Report No 42/2002

Northern Area Health Board

Proposed Management of New Long-Stay Bed Capacity Pilot Initiative

1.OUR BOARDS STATEMENT FOR OLDER PERSONS

Our Boards Service for Older Persons promotes the enhancement of the health and social status of older persons in our Boards area, in partnership with our statutory and voluntary organisations, through the provision of a range of support services at community level to allow older persons remain in their homes for as long as is practical with dignity, independence and a good quality of life. The transfer of an older person from his/her home to in-patient care should only be considered when the older person has been medically assessed as in need of such care and when all other care options to support and facilitate the older person to continue living at home have been exhausted.

2.ACUTE HOSPITAL BED CAPACITY REVIEW

2.1 National Recommendations for Additional Acute Hospital beds required in Ireland to 2011

Current Indicators for Inadequate Bed Capacity	
Additional beds required to reduce average bed occupancy in major hospitals	883
Strategies with the Potential to Reduce Need for Additional Beds	
Investment in measures to reduce delayed discharge from Acute Hospitals	675

2.2
The 10 Year Action Plan showed the disparity in the East in comparison with the rest of the country. This is re-enforced by the Minister announcing the development of nine Community Units (PPP) in the ERHA region and in Cork because of this disparity, of which three relate to the Northern Area Health Board.

3.NON-ACUTE RESIDENTIAL SERVICES

Our Board provides a broad range of residential care services as a step down from acute care and as a step up/support to the community services:

- **Assessment/Rehabilitation Services**

Assessment / Rehabilitation services is usually for older patients who have completed the acute phase of their treatment, but require further intensive rehabilitation over a planned period. The intensive assessment / rehabilitative services are put in place for each patient by a multi-disciplinary team and is critical in allowing the patient attain the highest possible health gain so that he/she can return to his/her home in the community.

- **Respite/intermittent Care**

Respite / intermittent care supports relatives caring for dependent older persons at home by providing respite care while the family is on holiday, crises admissions due to ill health, or events in the family, and appropriate cases the regular (intermittent) admission of a dependent relative for a short period of time. This service enables patients to remain in their own home for longer where this may otherwise not have been possible.

- **Welfare Services**

Welfare services are low support facilities, which provide support to residents of a non- nursing nature within the community.

- **Convalescent Care**

Convalescent facilities are available for older persons who have completed the acute phase of their treatment in an Acute General Hospital and require a specialised period of convalescence for either one or two weeks before returning to their home environment. The older persons enjoy the full range of facilities of the hospital / home in order that they achieve the highest possible health status before returning home.

- **Extended Care Beds**

Extended care is available to older persons who have been medically assessed by a Consultant Physician in Medicine for Older Persons and who have been found to be in need of this level of care and for whom both community and a lower level of residential based care is no longer feasible. Patient care is provided in this setting by a multi-disciplinary team consisting of medical, nursing, para-medical, care and support staff. A range of para-medical and social services are provided as appropriate. Extended care for older persons is provided throughout the Northern Area Health Board at a variety of hospitals, residential homes and community units.

These services are provided in our Board's institutions and in private nursing homes- and are set out as follows see ***Appendix I:***

4. TRANSITION TO EXTENDED CARE

The transition of a client into extended care is a serious life event both for the client and also for his/her family. It generates a considerable amount of emotion and it is not usually either the clients or the carer's first choice of accommodation. A decision is not simply that of occupying the next vacant bed rather consultation with regard to access and assessment of the client to match care of the client with the potential level of care provided by the contracting agency. For this reason there is often understandably a time delay between the time the bed becomes vacant and the time the bed is filled. It is therefore not simply a "bed" but a place of residence and effectively a "home" for this person.

5. IMPROVED MANAGEMENT SYSTEMS / COMMUNITY BED STOCK.

The Northern Area Health Board has developed a policy for the equitable and transparent division of the long stay inpatient bed resource. Through a common hospital / community waiting list it is envisaged that the implementation of an automatic bed management system will allow better and more cost effective management of this valuable bed resource.

The genesis for change as recognised and identified in successive reports is that all resources for the elderly in each catchment area including beds, are at the disposal of the Consultant and the Managers for Service for Older Persons so as to facilitate the widest possible choice of care paths for each client requiring a service within our resource capacity.

The key element in future management of the non-acute service will be our Board's efforts to ensure an equitable system of access to the various beds particularly extended care beds. The key to an equitable distribution of long stay beds lies in the maintenance of hard and accurate data which monitors the demands that are being experienced both by the acute hospitals and by the Community Care Service in placing people who have been medically assessed as requiring long stay care.

It is recognised that in order to achieve maximum bed occupancy and make timely decisions it is necessary that Managers have available -

- **Number of beds at their disposal**
- **Timely information with regard to the bed stock activity**

6. CONSULTATION WITH SERVICE PROVIDERS

Consultation has been ongoing since March of this year when agreement was reached in principle to the realignment of beds per Community Area in line with morbidity and the establishment of a Steering Group to oversee implementation. Consultation is ongoing and involves-

- Mater and Beaumont Hospital Management
- Consultant Geriatricians
- Consultant Psychiatrists in the Psychiatry of Old Age
- Our Board's Service Managers and Community Staff
- IT EHSS (IT Section)
- ERHA

The outcome of the Consultation process to date has been the –

- Development of an IT system to manage the bed stock by illustrating activity through reports. This will facilitate timely decisions and identify gaps with regard to respite or convalescent placement whilst optimising extended care.
- Proposed alignment/division of Beds to the catchment Area/ Hospital in line with morbidity and are set out as follows ***Appendix II.***

7.1 Combined Waiting List

A joint waiting list managed by the Consultant Geriatricians and the Managers of Services for Older people is proposed. Hospitals/Nursing Homes will be set up as wards allowing admission and discharge see ***Appendix III***

7.2 Reporting

Reporting capability currently exists that will capture waiting times equity between hospitals/community, and bed occupancy, bed days etc. This will provide management analysis for effective information sharing allowing us to see immediately clear and accurate bed data, which allows us to manage effectively current demands and plan, schedule and anticipate future requirements

7.3 Enhanced Bed Management

Enhanced bed management will be bolted onto the modified system in 2003 allowing in addition a region wide view across Community Care Areas and bed number reports. In essence, it will be an up-dated version of the current NAHB PAS (Patient Administration System).

7.4 Website

Enquiries are being made into the feasibility of holding a Shared Folder on a website. This would allow visibility and access by all service providers and be in line with our concept of transparency and accountability.

7.5 Role of Bed Co-ordinators

The key players in the scenario are the proposed bed co-ordinators in each Community Care Area. To date each has been invited to sign off on the proposed new system and has undertaken training as a result. They will not be decision makers or manage the waiting list, but will be responsible for data input and report selection and the transfer of this information to the Manager for Services of Older Persons and Consultant Geriatricians see ***Appendix IV***.

8 Service Enhancements

Currently our estimates for public bed occupancy is approximately 90% and our Contract bed occupancy is approximately 85%. Our Board's target for 2003 with the introduction of our proposed new management system to achieve a greater use and occupancy of our existing bed stock and therefore achieve maximum efficiency.

8.1 Independent Audit

In order to progress the initiative the proposal of an independent auditor was accepted by the Steering Group. The audit will act as a safeguard for the integrity of the new system and also as a mechanism to facilitate reviews. The audit will be conducted by Trinity College Dublin of which terms of reference, parameters and boundaries will be discussed as a first step in this process.

8.2. Revised Protocol & Procedure

It was agreed, that in order to progress the work associated with the implementation of the plan, policies/protocols for referrals/assessments, management of waiting lists, admissions and discharge to acute and non acute services including review of long-stay patients and monitoring and evaluation would need to be established and this will be part of our work programme in 2003.

CONCLUSION

Collaborative consultation is ongoing, and will be audited independently and therefore this project is being rolled out on a phased basis. I will bring a further Progress Report to the Board Members during 2003.

M Windle ***21st November, 2002***
Chief Executive

Appendix I

Range of Non-Acute Residential Services

	Assess/Rehab	Respite/Intermittent Care	Welfare	Convalescent Care	Extended Care Beds
	2002	**2002**	**2002**	**2002**	**2002**
AREA 6					
Mater	20	-	-	-	-
JCM	54	2	-	-	60
St. Mary's	52	12	16	-	207
Ashgrove	-	-	39	-	-
Cuan Ros	-	10	-	-	35
AREA 7					
Clarehaven	-	-	39	-	-
St. Clare's	-	2	-	-	61
Sean Chara	-	10	-	-	40
Clontarf Orthopaedic Hosp.	-	2	-	-	-
St. Monicas Home	-	2	-	-	43
AREA 8					
Beaumont Hospital	24	-	-	-	-
St. Gabriel's	-	1	-	-	-
Lusk Community Unit	-	10	-	-	25
Baldoyle					
Contract Beds	-	-	-	-	487
Subventions Granted	-	-	-	-	204
Enhanced Subventions	-	-	-	-	335
TOTALS	**154**	**51**	**94**	**0**	**1497**

Appendix II

5. Proposed alignment / division of Beds to the Catchment Area / Hospital in line with morbidity.

(1) Public Beds

Community Area6	JCM Hospital Cuan Ros Community Unit St. Mary's Hospital Sean Chara Community Unit	60 Beds 18 Beds 75 Beds 8 Beds
TOTAL		**161**
Community Area7	Sean Chara Community Unit Cuan Ros Community Unit St. Monica's Home St. Mary's Hospital St. Clare's Home	22 Beds 7 Beds 23 Beds 75 Beds 20 Beds
TOTAL		**147**
Community Area8	Lusk Community Unit St. Clare's Home St. Mary's Hospital St. Monica's Home	25 Beds 41 Beds 57 Beds 20 Beds
TOTAL		**143**

Overall total public beds TOTAL 451

(2) Contract Beds

Community Area6	127 Beds
Community Area7	189 Beds
Community Area8	140 Beds
TOTAL	**456 Beds**

Overall total contract beds TOTAL 456

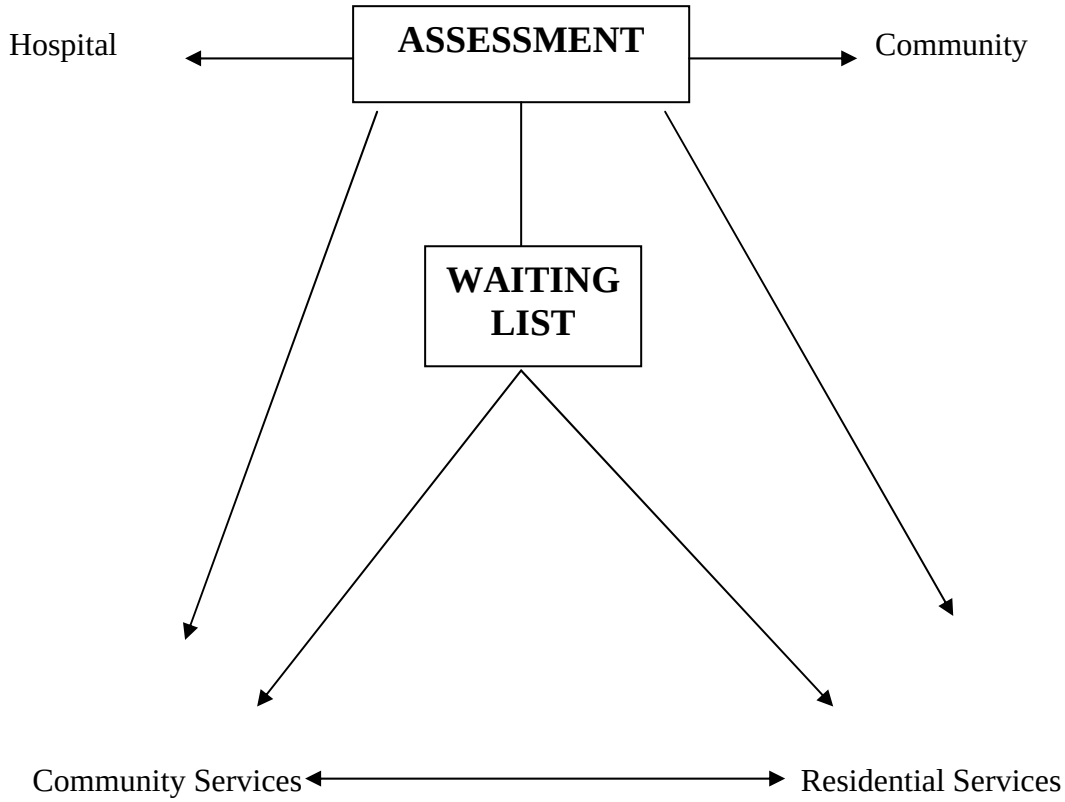
	Public Beds	**Private Beds**	**Total**	**Overall % of Beds**
Community Area6	161	127	288	31.75
Community Area7	147	189	336	37.05
Community Area8	143	140	283	31.20

Total number of beds = 907

Appendix III

COMBINED WAITING LIST

There will be a combined community and acute hospital waiting list for non-acute services.



Appendix IV

SHARING OF INFORMATION