Frailty Intervention Team (FIT –RSH)

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Frailty – FIT team

Plan	To implement an integrated community and acute multi disciplinary team at the 'front door' who are responsible for early identification, rapid assessment and treatment of patients presenting as frail and complex via A&E, AMU, CDU in order to prevent unnecessary admission to the medical bed base, thereby preventing the risk of decompensating and an increased length of stay.
Aim	• Improve patient outcomes by reducing the risks associated with unnecessary days stay in an acute setting • All Patients to be assigned a Frailty Score from A&E • Provide senior specialist decision making at point of admission for Frail and Complex patients • Set a Clinical criteria for discharge for every patient at the earliest possible point in their patient journey • Reduce the reliance on accessing unplanned escalation areas and boarding patients
Current Status	• PDSA launched for 2 weeks early September Positive evaluation - secured investment from STP to March 2018 to further prove impact and proof of concept • March 2018 Evaluation presented to A&E delivery board and Frailty Board who then agreed for a further 12 months funding to support the system's overall programme of improvement for the Frailty pathway

The ‘integrated’ Team

Profession	Provider
Programme Manager	SaTH
Therapy/ Project lead	SaTH
Advanced Care Practitioner x 2	SATH
Consultant Geriatrician	SaTH
Physiotherapist	SaTH
Occupational therapist	SaTH
Therapy support worker	SaTH
Admin	SaTH
Data Analyst	SaTH
ICS Nurse/ therapist	SCHT
Community Matron	SCHT
Social Workers	SC

Daily Huddles 9am -Red Cross, Carers support worker, End of life Coordinator, DaART, SaTH2Home, Dementia support worker and Patient reps have all attended to share learning and develop external networks of support

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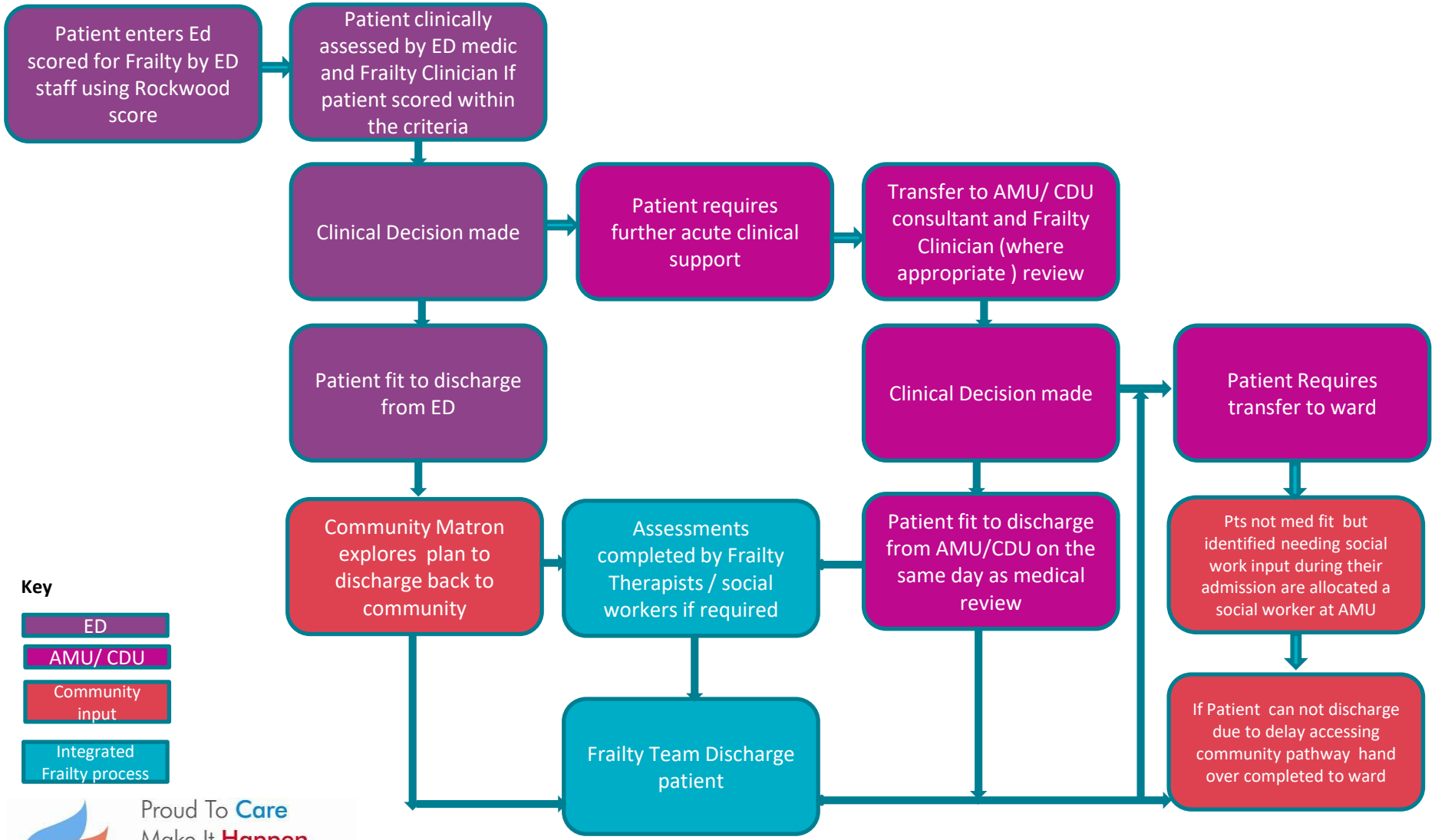
The Model (Evolved with AFN and PDSA cycles)



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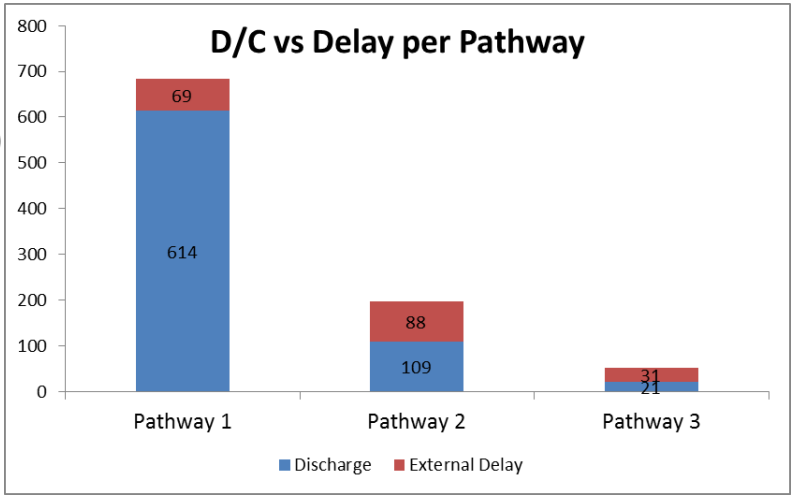
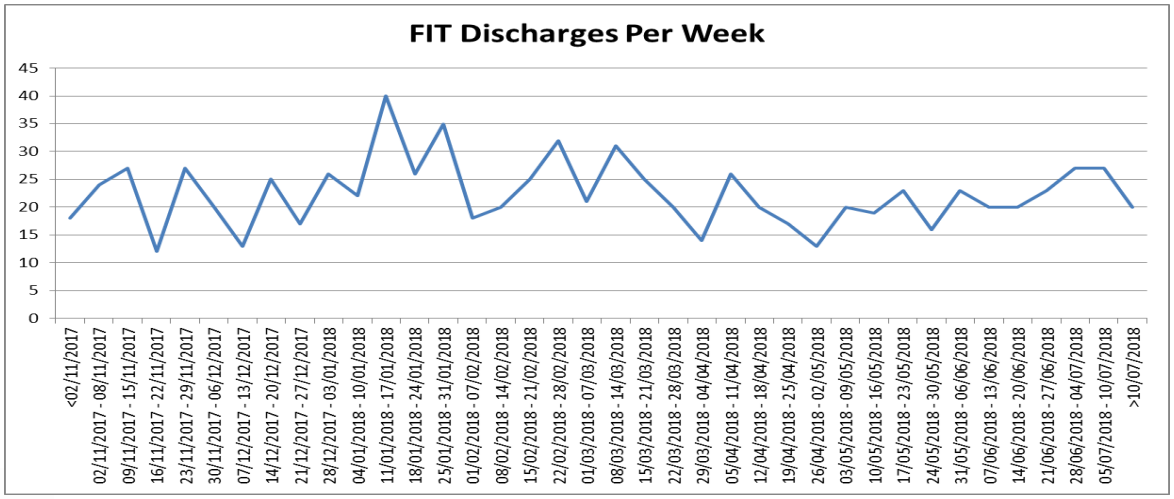
Frailty Service Activity Summary Report (36 Weeks)

Activity:

- 95.5 patients added to the FIT case load each week (3407 total)
- 23.7 discharges directly facilitated by the FIT each week (744 total)
- 10 discharges directly from ED each week (256 total)
- 16 patients discharged each week from AMU/CDU (577 total)
- 82% of FIT discharges go home (614 total)
- 55% of patients over 75 were screened for Frailty In June 2018 compared to 3% in September 17



- FIT facilitates a total of 4.7 discharges every day



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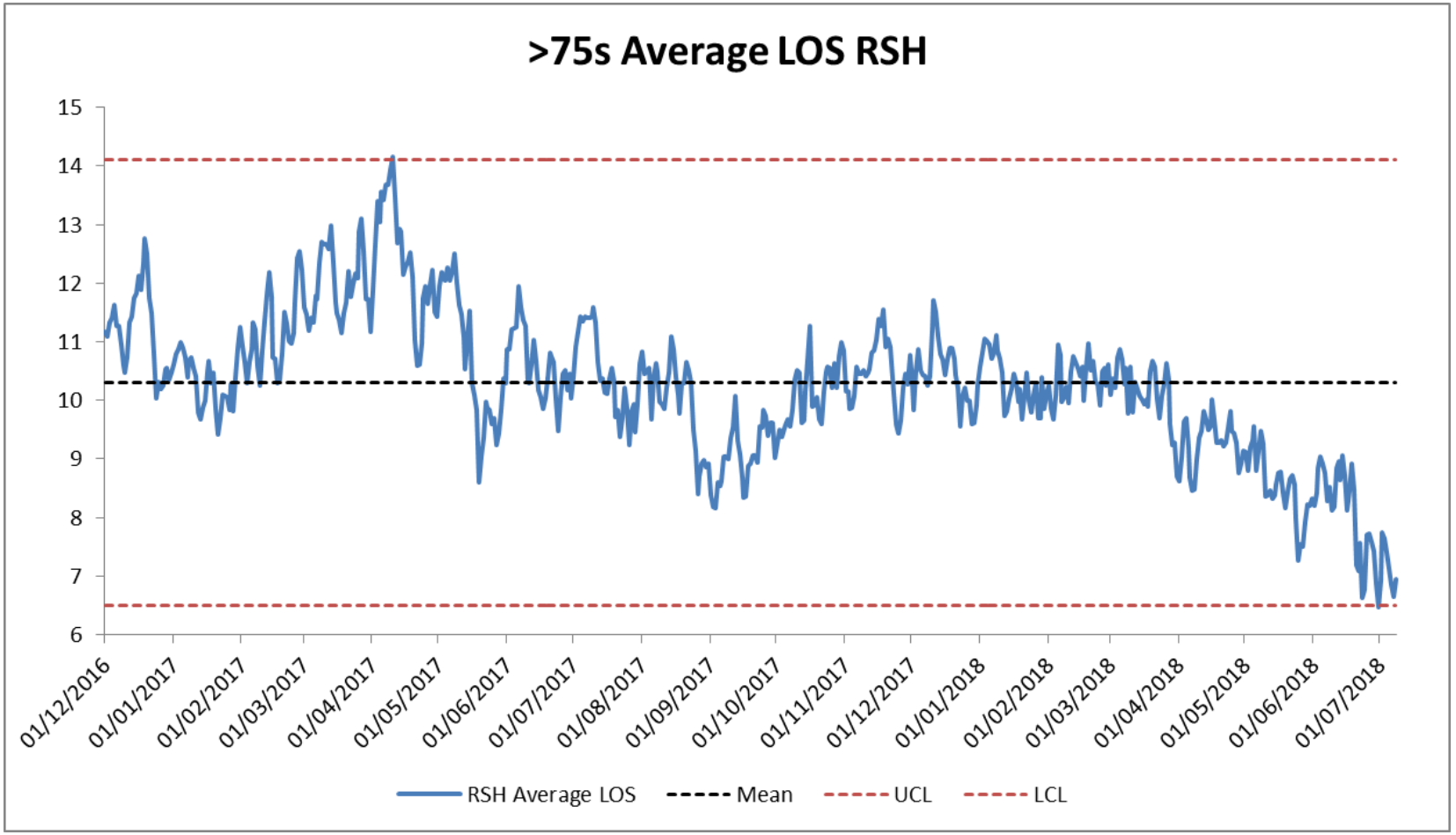
Royal Shrewsbury Hospital



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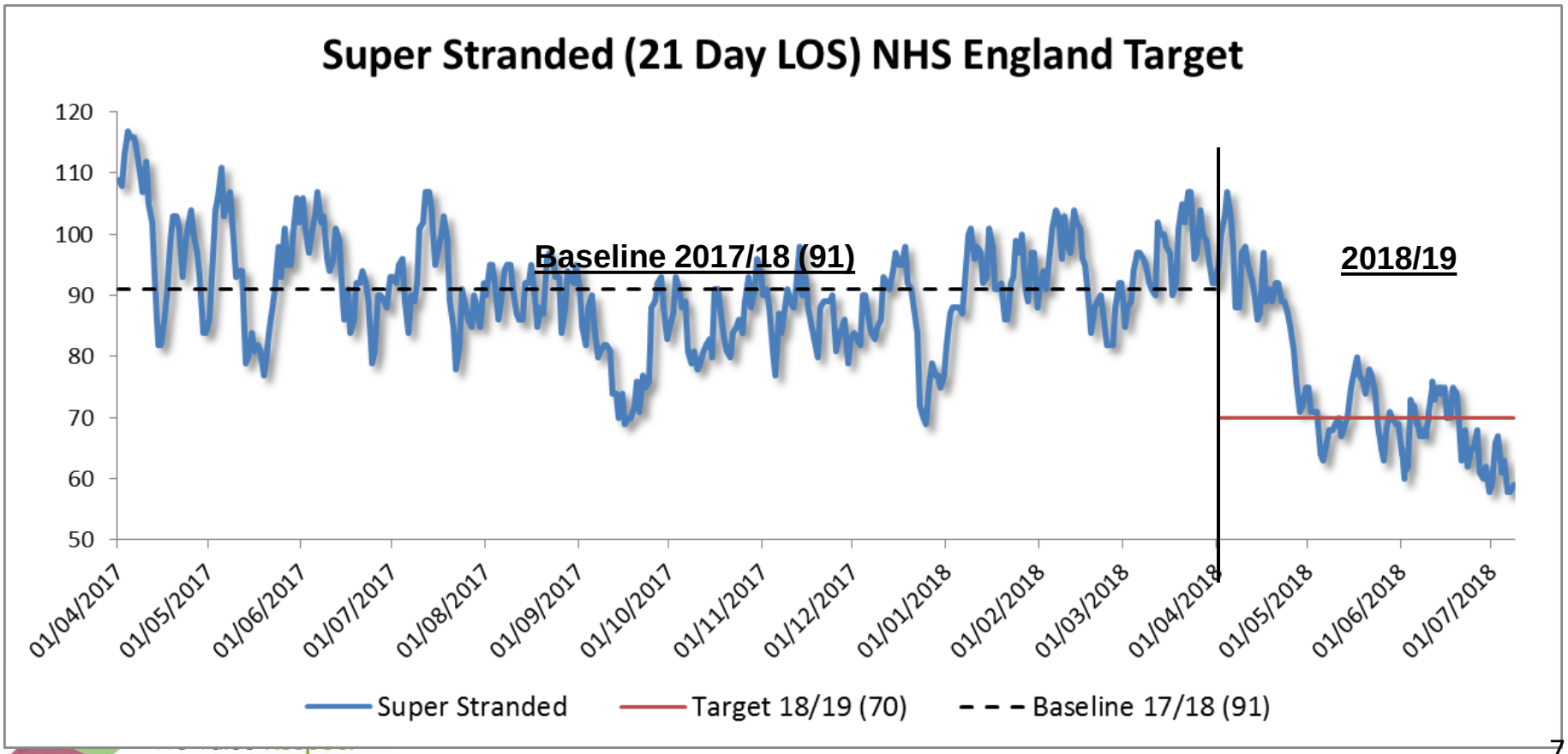
Average LoS for >75s in SaTH has reduced from nearly 14 days in April 2017 to under 8 days in July 2018

Super Stranded Patients (LOS >21 days)

- NHS England have set a long length of stay improvement target for each trust
- SaTH's baseline number from 2017/18 (April to April) was 91 super stranded patients
- 23% improvement set by NHS England gives SaTH a target of 70 super stranded patients
- Work on super stranded patients was already in progress and we have been floating around the 70 target since May
- Super stranded patients was consistently above 90 this time last year
- Only 11 other trusts of the 134 have a lower % of super stranded per bed base (SaTH 13.5%)



Patient Story

Feedback so far around the Frailty Intervention Team has given multiple examples of efficiency of MDT working, expediting discharges and complex decision making in the patient's best interests. This week, we wanted to share an incident that enabled us to provide specialist person centred, quality care from ED

- 97 year old Male twins – fell in their own homes almost simultaneously on the same morning! One twin known to the service from a previous admission so notes accessed on arrival to ED following spotting patient on ambulance CAD
- Both brought in by ambulance and arrived at the department within 9 minutes of each other – accompanied by their niece
- Proactively added to the caseload by screening ED screen (identified as appropriate for service within <30 minutes of their arrival) Flagged as Green
- Gathered collateral social and functional history from niece re: both ladies prior to investigations being carried out to ensure early identification of potential barriers to discharge
- Once both men physically examined FIT facilitated bringing them into the same cubicle once gaining mutual consent
- This enabled a huge reduction in stress for the accompanying relatives as they could be present for both aunts at all times and were guaranteed to be involved in discussions
- This was the first time the brothers had seen one another since before Christmas – socially beneficial
- Opportunity to facilitate discussion amongst MDT, family and patients re: future management strategies – sisters keen to move in together to support each other – much more feasible for the niece provide extra care, likely reduction in attendances and admissions in the longer term
- One twin assessed as being able to return home the same day with additional equipment and a restart of existing care package
- Second twin unfortunately required admission under orthopaedics however clinical criteria for discharge and full social plan documented in notes as he transferred to bed base

Frailty – Next Steps

- NHS England asked to film the team to share as a 'best practice approach' when appropriate patient consents to be used as a case study
- SaTH asked to support with developing 'next years' AFN eLearning tools
- SaTH presenting the 'Shropshire' model at AFN event 20TH September
- Enhance the pathway following the opportunity of the 'fire work' with ward 21 (COE bed base)
- Continue to promote Criteria led discharge
- Grow Geriatrician work force
- Rotate staff to influence culture
- Develop stronger pathways with Daart / WMAS / Primary Care
- Work with SCHT and CCG's regarding the Community Matron role (clinical nurse specialist) and prescribing pharmacists also links back to community – silver line/ tele health
- Scope extending service to 7 days
- Plan for roll out at PRH (tweak model)

Any Questions?

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