Today’s agenda

10:15-11:00 Board round up: Graham Ellis, National Clinical Lead

11:00-12:00 Acute Frailty Network England: David Hunt, Acute Geriatrician, Western Sussex Hospitals NHS Foundation Trust

12:00-12:45 Lunch and networking

12:45-13:45 Effective communication to help with change: Cathy MacDonald, Communication Coach and Consultant, The Art of Communication

13:45-14:15 Understanding patient experience: Anna Milsom, Health Services Researcher

14:15-14:30 Coffee and networking

14:30-15:45 Thinking differently – understanding strategic commissioning: Zaid Tariq, Strategic Planning Portfolio Lead

15:45-16:15 Board planning

16:15 – 16:30 Next steps and Chairs closing
Aims of the day

- Provide the opportunity to network, share progress and explore opportunities to collaborate
- To illustrate the types of challenges experienced when undertaking improvement work and develop strategies to encourage and embrace change within your organisation
- Generate and explore ways to collate qualitative data that supports improvements
- Enhance understanding of strategic commissioning and what that means within the local context
Board round up

Graham Ellis
National Clinical Lead
Healthcare Improvement Scotland
7 months in.....
7 months in.....
If I had only an hour to save the world, I would spend 59 minutes trying to understand the problem.

Albert Einstein
WHO WANTS TO BE A MILLIONAIRE

50:50
NHS Dumfries and Galloway

Presented by: Joan Pollard
Site and project recap...

**General Context**
- Dumfries and Galloway provides acute care for a population of circa 150,000. Almost 25% of the population is aged over 65 yrs
- Acute care is provided from 2 sites: DGRI and Galloway Community Hospital
- DGRI moved to a new site in December 2017 and will be our area of focus.
- DGRI emergency department has approx 36,500 attendances per year with 16% aged 75 years or over
- DGRI admissions unit has approx 8,250 admissions per year with 42% of admissions aged 75 years or over

**Project Context**
- At commencement of the project:
  - no frailty identification tool was consistently in place - testing
  - Overall feeling of lack of understanding of need for frailty identification/ potential impact across the system
  - AHPs in post supporting flow from the front door CAU and ED on a 5/7 basis
  - Significant drive from clinical lead and recognition within senior management team of need for change
  - Resistance to change from significant areas
  - Significant turbulence due to hospital move and winter pressures.

**To April 2018**
- Successfully working on awareness raising, inspiring interest,
- Undertaking baseline mapping understand current process and identification of initial ideas for test of change.
- Changing personnel with Programme Lead stepping down within last few weeks
Next steps...

• Undertake snap shot audit, establishing operational team and exploring data capture

• Test 1: Testing the frailty screening tool with middle grade doctors in CAU

• Test 2: Clinical lead and AHPs reviewing in am and commencing comprehensive geriatric assessment. Feeding back into CAU huddle

• Reviewing learning and ideas to progress to further tests of change

• Keeping the momentum by developing a Frailty Circle of interested individuals from across the system
NHS Forth Valley

• Based in Forth Valley Royal Hospital

• AIM - to improve outcomes and experience for older people and their carers living with frailty presenting to acute services.
1. Rapidly and reliably identifying frailty at the front door.

- Previously board round and random assignment of Frailty by team doing board round.
- Initially tried using our call handler to screen GP calls but this was not reliable enough.
- NOW.... have a nurse working Mon-Fri 7am-3pm who screens the whole of the front door first thing as a sweep using THINK FRAILTY TOOL.
% of people over 75 years old who are screened for frailty on arrival to front door

% of people over 75 years old who are screened for frailty on arrival to front door in FVRH

Nurse starts screening patients 16th April

Call handler screening commenced
Then........

- The team meet at noon for a “Huddle”
- Discuss all the patients in the front door who are Frail and make a plan.
- Representation from health & social care as well as community teams.
- Tell our patient flow teams who we are admitting and where they have to go.
Slight downward trend!

Number of people admitted to specialist inpatient geriatric bed who's LoS is longer than 7 days
(A11/A32/B21/B22)
2. Delivering early Comprehensive Geriatric Assessment.

% of people over 75 years old who have CGA initiated within 24 hours
Other Aims

• Ensure the person experiences well coordinated care and support attuned to their needs, with the focus of support at home or in a homely setting where possible.

• Improve interface and collaborative working between health and social care.
Next steps...

1. Currently nurse is on secondment so we need to work out how that will be permanent and how it will expand/grow over 7 days and how we fund other posts such as therapy.

2. To work on our huddle model to ensure that it delivers well coordinated care

3. Work together with health and social care to ensure that we are providing what is needed for the patients who present to our service both in hospital and in the community.
Couch Potato to 5K Hero

Open to All Ages
Wednesdays: 6:30 - 7:30 PM
Northfield Park, Room B
Grades: 3-6th
Spots Limited
Registration Fee: $20

Questions? Call Pamela Moot at 718-801-3687 or e-mail: panwally@gmail.com
QEUH timeline

May 2015
Amalgamation of three hospitals - started to think about frailty

Early 2016
Multiple pilots in IAU
Feedback from each test of change (quantitative and qualitative)

Aug 2016
Stakeholder meeting - presentations from other sites

Dec - Feb 16/17
HIS invited to visit/ advise
- Driver diagrams
- Pathway planning
- Frailty charter for QEUH
Peer reviews and visits to other sites
AHP winter monies

Feb 2017
Option appraisal paper - short stay frailty

March 2017
Additional AHP locums - and formed Frailty team

June 2017
Opening of short stay frailty ward (changed the function of a ward)
QEUH timeline

June 2017
Involvement in HIS Frailty collaborative
GGC meetings
Local Frailty group

July 2017 onwards
Frailty team- South Sector winners!
Screening for frailty whole of ground floor
Demonstrating our benefit

March 2018 onwards
Frailty pathway
HIS visit and review
Value stream mapping and subsequent action plan
  ▪ Continue to analyse and feedback data
  ▪ Work on action plan
**Value stream mapping**

### High Impact - Minimal Effort

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Aims</td>
<td></td>
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</tbody>
</table>
1. Improve patient flow in the ED.  
2. Enhance communication between departments. |
| Issues |  
1. Limited space in the ED.  
2. Lack of resources. |
| Actions |  
1. Audit ED workflow.  
2. Implement new protocols for patient flow. |
| Timeline and Timelines |  
| Status |  
Ongoing. |
| Lead |  
Dr. Smith. |

### Greater Identification of Frailty

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
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<tbody>
<tr>
<td>Aims</td>
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</tr>
</tbody>
</table>
1. Increase awareness of frailty among staff.  
2. Develop a frailty identification tool. |
| Issues |  
1. Limited resources.  
2. Staff training needs. |
| Actions |  
1. Conduct staff training sessions.  
2. Launch the frailty identification tool. |
| Timeline and Timelines |  
1. Staff training: June 2023.  
| Status |  
Ongoing. |
| Lead |  
Ms. Johnson. |

### HIS Screening in the Triage Room

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
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<tbody>
<tr>
<td>Aims</td>
<td></td>
</tr>
</tbody>
</table>
1. Enhance patient care by screening for frailty.  
2. Reduce hospital stays. |
| Issues |  
1. Limited staff resources.  
2. Technical difficulties. |
| Actions |  
1. Conduct daily screening.  
2. Address technical issues. |
| Timeline and Timelines |  
| Status |  
Ongoing. |
| Lead |  
Mr. Brown. |

### Collected Evidence

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1. Patient feedback.  
2. Staff reports. |

### Challenges

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1. Limited staff resources.  
2.Technical difficulties. |

### Solution

<table>
<thead>
<tr>
<th>Solution</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1. Increase staff hiring.  
2. Implement new technologies. |

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**Value Stream Mapping Workplan**

[Table showing the workflow and details of each step, including dates and responsible parties.]
100 % CGA within 24 hours
Next steps

• Frailty short stay ward permanent in a new location (July ‘18)
• Develop Frailty team in conjunction with above
• IT/ metrics
• Screening once trakcare updated in Nov
Monklands Update
Background

- Frailty screening and early CGA well imbedded into COTE post take.
- Good flow into specialty beds, frequently empty beds in our 4 wards to receive patients into out of hours. Patients can’t move as no consultant review.
- Medical directorate redesign of ERU/GP bay into MAU/AMRU has left us picking up new patients in up to 6 different wards.
MRRP

• Blank sheet of paper to design our future care model.
• Data and subsequent modelling have identified that we would need a 24 bedded assessment unit with 48 hour length of stay.
• Some years away – will result in a reduction in downstream beds.
• Can we bring this in to being with what we have?
What next

- Ongoing planning
- PDSA cycles
- Direct admissions to a COTE “frailty unit” – gradually convert existing ward into this 24 bedded future unit
- Earlier access to AHP and discharge coordinators
NHS Lothian

Presented by: Dr. Latana Munang
Site and project recap...

- Frailty at SJH
- REACH Team based in MAU within SJH
- Tests of change to expand service into other areas
- Evaluation of work so far
Next steps...

- **Current Test of change: REACH Nurse in one of the General Medical Wards**
- **Hospital-wide REACH service to positively impact Front Door**
- **Close collaboration between Consultants, REACH Nurse and existing ward staff**
- **Two Week Period**
- **Measurement Plan in place**
Acute Frailty Network England

David Hunt
Acute Geriatrician
Western Sussex Hospitals NHS Foundation Trust
Using Lean for Service Design: Front door services for older people with frailty

Dr David Hunt
Acute Geriatrician &
Clinical Director for the Department of Medicine for Older People

@davidceh08
David.Hunt@wsht.nhs.uk

With slides from
Simon Conroy, BGS, Coastal Care, Coastal West Sussex CCG and AFN
Caring for older people with multi-morbidity and frailty is our core business

... my Grandmother, my motivation
Stroke Improvement:

- July - Sept 2013
- Oct - Dec 2013
- Jan - Mar 2014
- Apr - Jun 2014
- July - Sept 2014
- Oct - Dec 2014
- Jan - Mar 2015
- Apr - Jun 2015

- 2nd quartile
- National Median
- Worthing
- SRH

A
B
C
D
E

Western Sussex Hospitals NHS Foundation Trust
Western Sussex Hospitals NHS FT
Quality Improvement
Executive Team Visiting Toyota

- Building on learning from Salford Royal and Virginia Mason in terms of Lean Management System
- To take seriously the importance of the leadership role in modelling improvement behaviour and commitment
Sheffield MCA:

"I have no idea what it means but I love the action."
Figure 1. Projected population by age, United Kingdom, 2010–35
(2010 = 100)

By 2030 men aged 65 will live on average to 88 and women to 91

Age

45–59
60–74
75 and over
75–84
85 plus


Number of difficulties with activities of daily living by age, England, 2012/13 (Age UK, 2015)

Number and percentage of people receiving support with social care in England, 2005/06 – 2013/14
Polypharmacy and more drug interactions.
Primary Care is more stretched..

Average number of GP practice consultations per person per year, by sex and age group, 1995 to 2008
Unsurprisingly more emergency admissions..
(2000-2011)

Emergency admissions to NHS hospitals in England 2000-11
... into fewer beds (1980-2011)
...with less money

Figure 1: NHS provider organisations financial position: 2009/10 to 2015/16

Data source: Department of Health Annual Accounts; Monitor 2016
...and fewer nurses
...so performance in England is worsening

Percentage of emergency admissions (type 1) seen, transferred or discharged within 4 hours, 2009-2016

**Observation:** Coastal West Sussex has one of the oldest populations in England, with **25% over 65** (see amber lines above) with more over 50’s and over 80’s than most other areas.

Older population expansion in England will accelerate in the next 20 years. In England over 65s will increase from **17% (2010)** to **23% by 2035**. In 20 years time the national average for over 65s will still be less than Coastal’s is now at 25%, when it will be more like **33%**...
### Adult Social Care Outcome Indicators – 14/15 to 15/16

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Eng Av</th>
<th>WSCC</th>
<th>Cluster</th>
<th>Move</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care Quality of Life (out of a score of 24)</td>
<td>19.1</td>
<td>19.5</td>
<td>19.3</td>
<td>Lower</td>
</tr>
<tr>
<td>Service Users with control over their daily life (%)</td>
<td>77.3</td>
<td>80.3</td>
<td>79.4</td>
<td>Lower</td>
</tr>
<tr>
<td>Service users receiving self directed support (%)</td>
<td>83.7</td>
<td>97.8</td>
<td>83.6</td>
<td>Higher</td>
</tr>
<tr>
<td>Carers receiving self directed support (%)</td>
<td>77.4</td>
<td>97.1</td>
<td>75.8</td>
<td>Lower</td>
</tr>
<tr>
<td>People receiving direct payments (%)</td>
<td>26.3</td>
<td>28.4</td>
<td>28.5</td>
<td>Lower</td>
</tr>
<tr>
<td>Carers receiving direct payments (%)</td>
<td>66.9</td>
<td>97.1</td>
<td>64.0</td>
<td>Lower</td>
</tr>
<tr>
<td>Carer-reported quality of life (out of a score of 12)</td>
<td>7.9</td>
<td>7.7</td>
<td>7.8</td>
<td>DNR</td>
</tr>
<tr>
<td>Adults with learning disabilities in employment (%)</td>
<td>6.0</td>
<td>2.2</td>
<td>7.3</td>
<td>Same</td>
</tr>
<tr>
<td>Adults in contact with Mental health Services who are in paid employment (%)</td>
<td>6.8</td>
<td>6.8</td>
<td>8.3</td>
<td>Same</td>
</tr>
<tr>
<td>Adults with learning disabilities in stable accommodation (%)</td>
<td>44.8</td>
<td>45.5</td>
<td>46.6</td>
<td>Higher</td>
</tr>
<tr>
<td>Adults in contact with Mental health Services who are in stable accommodation (%)</td>
<td>38.5</td>
<td>36.1</td>
<td>35.7</td>
<td>Higher</td>
</tr>
<tr>
<td>Adults in contact with Mental health Services who are in paid employment (%)</td>
<td>14.2</td>
<td>14.7</td>
<td>13.3</td>
<td>Higher</td>
</tr>
<tr>
<td>Adults with learning disabilities in stable accommodation (%)</td>
<td>668.8</td>
<td>340.8</td>
<td>599.5</td>
<td>Higher</td>
</tr>
<tr>
<td>Adults in contact with Mental health Services who are in paid employment (%)</td>
<td>82.1</td>
<td>71.4</td>
<td>81.9</td>
<td>Higher</td>
</tr>
<tr>
<td>Adults with learning disabilities in stable accommodation (%)</td>
<td>3.1</td>
<td>1.4</td>
<td>3.1</td>
<td>Lower</td>
</tr>
<tr>
<td>Delayed transfers of care (per 100000)</td>
<td>11.1</td>
<td>11.8</td>
<td>12.5</td>
<td>Higher</td>
</tr>
<tr>
<td>Delayed transfers of care attributable to social services (per 100000)</td>
<td>3.7</td>
<td>3.3</td>
<td>4.4</td>
<td>Higher</td>
</tr>
<tr>
<td>The outcome of short term services : sequel to service (%)</td>
<td>74.6</td>
<td>92.5</td>
<td>75.5</td>
<td>Lower</td>
</tr>
<tr>
<td>Client satisfaction with care &amp; support (%)</td>
<td>64.7</td>
<td>67.8</td>
<td>65.6</td>
<td>Lower</td>
</tr>
<tr>
<td>Carer satisfaction with social services (%)</td>
<td>41.2</td>
<td>37.7</td>
<td>40.3</td>
<td>Lower</td>
</tr>
<tr>
<td>Carers included or consulted in decisions (%)</td>
<td>72.3</td>
<td>73.5</td>
<td>73.5</td>
<td>DNR</td>
</tr>
<tr>
<td>Service users who find it easy to get information (%)</td>
<td>74.5</td>
<td>75.6</td>
<td>75.2</td>
<td>DNR</td>
</tr>
<tr>
<td>Carers who find it easy to get information (%)</td>
<td>65.5</td>
<td>61.3</td>
<td>65.8</td>
<td>Lower</td>
</tr>
<tr>
<td>People who use services and feel safe (%)</td>
<td>68.5</td>
<td>74.4</td>
<td>70.6</td>
<td>Lower</td>
</tr>
<tr>
<td>People who say the services they use make them feel safe &amp; secure (%)</td>
<td>84.5</td>
<td>88.3</td>
<td>84.2</td>
<td>Lower</td>
</tr>
</tbody>
</table>

**Older people receiving reablement services after leaving hospital (%)**
National Audit of Intermediate Care 2015

Referrals
Per 100,000 population

- Crisis response: 543
- Home based: 808
- Bed based: 266
- Re-ablement: 497

Beds commissioned
Per 100,000 population

- Crisis response: 34
- Home based: 25.6

Waiting times
Referral to assessment

- Crisis response: 3.7 hours
- Home based: 6.3 days
- Bed based: 1.3 days
- Re-ablement: 8.7 days

in CWS
A&E Attendances by Manchester Triage Category and Month

Increase in acuity of patients using Manchester triage categories
A&E Admissions achieved within 4 Hrs

**Medicine - A & E Admissions within 4 Hours**

**DOME - A & E Admissions within 4 Hours**

**Surgery - A & E Admissions within 4 Hours**

**All Admissions - A & E Admissions within 4 Hours**
WRG DoME Emergency Admissions 2017

- Emergency - A&E: 79%
- Emergency - GP: 17%
- Emergency - Transfer: 1%
- Emergency - OP: 0%
- Emergency - Other: 3%
Geriatric Medicine: 430

- Given a modest local impact of demand management in the community..
- 30% more patients next 5 years

= 22,500 more bed days

= 62 more beds, just at Worthing...

Costing £3million+
Older People’s Care in Acute Settings 2015-16 NHS Benchmarking audit

Service user audit

Age profile

Age profile of service users

- Under 65
- 65 - 74
- 75 - 84
- 85 - 89
- 90 +

- National position
- OP036
Geriatric Medicine 430
Rolling annual mortality
Comprehensive geriatric assessment for older adults admitted to hospital

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Favours control n/N</th>
<th>Control n/N</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appleby 1990</td>
<td>62/78</td>
<td>47/77</td>
<td></td>
<td>2.0%</td>
</tr>
<tr>
<td>Arplund 2000</td>
<td>121/190</td>
<td>134/223</td>
<td></td>
<td>9.4%</td>
</tr>
<tr>
<td>Collard 1985</td>
<td>163/218</td>
<td>319/477</td>
<td></td>
<td>10.6%</td>
</tr>
<tr>
<td>Cournsell 2000</td>
<td>536/767</td>
<td>531/764</td>
<td></td>
<td>33.6%</td>
</tr>
<tr>
<td>Frewell 1990</td>
<td>104/221</td>
<td>92/215</td>
<td></td>
<td>10.4%</td>
</tr>
<tr>
<td>Harris 1991</td>
<td>67/97</td>
<td>106/170</td>
<td></td>
<td>5.0%</td>
</tr>
<tr>
<td>Kay 1992</td>
<td>16/30</td>
<td>17/29</td>
<td></td>
<td>1.7%</td>
</tr>
<tr>
<td>Landefeld 1995</td>
<td>260/327</td>
<td>233/324</td>
<td></td>
<td>10.1%</td>
</tr>
<tr>
<td>Rubenstein 1984</td>
<td>46/62</td>
<td>32/60</td>
<td></td>
<td>1.9%</td>
</tr>
<tr>
<td>Saltzett 2002</td>
<td>101/127</td>
<td>79/127</td>
<td></td>
<td>3.4%</td>
</tr>
<tr>
<td>White 1994</td>
<td>14/20</td>
<td>7/20</td>
<td></td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>2138</strong></td>
<td><strong>2486</strong></td>
<td><strong>88.5%</strong></td>
<td><strong>1.31 [1.15, 1.49]</strong></td>
</tr>
</tbody>
</table>

**Total events: 1490 (Favours control), 1597 (Control)**

**Heterogeneity:** Chi² = 25.36, df = 10 (P = 0.03), I² = 51%  
**Test for overall effect:** Z = 4.17 (P = 0.000031)

<table>
<thead>
<tr>
<th>2 Team</th>
<th></th>
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<tbody>
<tr>
<td>McVey 1989</td>
<td>61/93</td>
<td>64/92</td>
<td></td>
<td>4.6%</td>
</tr>
<tr>
<td>Naughton 1994</td>
<td>39/51</td>
<td>44/60</td>
<td></td>
<td>2.0%</td>
</tr>
<tr>
<td>Winograd 1993</td>
<td>68/99</td>
<td>74/98</td>
<td></td>
<td>4.9%</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>243</strong></td>
<td><strong>250</strong></td>
<td><strong>11.5%</strong></td>
<td><strong>0.84 [0.57, 1.24]</strong></td>
</tr>
</tbody>
</table>

**Total events: 168 (Favours control), 182 (Control)**

**Heterogeneity:** Chi² = 0.87, df = 2 (P = 0.65), I² = 0.0%  
**Test for overall effect:** Z = 0.86 (P = 0.38)

| **Total (95% CI)** | **2381** | **2736** | **100.0%** | **1.25 [1.11, 1.42]** |

**Total events: 1658 (Favours control), 1779 (Control)**

**Heterogeneity:** Chi² = 25.57, df = 13 (P = 0.02), I² = 49%  
**Test for overall effect:** Z = 3.70 (P = 0.000021)

**Test for subgroup differences:** Chi² = 4.43, df = 1 (P = 0.04), I² = 77%

Cochrane Database of Systematic Reviews

6 JUL 2011 DOI: 10.1002/14651858.CD006211.pub2
WARD BASED (ZONED) CARE WORKS IN REACH OR INTEGRATION DOES NOT
Emergency Floor Admissions - DOME
(Jan 2014-March 2017)

Period 1 mean = 53
Period 2 mean = 68
Period 3 mean = 73

Emergency floor opened
Data: DoME EF Patient Outcomes

DoME Average LoS on EF

EF opened Dec 2014

Period 1 mean = 2.50
Period 2 mean =
Period 3 mean =

DoME Discharged within 24 hours on EF

Period 1 mean = 27.9%
Period 2 mean =
Period 3 mean =

DoME Mortality on EF

Period 1 mean = 14.5%
Period 2 mean =
Period 3 mean =

DoME 28/7 readmissions on EF

Period 1 mean = 18.2%
Period 2 mean =
Period 3 mean =
Data: DoME All Patient Outcomes

Average Length of Stay Ward - DOME

41% Discharged Ward less 24 hours - DOME

30 Day Readmissions Ward - DOME

In Hospital Mortality Worthing Emergency Floor DOME Patients Transferred to Ward
Data: Patient Experience Measures

Western Sussex Emotional mapping - AFN

<table>
<thead>
<tr>
<th>Emotional State</th>
<th>HW</th>
<th>SW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assured</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Comfortable</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Cared for</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>OK</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Good</td>
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Surveys

Waiting time measures

Friends and Family

"It’s a really busy unit but the staff have plenty of time for you.... The stay here has been excellent, really excellent. I couldn’t fault it"

Patient Interview, HSJ Film, May 2017
“I feel it is essential as the learning opportunities on the EF are great. I managed to complete almost 80% of all my CbDs, CEXs and core-procedures during the 4-month rotation on the EF.”
A&E 4-hour target performance - December 2015 - November 2016

Western Sussex Hospitals

England average

% patient seen within 4 hours

English Acute Hospital Trusts
Did co-location work?

• No change in patient outcomes as a result of co-locating the Acute Frailty Unit on the Emergency floor with AMU and SAU

• But better access for everything

• Difficulty for staffing due to the change, with high sickness and turnover; don’t open in December...

• ...and ongoing competition for resources in a finite area
Acute Medical Units = 103

Frailty Units = 35

Acute Surgical Units = 8

Worthing
AFN Toolkit Principles (2016):

- Establish a mechanism for early identification of people with frailty
- **Put in place a multi-disciplinary response**
- Set up a rapid response system for frail older people in urgent care settings
  - "The evidence says in a unit not as in reach"
- Adopt a 'Silver phone' system
- Adopt internal clinical professional standards to reduce unnecessary variation
  - e.g. Initial CGA within 1 hour
  - e.g. Stratified problem list in 2 hours in day or 12 hours overnight
- **Strengthen links with services outside**
- Put in place appropriate education and training
- **Develop a Measurement mind-set**
- Leadership - Clinical change champions
- Exec sponsor and project management
AFN Toolkit Principles (2016):

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| Title Of Improvement Project/Problem Solving Item: |
|-----------------|-----------------|-----------------|
| **Step 1: Problem Statement** | **Step 4: Vision / Goals:** | **Step 6: Actions and Risks:** |
| **Step 2: Current Situation:** | | |
| **Step 3: Analysis Issues and Root Causes (Root Cause – 5 Why’s):** | **Step 5: Counter Measures and Future State** | **Step 7: Cost / Benefit:** |
| | | |
| **Project Team** | | **Step 8: Insights:** |
Acute Frailty Pathway Improvement Project: Project lead: David Hunt

Step 1: Background
The Coastal West Sussex population is one of the oldest in the country and is likely to increase in the very near future. This growth rate is similar to that of other coastal populations. However, an older population with frailty presents difficulties for both Trusts. Frailty is a condition associated with increased numbers of older people with frailty and consequently increased morbidity and mortality. Additionally, the increased severity of illness associated with frailty makes the management of frail older patients a challenge. The resultant increased costs in A&E and EF are greater opportunity with possibly (15% vs 2% no CFS score) twice the capacity at WRG.

Step 2: Current Situation

Refined Problem Statement for Analysis

As a result of predicted demographic changes, increasing multimorbidity, polypharmacy and inadequate community resources, following unscheduled attendance on A&E to the WSHT acutec sites (Worthing and SRH) there is an excess avoidable conversion to admission of older people with frailty. This is likely to continue to result in worsening patient outcomes (length of stay, mortality), Trust outcomes (HSMR, total number harmed as in an patient by HAI and falls, DoTC) and increased resource utilisation eg bed days occupied, seasonal bed requirements and ward staffing costs.

Redefined Problem Statement for Analysis

A&E and EF attenders with CFS 4-5 resulted in a greater spend and a stretched workforce.

Step 3: Vision:

Step 4: Analysis Issues and Root Causes

Top Contributor: (add any proof you have for these, and/or root cause of impact vs ease of implementation)

Root Cause of Top Contributors

No standard process for early CGA

Lack of frailty competencies

No education

Lack of understanding;

Concern that A&E target will worsen

Counter measure to the Root Cause

Frailty Intervention Team

Educational programme

Education, pilot or agree to excl from 4 hours

Prioritisation of Opportunities

Step 5: Opportunities & Countermeasures

No standard process for early CGA

Lack of frailty competencies

No education

Lack of understanding;

Concern that A&E target will worsen

Counter measure to the Root Cause

Frailty Intervention Team

Educational programme

Education, pilot or agree to excl from 4 hours

Prioritisation of Opportunities

Step 6: Benefits & Impact

Patient - 10% Reduction of avoidable conversion to admission, improved patient enrolment, overall reduction in total harm

Sustainability - 30% conversion reduction for >65 A&E attenders with CFS 4-5, and hence reduction in occupied bed days (OBD) will allow for improving effective flow and a reduction of seasonal capacity for NEPs patients

Ours - Improved staff wellbeing and satisfaction. Improved knowledge of frailty and competencies in managing older people with frailty syndromes

Quality Improvement - Improvement in stranded patient metric, fewer overall harm events in terms of reduced OBH

Systems & Partnerships - Improving links with front door community services

Risks:

Lack of A&E >65 frailty conversion reduction resulting in resource cost

Improved breach rate as a result of a ‘slow’ MIDT process (not born in out in data so far)

Cultural acceptance of a new team in an existing area either A&E or Emergency Floor

Cost neutral pilot may not gather enough data to show statistical impact

Cost neutral pilot may not show potential gain which could be achieved with investment

Unknown workforce costs. For nurse practitioner (band 7 WTE) approx £70 - 80K. Consultant appointment, if necessary £90K. AHP costs.

Step 5: Opportunities & Countermeasures

No standard process for early CGA

Lack of frailty competencies

No education

Lack of understanding;

Concern that A&E target will worsen

Counter measure to the Root Cause

Frailty Intervention Team

Educational programme

Education, pilot or agree to excl from 4 hours

Prioritisation of Opportunities

Step 4: Analysis Issues and Root Causes

We have performed a root end process mapping of the pathway (WSHT version shown below) for admission of older people with frailty as relevant stakeholders, aiming to identify all wasted resources and adopt best evidenced practice. This involved as a result we have a worked with the IT department to standardize the identification of frailty across the Trust.

Main issues following VSM and Opportunity Prioritization and Affirmation in ranked order are:

- lack of early frailty decision/commencement of CGA (24)
- lack of frailty competencies (20)
- A&E>Patient Assessment (15)
- lack of A&E and EF target setting (8)
- lack of A&E frailty decision/miscommunication of CGA (4)
- lack of education (4)
- lack of frailty competencies (4)
- lack of frailty decision (4)
- lack of A&E frailty decision (4)
- A&E>Patient Assessment (4)
- lack of education (4)
- A&E>Patient Assessment (4)
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- lack of frailty competencies (4)
- A&E>Patient Assessment (4)
- lack of education (4)
- lack of frailty competencies

Impact: Acute Frailty service will offer A&E intervention for CFS scoring before to hospital, unhinging long and saving money as any patient in 2-3 days improves the Tome and saves others of patients with frailty to applying the principles of the Silver Book and Comprehensive Geriatric Assessment

Step 1: Background
The Coastal West Sussex population is one of the oldest in the country and is likely to increase in the very near future. This growth rate is similar to that of other coastal populations. However, an older population with frailty presents difficulties for both Trusts. Frailty is a condition associated with increased numbers of older people with frailty and consequently increased morbidity and mortality. Additionally, the increased severity of illness associated with frailty makes the management of frail older patients a challenge. The resultant increased costs in A&E and EF are greater opportunity with possibly (15% vs 2% no CFS score) twice the capacity at WRG.

Step 2: Current Situation

Refined Problem Statement for Analysis

As a result of predicted demographic changes, increasing multimorbidity, polypharmacy and inadequate community resources, following unscheduled attendance on A&E to the WSHT acutec sites (Worthing and SRH) there is an excess avoidable conversion to admission of older people with frailty. This is likely to continue to result in worsening patient outcomes (length of stay, mortality), Trust outcomes (HSMR, total number harmed as in an patient by HAI and falls, DoTC) and increased resource utilisation eg bed days occupied, seasonal bed requirements and ward staffing costs.
Problem Statement:

- No standardised, centrally recorded method of identifying all older people with frailty on presentation at the acute hospitals. As a result, a proportion of attendees do not derive the benefit of a comprehensive geriatric assessment (CGA). This cohort size is undefined. Population estimates from a systematic review identify 26% of over 85 year olds as frail.

- There are different pathways for older people with frailty on the two acute sites.

- We currently do not meet all of the AFN principles for an acute frailty pathway.
## Countermeasures:

<table>
<thead>
<tr>
<th>Top Contributor. (add any proof you have for these, and/or prioritisation matrix of impact vs ease of implementation)</th>
<th>Root Cause of Top Contributors (using 5 why’s)</th>
<th>Countermeasure to the Root Cause</th>
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<tbody>
<tr>
<td>Lack of Frailty Identification</td>
<td>No definition, no assessment tool, no method for assessing</td>
<td>Introduce Clinical Frailty Scale on PatienTrack and/or in A&amp;E</td>
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<tr>
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<tr>
<td>Concern that A&amp;E target will worsen</td>
<td>Lack of understanding;</td>
<td>Education, pilot in A&amp;E or find alternative location or agree to excl from 4 hours</td>
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</table>
Clinical Frailty Scale (CFS) on PatienTrack

Clinical Frailty Scale

1. Very Fit - People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. Managing Well - People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "sloowed up", and/or being tired during the day.

5. Mildly frail - These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation.

6. Moderately frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely frail - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely frail - Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <5 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia.

Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

Clinical Frailty Ver: 10.0
Making changes based on data:

Emergency Floor Occupied Beds - July 2016
Emergency Floor

Ambulatory Care

Acute Frailty Zone

High Care Area
Emergency Floor

Ambulatory Care

Acute Frailty Zone

High Care Area
Measure time to Comprehensive Geriatric Assessment (professional clinical standards)

Principle 4
Adopt clinical professional standards to reduce unnecessary variation

Pareto chart of time to therapy assessment
DoME Mid-Take Ward Round Trial

Average Time to Consultant Review - Monday-Sunday

Average Time to Consultant Review - Monday-Friday

Mid-Take trial start
Causes for delay in early discharge

DOME only_Reason if query discharge

- Therapist Assessment
- Care Package
- Period of Observation
- Bloods
- Scan
- Speciality Review
- Other

Series 1
Series 3

Heal care Improvement Scotland
# Frailty Patients in Barrow Ward

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**Admitted:** 02/03/17 (100)  
**Elderly Medicine - Dr C Kirk**  
**Bed:** Barrow - 2

**Previous Spell from:** 07/05/13 to 24/05/13  
**Previous Diagnosis:** Subdural haemorrhage (acute) (nontraumatic) (I629)

**Diagnosis:** Admitted 2/3/17:  
- Fall  
- Vomiting  
- CAP  
- SDH 4/3  
- Transaminitis 6/3  
- For ward based care  
- BG: Flat, No PoC, ZF

**CoMorbidity:** Previous SDH with burr hole drainage 1/5/2013  
Severe MR - HF  
AF, L breast CA - mastectomy, CKD 3b  
GORD, glaucoma, osteoporosis, HTN, OA

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**Weight:** 61.00Kg on 03/06/17  
**Frailty:** 6 on 06/03/17

**AKI:** Amber - Daily Medication review

**Date:** 08/06/17 03:15  
**Bowels Open:** No  
**Stool Type:** 5  
**Stool Colour:**

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<th>K</th>
<th>eGFR/Cr</th>
<th>CRP</th>
<th>Urea</th>
<th>Bil</th>
<th>AST</th>
<th>ALP</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/05/17</td>
<td>131</td>
<td>6.6</td>
<td>157</td>
<td>137</td>
<td>3.6</td>
<td>36/122</td>
<td>15</td>
<td>11</td>
<td>33</td>
<td>146</td>
<td></td>
</tr>
<tr>
<td>08/06/17</td>
<td>141</td>
<td>7.5</td>
<td>135</td>
<td>141</td>
<td>3.6</td>
<td>34/127</td>
<td>18</td>
<td>33</td>
<td>45</td>
<td>146</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** Saturday 10 Jun 2017  
**Time (24Hr):**

Printed by SUSSEX\hundt on: 10 Jun 2017 12:34
Frailty Scores for >65 A&E Admissions at WSHFT (1 April 2017 to 31 Dec 2017 PatienTrack data)

- **No Frailty Score**: 48.3%
- **Very Fit**: 0.4%
- **Well**: 2.6%
- **Managing Well**: 8.2%
- **Vulnerable**: 9.9%
- **Mildly Frail**: 8.6%
- **Moderately Frail**: 11.0%
- **Severely Frail**: 1.6%
- **Very Severely Frail**: 1.6%
- **Terminally Ill**: 0.6%

**Emergency Admitted Patients - Frailty scores for 65+**

<table>
<thead>
<tr>
<th>Frailty Score</th>
<th>SRH</th>
<th>WSH</th>
<th>WSHFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Frailty Score</td>
<td>51.0%</td>
<td>45.8%</td>
<td>48.3%</td>
</tr>
<tr>
<td>1 - Very Fit</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>2 - Well</td>
<td>2.8%</td>
<td>2.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>3 - Managing Well</td>
<td>8.2%</td>
<td>8.2%</td>
<td>8.2%</td>
</tr>
<tr>
<td>4 - Vulnerable</td>
<td>9.3%</td>
<td>10.5%</td>
<td>9.9%</td>
</tr>
<tr>
<td>5 - Mildly Frail</td>
<td>7.6%</td>
<td>9.5%</td>
<td>8.6%</td>
</tr>
<tr>
<td>6 - Moderately Frail</td>
<td>10.5%</td>
<td>11.5%</td>
<td>11.0%</td>
</tr>
<tr>
<td>7 - Severely Frail</td>
<td>8.1%</td>
<td>9.2%</td>
<td>8.7%</td>
</tr>
<tr>
<td>8 - Very Severely Frail</td>
<td>1.5%</td>
<td>1.8%</td>
<td>1.6%</td>
</tr>
<tr>
<td>9 - Terminally Ill</td>
<td>0.5%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

**Frailty scores from PatientTrack**
1 April 2017 to 31 Dec 2017

**Frail 5 - 8 (Mild to Very Severe)**

- SRH: 27.6%
- WSH: 31.9%
- WSHFT: 29.9%
65 NEL Admissions Occupied Bed Days at WSHFT by Frailty Scores (1 April 2017 to 31 Dec 2017 PatienTrack data)

### Emergency Bed Days – Frailty scores for patients over 65

- **7 - Severely Frail**: 21.1%
- **6 - Moderately Frail**: 23.8%
- **5 - Mildly Frail**: 16.1%
- **4 - Vulnerable**: 15.0%
- **3 - Managing Well**: 9.1%
- **2 - Well**: 2.6%
- **1 - Very Fit**: 0.4%
- **9 - Terminally Ill**: 0.7%
- **No Frailty Score**: 8.4%

### Bed Days - Frailty scores for 65+

<table>
<thead>
<tr>
<th>Frailty Score</th>
<th>SRH</th>
<th>WSH</th>
<th>WSHFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Frailty Score</td>
<td>9.8%</td>
<td>7.4%</td>
<td>8.4%</td>
</tr>
<tr>
<td>1 - Very Fit</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>2 - Well</td>
<td>3.0%</td>
<td>2.3%</td>
<td>2.6%</td>
</tr>
<tr>
<td>3 - Managing Well</td>
<td>10.2%</td>
<td>8.3%</td>
<td>9.1%</td>
</tr>
<tr>
<td>4 - Vulnerable</td>
<td>14.3%</td>
<td>15.5%</td>
<td>15.0%</td>
</tr>
<tr>
<td>5 - Mildly Frail</td>
<td>13.5%</td>
<td>17.9%</td>
<td>16.1%</td>
</tr>
<tr>
<td>6 - Moderately Frail</td>
<td>24.1%</td>
<td>23.6%</td>
<td>23.8%</td>
</tr>
<tr>
<td>7 - Severely Frail</td>
<td>21.1%</td>
<td>21.0%</td>
<td>21.1%</td>
</tr>
<tr>
<td>8 - Very Severely Frail</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>9 - Terminally Ill</td>
<td>0.5%</td>
<td>0.8%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

- **Frail 5 - 8 (Mild to Very Severe)**: 61.6% 65.4% 63.8%

Frailty scores from PatientTrack
1 April 2017 to 31 Dec 2017
New A&E mandatory Frailty assessment field in Semahelix
Frailty Scores for >65 A&E Attendances at WSHFT (1 Dec 2017 to 28 Feb 2018 SemaHelix)

A&E Data - SEEMA
1 Dec 2017 - 28 Feb 2018

<table>
<thead>
<tr>
<th>Frailty Score</th>
<th>SRH</th>
<th>WSH</th>
<th>WSHFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Frailty</td>
<td>11.5%</td>
<td>2.1%</td>
<td>6.3%</td>
</tr>
<tr>
<td>1 - Very Fit</td>
<td>5.6%</td>
<td>5.6%</td>
<td>5.6%</td>
</tr>
<tr>
<td>2 - Well</td>
<td>25.1%</td>
<td>30.9%</td>
<td>28.3%</td>
</tr>
<tr>
<td>3 - Managing Well</td>
<td>26.8%</td>
<td>26.4%</td>
<td>26.6%</td>
</tr>
<tr>
<td>4 - Vulnerable</td>
<td>13.2%</td>
<td>23.4%</td>
<td>18.8%</td>
</tr>
<tr>
<td>5 - Mildly Frail</td>
<td>7.9%</td>
<td>5.9%</td>
<td>6.8%</td>
</tr>
<tr>
<td>6 - Moderately Frail</td>
<td>5.4%</td>
<td>3.6%</td>
<td>4.4%</td>
</tr>
<tr>
<td>7 - Severely Frail</td>
<td>3.9%</td>
<td>1.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>8 - Very Severely Frail</td>
<td>0.5%</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>9 - Terminally Ill</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Frail 5 - 8 (Mild to Very Severe)</td>
<td>17.7%</td>
<td>11.4%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>

A&E Attendances – Frailty scores for patients over 65

[Diagram showing distribution of frailty scores]
PatienTrack (Dr score) v Sema Helix (A&E triage score)

Average difference between frailty and A&E frailty - both sites

[Bar chart showing the average difference between frailty and A&E frailty across sites, with data points for Worthing and St Richard's hospitals.]
WSHT: Frailty by age breakdown
(2017/18 M1 – M9 Sema & PatienTrack )

- 36,696 emergency spells for all ages for M1-9
- 11,675 of the 36,696 spells have a frailty score (32%)
- 11,489 of 22,223 spells for >65 had a frailty score (52%)
- 57.8% of those with a frailty score were Frail CFS 5 (mildly frail) to CFS 8 (very severely frail)
- Of those with a score :

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Spells</th>
<th>% Age breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-64</td>
<td>186</td>
<td>1.6%</td>
</tr>
<tr>
<td>65-74</td>
<td>2,352</td>
<td>20.1%</td>
</tr>
<tr>
<td>75-84</td>
<td>4,312</td>
<td>36.9%</td>
</tr>
<tr>
<td>85+</td>
<td>4,825</td>
<td>41.3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>11,675</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
WSHT: >65 with a Frailty Score & LoS (2017/18 M1 – M9)

- Of the 11,489 spells for 65+ with a frailty score:

<table>
<thead>
<tr>
<th>Frailty Index</th>
<th>Spells</th>
<th>Total Bed Days</th>
<th>ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail1 - Very fit</td>
<td>99</td>
<td>771</td>
<td>7.79</td>
</tr>
<tr>
<td>Frail2 - Well</td>
<td>576</td>
<td>4,550</td>
<td>7.90</td>
</tr>
<tr>
<td>Frail3 - Managing Well</td>
<td>1,831</td>
<td>16,048</td>
<td>8.76</td>
</tr>
<tr>
<td>Frail4 - Vulnerable</td>
<td>2,200</td>
<td>26,465</td>
<td>12.03</td>
</tr>
<tr>
<td>Frail5 - Mildly Frail</td>
<td>1,908</td>
<td>28,367</td>
<td>14.87</td>
</tr>
<tr>
<td>Frail6 - Moderately Frail</td>
<td>2,445</td>
<td>42,075</td>
<td>17.21</td>
</tr>
<tr>
<td>Frail7 - Severely Frail</td>
<td>1,926</td>
<td>37,181</td>
<td>19.30</td>
</tr>
<tr>
<td>Frail8 - Very severely Frail</td>
<td>565</td>
<td>5,072</td>
<td>13.90</td>
</tr>
<tr>
<td>TFrail9 - Terminally III</td>
<td>139</td>
<td>1,188</td>
<td>8.56</td>
</tr>
<tr>
<td><strong>Total (with a Frailty Score)</strong></td>
<td><strong>11,489</strong></td>
<td><strong>161,717</strong></td>
<td><strong>14.08</strong></td>
</tr>
<tr>
<td><strong>With no frailty Score</strong></td>
<td><strong>10,734</strong></td>
<td><strong>14,895</strong></td>
<td><strong>1.39</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,223</strong></td>
<td><strong>176,612</strong></td>
<td><strong>7.95</strong></td>
</tr>
</tbody>
</table>
30% of all NEL spells were scored as older patients with frailty and they made up 64% of the occupied bed days.

20% were moderate or severely frail and they occupied 45% of the beds.
Table 4: Mildly to Very Severely Frail Patients that died in Hospital - what was their length of stay?

The length of stay for these patients ranged from 0 to 114 days

<table>
<thead>
<tr>
<th>Lenth of Stay</th>
<th>Patients who died in Hospital</th>
<th>% Split</th>
</tr>
</thead>
<tbody>
<tr>
<td>0/1 days</td>
<td>52</td>
<td>6.9%</td>
</tr>
<tr>
<td>2/3 days</td>
<td>57</td>
<td>7.5%</td>
</tr>
<tr>
<td>4-7 days</td>
<td>146</td>
<td>19.3%</td>
</tr>
<tr>
<td>8 to 14 days</td>
<td>179</td>
<td>23.7%</td>
</tr>
<tr>
<td>15 to 21 days</td>
<td>112</td>
<td>14.8%</td>
</tr>
<tr>
<td>22 to 28 days</td>
<td>71</td>
<td>9.4%</td>
</tr>
<tr>
<td>1 to 2 months</td>
<td>112</td>
<td>14.8%</td>
</tr>
<tr>
<td>&gt;2 months</td>
<td>27</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>756</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

33.7% of patients died within their first week in hospital
18.4% of patients spent over a month in hospital
Proportion of >65 NEL admissions who died since discharge following admission between 1 April - 31 Dec 2017

**Table 2: Frailty and mortality - how many patients have died since discharge from hospital:**
*(where death date was recorded as of 4th Apr 2018)*

<table>
<thead>
<tr>
<th>Frailty Score</th>
<th>Frailty_Index</th>
<th>Patients Died</th>
<th>Spells</th>
<th>% deaths of total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail1</td>
<td>Very fit</td>
<td>3</td>
<td>99</td>
<td>3.0%</td>
</tr>
<tr>
<td>Frail2</td>
<td>Well</td>
<td>48</td>
<td>576</td>
<td>8.3%</td>
</tr>
<tr>
<td>Frail3</td>
<td>Managing Well</td>
<td>247</td>
<td>1,831</td>
<td>13.5%</td>
</tr>
<tr>
<td>Frail4</td>
<td>Vulnerable</td>
<td>507</td>
<td>2,200</td>
<td>23.0%</td>
</tr>
<tr>
<td>Frail5</td>
<td>Mildly Frail</td>
<td>513</td>
<td>1,908</td>
<td>26.9%</td>
</tr>
<tr>
<td>Frail6</td>
<td>Moderately Frail</td>
<td>783</td>
<td>2,445</td>
<td>32.0%</td>
</tr>
<tr>
<td>Frail7</td>
<td>Severely Frail</td>
<td>819</td>
<td>1,926</td>
<td>42.5%</td>
</tr>
<tr>
<td>Frail8</td>
<td>Very severely Frail</td>
<td>230</td>
<td>365</td>
<td>63.0%</td>
</tr>
<tr>
<td>TFrail9</td>
<td>Terminally Ill</td>
<td>119</td>
<td>139</td>
<td>85.6%</td>
</tr>
<tr>
<td>No Frailty Recorded</td>
<td>No Frailty Recorded</td>
<td>1,686</td>
<td>10,734</td>
<td>15.7%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>No Frailty Recorded</strong></td>
<td><strong>4,955</strong></td>
<td><strong>22,223</strong></td>
<td><strong>22.3%</strong></td>
</tr>
</tbody>
</table>

**Proportion of >65 NEL admissions who died since discharge following admission between 1 April - 31 Dec 2017**

**No Frailty Recorded**

*No Frailty Recorded*
There are 6,644 spells for mildly to severely frail patients - 2,345 have a recorded death date (35%)
The duration between discharge from hospital and date of death is as below:

<table>
<thead>
<tr>
<th>Duration between Discharge and Death</th>
<th>Number of patients with death date</th>
<th>% Split</th>
</tr>
</thead>
<tbody>
<tr>
<td>Died in Hospital</td>
<td>756</td>
<td>32.2%</td>
</tr>
<tr>
<td>0 days**</td>
<td>9</td>
<td>0.4%</td>
</tr>
<tr>
<td>1 to 2 days</td>
<td>43</td>
<td>1.8%</td>
</tr>
<tr>
<td>3 to 4 days</td>
<td>38</td>
<td>1.6%</td>
</tr>
<tr>
<td>5 to 7 days</td>
<td>62</td>
<td>2.6%</td>
</tr>
<tr>
<td>8 to 14 days</td>
<td>136</td>
<td>5.8%</td>
</tr>
<tr>
<td>15 to 21 days</td>
<td>123</td>
<td>5.2%</td>
</tr>
<tr>
<td>22 to 28 days</td>
<td>102</td>
<td>4.3%</td>
</tr>
<tr>
<td>Between 1 and 2 months</td>
<td>328</td>
<td>14.0%</td>
</tr>
<tr>
<td>Between 2 and 3 months</td>
<td>193</td>
<td>8.2%</td>
</tr>
<tr>
<td>&gt;3 months</td>
<td>555</td>
<td>23.7%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,345</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Patients that died on day of discharge but not in the hospital

32.2% died in hospital
6.5% died within a week of discharge from hospital, 21.9% within a month, 36% within 2 months.
Table 5: Mildly to Very Severely Frail Patients who died in Hospital with a LOS over 1 month - Were they MFFD patients at some point during their stay?

<table>
<thead>
<tr>
<th>MFFD Status</th>
<th>Frail Patients who died in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - MFFD at date of death</td>
<td>30</td>
</tr>
<tr>
<td>Yes - MFFD during stay but not at date of death</td>
<td>50</td>
</tr>
<tr>
<td>No - No MFFD Record</td>
<td>59</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>139</strong></td>
</tr>
</tbody>
</table>

What was the primary diagnosis of these patients?

<table>
<thead>
<tr>
<th>Diagnostic_Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other sepsis</td>
<td>22</td>
</tr>
<tr>
<td>Pneumonia, organism unspecified</td>
<td>20</td>
</tr>
<tr>
<td>Cerebral infarction</td>
<td>8</td>
</tr>
<tr>
<td>Other symptoms and signs</td>
<td>7</td>
</tr>
<tr>
<td>Fracture of femur</td>
<td>7</td>
</tr>
<tr>
<td>Other Diagnoses</td>
<td>75</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>139</strong></td>
</tr>
</tbody>
</table>

Note: Primary diagnosis is the dominant reason for their stay in hospital. Not necessarily the reason they were admitted and not necessarily the cause of death.
LCN Severe Frailty Totals 2017/18 Q3

Total Number Severe Frailty

- WHAT (North Cissbury): 875
- Rural North Chichester: 193
- Regis: 706
- CiC (South Cissbury): 838
- Chichester: 559
- Chanctonbury: 283
- Arun: 1,010
- Adur: 1,149

Severe Frailty as % of LCN Population

- WHAT (North Cissbury): 1.21%
- Rural North Chichester: 0.52%
- Regis: 0.73%
- CiC (South Cissbury): 1.97%
- Chichester: 0.66%
- Chanctonbury: 0.61%
- Arun: 1.63%
- Adur: 1.95%
Learning:

• COMPREHENSIVE PROCESS METHOD FOR COMPLEX PROBLEM SOLVING

• UNDERESTIMATED THE AMOUNT OF SUPPORT WITH REGARD TO TIME AND EXPERTISE THAT WAS REQUIRED TO WORK THROUGH THE PROCESS

• JUMPING AHEAD WITH A SOLUTION TO SOLVE A PROBLEM THAT HAD NOT YET BEEN IDENTIFIED

• GOOD ADHERENCE TO CHECK AND ADJUST
• OVER-RELIANCE ON CLINICAL LEAD, PROJECT MANAGER AND KAIZEN SUPPORT DUE TO THE AMOUNT OF COMMITMENT AND TIME NOT AVAILABLE FROM WIDER GROUP

• LARGE SCALE REDESIGN REQUIRES A GREATER DEPTH OF KAIZEN KNOWLEDGE

• NOT A DETAILED ENOUGH PROJECT PLAN

• LACK OF CLEAR ENOUGH GOVERNANCE PROCESS EG. REPORTING ACTIVITY, HOLDING TO ACCOUNT FOR DELIVERY MILESTONES
• LACK OF UNDERSTANDING OF EVIDENCE BASED CO-DESIGN SLOWED PROGRESS: PATIENT CONSULTATION RATHER THAN INVOLVEMENT IN DESIGN

• FRUSTRATION - NOT PROCEEDING WITH AN INTERVENTION TO ALLOW FOR PROCESS TO BE COMPLETED

• CONTINUE TO STICK TO BEST PRINCIPLES WITH QI METHODOLOGY
# Frailty Screening Criteria

<table>
<thead>
<tr>
<th>F</th>
<th>Falls (not alcohol related) or new reduced mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Repeat Hospital attendances &gt;= 3 in last 12 months and/or Rated as at least moderate Frailty in the community</td>
</tr>
<tr>
<td>A</td>
<td>Acute confusion (Delirium) or Chronic Confusion (incl. Dementia)</td>
</tr>
<tr>
<td>I</td>
<td>New INCONTINENCE (urinary/faecal)</td>
</tr>
<tr>
<td>L</td>
<td>Lives in residential or nursing home</td>
</tr>
<tr>
<td>T</td>
<td>Treatment for Parkinson’s</td>
</tr>
<tr>
<td>Y</td>
<td>Years &gt;=85 years old</td>
</tr>
</tbody>
</table>

**Exclusion criteria – These will be used to exclude those who are seen by the frailty team.**

- Suspected new stroke or TIA, consider thrombolysis and care in the stroke unit
- Trauma with suspected fracture requiring surgical intervention
- Abdominal pain if a surgical emergency or a post-operative surgical complication
- Chest pain with high risk ACS and cardiac emergencies
- Clear need for other specialty input, for example flare-up of known chronic condition E.g. exacerbation of COPD, alcoholic liver disease.
What next for Acute Frailty at WSHFT?

- Iterative development of front door team in A&E (PDSA) incorporating development of a bespoke frailty pathway at St Richards Hospital
- Development of a single MDT assessment document
- Expansion of the use of Primary Care Systems (SystmOne/ROCI) for gathering background information
- Systematise Frailty Patient Experience measurement using emotional mapping on both acute sites
- Better manage mental health crisis presentations
- Standardise a Medicines Optimisation process with Pharmacy
Metrics for success:

- Dashboards already designed for both emergency floors
- A&E Analysis suite necessary to include:
  - SPC charts for A&E conversion for
    - >65 CFS 4-8
    - >85 CFS 4-8
  - for all CFS 4-8: average length of stay, 0-1 day discharges, mortality, 30 day readmissions, stranded and extended patient metric;
  - A&E numbers of breaches
    - CFS <4
    - CFS 4-8
  - Collect patient experience data including repeated 50 patient emotional mapping reports post intervention using new Evidence Based Design app.
Lean Key Messages

• DATA, DATA, DATA – Measure to improve
• DO LEAN PROPERLY - QI can really help but know what you are doing; beware enthusiastic untrained early adopters
• LEAN MUSCLE – To do well clinicians need help from QI experts & Informatics Team
• EXEC SPONSORSHIP – Is a critical success factor
• PROJECT MANAGEMENT – Is also key
• COMMUNICATIONS STRATEGY – Have an explicit strategy
• And then SHARE & BORROW widely
Frailty Key Messages

• IDENTIFY FRAILTY
• CO-LOCATION CAN MAINTAIN PATIENT OUTCOMES AND IMPROVE ACCESS – But beware of the cultural impact of teams competing in a single area for scarce resources
• TIMING - Don’t open in December / 10% initial staff uplift vs losses
• EFFECTIVE INFORMATION SHARING – vital across primary and secondary care
• WEST SUSSEX HAS THE ENGLAND DEMOGRAPHIC FOR 2035 – “Go and see” the future..
Want to know more?

tinyurl.com/westernafn
- PFIS

tinyurl.com/westernEF
- WRG EF
Measuring Patient Experience: some examples from NHS Scotland and beyond

Evidence and Evaluation for Improvement Team

Healthcare Improvement Scotland
What is ‘patient experience’?

- Respect for patient-centred values, preferences, and expressed needs?
- Coordination and integration of care across the health and social care system?
- Information, communication, and education on health status, progress, prognosis, and processes of care?
- Physical comfort including pain management?
- Emotional support and alleviation of fear and anxiety?
- Welcoming the involvement of family and friends in decision-making?
- Transition and continuity of care?
- Access to care with attention?

Taken from NHS Patient Experience Framework (2011) Department of Health
Commonly reported important aspects of care

- Finding out about the latest technologies, innovations and medications
- More public awareness of condition
- Positive outcomes
- Efficient processes

- Being treated as a person, not a number
- Staff who listen and spend time with patient
- Individualised treatment and no labelling
- Using language that is easy to understand
- Feeling informed, receiving information and being given options
- Patient involvement in care and being able to ask questions
- Knowledgeable health professionals
- Aftercare support
- Continuity of care
- Good relationships and positive attitudes among staff
- The value of support services

http://www.institute.nhs.uk/patient_experience/guide/the_patient_experience_research.html

as cited by US-PEx: Resource book for Participating frontline medical ward teams v0.76
Why measure patient experience?

• It tells us how patients are experiencing the current service and measure whether improvement efforts have made a difference
• Patients can tell us if they consider there are issues within the service – we may assume some where there are none, or vice versa
• It can offer insights if care experience is not as good as intended and generate ideas for change
• It can offer patient suggestions for better ways to do things – simple changes
• It often motivates taking action

Adapted from US-PEx: Resource book for Participating frontline medical ward teams v0.76
Measuring patient experience - first considerations

What specifically about patient experience do you want to know?

What | Why
--- | ---

Who | When | Where

What are you going to do with the results?
Measuring patient experience - how

- **Surveys**
- **Online feedback**
- **Local feedback and complaints**
- **Stories and interviews**
- **Group discussions/focus groups**
- **Observation and shadowing**

Taken from US-PEx: Resource book for Participating frontline medical ward teams v0.76

(Adapted from Health Foundation, 2013)
Example: Patient Reported Experience Measure (NHS England)

Images taken from NHS Benchmarking Network, Patient Reported Experience Measure (PREM) for Care of Older People in Acute Settings (British Geriatric Society and NHS Benchmarking)
Example: Care Opinion (NHS Fife)

- Endoscopy Team
- Used Care Opinion online feedback as starting point to identify areas for potential improvement

"Tell your story of an experience in health and social care within the last 3 years"

"Your story might be about you, or someone close to you"

"You can say what happened, what was good, and what could have been better"
Example:

Example: Patient Stories (NHS England)

- NHS East Lancashire – Frailty Project
- Led by senior patient experience facilitator
- Asks patients for their personal experiences of hospital and aftercare
- Patient experience is analysed monthly and key themes are collated
- Communication and involvement most common issues
- Guidelines and interview prompt sheets available
Example: Observation (Australia)

Taken from US-PEx: Resource book for Participating frontline medical ward teams v0.76
Example: Real time feedback (NHS Lanarkshire)

Person-centred Care Team (HIS) piloted a conversational approach to gathering experience stories rather than using a survey.

1) Gather care experience stories using a **conversational** approach

2) Reflect on the **care experience stories** as a team and identify improvement ideas

3) Test, develop and implement practice improvements

4) Evaluate change by gathering more care experience stories

(Taken from Person-centred Care Team, Healthcare Improvement Scotland, 2018)
Lanarkshire case study:

Example: What matters to you?  
(NHS Forth Valley, NHS GGC)

Susan Gallagher: Senior Charge Nurse, Care of the Elderly, NHS Greater Glasgow and Clyde

I spoke with the carer of a patient who has advanced dementia. The carer was the patient’s daughter, who appeared to be unhappy with some of the care being delivered to her mother. I felt apprehensive because I anticipated the daughter being very negative as she didn’t seem to be happy at all when she visited the ward.

The patient’s daughter began to open up when asked the 'What matters to you?' question and it transpired that she was frightened that her mum would choke during the night and there would be no one to help her as she was unable to press the nurse call system.

We decided to use the John’s campaign “Carers are welcome here” strategy and invited her to stay overnight with her mum. The lead nurse provided a fold-down bed. The daughter thanked me and said that she felt that someone was finally listening to her.
Resources

US-PEx: Resource book for Participating frontline medical ward teams

Health Foundation: Measuring Patient Experience

British Geriatric Society and NHS Benchmarking: PREM for Care of Older People in Acute Settings

NHS East Lancashire - Frailty Patient Stories

Real time feedback (Person-centred Care Team)

What Matters To You Guidance

Scottish Health Council patient public participation toolkit
Discussion
Surveys, Care Opinion, Observation, Real-time feedback, Patient Stories, WhatMattersToYou

• What do you want to know from your patients about their experience?
• What will you / your team do with what they tell you?
• What approach(es) do you think you might be able to use?
• What is the next step for you / your team?
References


Thinking Differently

Understanding Strategic Commissioning

Enabling health and social care improvement
Introducing Strategic Commissioning

Are we doing the right thing?

Or are we doing things right?
Strategic commissioning is about planning and delivering services and support for people in a new way. It includes identifying population-level needs (including those of communities and individuals) to inform how resources are used across health and care systems.
An Overview Of Strategic Commissioning

- Addressing personal and policy outcomes
- Increase value and sustainability of care
- Apply resources where they are most effective
- Considers both capacity and flow
Strategic Planning and Commissioning

- Health and Social Care Partnerships
- Strategic Plans/Strategic Commissioning Plans
- Integration Joint Boards
- National Health and Wellbeing Outcomes
- National Health and Care Standards
- Locality planning influencing SP/SC
- GP Clusters influencing SP/SC
- Linkages with Health Boards and Strategic Plans
- Acute Clinical Services Strategy
- Acute Strategic Planning
Peter’s Story

Low Mood
Arthritis in legs / Collapsed
Consultation with orthopaedics
Knee Replacement Surgery
Home Visit
Physiotherapy
Friend Visit (links to SSAFA)
Phoned Veterans UK
Sensory Service Council
Housing Care & Repair Council

*SSAFA – The Armed Forces Charity
What would improve Peter’s journey?

• How could having a ‘What Matters To You?’ conversation at initial point of access have changed Peter’s story?

• What impact might this have on services required/accessed?

• What pathways and connections exist in your area? What would Peter’s journey look like in your area?
Peter’s Story

“I see something military wise and I break down, I fill up and I cry and I cannnae stop it. I said there is something no right. I knew I wasnae 100% but I still wouldnae go out the house.”

“I couldnae go in and have a bath because I couldnae bend down to go into the bath and if I did get into the bath I couldnae get back out again. I had to get washed at the washhand basin. It was really degrading, it was very degrading.”

“He said right what I’ll be able to do for you is I’ll be able to take away at least 50% of that pain, he said I’ll no cure it all. I’d love to but I’m being realistic, I’m being honest with you. I said that’s all I’m asking is for someone to be honest with me.”

“when I seen the tube going in to get the blood put into me that I had lost, it made me think back to the army and after I was injured in active service I remember being choppered out of Belfast with a drip in my arm and again my morale went rock bottom.”

“I knew there was help out there but I didn’t know where to turn and know who to go to and I didnnae know who to ask’”

“the minute I spoke, a great big weight just lifted. I felt so relieved, all that pressure, stress, everything just lifted.”

“when I seen the tube going in to get the blood put into me that I had lost, it made me think back to the army and after I was injured in active service I remember being choppered out of Belfast with a drip in my arm and again my morale went rock bottom.”

“all my mates are dead, my best mates are all dead, my best muckers are lying in the battlefields of Bosnia, the Gulf, Iraq, Northern Ireland.”

“the minute I spoke, a great big weight just lifted. I felt so relieved, all that pressure, stress, everything just lifted.”

“He said to me how do you feel now? I said I feel great. It’s the first time in 20 years I feel like Charles Atlas. I feel like I can put the world on my shoulders and just run a marathon”

“for the first time in a long time I felt happy, glad because people were going out their road to help me”

“when I seen the tube going in to get the blood put into me that I had lost, it made me think back to the army and after I was injured in active service I remember being choppered out of Belfast with a drip in my arm and again my morale went rock bottom.”

“My left knee is terrible. I’ve got to go and get my left knee done. After everything I went through with my right one I’m no doing it. I’m no doing it because I’m not a hospital person and I feel as if I can get about the way I am the now and touch wood I’m happy.”
What support is available that could help a person to live happily and safely in their own home for as long as possible?
Strategic Planning Approach

Traditional Pathway for older people

Home

Scottish Ambulance Service

Hospital

A&E
Acute non-Elective
Mental Health
Delayed Discharge

Residential Home
Care Home: Old Age
Disability Mental Health
Supported Housing
Nursing/Palliative Care
Strategic Planning Approach

- Holistic
- Whole-system
- Multi-disciplinary
- Interconnected
Time to Reflect on your ‘whole system’

- Where do conversations take place?
- Who is involved?
- What are your community assets?
Thank you for your time today

website: ihub.scot
email: hcis.strategiccommissioning@nhs.net
twitter: @ihubscot
Next steps & close

Geraldine Jordan
Portfolio Lead- Acute Care
Healthcare Improvement Scotland
Next steps...

- Experiential learning
- Patient experience
- Having the right conversations
- Strategic commissioning
Next steps...

LS1 – Glasgow
6th June

Steering group (FVRH)
5th September

Action period

LS2 – Glasgow
6th December