SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY: REPORT TO THE TRUST EXECUTIVE GROUP

Subject:	Report on Governors' Visit to Frailty Unit at NGH, 5 September 2013
Supporting Director:	Neil Riley
Authors	Andrew Manasse and Anne Eckford
Status (see footnote):	For Directorate and TEG response and note

PURPOSE OF THE REPORT:

To provide feedback on Visit for the benefit of Council of Governors, TEG and the Department staff

KEY POINTS:

A great deal of inspiring thought and research has gone into looking afresh at the Geriatric and Stroke Medicine (GSM) department, as a result of which a new, evidence based, way of working has been put into practice, in the form of the Frailty Unit, with significantly improved performance and the potential for even greater improvement when related services function optimally.

OBSERVATIONS/RECOMMENDATION(S):

Governors comments	Directorate Response	TEG Response
1. Availability and timing of transport is a problem. Interim private provider has worked well. What can be done to find a dependable solution?	**1.** An on-going issue receiving active attention from STH Operations team, the Right First Time Programme and the CCG. It is not yet resolved.	**1.** TEG is aware of this issue & content that action to resolve will emerge from the work underway.
2. How can facilities in the community, outside STH control, to assess a patient ready for discharge be dependably improved?	**2.** This is improving rapidly; considerably better even since Governors' visit. Community social and health care teams are working cooperatively. Further improvements predict in the near future.	**2.** TEG pleased with the progress being made
3. There is much to learn from GSM in utilising Clinical Microsystems to improve organisation, effectiveness, engagement and morale in a department. Is as much as possible being done to cascade this across the Trust?	**3.** The Microsystems Academy has recently had external evaluation. Two issues indentified were: **(i)** Ensure senior and middle management understanding of the Microsystems approach to quality improvement. **(ii)** Continue to promote ownership of the vision of the MCA amongst senior and middle managers. The Academy is responding positively and is hoping to increase delivery of quality improvement training to middle to senior managers better preparing their engagement with methodologies like Clinical Microsystems.	**3.** TEG agrees & happy with the action being taken

GOVERNORS' VISIT TO FRAILTY UNIT, NORTHERN GENERAL HOSPITAL
5 September 2013

Present: Anne Eckford
Joyce Justice
John Laxton
Andrew Manasse
John Warner
Shirley Harrison (Non-Executive Director)

Staff: Tom Downes
Paul Harriman

The visit was facilitated by Paul Harriman, Assistant Director, Service Improvement, and Professor Tom Downes, Consultant Geriatrician and Clinical Lead for Service Improvement, who in addition to being a consultant geriatrician also has an interest and expertise in Business and Public Health, Improvement Science, and Clinical Microsystems.

The afternoon began with a presentation and Governors heard that it was recognised that there was an inverse relation in healthcare between quality and costs and that in this context it had been evident for some time that change was required in geriatric services. At STH it was agreed to investigate the situation and in 2009system improvement expert Kate Sylvester from Warwick University joined Paul with Tom joining the work later in 2010 on return from his Fellowship in the US. The Big Room concept was applied: this is a weekly brainstorming meeting for an hour, involving multidisciplinary staff at all levels, various relevant hospital agencies and community staff, working together on the problems and the possible solutions, applying the principles of Clinical Microsystems. The outcome of all this work is the Frailty Unit, based on the principle that for individuals to gain the most from their experiences, either as staff or as patients, the care must be well organised.

Governors were provided with the following background information:

- Nationally, one third of medical intake is aged over 80 years
- 10% of patients stay in hospital more than two weeks constituting more than half of all acute bed days
- 75% of medical consultants feel more pressure than they used to
- Between 2001 and 2011 there was a 6% increase in healthcare funding compared to a 4.3% increase of healthcare inflation. The drivers in increasing costs are predominantly technology and expectations rather than escalating age. In five years time 20% more care will be required

This position was described to Governors as unsustainable and suggesting the need for significant transformation of the NHS.

STH is in the vanguard researching the challenge and undertook a survey, over a three-month period, of all GSM patients whose stay in hospital was longer than the majority, and who incurred significant additional costs both to the Trust financially and to their own health. It was highlighted that recently the STH length of stay of over 65s was 12.1 days – higher in the context of England.

The Clinical Microsystems approach has been utilised in a trial, with consultants seeing patients on their day of attendance/admission. This often avoided patients requiring an overnight stay and also enabled consultants to meet relatives and carers at the time of admission rather than days later, which was beneficial and resulted in a significantly reduced length of stay. Following the trial from April 2012 all geriatric medicine consultants have been seeing patients on the day they are admitted. Contrary to expectations, it transpired that this practice was no more onerous for consultants than the previous approach. GSM are in the vanguard of seven day working with geriatricians now on call on the Frailty Unit seven days a week.

Geriatric in and out patients were historically viewed as different, but they and their needs are in fact similar and the aim, since April 2012, is to see them all in real time. There has been a change from twice weekly to daily ward rounds and multidisciplinary meetings from weekly to as needed.

The main difficulty with seeing patients in real time is availability of transport at the time when it is needed to bring patients to hospital, and this problem remains to be resolved.

Opened in May 2012 following extensive refurbishment, the Frailty Unit occupies a Firth ward. It is a busy ward with male and female bays and some single rooms; each bay has a nurse station allowing good observation of patients. Referrals come via A&E, bed bureau and GPs and the Unit works on the principle that frail elderly patients require more input and care than 'normal' patients. There is a multidisciplinary approach including physiotherapists and occupational therapists ensuring that all needs are assessed and managed, with the aim of discharging patients as soon as they no longer need hospital based care, and for them then to be assessed at home where the assessment is relevant rather than time being wasted waiting for assessments in hospital. Since 2012, bed usage has reduced significantly, unrelated to demand, and there has been no increase in readmission rates 32% of patients seen can be discharged home within the day and mortality in hospital, (HMSR) has reduced.

Governors then visited the Unit and were impressed. We met cheerful staff and we were introduced to an elderly man - 110 years old - who had been in for three days, had had his chest infection treated and was looking forward to going home. We also met a lady who had had a bad fall, had been rapidly assessed, found not to need further hospital care and was awaiting discharge for assessment at home. Previously these patients would have both been in for much longer and might have suffered from the many things that affect old frail people when they are hospital even slightly longer than necessary, such as institutionalisation, exposure to infection, discontinuation of care at home and difficulty in restarting it.

There are two main constraints to success of the Unit:

1. Patient transport: it still takes too long once the decision to be seen in hospital has been made, for the patient to arrive in the Unit.

2. Ability to Discharge to assess: the necessary facilities are often not available when the patient is ready to be discharged, and the responsibility here is largely with the City Council and therefore outside the control of the Trust. This is a very important area for Right First Time.

Governors came away with a very positive impression and with no suggestions for improving the Unit. However Governors consider it is important to recognise and give some lateral thought to the issues around patient transport and aspects of Right First Time that relate to bed availability for the frail elderly in the community, as this would not only enable the unit to work as intended, but would also reduce inappropriate bed occupancy (outliers), improve the patient experience and provide significant cost savings. It might also be good if the positive experiences in GSM could be shared more widely across the whole organisation.

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