Surrey and Sussex NHS
Healthcare NHS Trust

Pendleton Unit – Frailty Model

Alison James
Associate Director of Operations
Medicine
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An Associated University Hospital of Brighton and Sussex Medical School

Background

- East Surrey **population is expected to grow** by 11% over 10 years (vs. 8% average). Over 65s to grow by 21% and **over 85s by 40%**.
- Aged 75+ are the **most intensive users** of healthcare services
- Currently SaSH health economy spends **in excess of £40m** on acute care for the over 75 population
- **Frailty Unit** is part of East Surrey transformational integration of health and social care, for assessment, diagnosis, observation, triage to treatment and rehab services for frail patients
- Currently frail, elderly patients can find **their needs are not met** in hospital; HCPs not trained in geriatric medicine can find these patients challenging
- **Co-location** of the entire specialist, medical, nursing and therapy team within one place provides a rapid assessment and intervention for older people, **appropriately divert them when they arrive at hospital and intervene as early as possible** to avoid lengthy hospital stays

The Frailty Model

- Working in collaboration with East Surrey CCG and local CCGs and GPs a new model of care for frail elderly patients has been designed.
- Design of model is based on a multi-disciplinary team approach with a service that is consultant led, community facing and will have close working links with discharge and community based services to ensure speedy turnaround
- Aim for the assessment, diagnosis, observation, triage, treatment and rehabilitation services for the patients to be supported with rapid discharge and prevention of unnecessary admission.
- Purpose to intervene early to assess and treat frail elderly earlier in the pathway than currently to improve outcomes and patient experience.

What is the Pendleton Unit?

- A new unit dedicated to treating the increasing number of frail and elderly patients that the hospital is seeing. Built within the entrance to Bletchingley and Hazelwood wards.
- The Frailty Unit is Consultant led, staffed by a dedicated team of doctors, nurses, Social Care and therapists with the aim to reduce the number of unplanned admissions by quickly assessing patients, treating them and getting them back into their own homes as soon as possible.
- By working with GPs, social workers, community-based services, carers and patients' families, the Unit provides the care that is needed whilst avoiding any unnecessary hospital stays for patients. Most patients will be directly referred by GPs and from the Emergency Department. The Voluntary Sector will prove invaluable going forward in supporting patients back home following discharge from the unit.
- Patients are identified for the Frailty Unit using the Rockwood Frailty index, stratifying patients according to their level of functional ability and presentation, targeting those scoring 5-7 on the tool.

What will this mean for the patient?

Keeping people independent at home longer

- Maximising medical and social care support
- Multidisciplinary team including voluntary sector support
- Supporting carers
- Working towards seven day support

Admitting people to hospital only when necessary

- Maximising urgent medical, social and voluntary care support in the community

Better support for patients with long term complex needs

- Bringing together hospital and community teams to support the patient
- Co-ordinating hospital and community knowledge and risk assessment with rapid access to diagnostics and specialist advice
- Improved case management for patients to prevent future recurrence or deterioration

Advantages of the Frailty Unit

- Improved Patient and Carer experience with rapid support close to home
- ED avoidance and rapid access to diagnostics
- Fewer Transfers and Interfaces
- Improved patient safety
- Good discharge planning and post-discharge support
- Better integrated approach to care with true co-located MDT approach – reducing duplication of assessments and improved relationships between care providers
- Decreased LOS, with fewer patients admitted and those who are admitted being captured by community teams and pulled through the acute sector quicker
- Efficient use of staff resources with instant access to specialist advice
- Improved morale for staff working within this dedicated unit
- Improved support for patients will lessen the burden on carers, reducing the likehood of the patient deteriorating to crisis point and increasing the carers workload
- Supporting development of other parts of the elderly care pathway
- Delivery of a service with direct ambulance admissions and a rapid assessment clinic function - “one-stop shop”

Pendleton Unit

The Pendleton Unit

- 5 bedded assessment area, 2 clinics rooms and a waiting area.
- Opened on 3rd October 2016 initially 9-5pm Monday to Friday with aim to move to 7 day service 8am to 8pm once fully recruited to.
- Staffing for Pendleton – geriatricians, therapists, nursing staff and administrators who all have a keen interest and skills in managing the treatment of the frail elderly
- Input also from social care and voluntary sector.
- Hot clinic appointments created to support prevention of admission and early review.
- KPIs developed with our local CCGs which we will measure against monthly

Review of first two weeks

- Opened Unit on 3rd October
- Over first two weeks 38 patients have been seen in the Unit
- Of all the patients through the unit only 1 required admitting to a care of the elderly bed for further investigation and 2 required overnight stay in the discharge unit.
- Of the 35 other patients it was felt that 80% of them would have had at least an overnight admission prior to the opening of the Pendleton Unit.

Jack's story