Evolution and Innovation

-Hospital Care for the Acutely Ill Frail Elderly

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May 2014

HSC Belfast Health and Social Care Trust

Components of Care of Older People

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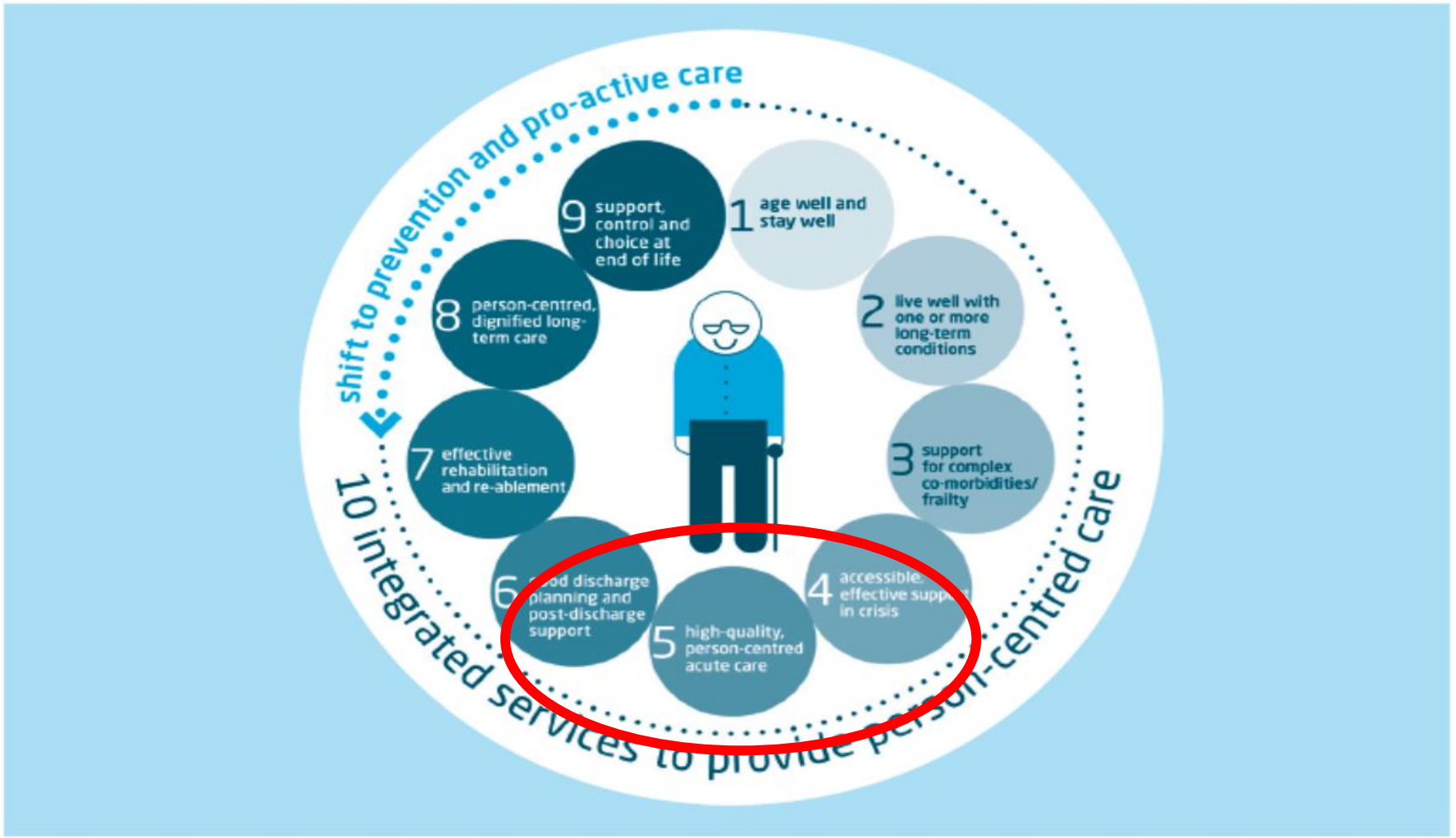
Kings Fund, 2014

Components of Care of Older People



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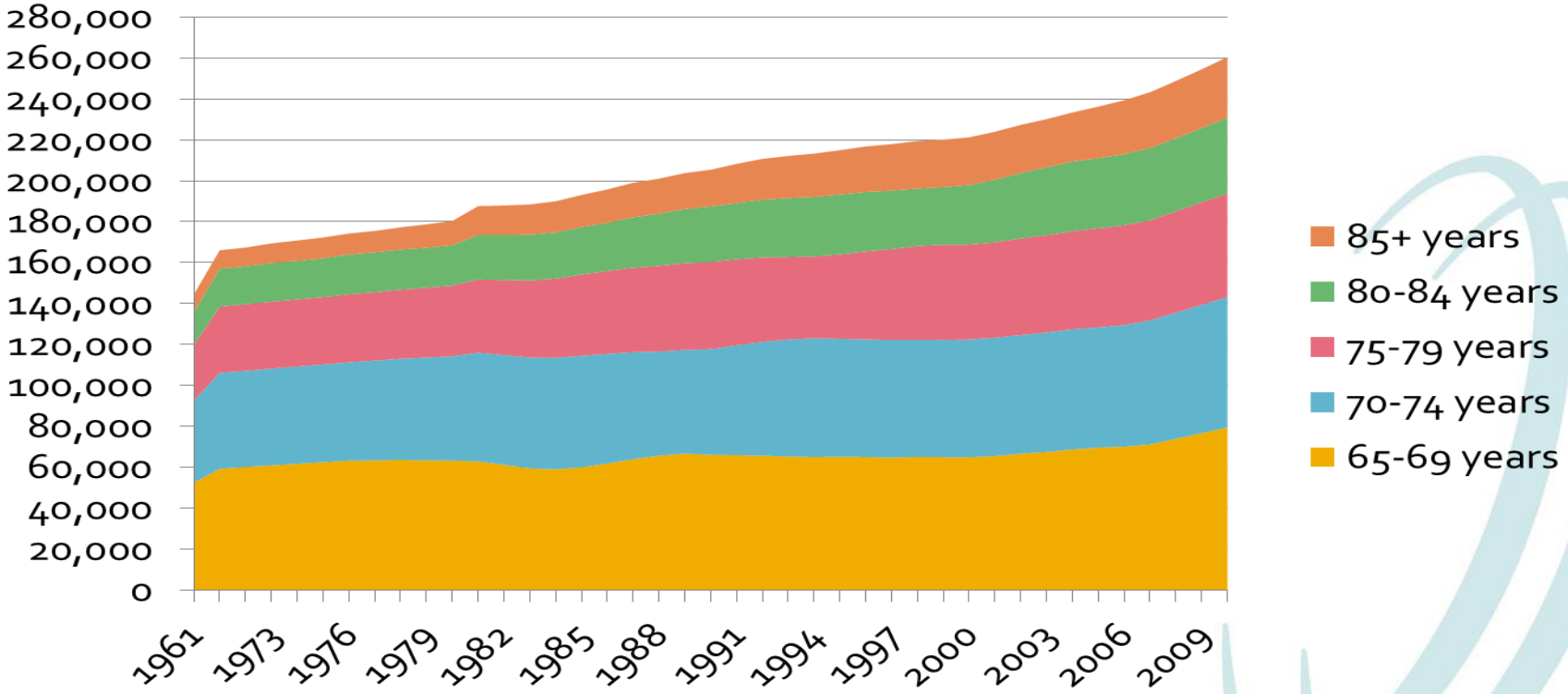
The Ageing Population

1. Increasing in numbers
2. Increasing complexity (co-morbidity)

NI Population over 65y, 1961-2010

By 2028 will be 375,000



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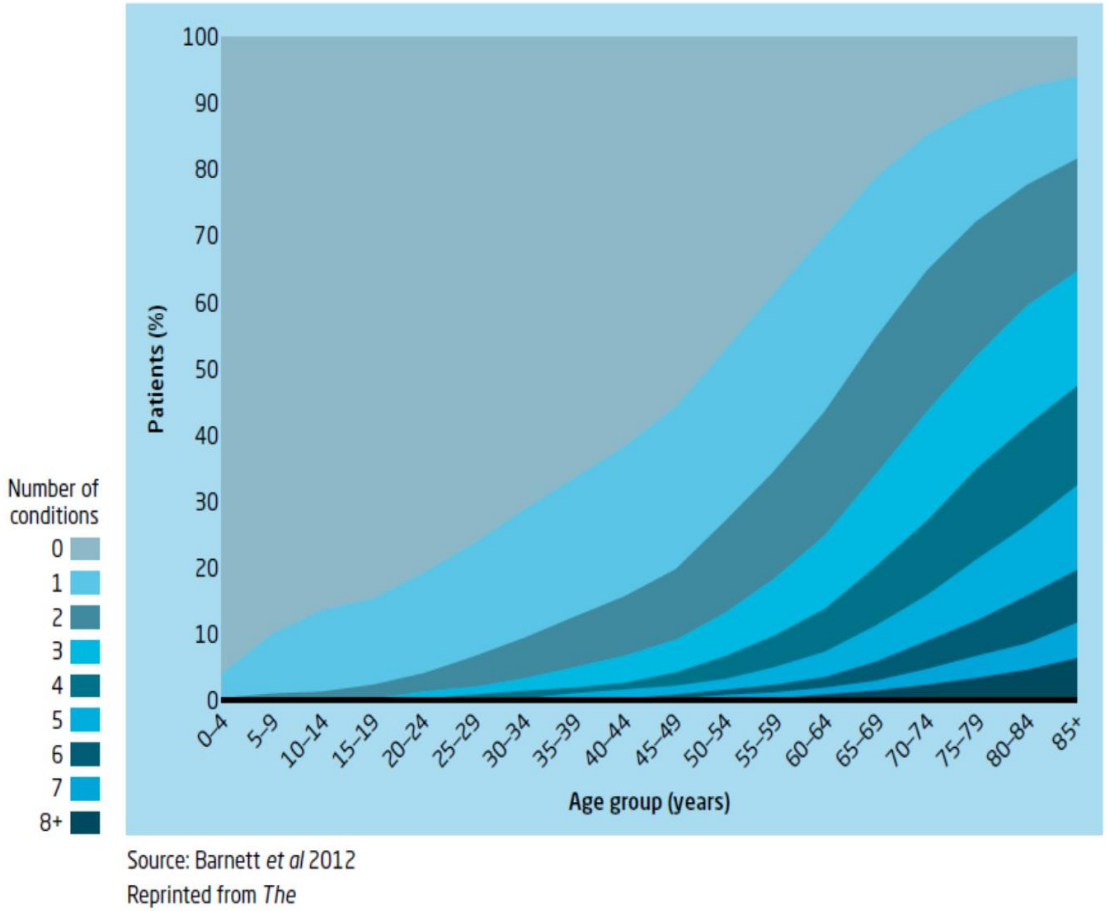
General Registrar Office, 2011

Morbidity (number of chronic conditions) by age group



Source: Barnett *et al* 2012
Reprinted from *The*

2000-2010
66% increase in >75 years
This group have higher LOS / Readmissions
(JRCPE, 2013)

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Kings Fund 2014

The buckaroo phenomenon

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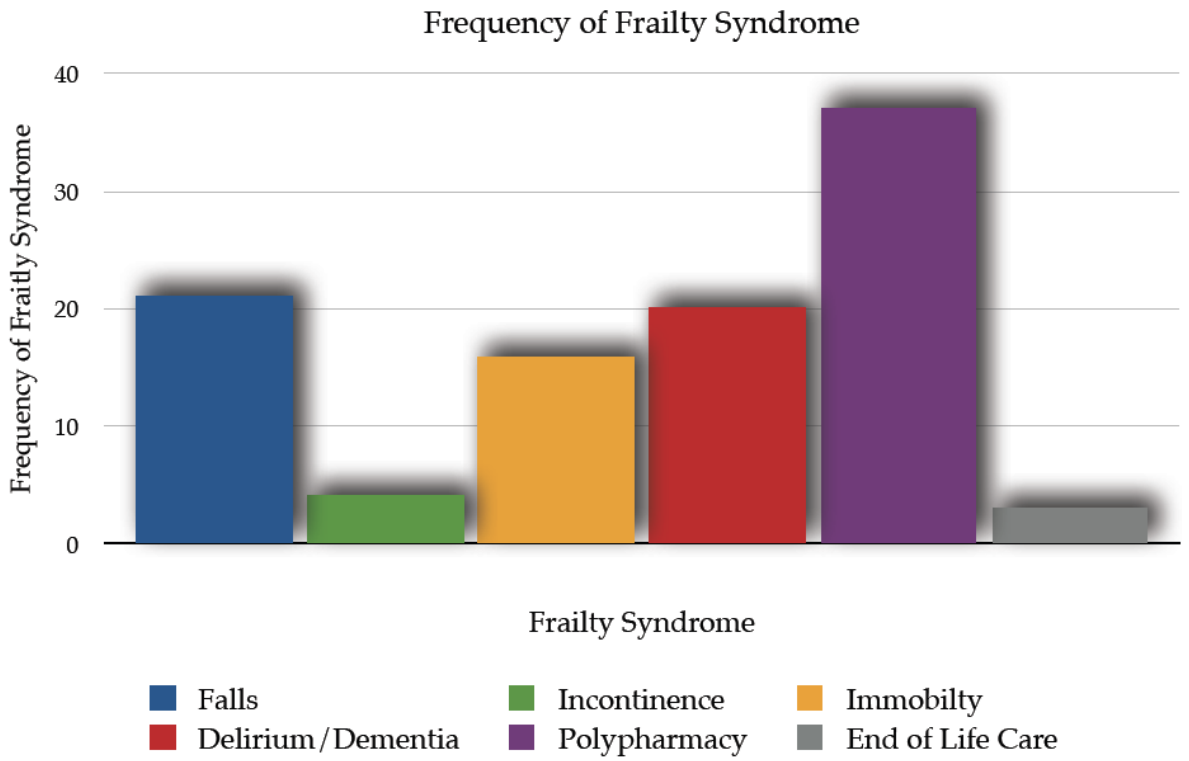
Frailty Syndromes- the Big 5

1. Immobility / ‘Off legs’
2. Delirium and dementia
3. Polypharmacy
4. Incontinence
5. End of life care

The presence of one or more frailty syndrome (see Box 1) should trigger a more detailed comprehensive geriatric assessment, to start within 2 hours (14 hours overnight) either in the community, person’s own home or as an in-patient, according to the person’s needs

Silver Book, BGS, 2012

Frailty syndromes in patients over 65y in RVH AMU (Jan 2014)



- Audit of 50 patients
- 46 (92%) had one or more frailty syndrome

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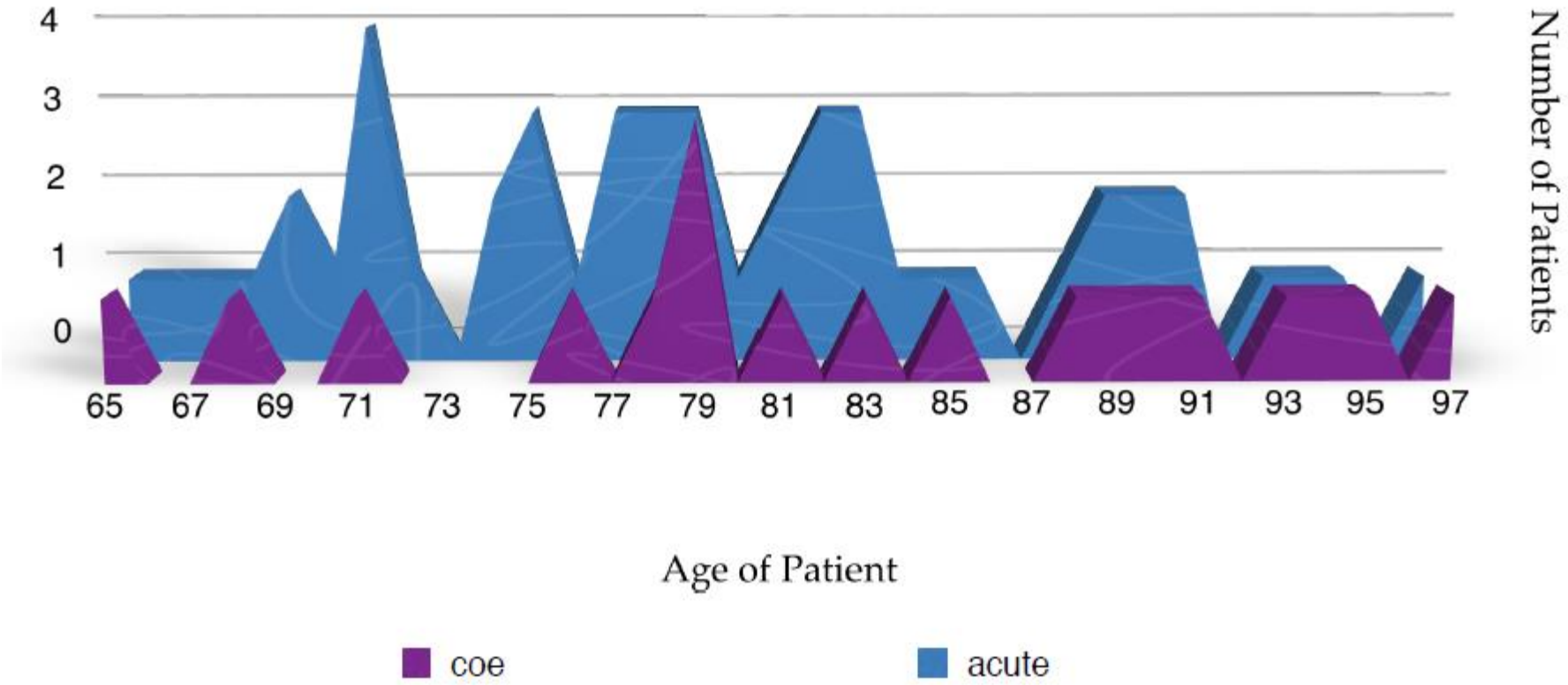
Jane Anketell, Chris Speers, Ken Fullerton, 2014

Divide of patients between COE and Acute



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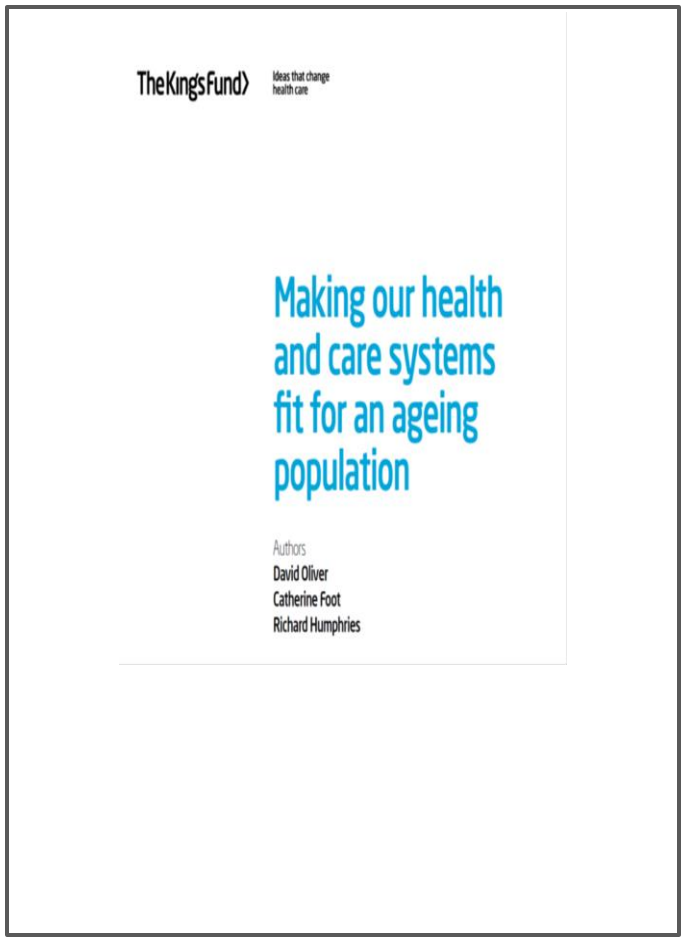
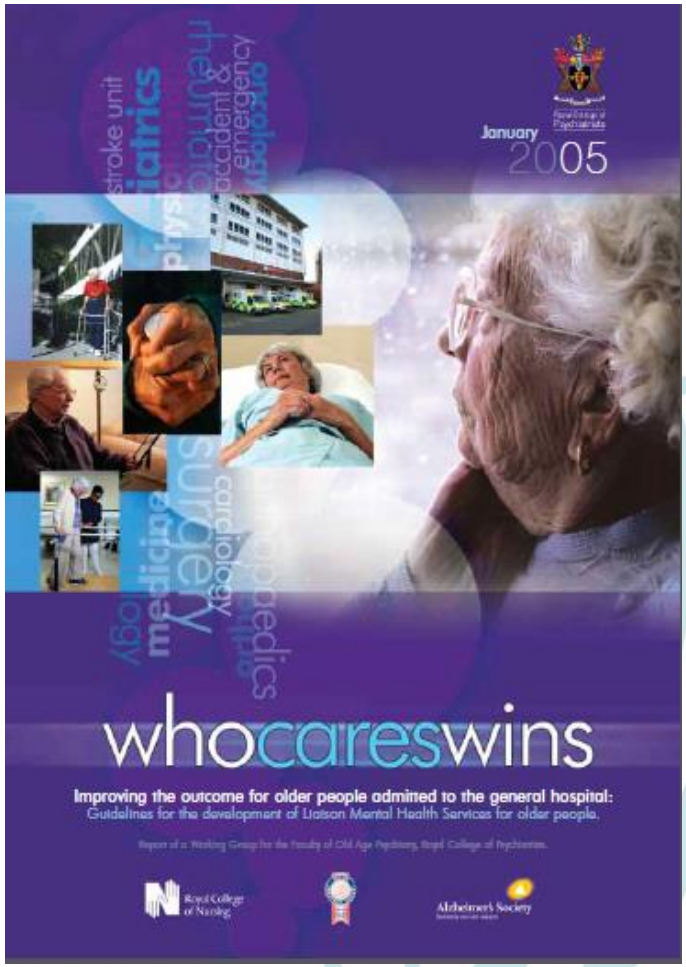
How should frail older people be managed?





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How should frail older people be managed?

1. Focus on dignified person-centred care
2. Use CGA
3. Introduce RAID
4. Focus on frailty
5. Specialist elderly care wards
6. Liaison services / specialist advice
7. Maximise continuity of care / minimising ward moves
8. Improve safety
9. Minimise harm of hospitalisation

Oliver et al, Kings Fund 2014

What is CGA?

Elements of comprehensive geriatric assessment

Medical assessment

- Problem list
- Co-morbid conditions and disease severity
- Medication review
- Nutritional status

Assessment of functioning

- Basic activities of daily living
- Instrumental activities of daily living
- Activity/exercise status
- Gait and balance

Psychological assessment

- Mental status (cognitive) testing
- Mood/depression testing

Social assessment

- Informal support needs and assets

Environmental assessment

- Care resource eligibility/financial assessment
- Home safety
- Transportation and telehealth

(Adapted from Ellis *et al* 2011)

What difference does CGA make?

Meta-analysis of CGA v usual medical care

Outcome measure	Odds Ratio	p
Alive at living at home (6/12)	1.25 (1.11-1.42)	<0.001
Living in residential care	0.78 (0.69 – 0.88)	<0.001
Death or deterioration	0.76 (0.64 – 0.90)	0.02

1. "Benefits seem to arise solely from trials of geriatric wards and are not seen for geriatric teams"
2. "Can provide only limited guidance on which types of patient should undergo CGA"

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Ellis et al, BMJ 2011

Hospitals on the edge.

Can our NHS hospitals survive without better and more effective mental health service and dementia specialist care?

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RAID - Older People in Acute Hospitals

- @70% beds occupied by older people
- 30-50% have a 3D

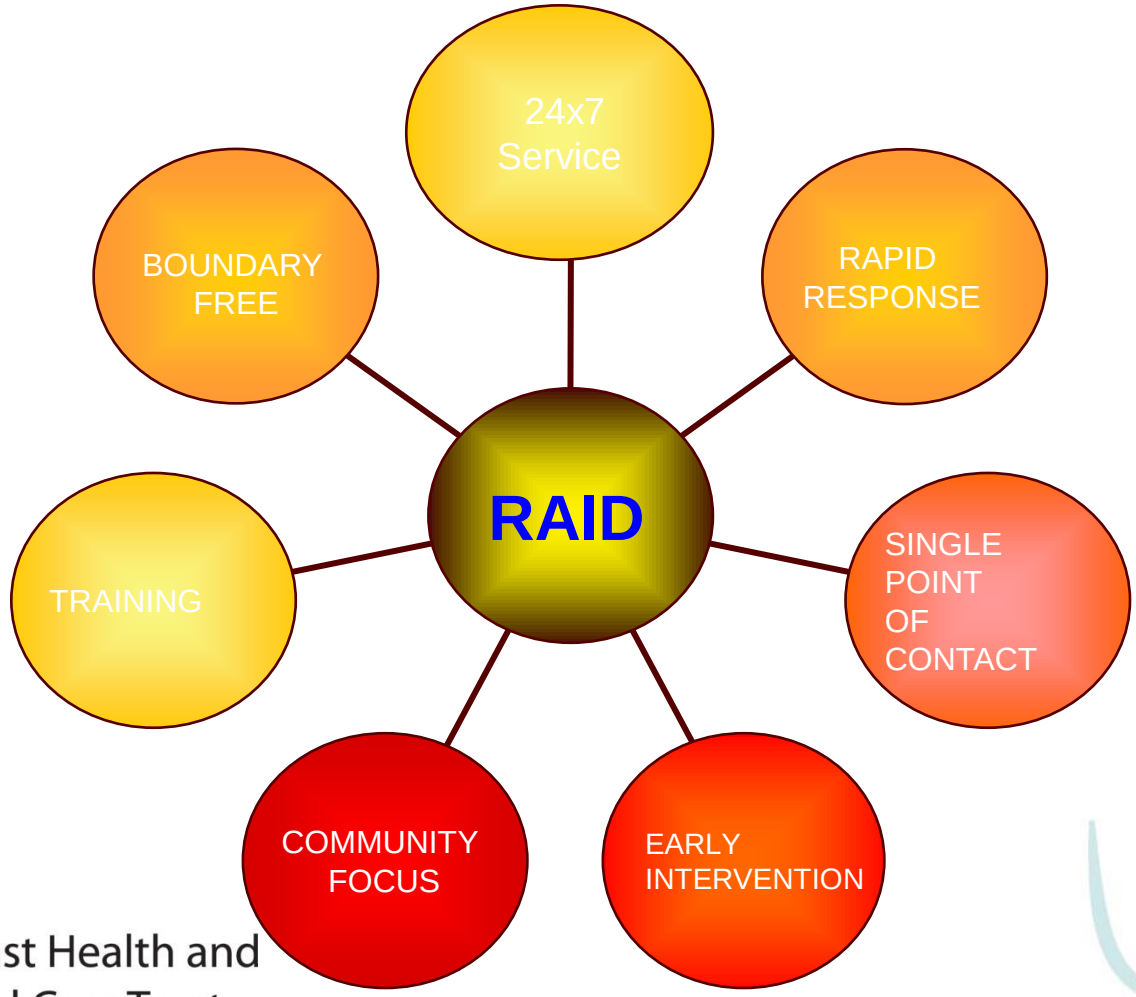
Mental Disorder increases

- LOS
- Readmission
- Institutionalisation
- Mortality
- Falls
- Poor Outcomes

RAID- Older people: Who Cares wins (2005)

- Older adults and a typical 1000 bed DGH
  - 700 beds occupied by older adults
  - 350 will have dementia
  - 480 for non-medical reasons
  - 440 with co morbid physical and mental disorder
  - 192 will be depressed
  - 132 will have a delirium
  - 46 will have other mental health problems.
- 500 beds hospital would have 5,000 admissions/annum, of whom 3,000 will have or will develop a mental disorders. Who cares wins, 2005.
- In a typical acute hospital (500 beds), failure to organize dementia liaison services leads to excess cost of £6m/year.
- Dementia CQUIN (FAR)

Rapid Assessment Interface Discharge (RAID)



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RAID-Combined total savings: beds/day

- **On reduced LOS**
  - ÷ 365 = 38 days/day (35 beds/day for the elderly)
- **Saved bed days through avoiding admissions at MAU**
  - **Saved bed days = 6 beds / day**
  - **Elderly .. = 6 beds**
- **Increasing survival before another readmission**
  - Admissions saved over 12 months =1800 admissions
  - Average LOS 4.5 days
  - = 8100 saved bed days
  - ÷ 365 = 22 beds/day
  - 20 for the elderly
- **Total Saved beds every day**
  - **= 38 + 22+ 6= 66 bed/ day (Maximum) {Elderly: 59 beds/day}**
  - **= 21 +22+ 6= 49 bed days (minimum) {Elderly: 42 beds/ day}**

✓ ***2010: Birmingham City Hospital has already closed 60 beds.***

The case for change in BHSCT

Frailty Focus
Increased Mental Health Provision
Interfaces reduction
Staff Resource

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One approach….

1. Facilitate direct admission of targeted Frail Elderly group to specialist COE wards
2. Empower other teams to manage other patients with frailty syndromes in AMU (Frail-safe checklist, specialist support, RAID)

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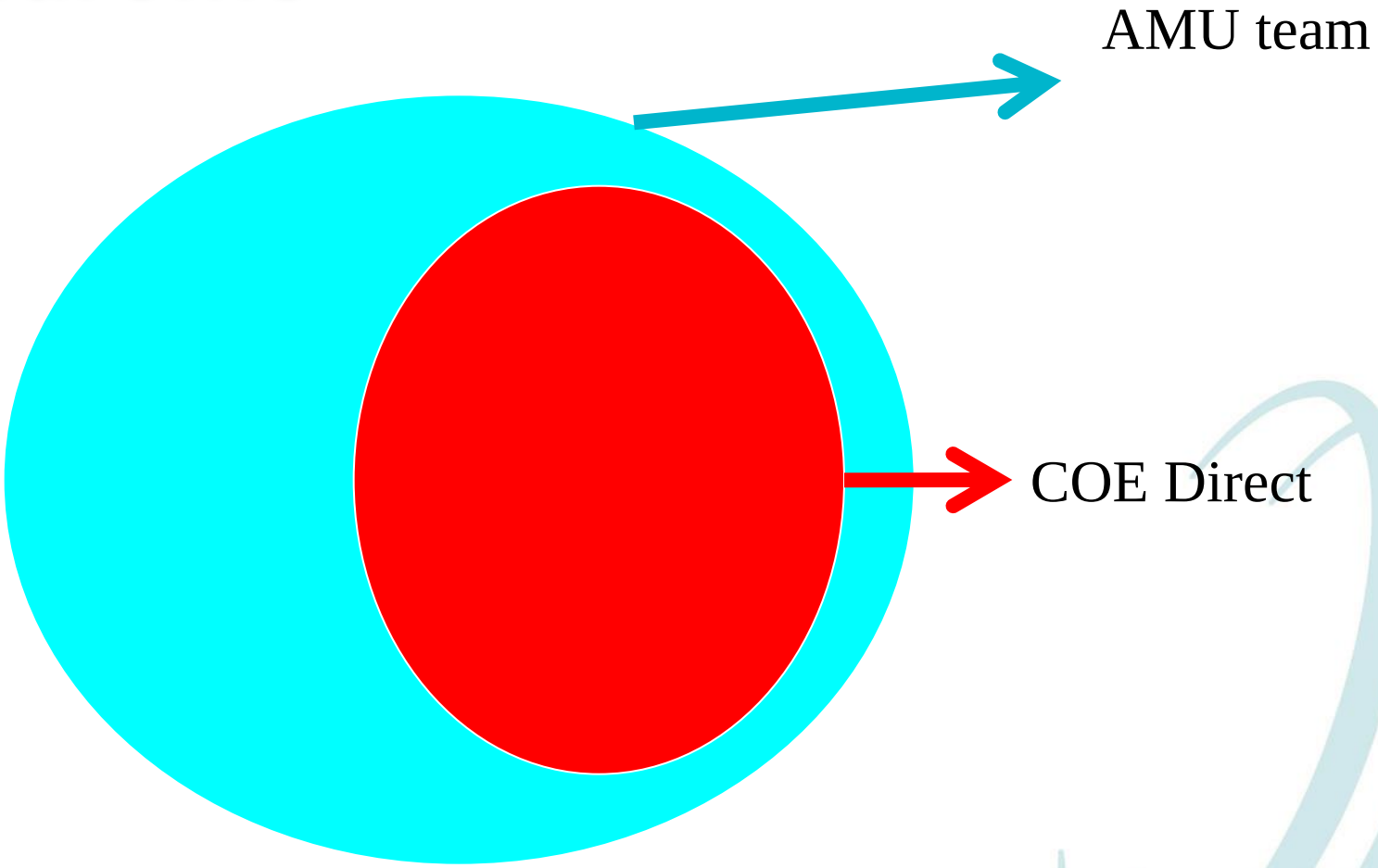
Older people with frailty syndrome



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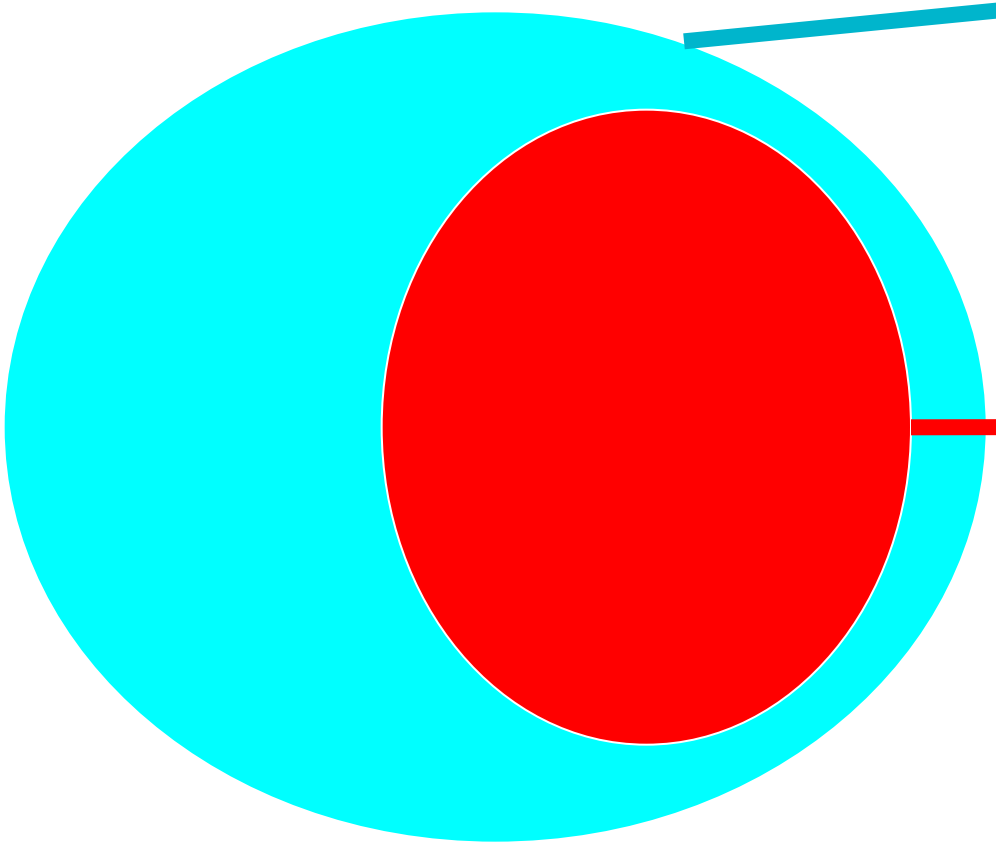

AMU team
- Frailsafe
- Specialist support

COE Direct

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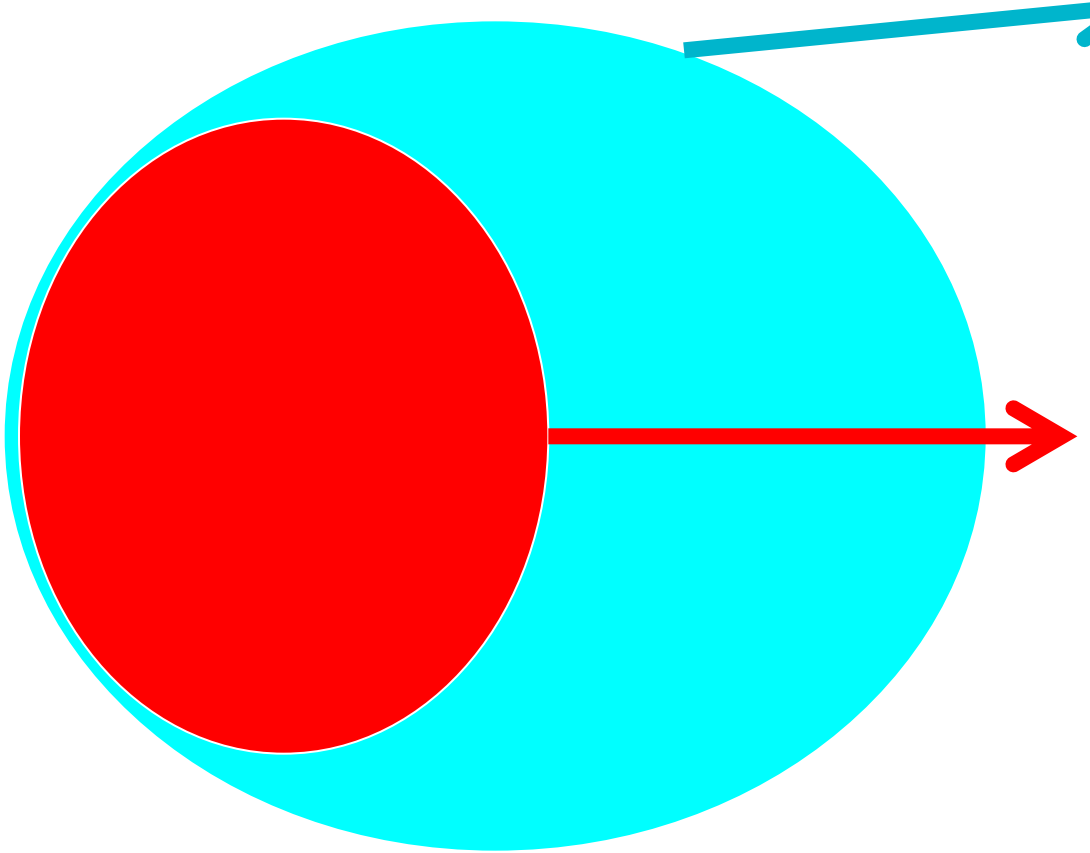
Older people with frailty syndrome



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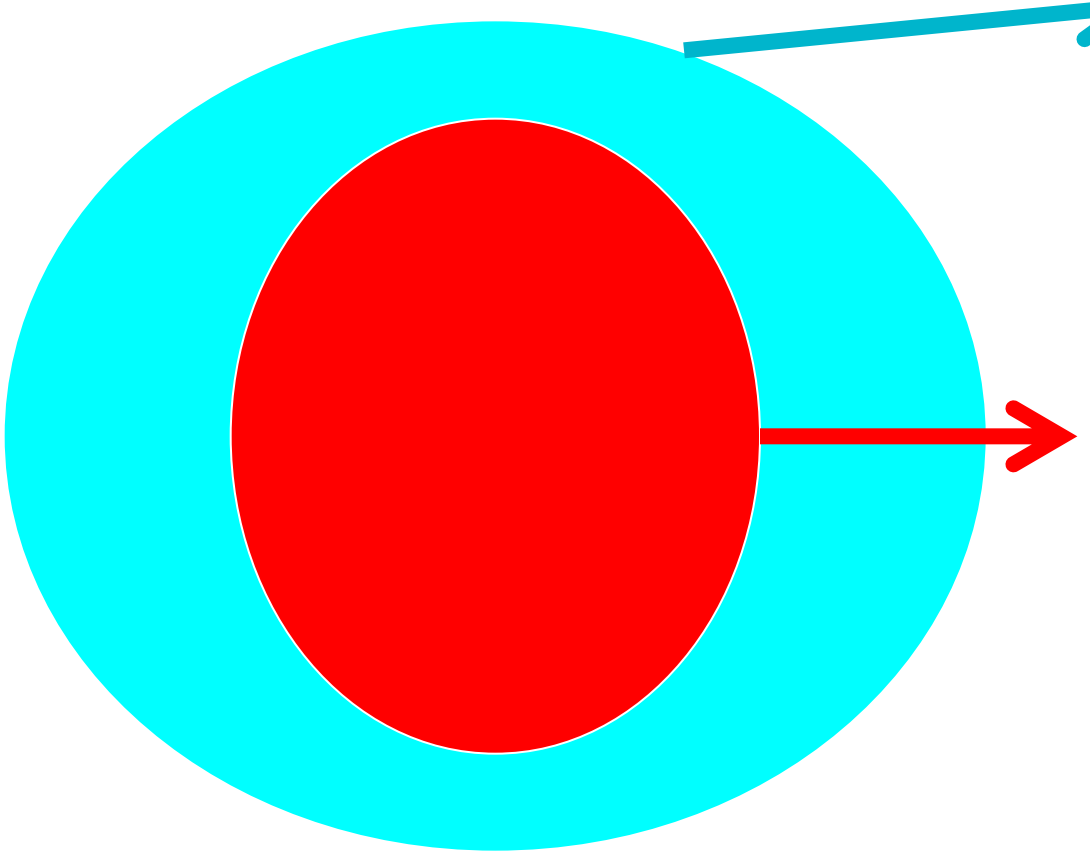

AMU team
- Frail-safe
- Specialist support

COE Direct

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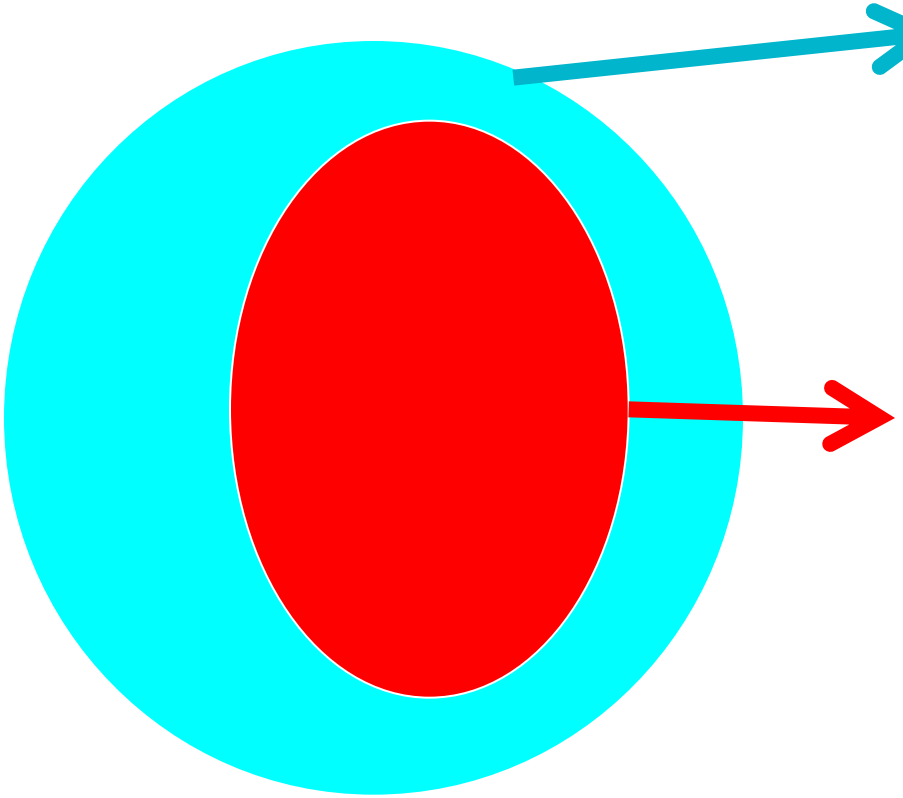
An example of a targeted approach (Birmingham & Shrewsbury)

Frailty based on 3/5 criteria (56% of over 75s were “frail”)

1. Age 75+ (Age strong predictor of frailty)
2. Fall with injury/fracture, excluding NOF (53%)
3. Evidence of dementia or delirium (29%)
4. Care home residence (28%)
5. Reduced or lack of mobility over 24h (56%)

J R Coll Physicians Edinb. 2013;43:301-8

A person-centred approach



ED / AMU (RVH)

Added value from ED / AMU / RVH

- Possible fracture
- Haemodynamically unstable
- Possible MI / Stroke

COE Direct (BCH)

<u>No added value from ED /RVH</u>

- Age over 75y
- Evidence of dementia / delirium
- Care home residence
- Off feet

<u>Exclusion Criteria</u>

MI / Stroke / ?Fractures / Haemodynamically unstable

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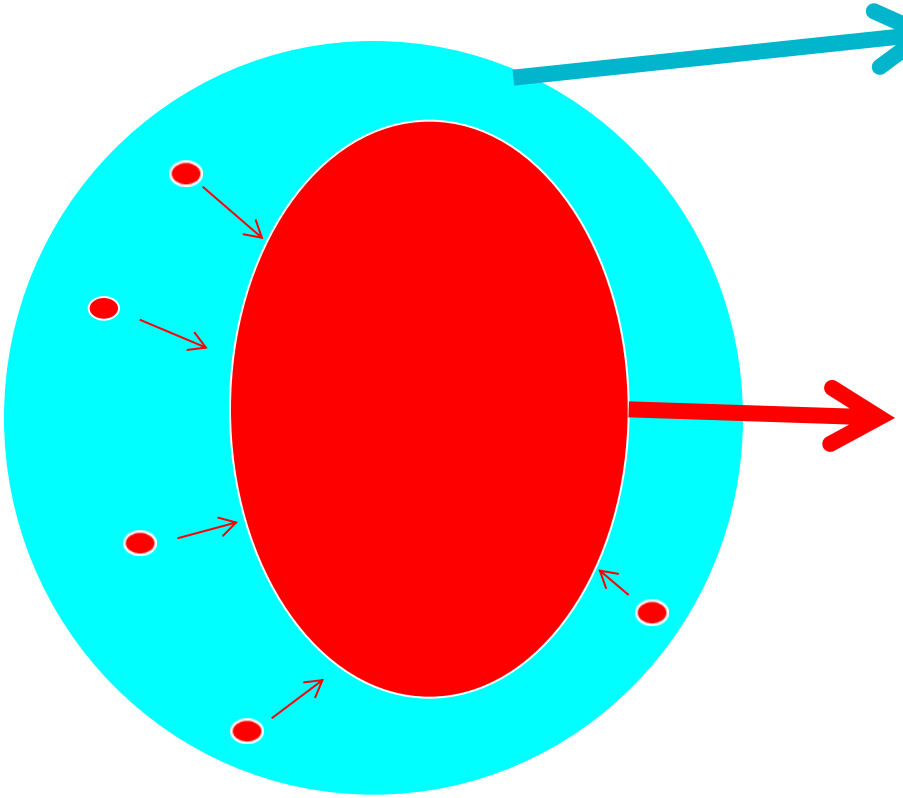
A person-centred approach



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How big should the "red blob" be?

- As big as possible (beds & staff)
- At least as big as before (~2500/ year = 6.8/day)

*Based on Jan- Sept 2013 PAS data

OPTIMAL 7

Older People's Timely Intervention, Management and Admission service on Level 7 South

OPTIMAL ACTIVITY DATA BY WEEK: 3rd March to 5th May

Week Beginning	total number of phonecalls	Redirected to A+E or advice only due to capacity reasons	Advice only including redirection to A+E/DMAU for clinical reasons	Accepted for admission	Same day discharge	Admitted following assessment
3rd March	12	0	5	7	1	6
10th March	18	4	2	12	5	7
17th March	13	0	3	10	2	6
24th march	12	3	2	7	1	6
31st March	10	0	2	8	3	5
7th April	19	0	6	13	2	11
14th April	22	0	7	15	0	15
21st April	4	0	2	2	0	2
28th April	8	0	2	6	1	5
5th May	15	1	1	13	1	12

An ambulance protocol will identify patients who should go directly to BCH

COE Direct (BCH)

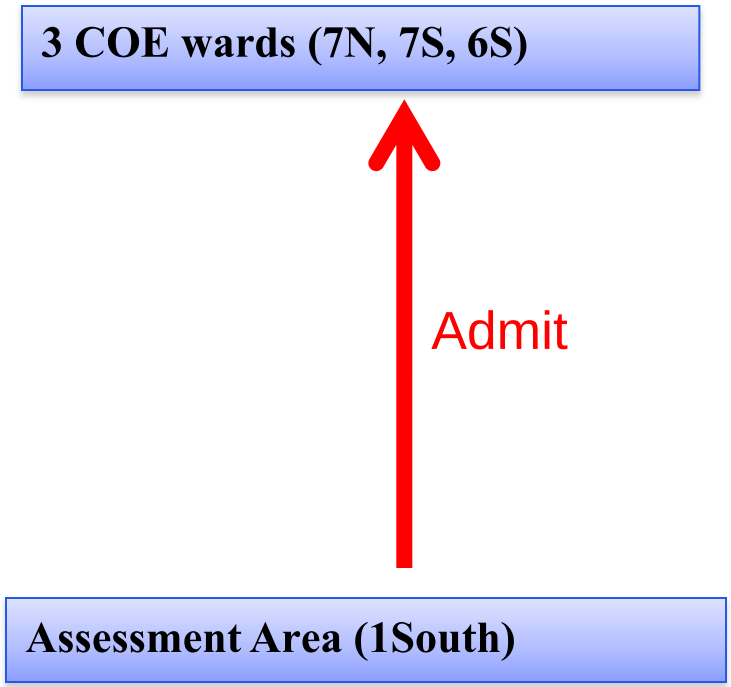
No added value from ED /RVH

- Age over 75y
- Evidence of dementia / delirium
- Care home residence
- Off feet

Exclusion Criteria

MI / Stroke / ?Fractures / Haemodynamically unstable

Potential model



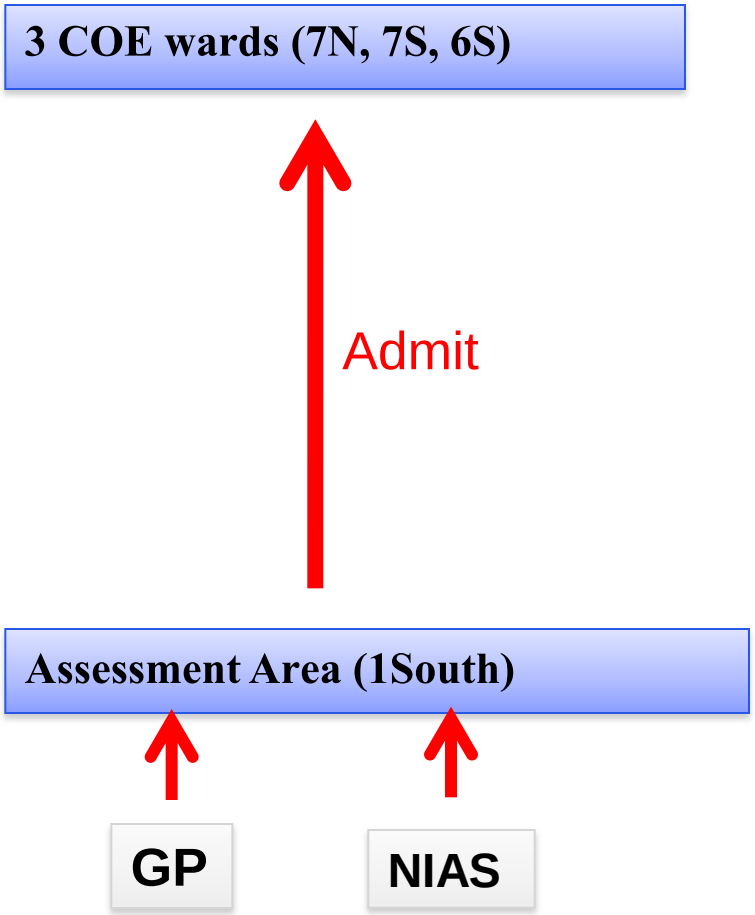
Key actions:

1.Expanded bed base from 67 to 75

- Ward 1 south move to 6S (4 extra beds)
- Assessment area to move from 7S to 1S (4 extra beds on 7S)

2.Concentration of medical resource on BCH site

BCH Age Centre



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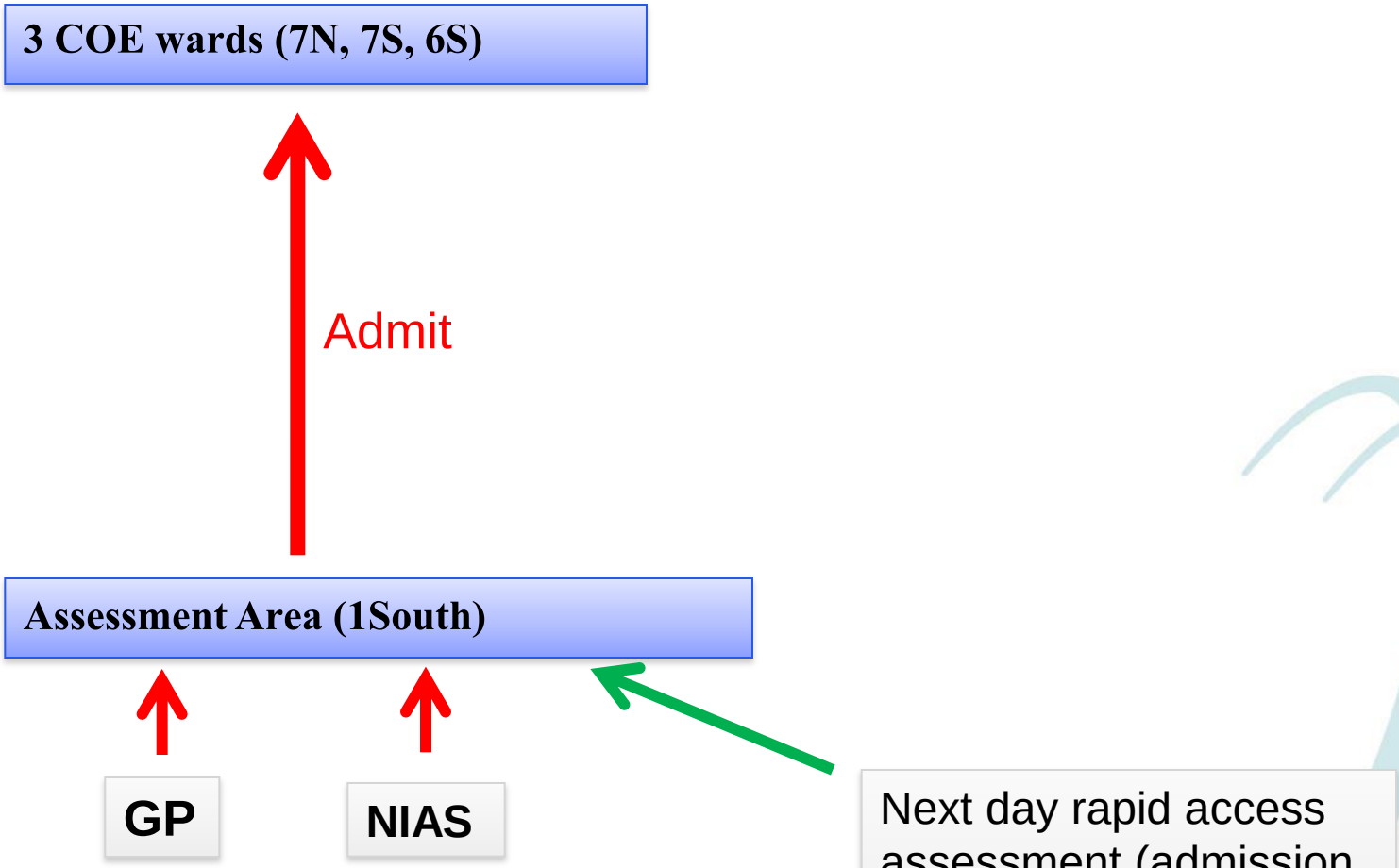

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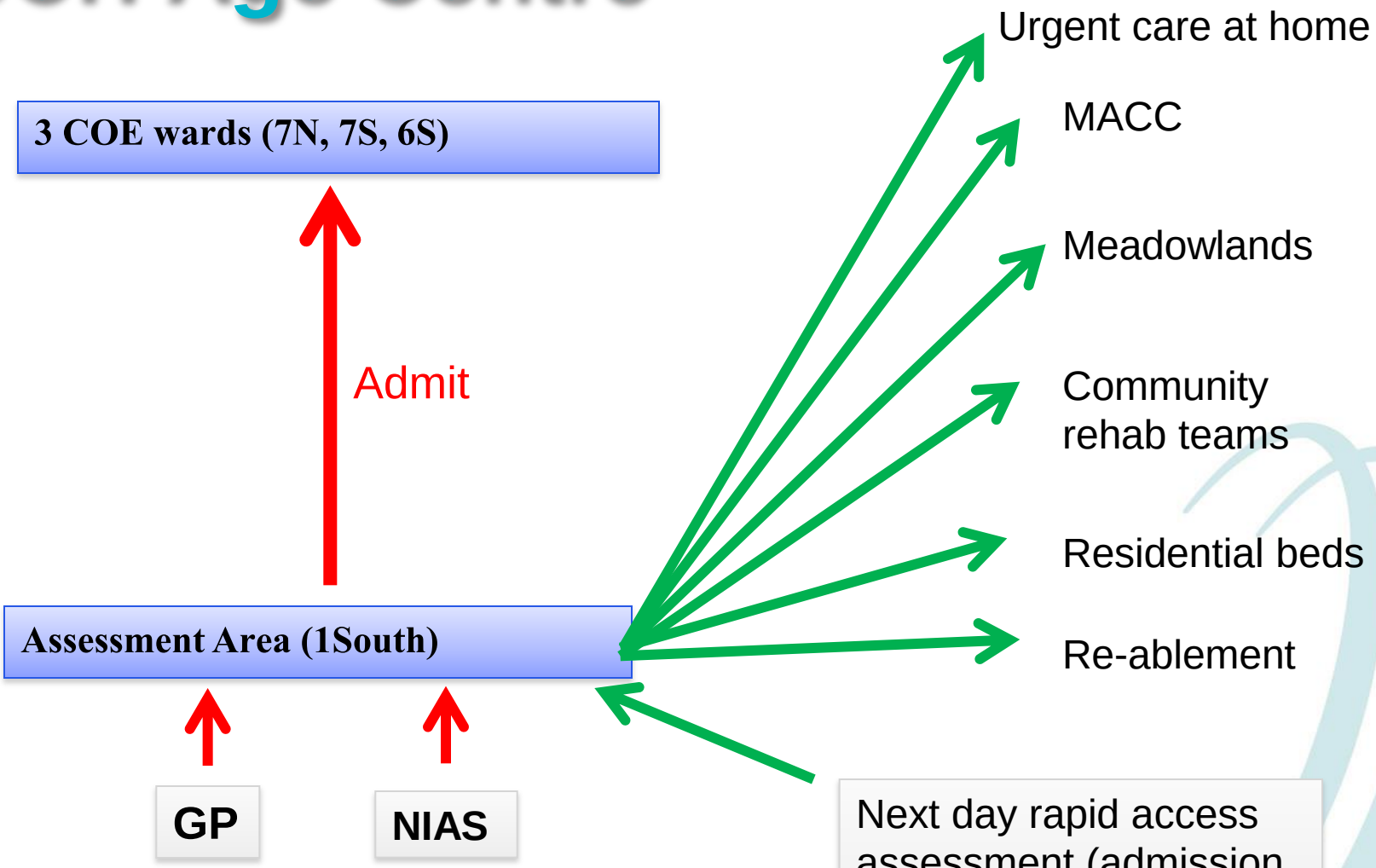
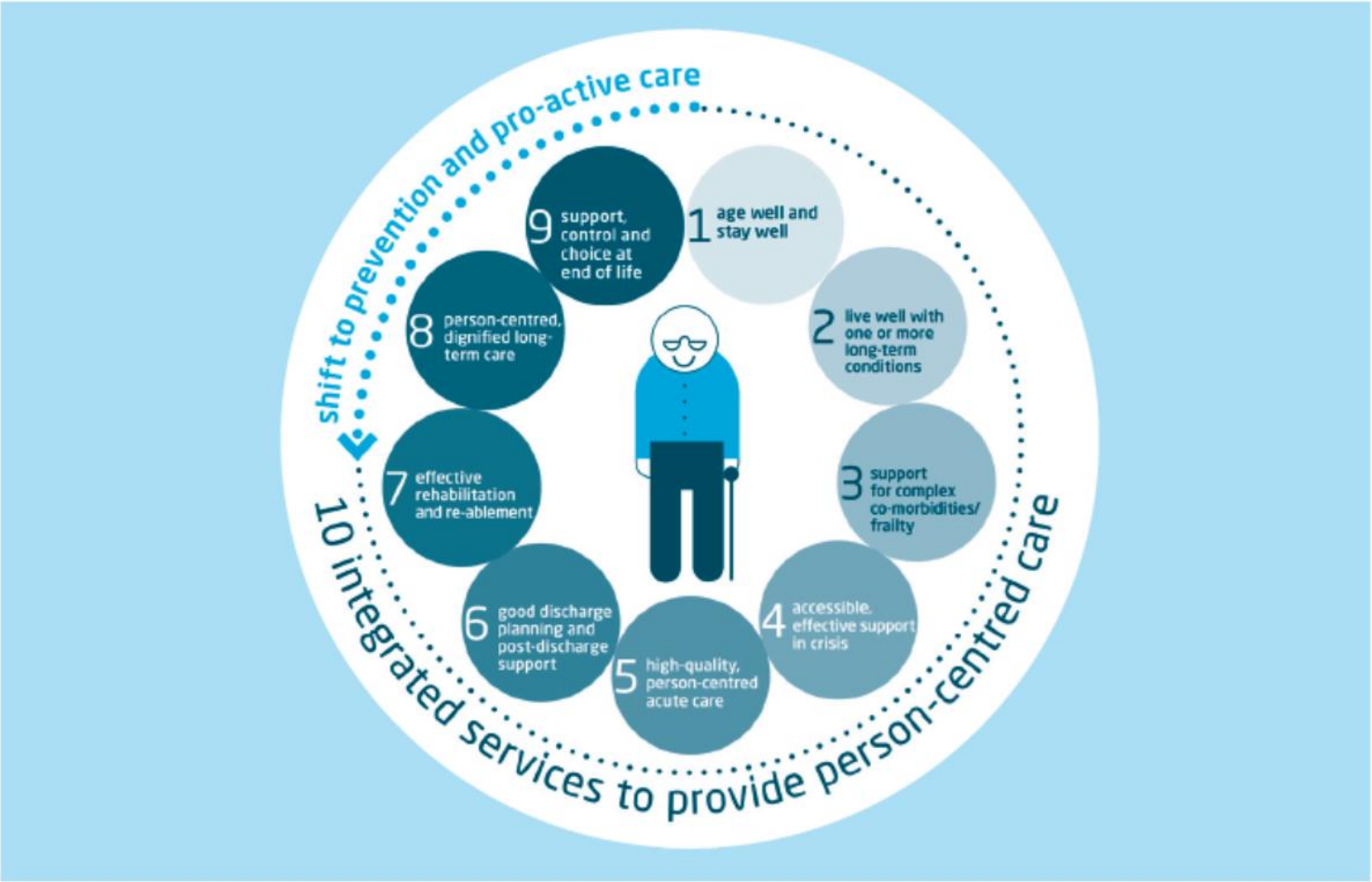


What will change…CGA / RAID

- Expansion, relocation, concentration of resources BCH site
- 24/7 service
- Enhanced GP pathway
- Direct Ambulance admissions
- Create small AFU within 1S

- Develop rapid assessment clinic function – “one stop shop”
- Re-profile MACC
- Re-profile elderly care outpatient clinics
- Develop community pathways/ resources, eg urgent care team (ICP vision) and nursing home liaison

Components of Care of Older People



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Advantages

- Improved Patient and Carer experience
- ED avoidance
- Fewer Transfers
- Fewer Interfaces
- Improved patient safety
- Improved continuity of care
- Decreased LOS
- Use of GCA according to evidence base
- Efficient use staff resources
- Improved morale
- Development other parts of elderly care pathway
- Professional “buy in”

Risks of change

- Being victims of our own success

The buckaroo phenomenon

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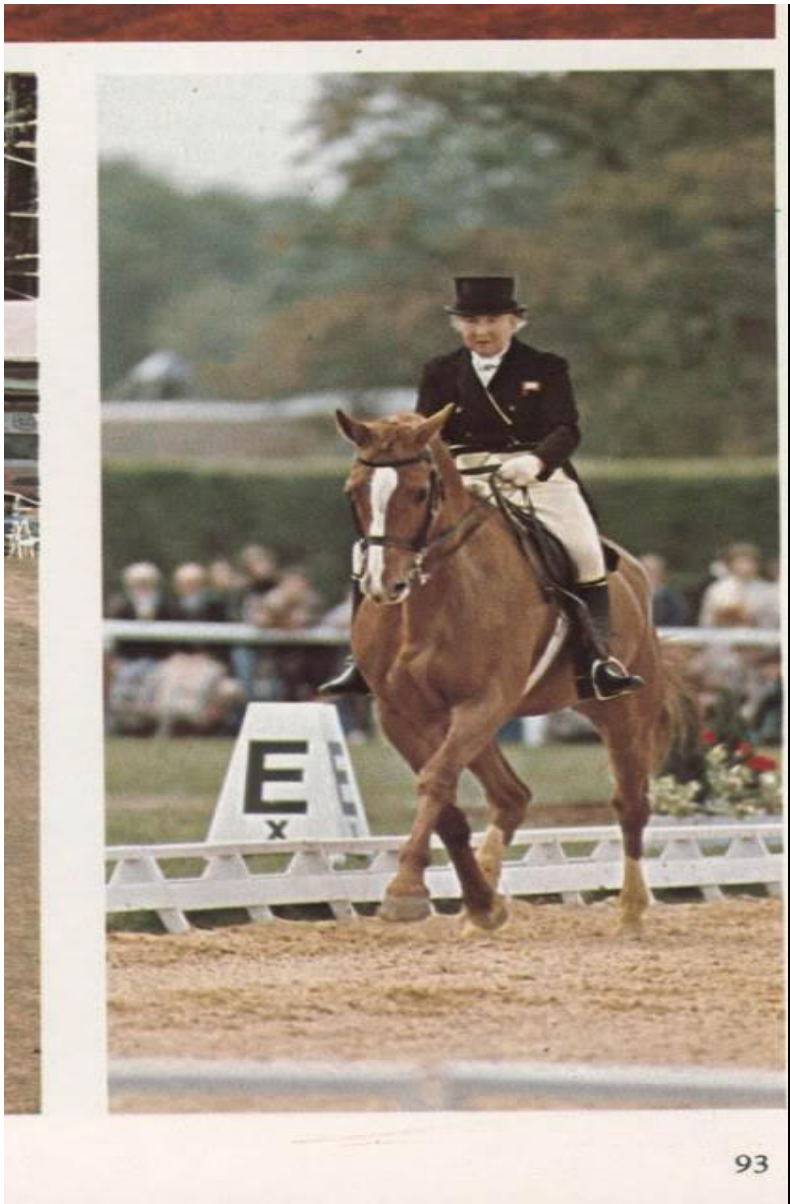

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Thank you

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