‘It's not just the patients who have grey hair!’
Princess Alexandra Hospital Frailty Assessment Unit
Dr Qasim A Shah – PAH Frailty Lead

29th June 2017
Background - Reasons for change

In 2014 West Essex Clinical Commissioning Group (CCG) and Essex County Council aligned on a shared vision for the transformation of health and care services in west Essex:

‘To help the local community stay healthy & independent – enabling each individual to access the services they need, at the right time and in the right place, to prevent illness and life crises and improve health and care outcomes’
Anticipated outcomes for Frailty @ PAH

- Introduce best practice by implementing the use of the comprehensive geriatric assessment
- Reduce length of stay of non-elective admissions of frail older patients – April 2016
  10.5 days LOS
- Positive patient experience for older people who find a busy ED confusing and unsettling
- Improve integration and multi-disciplinary working with an affordable model of care across the system
**Our Frailty Timeline**

- **Nov 2014**: Audit completed
- **April 2015**: RAC moved to PAH – First frailty service
- **Nov 2015**: Service reviewed and commenced on CDU Nov 2015
- **June 2016**: Re-location of service to Old stroke ward B40 June 2016
- **Oct 2016**: Old gym/activities room commence Frailty assessment unit (FAU) – Oct 2016
- **Jan 2017**: John Snow unit – January 2017

**Building for excellence**
Issues identified and resolved

1. **Reduced GP referrals**
   - GP’s confused to which service to refer too
   - All GP referrals through single point of access - algorithm created to support decision making

2. **Lack of referrals from ED**
   - Frailty lead attending ED daily huddles and weekly senior team meeting
   - CARS team agreed to accept referrals and refer direct to FAU

3. **Perceived overlap with CARS**
   - CARS team support short stay frailty and FAU

4. **Staff Dissatisfaction**
   - Frailty lead consultant appointed

5. **Temporary Location**
   - New location with established team
   - Chaired location agreed with 6 beds for short stay
   - Whole ward became John Snow Unit with 4 chairs and 22 short stay beds

6. **No regular identified consultant lead**
   - Consultant lead identified – hindered by other clinical duties
   - Consultant support for frailty allocated from neighbouring ward
   - Frailty lead consultant appointed

7. **High volume of leaves from unit**
   - New location with established team
   - New location – 6 beds chaired area identified but not agreed

8. **Service relocated – new site used as escalation beds**
   - New location – 6 beds chaired area identified but not agreed
   - Chaired location agreed with 6 beds for short stay

Events:
- Nov 2014
- April 2015
- Nov 2015
- June 2016
- Oct 2016
- Jan 2017

Building for excellence
Engaging with our Community services

Inclusion Criteria
- over 75 years
- Clinical Frailty Score of ≥4
- Patients presenting with falls/reduced mobility/breakdown of package of care/dehydration/UTI/Constipation/SOB/COPD/chest infection/confusion/dementia
- Patients requiring pain/pharmacy management

• GP Shutdown
• GP locality meetings
• Monthly frailty steering meetings

What is a CGA?
- Comprehensive geriatric assessment (CGA) is a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail elderly person in order to develop a coordinated and integrated plan for treatment and long-term follow-up.

How do you refer?
- Contact PAH GP hotline – 01279 652556 and ask for the medical GP Co-ordinator. You will need the following information regarding your patient:
  - What is their Frailty score?
  - What are their current obs?
  - What is the referral reason?
  - Is the patient able to make their own way to PAH?
  - Have you considered all alternative community pathways via single point of access?

Referral/triage form

Neighbourhood alliance with COE consultant

Care Provider steering meetings

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Was frailty sustainable?

- Lack of identity
- Lack of identified/agreed budget
- Resistance from Teams (community and Acute)
- Lack of ring fenced beds – short stay frailty
- Lack of support services – therapies, pharmacy, community support
- Inconsistent Medical cover – perceived conflicting responsibilities
- Dual purpose areas – assessment and gym, B40 rehab and frailty short stay
- Temporary Nursing cover
- Difficulty GPs having identifying most appropriate patients to refer to the service
The John Snow Unit

• 22 short stay frailty inpatient beds – maximum length of stay 72 hours
• 4 chaired assessment spaces
  ❑ Mon – Fri 9.00-17.00
• Frailty Lead Consultant
• Frailty Lead Practitioner
• Nursing – Ward Manager, 1 dedicated FAU RN, 3 qualified and 3 HCA
• Medicine – Registrar (Locum), 3 x Junior SHO level
• Admin – dedicated cover 08.00-20.00
• Therapy and pharmacy support
• CARS support for discharge
Improvements in use of the FAS

Admissions

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<th>Month</th>
<th>FAU (Chairs)</th>
<th>John Snow Unit (Beds)</th>
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Improvements – reduction in time spent in ED

Average Time in A&E
Over 75s

April-16 | May-16 | June-16 | July-16 | August-16 | September-16 | October-16 | November-16 | December-16 | January-17 | February-17 | March-17 | April-17

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Improvements – Reduction in length of stay

![Graph showing improvements in length of stay. The graph compares Trust LOS >75, John Snow, and linear trends for Trust LOS >75 and John Snow.]
Clinical Improvements

Iron Infusions:
When indicated can reduce side effects of oral supplementation and has a major impact on the quality of life in patients living with Frailty

Single Dose Antibiotic Treatment for selected Patients with uncomplicated UTIs:

Tailored Prescribing and Review of Medications:
On 5th May I attended the John Snow Frailty Unit in Princess Alexandra Hospital in Harlow. I am 79 years old and have recently been diagnosed with Grade 3 breast cancer. I was greeted by Sophie Buxton who escorted me to the unit. I found her a charming lady who made me feel at ease straight away. She explained to me the procedures I would have throughout the day.

I had my blood pressure taken, a blood sample and an ECG. I was then interviewed by a doctor who discussed my medical history and medication I was taking.

I was then provided with a very nice lunch. Shortly after I met doctor Vash who gave me a few tasks to do. He asked me how I felt about having surgery. I told him I was nervous. He was very reassuring and told me that I was fit enough to undergo surgery. I felt extremely relieved to know this.

I feel that the John Snow Frailty Unit is a vital part of the National Health Service. It offers patients the opportunity to spend the day at the unit, having procedures and receiving the results on the same day. I was more than satisfied on the day I spent at the unit.
Healthcare feedback

Cardiology referral

I saw a patient in clinic recently whom I had previously referred to the frailty unit due to her complex/multiple issues requiring an holistic review. Both the patient and her family were extremely happy about the service they received and the frailty unit as an working model for people in similar situations.

Of note the patient commented on the thoroughness of her medical review, the attention to detail in care provision by the support staff and the time taken to ensure the correct decisions were made along with full explanations of the plan and follow up procedures.

The patients relatives commented on the efforts made to gain a full picture from not only the patient but the wider support network (family/carers) and then the effort made to communicate directly with the patient.

I am very happy to pass on this feedback and will definitely utilise the frailty unit in the future.

Cancer services referral

A 91-year old patient is the first patient who underwent a Comprehensive Geriatric Assessment having being directly referred to the Frailty Assessment Unit as an exceptional case. The patient expressed a high level of satisfaction with the care she received during the CGA and Mrs A. verbalised her thoughts: “They all (geriatrician, physiotherapist and occupational therapist) seemed to understand how important it is to talk about how I manage to live on my own and do the things I need to…” The patient’s daughter who is Mrs A’s carer responded: “We were made to feel that support was available should we have any problems when mum starts her treatment…..we felt looked after and I feel less worried that mum will go in for surgery”
Future sustainability and Opportunities

- Continue to improve the quality of care and experience of the population with frailty e.g. more people, approaching end of life, receive care at PPC
- Effective crisis care plans co-produced with patient and carer, accessible across the system
- Programme for prevention of deconditioning or ‘pyjama paralysis’
- Learn from AFN partners
- Achieve dementia quality mark
- Continue to develop integration with community pathways & West Essex Neighbourhoods + East & North Herts
- PAH centre of excellence for older peoples care
Questions