Acute Frailty Network February 2017

Acute Frailty Network

The Role of the Improvement Analyst.

Analysis is all about picking out the “signals” from the “noise”. The noise refers the variation that is inherent in all systems that we observe. The signals are the “maths” that we look for to say there’s a difference from the noise. As a part of the AFN we are learning about the technical components of statistical process control (SPC), a way of demonstrating signals from noise. As a part of the measurement masterclass to learnt about a rigorous approach to the 7 steps of measurement from developing an aim, to reviewing the measures.

We have now completed two thirds of the measurement visits, on the visits we always talk about the differences between traditional analysis and being an improvement analyst. I have attempted below to list the characteristics of an improvement analyst for you to compare yourself to…

- Do you present data using triangulation of outcome, process and balancing measures?
- Have you helped design a clear aim for the project, that does not contain a potential solution?
- Improvement analysts tend to disaggregate the data, only using weekly data as the most aggregated, do you?
- Are you helping with the design of PDSA’s? Ensuring robust measurement it at the heart of the trial.
- Do you present your data using SPC, or other forms of displaying variation?
- Have you abandoned RAG ratings?
- Do you refer back to the 7 steps of measurement in your team meetings?
- Do you remind the team that not all changes are improvements?
- Are you thinking about the links to return on investment associated to any improvements?

If you said “yes” more times than you said “no”, that’s great, welcome to the improvement analyst club!

Keep up the good work.

Matt

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Blackpool Victoria Frailty Service

Overview

The Blackpool Victoria Hospital serves a resident population of approximately 333,000. There are large seasonal fluctuations in population with Blackpool and surrounding areas of the Fylde coast attracting up to 17 million visitors a year. The Victoria Hospital is a district general hospital with 849 beds and serves the three surrounding boroughs of Blackpool, Wyre and Fylde.

Blackpool is a major centre for entertainment, attracting visitors from all over the country. It also benefits from good access to the Lake District and Pennines and provides an ideal location for anyone interested in water sports. There are good road and rail links from Blackpool putting you in easy contact with other major cultural centres in the North West.

Blackpool has a transient population with increase in the summer months and is attractive to the Older Frail person. A number are born and breed here but some come to retire having spent their holidays here when they were younger.

The Unscheduled Care Division manages the Care of the Older Person Department where the Acute Frailty Service is delivered from. The team are working closely with Community Adults and Long Term Conditions Division to ensure the pre and post hospital service provision meets the needs of frail patients to create a seamless pathway across services.

The service began in December 16 on a small scale on Ward 23 for assessment and treatment of Frail patients who present via the Emergency Department.

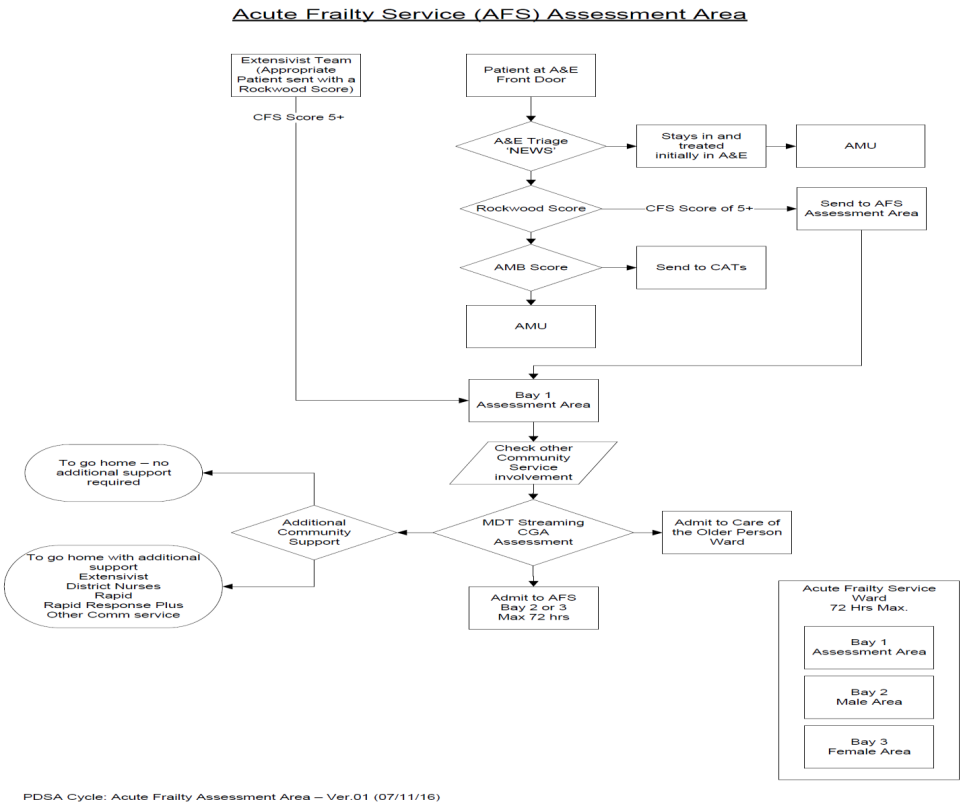
Our Journey So Far

To ensure Frail patients were given rapid access to a multi-disciplinary team (MDT), a team consisting of medics, therapists and nurses are aligned to the Acute Frailty Service. This team are able to ascertain very quickly the appropriate course of treatment, as well as the most appropriate environment to allow the best outcome for our patients.

A side room on Ward 23 was the first area available due to the continued pressure on bed availability across the Trust. Patients are assessed in the Emergency Department (ED) and then referred to a consultant to make the decision as to whether the patient is appropriate for the Frailty Service. Once agreed, the patient is then transferred to the ward and the Combined Geriatric assessment (CGA) is carried out with a management plan put in place. The overriding priority is to return the patient to their place of residence where possible.

Patient Pathway

The pathway below was developed to provide clarity on the patient pathway during the test cycle. A Health Economy Frailty Workshop took place on the 20th February providing an opportunity for all health and social care partners to have an opportunity to shape services to meet patient need.



Intended Outcomes

Above all, this is about a better experience and outcomes for our frail patients, with people receiving the right care at the right time. In particular, we want people to be identified and properly assessed as frail as near to the 'front door' as possible.

In this way we hope to improve the overall experience for patients, their carers and for our staff. We aim to then only admit those people who we know will benefit from admission. We therefore anticipate that while the number of people we identify as frail will and should increase, the overall number of frailty A&E attendances and admissions into our beds will decrease. We also hope the non-elective length of stay will decrease although are mindful that in admitting people we can look after better, this may increase length of stay in some cases.

We also hope to see a positive benefit to:

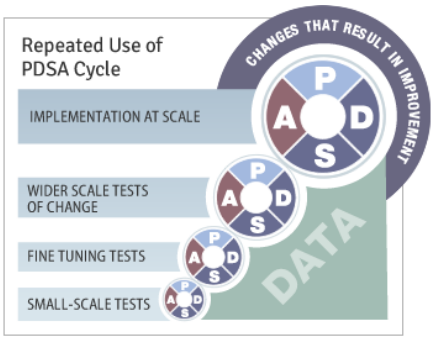
- 4 hour waits in A&E;
- Bed Days
- Referrals to HDT and subsequent DToC
- Readmissions
- Reduction in care home requirements for re-assessment of patients to enable discharge
- Higher uptake of the Extensive Care Service

Next Steps

- Development of Frailty Dashboard
- Test cycle of direct referrals from ED 24/7
- Test cycle with North West Ambulance Services
- Development of workforce model and business case to take service through to phase 3 and 4 of the Trust Frailty plan
- Follow up Health Economy Frailty Workshop

A View from the Front Line

Cohort 3 colleagues should by now be well underway with service redesign and hopefully measuring the impact, and revising where it is not heading in the way you wanted. Don't be put off by testing changes only to find out that they do not work. Every system is different and you will need to find out what works best in your setting, which inevitably means finding out what does not work. Try not to get sucked into writing business cases and pre-specifying the what, where, why when and how until you have sufficient understanding of what is likely to work from your PDSA cycles. You may find it challenging to persuade your colleagues about this approach, but again, don't be disheartened – we remain amazed and a little disappointed at how little QI knowledge there is in the NHS, so consider yourselves at the vanguard, leading the way! By acting as a team, showing shared leadership and coordinating and communicating clearly with your stakeholders, you will make progress.



Make sure to use the AFN to help you in your journey – you will have your site lead, and we can draw upon a wide range of support – from clinical advice through to leadership and QI – we are here to help!

And don't forget to register for the AFN conference in June this year – it should be a great opportunity to celebrate your achieving along with many other like-minded folk!

Dr Simon Conroy

Spotlight on Lancashire Teaching Hospitals NHS Foundation Trust

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Overview of LTHFT

We are one of the largest Trusts in the country, providing teaching hospital services to 370,000 people in Preston and Chorley, and specialist care to 1.5m people across Lancashire and South Cumbria.

We provide care from three facilities:

- Chorley and South Ribble Hospital
- Royal Preston Hospital
- the Specialist Mobility and Rehabilitation Centre

We have 4 WTE geriatricians working together to provide comprehensive assessment and specialist care including falls, stroke, dementia and movement disorders. In addition we provide surgical and medical in-reach on a daily basis.

Our Journey

We set up a multi-award winning proactive elderly care team (PECT) back in 2012 made up of specialist therapists and nurses plus daily geriatrician input. We targeted all patients over the age of 75 years who were screened for frailty using the Bournemouth criteria.

PECT also screened over 15000 patients for dementia and delirium, the highest number that we are aware of in the UK (if not the world).

PECT managed to reduce LOS by 50% and also reduced readmissions by 49%.

Successful as it has been, PECT usually sees most patients after they have already been in hospital for over 72 hours. We felt that if we changed the service so that patients are seen within 24 hours of admission, even greater benefits would be achieved.

Our Vision for Frailty

Having joined the 3rd cohort of the Acute Frailty Network in September 2016, we were keen to develop frailty criteria. We decided to use the Rockwood frailty tool to identify frail patients at the 'front door' ie in Accident and Emergency.

Once patients were identified as being frail, we used a modified Bournemouth criteria to decide who we would focus our efforts on.

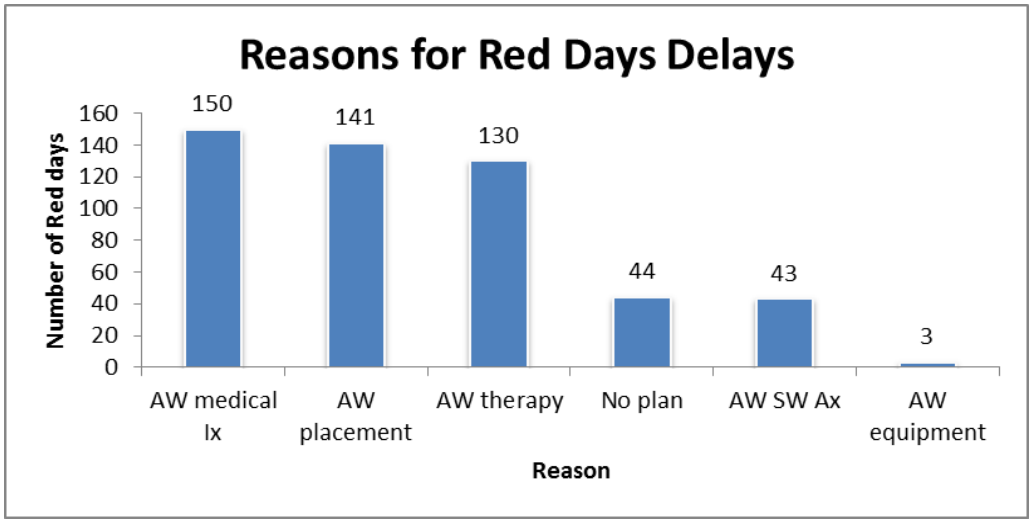
Patients would then have a comprehensive geriatric assessment performed by our new team: Lancashire Integrated Frailty Team (LIFT).

LIFT: Lancashire Integrated Frailty Team

LIFT is made up of all the elements of the pre-existing PECT team. That is specialist nurses, senior therapists and consultant geriatricians. Our 3 specialist nurses are currently undergoing further training to become nurse practitioners. We feel this is a key part of our future success.

In addition to the traditional healthcare professionals, we have recruited a data analyst to our team. We know from our work with PECT that getting baseline data is crucial – without it we cannot determine if this new model is successful or not.

We have already collected data and we have created our first ever Pareto chart.



Once patients have had a CGA they will be admitted onto our virtual frailty unit (VFU)

Virtual Frailty Unit

The Trust is undergoing a lot of changes and in particular there is a medium-term vision to amalgamate the existing hospitals into a single site. We want to have a physical acute frailty unit but to begin with we wanted to determine how big that unit should be.

We therefore decided to set up a VFU first consisting of 10 beds. Patients admitted onto the VFU would still be under their parent teams spread throughout the hospital.

However, our plan is to review each patient every day using LIFT. We want to see if the LOS will fall and get an idea of how many patients we can see every day.

Next Steps

We are just beginning this new chapter in our frailty journey that began in 2012. We are going to start doing CGAs in the next week and we will begin to populate the VFU.

In addition we want to computerise our note-keeping (it is currently all paper). We are also working with our partners in the CCG.

Future

If the VFU is viable and works with 10 beds we could expand to 15 or even 20. Ultimately we envisage a physical acute frailty unit working 7 days a week with full multidisciplinary input.

In an ideal world we would like to see all patients who are frail and perform CGAs for them.

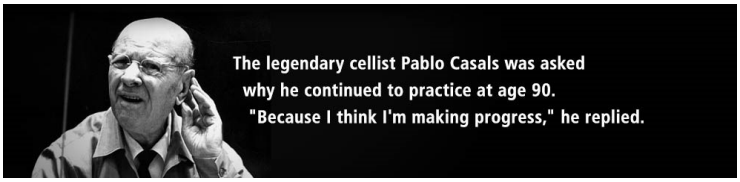
We must work with patients and carers/families and their opinions will shape how LIFT and VFU work in the future.

We have started to look at 'stranded' patients and we hope this work will have a positive impact in reducing those numbers.

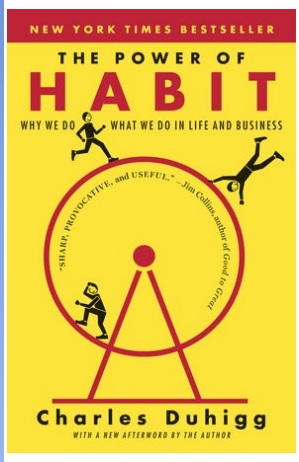
Finally we would like to develop community geriatric services and ideally geriatric in-reach across all appropriate wards in the hospital.

Progress or Perceived Lack of It!

Well you are now progressing into the second six months of the programme. How are you getting on? Has this Winter been the worst yet for you? I know some are telling me they think it is and are reeling from the volume of patients they are working with.



As Site Support to the Acute Frailty Network I find this is the time sites begin to panic about their progress or perceived lack of it. They can feel as if they are not progressing fast enough and duck away from having a conversation with the AFN associate who is offering support, thinking its like being in the Headmaster/mistresses office and we will pass judgement or tell you off. (human nature is funny like that, isn't it?) Meanwhile we as site supporters are aware of the difficulties you face and are there to support you and offer perspectives and ways you can move forward. Do use us - we are happy to hear from you when things aren't going as well and in between calls not just at our scheduled call times. We too juggle competing demands and are human, honest!



I have recently been reading "The power of Habit" by Chares Duhigg as part of a book club I belong to. It has made me reflect on Frailty and our habits in working in this area of care. We all need habits to survive and fall into hundreds of habits a day. These all start with a cue at which point we follow routines that we have developed and at the end of the routine we get a reward that reinforces the habit. To change a bad habit such as drinking excessive amounts of alcohol, into a good one, such as exercising more, we need to examine our cues and rewards for undertaking the habit. It made me think that in relation to Frailty, every year we know that the attendance for Emergency Care goes up during December to February (although many of us feel it now never goes down)- but what do we do to change our habits and work differently given we will be extremely busy? Or do we continue with the cues (increased workload) and fall into same routines with the same reward? We know and predict that the number of people coming into the service each Winter continues at a higher rate than previously.

What cues us into doing the same as we have always done and falling into the same routine expecting different results? We may feel the rewards are absent but as we fall into the same routines that drive our habits- think about what habit pattern you are falling into and how by changing one routine you could get a different outcome (then as Matt would say, measure it). Identify the cues that could push you back too easily in your past way of working and by doing so you can see how you can avoid these, therefore enabling a greater chance of success.

What are the habit patterns of your Organisation? what cues drive certain behaviours or attitudes? Can you change the habits by changing routines that follow these cues or by changing the cues themselves? (this maybe harder as the cue maybe the number of patients) and create better Organisational habits which can lead to better pathways and untimely better outcomes for Frail patients.

If the routines and our habits stay the same how can we expect different results? Are we somehow rewarded for our habitual pathway patterns? Start to look at your patterns and habits as you go about your daily work and see where change can lead to an improvement.

Use your Site Support Associate to provide support- call or e mail us with your problems as well as your successes. I look forward to sharing your future successes in the next 6 months as you build your Frailty story to share with all of us at the final event.

Site Support Acute Frailty Network Mandy Rumley-Buss, February 2017

Dates for your Diary

National Workshops

4th May 2017—Cohort 4's Launch Event

Master Classes/Workshops

2nd March 2017—Experience Based Design Workshop

16th May 2017—Cohort 3 and 4's Improvement Methodology Master Class

Leading Change in Complex Systems—Paul Plsek

Designed and delivered by Paul Plsek, an internationally recognised consultant on improvement and innovation in complex organizations. A systems engineer, former director of corporate quality planning at AT&T, and the developer of the concept of DirectedCreativity™, his work can be described as 'helping organisations think better'.

15th June 2017 —Cohort 4's Measurement Master Class

Webinars

19th May 2017—Getting off to a flying start

National Conference

29th June 20-17—AFN National Conference—Call for abstracts for network members

As network members our associates would be happy to support any abstract submissions from network members.

Completed proposals should be submitted to frailty@nhselect.org.uk by **27th March 2017** and the abstract template and guidance notes are attached.

Need help or advice or want to share your news contact
Frailty@nhselect.org.uk
Don't forget the web resource materials
www.acutefrailtynetwork.org.uk