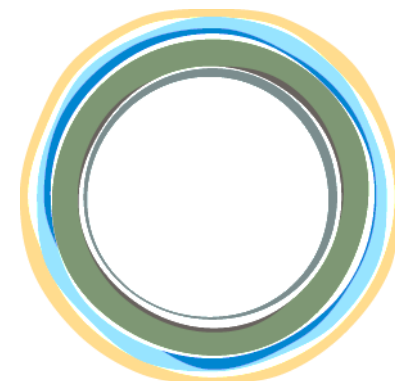


Development of community services – withdrawal from Hillside Annexe

Presentation to AWSC January 2018



- For every 10 days of bed-rest in hospital, the equivalent of 10 years of muscle ageing occurs in people over 80-years old, and reconditioning takes twice as long as this de-conditioning. One week of bedrest equates to 10% loss in strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength may make the difference between dependence and independence
- In 2017, two separate reviews of patients currently in receipt of care in Wye Valley NHS Trust community hospital beds identified that 40% of the patients were awaiting care elsewhere.

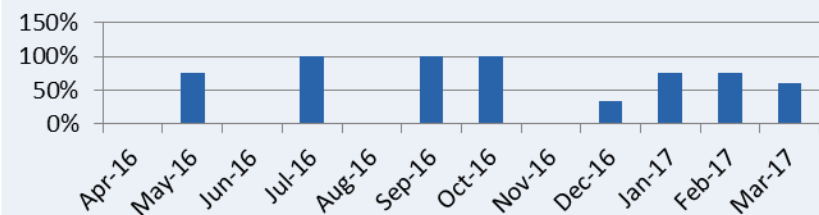
Herefordshire System Metrics

1. **Emergency admissions (65+) per 100,000 65+ population = 2nd out of 152**
2. **90th percentile length of stay for emergency admissions (65+) = 147th**
3. **Total Delayed Days per day per 100,000 18+ population = 99th**
4. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services = 74th**
5. **Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation = 127th**
6. **Proportion of Discharges (following emergency admissions) which occur at the weekend = 129th**

Hillside

- Hillside is a 22 bedded annexe of the county hospital. Most recently it has delivered a dedicated stroke re-ablement service, though the Trust has now successfully transitioned this to a community based service through CCG investment in the Early Supported Discharge team
- Currently average Length of Stay = 24.4 days
- Beds = 22
- Equates to 8030 bed days / 24.4
- Numbers of patients per annum = 329 patients per year

Percentage of patients who have a reduction in care calls on discharge from ESD



Home first

Increases in the community health team:

WVT –recruited to:

1x WTE Physiotherapist

1x WTE Occupational Therapist

4x Reablement Assistants

- Additional cover to Physiotherapist from Hospital at Home
- Will be seeking to recruit approx 4 further additional posts including Nursing to support discharge from Emergency Department and Acute wards directly to home.

Reablement team modelling

No. of New Workers Fte's:	11
Reablement Workers Total Weekly Hours:	407
Annual Weeks Worked:	40
Annual Hours Worked:	16,280
% Of Time With Clients:	65%
Annual Hours With Clients:	10,582
Average Calls Per Day	2.00
Average Length Per Call	0.75
Average Length of Service (weeks)	3.50
Average Hours per Client:	37
Annual No. of Clients:	288



Compassion • Accountability • Respect • Excellence

Overall increase in investment in services to support withdrawal from Hillside annex:

2017/18

£200,000 investment in Community Health Team (6 wte in post, 4 more being recruited)

£150,000 investment in HomeFirst service alongside improved training and pathways

Closer working between the health and social care teams to provide an improved experience for individuals.

2018/19

£400,000 investment in Community Health Team – full year effect of the investment in 2017/18.

£250,000 investment in HomeFirst service – full year effect of the investment in 2017/18

Length of Stay

- Bromyard – 28.8 days (14 beds) – 177 patients
- Leominster – 28.9 days (26 beds) – 328 patients
- Ross
 - Peregrine – 26.6 days (18 beds) – 247 patients
 - Merlin – 27.3 days (14 beds) – 187.2 patients
- Total 939 patients

10% improvement in LoS nets further 94 patients

Progress

- Red 2 Green initiated at all community hospitals
- Daily Huddles
- Constraint reporting
- In last 3 months overall reduction in LoS in community beds of 8%



- Continued operational programme oversight – Weekly meeting
- Management of Change concluded – all staff being aligned to alternative posts in Trust
- Zero redundancies
- Continual Executive review of closure planning balanced against operational delivery
- Intended reduction of flow of patients to Hillside site beginning February

- Further development of community based services including;
 - Development of Discharge to Assess programme
 - Improved support to Care Homes
 - Mobile working for community staff
 - Admiral (dementia) Nurses in all localities