

‘Health and independence’

Strategic Vision and Implementation Plan for the Shropshire Frail & Complex Service

Frail & Complex Service

The challenge to the local health & social care economy

The strategic aims of the F&C service

Implementation

Expected outcomes

Hospitals on the edge?

The time for action

**A report by the Royal
College of Physicians**

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The challenge to the local health & social care economy

HOSPITALS ON THE EDGE? The time for action

- In the past 10 years there has been a 37% increase in emergency hospital admissions
- The number of acute and general beds have reduced by 30% over 25 years
- 65% of admitted patients are aged over 65 years
- People aged over 85 years account for 25 % of occupied bed days
- Greater than 80% of patients aged over 80 years will be admitted if presenting to the ED department
- People aged over 85 have a length of stay around 8 days longer than those aged less than 65 years

The challenge to the local health & social care economy

HOSPITALS ON THE EDGE? The time for action

- Ageing population
- Presenting with complex conditions, not requiring single organ based specialist team management
- High prevalence of dementia and delirium
- Higher likelihood of multiple ward moves which breaks down continuity of care
- People aged over 85 have a length of stay around 8 days longer than those aged less than 65 years
- 10 days in hospital equivalent to de-conditioning associated with ageing 10 years
- Increased risk of falls, losing independence, need for prolonged rehabilitation, need for packages of care or long term residential care

The challenge to the local health & social care economy

Demography (ONS 2011 Census)

Shropshire County 2011

Population 306,129

8.1% increase in pop'n vs 2001; National 7.1%

Aged >65 20.7% (National 16.4%)

T&W 2011

Population 166,641

5.1% increase in pop'n vs 2001; National 7.1%

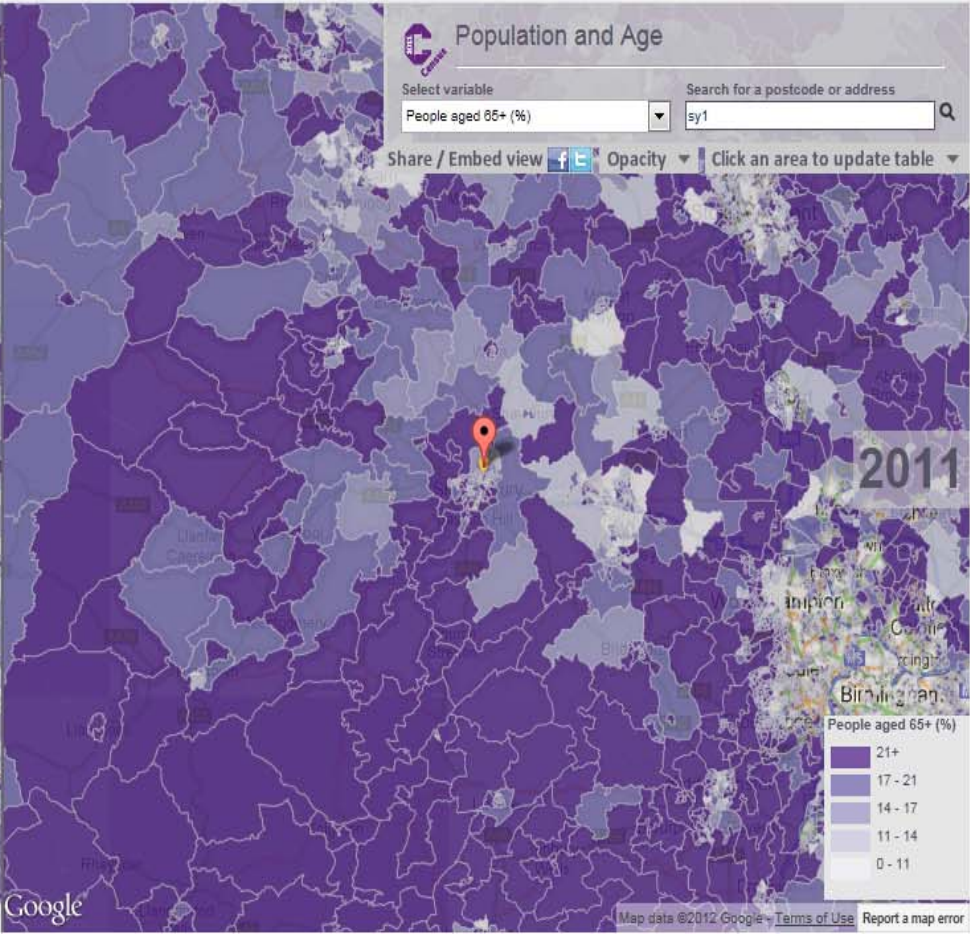
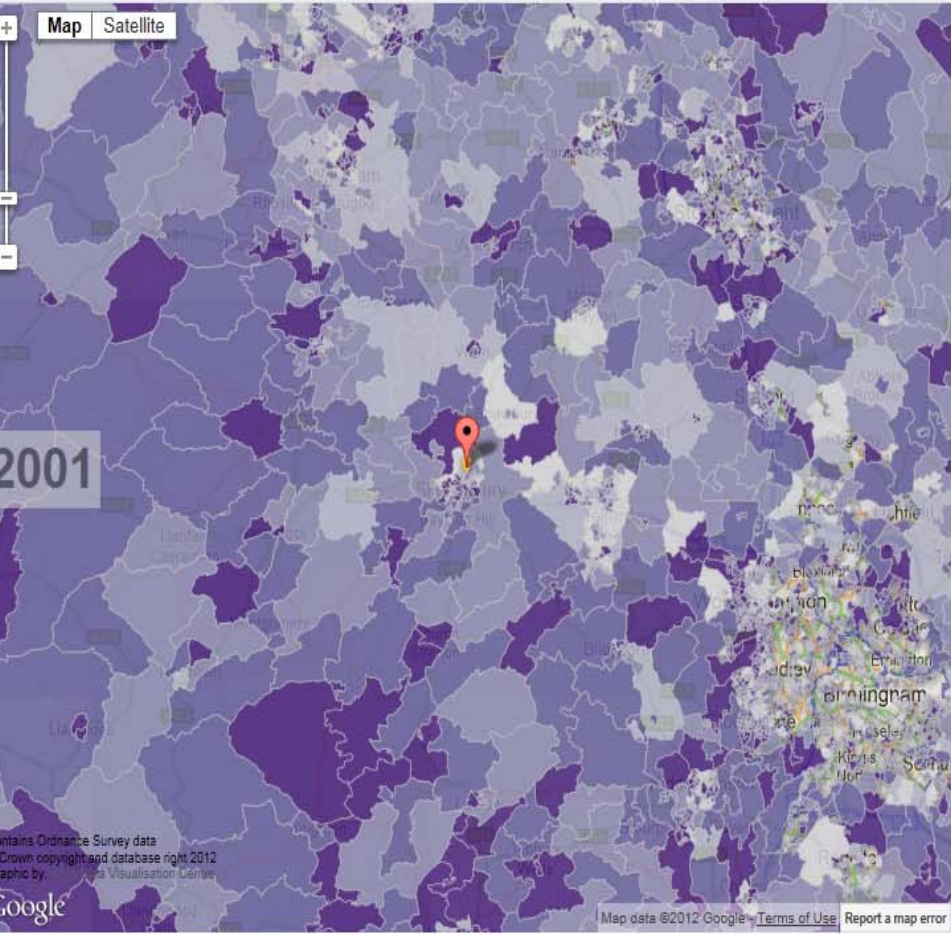
Aged >65 14.5% (National 16.4%)

Powys 2011

Pop'n 132,976

5.2% increase in pop'n vs 2001; National 7.1%

Aged >65 22.7% (National 16.4%)



The challenge to the local health & social care economy

PRH AMU

Average age 65 years

36% \geq 80 years

52% \geq 70 years

RSH AMU

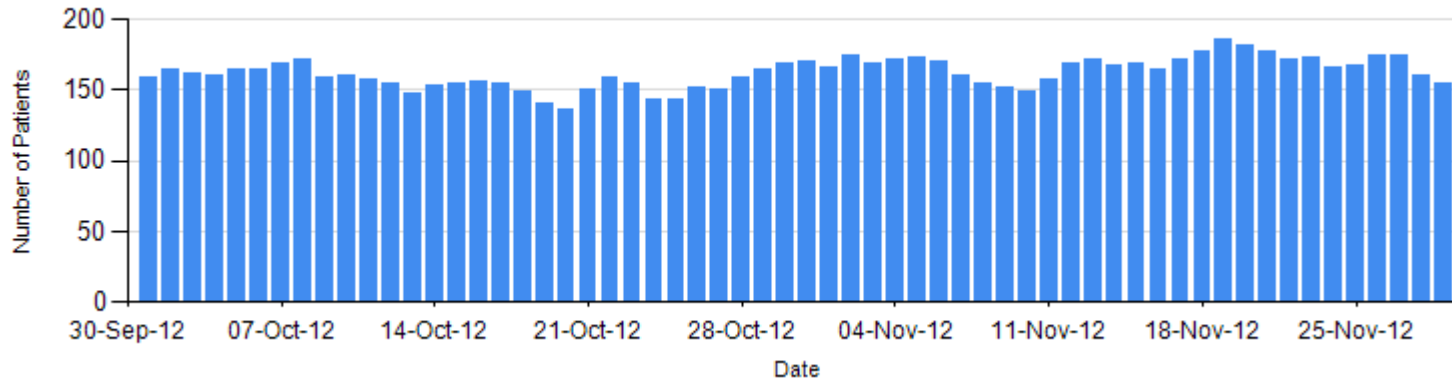
Average age 72 years

46% \geq 80 years

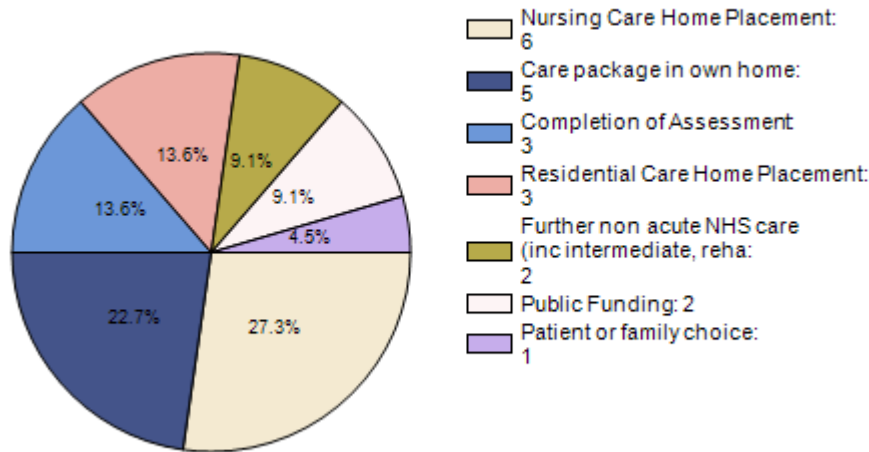
68% \geq 70 years

The challenge to the local health & social care economy

SaTH Total daily number of Patients on selected wards with a length of stay greater than 14 days (Ave = 162)

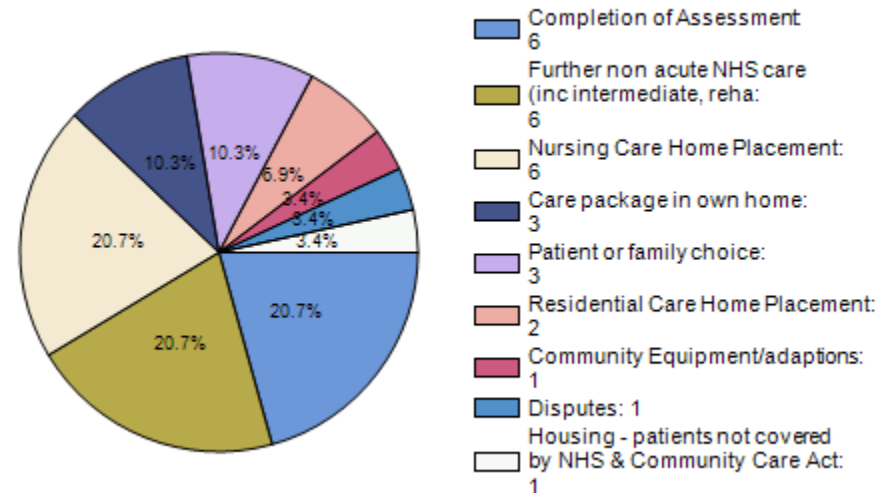


Today's Fit for Transfer Patients by Reason for Delay



PRH

Today's Fit for Transfer Patients by Reason for Delay



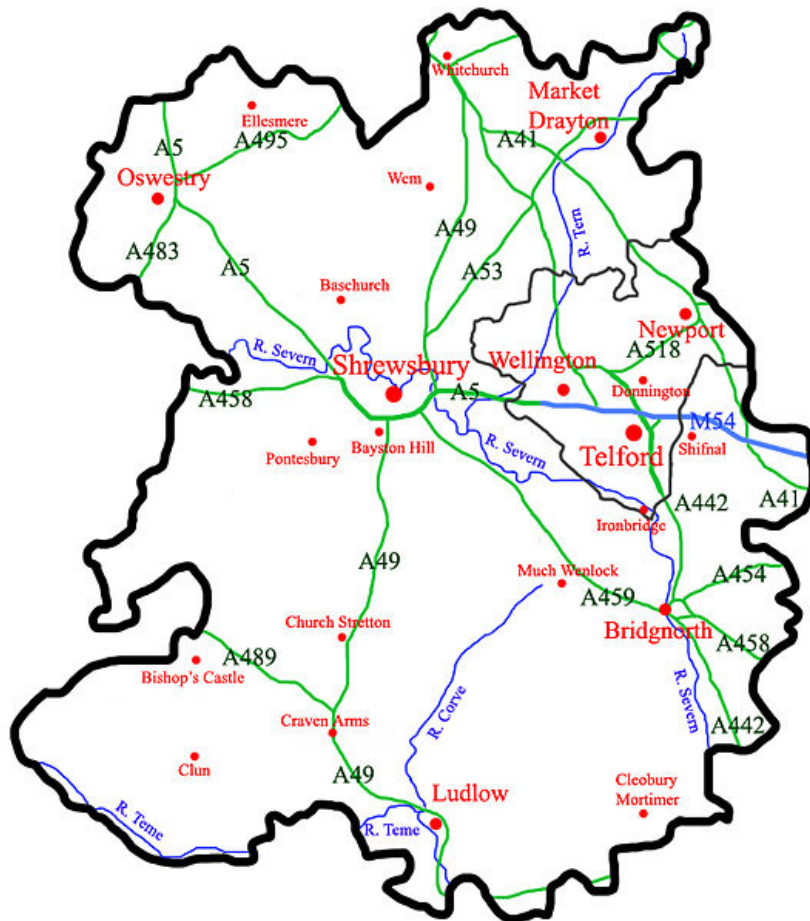
RSH

Urgent Care Network: 2011

- The current patterns of care for Frail & Complex people of Shropshire are untenable and are not treating patients as well as we could or in a way that best uses the available resources and skills.
- Present processes do not support patient's independence and promotes hospitalisation and institutionalisation.
- A much larger proportion of patients than now could be more effectively and safely treated in their own home environment if a new model of care and service were delivered.
- Health and social care services provided are complex, fragmented and extremely difficult to navigate.

Strategic aim for the F&C Service

'Health and independence'



Help ensure the F&C patient accesses high quality care in the right place, at the right time, by the right people, and in such a way that will help maintain their health and independence.

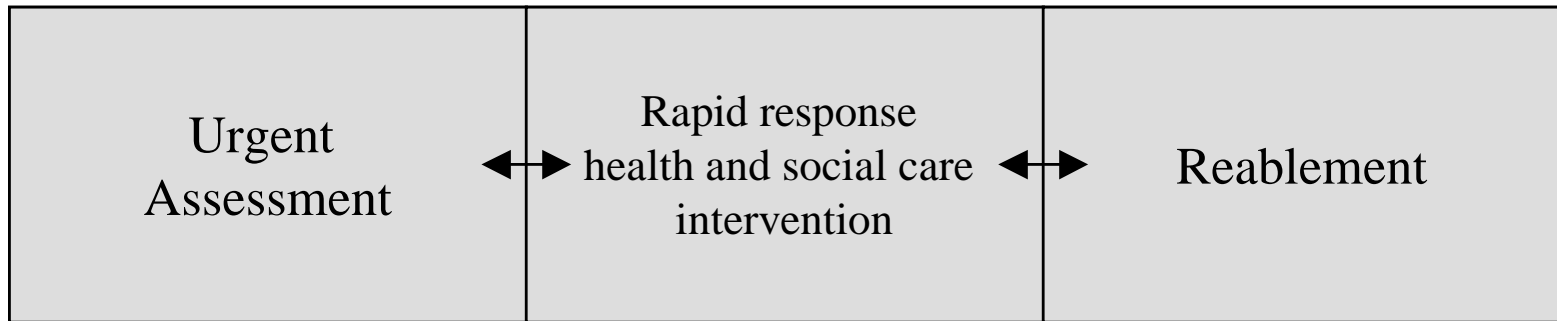
SaTH F&C Teams will optimise management of these patients thereby improving patient outcomes and reducing LoS.

Community F&C Teams will develop skills and capacity to support the GP in managing far more patients in the community.

This will change the focus of care from hospital beds (acute and community) to one that is centred around managing the patient in their home or in an intermediate care facility.

Strategic aim for the F&C Service

An integrated service supports seamless transfer of care from one needs based service to another.



Flexible health and social care workforce.
Potential to work across teams & move through the system with the individual to provide continuity.

- Perform Geriatrician led MDT Comprehensive Geriatric Assessments of all identified Frail and Complex patients in a range of care settings including SATH, acute community beds, care homes and people living in their own homes
- Embed clinical In-reach and Out-reach activity to improve patient journeys across organisational boundaries
- Re-structure and up-skill acute and community nurses and therapists to provide a flexible and generic F&C service as part of whole health economy virtual teams
- Integrate with Shropshire and T&W reablement / enablement programs

F&C Service: Implementation

Step 1: Establishment of Hospital Based Frailty Teams

- Early supported discharge from hospital of previously unidentified suitable patients
- Improve flow to and through community hospital/intermediate care beds
- Preventing unnecessary admission to SaTH
- Sub-acutely unwell F&C team assessment and treatment service

F&C Service: Implementation

Step 2: Increase capacity of community based therapy and nursing teams and appoint CoE physicians

- Improved patient flow through community hospitals
- Acute sector admission avoidance through increased capacity and expertise to manage more in community
- Increased capacity to support early discharge from acute sector

F&C Team

GPwSI

CoE Physician

Physiotherapist (SaTH, SCHT)

Occupational Therapist (SaTH, SCHT)

Social Worker

Community Nurse (In reach liaison nurses)

DAART nurses (RSH site)

RAID Team members

Working closely with:

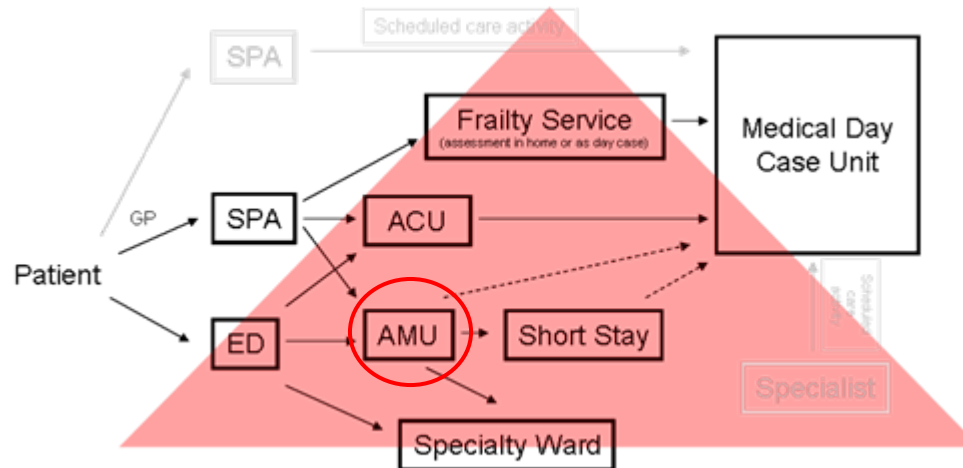
Acute Physicians

AMU and ED staff

Intermediate care/community hospital teams



Unscheduled care pathway into SaTH for the Frail & Complex patient Patient pathway scenarios (RSH & PRH)



Scenario 1: Decompensated frail elder patient sent to AMU. Reduced mobility due to UTI.

Frailty Tool flags patient (CCC/White Board/Sema)

EDD set as <72 hrs (Medical admissions proforma/early senior assessment/consultant <12hrs)

Frailty Team assess patient and supports admitting consultant team.

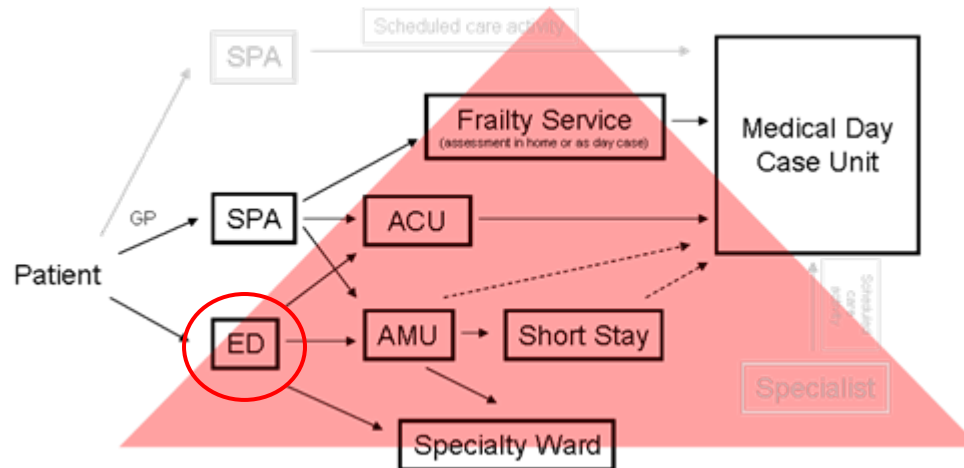
Patient goes to Short Stay/CoE ward (Tracked on Sema/Fraity IP list)

Early supported discharge.

Weekly CoE/GPwSI Frailty Team MDT and Community Teams.

Unscheduled care pathway into SaTH for the Frail & Complex patient

Patient pathway scenarios (RSH & PRH)



Scenario 2: Decompensated frail elder has a fall in RH and sent to ED.

Frailty Tool flags patient (white Board/Sema) on triage.

ED staff contact Frailty Team via hub. Bleep holder contacted.

Frailty Team assess patient in ED or in F&C ambulatory care centre.

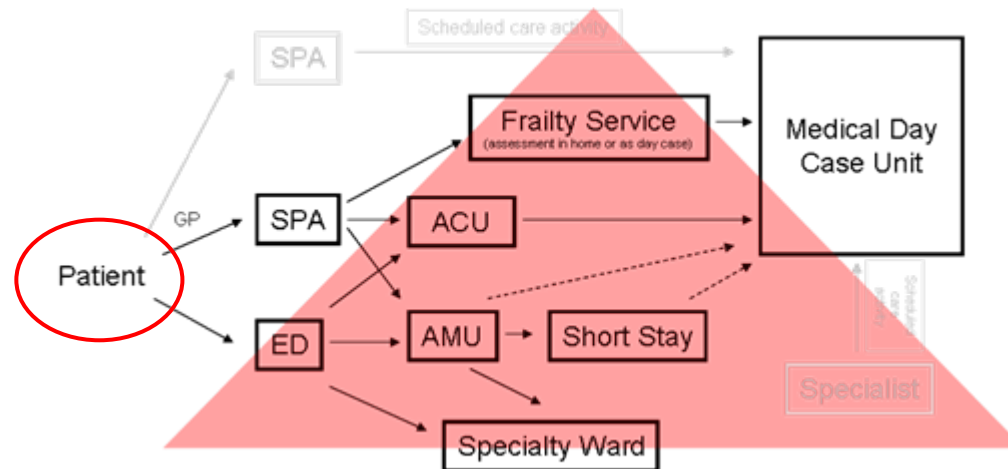
Arranges supported discharge with ongoing therapy into the patient's home.

Emergency SW supports discharge with Reablement package.

Weekly CoE/GPwSI Frailty Team MDT with Community teams (telehealth links)

Unscheduled care pathway into SaTH for the Frail & Complex patient

Patient pathway scenarios (RSH & PRH)

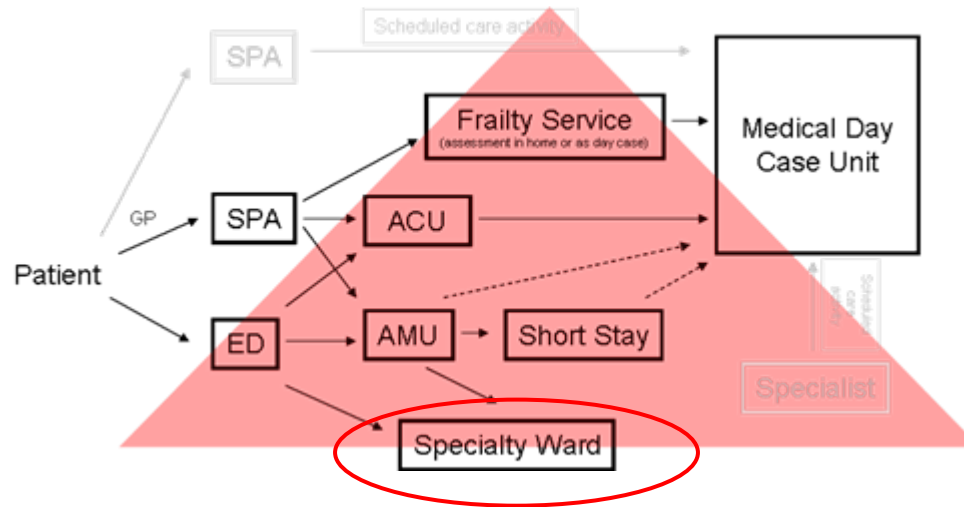


Scenario 1,2:

F&C Service will reduce LoS in SaTH or avoid admission

Unscheduled care pathway into SaTH for the Frail & Complex patient

Patient pathway scenarios (RSH & PRH)



Scenario 3: Decompensated frail elder patient on 23N awaiting community hospital bed.

Frailty Tool flags patient (White Board/Sema)

PSAG flags patients fit for discharge awaiting community bed

Referred by ward team to Frailty Team.

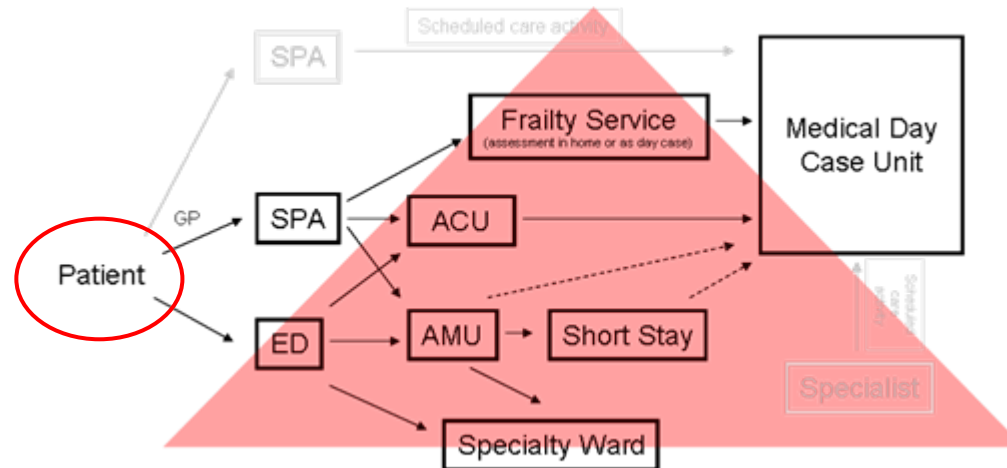
Frailty Team allocate case to physio who assesses patient and supports consultant team.

Supports on going therapy, supports discharge planning to home, ensures appropriate utilisation of community hospital beds.

Weekly CoE/GPwSI Frailty Team MDT with Community Hospital teams (telehealth links)

Unscheduled care pathway into SaTH for the Frail & Complex patient

Patient pathway scenarios (RSH & PRH)



Scenario 4: Decompensated frail elder has a fall at home and GP is requesting admission.

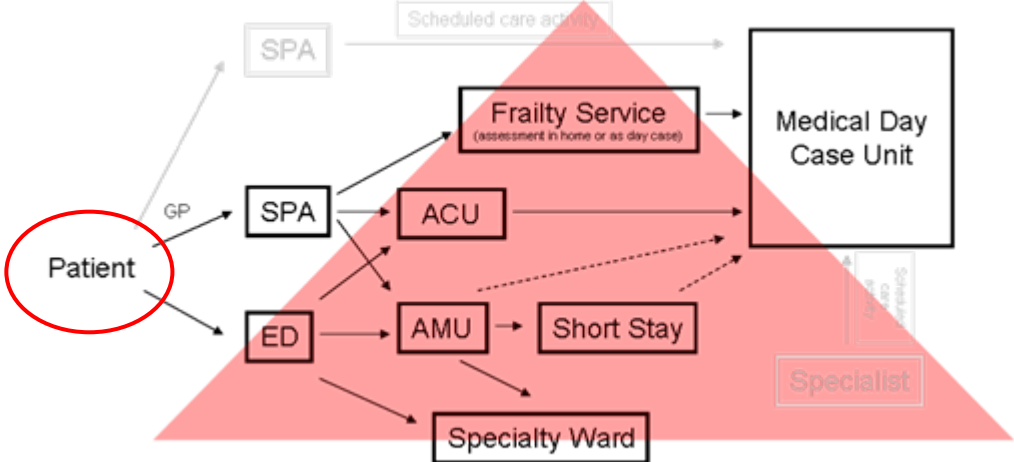
SPA contacted. Frailty Tool and discussions with GP identifies that with appropriate level of support could be managed in the patient's home.

CCC contact Frailty service who arranges rapid assessment and agrees management plan with GP (Immediate Care Team) which includes admission to community hospital bed.

Decision making supported by GPwSI/CoE Physician and/or acute physician.

Weekly CoE/GPwSI Frailty Team MDT with Community teams (telehealth links)

Unscheduled care pathway into SaTH for the Frail & Complex patient Patient pathway scenarios (RSH & PRH)

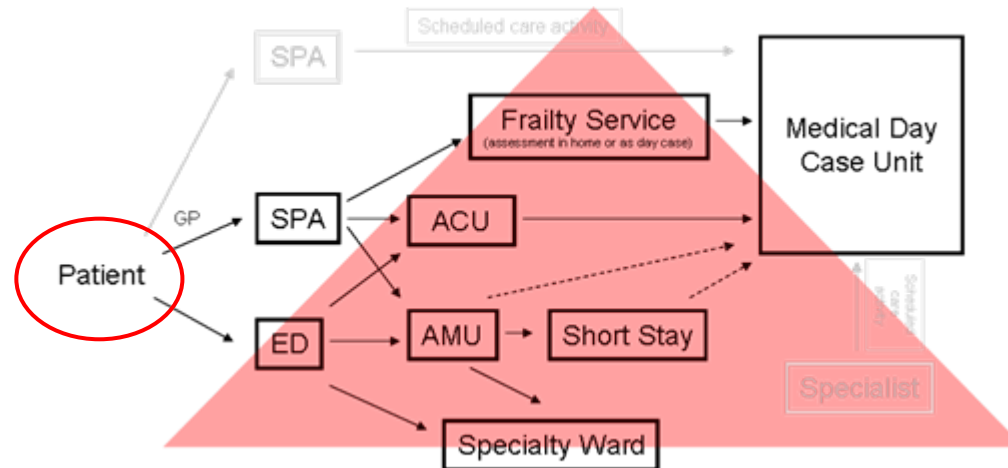


Scenario 3,4:

F&C Service will support appropriate utilisation of community hospital beds, reduce LoS in SaTH and in Community Hospital Beds thereby improving flow.

Unscheduled care pathway into SaTH for the Frail & Complex patient

Patient pathway scenarios (RSH & PRH)



Scenario 5: Decompensated frail elderly highly dependent man in a nursing home. Staff requesting admission.

SPA contacted.

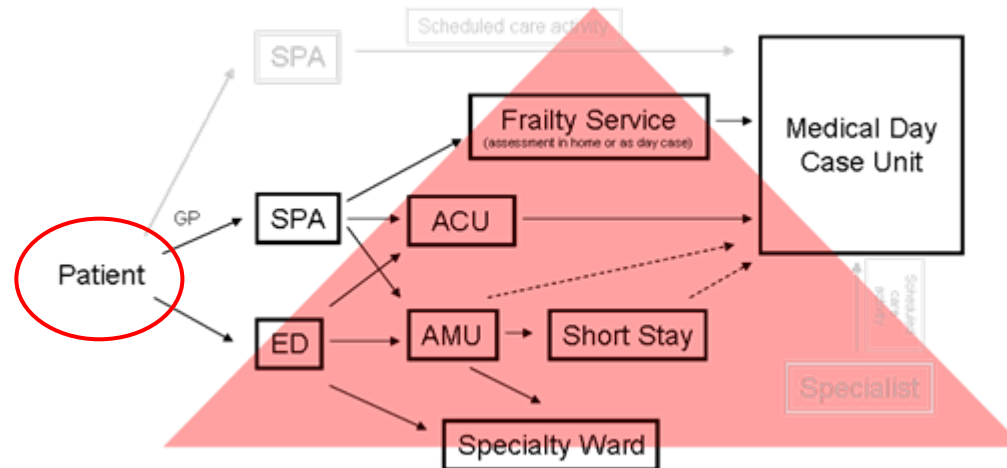
Conference call supported between Frailty Team clinical lead (GPwSI/CoE Physician), NH staff and GP, +/- acute physician.

Discussions with referring GP identifies that with appropriate level of support could be managed in the NH bed. Family involved in decision making.

Weekly (or adhoc) CoE/GPwSI Frailty Team MDT with Community teams (telehealth links)

Unscheduled care pathway into SaTH for the Frail & Complex patient

Patient pathway scenarios (RSH & PRH)



Scenario 6: Decompensated frail elder has a fall at home and GP is requesting admission to SaTH.

SPA contacted. Discussions between GP and CoE/GPwSI identifies that with appropriate level of support could be managed in the patient's home.

CCC contact Frailty service who arranges rapid assessment and agrees management plan with GP (Immediate Care Team) to manage patient in their home.

Decision making supported by GPwSI/CoE Physician and/or acute physician.

Assessed the next day having had appointment and transport booked in F&C Unit by the Frailty Team admin staff.

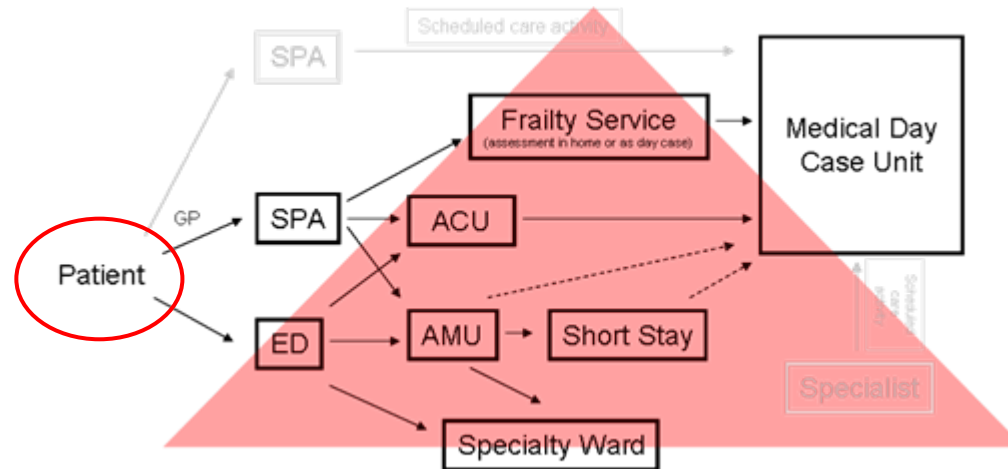
Weekly CoE/GPwSI Frailty Team MDT with Community teams (telehealth links)





Unscheduled care pathway into SaTH for the Frail & Complex patient

Patient pathway scenarios (RSH & PRH)



Scenario 5,6:

F&C Service will support the safe and effective management of F&C patients in the community. The MDT will support the GP and community team through sharing the decision making.

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F&C Service: Expected outcomes

Improved patient outcomes and experience

Reduction in admissions (rate of increase)

Reduction in readmissions

Reduced LoS (reduction in 14+day LoS)

Community focused model of care

Independence (reduction in demand on residential care)

Reduced demand for Acute and Community sector beds

Summary

- *The* biggest challenge faced by LHSE
- An effective F&C service will help return patients more quickly to health and maintain their independence
- A paradigm shift to a more community based model of care