FABulous CAT

Renée Ward
Rebecca Williams
Jane Shoote

29th June 2017
Service Introduction

Service

Commenced October 2015
Response to need
Winter pressure scheme
6 month pilot
Proactive
Direct Access

Service extended March 2016
Geriatric Interface Nurse role
September 2016
Improve integration of services

New integrated approach

A&E
CAT
Geriatric Interface Nurse
FAB

Our Values
Respect  Kindness  Listen and involve  Professional  Efficient  Improving together

Our Passion, Your Care.
Frailty Assessment Base (FAB)

Service Description

Comprehensive Geriatric Assessment with focus on acute issues.

- Multidisciplinary rapid assessment
- Assessment within 48 hours
- 8am – 6pm Monday to Friday
- Referrals from GP, Community teams, ED.
- Direct access to consultant phone
- Email communication
Frailty Assessment Base (FAB)
Team personnel and dynamics

To promote patient independence and return home or arrange alternative discharge destination. Shared Care Plan provided to patient.

Consultant geriatrician
2 Nurses
2 Physiotherapist
2 Occupational therapist
1 Therapy Assistant Practitioner
1 Healthcare assistant
Suffolk Family Carers
1 Administrator
1 Pharmacist
Crisis Action Team (CAT)
Service Description

Admission prevention service, with 24/7 multi-agency team (health, social care and voluntary care)

Outcomes are:

1. Support of adults experiencing a “crisis”, to remain in their own home, or

2. A rapid discharge from the emergency department to prevent an emergency admission.
Crisis Action Team (CAT)
Team personnel and dynamics

Each team member contributes an individual skill set to the CAT team, enabling a holistic team approach to each individual patient.

2 Physiotherapists
2 Occupational therapists
3 Nurses
13 Generic Workers
1 Social Worker
1 Suffolk Family Carer
7 British Red Cross staff
Geriatrician support
Establishing the Geriatric Interface Nurse was critical to achieving a truly integrated approach.

Role commenced: September 2016
Specialist geriatric input
Proactive case finding
Supporting safe appropriate discharges and/or admissions from the department
CAT and FAB liaison
Assessing the impact

1. Positive patient experience
2. Good stakeholder engagement and feedback
3. Admission avoidance
Impact 1: Positive patient experience

“Friendly and helpful, nothing was too much trouble and **answered everything clearly** - you would be hard pushed to improve the service.”

“For the **complete care and professionalism** they show. They are cheerful and help you come to terms with the difficulties being suffered. Anyone relying on the service can’t go far wrong. I would recommend them to anyone”

<table>
<thead>
<tr>
<th></th>
<th>Recommend</th>
<th>Not Recommend</th>
<th>Total Responses</th>
<th>Extremely Likely</th>
<th>Likely</th>
<th>Neither Likely or Unlikely</th>
<th>Unlikely</th>
<th>Extremely Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAB</td>
<td>99.6%</td>
<td>0%</td>
<td>246</td>
<td>228</td>
<td>17</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAT</td>
<td>100%</td>
<td>0%</td>
<td>74</td>
<td>68</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Impact 2: Good stakeholder engagement and feedback

I didn’t think you would add anything to what I already knew, but you did and have really helped manage my patient (GP).

Thank you and the team for the fantastic level of support you provided. This maintained her independence and reduced risk of muscle bulk loss hospitalisation is at risk of causing (GP).

This service has been invaluable to MAU (consultant).
Integrated service, fully operational from end Sept. 2016, showing clear reduction in ED Attendance to Medical Admission conversion rate.
Against a backdrop of 9% greater ED attendance, the integrated service yields 5.5% greater ED discharge rate, and 7.9% lower admission rate.
Staying ahead of emerging challenges

Initiatives delivered
• Already expanded FAB to 6 assessment areas
• Proactive ED case finding implemented

Initiatives in progress
• FAB to move to 7 day working
• To implement telephone patient follow-up
• Further staff training required

Remaining challenges to overcome
• Match capacity with volatile demand
• IT interface
Case Study 1:
92 year old, multiple A&E attender

A&E

Lead geriatric integration nurse

CAT ⇄ FAB
Case study 1: case background

Patient background:
- 92 year old male
- PMH PD IHD Ca Prostate LTC
- Lives alone in sheltered accom with no formal care

- ED 5 times in last 7 months, 2 of which resulted in admissions
- Presented to ED following a fall, and transferred directly to FAB
Case study 1: FAB intervention

• Clinically stable
• Diagnosed and treated on FAB
• SB therapy team. Footwear advice given and CAT referral made to assess home circumstances and provide reablement support
• Twice daily reablement from CAT Generic workers, further therapy review and BRC support with shopping/meals
• Shared care plan
• No further ED attendances
# Reflections

## FAB/GIN
- Integration of frailty into A&E
- Culture
- Referral Process
- Hours of service
- Link to community services
- Governance

## CAT
- Working with community therapists
- Referrals from EEAST
- Declining referrals at the start
- Governance, acute v community
Questions

Contacts:

renee.ward@ipswichhospital.nhs.uk
rebecca.williams@suffolkch.nhs.uk
jane.shoote@ipswichhospital.nhs.uk