Return on Investment (ROI)

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The challenge: Dorset has a higher than average population of people who are aged over 85. It was recognised that at Royal Bournemouth Hospital the pathway for frail older people involved unnecessary transfers, handovers and late moves which was leading to poor patient experience and delayed discharge. Working with the Acute Frailty Network, the service was reviewed and re-designed to ensure that the right patient is in the right place at the right time.

The approach: The original admission pathway for frail older people involved multiple moves and lead to delays. The new frailty pathway is more streamlined with fewer moves, early specialist input and earlier discharge.

An on-call geriatrician was allocated to cover all of the emergency admissions to Older Person’s Medicine (OPM). All patients over 75 years were screened for frailty within one hour of arrival to hospital and all patients identified as frail received a comprehensive geriatric assessment (CGA) within two hours of the decision to admit. The on-call geriatrician was also given a phone to take incoming GP calls, to help with reducing acute admissions and offer management advice and potential alternative options for patients.

A 28 bed short ward has been allocated for patients with frailty, run by a consultant geriatrician. The ward has an allocated social worker and therapy team, as well as a designated ward pharmacist with an on-ward dispensing service.

A ward was also allocated to cohort all patients under the OPM team who were deemed medically fit for discharge. This patient group included stranded patients (with a length of stay >7 days) and those with delayed transfers of care. The ward team consisted of a GP, nurses and therapists. There was a clear de-escalation plan prior to the ward opening and it was successfully closed after two years, in June 2016.

Working with community providers, the Interim Care Team has been developed, including the spot purchasing of interim beds in local residential homes for patients awaiting care. There is an Interim Community Assessment Team (ICAT) to support patients discharged home from hospital, enabling assessments to take place in the community setting rather than as an inpatient. This has resulted in a 23% reduction in care needs in patients discharged from an
interim residential home and a 24% reduction in long term domiciliary care needs for patients discharged home with ICAT.

**Return on investment:** The new frailty pathway at the hospital has significantly improved the care that is provided for older people in hospital including shorter length of stay, reduced bed occupancy rates and early CGA. The ROI savings described here are based on the reduced length of stay, with calculations undertaken with the support of the Acute Frailty Network.

The tariff given for the bed day rate was £171, although this is an average figure. There is an average length of stay reduction of 4.05 days which would give an approximate total weekly saving of £61,290, and an associated annual saving of £3,187,115.

<table>
<thead>
<tr>
<th>Weekly</th>
<th>LOS reduction</th>
<th>Discharges</th>
<th>Days saved (a week)</th>
<th>Based on Audit commission data (£59)</th>
<th><em>Based on Bed day rate (</em>£171)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using Averages</td>
<td>4.05</td>
<td>88.50</td>
<td>358 bed days</td>
<td>£21,122</td>
<td>£61,290</td>
</tr>
<tr>
<td>Using 80% Variation</td>
<td>3.87</td>
<td>108.08</td>
<td>418 bed days</td>
<td>£24,662</td>
<td>£71,478</td>
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<td>Using UCL</td>
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<td>127.66</td>
<td>470 bed days</td>
<td>£27,730</td>
<td>£80,370</td>
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</tbody>
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**Key System contacts**

Dr Andrew Williams (Clinical Director, Elderly Care Services Directorate)

Andrew.Williams@rbch.nhs.uk

Vanessa Mason (Associate Director for Integrated Care)

Vanessa.Mason@rbch.nhs.uk or vanessa.williams1@nhs.net