Acute Frailty Network Conference

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Wirral demographics

- Relatively high older population (over 80) and relatively low younger population (under 40) compared to England and Wales.
- The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021 which equates to a 29.9% increase.
- The biggest decrease is in the 35-59 year age group, from 108,548 in 2008 to 82,061 in 2021.
- 12% population (38,000) classed as carers, most in 35-59 year age group.
- The Index of Multiple Deprivation (IMD) places 30 of Wirral’s Lower Super Output Areas (LSOAs) in the lowest 5% in England and 23 LSOAs in the 3% most deprived nationally.
Wirral demographics

- Approximately 3500 care home beds of which 1500 are nursing beds
- Most care homes supported by multiple GP practices, trial of locally enhanced scheme covering some care homes.
- Currently 3 Intermediate Care facilities, different admission criteria, long lengths of stay
- Estimated 4,443 people over 65 living with dementia in 2011. This is projected to rise to almost 5,300 within the next 5 years
Department of Medicine for the Elderly

- WUTH large District General Hospital with 752 beds across two sites – Arrowe Park Hospital and Clatterbridge Hospital
- Large department, 11 wte Consultant Geriatricians (4 supporting ‘Community Geriatrics’)
- Approximately 75 medical admissions per day, review all acute take over 73 years of age
- 5 in patient wards, approx 140 beds
- Acute, Orthogeriatric, Movement Disorder and Community Geriatricians
- No community hospital beds
- Limited Intermediate Care services
- No vertical integration, separate Community Trust, Mental Health Trust
- One CCG, one local authority, one Community Trust
Life before the AFN......

2012: 12 beds out of 30 bedded area (ward 22), LoS- 8 days  
Renamed Older Persons Short Stay Unit  
Targeted admissions, increased Consultant and therapy input  
Older Persons Rapid Assess (OPRA) Clinic

2014: Move to 24 bedded (ward16) OPSSU,  
Increased medical, therapy, pharmacy input  
LoS reduced to 4.98 days  
OPRA – 2-3 times, aim to see patients within 48 hours of referral  
Redesign of acute older person’s care with CCG – ‘5 pathways’
Life before the AFN......

• 2015: Launch of the ‘5 pathways’ – additional £500k funding
   Appointment of 4 Specialist Nurses for Older People (SNOP’s), started Jan 2016 covering 8am-8pm, 7 days a week
   Visit from ECIP ‘worst 20 Trusts’ for 4 hour AED targets

• 2016: Jan 10th, moved to ground floor next to AED to 18 bedded unit – **Older Persons Assessment Unit**.
   AFN cohort 2
Older Person’s Assessment Unit (OPAU)

- 18 bedded unit
- No side rooms
- Large ambulatory area
  - Day case procedures
  - Transfers from ED
  - Ward discharges
- 2 clinic rooms
- Therapy space

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Challenges

- 95% + bed occupancy, challenges with flow through the hospital
- Change perception / culture around OPAU – assessment area vs DME ward
- Ring fenced assessment beds
- Need adequate therapy, pharmacy and junior medical support
- Extended hours of working, no increase in medical staff
- Current DME bed base – v- Consultant capacity
- Culture change – ‘Home First’ approach
- Delayed transfers of care due to poor access to rapid packages of care and community beds / short term placements
- Awareness raising / profile - AED/SPA/GP’s
- Current way acute medical take is organised
- Requirement for dedicated IDT service to the ward
Joined AFN cohort 2, January 2016
10 principles – Acute Frailty Network

1. Establish a mechanism for early identification of people with frailty
2. Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour
3. Set up a rapid response system for frail older people in urgent care settings
4. Adopt a ‘Silver phone’ system
5. Adopt clinical professional standards to reduce unnecessary variation
6. Strengthen links with services both inside and outside hospital
7. Put in place appropriate education and training for key staff
8. Develop a measurement mind-set
9. Identify clinical change champions
10. Identify an Executive sponsor and underpin with a robust project management structure
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Assessing Frailty

- Age >85 years   OR Age 74+ with:
  - Falls or Fragility fracture
  - Reduced mobility (e.g. Parkinson’s)
  - Altered cognition
  - Incontinence or Institutionalised
  - Lots of Medications

If patient does not fit the above criteria but is clearly frail, for example has large POC, please also consider referral.
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SPECIALIST NURSES FOR OLDER PEOPLE (SNOPs)

• 4 New posts
• Senior nurses from the community

• In-reach into ED / AMU
• CGA commenced within 1 hour
• Pull patients through to OPAU
• Co-ordinate prompt senior review
• Liaison with community teams to assist with complex discharges
• Data collection

• Importance of defining job description

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Silver Phone

• Community Geriatrician phone line Monday to Friday 9am – 5pm
• Consultant Geriatrician on-call available via mobile
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Standards

- Standard operating procedures – many
  - Specialist nurses for older people
  - Consultants on-call
  - Interface between AMU and frailty
  - Older person’s rapid assessment clinic
- Frailty clerking document
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Community Integration

• End-to-end review of frailty care (involving CCG, CT, mental health, social services)
  – Locally enhanced scheme for care homes
  – Integrated falls service
• Closer links with Single Point of Access (SPA)
• Shadowing of roles
• Discharge to assess model, ‘Home First’ pilot
• IMC review
• Accountable care organisation – Frailty / over 55’s identified as priority
• Appointment of 3rd and 4th Community Geriatricians
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Education

- Departmental meetings, stakeholder engagement
- AFN 1st site visit
- Executive presentation
- E-mail updates
- Liaison with Acute Medical Team / ED
- Weekly OPAU meetings
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Measurement

- Our **biggest** challenge?
- Data poor prior to AFN (and after!)
- Importance of involvement of data analysts from the beginning of the journey
- Involvement of whole team
- Much more work to be done!
- Significant improvements after AFN second site visit
Number of frail patients identified

Number of Frail Patients Identified

29/08/16 - Bank Holiday Monday. The number of SNOP patients identified as frail dropped to 4

Number of Frail Patients Identified
Average Number of Frail Patients Identified
Trend
Average LOS OPAU

11/10/16. Avg LOS (0.02) - Demand in the Hospital Emergency department was high. Subsequently, a number of patients were moved to contingency wards within 1 hour of being admitted.

30/08/16 Older Persons Assessment Unit (OPAU) beds were full – no admissions. Post Bank Holiday observations with limited consultant cover - on call cover only.

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OPAU discharges per month
Stranded Patients > 7 days

Stranded Patients (Non-Elective) LOS >= 7 days

- Tues- 18/10/16 to Mon - 31/10/16 MADE Event - Focus on Discharge
- Thurs - 15/09/16 to Fri - 30/09/16 MADE Event - Focus on Discharge
- Wed - 31/08/16 to Fri - 09/09/16 MADE Event - Focus on Discharge
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Executive involvement

- Crucial as investment and re-organisation of services may be required
- Many of the NED’s have a vested interest in how Older People are cared for!
- Levels of interest may vary depending on local challenges
- Visit other Trusts
Our PROUD Award for Patient Experience
Next Steps in hospital

- Electronic frailty assessment and frailty flag
- Improved measurement and use of AFN measurement tool
- Patient and staff feedback survey, service user groups
- Extended Consultant cover 8am-8pm, 7 days a week
- Possibility of ‘Emergency village’
- Increase virtual work and ambulatory care model
- Pilot work with specific GP surgeries using rapid PDSA cycles
- To roll out Frailty identification and CGA more widely across the Trust, starting with AMU/DME and subsequently across the wards
- To work with Single Point of Access to establish our Frailty criteria to enable them to triage GP referrals directly to OPAU
Next steps - integrated frailty care

- Renegotiation of tariff
- Review of IDT provision
  - Ensure continuity for ward areas, rapid access to POC / placements
- Review of IMC pathway
  - to ensure responsive step-up/step-down facilities
  - Visibility of beds
  - Standardised care across providers
  - Implementation of SAFER principles
  - Community Geriatrician support
- Closer links with mental health services and development of a dementia crisis pathway
- Frailty identification / frailty register
- Integrated falls assessment / services
Lessons learnt

• Frailty isn’t a ‘dirty’ word, it’s a powerful concept
• Measurement and QI methodology – understand and use your data, let it drive rapid quality improvement cycles
• Importance of IT support / data analyst at beginning of journey
• Importance of involving the whole team
• Importance of interface with AMU / ED colleagues
• Importance of CCG, external stakeholders being involved and aware of the vision (end to end review)
• Be brave
• Get some cheerleaders
OPAU and ED teams
Thank you
Any questions?