FRAILTY FRONT DOOR of ROYAL SHREWSBURY HOSPITAL

This project involves the formation of a dedicated integrated acute and community MDT 'frailty team' based in RSH at the Front Door (ED/AEC/CDU/AMU) who are responsible for the early identification, treatment and risk assessment and planning for frail patients. This improvement will facilitate appropriate triage of patients to either the acute /community /home setting.

It is intended that this team will liaise and work with existing teams in the community such as ICS/ICT, Care Co-ordinators etc. Clinicians and services will operate flexible working to in-reach and outreach in line with the agreed model to meet the needs of the patient. DAART may be a key focus for this process in terms of linking into existing acute frailty expertise, resources and skills. DAART and AMU at SaTH will be part of the process to highlight improvements and integrated working within the front door model.

The necessary resource to deliver the next phase of the model's development will be through a combination of new non-recurrent investment and utilisation of existing resources from all providers.

It is intended that this project will lead to tangible patient and system wide benefits in terms of:

- Improve processes and joint working in SATH and with the community to reduce avoidable admissions and reduced length of stay for frail patients
- Improve staff competence and confidence managing patients with Frailty and hence better patient experience
- More appropriate and effective triage at front door which identifies right care, right place and treatment for patient and better use of existing ambulatory pathways.
- Optimal deployment and delivery of the current staff skill mix to effectively meet the needs of frail older patients.
- Reduce conversion of A+E attendances to admission and readmission rates
- More patients having the opportunity to maintain their independence.
- Reduce the number of acquired complications from prolonged stays in acute setting.
- Reduced acute bed occupancy
- Reduced delayed transfers of care
- Reduced dependency on long term residential placements and large package of care
- Improve SATH performance against the 4 hour A&E standard
- Reduce demand on SATH to support the delivery of the Winter Plan Acute Bed Gap Bridging Plan

It is intended that the formal evaluation of the project will deliver an assessment of where in the Local Health and Social Care Economy benefits are accrued and costs incurred and by whom to form the basis on which any changes to current contractual arrangements and financial flows will be made and by when.

PERIOD OF OPERATION

A 5-month period from November 2017 to March 2018 has been agreed.

PRINCIPLES OF COLLABORATION

A Memorandum of Understanding been agreed which is designed to provide a clear commitment to a single vision and collaborative working for Shropshire and Telford & Wrekin Clinical Commissioning Groups, Shropshire County Council, Telford & Wrekin Borough

Council, Shrewsbury & Telford Hospitals NHS Trust and Shropshire Community Health NHS Trust.

In order to maximise the success of this collaborative model of working, these partners have agreed to deliver on the following commitments:

1) Deliver the actions within the implementation plan, both in terms of leading actions where appropriate and supporting the action leads and clinicians to develop and deliver whole system ownership of the model and its supporting systems and processes.

2) Ensure timely access and transparency of agreed monitoring and evaluation data set relating to services, activity and budgets.

3) Develop and use a common understanding and language which is understood by partners.

4) Develop ways of working which promote trust and respect for the work of partners.

5) Ensure objectivity and fairness: Doing what is best for the patient.

6) Support and enable at operational level an acceptance of challenge to the status quo to inform operational improvements and a tolerance of a degree of uncertainty as system and practice evolves in real time in light of the PDSA learning approach.

7) Recognise that this model is across the health and social care economy and therefore the benefits need to be felt by all partners. Ensuring clarity of anticipated benefits – and monitoring whether these are achieved.

8) Provide clarity of risk and mitigation: Recognising the risk to respective organisations.

9) Maximise value for money across the system as a whole.

10) Ensure clarity of benefits across the system and monitoring whether this is achieved.

11) Align SaTH workstreams with Acute Frailty Network support to develop the frailty model utilising agreed measurement and PDSA tools.

12) Identify workforce capacity and skills gap.

COMMISSIONING AND FINANCIAL RESPONSIBILITIES

The CCGs will provide Executive and Project Management leadership to the project.

The CCGs will provide a non-recurrent investment of £194,928 for the period 1st November 2017 to March 2018. This non-recurrent investment is based on an early November relaunch date for phase 2 implementation.

SPG Lead
Colin Kelcey doctor.kelcey@icloud.com