

STANDARD 2
TIME TO FIRST
CONSULTANT
REVIEW

STANDARD 3
MULTI-
DISCIPLINARY
TEAM REVIEW

STANDARD 9
TRANSFER TO
COMMUNITY,
PRIMARY &
SOCIAL CARE



NHS
England

SEVEN DAY SERVICES CASE STUDY

OCTOBER 2015

Ashford and St. Peter's Hospitals NHS Foundation Trust

Improving access to consultant delivered care to avoid readmission of older people to hospital

AT A GLANCE:

- Ashford and St. Peter's Hospital NHS Foundation Trust set up an interdisciplinary seven day Older People Assessment and Liaison Service (OPALS) in October 2013 in response to high readmission rates for elderly people and fragmentation in care delivery at St. Peter's Hospital.
- This seven day interdisciplinary team, based on the medical assessment unit, assesses all older people potentially to be admitted to hospital and develops a plan for potential transfer to the most appropriate place to meet the person's needs within the community or hospital.
- As a result there have been significant reductions in readmissions to hospital from 21.7% in 2013 to 15% in 2014 as well as a reduction in length of stay from 10.1 to 9.1 days.
- Quality and experience of care has improved as a result of improvements in times to see a consultant geriatrician from 25% to 100% at night and by day patients seen within two hours of admission has improved from 0 to 77%.

Ashford and St. Peter's Hospital NHS Foundation Trust set up a seven day Older Peoples Assessment and Liaison (OPAL) service in October 2013, as they were unable to secure estates for a frailty unit and there was evidence of fragmented care delivery on wards coupled with high admission rates.

How the improvements were made

The OPAL team was initially piloted in October 2013 for six months using a dedicated multi-disciplinary resource with all members having expertise in the care of older people. The seven day team includes 1.4 whole time equivalent (WTE) consultant geriatricians, 1 WTE nurse, physiotherapist and occupational therapist, pharmacist, all at band seven, and 1 WTE Band six dietician.

The consultant geriatrician is supported by an SHO for eight hours per day seven days a week. The service is funded at an approximate cost of £12,172.

Baseline data was collected prior to set up and included age, condition, and length of stay and readmission rates for elderly patients. There were also a range of process measures including data in relation to consultant assessment and documentation of plans, falls, dementia, and incontinence as well as patient and carer involvement and satisfaction measures.

Following successful piloting of the service and evidencing of the impact of the delivery model, the service was fully funded at an annual cost of £776,800 (which includes consultant geriatrician, senior house officer, nurse, pharmacy, dietician and therapy staff cover seven days a week, eight hours a day).

Findings from the pilot and patient feedback to staff provided continuous improvement for the operation and system management of the service.

What was achieved?

- The OPAL team is based in the Medical Assessment Unit at St. Peters Hospital, has a constant presence in the emergency department (ED) and also provides follow-up care in the medical short stay unit. The team work eight hours a day and sees all patients over the age of 85 years of age and those patients over the age of 75 who have three or more frailty triggers.
- All patients are screened by an OPAL nurse or therapist using a Frailty Syndrome Assessment, in the ED or medical assessment unit and if they are identified as frail and need medical assessment they are managed by the service.
- All patients referred to OPAL team have a comprehensive geriatric assessment, which involves the key health and social care professionals known to the patient, family carers and the patient themselves. This assessment then informs care planning for patients during their admission and also supports plans for transfers of care. On leaving hospital, patients have access to telephone support from the OPAL team.

Table 1: Improvements as a result of implementation of OPAL team during pilot

Function	Baseline	Post pilot
Comprehensive assessment	12.5%	18.4%
Falls risk assessment	29%	75%
Core care plan	29%	88%
Medication review	43%	87%
OT review	0%	62.5%
PT review	14%	100%
Dementia diagnosis	50%	89%

What was the impact?

Between October 2013 and November 2014, the OPAL team received over 2,600 referrals (average of 220 per month). After operating for six months the team was able to demonstrate:

- Significantly fewer patients converted from MAU to ward admission. This had reduced from 90% to 81% and for last three months has gone down to 75%.
- Reduction in readmissions from hospital from 21.7% in 2013 to 15% in 2014 (although may not have been as a direct result of the OPAL team).
- Length of hospital stay has reduced from 10.1 to 9.1 days.
- Geriatric assessment has improved from 25% to 100% at night and from 0% to 77% within two hours during day time hours, as well as general evidenced improvements reviews and management from baseline seen in table 1 (below).

Patient and carer satisfaction has also improved with 100% of relatives/carers feeling involved with their relatives care planning and discharge plan. 94% of patients felt involved with their care planning and discharge plan 100% of patients felt a follow up call reassuring and supportive. The Friends and Family Test shows that 90% of patients are extremely likely or likely to recommend the service.

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TOP TIPS

- **Clinical leadership and patient centeredness was a critical success factor.**
- **Plan data collection measures for baseline to evaluation of impact of service and securing resources.**
- **Use feedback loops to help to resolve any teething problems and to make continuous improvements in practice. Engage early with partners across community, social care and care home to get buy in to support the smooth transition of care for patients.**