Sheffield Frailty Service-our Improvement Journey for the Vulnerable Elderly
Topics

• How we started the journey
• Setting up the Frailty Unit
• Discharge to Assess
How we started the journey

• Lots of anecdote
  • Why does GSM always have outliers?
  • Bed blockers
  • Increase in frail elderly admissions in winter
  • If only we had daily ward rounds it would improve

• No evidence
• Started as an offshoot of “Flow, Cost, Quality” work
• Firstly understand your system
  • Map it
  • Measure it - get data
Sheffield 12.1 days

23 sets of notes
No medical issues
Windows of opportunity
2,259 days could have been 515
From MAU to Frailty Unit

- For non-elective admissions the traditional way of working was the post-take ward round (PTWR)
- Patients reviewed for discharge were referred to a discharge team who assessed their needs for discharge
- GSM team worked across 3 MAU’s, ED and often SAC
- The system was designed so that a patient was almost guaranteed at least one overnight stay
- I followed a number of ward rounds - lots of activity but most was repeating previous stages and little observed value was added
• Started with one consultant and one test; can we see patients in real time on the day that they arrive?
• This reduced time to see consultant by half and improved clinical care decisions in over 20% of patients
• What is the impact of different working-day timings?
• What happens if we go back to the previous system?
• Extended the test to over 3-days and involved 4 consultants
• Patients with the same clinical conditions arrive via OP system or NEL system
• What happens if we combine the 2 systems?
• We repeated over 7-days and involved 8 consultants.
• Same results
• We also learned that staff walk 1,000 paces per hour
• Major delays to specialty care

Data from GSM test Jan ’12 showing
time patients asked for health care,
time they arrived in AE and time
seen by GSM

So reduce the delays to arrival
to ensure patients arrive more
reliably during the day means
we might not need so much
staff resource in the very late
evening
• The current layout of the MAUs caused loss of efficiency due to motion waste; therefore we needed to co-locate the team
• In April 2012 all the GSM consultants changed their job plans from a 1 session PTWR to a 3 session on-take system
• In May 2012 the physical entity of the Frailty Unit came into operation
The percentage of patients who were directly discharged increased by 34%.

The in-hospital mortality dropped by over 13%.

Midnight bed occupancy dropped by over 60 beds (no similar change in previous years).
Discharge to Assess

• Standard method of discharge = ASSESS to DISCHARGE
• Frailty Unit set up elevated this as a major cause of overnight/multi-day stays
• Tested “jumping in an ambulance”
• Started with 1 patient....
• Repeated with 3 and then a whole week
• That became standard work on the Frailty Unit
• Tested concept on base ward – failed...
• No progress until Sept 2013.
• Started with 1 patient; she took 8 hours to process, successfully left at home with the appropriate care package.
• Repeated with 2 patients. They took 5 hours.
• Re-repeat with 2 changing an internal process. They went in 4 hours and required less ward OT/PT time.
• Tested for 5 days.
• Most patients were assessed as needing lower levels of care than predicted by ward staff
• The following Monday the new process was adopted as routine for that ward.
• Data collected on 2 wards suggest that on average patients stay 6.7 to 10.3 days after they no longer require to be in hospital. Our specific aim was to reduce that to less than 1 day.
Discharge count increased by 34%

Mean LoS reduced by 30%

Falls count reduced by 30%
Summary

• It’s hard work, but worth it!
• You can’t design good care, you discover it
• Produces better patient care at lower cost
• Need to involve everyone in the system
• Don’t jump to solutions find out what works for you
• There is a science behind this!
• Ref:
  • http://www.health.org.uk/publications/improving-patient-flow/
  • Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources
    Kate M. Silvester; Mohammed A. Mohammed; Paul Harriman; Anna Girolami; Tom W. Downes
    Age and Ageing 2013; doi: 10.1093/ageing/aft170