Monitor
Making the health sector work for patients

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.

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.

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.

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

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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.

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[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.

This is one of a suite of case studies designed to increase awareness of schemes to move healthcare closer to home. For more materials see Moving healthcare closer to home