Population of Older People in Dorset

• Higher than average population for over 85 in Dorset

• 36% of the Dorset workforce is aged over 50 compared with 28% in England

• Over 65's population projected to grow by 50% over the next 25 years

• 28% population over age 65-69 (comparison of 18% in other counties)

• Increasing pressure on adult services in local authorities

• Services for older people accounts for 55% of the adult social care budget
• 48% of people over 85 die within one year of hospital admission

Imminence of death among hospital inpatients: Prevalent cohort study
David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*

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If you had 1000 days left to live how many would you chose to spend in hospital?

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• 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80

Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

A definition of frailty

- Frailty is not a disease but a combination of the natural ageing process and a variety of medical problems.
- It focuses on the loss of reserve, energy and wellbeing.
- A useful definition is: “Multidimensional loss of reserves - energy, physical ability, cognition and health”

Rockwood et al (2005)
Challenges at Royal Bournemouth Hospital

• Older people presenting to hospital with increasing levels of frailty
• 6 Medical Wards for Older People (168 beds)
• 50% of beds occupied by older people medically stable for discharge
• Delayed transfers of care running at 5.5%
• Acute Trust supports patients living in Bournemouth, East Dorset & Hampshire:
  • 2 Clinical Commissioning Groups
  • 3 Local Authorities
How we started our journey...

- Understanding the situation and our potential outcomes?
- Understanding our fears and our hopes
- What we were willing to sacrifice and what we were not willing to sacrifice
- What is the best course of actions that would meet all of this
Beds aren’t capacity

‘Beds are where patients wait for the next thing to happen’

How many red days?
An example of a patient journey... need for change
Mrs Andrew’s Story

https://www.youtube.com/watch?v=Fj_9HG_TWEM
Older Persons Medicine: Our Vision

Safe compassionate care for older people living with frailty:

“Care needs to be just as important as treatment. Older people should be properly valued and listened to, and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care”

10 principles of delivering a frailty pathway

• Ensure early identification of people with frailty
• Initiate CGA within 1 hour
• Initiate a rapid response system
• Adopt a silver phone system
• Adopt clinical professional standards to reduce unnecessary variation
10 principles of delivering a frailty pathway

• Strengthen links inside and outside of the hospital
• Introduce appropriate education and training
• Adopt a measurement mind set
• Clinical change champions, collaborative leadership approach
• Support from an executive sponsor and project management
How we are doing this?

- An integrated frailty pathway
- Frailty Unit – short stay (5 days LOS)
- Older Persons Medical Unit (10 days LOS)
- Locality Hub in Bournemouth & Christchurch
- Admission Avoidance
- Discharge to Assess
- Expertise of health, social care and third sector services
- Developing professional standards in discharge planning
The current pathway for older people involves unnecessary:

- transfers
- handover
- late moves leading to poor experience and increased length of stay

The new frailty pathway will ensure the right patient is in the right place at the right time........
Frailty Pathway September 2016

**Admission Avoidance**
via Locality Hub

**Emergency Department Admissions**

**Older Persons Assessment Unit**
25 beds
12 hours LOS

**Short Stay Unit : Wards 24&25**
50 beds
5 days LOS

**Medical Unit – Wards 4&5**
50 beds
10 days LOS

**Discharge to Assess**
via Locality Hub

**or**

**GP Admissions**
Simple Rules and doing what is known to work each day every day
Locality HUB

DISCHARGE TO ASSESS

INTERMEDIATE CARE
INTERIM TEAM
REABLEMENT
ROAMING NIGHT SERVICE
THIRD SECTOR SERVICES
OPAC
CONSULTANT NURSES
COMMUNITY MENTAL HEALTH TEAM

STEP DOWN BEDS VIA COMMUNITY HOSPITALS OR INTERIM CARE HOMES

SAFE GUARDING
GERIATRICIANS
SILVER PHONE
DAY HOSPITAL
SOCIAL WORKERS
OCCUPATIONAL THERAPISTS
PHYSIOTHERAPISTS
DISTRICT NURSES
VOLUNTEERS
VIRTUAL WARDS

STEP-UP BEDS VIA COMMUNITY HOSPITAL OR INTERIM CARE HOMES

ADMISSION AVOIDANCE
VISION OF THE HUB

• Admission Avoidance & Discharge to Assess as expectation rather than exception
• Integrating factors: single assessment process, single record, transdisciplinary roles (NHS England: associated with improved outcomes and added value with only small investment)
• Identifying patients at the right time – proactive rather than reactive, (impact of two day wait).
• Exploration of other options for discharge to assess: interim bed arrangements and extra care housing opportunities
• Putting the needs of the patient before the needs of the service
• Eliminating ‘hand-offs’
• Simplifying decision-making
• Increasing efficiency
• Access to Geriatrician via silver phone
Significant reduction in number of patients with a length of stay of over 14 days. Evidence of early success with stranded patient reviews.
Occupyed Bed Days

Number of Beds occupied by patients has significantly reduced – by an average of 20 beds per day.
% Bed Occupancy

Average: 96%
Upper Control Limit: 101%
Lower Control Limit: 91%
Evidence shows that increasing discharges before midday facilitates improved patient flow.
Discharges - Geriatric Medicine

Fridays

Ave. No. of discharges = 18.6 per day
Questions...

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