A ‘big room approach’ to improving acute frailty services

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As the Trust emerged from breach of licence and financial turnaround, services for older people were identified as an area for improvement. Although key clinical leaders had long had a vision of an improved acute frailty service, they had encountered the perfect storm of financial crisis, a transactional culture and poor supportive mechanisms to deliver transformation. In early 2017, the new Chief Executive led a re-structure that resulted in the Trust being more clinically led. Consultant James Adams was appointed as Clinical Director for Frailty Services and the Department of Ageing Health was supported in joining the Acute Frailty Network (AFN). This was to act as a key vehicle for the forthcoming change in services for older people, as well as providing the impetus to deliver and sustain the change.
What were services for older people like before the change?
For around fifteen years the Trust had in place a specialist group of therapists and social care practitioners that made up the Integrated Discharge Team (IDT). The team were highly skilled, autonomous and were comfortable in managing risk and early supported discharge. In spite of this, patients living with frailty who arrived in the Emergency Department (ED), were not generally identified at this early point in their journey, leading to a delay in early proactive assessment. There was an Older People’s Advice and Liaison (OPAL) team at the front door of the hospital, including junior doctor support, reporting to Consultants. There were no standardised processes for identifying frailty or referral into the service. Ways of working were traditional, with little use of standardised assessment tools. Due to the clinical environment, the doctors and IDT worked in isolation, with a small number of referrals adding to variation in care and approach.

Starting the Acute Frailty project
The project aimed to reduce the amount of time some older people need to spend in hospital by reconfiguring the existing service, using new tools and techniques, and facilitated by the AFN.

The team developed four work streams:
1. Creating a front door frailty team, including identification of frailty.
2. Reconfiguring an 18-bedded General Medical ward into an Older Peoples’ Short Stay Unit (OPPS).
3. Applying a quality improvement and measurement mind set to the existing 60-bedded Older Peoples’ Unit (OPU).
4. Applying a quality improvement and measurement mind set to the existing inpatient Older Peoples’ Advice and Liaison (iOPAL) service with addition of a full-time doctor.

The Acute Frailty Service Vision
There were a number of objectives that James, as project lead, and the team wanted to achieve via the reconfiguration of the service. These included:

1. **Older patients showing signs of frailty to be seen by a new specialist team when they arrive at Royal Surrey County Hospital.** The Acute Frailty Team, which includes a Consultant Geriatrician and a specialist Acute Frailty Nurse, are now based in the Trust’s ED. They help the ED team identify people living with frailty and provide early Comprehensive Geriatric Assessment (CGA). They can then triage patients into the right system of care if there is a decision to admit, either OPU or OPSS.

2. **The development of standardised means for identification, routes for referral, with a Comprehensive Geriatric Assessment (CGA) document to reduce variation of assessment.** As an outcome of the project, clinicians now use standardised tools for identification (the Clinical Frailty Scale) and assessment of all patients showing signs of frailty, such as confusion, falls and mobility issues, within one hour of their arrival.

3. **Individual care plans to be put in place for each patient, with the support of a multidisciplinary team, to ensure they receive the treatment and support they need either as an in-patient or at home.** Multidisciplinary teamwork is now the norm and the Acute Frailty Team manages 100% more patients than it did with the traditional OPAL model. Patients volumes have shot up, with key interventions that have resulted in an improvement in outcomes. Early intervention has resulted in early discharge home, rapid transfer to OPSS, OPU, the Emergency Assessment Unit, or another appropriate ward. The team were initially available from Monday to Friday with plans to expand to offer a seven-day service.
Creating the Older Peoples’ Short Stay Unit (OPSS).

In winter 2017, the team used AFN methodology to open the short-stay unit within six weeks of starting. It was a 16-bedded ward run by diabetes consultants next to the OPU. To achieve this, junior doctors, nursing teams and all allied healthcare professionals came together to create a new multidisciplinary team in order to deliver rapid CGA in a short stay environment. An Acute Frailty Consultant took ownership of the ward with daily Consultant-led multidisciplinary care. This improvement led to the permanent closure of a surgical ward and was a major factor in the Trust being identified as the most resilient Trust by NHS Improvement during winter.

The Big Room

James took inspiration from the Japanese in creating the Oobeya, loosely translated to ‘Big Room’. This part of Lean methodology had been taken from the Toyota production system and applied to healthcare. It has successfully been applied in healthcare settings through the Flow Coaching Academy originating in Sheffield.

The Big Room provided a focal point for the whole team, with a flat hierarchy and an open door for anyone who would like to attend. Those directly involved included Consultants, junior doctors, nurses, physiotherapists and occupational therapists, operations managers, community staff, senior nursing leaders. One key piece of learning was to incorporate a data analyst into the Big Room. They used the Big Room concept once a week, at the same time, in the same place. The approach and philosophy felt different to the staff. They used the walls to display AFN principles, as well as for problem solving, vision, process-mapping and working out how to measure change together.

Russel Bird, PMO Senior Change Lead, co-ordinates and updates the Big Room each week. The Trust Change philosophy had been based on Lean methodology for 10 years, but he had never used the Big Room before. Russel comments ‘The Big Room encompasses a huge number of people from the front door to wards. We have tried a number of agenda formats, and it continues to evolve. Visuals and the use of the sustainability dashboard are shown regularly and – along with Laura, our information analyst – they continue to be a very good part of the Big Room.’

The Big Room concept has been applied to other clinical areas and teams, for example, in the ED. There has also been communication with the rest of the Trust along the way, including presentations at a variety of levels; Trust board, transformation boards, and front line staff who have not been to the Big Room.

How did the AFN help?

The 10 AFN principles were displayed on the wall of the Big Room and were the key framework which enabled the teams to change. The AFN offering included a site visit, to assist in framing local contexts and issues and provide support in getting started, including quick wins. They helped with a sustainability audit and provided a list of conferences to attend. Change leaders from the Trust, including James and Russel were inspired by the AFN masterclasses and applied their learning in the Big Room to inspire others. The AFN facilitator spent lots of time on site over the next few months, and provided energy, expertise and sharing. The AFN team also facilitated functional mapping with measures. Most importantly, the AFN helped the Trust develop a measurement mind-set.
Developing a measurement mind-set

The AFN team provided the expertise and methodology for measuring change properly. This included developing skills in statistical process control and what to measure when applying these principles to change and developing services and pathways. The team developed their own sustainability dashboard of process, outcome and balancing measures for each component of the new pathway. These included length of stay, throughput, number of older people as medical outliers and 30 day readmissions were identified as important in the monitoring of improvements. They were incorporated into the sustainability dashboard, which became the key medium in the Big Room for monitoring and spreading change. It made the frailty service project stand out in the Trust and provided an on-going illustration of performance in each clinical area, as well as showing a longitudinal summary picture of the frailty service across the organisation.

The Trust continues to use the dashboard and outcome measures to ensure on-going sustainability and improvement.
How are things now?
Although change has slowed down this has allowed the clinical teams to take stock. 18 months on, there is sustained improvement in quality of care and performance. The Big Room needs a re-boot following the summer holidays, but change and the use of quality improvement methodology have become the norm and as James says, this is now ‘the way we work.’

James’ role changed the day the short-stay unit opened. He is now Chief of Service for the whole Access and Medicine division and although he remains the clinical lead for the Acute Frailty Team, his time with the team on the ground has reduced. The team secured transformation funding to back-fill a band 7 therapist to help lead continuous improvement. Most recently funds from the vacant Chief SpR scheme have been used to back-fill a senior Registrar in Geriatric Medicine. Russel Bird, has been consistent throughout, and one of the lessons learned is the need for sustained clinical leadership and champions, one of the key principles outlined by the AFN.

The organisation is using the practice development team to support development of the two specialist nurses in frailty. James is adapting the Skills for Health Core Competency Framework for local use to provide the scaffolding for learning and development for the nurses. In addition, ward Sisters have embraced the quality aspects of the project and have ownership of the workstreams on the wards. The nursing leadership have embraced quality improvement methodologies and are now well versed in PDSA (plan, do, study, act) cycles. They were key players in embedding the #EndPJParalysis campaign on the wards.

It feels like there have been spinoff benefits; for example, increased surgical activity, improvement in meeting cancer standards and better quality of care. In addition, the project has had its own data analyst from the beginning of the project. She remains a key part of team and a responsive resource.

Have the changes been successful, and are they sustainable?
75% of older people in audits of inpatient beds will have frailty markers, but it is the philosophy and the team that have changed the management of this group. The sustainability dashboard demonstrates huge reductions in length of stay; for example, there has been an overall reduction in median length of stay of 30% for patients aged over 75 years, which has been sustained over a year. This is reflected in each aspect of the service, from the emergency floor, through to OPSS and OPU.

Because of this, winter pressures were more bearable in 2017/18, and more manageable than the last three years. The project eliminated all medical outliers in surgery in the summer and has consistently reduced older people being managed in outlying surgical wards by over 75%.

The AFN’s sustainability tool was completed at the start of the improvements and again towards the end of the year of AFN support. It demonstrates large improvements in sustainability from the multidisciplinary teams, the best in cohort six of the programme.

What’s next?
This year, the service developed an in-reach model in the form of two frailty nurses to start the pathway earlier in the journey – at ED streaming. The nurses are very much the ‘glue’ bringing the frailty team together at the front door. This development is a work in progress, and the nurses are the driving force going forward.

This methodology has expanded to the emergency floor – they have their Big Room and are sharing the PMO resource. They have a problem-solving wall and the other components that make up the Big Room. Early results include enhanced 30-minute handover time, increasing from 13% to 63% in a week.

The organisation has now taken on community services, which provides a massive opportunity to extend the frailty pathway. Community staff are coming to the Big Room, so their contribution will ensure that services are integrated. These teams will use the methodology and AFN principles to create a community Big Room, with a focus on integrating community teams to deliver co-ordinated proactive and reactive services for older people living with frailty. The teams will work together to ensure robust discharge to assess pathways and early supported discharge home.

For the hospital teams the focus for the next months and years will be sustaining improvements in identification of frailty, ensuring early proactive CGA for those who require it and a continued emphasis on improving care in the inpatient wards. In addition, the service will expand to include rapid assessment within an ambulatory care setting and a Trust-wide educational programme alongside developing Advanced Clinical Practitioners in frailty.

Return on investment (ROI)
The reconfiguration of service and new frailty pathway have significantly improved the care that is provided for older people in the organisation, including shorter length of stay, reduced bed occupancy rates and early CGA. The ROI done with Royal Surrey demonstrated financial savings associated with a reduction in occupied bed days. Based upon a daily bed day cost of between £59 and £171, it is estimated that between £372,378.76 and £1,079,266.76 is being saved. The full ROI case study with calculations can be found at www.acutefrailtynetwork.org.uk