NHS Fife story....
Create the standard with consensus across NHS Scotland

Offer improvement support and clinical network for improvement and clinical innovation

Assure care Check against the standard
High resource individuals

2% of the population

Use 50% of acute hospital and community prescribing resource

And 77% of bed days
Aims
To deliver the highest quality healthcare services to the people of Scotland

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting
Challenges

• Older people who are discharged under traditional arrangements often have sub-optimal outcomes

• Acute hospital admission may not be the best pathway for managing the older person with frailty

• Frailty therefore identified within NHS Fife as high volume patient flow priority
Victoria Hospital
Key components of Nurse Consultant role

- Expert clinical practice
- Practice/service development
- Leadership
- Education/research
- Key components
LEVEL 9 – (MORE SENIOR STAFF)
Staff with ultimate responsibility for decision-making and full on-call accountability.

LEVEL 8 – (CONSULTANT PRACTITIONERS)
Staff working at a very high level of clinical expertise and/or have responsibility for planning services.
Non-clinical examples might be, for example ‘Divisional Manager’.

LEVEL 7 – (ADVANCED PRACTITIONERS)
Experienced clinical practitioners with high level of skill and theoretical knowledge. Will make high level clinical decisions and manage own workload.
Non-clinical staff will typically be managing a number of service areas.

LEVEL 6 – (SENIOR PRACTITIONERS)
A higher degree of autonomy and responsibility than level 5 in the clinical environment.
Non-clinical staff who would be managing one or more service areas.

LEVEL 5 – (PRACTITIONERS)
Registered practitioners consolidating pre-registration experience and getting ready for a higher level of functioning.
Non-clinical examples might include Management Accountant.

LEVEL 4 – (ASSISTANT PRACTITIONERS)
Some work involving protocol based care under the supervision of a registered practitioner.
Non-clinical roles can include IT support worker and Technician.
Other developments

• Frailty screening pilot with SAS for people over 65 not conveyed to hospital
• Frailty screening pilot with Dementia Post Diagnostic Support Service
• Honorary Lecturer posts with HEI (Dundee and QMU)
Would this person benefit from Comprehensive Geriatric Assessment? If answered “Yes” to any of the following questions please refer to the Integrated Assessment Team.

1. Has the patient been admitted from a nursing or residential home?
2. Does the patient have **NEW functional** decline?
3. Dementia diagnosis or are there any concerns about memory/cognition?
4. Is the patient acutely confused, more confused than usual or more sleepy/drowsy than usual?
5. Has the patient fallen in the past 3 months or is a fall the reason for admission?
6. Does the patient attempt to walk alone although unsteady or unsafe?
7. Does the patient or their relatives have fear or anxiety re falling?

**If YES to Question 3, 4 or 5:** Complete 4AT below. THINK DELIRIUM. Initiate FALLS PATHWAY if FALLS and COGNITIVE questions positive.

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**RAPID ASSESSMENT TEST FOR DELIRIUM**

- **Total score:**
  - 0: no
  - 1: very mild
  - 2-4: moderate
  - 5-6: severe

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**4AT score**

- Possible delirium/cognitive impairment. THINK DELIRIUM = Initiate TIME out Bundle:
  - 1-3: moderate
  - 4: severe
  - 5-6: very severe
FRAILTY HUDDLE
IAT: Front door Frailty Team

• Starts at Front Door ED, Medical & Surgical assessment

• CGA + decision-making + Plan + ACTION

• Facilitating discharge direct from ED, AU1, AU2

• Liaising with Care Homes, GPs and community services including intermediate care & community hospitals

• Advance care planning, Assess to EOL care
The Journey begins……

- **April 2014**: Frailty Focus. Therapists & Nurses
- **August 2014**: Team Rebranded IAT
- **December 2014**: 5/7 Service 2 teams in 1
- **Summer 2015**: Skill mix & new roles
- **October 2015**: Introduce Extended Length of Day Service
- **January 2016**: Introduce 12 hrs shift patterns 7/7
- **Future Plans**: Independent Prescribing, Acute Medical Management

**Timeline:**
- April 2014
- August 2014
- December 2014
- Summer 2015
- October 2015
- January 2016
Meet the team....

- Team Lead Physiotherapist
- Frailty Nurse Practitioners
- Specialist Static Physiotherapists
- Specialist Static Occupational Therapists
- Rotational Band 5 Therapists
- Staff nurses specialising in Frailty
- Assistant Frailty Practitioners
IAT will deliver a 12.5 hour service from 7.00am until 7.30pm, 7 days a week, 365 days a year to all front door areas within VHK (including AU1, A&E and AU2).
Vision

To improve patient experience by promoting independence in patients presenting with frailty to all front door areas at the Victoria Hospital Kirkcaldy by providing alternative pathways rather than acute care and supporting patients as close to home as possible, using a patient centred approach. The team promptly recognises deterioration of the older adult and ensures that appropriate pathways are identified for patients who require acute hospital care.
Typical day @ Front door

- Patients screened on admission AU1/ attendance ED.
- 7.00am triage begins of all patients with positive screen and prioritisation system followed.
- IAT board round – tasks allocated according to skill mix.
- Team assesses priority patients.
- 11.00am Frailty Huddle – real time case conference and pathway determined and whole MDT aware.
- IAT activity continues, ED and GP Assessment phone with additional referrals and dedicated 30min response time.
- 2.30pm Frailty Huddle – further MDT discussions and pathway decisions made with re: prioritisation of IAT caseload.
Frailty @ Front door Pathway

- Frailty Screening at point of access to Acute Care
  - AU1
  - ED
  - AU2

- Triaged by IAT
  - 7.00am
  - Telephone calls referrals throughout 12 hour period.

- Frailty Huddle @ 11.00hrs & 14.30hrs
  - Real-time MDT/Case Conference with access to:
    - Geriatrician of the day (GOD)
    - Older Peoples Nurse Consultant
    - Proactive Pharmacy Team
    - Discharge Hub
    - MOE liaison

- Patients Needs can be supported in alternative to acute care
  - H@H
  - ICASS
  - Supported discharge service
  - Discharge to Assess
  - Community Beds

- Patient Needs Acute Hospital Care
  - Admit MOE
  - Or Specialist Bed

- Patients Needs can be supported in alternative to acute care
## Skill sharing & Frailty Assessment

**NHS Fife Operating Division**

**Therapy Competencies for Integrated Assessment Team Nurses**

<table>
<thead>
<tr>
<th>Competency</th>
<th>Support and Learning</th>
<th>Suggested Evidence</th>
<th>Therapists Signature and date achieved</th>
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<tbody>
<tr>
<td>1. Understanding &amp; ability to assess ROM</td>
<td>Teaching session with physiotherapist, joint assessment with physiotherapist</td>
<td>Ability to demonstrate, identify when would need referred back to team therapist for specialist assessment.</td>
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<td>2. Understanding &amp; ability to complete basic strength assessment (Oxford Gait)</td>
<td>Teaching session with physiotherapist, joint assessment with physiotherapist</td>
<td>Ability to demonstrate, identify when would need referred back to team therapist for specialist assessment.</td>
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<td>3. Mobility Assessment (able to assess &amp; describe mobility, gait, ex tolerance, walking aid, etc)</td>
<td>Joint assessment with physiotherapist, discussion with team.</td>
<td>Demonstrate in practice.</td>
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<td>5. Ability to check safety of frames, stretchers &amp; sticks</td>
<td>Teaching session with physiotherapist</td>
<td>Ability to demonstrate: Safe provision of walking aids, Safety check of equipment.</td>
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<td>6. Ability to dose and educate in the safe use of existing equipment (Frames, stretchers, sticks)</td>
<td>Teaching session with physiotherapist</td>
<td>Ability to demonstrate to physiotherapist provision of aids.</td>
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**Integrated Assessment Team**

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<th>Functional Changes</th>
<th>Summary</th>
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**Identified Issues/Functional Changes/Summary**

- Fat
- Polypharmacy
- Pressure Sores
- Incontinence

**Pathway/Assessment to be Followed**

- Falls
- Delirium
- Cognitive impairment

**Medication (polyphtahmy) review**

- Conference - Nursing Staff should ensure basic conference assessment and advice given on ward and refer to DN or discharge if follow required.

**Predicted Length of Stay**

- >48hrs
- ≤48hrs

**Recommendation** (predicted destination of care):

- Admit to Admissions Unit!
- Admit to MOC In-patient Bed
- Admit to single specialty in-patient bed
- Refer to ICAAS (HC/HH) - specify service/ team
- Discharge Home/Discharged with IAT follow up
- Outpatient / Day Hospital follow up - specify

**Signed**

**Print**

**Date**

**Time Completed**

October 2014
Successes

1. Rapid Response from dedicated Frailty team.
2. Twice daily huddles and access across acute/community interface.
3. Extended length of service with AHP working 12.5 hrs shifts.
4. Frailty screening within A&E.
5. Development of new AFP roles.

Future developments

1. Fully integrated 7 day service with equity of service and pathways at weekends.
2. Education for all staff in designated areas in frailty and pathways.
3. Liaison service for front door areas for patients, carers and staff
4. Integration of team into AU2.
5. Enable frailty friendly environments within front door areas
“Very friendly”

“I felt safe and understood”

“Made me feel at ease”

“I arrived in a state of panic but soon felt calm”

“Staff were very helpful and kind which makes it more hopeful for the future for us golden oldies”

“I feel positive about my future as everything has been better explained to me and I’m going home with ongoing treatment from hospital at home”
Winter capacity ward

Four seasons ward?

Front Door Discharge Support Model - Process

Nursing staff in Emergency Department and Admissions Unit 1 complete Frailty screening

Patient is Frailty Positive

Colour Key
- Completed by NHS Fife Staff
- Decision
- Completed by Avenue Staff

Integrated Assessment to Avenue Staff

Basic information including possible services required

Frailty assessment documented to Avenue Staff

Cost comparison results

Table 1 below displays the total costs of the support for discharge package versus the potential hospital stay costs avoided for this patient group.

The total cost of the support for discharge Package for 87 patients over the 10 week duration is £17,816. The potential resource savings from the avoided hospital admissions for these patients equates to £283,360. The overall potential resource saving as a result of the Support for Discharge Package is estimated to be £265,544.

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AU1 Average LoS (hrs) 65+ who were transferred to MOE

Frailty huddle Apr 15
Average hospital LoS for patients discharged from MOE
Discharged to Community Hospital step down

Frailty Huddle April 15
AU1 Number of patients and LoS >48 hours for >65 year olds

Frailty huddle Apr 15
It doesn’t matter how many resources you have...

If you don’t know how to use them, it will never be enough.