
- Capacity in Nursing/residential care, occupancy levels and admission/discharge rates (aggregated) - recent trends as for above if possible;
- And, if available, any information on the length of delay at Neville Hall/community hospital?

3 Workshop 2 (12th March 2003)

3.1 Review of the model

The qualitative model developed from the 'rich pictures' drawn at the first workshop was presented and welcomed by the participants. The workshop participants were then asked to consider two key questions for moving forward:

1. What interventions or policy options should be considered with which to explore the behaviour of the model once quantified?
2. What information would be required to enable this to take place?

3.2 Interventions and policies

The following interventions and policies were identified in group discussion:

- Re-education of service users/families/general public/health and social care staff members using independence based models;
- Provision of information to aid recognition of what is possible on expectations/opportunities/interventions for example how to improve quality of life and supporting people/integrated services;
- Developing more flexible services to meet the needs of people better and closer to own home and thereby improve choices, free up log jams, target dependency, support independence;
- Development of joint provision/teams with local services where possible;
- Developing more intermediate extra care;
- Ensuring financial Assessment to make people aware of what's available - better information to public and link welfare rights to other sectors;
- Ensuring that Local Authority accommodation meets need better and therefore avoid placement;
- Harnessing technology to aid independence for example 'smart houses' tracking i.e. dementia, or electronic 'monitoring' i.e. health/medication;
- Developing assessment and Care Planning including unified assessment to accurately identify and plan needs;
- Developing better joint commissioning to use resources better and ensure services that meet needs better, whole packages, joined up working and health purchasing beds i.e. Monmouth;
- Developing preventative strategies in order to prevent health deterioration or re-admission through re-ablement/intermediate care, health promotion, case finding/diagnostic checks, over 75's checks, involving LA and private sectors and promotion of independence models;
- Reconfiguration of existing services i.e. eligibility/change current ways in which needs are assessed and met - interventions will increase independence, prevent initial deterioration, prevent admission, prevent re-admission, remove log jams, change culture and so discharge expectations, clarify who should receive high degree of enabling services and target resources better;

- Developing Re-ablement towards Intermediate Care Team using a multi-disciplinary approach;
- Developing rapid response to clinical intervention at home;
- Developing the therapy input to services;
- Following the patient/client through the system especially with respect to the acute sector;
- Implement the unified assessment process and monitor impact;
- Develop the nurse liaison role;
- Ensure clinical input to community based services;
- Ensure adequate out of hours support;
- Ensure access to diagnostic services;
- Develop the joint equipment store/service;
- Develop care packages that encompass manual handling and aids to daily living;
- Further explore the co-operative model for LA Residential Homes;
- Consider impact of fairer charging policy and eligibility criteria;
- Ensure impact on resources can be modelled.

Some of the intended impact, as well as reductions in delayed transfers of care, would be:

- To reduce the number of admissions to Acute;
- 'Fast track' people through the acute system;
- Ensure that re-ablement impacts on throughput in Acute;
- Develops 'In reach' model.

Whilst not all of this information would be readily available it was important to identify the information that would be important in testing the model in the areas identified.

3.3 Information and data collection

The following information was considered important in developing the modelling approach:

- Age profiles/general demographics/economic activity;
- Public health data specific to Blaenau Gwent;
- Better analysis/prediction of medium/long term trends;
- Local support mechanisms and their capacity to cope with predicted trends including family support;
- Skills availability of health and care staff;
- Capacity at present to provide services;
- Accurate prediction of future needs.

Some issues that were identified with regard to information included:

- Needed to ensure that the information was as specific as possible to Blaenau Gwent;
- Commissioning information was not generally available;
- There was no co-ordinating group for information.

3.4 Key areas and next steps

The third workshop would be held on the 30th April following a period of model development. At that workshop a small number of key interventions will be explored. These should be chosen from the issues identified above and represent different types of intervention at different points along the care pathway. Initial suggestions include:

1. Development and increased capacity for the reablement team to undertake a pro-active approach to care co-ordination and greater integration with rapid response with the possibility of creating increased community capacity through the re-alignment of existing therapy staff with community services and then in-reaching to the acute sector;
2. The development of improved/enhanced education and preventative work;
3. The development of and speeding up of access to home improvements, and other suitable accommodation other than long term residential care;
4. Tackling the cohort of community hospital 'residents' who have become institutionalised and therefore experience extended lengths of stay.

The measures and outcomes required of the model will include:

1. The impact of changes on the levels of DTOCs;
2. The impact of changes on capacity requirements within the acute sector in terms of occupied bed days;
3. The impact of changes on the use of community hospitals;
4. The impact of changes on the balance of provision for long term care including the residential and nursing home sector with reference to any levels of occupancy that may precipitate significant numbers of closures.

Participants were invited to comment on these options by e-mail prior to the third and final workshop.

4 Workshop 3 (30th April 2003)

4.1 Purpose of workshop

The purpose of the third workshop was to feed back some of the findings of the data analysis and to explore a limited number of scenarios using the model developed. This would then lead to the identification of action that would serve to address the needs of local people in the context of the simulations explored.

Key interventions identified for exploration were:

- The development of the reablement team to undertake pro-active approach to care co-ordination;
- The development of improved/enhanced education and preventative work;
- Improvements in the housing stock to enable more people to be supported at home rather than being delayed in hospital or admitted to long term care;
- Tackling the cohort of people who have long lengths of delay in community hospitals, particularly Abertillery and Ebbw Vale.

Key outputs required from the modelling were identified as:

- The impact of changes in the system on delays in hospital and if possible at home;
- The impact of changes on acute sector capacity requirements and targets;
- The impact of changes on the use of community hospitals;
- The impact of changes on the need for long term care.

Output from both the analysis and simulation would inform the choices in the light of emerging findings.

4.2 Findings from the initial analysis

4.2.1 Demographics

The total number of older people in the Borough is set to rise although different age groups (65-74, 75-84 and 85+) will reflect different patterns. As well as absolute changes it is important to note the generally low levels of health and therefore the needs of people becoming greater at a relatively young age compared with elsewhere. The number of over 75 years olds will actually fall slightly between 2004 and 2014 from 5,532 to 5,492. The number of 65 to 74 year olds, however, will rise from 6,378 to 7,773 over the same ten-year period (nearly a quarter higher). This is illustrated in Figure 1.

In the absence of radical changes and in the light of the shorter time-scale over which the modelling in this project has been undertaken no account has been made for changing demand due to demographic change.

4.2.2 Admissions to community hospitals

An analysis of admissions to community hospitals by GP reflects the use of different hospitals for the purposes of accommodating people whose discharge is significantly delayed (over 57 days). 87% of admissions were to either

Blaina or Tredegar confirming the use of Ebbw Vale and Abertillery for the purposes of delayed transfers.

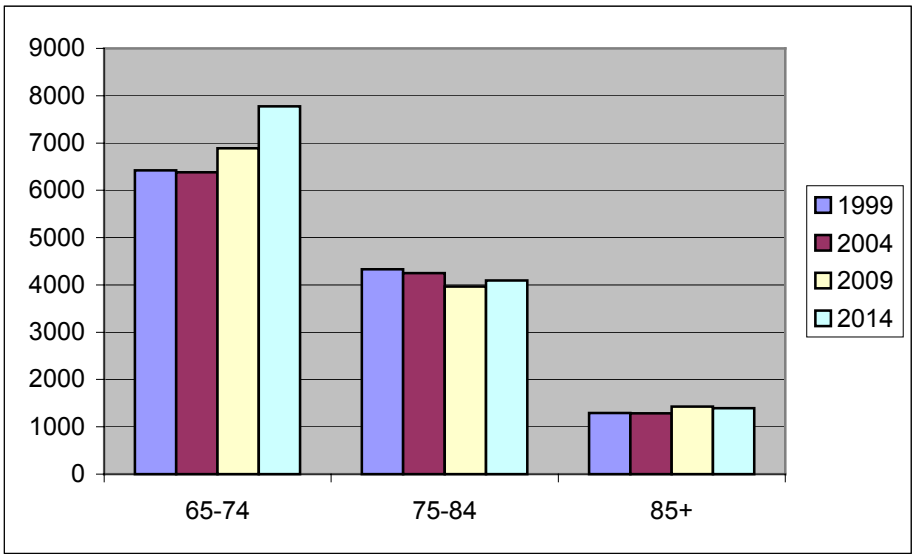


Figure 1 Demographic change in Blaenau Gwent between 1999 and 2014

The difference in referral rates between GPs was significant with a cluster of practices utilising the community hospitals at a rate of just over 16 per 1,000 population compared to the lowest practice at 6.9. This suggests significant potential for greater use of the community hospitals by some GPs.

It is also clear from the analysis that the capacity in the community hospitals is not being maximised, particularly with respect to low occupancy levels (between 45% and 62%) for GP beds and on average 20 people whose discharge is delayed by over 57 days.

If all practices were to use the community hospitals at the average rate of the four highest practices it would require 16 beds within the community hospitals and, on the basis of an average length of stay in the acute hospital of 8.2 days that could as a result be avoided, a saving of 7 acute beds.

4.2.3 Non-elective acute admissions

Amongst the over 75 year old population the rate of emergency admissions was 264 per 1,000 for 2001/02. This was 9% higher than for Gwent as a whole. However, the length of stay for these patients was less than the average for Gwent residents at 8.2 days. This is felt to be due largely to the significant number of community hospital beds available. The number of delayed discharges at Neville Hall is minimal. The capacity used by Blaina Gwent residents at Neville Hall is equivalent to about 60 beds.

4.2.4 Delayed transfers of care

The number of delayed transfers of care has remained relatively high over the last two years. Figures 2, 3 and 4 identify the total number, the number waiting for funding, the number at each community hospital and the number waiting at home. Together these represent a significant challenge to the system.

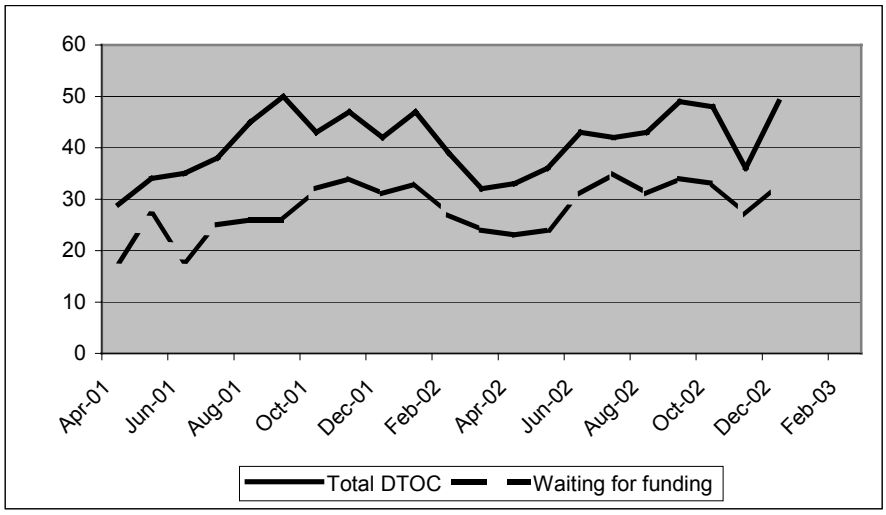


Figure 2 **Delayed transfers of care in community hospitals in Blaina Gwent**

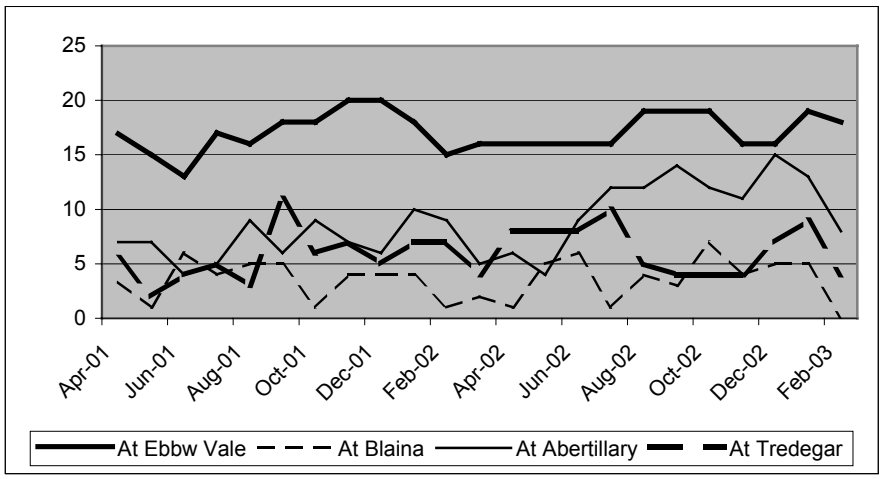


Figure 3 **Location of delayed transfers of care**

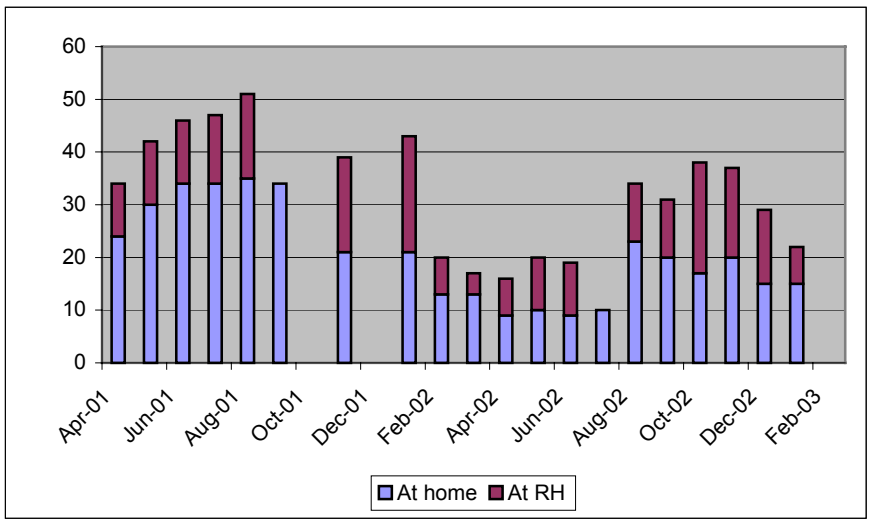


Figure 4 **People delayed/waiting for a package of care at home**

The analysis suggests that:

- There is a similar scale of problem and associated risk with regard to people delayed for funding whilst still at home;
- The use of Abertillery for significant number of delayed transfers of care has been growing over the last two years;
- The number of people waiting different lengths of time suggests that there is a reasonable 'throughput' of people staying for relatively short periods but a significant cohort of patients whose stay has become significantly longer.

4.2.5 Long term care

There was relatively little data available within the timescale of the project to illuminate this area. The volume of contracts for nursing and residential care was 249 and 271 respectively and the rate of admission was scheduled to reduce from 38pcm in 2001/02 to 31pcm in 2003/04. There was no evidence, however, of monitoring for this making its inclusion in the modelling difficult.

4.2.6 Reablement and rapid response

The key information for these services was available for use in the simulation exercise. Rapid response saw on average 30 referrals a month, 60% of which came from Nevill Hall. On average they stayed in the service for 5 days.

The reablement services saw approximately 18 referrals a month, 62% came from hospital (including community hospitals) and the average length of stay was 5 weeks. Capacity was 25 but extended into the 30's regularly in light of lower levels of need toward the end of somebody's support. 73% of clients left with no need for further services and there was on average a waiting list for the services of about 5 clients.

4.3 Scenarios

Appendix 4 outlines the data assumptions underlying the systems model developed using ithink software ('wiring diagram' included as Appendix 5). This model remains draft and reflects the stage of learning and understanding developed during the workshop process.

Three scenarios were tested out using the model:

1. Increasing the rate and capacity for reablement;
2. Diverting emergency admissions away from acute to community hospital admission;
3. Development of extra care housing as an alternative to nursing or residential care home admissions.

The initial findings from the scenarios are reflected below.

4.3.1 Increased capacity for reablement

Increasing the capacity for reablement from 25 to 36 and increasing the percentage of people assessed as requiring reablement from 11 to 20% of those discharged from hospital.

Assumptions within the model were not adequate to fully demonstrate the impact of these changes although the immediate effect was to shift patient flows away from community hospitals and therefore present the risk of delays in

hospital for reablement if capacity and throughput were not held in balance. In view of the current levels of work undertaken by the reablement team it would be important to ensure increased capacity preceded changed patient pathways.

The changes did also suggest reductions in admissions to both nursing and residential care homes as well as intensive home care as current assumptions were based on the fact that 73% of clients left the reablement team needing no further services. This may change if higher dependency patients were included in any increased capacity.

4.3.2 Diversion of admissions from acute to community hospitals

The simulation here suggested a transfer of 5% of acute admissions to community hospitals which was consistent with the findings outlined in the earlier analysis section in relation to current GP referral rates.

Again current assumptions within the model would need more careful validation and impact of any changes carefully monitored but some of the interesting behaviours of the system were to see a reduction in referrals to the reablement team due to reduced throughput in hospital and an increase in community long term care requirements due to the assumptions that the current destination of discharge from community hospitals had a higher rate of need for long term care than for acute discharges.

4.3.3 Development of extra care housing

The scenario considered a reduction of 10% in the admission rate to residential care with extra care housing being substituted. The model suggested the need for 46 places in extra care housing as a result with a reduction in residential care home places of 34. The difference being related to the length of stay in these settings which were assumed to be longer in extra care housing.

4.3.4 Impact on delayed transfers of care

The project continued to address the need to reduce the number of delayed transfers of care. Action has been included below that specifically addresses this issue in the context of the wider model.

It was the project groups belief that a strategy for reducing delays should consist of parallel strategies to deal with both the tendency for people to become ‘stuck’ in community hospitals, often due to the lack of funding, and the need to ensure community and housing solutions are made available swiftly in the context of reablement and a preference for moving people home.

The model outputs reflected the possible strategies outline below in that if a policy were agreed to remove the possibility of people staying for over 57 days the natural reduction in this client group would gradually reduce the number of delays.

At the same time the reduction in the length of delay for those waiting for under 57 days could have a similar impact. Together these strategies could see a medium term reduction over say 12 to 18 months to a level of DTOCs for Blaenau Gwent residents of roughly half the current level. New cross-agency monitoring of delays would assist in applying the necessary pressure to see these strategies, once agreed, implemented.

4.4 Action planning

The alternative scenarios described above should not be seen in isolation. Future work should explore the inter-relationship of these interventions using the learning and common perception of the system developed through this project.

As a final part of the third workshop participants were challenged to consider immediate actions that could achieve a difference over the next 6 months based on their enhanced understanding of the whole system. This section organises and summarises these as a basis for forward planning. They will need to be organised, discussed and prioritised by the multi-agency group that originally sponsored the work.

Potential action identified included:

- Ensure options for clients whose length of delay has become excessive are fully explored and wherever possible alternatives implemented;
- Review discharge processes from community hospitals to reduce the length of delay for people whose destination is clear and ensure more responsive community services where appropriate;
- Explore the development of an agreement between health and social care regarding delays for funding in the light of the possible introduction of reimbursement charges;
- Improvement in the quality and quantity of social services assessment processes to achieve more equitable application of eligibility criteria;
- Consultation with older people to determine their preferences coupled with work on needs analysis;
- Bring together disparate elements around the discharge process and integrate/co-ordinate around a revised discharge policy;
- Develop a community based, clinically led, multi-disciplinary team with an assessment and intervention function;
- Support GPs with single point of access for assessment and referral on to rapid response, reablement, community services etc;
- Explore the potential for a single budget community services, possibly with an initial focus on reablement, rapid response and the proposed community assessment multi-disciplinary team but with options for extending this more widely to cover other general community services;
- Increase preventative work;
- Extend reablement as a philosophy across all staff groups;
- Develop an effective joint co-ordinating body at a strategic/executive level to steer change and release any blockages in the system that threaten to delay implementation;
- Review current initiatives to ensure robust evaluation and refinement/roll-out where appropriate, for example ECAS and EPIC;
- Develop a project management structure for implementation;
- Ensure resource neutrality – doing things differently.

Appendix 1 – Project outline

1 Approach

Benefits are derived from sharing people's mental maps and therefore developing a common understanding of a complex system. In addition it is possible to identify responses within the system that may be counter-intuitive or hidden from our normal appreciation of the system. It is also possible to gauge the broad magnitude of the impact of one change in the system on other parts. This gives greater confidence in identifying the potential outcomes of new initiatives.

The approach is widely used in industry particularly in matters of supply chain dynamics but has also been applied within the public sector. Local applications have been developed within the older people's project and scenario planning for winter pressures.

2 Project outline

The standard approach would involve the following steps:

1. The identification of the key issue in question and the initial development of a qualitative model of the whole system as understood by a multi-professional group. This would involve initial interviews followed by a facilitated workshop in which the different perspectives would be shared with a view to developing a single model of the whole system;

2. The development of a qualitative model based on the output of the first workshop;

3. Feedback of qualitative models at a second workshop and the exploration of potential consequences and feedback mechanisms operating in the proposed system;

4. The identification of appropriate data sources to enable the qualitative model to simulate possible behaviour of the whole system in the real world;

5. The development of a simulation model which illustrates the behaviour of the whole system and enables key learning points to be derived by the multi-professional group at a third and final workshop;

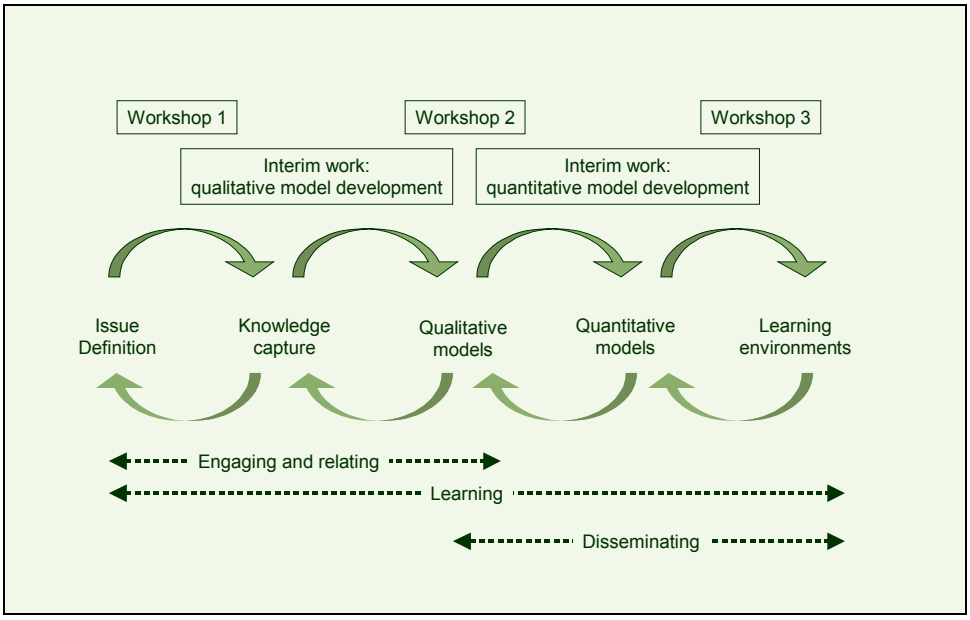
6. A final report for those involved in the process including recommendations for ways in which the information gained from the exercise can be incorporated into proposals for streamlining the system.

3 Resources and timescale

An exercise such as that described above could be undertaken in a timescale of 2 to 3 months. Facilitation and model development would consist of:

- One day of preliminary interview and preparation for the first workshop;
- Three days for preparation, facilitation and reporting on the workshops;
- Approximately three days building and populating the model with data;
- Two days for the development of a final report and any necessary communication of that report;
- Follow-up support for the model of one day to ensure any model if available locally.

Participants in the project would need to be representative of the whole system being explored. They would need to commit themselves to three half-day workshops over a two to three month period. In addition a small core group would need access to relevant data sources.



Appendix 2 – project participants

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The workshops were facilitated by Peter Lacey and Paul Gisborne of Woodville Consultancy (www.woodville-consultancy.co.uk).

Appendix 3 – workshop programmes

Workshop 1

Welcome and introductions	9.30
Introduction to the project	9.40
Group discussion – issue definition	10.00
BREAK	10.30
Introduction to systems modelling	10.45
Mapping the local system (small groups)	11.15
Feedback and discussion	12.15
Next steps	12.45
CLOSE	1.00

Workshop 2

Re-introductions	9.30
Review of output from first workshop	9.35
Walk-through the proposed model	9.50
Model review & discussion (small groups)	10.15
Feedback	10.45
BREAK	11.00
System behaviour and outputs (small groups)	11.15
Feedback and discussion	12.15
Next steps and data collection	12.45
CLOSE	1.00

Workshop 3

Re-introductions	9.30
Review of output from second workshop	9.35
Findings from data analysis	9.45
Presentation of model	10.15
BREAK	10.45
Scenarios and model outputs	11.00
Action planning (small groups)	11.45
Discussion of next steps	12.45
CLOSE	1.00

Appendix 4 – modelling assumptions

1 Demographics

Spreadsheet contains population projections[1].

2 DTOC

Spreadsheet contains profile of DTOCs in community hospitals and at home from April 2001.

Also spreadsheet contains profile of lengths of stay – this suggests the need to split the DTOC stock into two with one for people waiting up to 56 days and an average of 12 days delay (and ability to slide) with those waiting over 57 days representing a backlog. What we will simulate then is a commitment to not to allow anybody new to wait over the 56 day limit if at all possible and then allow these long delayed people to reduce gradually over time whilst putting in place processes to ensure the remainder flow through effectively.

Length of stay for people delayed over 57 days – average for the 21 people currently in a community hospital is 153 – but they're still there, mostly waiting for Nursing Home places (16 out of 21). 16 of these people are at either Abertillery or Ebbw Vale.

3 Long term care

3.1 Rate of admissions

Assume rate of admission to care homes (combined RH/NH) as 38pcm in 2001/02 falling to 31pcm in 2003/04[2].

3.2 Unit costs & numbers of people

The following average costs and volumes for older people were contained in the SSD Joint Review Position Statement (May 2002):

	Ind. sector	Local Authority	Volume (total)
Nursing care (weekly)	£341	N/A	249
Residential (per week)	£227 to £290	£385	271
Home care (per hour)	£7.50 to £9.11	£9.26	1,938
Day care (per session)	£25	£74	117

4 Rapid response

Detail in spreadsheet but assume an average of 30 referrals a month for an average length of stay of 5 days and 60% coming from Nevill Hall and 40% from the community (very few from community hospitals – the occasional one).

[1] The spreadsheet referred to has been provided on disc along with this report and represents the original workings from information provided locally.
[2] Health & Social Care Plan Strategic Intentions 2002-07.

5 Reablement

Last quarter (August – November) information was as follows:

- Average appropriate referrals running at 18 per month in last full six months of records (Aug 02 to Jan 03).
- Average length of stay is 5 weeks.
- Average age of client was 79 (just interesting).
- Referrals 61.9% referred from hospital (e.g. hospital social worker, OT, consultant, staff nurse etc); 38% referred from the community (e.g. community nurse, social worker, physiotherapist, occupational therapist).
- Outcomes 23% were referred to Homecare- either receiving the same services or reduced services.
- 73% totally independent and required no further services;
- Capacity is 25 but regularly runs at 30-35;
- Waiting list for re-ablement is on average 5 clients.

6 Acute

Summary table in spreadsheet. Key facts are:

- Rate of emergency admissions for +75 population is 264 per thousand pa = 156 per month. The number that go to N Hall is c.148. Rate is 8.6% above average for the whole of Gwent. Could therefore be reduced theoretically to 136.
- Average LOS for all admissions is 8.2 suggesting that 60 acute beds are used by B Gwent residents who are over 75.
- Average LOS for emergency admissions is 10.0 for N Hall hospital (compared to 10.6 for Royal Gwent and 10.4 for Caerphilly).

7 Community Hospitals (including outline business case - July 2002)

Current position is as in table below.

Hospital	Beds	% occupancy	LOS
Blaina	16 (GP)	53%	19
	31 (consultant)	88%	23
Tredegar	16 (GP)	45%	20
	26 (consultant)	83%	25
Abertillery	16 (GP)	62%	17
	18 (consultant)	80%	76
Ebbw Vale	28 ('cont care')	90%	100

Numbers and lengths of delay contained in spreadsheet. Most long delays are in Aberbeeg and Ebbw Vale.

Basic proposal for the future is for a 100 bed intermediate care community hospital with Blaina and Tredegar hospitals retained as local outreach re-enablement units.

At present – for the purposes of this modelling, the introduction of a new community hospital does not change the overall capacity in the community – what is important, however, is to run down the inappropriate use of community hospitals for continuing care/long institutionalised delays and to increase the use of the beds for appropriate rehab and intermediate care.

Appendix 5 – Map of system developed for simulation