



Phase 1: Frail and older people

The Mid Yorkshire Hospitals NHS Trust

Aim

To ensure all patients with frailty and complexity are appropriately assessed when they arrive in hospital by geriatricians at the traditional 'front door'.

Outline

The Mid Yorkshire team aimed to develop a dedicated acute service for frail older patients to improve patient outcomes and experience, and integrate working practices across professional teams. They established the REACT team:

Rapid, multidisciplinary assessment of those with frailty.

Ensuring patients are at the centre of everything we do.

Achieving holistic, comprehensive geriatric assessment in eligible patients.

Caring for and engaging with patients and members of the team.

Taking time to ensure the best for patients and sharing experiences and challenges.

Key messages

- Creating **collaborative teams** can make a real difference to the care of older people, especially those with frailty. A culture of openness enables problems to be addressed and create change.
- **Co-production with patients** to ensure true patient-centred care drives improvements and is at the heart of everything the team does. Putting patients and their families first is key.
- Working **holistically** is vital to ensure that frail older people have access to comprehensive geriatric assessment and to achieve excellent patient experience each and every time.
- Rolling out services trust-wide, creating two acute care assessment units (for older people), **minimises the inequalities** in healthcare provision.
- **Professional and personal development** helps to create new leaders and encourages staff engagement in improvement.
- Being involved in the FHP has ensured **shared learning** within the team, trust and region. This encourages networking within and beyond the community.

Methods

Clinical model

- The service operates 7 days a week.
- Opening hours of the service are continually reviewed for optimal benefit to patients.
- A clinical model was set up for patients aged 80+, and 65+ from nursing homes, with an understanding that patients who are otherwise frail over the age of 65 can be referred for rapid assessment on an individual basis to the acute geriatrician.
- In place in two sites: Pinderfields and Dewsbury Hospital.
- Assessment moved to a frailty-based service for those aged over 65 in 2017 at both sites. Dedicated telephone service with direct access to GPs, operational at both sites.
- A&E consultants can directly refer to the REACT team for advice and support.

Milestones

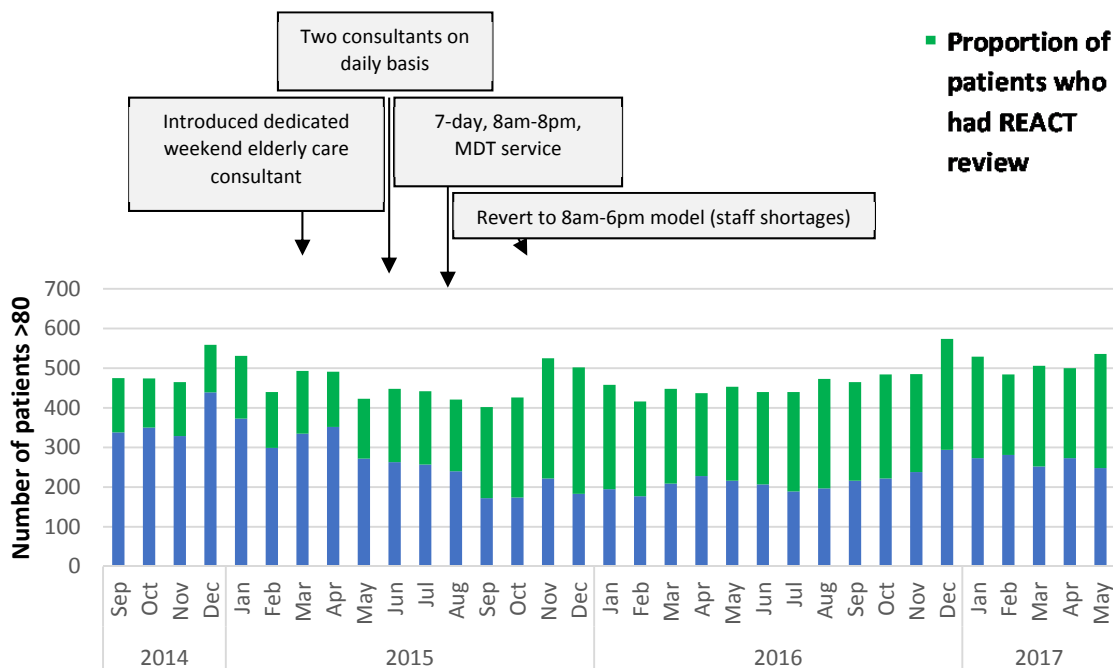
- Sep 2014: Appointed as an FHP development site.
- Apr 2015: Dedicated on-call geriatrician rota. Two ward rounds during weekdays and a weekend elderly care consultant.
- Jul 2015: Third consultant joins REACT team (part-time). Two consultants in team on daily basis.
- Jul 2015: RCP Patient and Carer Network (PCN) member and local patient representative join project team.
- Sep 2015: Move to 7-day service (8am–8pm) for patients aged 80+, or 65+ from nursing homes.
- Sep 2015: 7-day multidisciplinary team (MDT) service established.
- Oct 2015: Dedicated telephone service established. Patients admitted from A&E handover.
- Nov 2015: Service reverts to 8am–6pm model due to staffing constraints.
- Apr 2016: New chief executive appointed.
- Sep 2016: Shared competency model for occupational/physiotherapists and nurses.
- Sep 2016: Frailty champion appointed.
- Dec 2016: Shared competency model for nursing staff.
- Mar 2017: Fourth consultant appointed. Two consultants present on daily basis.
- Jul 2017: New acute care of the elderly pathway comes into use.
- Jul 2017: Acute care of the elderly assessment unit opens at Dewsbury and District Hospital.

Outcomes

1. Rapid assessment

More patients admitted acutely are seen by REACT, with increasing numbers presenting with frailty. Prior to the introduction of a weekend elderly care consultant rota, an average of 28.5% of patients over the age of 80 were identified for early discharge. The introduction of a dedicated geriatrician increased pick-up rates to 38%. The impact of a 7-day REACT service increased this further to 53.8%.

Increasing numbers of patients are identified by REACT, especially since moving to a 7-day service

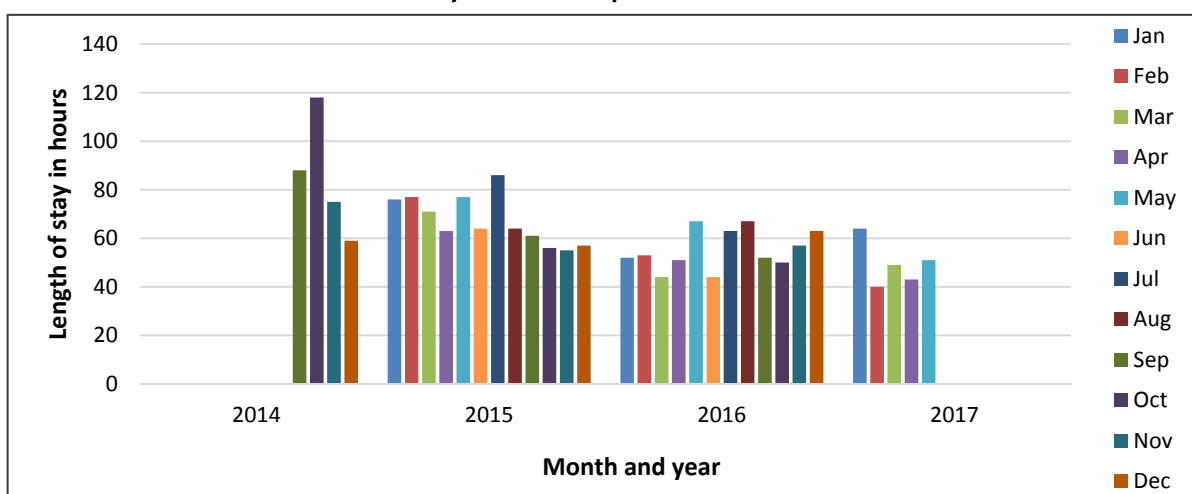


2. Reduced length of stay

The **overall length of stay of REACT patients has reduced** on a month by month comparison, except through the winter months. Year on year there has been a reduction in the length of stay of those admitted and discharged by REACT.

Prior to the introduction of a dedicated geriatrician, the length of stay was an average of 80.9 hours (Sept 2014–April 2015). Post-April 2015, after the introduction of a 7-day service, the average was 70.7 hours. This has fallen further to 55.7 hours in 2016 and 50.9 hours in 2017.

Length of stay has reduced since 2014 for those assessed by REACT, especially following the extension of the team to a 7-day service in September 2015

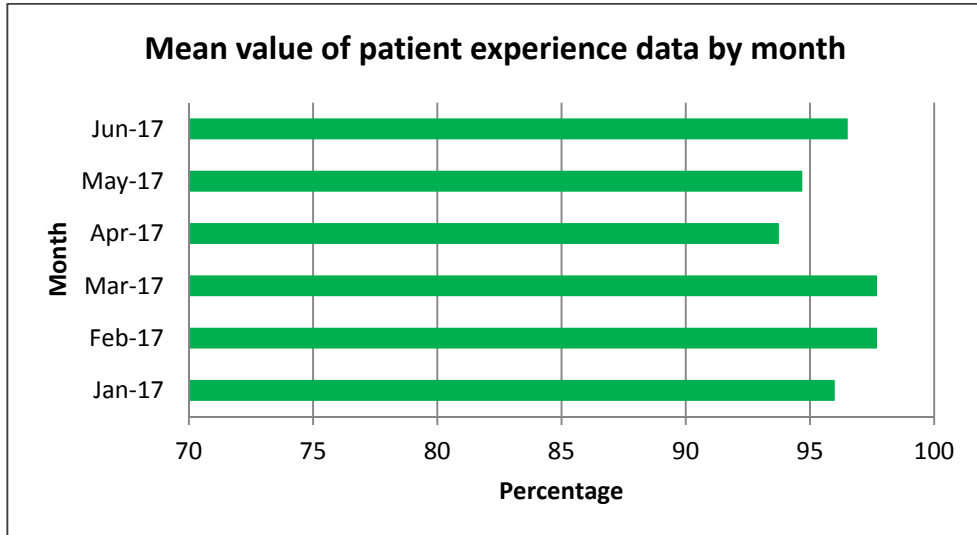


3. Patient experience

Patient-centred questionnaires have evolved over the course of the project, together with guidance for face-to-face interviews (minimum two sessions per month) to ensure consistency. In 2017, follow-up phone calls were arranged after discharge.

Low levels of complaints despite numbers assessed being high. There were six formal complaints out of 1,618 patients managed by the service between July and December 2016 (0.04%), of which two related to external agencies beyond the control of the team.

In the graph below: very satisfied = 70, highly satisfied = 100.



Successes and challenges

Successes

- ✓ The development of shared competencies and a revision of workload, therapists have maintained the service. (No extra physiotherapy / occupational therapy recruitment has been feasible due to freezes on funding.)
- ✓ All comprehensive geriatric assessments for older patients have been standardised.
- ✓ Staff have improved access to personal and professional development and there is a greater sense of loyalty/belonging.
- ✓ The whole department has been involved in frailty workshops and has a great reputation in the organisation, with 150 applications for two–three band 3 posts, and 15 for two band 6 posts.
- ✓ Patient involvement has been important throughout the project. The team has co-produced service developments with local patients and RCP PCN representatives, and benefited from the full support of two patient representatives from 2017.

Challenges

- There are high patient numbers and a constant stream of eligible patients who would benefit from comprehensive geriatric assessment.
- Increasing patient numbers have led to a higher risk of patients not being able to move through the care pathway. While demand is high, there is a continuing need to move to a frailty model which is also challenging in relation to available resource.
- The aim was for generic therapy skills to be shared with nursing staff. This has not been possible due to staffing numbers and other strains on resources.

Read the full report from Mid Yorkshire's development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

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