

Moving healthcare closer to home case studies: Improving acute pathways

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Older Persons Assessment and Liaison team: Ashford and St Peter's Hospitals NHS Foundation Trust

The Older Persons Assessment and Liaison (OPAL) team provides early comprehensive geriatric assessment (CGA) in the acute hospital to prevent avoidable admissions to inpatient wards and remove barriers that can lead to longer stays for older patients. Important features of the service are senior clinical leadership and working with partners.

Ashford and St Peter's Hospitals NHS Foundation Trust is a multi-site acute trust operating across Surrey; it serves a population of more than 380,000. St Peter's Hospital offers a full A&E service with all major specialties, including major trauma and resuscitation, while Ashford Hospital has a walk-in centre for non-urgent care and a range of medical and day-surgery services.

Aims

The OPAL team is a multidisciplinary, multi-agency team of geriatricians, nurses and therapists operating in St Peter's Hospital. Rather than providing care for patients in alternative settings, the OPAL team aims to improve the quality of care in the acute hospital for frail older patients with complex conditions to support the trust in meeting its operational objectives.

Characteristics

- aims to improve in hospital pathways for frail older patients
- staffed by a multidisciplinary team
- 7-day service

The service aims to:

- appropriately divert patients when they arrive at hospital
- intervene as early as possible to prevent lengthy hospital stays.

Origins

The OPAL service was set up in October 2013 when the trust identified high pressure on its inpatient emergency services and began to engage closely with the local community care provider, Virgin Care, to consider different ways of working.

Their top priorities were to:

- help meet the four-hour A&E target
- improve the emergency care pathway
- help ensure the efficient and safe discharge of patients from hospital into the community.

The scheme does not have an explicit aim to close beds or reduce workforce commitments.

They identified older patients as a target group partly because once admitted to hospital, older people frequently stay longer and are more likely to be readmitted.

The trust's chief nurse was tasked with developing a care model to meet the challenge outlined by the 'Silver Book' – providing specialist time and resource at the start of an older person's episode.

'Silver Book' quality care for older people with urgent and emergency care needs

The 'Silver Book', published by the British Geriatric Society,¹ sets a challenge for trusts to prevent hospital admissions, reduce length of stay and facilitate earlier and safe discharge.

It suggests four elements for a new model of care:

- **a frailty syndrome assessment** on initial assessment in the medical admissions unit (MAU) or A&E following referral to the medical team
- **a frailty unit** located in bays on existing wards
- **an older persons assessment and liaison team**
- **comprehensive geriatric assessment (CGA).**

OPAL supports wider hospital staff in conducting frailty syndrome assessments and CGAs. The trust did not create a frailty unit because of estate constraints.

Structure

Dedicated resource, multidisciplinary team The team members are all experienced in the care of older people and work solely in the OPAL team.

Acute-based The team is based and mainly operates in the MAU of St Peter's Hospital, and also provides follow-up in the medical short-stay unit. It has recently started maintaining a constant presence in A&E. The scheme does not provide care to the patient in alternative settings.

7-day service The team operates seven days a week between 8am and 6pm. Consultants work from 8am until 4pm.

¹ www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

Staffing

- consultant geriatricians
- clinical nurse lead
- senior nurse
- clinical nurse
- physiotherapists
- therapy assistant
- dietician
- pharmacist
- in-reach community nurse

Enabler: strong leadership from geriatricians

The trust identified the importance of leadership by consultant geriatricians to the success of the scheme. The consultants have also adopted flexible working patterns to enable the delivery of the service.

Patients are sent home before they have fully returned to their clinical baseline with plans in place for continued care from community nursing and to address social and mental health issues. OPAL can identify additional components to care that will address patients' overall needs and help prevent readmission.

Working with partners to implement care planning The team works closely with care homes and residential homes, and refers patients to support services to minimise their risk of readmission. It also develops care plans to help primary and social care teams support patients. The service aims to prevent readmissions by using the OPAL team's specialist skills to support community colleagues.

How patients benefit

Patients are referred to OPAL if they are identified as frail. All patients over the age of 85 are automatically referred to OPAL. All patients aged between 75 and 85 are screened by an OPAL nurse or therapist using a frailty syndrome assessment in A&E or MAU, and if they are identified as frail and need medical assessment are referred to OPAL. Patients under 75 are not eligible.

CGAs are carried out with an OPAL team geriatrician. All patients referred to OPAL have a CGA, which informs the care they receive while in hospital and supports safe and effective discharge planning from the beginning of the patient's acute episode. The process involves relatives, carers and other health and social care professionals known to the patient.

Patients either remain in the MAU with clinical responsibility held by the OPAL consultant or are transferred to a specialty bed within the acute hospital.

Enabler: engagement with community and social care partners

The scheme has engaged closely with partners from community, social care and care homes. They have worked together to design the service and develop systems for the smooth transition of care.

The community provider, Virgin Care, also provides a community in-reach nurse as part of the OPAL project team. Their role is to facilitate and expedite the discharge of patients into community services.

Enablers: clear objectives and key performance indicators

It is critical to have clear objectives that hold the scheme to account.

The trust found that it was beneficial to carry out a baseline audit and set key performance indicators (KPIs). However, it suggested that future projects should have these in place before implementing service redesigns.

The process of developing KPIs should involve the whole project team, including clinical leads.

OPAL provides dedicated post-discharge support. On discharge, patients and relatives are given access to a dedicated telephone support line. This allows patients to contact clinicians who understand their needs and with whom they have developed a relationship.

The OPAL team supports other hospital-based admissions avoidance initiatives. When referring patients, GPs can get advice from nurse navigators, and OPAL clinicians feed in specific guidance on the needs of older patients. The OPAL team does not provide a dedicated advice line for referring GPs,

as this would require significant additional resources.

Challenges

Funding arrangements restricting service flexibility

The business case for establishing the OPAL service was part of a whole-system patient reablement model and was predicated on investment from the clinical commissioning group (CCG). Its design was therefore restricted due to parameters established by the CCG, which was not involved in creating the OPAL project.

Staffing

OPAL has struggled to maintain the long-term staff needed to operate consistently. Posts have been vacant for significant periods, and bank and locum staff have been needed to limit negative impacts on the service.

Senior clinical buy-in

The trust's executive team supports the OPAL project, but there was little engagement and support from senior clinicians when it was established. As a result, it was difficult to drive through service change.

Impact

In its first year of operation, from October 2013 to November 2014, over 2,600 patients were referred to OPAL – around 220 patients a month.² The introduction of the team has coincided with improvements in a range of trust operational metrics.

In its first six months (October 2013 to April 2014) there were improvements in performance indicators for the target cohort of patients (aged 85 or over). These included:³

- an increase in the number of patients being discharged directly from the MAU, with admission to inpatient wards falling from 90% to 81%
- a reduction in the length of stay for patients admitted via the MAU by one day from 10.1 to 9.1 days
- a reduction in the percentage of patients readmitted within 30 days, dropping by almost a quarter from 20.7% to 15.3%
- a reduction in the crude mortality rate for the patient cohort from 11.1% to 10.8%.

More information

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OPAL

Ashford and St Peter's Hospitals NHS Foundation Trust

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Annex: Patient story

Mr J is 92 years old. He lives alone following the death of his wife and takes medications to manage pre-existing medical conditions including heart failure and diabetes. After a fall, despite no obvious injuries, Mr J was taken to A&E because of ambulance crew concerns that he was confused and unable to manage at home.

On arrival a member of the OPAL team identified Mr J as requiring a comprehensive geriatric assessment, which was completed with him and by telephone with his daughter. The assessment identified that he had an underlying cognitive impairment and chronic pain in his right foot. These were affecting his ability to manage his medication, make meals and get around independently.

² Source: ASPH OPAL team database.

³ Abstract book; British Geriatrics Society Autumn Scientific Conference 2014.

The OPAL pharmacist came to speak to Mr J about his medication and arranged a dosette box. The nurse initiated the reablement service to support him at home. The geriatrician ruled out an acute illness or injury from the fall; advised on suitable analgesia for his chronic pain and requested that his GP refer him to the memory clinic. The physiotherapist issued Mr J with a stick to improve his stability and arranged an urgent community falls assessment.

This thorough and prompt assessment enabled Mr J to return home that afternoon and gave him and his daughter confidence in future support. His daughter contacted the team a couple of days later to advise that he was well at home and getting on very well with the carers from the reablement service.

Rapid Assessment Interface and Discharge (RAID) Service: Birmingham and Solihull Mental Health NHS Foundation Trust

The Rapid Assessment Interface and Discharge (RAID) team provides an in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay associated with mental illness as a co-morbidity to physical conditions. Important features of the service are a rapid response and 24-hour, seven-day service.

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental healthcare to over 1 million people. It offers inpatient, community and specialist mental health services including rehabilitation, home treatment, community mental health services, assertive outreach, early intervention, inpatient services, day services and mental health wellbeing services.

Aims

The service provides rapid response assessment and management of mental health conditions for patients attending hospital due to physical health conditions. RAID is based in the A&E departments of five acute hospitals as an in-reach service.

The RAID team aims to:

- improve outcomes for patients with mental health conditions receiving acute care
- divert and discharge patients from A&E
- promote effective and appropriate early discharge from general wards
- reduce readmissions.

Characteristics

- based in A&E
- senior clinical leadership
- 24-hour care
- integrated into the acute hospital
- mental health staff help acute staff to manage mental health needs
- referral to community mental health services

Origins

In December 2009 Birmingham and Solihull Mental Health NHS Foundation Trust launched the RAID service as a pilot project to improve outcomes for patients in the acute hospital who also have mental health conditions.

Co-occurrence of physical and mental health conditions often leads to poorer health outcomes, longer hospital stays and higher readmission rates. Early detection of mental health problems can enable rapid and appropriate interventions, as well as help with discharge planning from acute wards.

Research has shown that a significant proportion of patients attending A&E or being admitted to an inpatient bed have mental health issues as a co-morbidity. Rapid

assessment to identify mental health conditions when a patient is admitted and 'in-reach' into inpatient wards may therefore have a demonstrable impact on patient outcomes and hospital flows.

Co-occurrence of physical and mental health conditions lead to poorer health outcomes:

- patients with mental health co-morbidities generally have longer stays, more frequent readmissions and higher incidence of institutionalisation⁴
- 12% of A&E attendances and 40% of acute admissions result from alcohol and substance misuse⁵
- two-thirds of inpatient beds are occupied by older people and 60% suffer from, or will acquire, a mental disorder during an admission⁶
- patients who have long-term conditions and mental health co-morbidities generally cost 45% to 75% more to treat than those with physical health needs only⁷

Structure

In-reach service Birmingham and Solihull Mental Health NHS Foundation Trust operates and administers RAID in five hospitals (in three acute trusts) across Birmingham. Mental health trust staff integrated with the acute trusts' clinical teams deliver care. The team is based in A&E, with staff outreach to other wards.

24/7 care The service operates with 24-hour nursing cover in each hospital. Consultants are present at each site between 7am and 9pm, and a team of senior clinicians including a consultant is on call outside these hours.

Managing mental health conditions RAID clinical staff do not provide treatment for mental health conditions. Instead, to improve treatment outcomes, they help acute clinicians manage the mental health needs of patients presenting with physical conditions, and refer patients to community services for mental health treatment.

⁴ Singh et al (2013) *The Rapid Assessment Interface and Discharge service and its implications for patients with dementia*.

⁵ *National Indicators for Local Authorities and Local Authority Partnerships* (2009).

⁶ Tadros et al (2013) Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model, *The Psychiatrist* (2013), 37, 4-10.

⁷ The King's Fund (2012) *Long-term conditions and mental health. The cost of co-morbidities*.

How patients benefit

The RAID team is a **single point of contact** for mental health services in acute hospitals.

The team enables all patients referred to the scheme to be:

1. assessed
2. treated for their acute care needs
3. signposted to community care
4. referred for treatment in the community.

Referrals come from both A&E and inpatient wards with a rapid response approach. RAID aims to respond to referrals from A&E within an hour (and usually within 20 minutes). From their base in A&E, RAID nurses also outreach to wards when patients are referred. RAID's target is to respond to wards within 24 hours and it usually does so well within this time.

Patients are treated by nurses with advice from consultants available 24 hours a day.

The team trains acute hospital staff to better identify, treat and refer patients with mental health needs. It helps acute staff to understand mental health needs and focus on them as part of their role and responsibility. This means RAID benefits all acute patients with mental health conditions, as well as patients it interacts with directly, reinforcing its impact across the hospital. It also enables the RAID team to concentrate on supporting patients with the most complex needs.

RAID enables faster access to mental health services. Before RAID, if acute patients had mental health needs, staff had to be called in from community mental health services. This made community services less effective and caused long waits in the acute hospital, particularly for patients who arrived out of hours.

Enabler: integration within the acute hospital

RAID nurses are based in A&E:

- positioned to respond to cases directly without the need for calls and delays
- able to monitor all patients in A&E and pick up cases at an early stage
- able to quickly identify patients referred by A&E staff who are already being effectively managed in primary care
- able to outreach to wards across the hospital.

Working within the acute hospitals, the trust gains an in-depth understanding of its impact across the wider health system. This integration facilitates more rapid referrals from the acute to mental health services by breaking down barriers in patient handover.

Enabler: rapid response 24/7 service provision

RAID offers a rapid response service 24 hours a day, with on-call consultant back-up. This means that the service is able to meet patients' needs at any time of day.

In addition, as a constant presence in the trust, the RAID team gives other staff confidence to treat patients with mental health issues. Clinicians are better able to manage risk, as they have senior mental health professionals available to help if they need to escalate patients.

Enabler: consistent senior leadership and integration within the acute hospital

The same two consultants have led the service since its first pilot, giving it strong and consistent leadership.

They designed RAID to be different from their previous experiences of psychiatric liaison, in which fragmented services working limited hours were located in the 'bowels' of acute hospitals.

Being integrated within the acute hospital facilitates rapid referrals to mental health services by breaking down barriers in patient handover.

Impact

RAID has an impact on operations across the entire acute trust, because the RAID team trains staff as well as supporting patients directly. Economic assessments of RAID during its pilot phase and roll-out across multiple hospitals⁸ indicate benefits for patients who directly interact with RAID staff and for patients with mental health conditions treated across the trust. RAID's benefits include:

- fewer admissions from A&E and the emergency medical unit to inpatient wards
- shorter average length of stay for inpatients
- twice as many elderly patients discharged to their own homes
- identifying more people with mental health conditions, with more patients being given an MH diagnosis code after RAID's introduction, suggesting the service is addressing previously unmet need.

The scheme may reduce costs in the acute trust by reducing admissions and length of stay, but it will divert more patients to existing community mental health services.

⁸ Parsonage M, Fossey M (2011) *Economic evaluation of a liaison psychiatry service*. London: Centre for Mental Health 2011. /www.centreformentalhealth.org.uk/evaluation-liaison-psychiatry
Central Midlands Commissioning Support Unit (2012) *Rapid assessment interface and discharge liaison: economic evaluation of the Birmingham and Solihull roll out*.

Challenges

A yearly commissioning cycle

This can lead to greater uncertainty over the future of services because it:

- places a burden on the trust to continually review and highlight the scheme's impact to maintain funding
- causes a lack of clarity and stability for long-term investment to improve cost-effectiveness
- makes it difficult to recruit to senior roles, with staff lost to more secure jobs in similar schemes.

Pressure of A&E targets

Some A&E leads at trusts can be quick to apportion blame where delays and target breaches affect patients being treated with a RAID intervention. The team suggests this is often due to referrals to the RAID team coming late in the A&E pathway.

Differences in service specification

The trusts in which RAID operates use slightly different service models from each other. If they were more consistent, more efficiency gains would result.

Enabler: service delivered across Birmingham

RAID is commissioned across Birmingham as a whole, which brings economies of scale. Staff move across the five sites, making the service flexible and meaning it needs fewer staff than it would otherwise, bringing cost savings.

Because the service can offer benefits across the local health economy, hospitals commissioning services in combination may enjoy a higher level of provision overall than those commissioning in isolation.

More information

[RAID service](#)

[Birmingham and Solihull Mental Health NHS Foundation Trust](#)

[Dementia in acute hospitals](#)

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Acute Care of the Elderly Service: Croydon Health Services NHS Trust

The Acute Care of the Elderly Service (ACE) provides a comprehensive assessment of treatment needs for older people arriving at A&E. It aims to avoid admission or to help the patient move rapidly through the hospital and back into the community. A key feature is the comprehensive geriatric assessment (CGA) completed by a consultant-led multidisciplinary team when the patient presents at A&E, facilitated by access to rapid same-day diagnostics.

Croydon Health Services NHS Trust provides acute and community healthcare across the borough of Croydon for a population of over 380,000. The trust includes Croydon University Hospital, a district general hospital with more than 500 beds.

Aims

ACE supports older people with deteriorating and complex health needs to avoid further deterioration or crisis. Hospital specialists in elderly care work alongside primary and community services to manage the patient journey and make sure frail older patients get specialist treatment in the right place at the right time.

The service aims to:

- rapidly and comprehensively assess older patients who have come into A&E
- facilitate packages of care to support patient recovery at home where possible
- improve hospital efficiency to shift the care of older patients closer to home, safely and seamlessly.

Characteristics

- multidisciplinary team
- consultant-led
- comprehensive geriatric assessment as close to patient presentation at hospital as possible
- integrated with acute teams, rapid response team, ambulatory care, primary and social care
- GPs and community teams can speak to an ACE consultant for advice and referral from Monday to Friday between 9am and 5pm.

Origins

Croydon University Hospital Trust set up ACE in November 2012 to meet the needs of frail older people. The service is funded internally as part of the trust's whole-system transformation, improving the management of older patients.

Underlying ACE is the recognition that frail older people can reach crisis rapidly and unpredictably. Accurately diagnosing, managing and treating them can be challenging, so they need easy and rapid access to specialist geriatric assessment and treatment.

Structure

Acute-based The ACE team is based at two main locations within the acute hospital: the observation ward, next to A&E, and an outpatient rapid assessment setting.

7-day service The service operates seven days a week, 9am to 7pm.

Senior multidisciplinary team

The team includes five consultants in elderly care, a specialist nurse, physiotherapist, occupational therapist, social worker and voluntary sector representatives.

How patients benefit

There are two components to this service: 'in-reach into the emergency department' and the 'fast-track rapid assessment clinic'.

Older patients are assessed as soon as they arrive at the hospital.

The 'in-reach' element looks after complex frail patients who have presented at the front door of the hospital as an emergency or patients who are entering crisis. The consultant-led, multidisciplinary team provides early **comprehensive geriatric assessments** of frail older patients, with a view to managing and treating them so they can return safely to the community and to their own homes.

Enabler: rapid access to diagnostics

- Early consultant-led CGAs for frail older adults improve care quality, patient satisfaction and patient flow, and reduce length of stay.
- Rapid access to same-day diagnostics makes the CGAs possible.
- The ACE team managed this change of focus by working closely with diagnostic departments from the outset to secure senior commitment.
- Diagnostic departments have been highly responsive to this way of working. They particularly appreciate the consultant-to-consultant discussions about patient care.

The service initially delivered care in the A&E observation ward, where most of these elderly patients were being admitted. It has now extended further into A&E, liaising with a number of hospital teams to identify suitable patients.

The service is primarily for patients over 80 years old, but the ACE team will see younger patients if their needs are suitable for the service.

Enabler: communication with primary care

Apart from being able to follow up patients rapidly if necessary, the fast-track assessment clinic mainly aims to provide primary and community teams with an opportunity to refer patients for same-day care as an alternative to emergency admissions.

GPs can directly speak to the ACE consultant on call for advice and/or referral to the clinic, Monday to Friday 9am to 5pm, on the ACE consultant mobile number.

The consultant-led MDT administers a CGA and treatment plan. The CGA assesses the patient's medical, nursing, mobility, functional and social needs. Physiotherapists assess mobility and risk of falls, and recommend community mobility programmes and other rehabilitation pathways as required. Occupational therapists assess patients' ability to manage daily tasks at home, and refer to social services teams or rehab teams as required. Social workers arrange or optimise home care for patients, assist with respite care or arrange for a patient to have an interim care home placement, as well as addressing any safeguarding issues.

ACE aims not to admit patients if there is no medical reason to do so. Rather, the ACE team completes a comprehensive assessment of the patient and sets up ongoing care packages to

support them in the community. The trust reports that without the ACE service these patients would have been admitted and therefore exposed to the risks associated with an acute inpatient stay.

The CGA supports timely patient flow through the hospital if a patient does need to be admitted to acute medical units or hospital wards. Early consultant geriatric review and multidisciplinary review can lead to better outcomes for patients, as well as assisting with patient flow.

Out-of-hours patients are seen the next morning by the ACE team. Outside operating hours, patients who previously would have been referred to the on-call team and admitted to a ward or acute medical unit, are admitted to the observation ward and seen by the ACE team the following morning.

Fast-track rapid assessment clinic The second element of the ACE service is the fast-track rapid assessment clinic. Patients may need to return to this clinic for follow-up following discharge from the in-reach element of the ACE service. It is run by a consultant in elderly care and staffed primarily by the ACE team, although routine clinic staff also provide support.

This clinic is both a hotline and a treatment centre. GPs, community teams, rapid response and intermediate care teams can call this clinic if the condition of patients in the community is deteriorating, as an alternative to referring them to the emergency department. The ACE consultant takes all the calls so specialist advice can be given as well as referrals to the service accepted. The consultants carry a designated ACE mobile phone and pager. Patients can be seen within 24 to 48 hours of referral. If they are well enough to go home the same day, they are discharged from the unit straight home.

Onward care Once patients are discharged from the ACE service, ACE nurses can provide follow-up calls, and the service directs patients towards other community pathways as appropriate, such as reablement services, day centres, rapid response, or the intermediate care team.

The ACE team works particularly closely with the trust's rapid response service, a 24/7 scheme that provides intensive nursing and therapy interventions in the home to prevent and manage crisis among high intensity hospital users and avoid unnecessary admissions. The ACE and rapid response services support each other to provide care for older adults with patients being referred between the two teams.

Impact

The ACE service can improve quality of care for older patients. The immediate provision of CGAs by a skilled multidisciplinary team as soon as frail older adults arrive at the hospital is widely regarded as best practice. It increases the likelihood that conditions such as dementia, falls and stroke are recognised and appropriate treatment plans are put in place. This can improve patient health and reduce the time the patient has to spend in hospital.

Enabler: dedicated area

- fast-track assessment clinic based in a quiet area of the hospital, dedicated to assessing and treating patients aged 75 and over and staffed by staff with specialist skills
- looks and feels like an outpatient centre, with four clinic rooms and three beds
- offers a better experience for patients who do need to be admitted
- designed to be dementia friendly

This scheme may be important in alleviating operational pressure at the trust caused by increasing demand. The trust reports that ACE has contributed to reductions in length of stay at the trust. Since November 2013 the average length of stay across elderly care wards has reduced by five days and 84 inpatient beds have been closed. Since ACE began, there have also been fewer admissions into hospital from the A&E observation ward at Croydon University Hospital for patients over 80 years of age. This is despite increasing attendance at A&E and admission to the observation ward among this age group.

Reductions in length of stay and fewer admissions suggest potential for the service to deliver cost savings, if fixed costs can be taken out.

Challenges

ACE needs capacity to cope with increasing numbers of referrals, particularly in the fast-track clinic.

There are demands on the workforce due to increasing demands on the service. The trust has responded by:

- investing in greater consultant input
- providing nursing staff with ongoing training to develop their specialist elderly care skills
- recruiting a full-time social worker to be part of the team.

More information

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Older People's Assessment and Liaison (OPAL) Service: Gloucestershire Hospitals NHS Foundation Trust

The Older People's Assessment and Liaison (OPAL) Service at Gloucestershire Hospitals NHS Foundation Trust ensures that older people presenting at the trust's A&E receive comprehensive clinical assessment and care planning from a consultant geriatrician. An important feature is the OPAL consultants' close working with the integrated discharge team to facilitate supported discharge and recovery at home.

Gloucestershire Hospitals NHS Foundation Trust serves a population of 612,000, runs two district general hospitals and employs more than 7,400 staff. Its doctors and nurses also treat patients at clinics, other smaller hospitals and through outreach services in the community.

Aims

The service aims to reduce the number of people over 80 years old who are inappropriately admitted to hospital. The immediate assessment aims to meet patients' needs while avoiding hospital admission – for example, by co-ordinating a package of community support. For patients who are admitted, care planning and treatment start immediately.

Origins

The trust has a range of initiatives to support patients being treated in the most appropriate location. It developed OPAL after recognising that older patients deteriorate once in hospital, which can lead to a longer stay and a risk to their health. Most patients prefer to stay independent and in their own homes, rather than be admitted to hospital.

Structure

Acute-based The service has operated from the Gloucestershire Royal Hospital (GRH) site (since October 2013) and from Cheltenham General Hospital (CGH) since October 2014.

Multidisciplinary team The service is consultant-led, with several consultants (including geriatricians) contributing to the rota at each site. GRH currently has one full-time specialist nurse, and there is a part-time GP at CGH. The teams work alongside the integrated discharge team, which includes therapists and nurses but no social worker.

Characteristics

- senior geriatricians at the front of the hospital in A&E
- joint working with integrated discharge teams
- originally funded by commissioners on a non-recurrent block contract basis; now recurrent

Monday to Friday service OPAL currently operates five days a week, 9am to 5pm at both sites; this does not necessarily align with hospital admission patterns.

How patients benefit

Geriatricians carry out thorough assessments at the front of the hospital with the aim of turning patients around without an admission. Early comprehensive geriatric assessment (CGA) means that senior geriatricians can decide diagnoses, avoiding admissions and ensuring that more patients are supported in their own homes or move to ‘intermediate’ care/community hospitals for rehabilitation. For patients who are admitted, early CGA means they receive specialist care, which should improve the quality of their care and reduce how long they stay.

Enabler: high quality leadership

High quality leadership and service management by committed senior consultants have been crucial. The most successful model for the service was where existing geriatricians moved from the wards into OPAL and locums took their place on the wards, rather than hiring temporary practitioners to staff the OPAL service.

An ambulatory approach to short-stay admissions In some instances, a short-stay admission will be necessary for an intense period of hospital treatment. However, these short-stay facilities do not have beds; they look and feel like an outpatient clinic. The philosophy and focus are about maintaining the patient's independence.

Many patients are seen and discharged either without staying or with just a one-day stay. Patients are transferred to appropriate primary and community care teams to complete their recovery outside hospital.

OPAL, supported by nurses from the trust's integrated discharge team, supports patient discharge and transfers patients to community teams, activating access to reablement, sit-in services or other services that the patient needs to be kept well at home. Some patients are also transferred into community hospitals. The OPAL and integrated discharge team nurses can follow the patients into the community and carry out home visits if necessary.

Enabler: synchronisation of projects within the local care trust

As service models change, there is increasing overlap between the two organisations. It is essential that services are lined up for patients to receive high quality integrated care.

The consultant geriatricians have close working relationships with community teams and they attribute OPAL's success to the close positive working between its practitioners and community teams.

Community teams can phone the consultant geriatrician directly if they are concerned about a patient. GRH consultants carry a mobile phone, partly for this reason. CGH does not offer this service currently because of resource constraints but hopes to in future.

Impact

Reduction in older people being admitted to acute wards The trust reports that the number of people over 80 admitted to the hospital in 2014/15 is lower than in previous years, even though admissions in all other age cohorts are rising. This has improved flow through the hospital, helped the trust reach its access targets and ensured beds are available for acutely unwell patients.

Monitoring quality improvement The trust has developed an internal set of metrics based on data collected by the OPAL team, including an analysis of patient cohort by age band and the Rockwood Clinical Frailty Scale.⁹ Other monitoring covers length of stay, readmission and mortality rates for the patients seen by the OPAL team compared to all 'frail' patients (locally defined). The trust is also working with the Acute Frailty Network, which provides technical support and a 'measurement for improvement' tool.

Challenges

Recruitment

- Developing OPAL took longer than expected, partly because a lack of available applicants meant it took time to recruit staff.
- Competition for staff also brings issues of negotiating pay rates and reliance on locums or agency workers.

Capacity

- There are pressures on existing staff who are being asked to develop and run a service simultaneously.
- The trust has concerns that the current OPAL staff resource may not be sufficient to meet current and growing demand.

⁹ A global clinical measure of fitness and frailty in elderly people ranging from Very Fit to Terminally Ill.

More information

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Acute Frailty Network

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These case studies are part of a suite designed to increase awareness of schemes to move healthcare closer to home. For more materials see [Moving healthcare closer to home](#)