

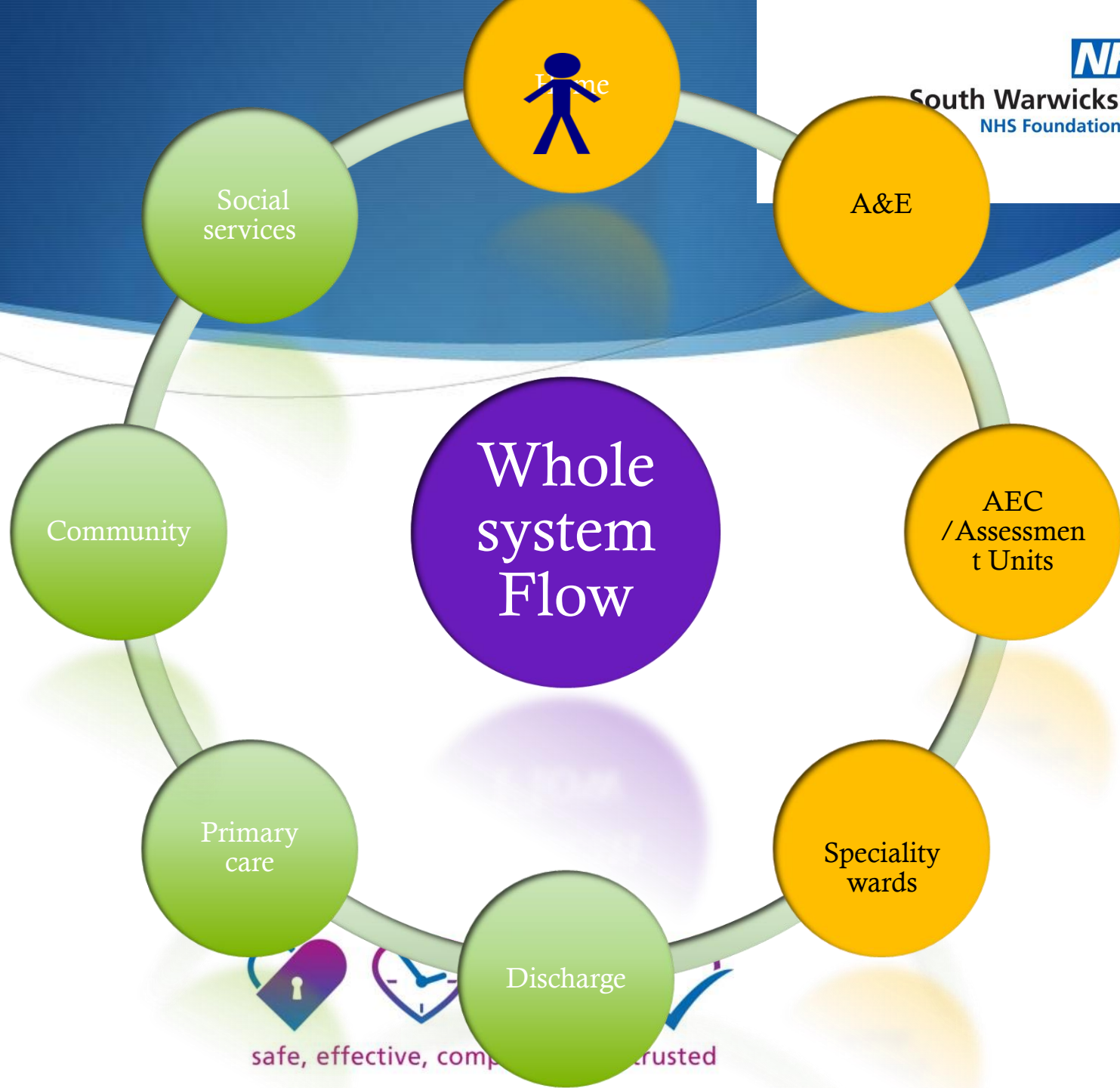
# Flow

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ECIP Clinical Lead – Midlands and East



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# Clinical Systems Improvement - Principles

- **Match workforce to workload** – Use data
  - Extended day working – 7 days
- **Focus on competencies** and skill mix needed – not professionals or speciality
- **Minimise queues** – Today's work today.
- **Minimise wastage** – Right Specialist, first time. Right sizing specialities
- **Minimise variation** – Standardise pathways and SOPs – job planning
- **Focus on the system gains** – Not on individual areas



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# High impact interventions - to facilitate Flow

- Senior clinical

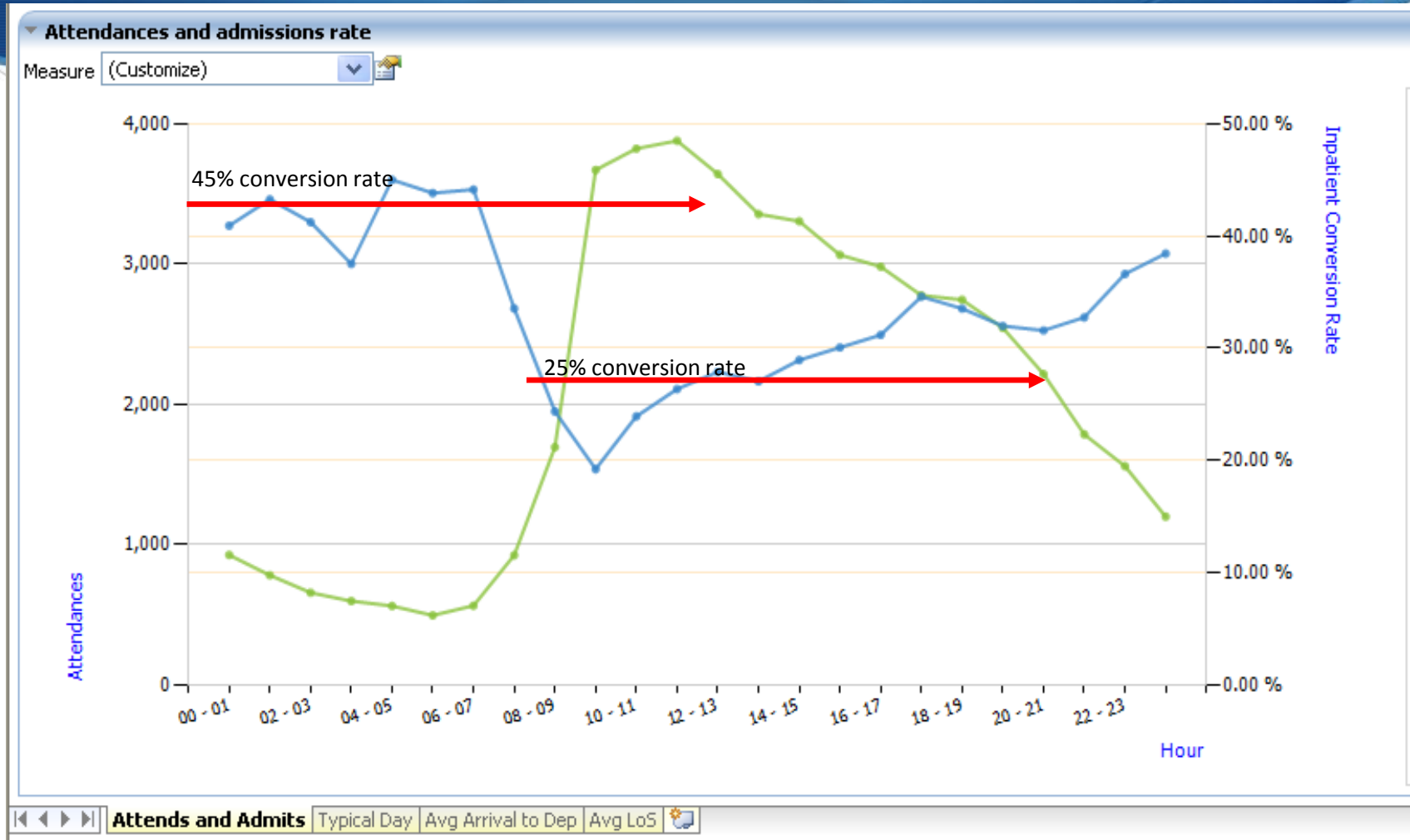
Will ensure admissions are appropriate

- Timely

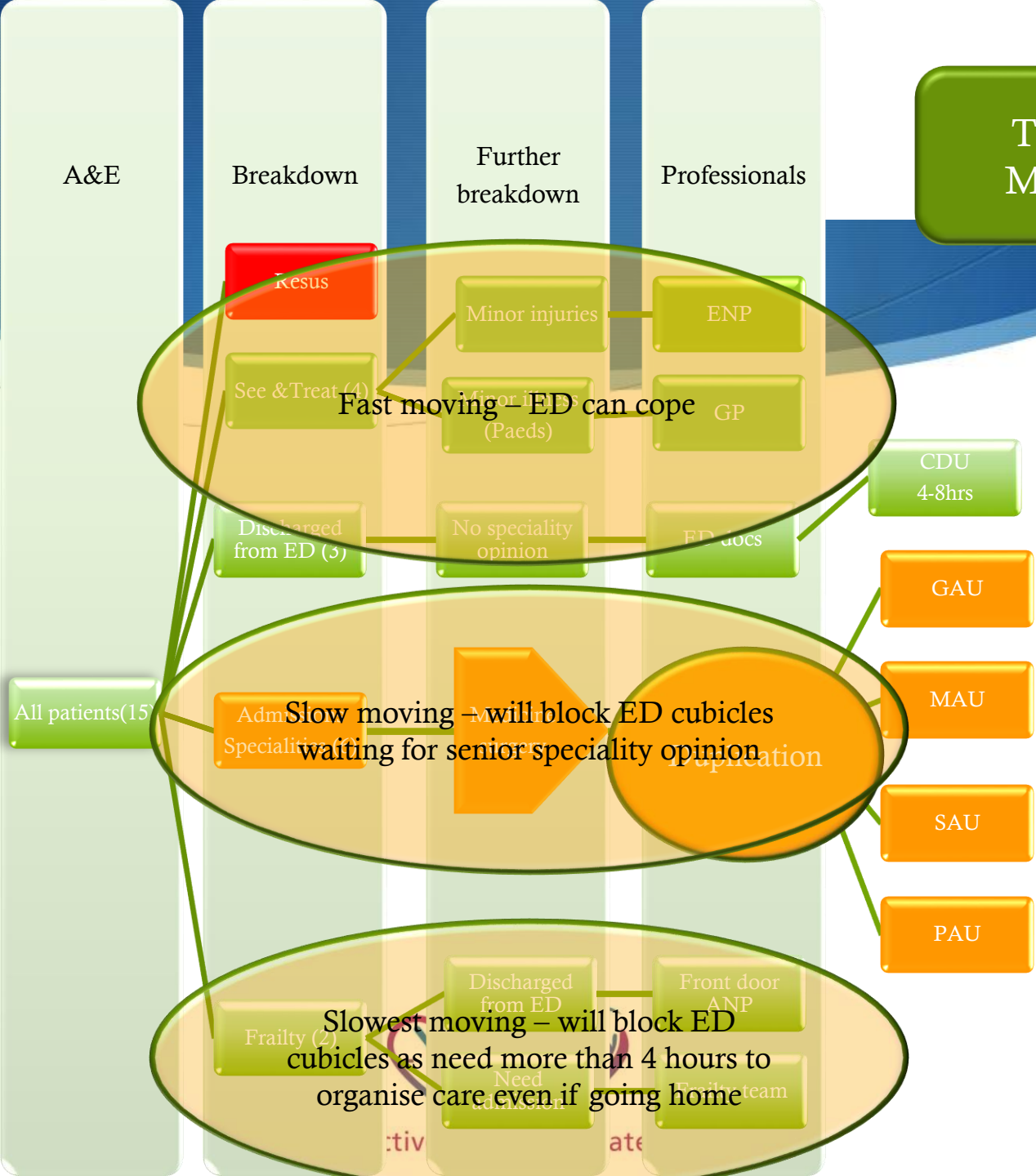
- Robust ward and ward rounds

Will ensure those admitted are managed effectively and sent home in a timely way

# Build systems to allow for reduced flow OOH



# The Flow Motorway



A&E

Breakdown

Further breakdown

Professionals

Resus

See & Treat (4)

Discharged from ED (5)

Minor injuries

Paediatric (Paeds)

No speciality opinion

ENP

GP

ED does

CDU  
4-8hrs

GAU

MAU

SAU

PAU

All patients (15)

Admission  
Speciality opinion

Slow moving - will block ED cubicles waiting for senior speciality opinion

Frailty (2)

Discharged from ED

Need admission

Front door ANP

Discharge team

Slowest moving - will block ED cubicles as need more than 4 hours to organise care even if going home

# Tackling frailty - staff engagement to facilitate sustainable change



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# In this talk...

- ◆ Take you through a small project we did
- ◆ Demonstrate the magic that can be created by motivated teams in a short time
- ◆ Identify what led to staff engagement



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# Over 75's Frailty Flow project

January 2016

Launch of Flow programme

May 2016

PDSAs/Pilots started

October 2016

Standardized sustainable PDSAs and Implemented



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# How did we work?

- ◆ We believe that any sustainable improvement is best delivered by people in the **frontline**.
- ◆ We brought all stakeholders into **one room** – The Big room – shared common purpose
- ◆ The frontline team came up with ideas on how to improve
- ◆ Used patient stories, data, implemented small changes with evaluation
- ◆ Senior management supported by breaking traditional barriers and myths between teams, departments, divisions and organisations



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# Role of Senior management

- ◆ Listening and Enabling
- ◆ Breaking Barriers - inter- departmental, divisional, or organisational (budget, workforce, line management)
- ◆ Creating a safe and permissive atmosphere to try anything new
- ◆ Busting myths on 'not done' 'not allowed' 'that's what we were told'



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# Global Aim – decided by the team

To minimise hospital stay by **Why** associated with prolonged

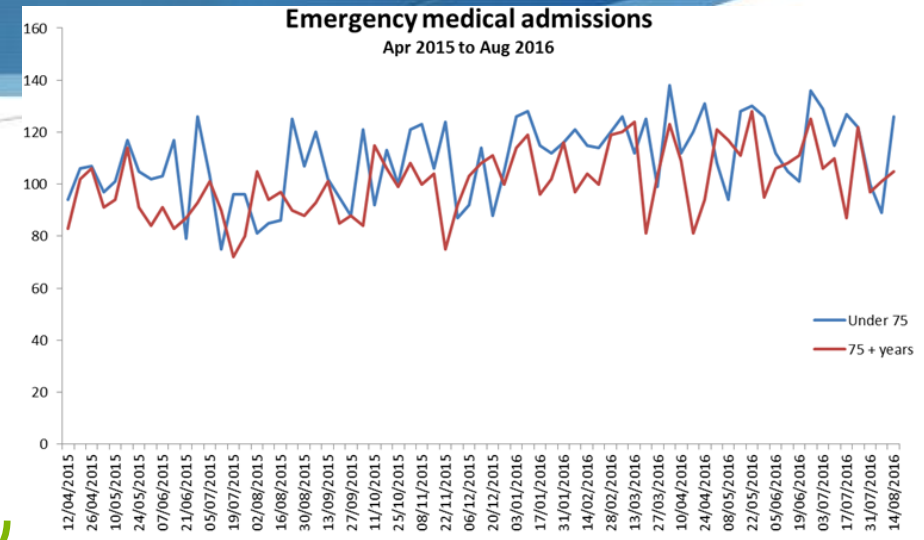
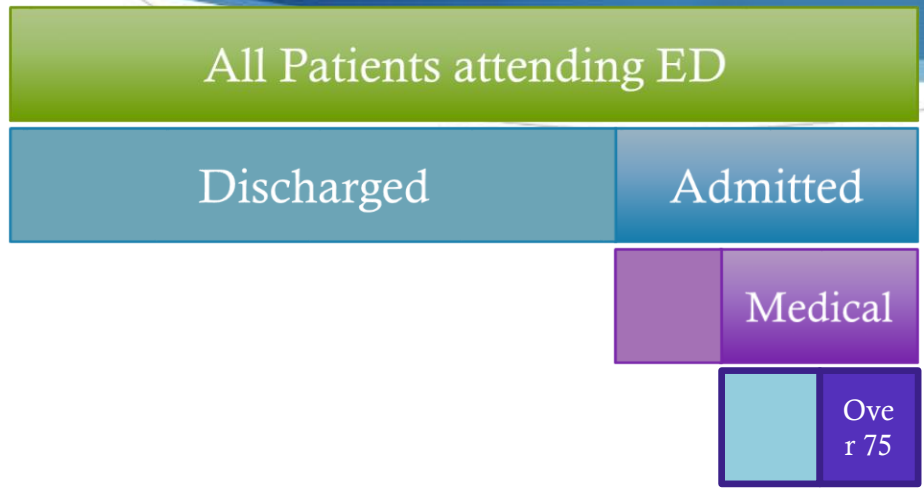
Early recognition of frailty in elderly,

Retaining **How** assessment by the frailty team,

Enabling early discharge with appropriate support

Leading **What**

# Size of the problem

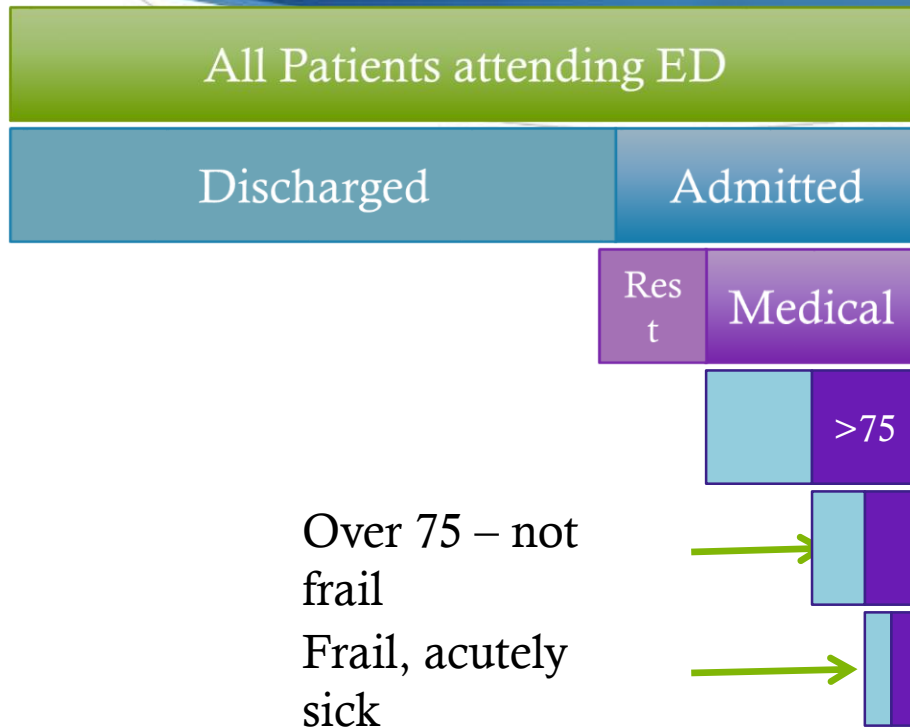


**Over 75s are nearly half of the medical admissions**



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# Size of the problem



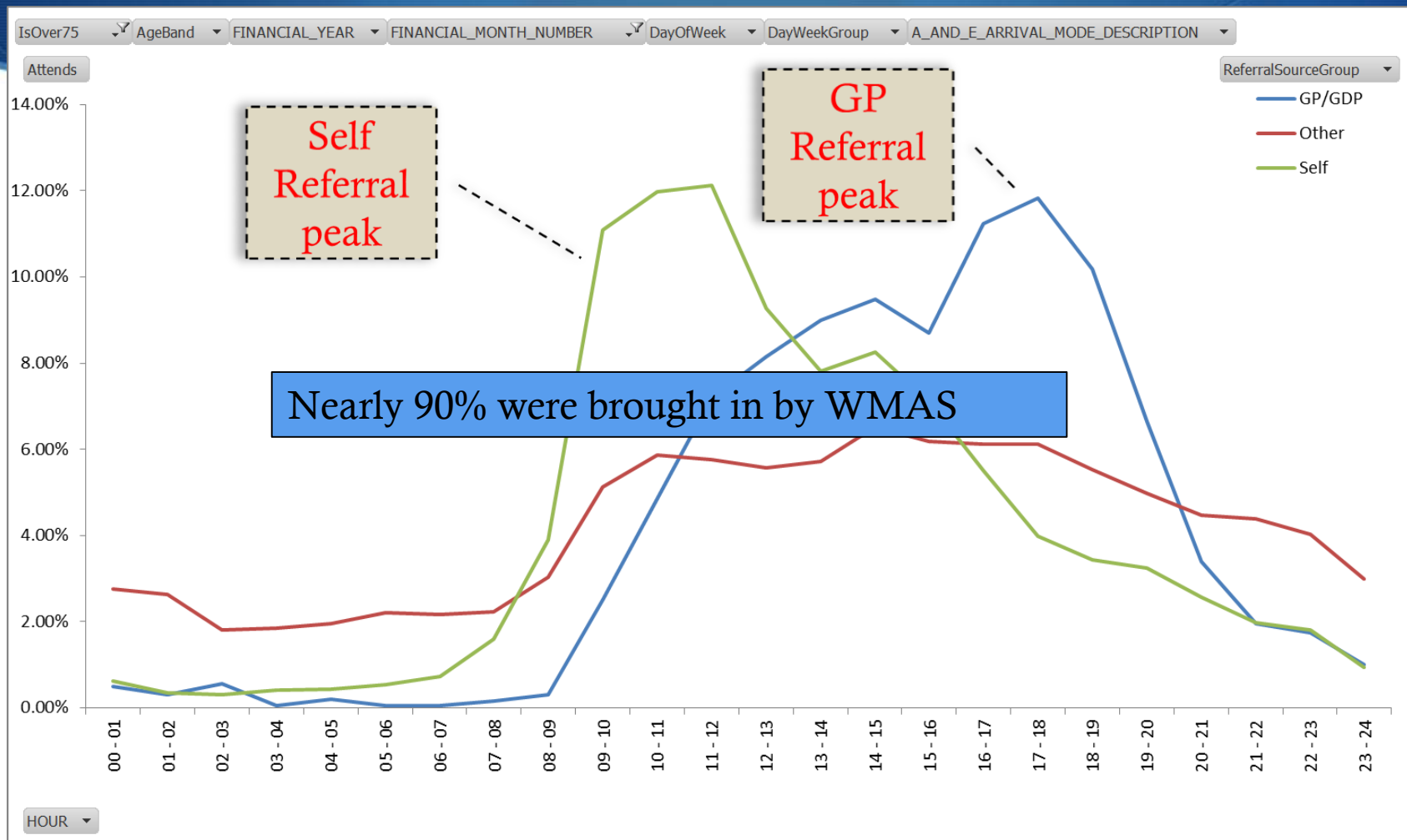
Small numbers,  
but the impact is  
high

The short stay frail  
older people



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# Who refers them to us?



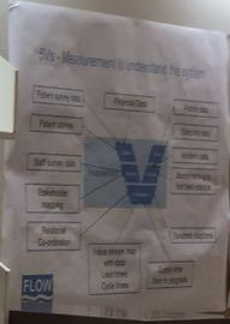
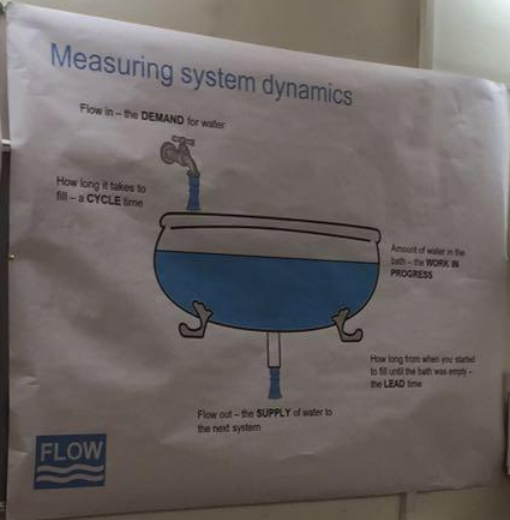
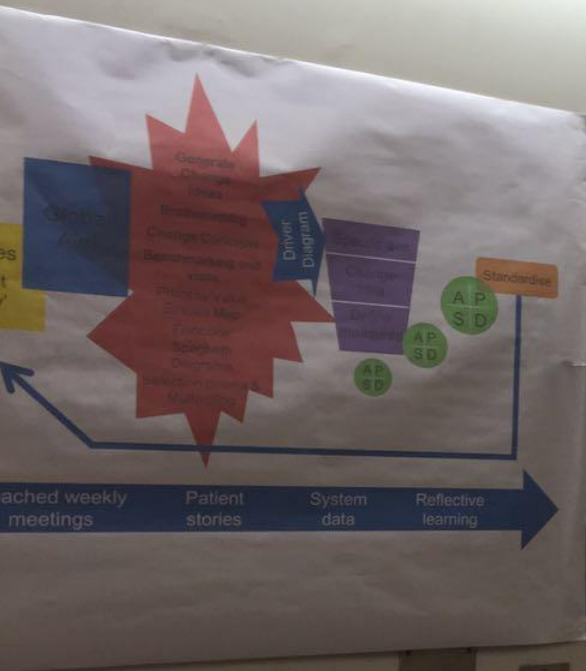
# What special skill do the frailty team have?

- ◆ Extra **time** for assessment (CGA) to identify what is 'normal' for them and tease out the current problem and the **appropriate** needs.
- ◆ Why can this not be done in by ED or AMU teams?
  - ◆ expertise,
  - ◆ motivation
  - ◆ **time**



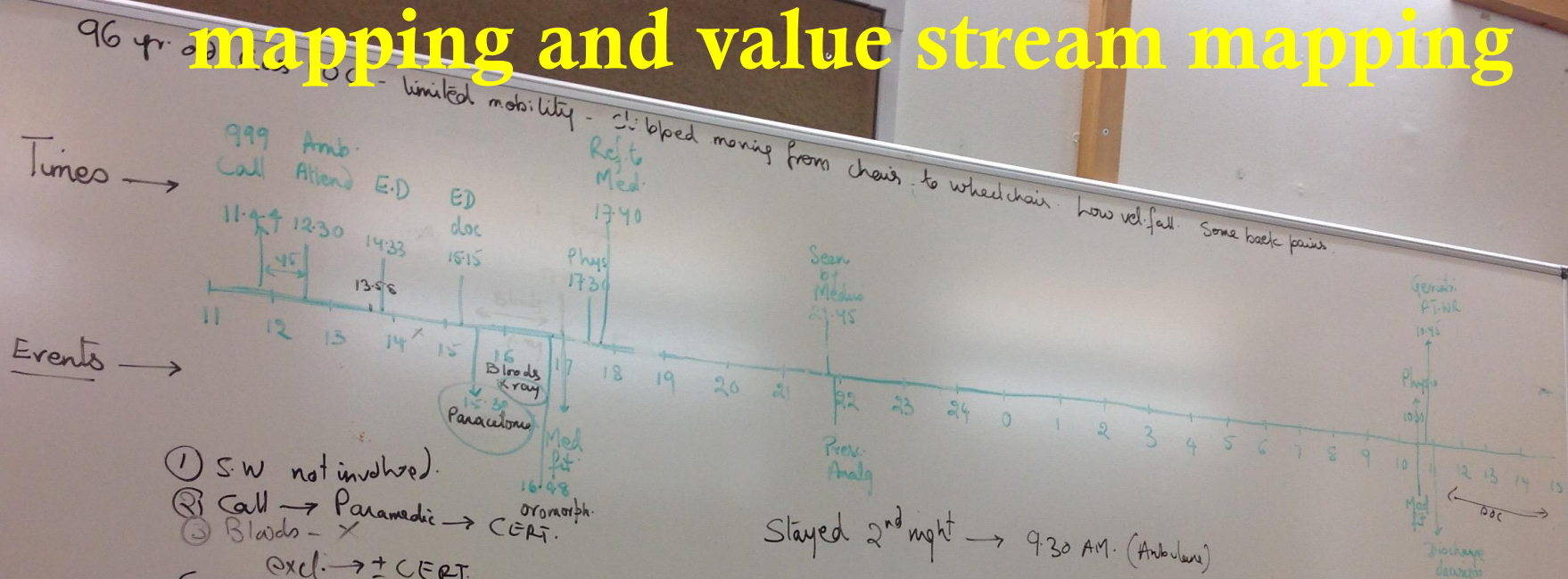
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**The ideas room - Obeya**

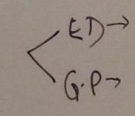
# Using patient stories, process mapping and value stream mapping



- ① SW not involved.
- ② Call → Paramedic → CERT.
- ③ Blads - X
- ④ Cert. → ± CERT.
- ⑤ Call ↑↑
- ⑥ 11:45
- ⑦ ED
- ⑧ ED - Nurses - X-ray.
- ⑨ Ref. to frailty team
- ⑩ Turntable - in ambulance
- ⑪ Social work - A&E
- ⑫ Double tech crew

- ED - Nurses.
- ED - Radiology
- Paramedics
- Ac. Med
- ED
- CoE
- MDT
- S.W
- Age/mob
- Pharmacy
- CERT
- Transport

- ① Would Molly experience it?
- ② Would Molly want it to happen?
- ③ Would Molly Care if we changed it?



Ward manager

Consultant

ED sister

Ward sister

Business analyst

Physio

Pharmacist

Acute physician

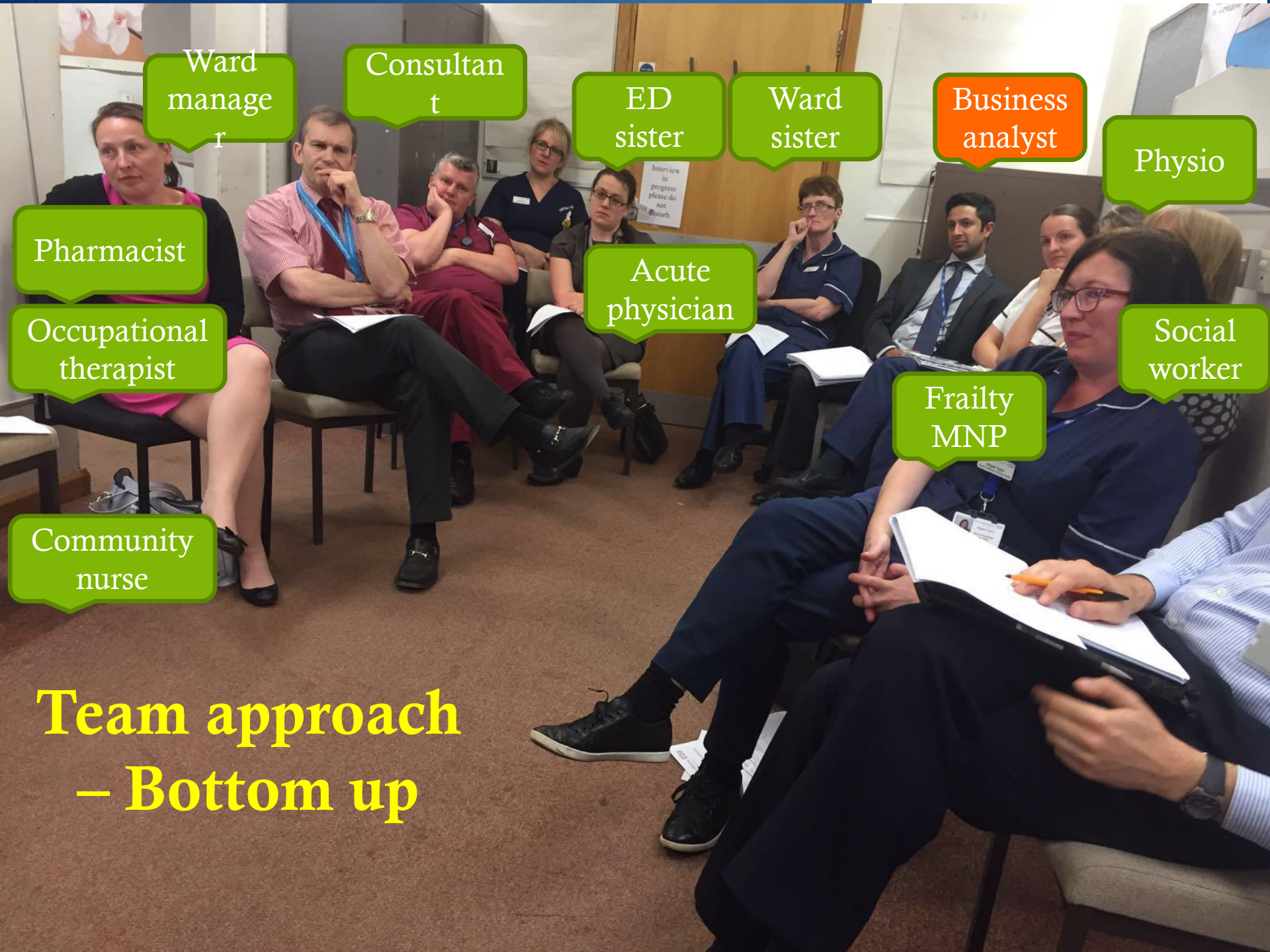
Occupational therapist

Social worker

Frailty MNP

Community nurse

**Team approach  
– Bottom up**



# Team approach – Top down

WMAS area  
manager

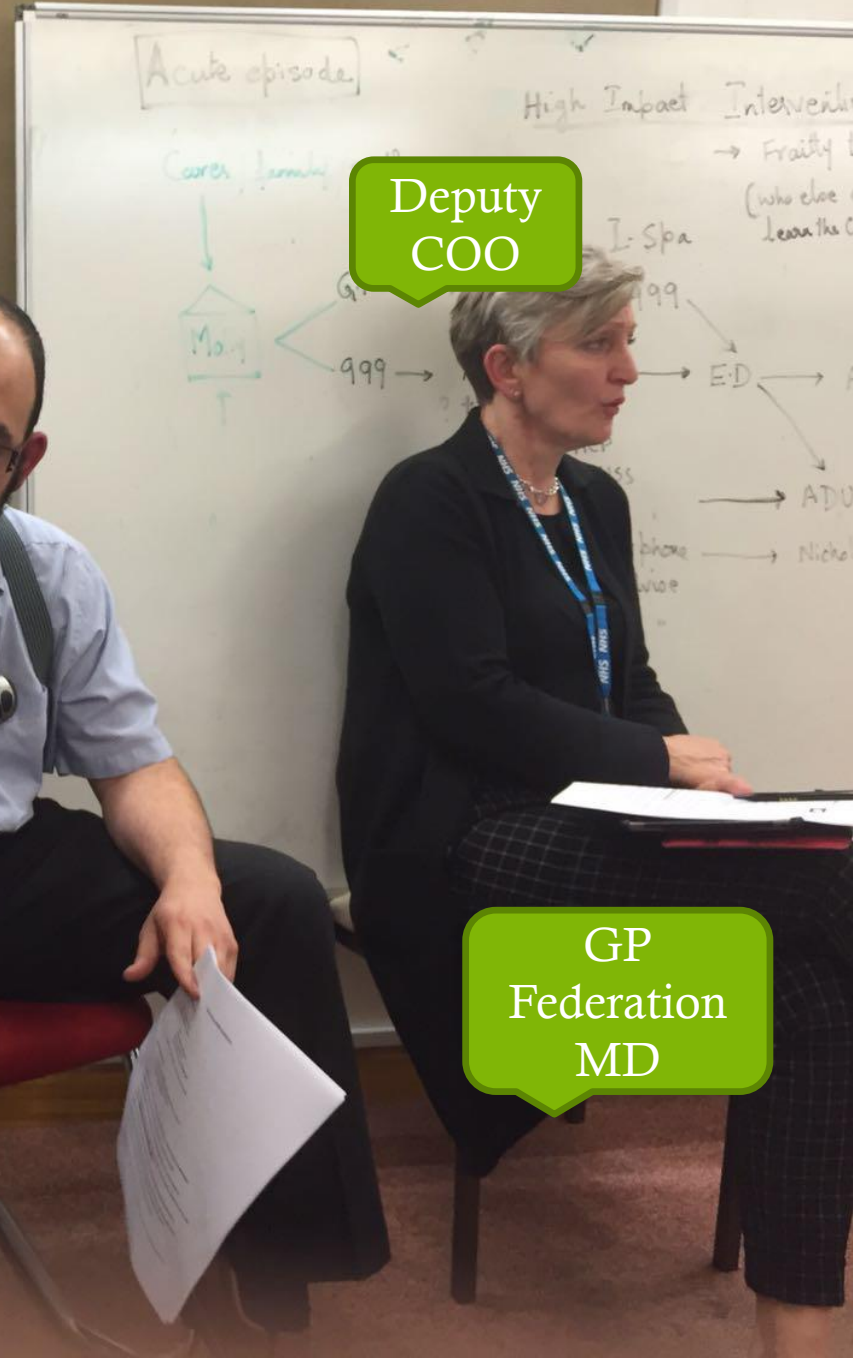
AMD

Deputy  
COO

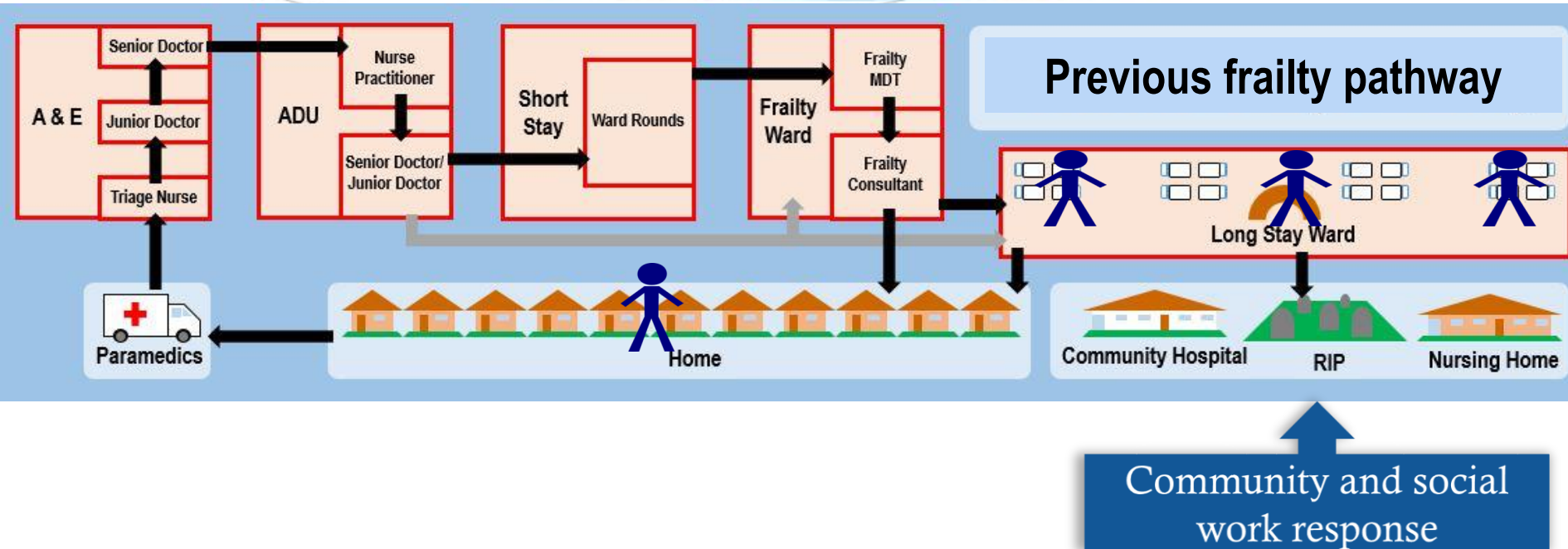
CCG  
GP

GP

GP  
Federation  
MD



# Previous Frailty Pathway

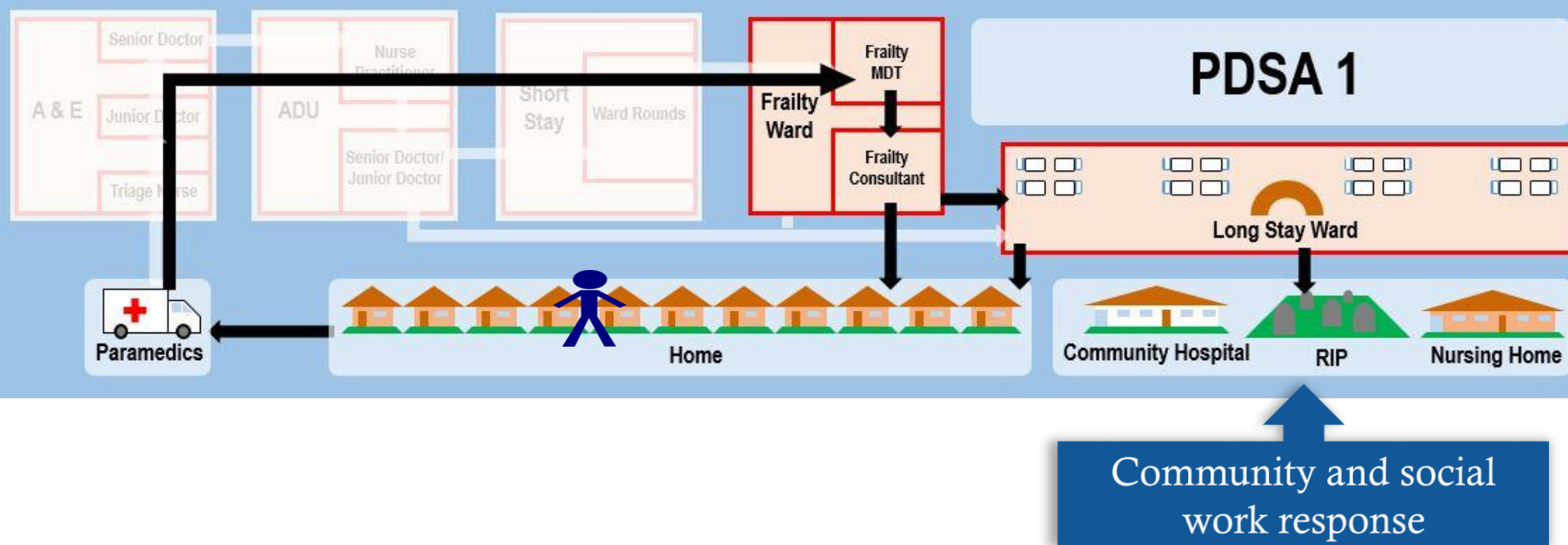


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# PDSA 1

5 days a week **0800 to 2000hrs**

Paramedics given access to frailty and consultant phone



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# Warwick Hospital Frailty

For any WMAS crew attending a frail patient aged OVER 75 in South Warwickshire please follow this process to enable the best patient care.



Warwickshire  
NHS Foundation Trust

**Is the patient 'Frailty' positive?** (Has at least one of the following criteria):

- Has had a fall
- Dementia or Delirium
- New Immobility
- From 24hr Care or Carers 4 times a day



Yes

**Does the patient meet any of these exclusion criteria?**

- **Observations**  
BP <90 systolic  
SpO2 < 88%
- **Requiring Speciality Care**  
Possible fracture  
Stroke / TIA  
Unstable angina / chest pain  
Surgical presentation
- **Likely to need prolonged admission due to medical problems / social needs >72hrs**



No

Please select from these three options:

## CONVEYANCE

Contact the frailty line  
**07789 945003** to  
arrange admission.

Convey direct to  
agreed Ward, book  
patient in there and  
enter pin into CAD.

## FRAILITY ADVICE

If you need advice or  
elective assessment  
support contact the  
on-call consultant on  
07789945003.

This number is for  
advice and support  
when considering  
alternative pathways.

## NON-CONVEYANCE

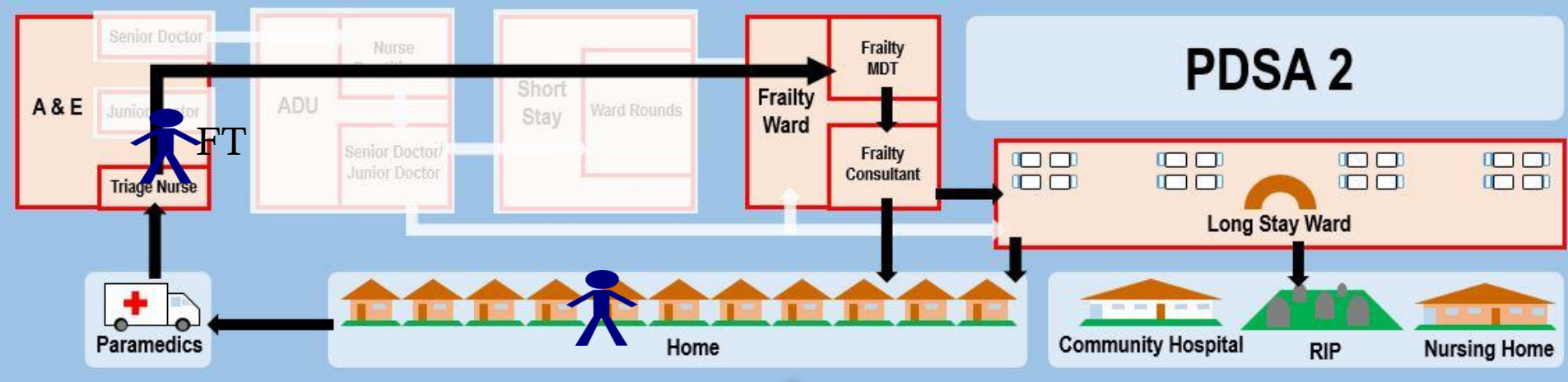
Consider the following  
options to support  
safety netting:

1. ISPA - **01926 600818**  
for community  
nurse / Home First  
Response
2. Patient's GP
3. Frailty line:  
07789945003

Collaboration with  
WMAS

# PDSA 2 – Current

5 days a week **0800 to 1700hrs**  
Frailty team access from ED triage



Community and social  
work response

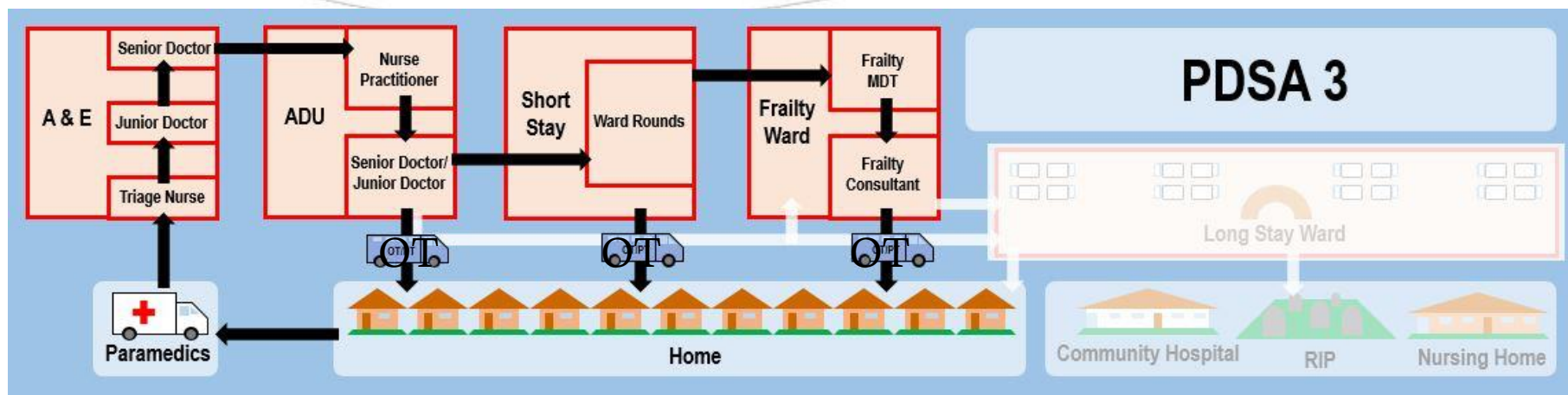


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# PDSA 3

Hospital OTs doing assessments at home



Collaboration between acute and community teams  
 Avoided duplication and saved time from community teams,  
 Saved bed days



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# Key Ingredients

- ◆ 1. Prioritisation of adults with frailty accessing acute care
- ◆ 2. Rapid identification, assessment and intervention at point access.
- ◆ 3. Promotion of independence and mobility from 1<sup>st</sup> contact
- ◆ 2. Discharge or transfer to the best place of care
- ◆ 3. Retention of clinical care ownership in those admitted providing clear continuity.



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# Results of Flow Project

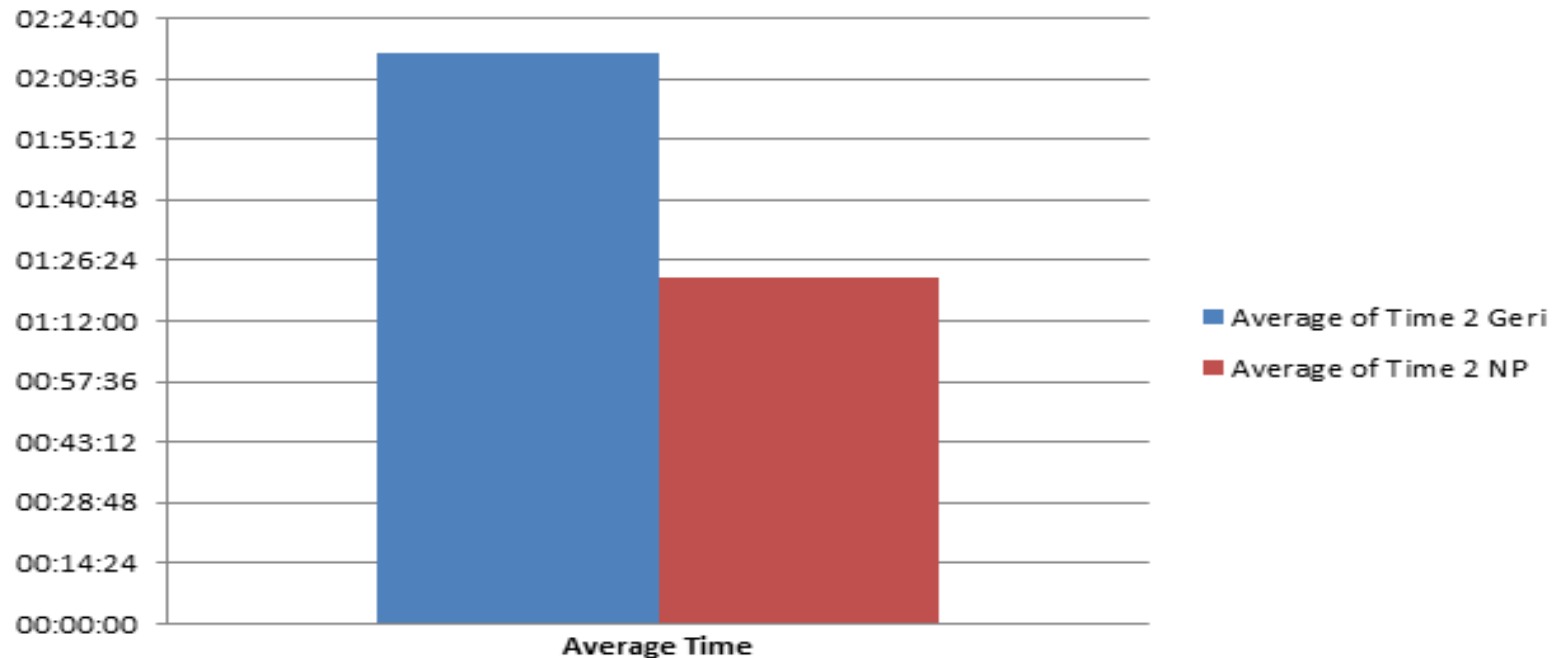


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# Time to see ANP/Geriatrician – in hours

## Time to see Nurse Practitioner and Geriatrician from Hospital Arrival

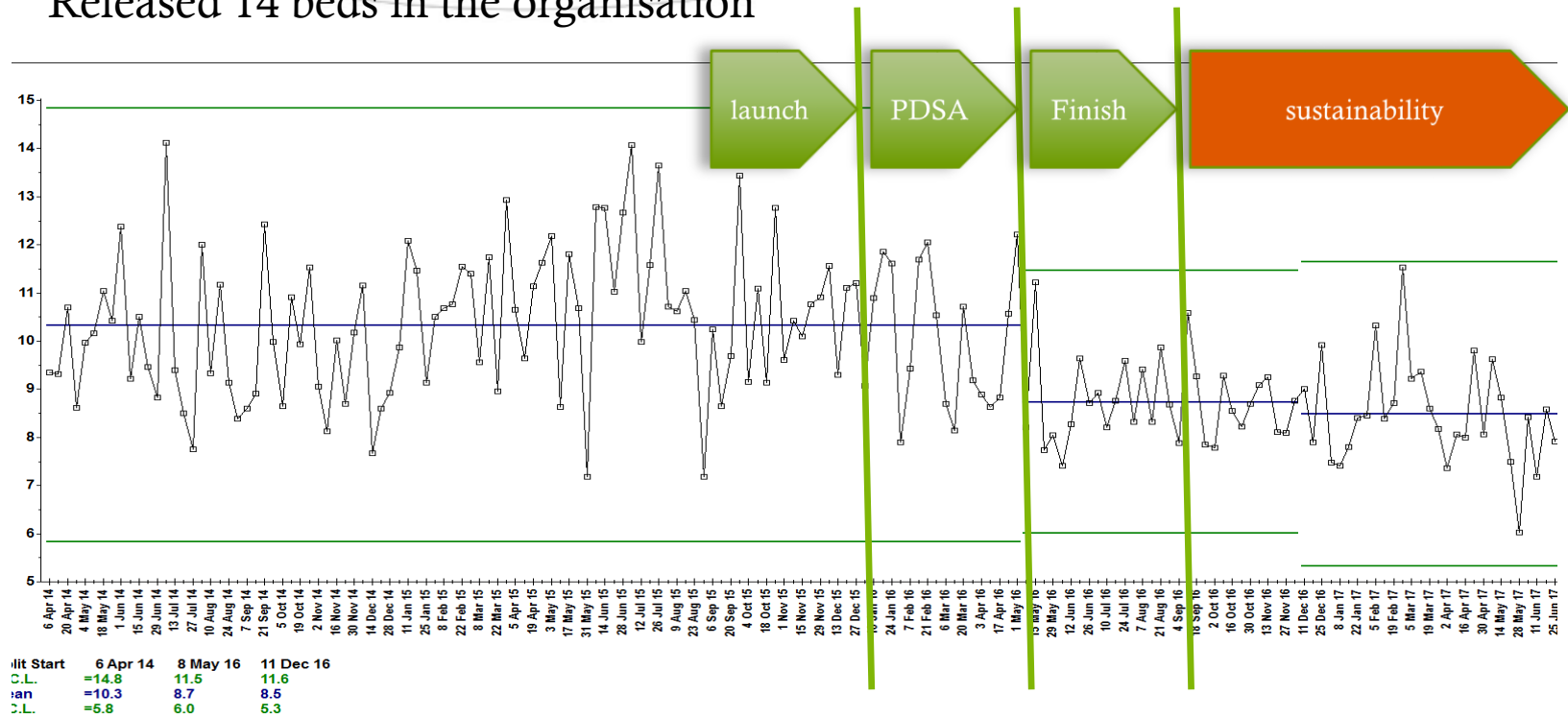


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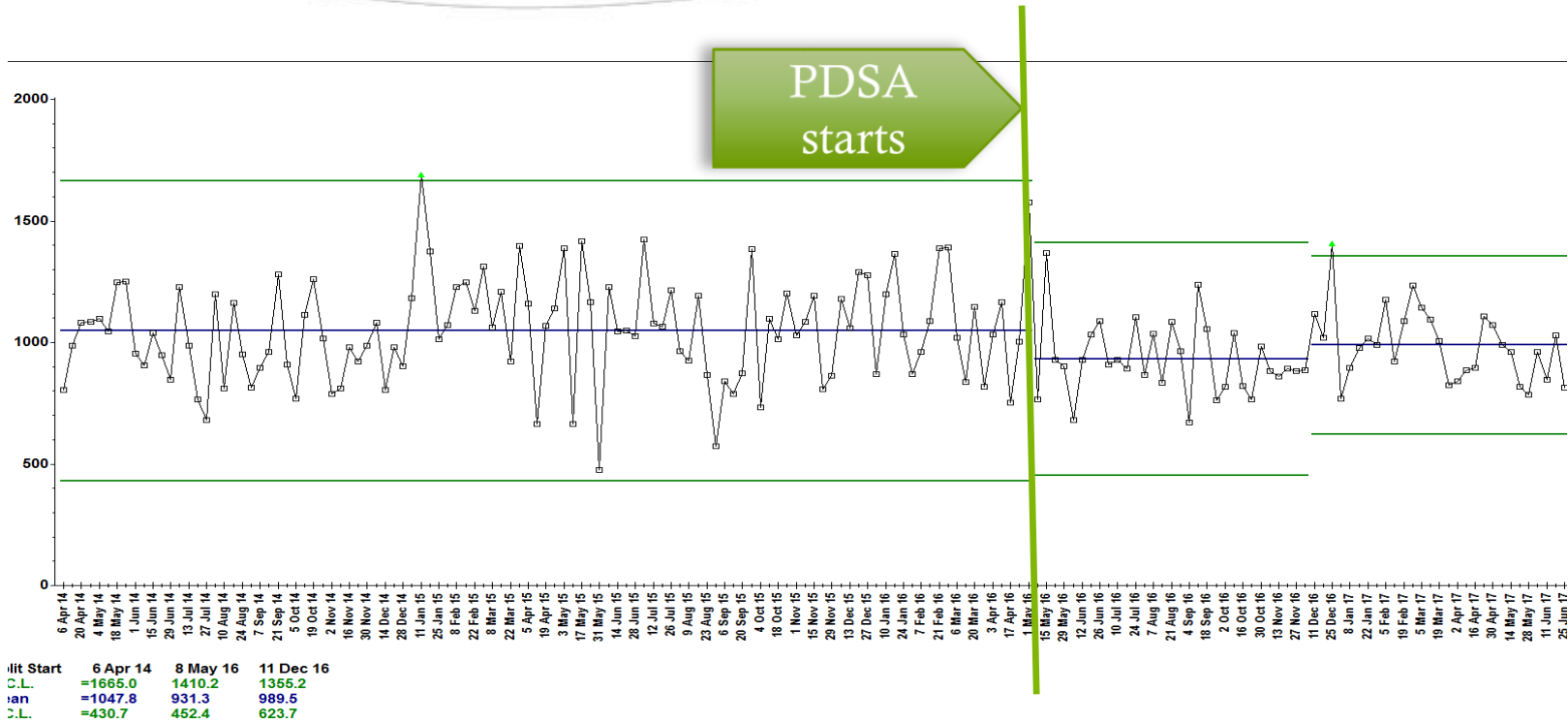
# Over 75s LOS – Step change

## - decrease

Released 14 beds in the organisation

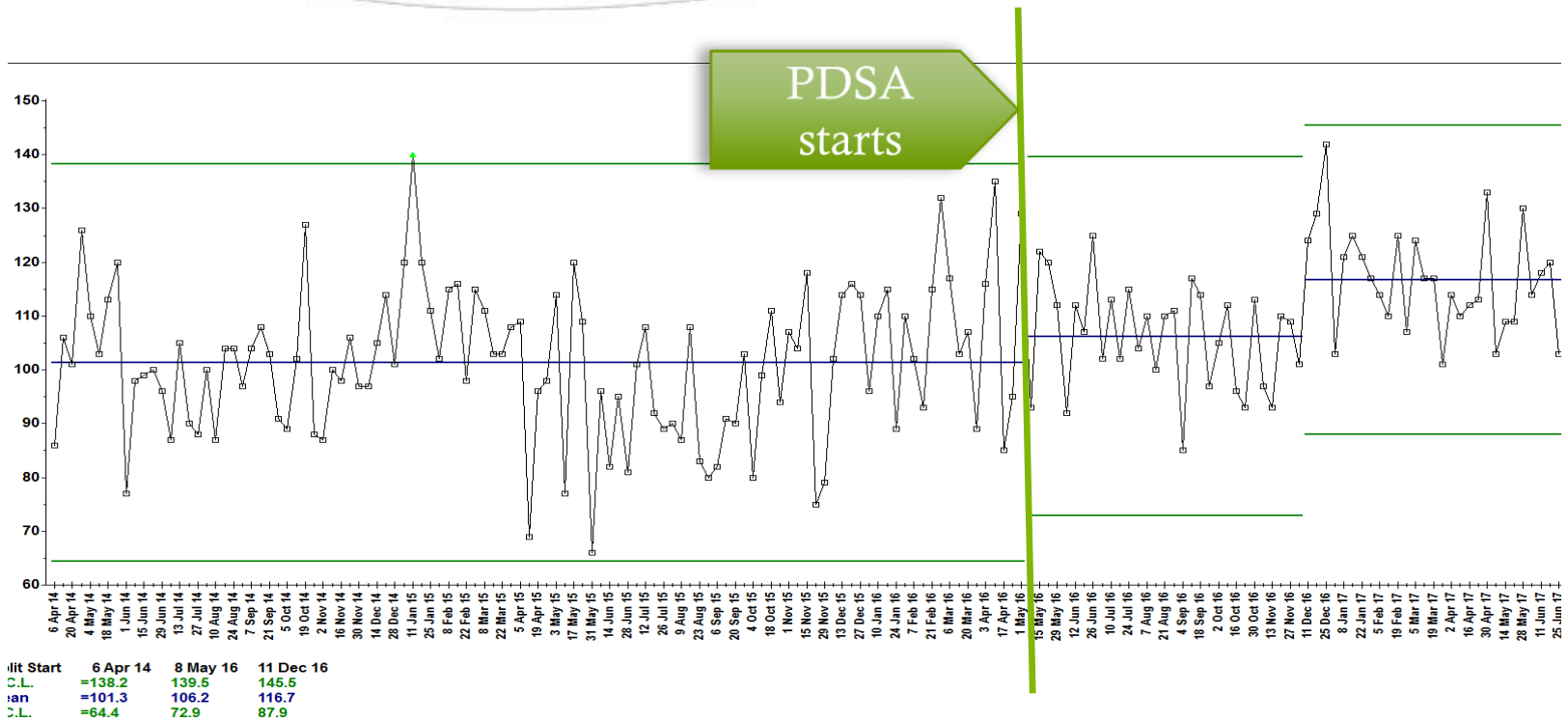


# Total bed days – step change – decrease



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# Total admissions of over 75s – Increase



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# Why did it work?

- ◆ Open invitation to ALL involved in the pathway
- ◆ No hierarchy, respect everybody
- ◆ Patient focus – not ‘me’ or ‘you’
- ◆ Visual presentation of the problem- every understands
- ◆ Everybody gets minutes every week, whether they attend or not
- ◆ Honesty and transparency
- ◆ **Keeping pace and momentum**
- ◆ Show results quickly- reinforces belief
- ◆ Recognition of the work – present at various platforms
- ◆ Dedication and commitment from leadership



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# When staff engage....

- ◆ AHPs volunteered to work long hours and 7 days
- ◆ Consultants simply changed their way of working – in 2 weeks
- ◆ Asked for more beds under their care – increased by 12
- ◆ Collaborating & coming up with more innovations



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# Questions....?



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