

**Service Delivery Model for Integrated Medicine for Older
People**

Swansea Bay University Health Board

March 2021

Contents

Introduction

Comprehensive Geriatric Assessment

Background

Frailty

Demographics Changes

E frailty Scores

Frailty & Use of Health Resources

Virtual Wards

Identification and risk stratification

Step Up – Admission Avoidance where appropriate

Step Down – Facilitate safe, timely and supported discharge

Chronic Conditions Management

Community Falls Programme

Same Day Emergency Care (SDEC)

Acute Medical Care for Older People

Emergency Frailty Unit / Older Peoples Assessment Service

Acute Frailty Unit / Integrated Care of Older People

Inpatient Geriatric Medicine

Rehabilitation

Ortho-geriatrics

Perioperative Medicine for Older People Undergoing Surgery

Current Medical Staffing

Proposed Job Plans

Conclusion

Appendix 1 : Job Plan Inpatient Geriatric Medicine including Community Geriatric Session

Appendix 2 : Job Plan Emergency Frailty Unit/Older Peoples Assessment Service

Appendix 3: Job Plan Acute Frailty Unit

Appendix 4 : Job Plan Inpatient Geriatric Medicine including Rehabilitation Sessions

Appendix 5: Job Plan Ortho-geriatrics

Appendix 6: Job Plan Surgical Liaison Service

Acknowledgements

This paper was prepared by Dr Rhodri Edwards (Consultant Geriatrician and Clinical Director for Older People) to take a holistic look at the service delivery model for older people in Swansea Bay University Health Board.

Dr Anjula Mehta (Medical Director Primary Care and Community Services) prepared the virtual ward model described in the document.

Dr Firdaus Adenwalla, Dr Chris Hudson, Dr Liz Davies, Dr Nicky Leopold and Fiona Hughes have all commented on and contributed to development of the manuscript.

Introduction

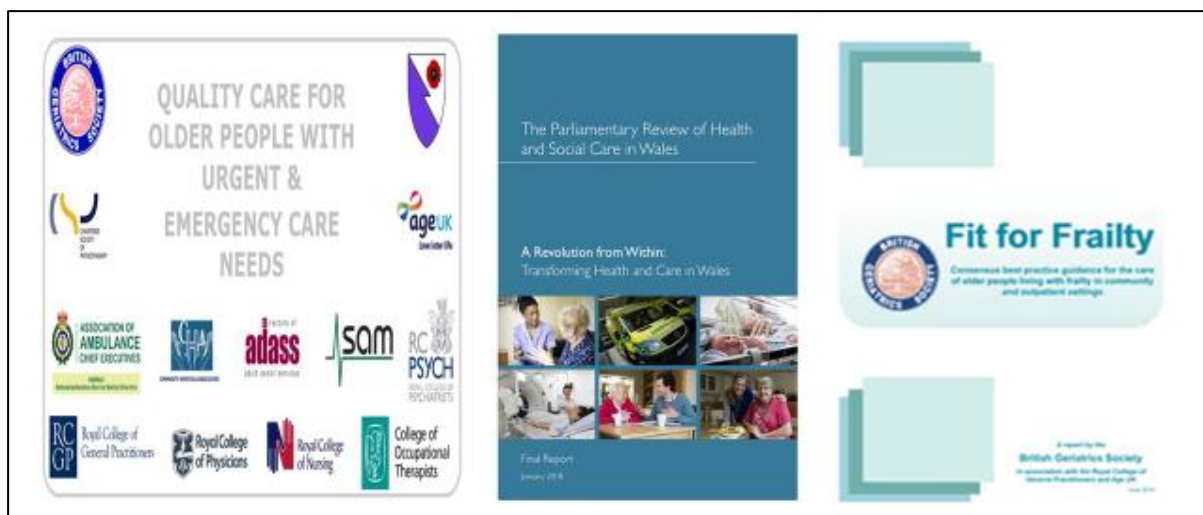
This document sets out a service delivery model for an Integrated Department of Medicine for Older People within Swansea Bay University Health Board (SBUHB). It highlights the priority for Consultant Geriatrician expansion and the creation of Cluster/Community based virtual wards.

The population served by SBUHB is ageing and the prevalence of frailty is increasing. This demand this places on the health and social care system is one of the biggest challenges for the Health Board.

An Integrated Department of Medicine for Older People should aim to:

- Support older people to live well in the community including management of complex co-morbidities, dementia and frailty
- Provide rapid support close to home at times of crisis
- Deliver good acute hospital care when needed
- Offer high quality rehabilitation and re-ablement after acute illness or injury including good discharge planning and support
- Offer choice, control and support toward end of life

These priorities reflect the priorities and ambitions of the Swansea Bay Clinical Service Plan, The Parliamentary Review of Health and Social Care in Wales and extensive guidance from the Royal College of Physicians and British Geriatric Society^{1,2,3,4,5}.



Comprehensive Geriatric Assessment

Comprehensive geriatric assessment is the gold standard for assessing older people living with frailty and leads to better outcomes for patients. Comprehensive geriatric assessment (CGA) is defined as a multidimensional, interdisciplinary diagnostic process focused at determining a frail older persons medical, psychological and functional capability in order to develop a co-ordinated integrated plan for treatment and long term follow up.

The key components of CGA are:

- Co-ordinated multidisciplinary team assessment
- Geriatric Medicine Expertise
- Identification of the medical, physical, social and psychological problems
- Formulation of a plan for care including appropriate re-ablement and rehabilitation

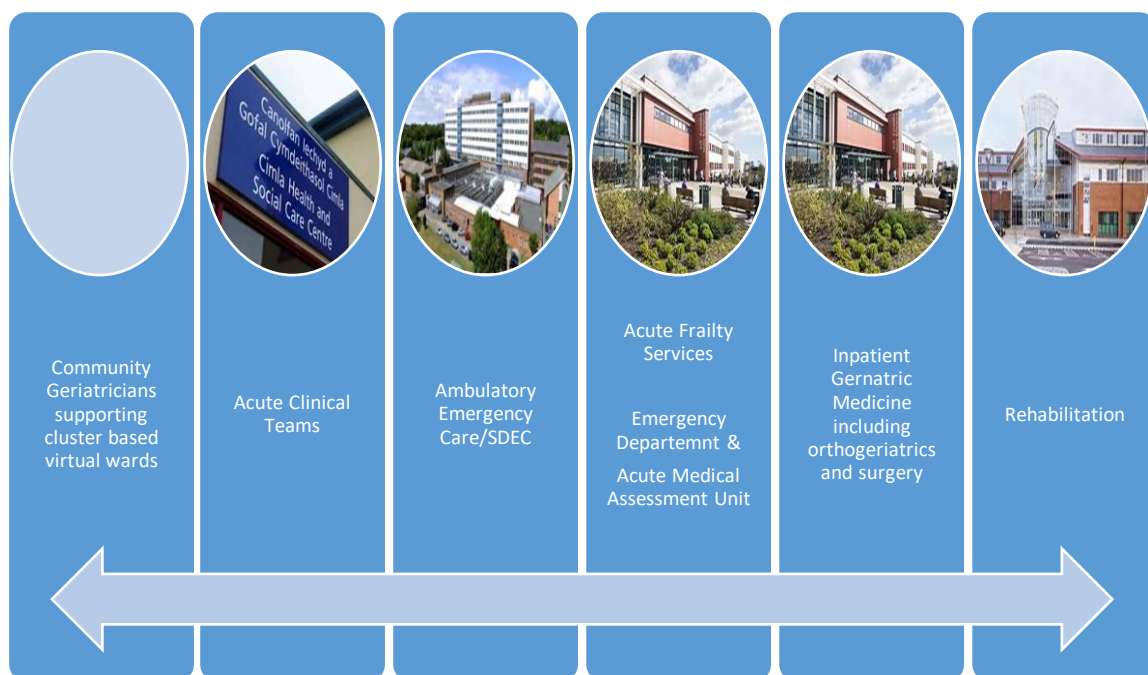
There is compelling evidence to support the benefits of early and effective comprehensive geriatric assessment for older people living with frailty wherever they present⁷.

Optimal outcomes are only achieved when community health and social care services and hospital systems are fully aligned, well-coordinated and integrated.

This document describes a service model delivering medicine for older people in a number of areas including:

- **Community geriatrics:** working in collaboration with primary care and community services to support older people to live well in the community via the creation of virtual wards.
- **Cluster based Virtual Wards:** Co-ordinating a range of services for the patient to improve health and wellbeing, reduce risk of hospital admission and facilitate early supported discharge from hospital sites.
- **Same Day Emergency Care (SDEC)** via the Acute Clinical Teams (ACT) and an Ambulatory Emergency Care unit (AECU)
- **Acute Frailty Services** based in the Emergency Department and on the Acute Medical Unit
- **Inpatient Geriatric Medicine**
- **Ortho-geriatrics and Perioperative medicine for Older People** undergoing emergency surgery
- **Rehabilitation**

The paper describes the Consultant expansion required to address these challenges and the investment required to develop and expand existing and new services to create an effective virtual ward service delivery. However, medical services for older people need to be multidisciplinary and additional multidisciplinary support will be required to deliver the fully integrated person-centred co-ordinated care aspired to.



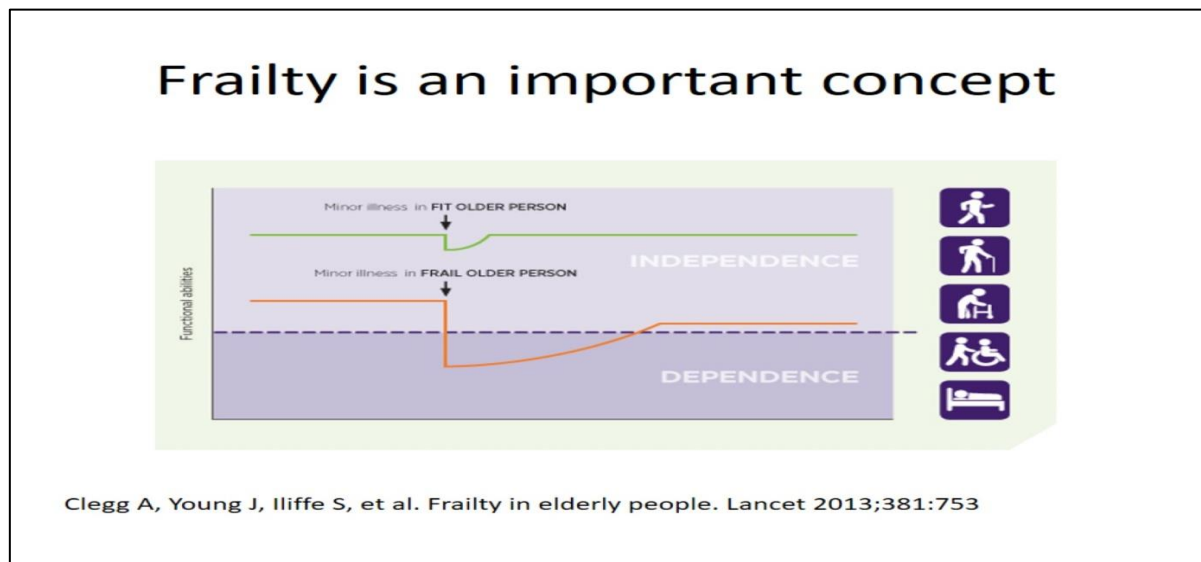
Comprehensive Geriatric Assessment delivered by Consultant led multidisciplinary teams

Background

Frailty

Recognising frailty in the older population is essential in order to offer appropriate intervention in the correct setting at the right time.

Frailty is a well described health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people with Frailty are at risk of unpredictable deteriorations in their health resulting from minor stressor events (BGS 2014/15).



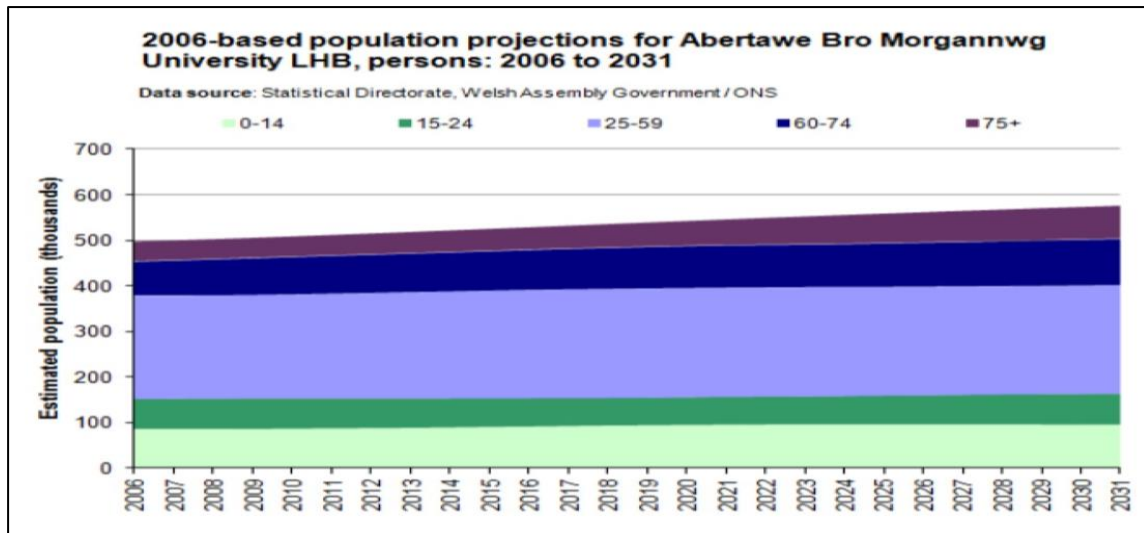
Frailty is a predictor of poor health outcomes and mortality. The e frailty index has been shown to identify older people with mild, moderate and severe frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission⁹.

Frailty is associated with lower education, income, poorer health, a greater number of co-morbid chronic diseases and disability. 60 % of patients defined as severely frail by an electronic frailty index may be expected to die in the following 4 years.

Demographics Changes

The number of older people living with frailty in the Swansea Bay region is increasing. 19.7% of Swansea's population are aged 65 and over (48,700 people)¹¹. 6,600 people in Swansea are aged 85 and over. 29,981 people in Neath Port Talbot are aged >65¹².

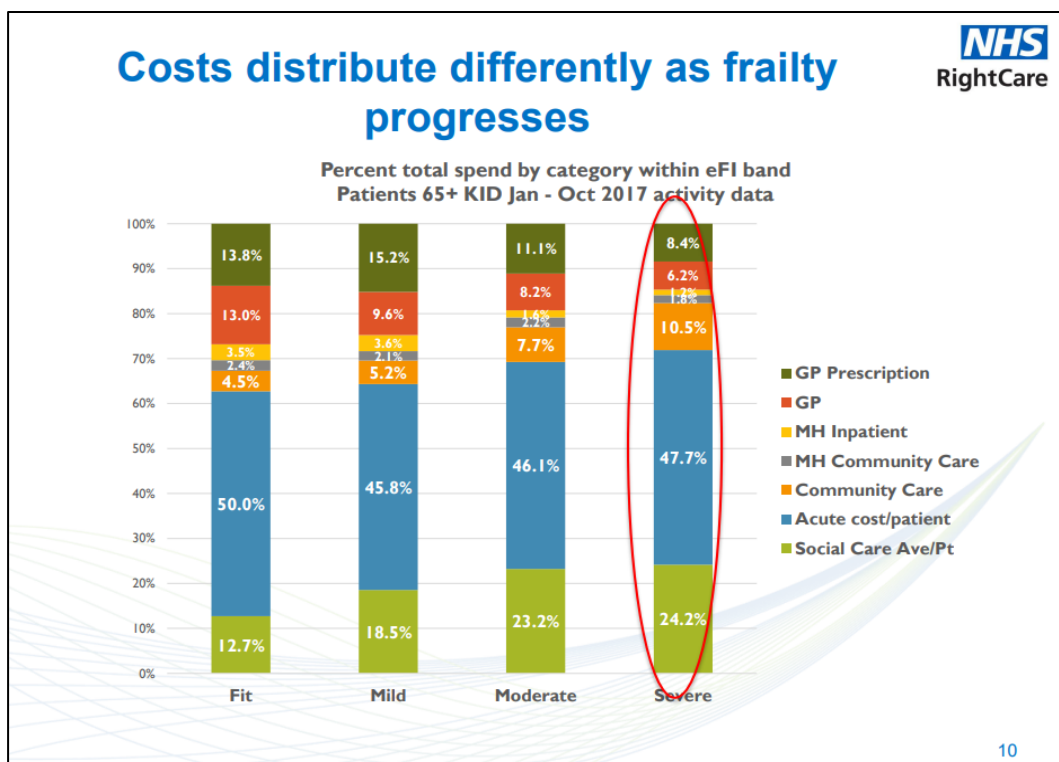
These demographic changes command a model of care tailed to older people living with frailty.



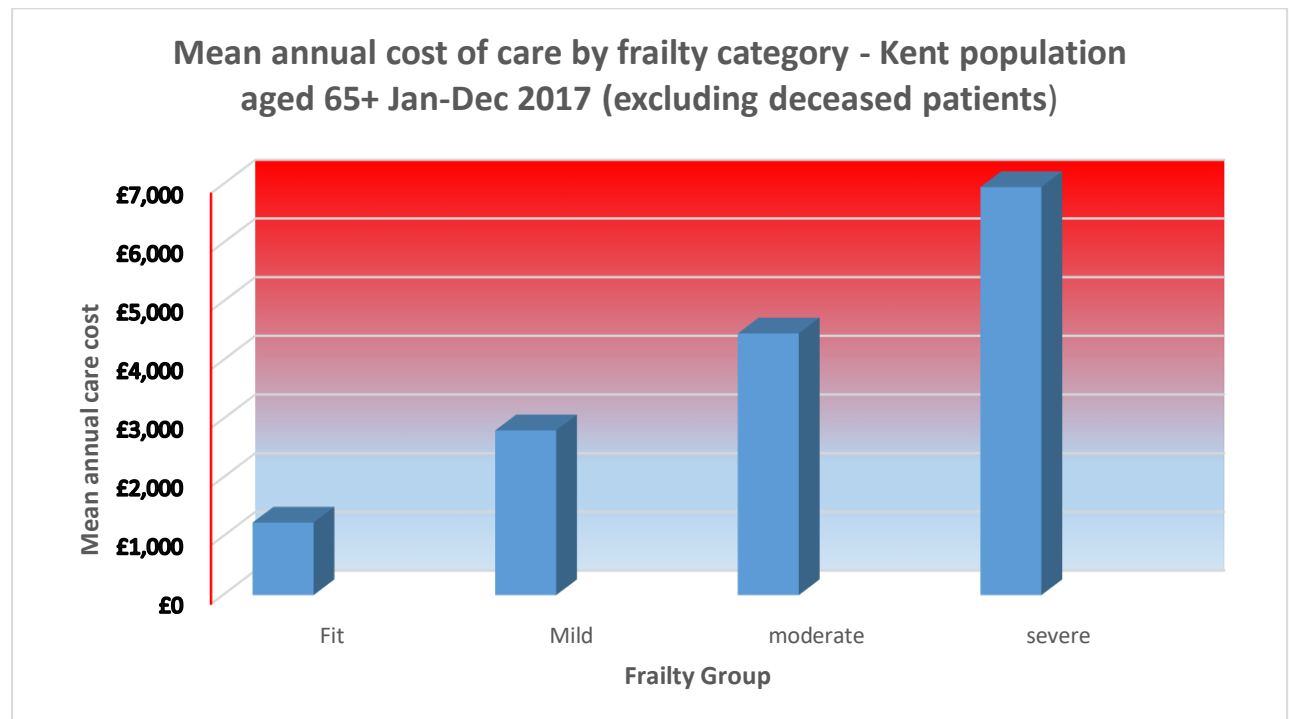
Frailty and Use of Health Resources

NHS Right Care have provided frailty data from the Kent population¹³. The Electronic Frailty Index (eFI) was applied to the Kent population. 3.6% of population 65+ fall within the Severe Frail category.

In the Kent Study the population aged >65 were analysed for health and social care activity and expenditure for a 12-month period starting on 1st April 2016



Almost half of all the health and social care expenditure for severely frail patients occurred in acute hospital care. The average annual NHS spend by frailty category in Kent was £1,688.94 for mild frailty, £2,748.12 for moderate frailty and £4,189.07 for those deemed severely frail.



Prevention frailty progression can lead to a significant cost impact. Adjusting for age, gender and deprivation the Kent data analysis showed:

- If 10% of the severely frail had remained moderately frail the gross savings in Kent would be 1.6m over 10 months
- If 10% of the mildly frail had remained fit, gross savings would be nearly £9m (owing to higher patient numbers)

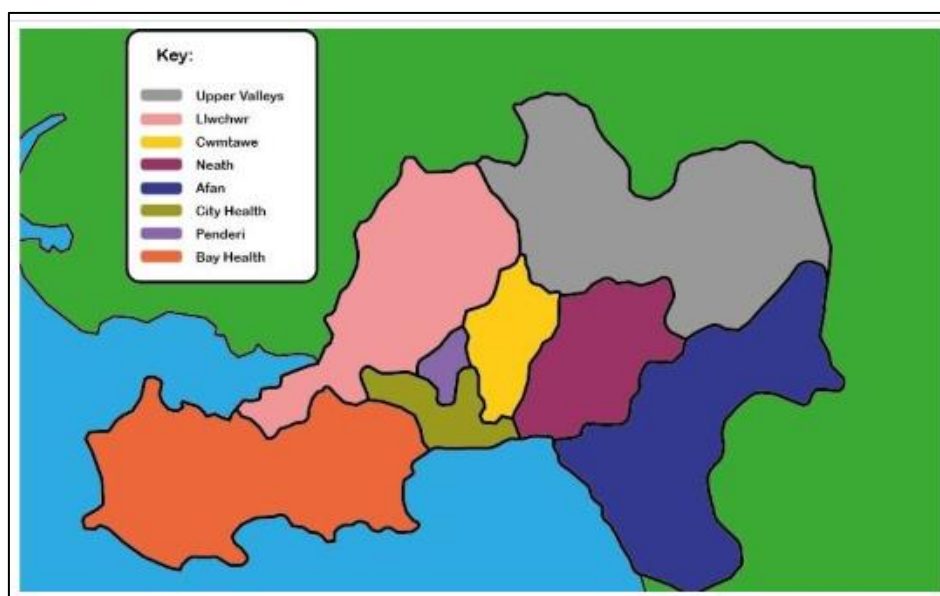
In Swansea and Neath Port Talbot this would equate to over £11 million spent on patients with severely frailty.

It is well recognised that health expenditure is considerably higher for those in the last year of life. The Institute for Fiscal Studies published data which showed the average health spend in the last year of life was £6,651 compared to £624 per annum for those who lived for at least another five years¹⁴.

Prudent use of health resources for the greatest benefit to the patients is essential in managing this frail population.

Virtual Wards

SBUHB has currently three established virtual wards in Upper Valley, Neath and Cwmtawe clusters and there is agreement with Cluster Leads to ensure alignment with the proposed virtual ward service delivery model outlined below.



GP Clusters in Swansea and Neath Port Talbot

Virtual wards offer patient centred ‘wrap-around’ health and social care to people in their own homes ensuring they can receive timely and relevant support with the aim to facilitating earlier discharge from hospital and reducing avoidable hospital admissions in the first place. Virtual wards instantly create capacity in the health system without increasing inpatient beds

Virtual wards will use a multi-professional approach in healthcare provision in the community with core team members consisting of Cluster Geriatrician and GPs/ANPs providing clinical oversight, community teams delivering nursing and therapy care and Local Authorities enabling social care assessments and interventions. However, a wider membership will be required to ensure targeted input from palliative care teams, Third Sector and Old Age Psychiatry and Mental Health Services. Designing virtual wards will use a predictive risk model such as the e-frailty index which identifies patients truly at high risk of emergency admission¹⁵.

The virtual wards will target patients who are at high risk of future unplanned hospitalisation and who are likely to respond to multidisciplinary intervention in the community to avoid admission.

The virtual wards will focus on managing patients at critical transitions of care for example following a recent hospital discharge.

Each virtual ward comprises a multidisciplinary team including nursing staff, pharmacy, social work, physiotherapy, occupational therapy, mental health, palliative care and the voluntary sector.

Typically, older people are at high risk of emergency hospital admission due to multiple chronic conditions which are often compounded by psychological and social issues.

A community geriatrician would add to this model providing expert assessment of older people who often present “non-specifically” with falls, immobility, confusion or failure to thrive. The geriatrician

will optimise the treatment of medical conditions as well as facilitating challenging conversations about prognosis and treatment escalation decisions. The geriatrician will support early identification of patients approaching the end of life.

The geriatrician should assist in delivering enhanced health in care homes and contribute to comprehensive assessments for these patients where appropriate¹⁶.

The virtual ward will focus on four objectives:

- **Risk stratification –identifying frailty**
- **Step Up – Admission Avoidance where appropriate**
- **Step Down – Facilitate safe, timely and supported discharge**
- **Chronic Conditions management**

Outcomes will be quantified and evaluated during the project implementation:

- Reduction of Inpatient bed days by facilitation of early discharges
- Reduction of admissions of patients with exacerbation of LTC – HF/COPD/DM
- Reduction of attendances/admissions of ‘frequent attenders’
- Reduction of attendances/admissions of
 - care home residents
 - patients with agreed ceilings of care/ end of life care
 - very frail/high CFS patients if clinically safe and agreed with patient/relatives
- Improved patient flow – front and back door
- Improved patient experience – PROMS/PREMS

Virtual Ward workload :

A Cluster Virtual will serve a population of approximately 50,000 from 3 to 8 GP practices. Each Virtual Ward will initially hold a caseload of 50-60 patients with the intent to increase this number as part of the roll out across SBUHB. Patients will be divided into three categories depending on their clinical presentation and stability which will define the frequency of care discussions needed. Patients will either require daily, weekly or monthly discussions/ward rounds. The community sister can move patients freely following discussion with the Virtual GP/Cluster Geriatrician between these different intensity ‘beds’ according to changes in their clinical conditions. The following distribution will be expected for a 50 patient virtual ward based on data from a pilot of a 100 patient virtual ward in Croydon¹⁵:

Daily	Weekly	Monthly
3 patients	18 18/5 = max 4	30 30/20 = max 2

This will result in $3+4+2 = 9$ patients for discussion each day. Patient requiring a multi-professional discussions and any new referrals will be discussed as part of the weekly virtual ward meetings.

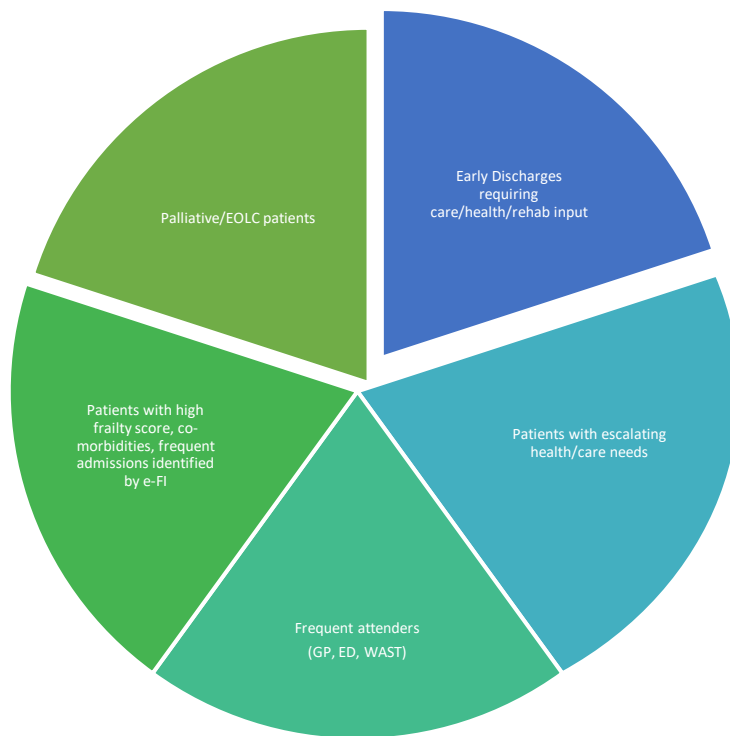
Virtual Ward Team:

1. 1x WTE Community Sister Band 7: Manages caseload of each Virtual Ward, coordinates agreed care plans, attends daily board rounds with Cluster Virtual Ward GP and/or Cluster Geriatrician and identifies appropriate patients for multi-professional virtual ward meetings.
2. 1x HCSW/Ward clerk B3: supports Community Sister in coordination of care, collating information on progress in preparation for virtual ward meetings, completes admission and discharge documentation, communicates with services if required.
3. 4 x GP sessions/week: provides clinical leadership to virtual ward team, attends daily virtual ward board rounds (shared responsibility with Cluster Geriatrician), chairs virtual ward meetings
4. 4x Cluster Geriatrician sessions: provides expert advice to optimise clinical management of virtual ward patients, attends daily virtual ward board rounds (shared with virtual ward GP), attends virtual ward meetings, takes clinical responsibility for patients on early supported discharge pathway, liaises with secondary care colleagues regarding arranging urgent interventions/diagnostics/ambulatory care/focussed admissions,
5. 0.5 Project Manager Band 7: provides operational management support to the virtual ward, monitors performance and provides information for cluster meetings
6. 0.5 call handler/single point of access Band 3 admin: responds to phone calls from secondary care, patients, carers, community services, collates information of new referrals

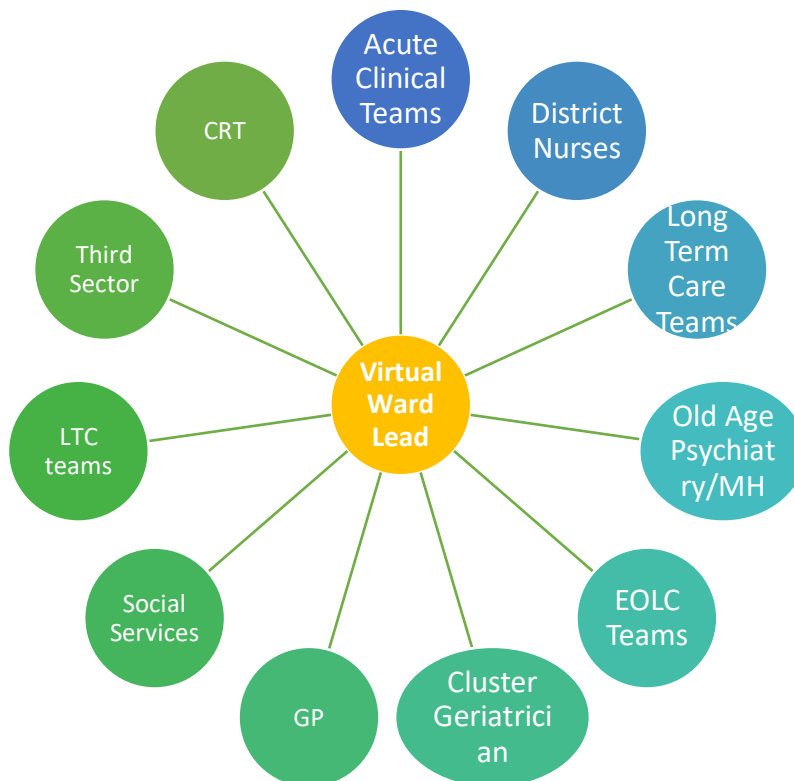
Virtual Ward meetings (weekly):

The weekly meetings with wider multi-professional teams will allow more detailed discussion and division of tailored management plan for patient identified/escalated from the daily board rounds. This forum will also allow discussion of any new referrals from General Practice and early supported discharges from secondary care. Referring GP will be invited to attend the virtual ward meeting to ensure all relevant information has been conveyed to team members of the new referral. The virtual ward will have dedicated administrative support to ensure discussions and actions are minuted at each meeting. Each patient will also receive an expected date of discharge from the virtual ward anticipating when the agreed care plan will be completed.

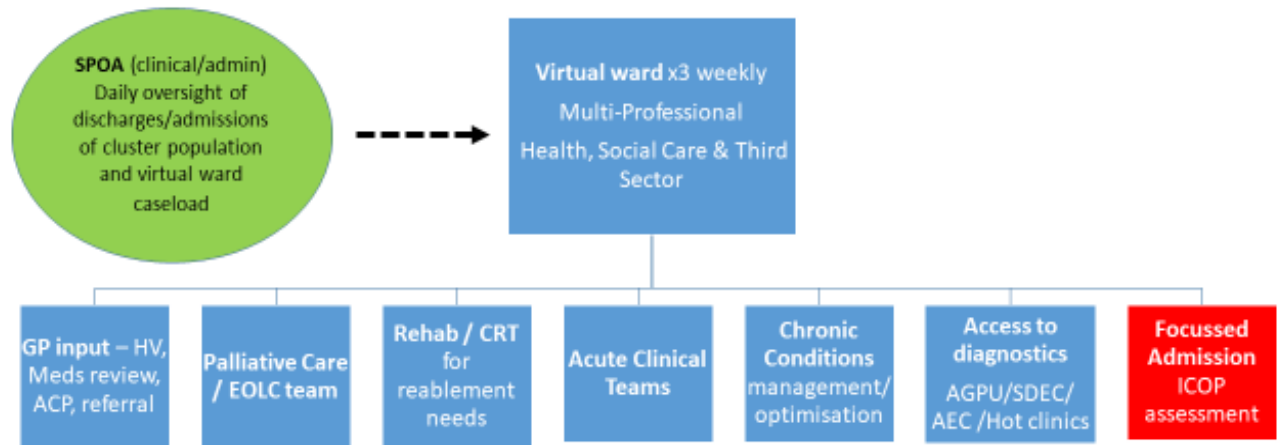
Expected caseload of virtual wards:



Virtual Ward attendees:



Outcomes of virtual ward meetings;



1. Identifying frailty and risk stratification

It will be essential to recognise frailty as a clinical problem in the older population in order to deliver appropriate and relevant interventions in a timely manner by the right professional and in the right setting. Frailty is accepted as a loss of resilience that means people living with frailty do not bounce back quickly or completely after a physical or mental illness, an accident/fall or other stressful event. In clinical terms frailty is characterised by a loss of biological reserves across multiple organ systems and increasing vulnerability to physiological decompensation after a stressor event. Frailty is therefore a predictor of poor health outcomes and mortality.

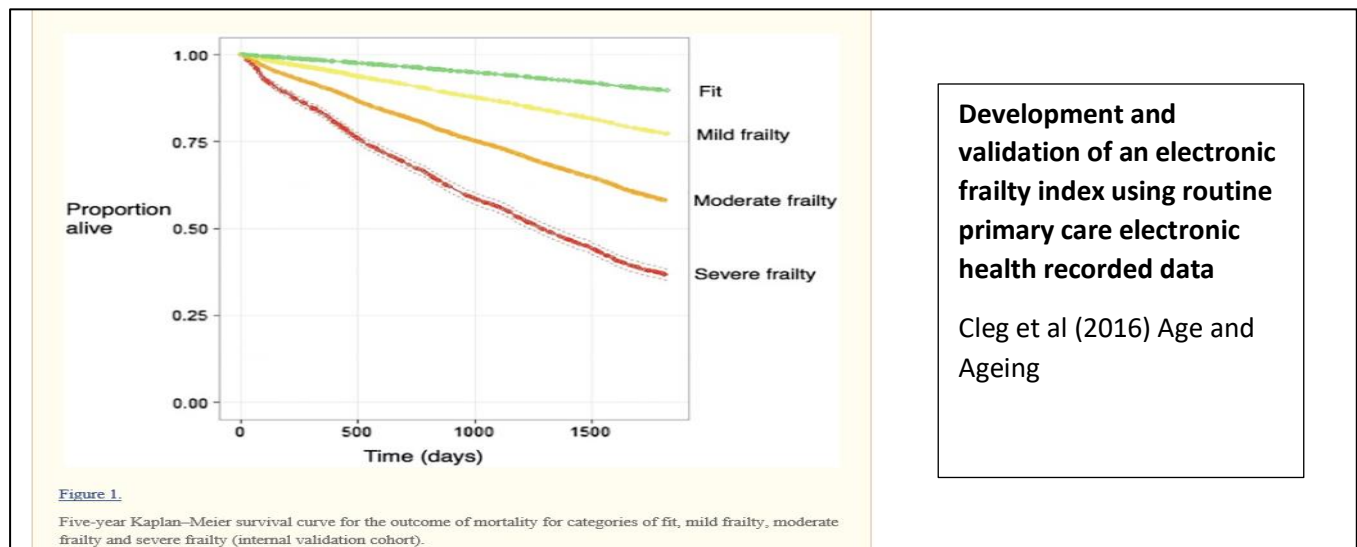
There are a various frailty screening tools available with the electronic frailty index (e-FI) shown to identify older people with mild, moderate and severe frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission⁷

The electronic frailty index is a tool that can be used to identify as they progress through different levels of frailty and is based upon a person's needs rather than their service use. It uses existing primary care data as opposed to acute data and is therefore more likely to identify people earlier in their progression of frailty before they experience an acute crisis. The e-FI uses a cumulative deficit model to identify and score frailty based on routine interactions with their GP. As individuals interact with GPs, their GP records accumulate a list of read codes and community prescriptions. The e-FI uses a subset of these read codes to interpret any number of up to 36 potential deficits. The number of deficits that an individual is considered to have is then divided by the total (36) to produce a score. This score determines whether a person is mildly, moderately or severely frail or severely frail and nearing the end of their life. This can be calculated for an individual or for a whole practice population over 65 years of age.

The e-FI was developed in England and has been validated against a population of 900.000 people aged 65 years and over.

Frailty is a predictor of poor health outcomes and mortality. The e frailty index has been shown to identify older people with mild, moderate and severe frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission⁹

Frailty is associated with lower education, income, poorer health, a greater number of co-morbid chronic diseases and disability. 60 % of patients defined as severely frail by the electronic index may be expected to die in the following 4 years.

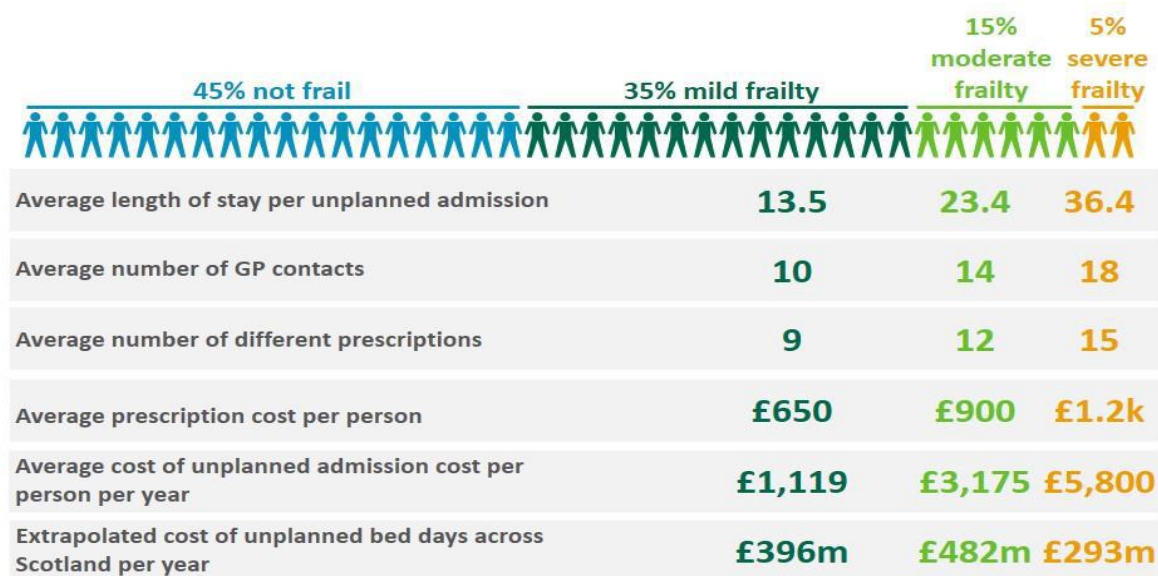


48% of patients aged >85 years of age admitted for any reason die within 1 year of admission¹⁰

e_FI Risk Prediction

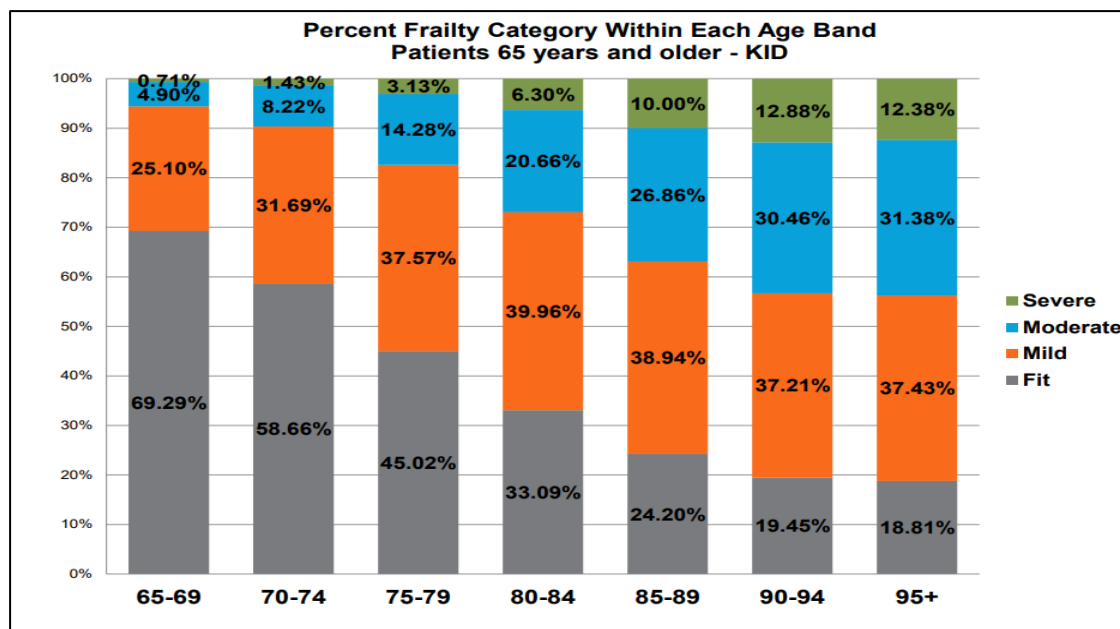
1 year outcome	Mild	Moderate	Severe
Mortality	1.92	3.1	4.52
Hospitalisation	1.93	3.04	4.73
Nursing home admission	1.89	3.19	4.76

Frailty is progressive and as expected there is an increase in service use as people become frailer. Midlothian Health and Social Care Partnership in Scotland have used the e-FI index to identify their frailty population. Data below from Midlothian Health and Social Care Partnership in Scotland demonstrates that as frailty increases in severity, so too does the average length of stay in hospital, the number of GP contacts and the number of medications resulting in higher costs for the person. The average medication cost for the general population is £255 per person.



Evidence shows that timely identification of frailty followed by appropriate evidence-based intervention can help to reduce the likelihood of progression of frailty and support the long term management of people's health and social well being.

NHS Right Care have provided frailty data from the Kent population¹³. The Electronic Frailty Index (eFI) was applied to the Kent population. 3.6% of population 65+ fall within the Severe Frail category.



Frailty in Swansea Based on an E-frailty score

If the Kent data is extrapolated to the population of Swansea the following frailty distribution. The data suggests 1,731 people over 65 in Swansea are living with severe frailty.

Age	All People (%of total)	Mild	Moderate Frailty	Severe Frailty
65-69	13,000 (5.3%)	3,263	637	92
70-74	12,900 (5.2%)	4,088	1060	184
75-79	9,300 (3.8%)	3,494	1328	291
80-84	6,900 (2.8%)	2757	1425	435
85-89	4,200 (1.7%)	1635	1128	420
90+	2,400 (1.0%)	893	731	309
TOTAL	48,700	16,130	6,309	1,731

Frailty in Neath Port Talbot Based on an E-frailty Score

If the Kent data is extrapolated for the population of Neath Port Talbot the following frailty distribution is created.

The data suggests 987 people over the age of 65 in Neath Port Talbot are living with severe frailty.

Age	All People (%of total)	Mild	Moderate Frailty	Severe Frailty
65-69	8,652	2,171	423	61
70-74	8,045	2,549	661	115
75-79	5,707	2,144	815	179
80-84	4,013	1,604	829	252
85-89	2,352	915	631	235
90+	1212	448	375	145
TOTAL	29,981	9,831	3,734	987

It is recognised that simply numbers of people of people identified as frail may be unmanageable to meaningfully review and act on, therefore when used through the e-FI toolkit refined high risk subgroups of patients can be identified. These high priority groups include people who:

- Escalate to being moderately frail
- Are moderately frail and have experienced significant change/increase in frailty
- Escalate to being severely frail
- Are severely frail and are experiencing significant change/increase in frailty

The e-FI is not a clinical diagnostic tool, it is a risk stratification tool which identifies groups of people who are likely to be living with varying degrees of frailty but it is not able to do this for specific individuals. Therefore when the e-FI identifies an individual living with moderate or severe frailty or has been identified as lying within the above high priority groups, clinical assessment and judgement is required to confirm the diagnosis.

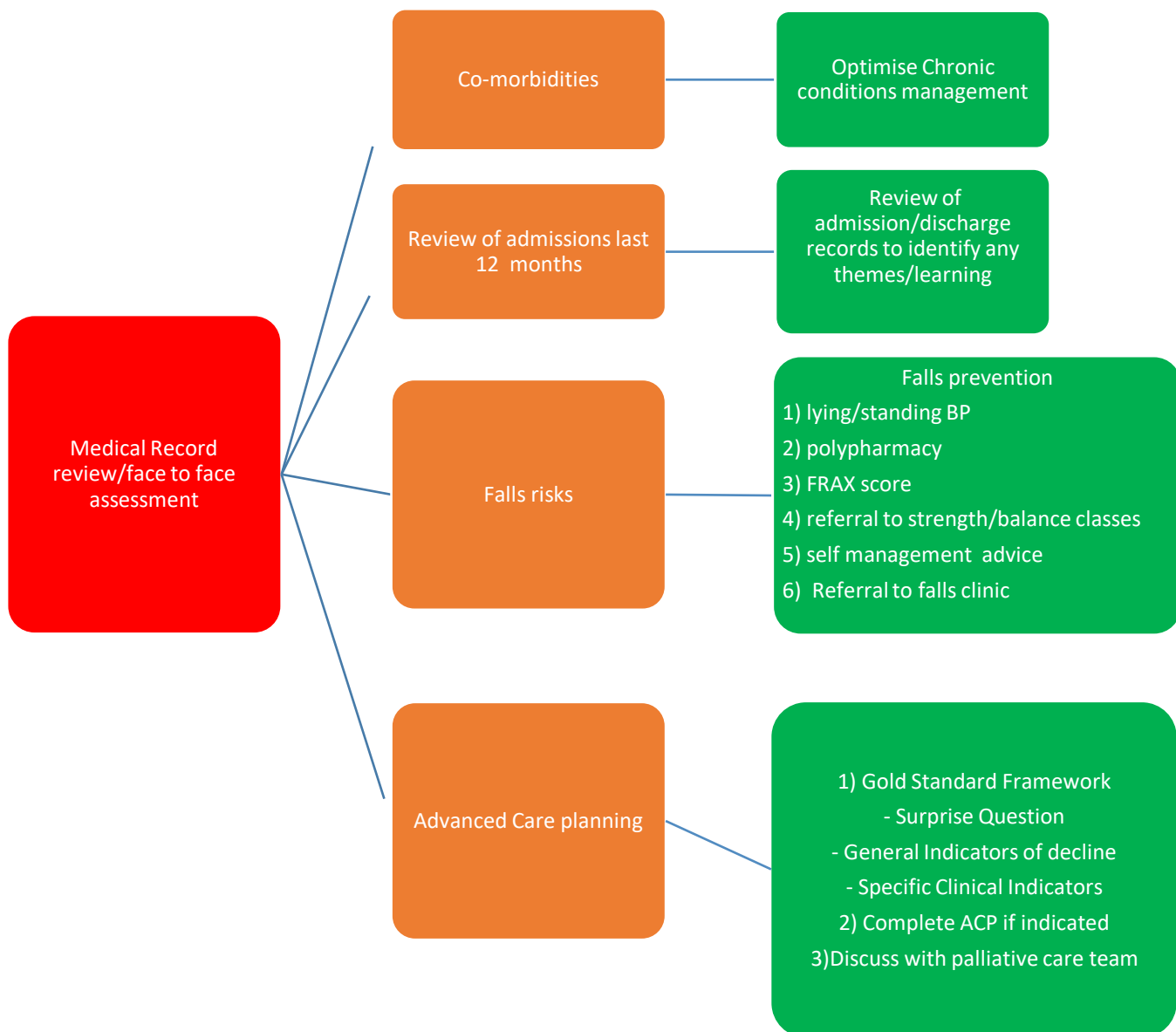
Swansea Bay University Health Board, Primary, Community and Therapies Group will invite GP practices to participate in this Framework before 30 April 2021. GP practices wishing to participate will be required to sign up to all components of the Framework. The Framework will be evaluated following its completion on 31 March 2022.

Appendix () outlines a Framework which will be offered to GP practice to undertake the frailty risk stratification and identification of their respective practice populations. The aims of this framework will be to:

- Identify patients who are at high risk of avoidable unplanned admissions by undertaking a medical record search of the practice population using the electronic frailty index tool.
- Establish a case management register of the identified patient cohort which should comprise of a minimum of two percent of the total practice population.
- Proactively manage and review patients on the register, improve/facilitate hospital discharge process and coordinate delivery of community care.
- Ensure timely telephone access for these patients/carers/families during in-hours GP opening hours and handover of any relevant information to out of hours services.
- Undertake regular internal practice reviews of emergency admissions and ED attendances within this patient cohort to ensure any learning is identified and shared and lessons learnt.

The GP practice will undertake monthly reviews of the register to consider any actions which could be taken to prevent unplanned admissions of patients on the register. These reviews should entail four mandatory components:

- Current management of any comorbidities/chronic conditions
- Review of admissions last 12 months
- Falls Risk
- Advanced Care Planning



Component	Areas for review	Actions required	Support
Co-morbidities/Chronic Conditions (CC)	<ul style="list-style-type: none"> Severity of CC (mild/moderate/severe/end stage) Level of control of CC – need for optimisation Number of exacerbation of CC last 3 months Patient's/carers/family level of understanding of CC 	<ul style="list-style-type: none"> Optimise CC by completing CC reviews including relevant investigations Complete medication review Complete CC patient care/management plans Patient education/self management Discuss/complete ACP Referral to specialist 	<ul style="list-style-type: none"> Cluster Geriatrician Chronic Conditions Management Team Virtual Ward Palliative Care team
Review of admissions	<ul style="list-style-type: none"> Number of hospital admissions/ED attendances over the last 12 months Reason for admission/attendance Avoidable or non-avoidable admission – i.e alternative pathways within community services explored/considered 	<ul style="list-style-type: none"> Discussion of any learning/concerns at practice and cluster meetings Implement any relevant changes on practice/cluster level Recommendations of change in practice/pathways required on wider system level 	<ul style="list-style-type: none"> Cluster PCTG Virtual Ward Community Services
Falls Risk	<ul style="list-style-type: none"> Number of falls last 12 months Current risk of falling 	<ul style="list-style-type: none"> lying/standing BP correct polypharmacy FRAX score referral to strength/balance classes self-management advice Referral to falls clinic 	<ul style="list-style-type: none"> Cluster geriatrician/falls clinic Virtual Ward CRT/Community teams
Advanced Care Planning	<ul style="list-style-type: none"> Need for ACP discussion Review/update of existing ACP 	<ul style="list-style-type: none"> Gold Standard Framework - Surprise Question - General Indicators of decline - Specific Clinical Indicators Complete ACP if indicated Discuss with palliative care team 	<ul style="list-style-type: none"> Cluster Geriatrician Palliative Care Team Chronic Conditions Management Team

Practices will have access to the following options of support in completing the reviews:

- Expert advice from dedicated Cluster Geriatrician
- Expert advice from dedicated Cluster Palliative Care Consultant
- Referral to Virtual Ward for MDT review and input
- Referral to Chronic Conditions Management Team

Participation in this framework will ensure population risk stratification and targeted relevant individualised interventions for optimal outcomes.

2. Step Up – Admission Avoidance where appropriate

The Acute Clinical Teams in Swansea and Neath Port Talbot deliver acute medical care for older people living with frailty in the community.

Service remit:

The service is managed by Nurse Practitioners with clinical oversight and governance provided by the Consultant Physician. Referrals are accepted from all professionals, for example, GPs (main referrers), Paramedics (including ACT having the ability to access the WAST ambulance stack), District Nurses and Secondary Care Clinicians, Learning Disability teams, Care Home staff and Local Authority colleagues. Referrals are responded to on the same day (resource allowing). The team works seven days a week between 0830hrs and 2200hrs and accept referrals until 1700hrs. There is always a nurse practitioner working every day including weekends.

Referrals are accepted for all adults over 18 years and the service takes clinical responsibility for all the patients under their care.

The service has a dedicated phone line which is manned Monday to Friday by a Duty Navigator who takes the referrals electronically. Referrals at weekends are taken by the nurse practitioner on call. Visits are allocated for the team via an electronic SharePoint calendar.

The ACT referral criteria are broad. The team is flexible and will work with a wide range of professionals and use innovative approaches to keep patients at home (*see appendix 1 for case examples*). A key partner is Afan Nedd Day Unit (ANDU) in Neath Port Talbot Hospital (NPTH) where patients can attend for the day for prolonged intravenous infusions, blood transfusions and more detailed assessments and investigations. If patients are deteriorating and require inpatient investigations and treatments ACT will liaise with the appropriate hospital for admission. This need not always be an acute hospital and ACT can admit to a “non-acute” bed at NPTH but there are no ring fenced beds.

Inclusion Criteria- Admission prevention

- Acute infections that need more intensive treatment (IV antibiotics) or patients have additional complications for example fast Atrial Fibrillation, Acute Kidney Injury
Some examples but not limited to:
 - a) Cellulitis and infected ulcers needing IV antibiotics
 - b) Community acquired pneumonia
 - c) Exacerbation of COPD, Bronchiectasis, Cystic fibrosis
 - d) Chest infection secondary to Aspiration
 - e) Urinary tract infections not responding to oral antibiotics
 - f) Gastroenteritis needing parenteral fluids/monitoring of renal function
 - Exacerbation of heart failure needing intensive titration of medication including IV diuretics.
 - Rate control for fast atrial fibrillation
 - Low risk pulmonary emboli, deep vein thrombosis
- Acute kidney injury requiring parenteral fluids and monitoring. Management of urinary retention.

- Electrolyte abnormalities- hyper and hypokalaemia, hyper and hyponatremia, hypercalcaemia. Significant hypocalcaemia and hypomagnesaemia to be managed with ACT support in Afan Nedd Day Unit (ANDU) where infusions can be safely given.
- Unstable INR requiring close monitoring/IV vitamin K
- Management of the older frail patient:
 - a) Complex falls- long lie, recurrent falls, history suggestive of syncope, vertigo, history suggestive of myelopathy or lumbar canal stenosis
 - b) Acute Delirium
 - c) Deterioration in ability to function, worsening mobility, unexplained weight loss, needing a comprehensive Geriatric assessment

Inclusion Criteria - Expedite Discharge

- Most of the conditions as stated above in certain circumstances may need a period of admission and patients can be discharged to continue treatment in the community and/or have a review in a rapid access clinic.
- Conditions requiring long term IV antibiotics e.g. Discitis, septic arthritis, Endocarditis, liver abscess

Exclusion Criteria

- Patients who are acutely unwell needing urgent hospital treatment. For example, sepsis with high NEWS score, Upper GI bleed with any haemodynamic compromise
- Acute stroke
- Acute Coronary syndromes
- Suspected fracture of long bone
- Fall with head injury needing further investigation
- Surgical presentations

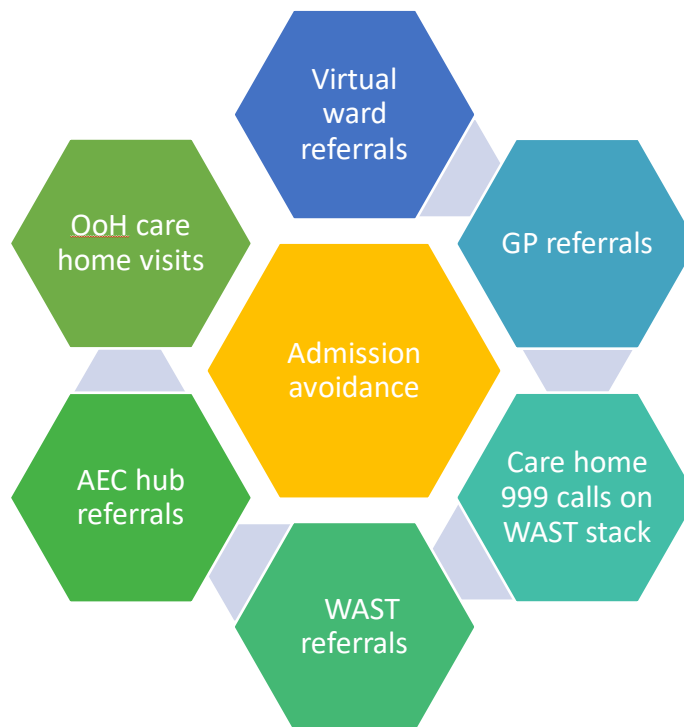
Appendix () outlines current performance data for the Acute Clinical Team in Neath Port Talbot.

To maximise the aim to reduce any avoidable admissions the following objectives for future service delivery have been agreed:

- Same day response to any new referrals
- Reduction of average duration on ACT caseload from current 8 to 5 days
- Increased referrals from WAST at scene following 999 call outs
- Increase caseload from current 33 to 50 patients

Appendix () describes the changes, expansion and resources required to achieve above objectives.

Sources of referrals for Acute Clinical Teams



3. Step Down – Facilitate safe, timely and supported discharge

The Virtual ward aims to reduce patient's length of stay in hospitals by facilitating effective and safe care at home. The aim is to reproduce the strengths of a hospital ward in the community by using a multi-professionals approach in healthcare provision whilst the patient returns to his own home/environment. The designated Cluster Geriatrician will in collaboration with the Virtual Ward GP/AP Lead take over the clinical responsibility for the discharged patient from the clinical team of the hospital sites. An agreed care plan will be implemented and if required adapted during the patient's stay on the Virtual Wards delivered by relevant multi-professional team members. Once the care plan including reablement needs is completed and with agreement of the Virtual Ward MDT, the patient will be discharged from the virtual ward.

Further developments and improvements will be needed to strengthen current discharge pathways:

- Access to Signal clinical record system by Virtual Ward team will allow timely sharing of relevant clinical information and care needs of the patient prior to transfer to Virtual Ward
- Completion of shared care plan with patient/relatives/carer prior to discharge outlining realistic outcomes, expected progress and current health and care needs.
- Comprehensive and timely transfer of relevant discharge information at the time of transfer to the virtual wards to ensure safety and continuity of care.
- Single point of access to virtual wards to enable early discussion between hospital and community how best to facilitate early supported and safe discharge.
- Effective discharge liaison/coordination team to create robust links between hospitals and Virtual Wards. This role will entail 'pulling' appropriate patients out from the acute sites, explaining the service, assessing patients, obtaining consent, and developing care plans.

DISCHARGE: THE PATIENT'S JOURNEY



4. Chronic Conditions Management

Chronic conditions are increasingly becoming a primary concern in an aging population with a high proportion of patients being diagnosed with one or more chronic conditions. Data shows that a large number of people who have chronic conditions are frequently hospitalised as an emergency. The Department of Health states that people with chronic conditions are significantly more likely to see their General Practitioner accounting for up to 80% of GP consultations. It also reports that:

- 60% of hospital bed days are for patients with chronic conditions or related complications
- Two thirds of patients admitted as medical emergencies have exacerbation of their chronic condition
- Some people are highly intensive users of services with 10% of in-patients accounting for 55% of in-patients days.

Patients with chronic conditions, primarily respiratory, diabetes and heart failure have very frequent often prolonged admissions to hospital. Proactive clinical management and earlier recognition of any exacerbations of this patient cohort is required within the community to prevent hospital admissions and achieve improved quality of care.

The aim of the focus on chronic conditions management is to improve the care offered to this patient group by:

- Case managing those most at risk of exacerbations/hospital admissions
- Timely assessment and intensive/targeted support to patients experiencing and acute exacerbations of their condition including coordinating a range of services to reduce admission to hospital
- Reducing length of stay at hospital site by facilitating earlier supported discharge back to patient's home/care home
- Offering a point of contact for care and advice for patients, carers and other Health Care Professionals with good access to secondary care access if required.

The chronic conditions team will report to the Virtual Ward Clinical Team and will receive referrals from the virtual ward following board rounds or weekly virtual ward meetings. Referrals can also be received directly from practices for patients identified on their high risk/severe frailty register.

Clinical input by the chronic conditions team will depend on the findings of the initial assessment and level of acuity. Input can range from daily visits to low intensity input during the time of stabilisation of the condition. Opportunities of patient education, patient centred care plans, ACPc and medication reviews will be utilised during the duration of the input.

Key benefits of improved chronic conditions management in patients with moderate/severe frailty will allow offering interventions/treatment for patients in their own home/care home. As a consequence hospital admissions can often be avoided and earlier discharges from hospital can be facilitated. Outcomes of a potential admissions avoidance and reduced length of stay in hospital will be monitored by the Virtual Ward project manager as part of the wider evaluation.

Workforce required:

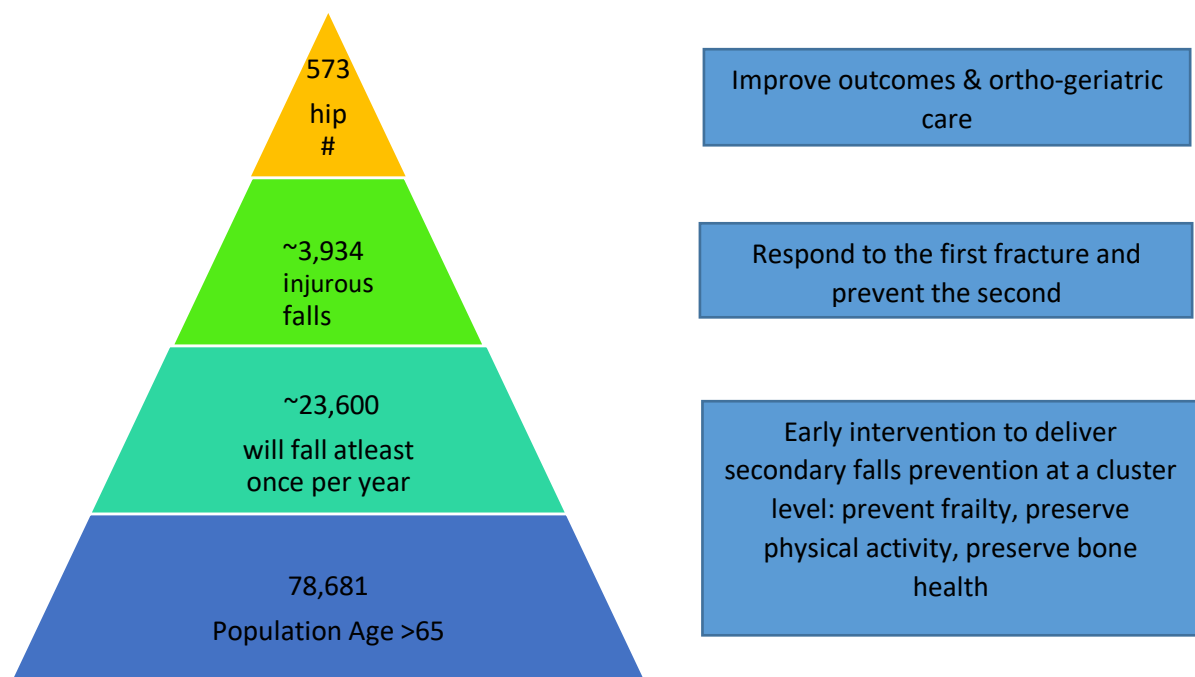
- Band 7 Nurse Practitioner – Chronic Conditions management sister: oversees and clinically manages caseload and ensures timely discussions or escalation to virtual ward, ACT, Cluster Geriatrician/GP or secondary care, undertakes initial assessment of new referrals and decides evidence based management plan.
- Band 6 RGN: - supports CCM Sister in service delivery, completes management plan, reports to CCM sister any concerns/escalation needed
- HCSW Band 3 – undertakes phlebotomy and physiological measurement as part of the agreed care plan

The chronic conditions team will have close links/relationship with pulmonary/cardiac rehabilitation services, CRT and ACT to ensure signposting and escalation if needed.

Community Falls Programme

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

A community falls service will ensure an evidence base approach to falls prevention is adapted at a cluster level. Taking a more proactive approach to falls prevention and management can significantly contribute to reducing avoidable hospital admissions and reduce the significant harm and financial burden associated with falls.



A systematic approach to falls and fracture prevention adapted for Swansea from Falls and fractures: Effective interventions in Health and social care DOH 2009¹⁷

The key features of the community falls programme would include:

- Recognition and modification of risk factors for falls including
 - Checking a lying and standing BP
 - Polypharmacy review
 - Assessment of environmental risk factors for falls
- Assessment of osteoporosis risk using a FRAX score & initiation of osteoporosis treatment where appropriate
- A consultant led community falls clinic for complex cases
- A cluster delivered, evidence based, strength and balance programme to prevent falls A tailored programme for falls prevention can reduce the risk of falls by up to 54 per cent, but not all exercises are effective in preventing falls¹⁸.

Each Cluster would have **4 sessions** of Consultant Geriatrician time per week to support this admission avoidance work.

The role of the Community Geriatrician would include:

- Attending **Virtual ward** at a cluster level to provide geriatric medicine expertise **(1 DCC)**.
- Link with Acute Clinical Team for acutely unwell patients where a community option for medical treatment would be more appropriate.
- Run a community based falls clinic as part of a community falls prevention programme **(1DCC)**
- Providing clinical reviews at a GP practice level/patient home for patient living with frailty including where appropriate care home patients. **(1 DCC)**
- Admin session (1 session)
- Hospital Consultant posts would include community geriatric sessions as part of an integrated job plan (see appendix 1)
- Initially we would provide Consultant Geriatrician input into ¾ clusters with the ambition to expand to all clusters in the next 5 years.

Same Day Emergency Care

Ambulatory Emergency Care Unit

Older people should have access to an ambulatory emergency care unit (AECU) which allows the investigation, treatment, and rehabilitation of patients for whom, in the absence of an ambulatory emergency care service, admission to hospital would have been the default option.

Frailty clinics with a number of “hot slots” should operate 5 days per week and accept referrals from all acute clinical interfaces including GPs, the acute GP unit (AGPU), virtual wards, Acute Clinical Teams, the Emergency department, Acute Frailty Services and inpatient wards.

The “hot” frailty clinics will also support referrals from Consultant Direct.

Ambulatory Emergency Planned Care

Older people living with frailty also require access to urgent planned ambulatory care where the clinical need may be anticipated a day or two in advance. This would include provision of chair based and bed based treatments including blood transfusion, iron infusion, intravenous bisphosphonates.

There should be same day access to radiology and speciality advice/services including access to specific clinical procedures (e.g. the respiratory pleural service or gastroenterology urgent paracentesis).

Many of these services are already offered via the medical day unit at Singleton Hospital and Afan Nedd day hospital in Neath Port Talbot.

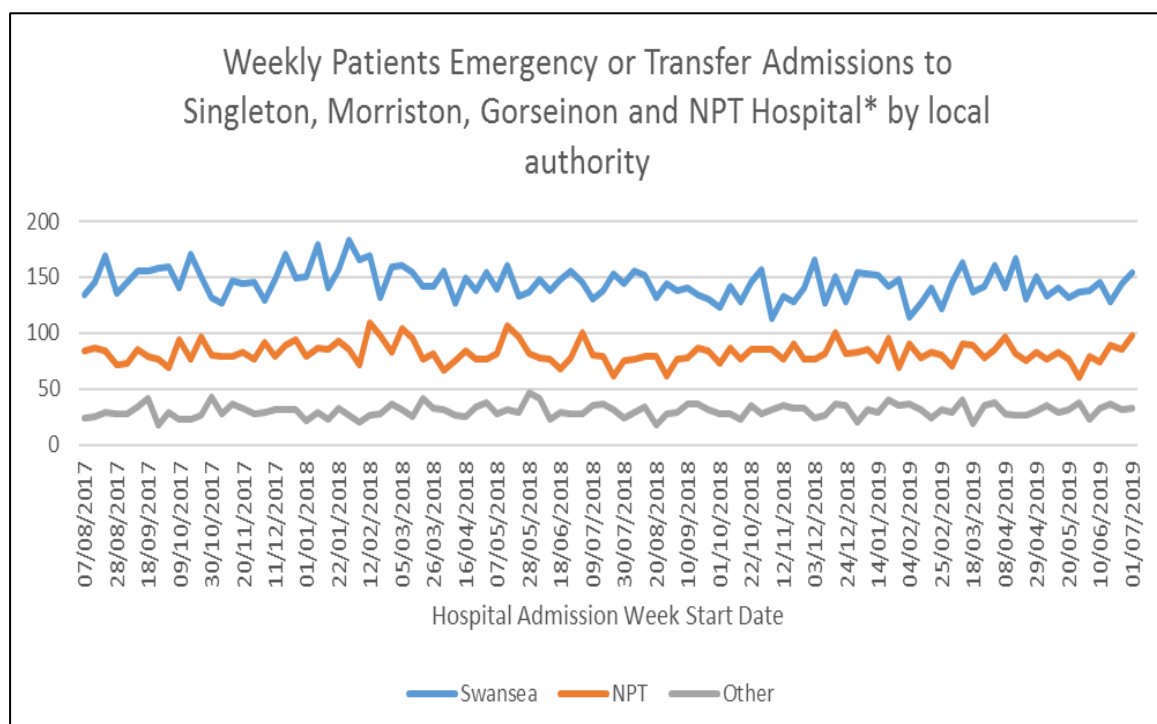
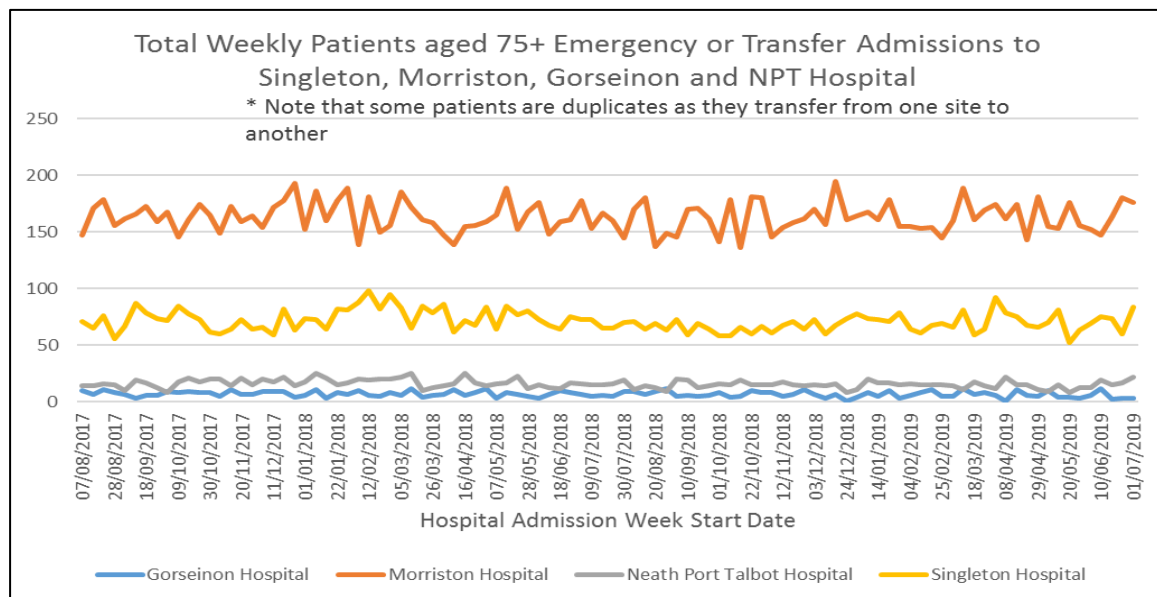
These planned ambulatory services are likely to need expansion to support the virtual wards and acute clinical teams.

Frailty Hot Clinics will require 5 DCC Sessions per week and will be allocated within Consultant Job Plans

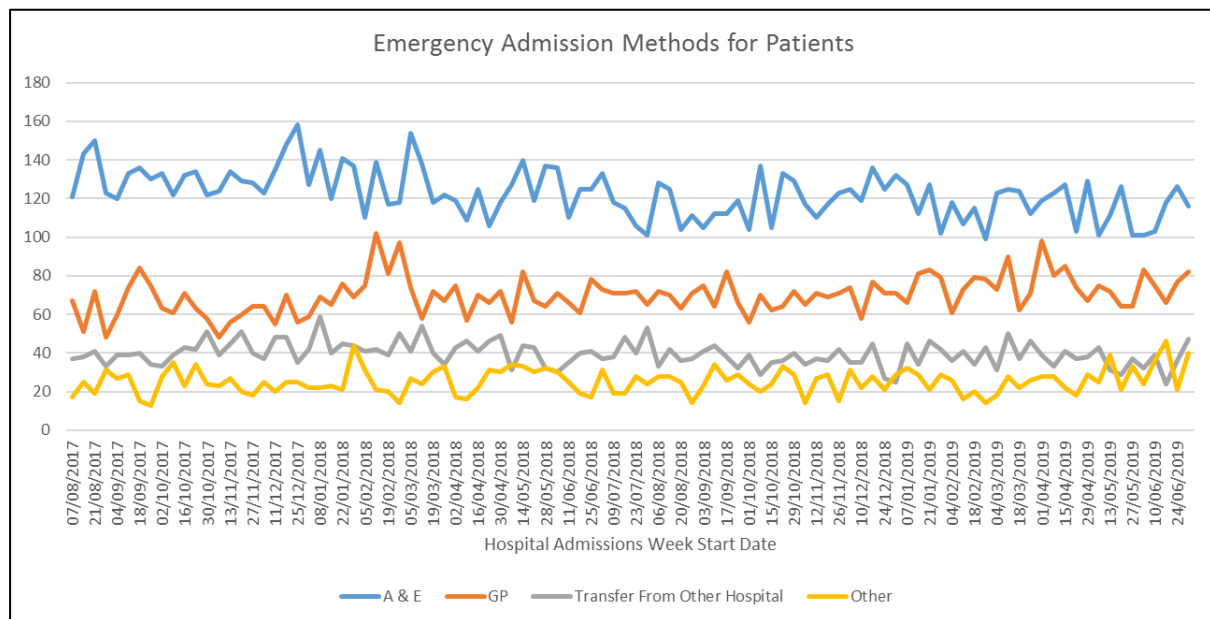
Acute Medical Care for Older People (0-72hours of admission)

Acute care for older people presenting to Swansea Bay University Health Board needs to expand to meet the acute care needs of frail older people. Acute frailty services must deliver the high quality, integrated, person centre care older people require.

Approximately 250 people over the age of 75 are admitted to Swansea Bay University Health Board each week. Approximately 100 patients over the age of 85 are admitted each week. Approximately 60% of admissions are Swansea resident and 30% are Neath Port Talbot residents and 10% are from other local authorities.

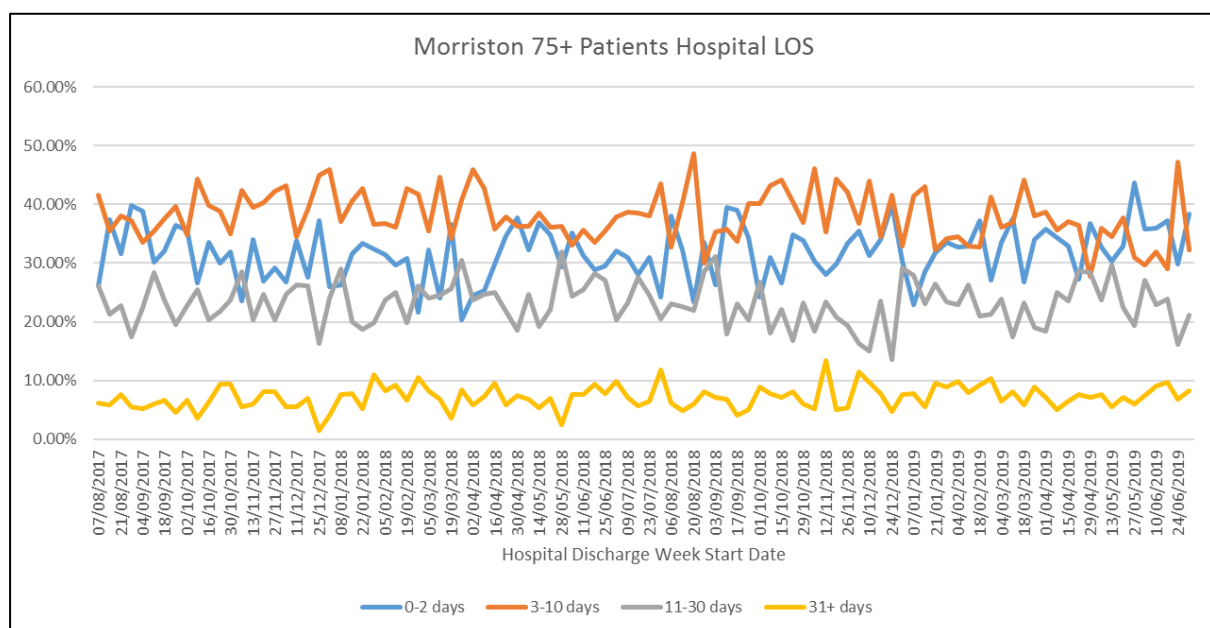


Approximately 50% of medical patients over the age of 75 are admitted via A&E. Conversion rates to admission are high for older people. A further 60-80 patients per week are admitted via their GP.



Length of Stay

The length of stay for older patients can be divided into 4 groups. Our medical model will reflect the needs of older people in each of these areas. Acute frailty services will optimise care for those with LOS 0-2 day. In-patient geriatric medicine should provide intensive input for LOS 3days -21days. Rehabilitation/re-enablement/complex discharge planning team should usually manage LOS > 21 days. Community options should be considered for all patients at every stage of the patient journey.



Acute Frailty Services

Building on the successful work of the Older People's Assessment Service (OPAS) in A&E at Morriston and the Integrated Care for Older People (iCOP) team in Singleton, acute frailty services will deliver holistic multidisciplinary comprehensive geriatric assessment (CGA) for older people living with frailty via

- an **Emergency Frailty Unit (EMU)** based in the Emergency Department
- an **Acute Frailty Unit (AFU)** based in the Acute Medical Assessment Unit

The key features of these services will be:

- Early identification of older people living with frailty
- Holistic multidisciplinary assessment (covering medical, functional, psychological and social problems) based on the principles of CGA
- Geriatrician led assessment of patients presenting with the major geriatric syndromes (e.g. falls, delirium, dementia) ensuring adherence to local and national guidelines and standards
- A clear multidisciplinary plan for treatment and rehabilitation from admission to hospital
- Clear links to inpatient and community services including community based acute clinical teams and re-enablement teams as well as Consultant led inpatient geriatric teams
- Improved identification of patients at the end of life requiring inpatient or community palliative care
- Health Promotion signposting appropriate patients for services such as memory clinic, strength and balance classes
- Clear communication at transitions of care

Emergency Frailty Unit (EMU) : Older Peoples Assessment Service

Older Person's Assessment Service (OPAS) is a front door service based in the Emergency Department at Morriston Hospital. The aim of the service is to provide multi-disciplinary care and comprehensive geriatric assessment to frail elderly patients following an emergency presentation to hospital. The OPAS team support front door management of frail elderly patients with a targeted focus on pathway management for falls patients (43% of patients admitted to the OPAS service present with falls).

Older people presenting with falls have particularly high rates of conversion to admission after presentation to ED (60%). In addition, they are a population that has been identified as being at high risk of poor health outcomes if they are discharged from hospital without multidisciplinary intervention or follow up.

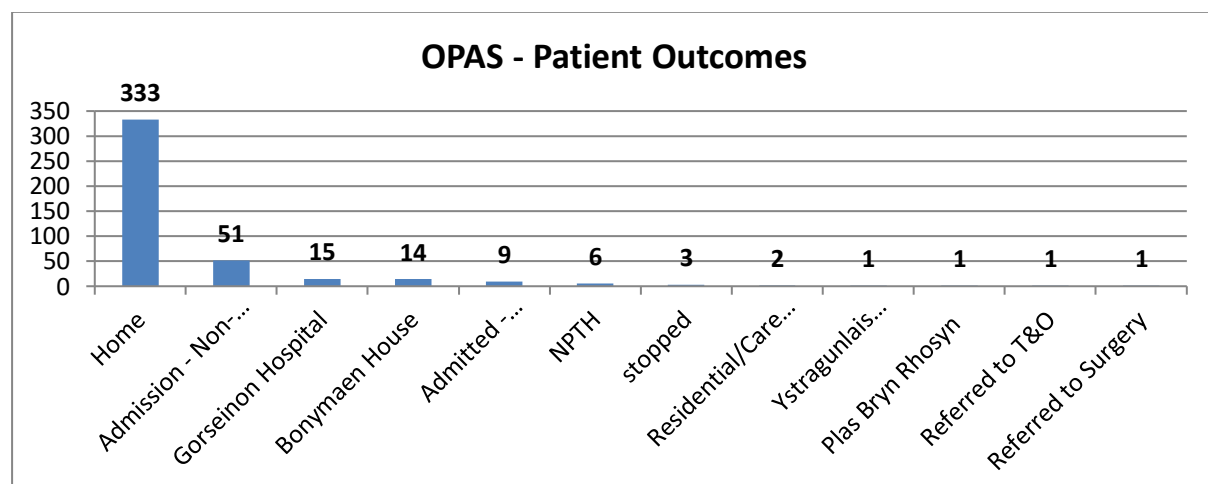
The OPAS multidisciplinary team includes consultant geriatricians, Elderly Care Clinical Nurse Specialists, an Advanced Nurse Practitioner, physiotherapist and occupational therapist.

The service is offered 5 days a week from 8-4pm.

Between the 16th April 2018 and the 31st August 2018, 437 patients were reviewed by the OPAS team. Approximately 76% of patients (333) were discharged home following OPAS intervention

OPAS successfully transferred 29 patients to alternative inpatient healthcare providers from ED (such as Gorseinon Hospital, nursing/residential home, NPTH etc).

Sixty patients required admission to Morriston Hospital (51 being admitted to a non-geriatric ward).



Outpatient Follow up

115 patients received outpatient follow up (90 in the Gorseinon Hospital based 'Falls Clinic' and 25 in Neath Port Talbot).

Re admission rate is low with 6% readmitted in 28 days

Development of the Emergency Frailty Unit /OPAS

- Dedicated Geriatrician to manage service as per Job Template Appendix 2
- Job Template would be part of a rotational commitment amongst all geriatricians
- Expansion of the multidisciplinary team to develop a 7 day a week service 8am -8pm

Acute Frailty Unit (AFU) /iCOP

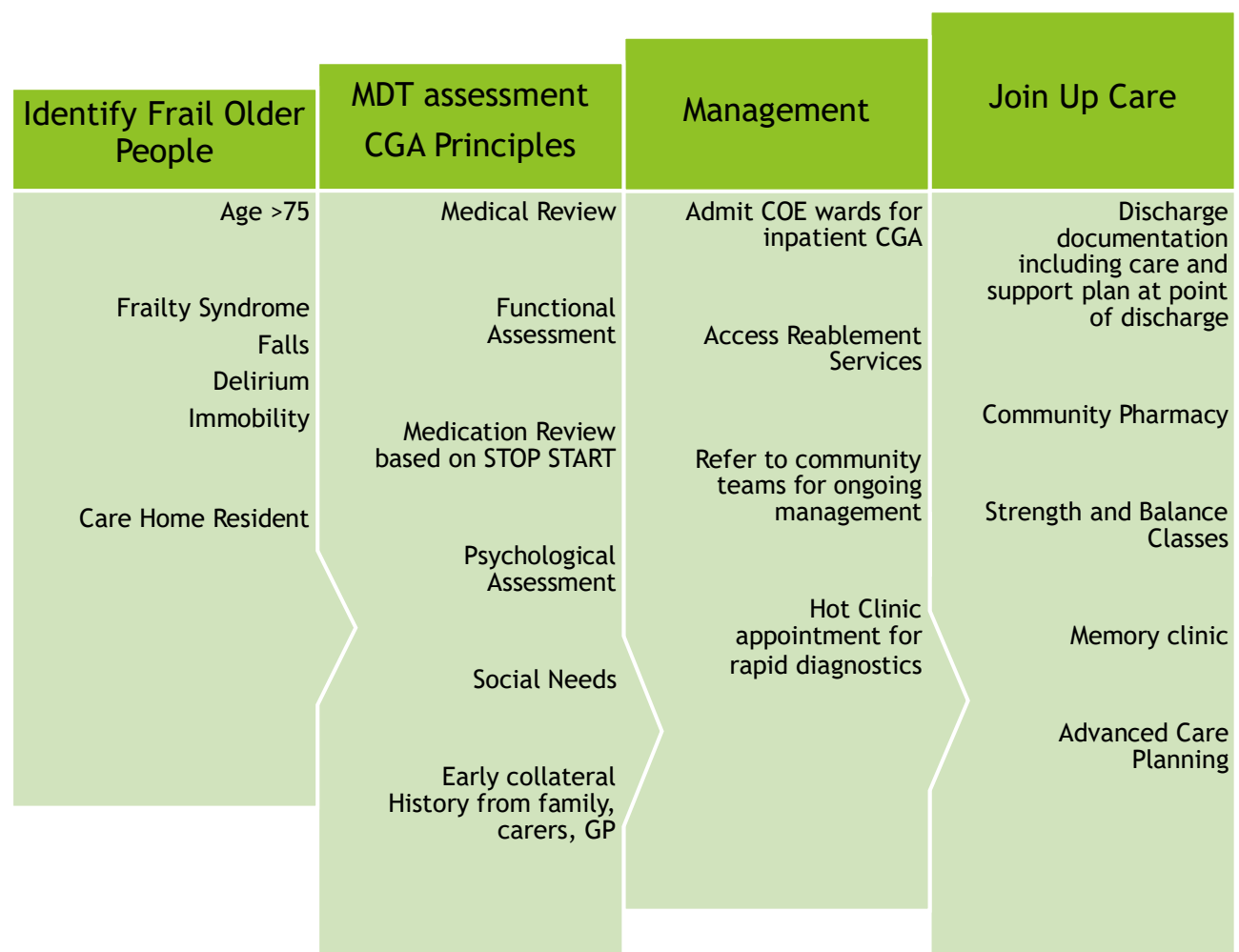
A geriatrician led multidisciplinary team should assess older people admitted to a dedicated frailty unit (15-20 beds) within the Acute Medical Assessment Unit.

The quality of the first 48 hours of acute medical care is an important determinant of clinical outcomes. Getting it right first time requires acute medical care delivered by the right person in the right clinical setting. Acute medical services for older people need to evolve to provide patients with the best quality of care in the right environment. A dedicated acute frailty team will deliver the early specialist management of a wide range of conditions affecting older people ensuring this is an actively managed process.

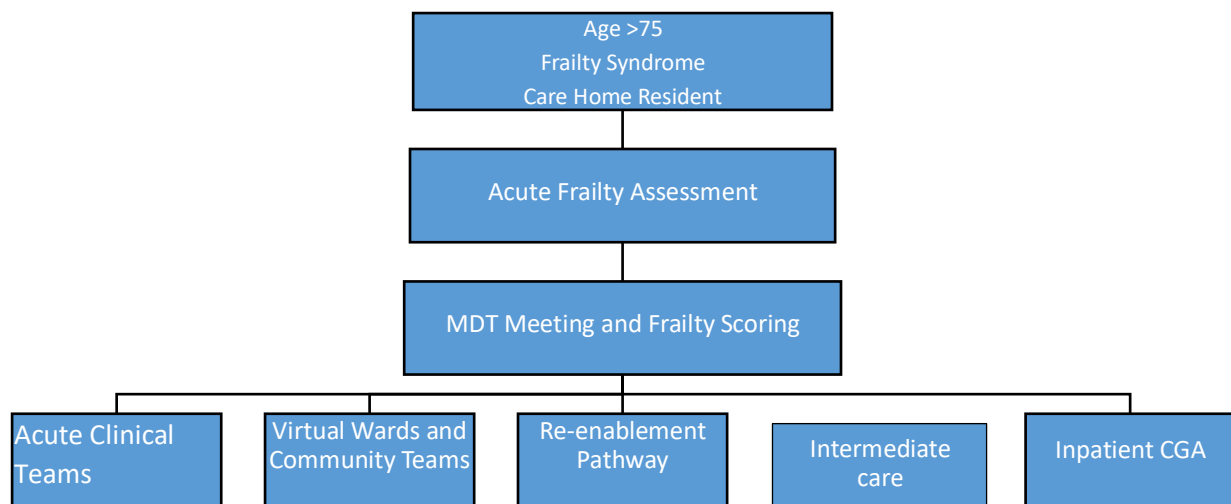
Patients aged >75, attending with a frailty syndrome (e.g. falls, delirium) or admitted from a care home will be prioritised. A daily multidisciplinary meeting will devise a comprehensive plan for treatment and rehabilitation for each patient assessed.

Optimal care should be established which includes consideration of whether community treatment options would be more appropriate.

The key functions of the acute frailty unit are summarised in the following diagram:



The following diagram illustrates the AFU pathway:



The integrated care of older people (iCOP) working in the Singleton Assessment Unit have delivered this type of acute frailty model since September 2018.

The multidisciplinary team included a Consultant geriatrician, Physicians Associate, Occupational Therapist (band 6), Physiotherapist (Band 7), Pharmacist, Pharmacy technician, Discharge Liaison Nurse, social worker and service co-ordinator.

1,697 patients received Comprehensive geriatric assessment on the Singleton Assessment Unit. iCOP usually carries a case load of 8-10 patients per day. The average age of patients is 85. 50% of patients assessed had a frailty score of >7 (severely frail) and 82% had a frailty score acknowledging at least moderate frailty.

The key outcomes have been:

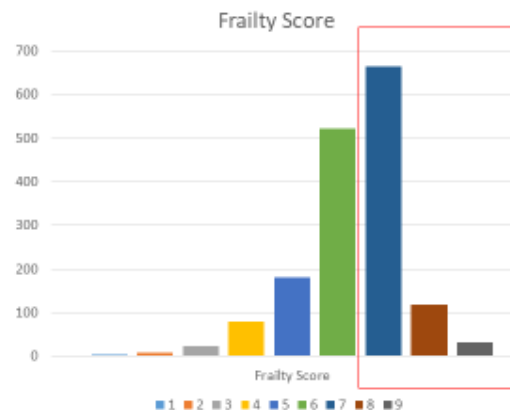
More Effective and Efficient Care

- 20-39% of general medical admission aged >75 each week receive comprehensive geriatric assessment within 24h of admission
- 40% of patients assessed by the acute frailty service are discharged from the assessment unit
- ~ 40% have a length of stay of less than 3 days
- Improved access to community services including the Acute Clinical Teams and re-ablement.

Improved Quality of Care

- A greater proportion of older people will receive timely comprehensive geriatric assessment which is recognised as the gold standard of care for frail older people in hospital
- Better adherence against National standards of care for frail older people, for example better recognition of delirium and dementia.
- Improvements in polypharmacy management
- Improved recognition of end of life care needs which can be met in hospital and community settings.
- Better communication at transitions of care.
- Most patients returned to their usual place of residence.
- >50% of patients identified as requiring inpatient CGA were transferred to a care of older person ward

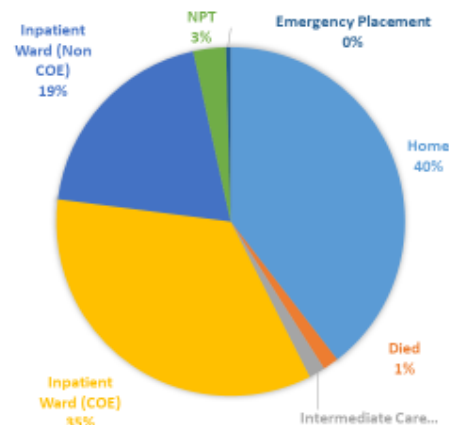
iCOP Frailty Scores



N=1635 (based on information up to March 2021)

iCOP Discharge Destination From SAU (n=1647)

Destination	%
Home	40%
Inpatient ward	54%
NPT	3%
Intermediate Care	2 %
Died	1%
Emergency Placement	0%



N=1647 (based on information up to March 2021)

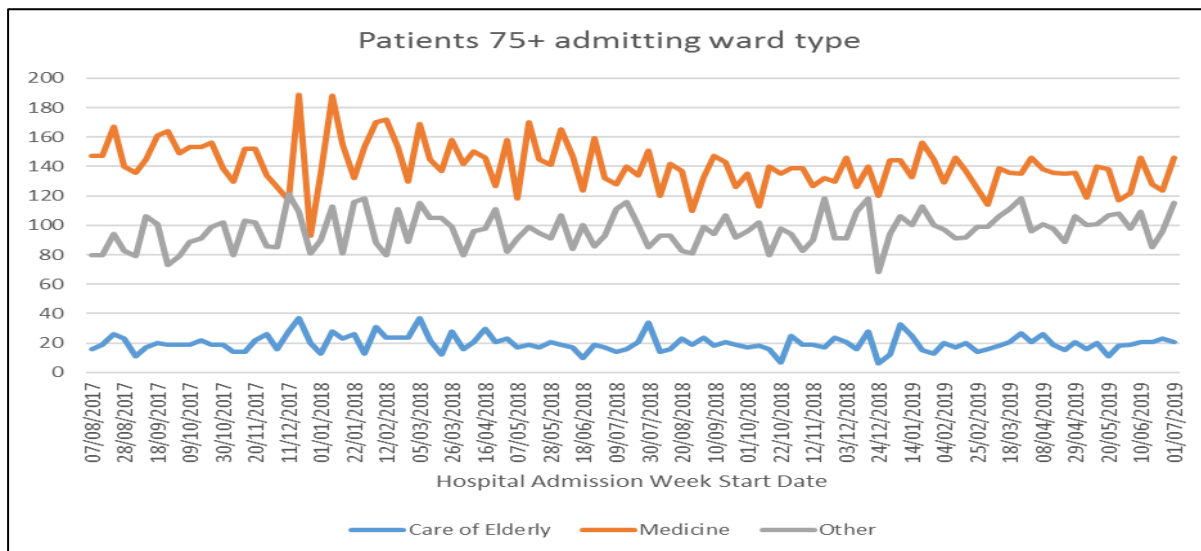
Development of Acute Frailty Service on Acute Medical Unit

- Dedicated Geriatrician to manage Acute Frailty Service as per Job Template Appendix 3
- Job Template would be part of a rotational commitment amongst all geriatricians
- Expansion of the multidisciplinary team to increase capacity and actively manage 15-20 beds within the Acute Medical Unit

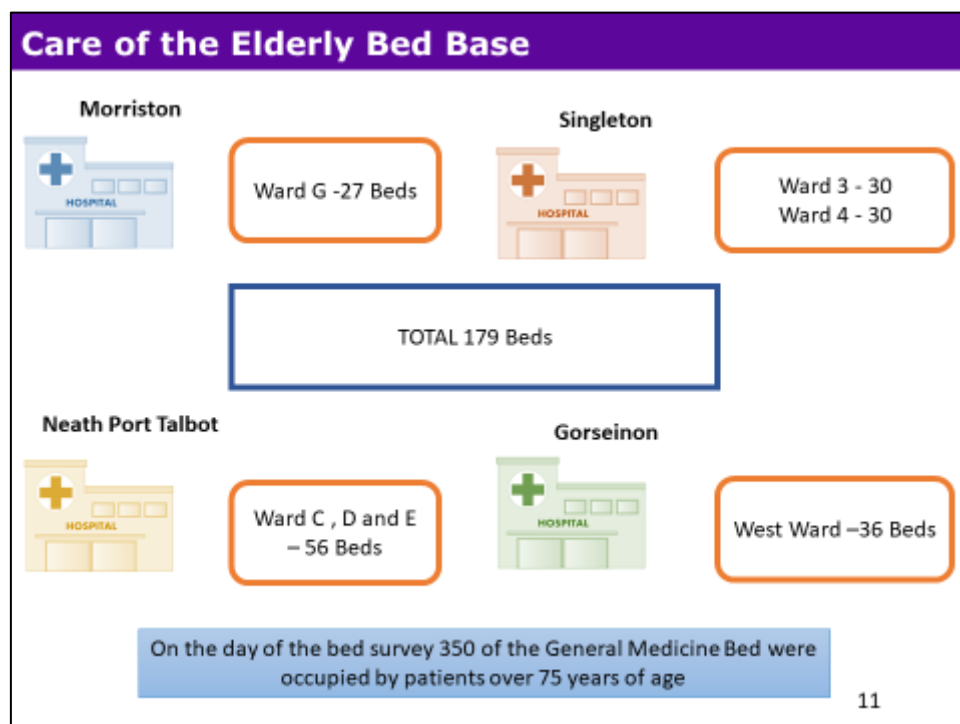
Inpatient Geriatric Medicine (usually 72 hours -21 days post admission)

Older people requiring a longer inpatient stay and these patients should be managed on dedicated medicine for older people wards with multidisciplinary teams delivering in-patient CGA.

At present only a minority of older people attending hospital receive comprehensive geriatric assessment and this is often delayed until they have been transferred to a care of older people ward. Many older patients who would benefit from a holistic CGA are transferred to non-care of the elderly wards and never receive this assessment.



The current model has a mixture of acute medicine for older people and rehabilitation on multiple hospital sites and frequently on the same wards. Only a small proportion of the beds offer acute geriatrics and the majority of beds are dedicated to slow stream rehabilitation although there is significant variability regarding of the acuity of patients on each ward.

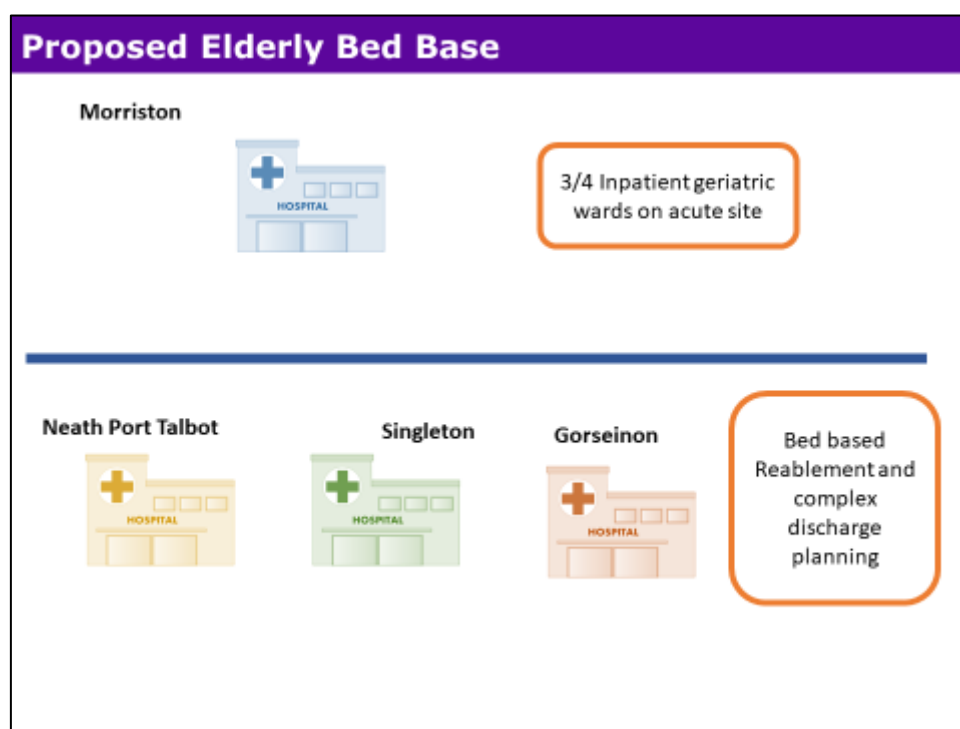


A new model of care would envisage 3/4 dedicated in-patient wards for medicine for older people (~30 patients per ward) on the acute site. These wards would manage patients with an anticipated length of stay 3-21 days.

Each ward would hold **daily** board rounds, provide **daily** Consultant review of new admissions/unwell patients and twice weekly full wards rounds in addition to a once weekly MDT meeting.

The inpatient wards would be supported by a full multidisciplinary team. The multi-disciplinary teams supporting inpatient geriatric medicine will require significant strengthening with additional physiotherapy, occupational therapy, speech and language therapy and dietetics.

Rehabilitation wards on the non acute site would offer bed base re-ablement/rehabilitation and complex discharge planning (see section rehabilitation).



Inpatient Consultant Sessions

4 sessions for DCC per 15 patients (2*WR + 1 MDT + 1 for additional board rounds and new patient reviews)

Rehabilitation

The integrated department of medicine for older people will support locality based rehabilitation/re-enablement beds.

These wards would be primarily support the slow stream re-enablement of patients requiring admission to hospital >21 days.

The wards would be primarily nurse/therapy lead with the support of a consultant geriatrician providing 1 ward round and 1 MDT per week.

Junior doctor/clinical fellow/staff grade cover would be required at other times.

Dedicated slow stream rehabilitation pathways would exist from hip fracture and stroke.

Currently this model would cover

- ~ 2 wards at Singleton Hospital
- 3 wards at Neath Port Talbot
- 1 ward at Gorseinon Hospital

Rehabilitation Consultant Sessions

Each rehabilitation ward will be allocated 1 DCC for a ward round and 1 DCC for a MDT meeting

These sessions would be incorporated into the job plans for

Ortho-geriatrics

Swansea Bay University Health Board admitted 573 older people with a hip fractures in 2019-2020.

The National Hip Fracture Database sets 5 Key Performance Indicators for hip fracture care. These are

- Will I see both an orthopaedic surgeon and a medical specialist after breaking my hip
- Will my operation be done today or tomorrow?
- Will my surgeon offer the type of operation recommended by NICE?
- Will I be able to get out of bed by the day after my operation?
- Will you check I don't become confused after my operation?
- Will you check that I get back to live in my usual home?

KPI overview: MOR. Morriston Hospital

Annualised values based on 589 cases averaged over 12 months to the end of January 2021.

1. Prompt orthogeriatric review

87%

NHFD overall: 87%

2. Prompt surgery

55%

NHFD overall: 68%

3. NICE compliant surgery

70%

NHFD overall: 71%

4. Prompt mobilisation

74%

NHFD overall: 81%

5. Not delirious post-op

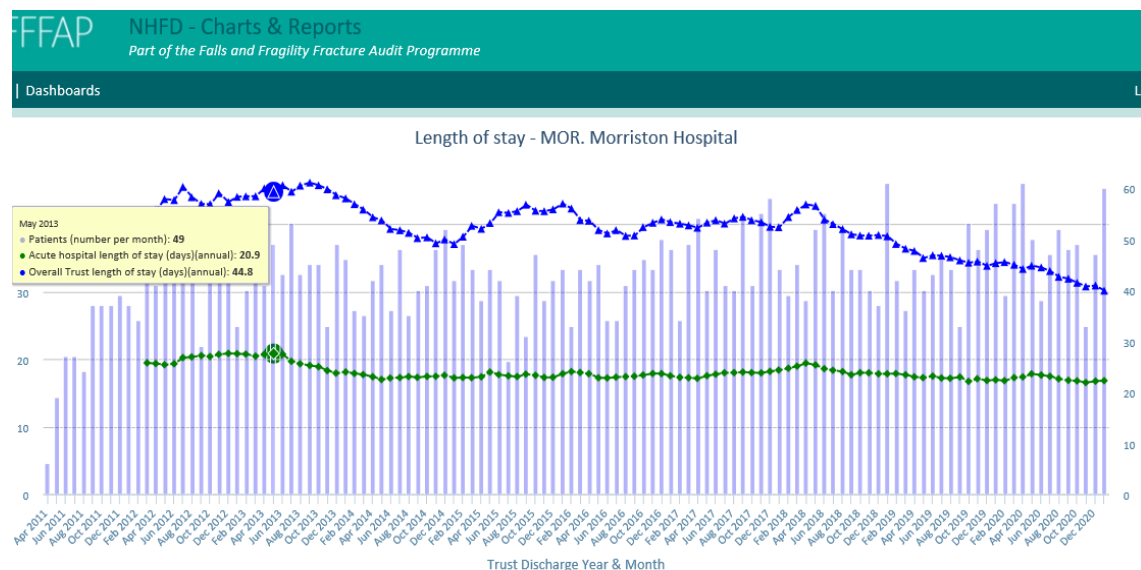
74%

NHFD overall: 58%

6. Return to original residence

76%

NHFD overall: 71%



Ortho geriatric Consultant Sessions

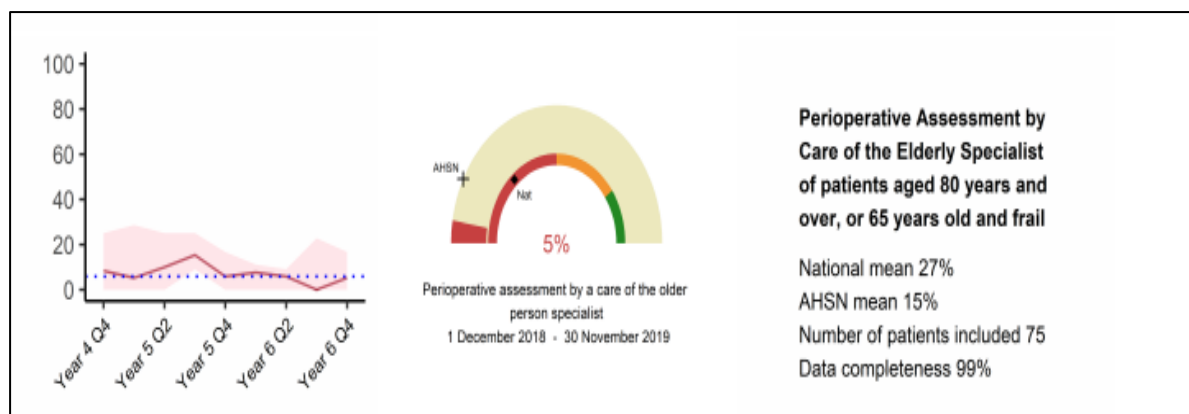
An additional Consultant appointment is required to provide an addition 8 DCC Sessions to support the ortho-geriatric pathway. This will include 2 sessions to support the ortho-geriatric bed based rehabilitation pathway.

Perioperative Medicine for Older People Undergoing Surgery / Surgical Liaison

In 2018-2019 249 patients underwent an emergency Laparotomy in Swansea Bay University Health Board. Emergency laparotomy has one of the highest associated rates of death of all types of surgery performed, almost ten times greater than that of major elective gastrointestinal surgery.

The National Emergency Laparotomy Audit (NELA) reports outcome for older people undergoing emergency abdominal surgery. Increased frailty is an independent marker of poor outcomes. The outcome of older frail patients undergoing emergency surgery is improved by the expertise of geriatric and frailty teams.

In the UK 56% of patients requiring this type of emergency surgery are aged >65. However, only 28.8% of frail patients over 65 had geriatrician input. In Swansea there is no consistent geriatrician input into this group of patients in the Health Board. The NELA annual report showed only 5% of patients in Swansea received an assessment by a care of the older person specialist.



Perioperative Medicine for Older People

Delivering perioperative medicine reviews will require 5 DCC for a daily Consultant input into older people undergoing emergency abdominal surgery.

Additional sessions in the job plan will back fill colleagues in acute medicine and deliver some input into the rehabilitation wards.

Current Medical Staffing

Consultant Physicians
Chris Hudson
Nicky Leopold
Rhodri Edwards
Praveen Pathmanaban
Claire Dinsdale
Brett Maddock
Liz Davies
David Burberry
Eunice Acquaye
Firdaus Adenwalla
Carla Dos Santos Gil
Angelika Plakantonaki
Moustafa El-Khatieb
Mohammed Yosry
Associate Specialists
Osama Taweel
Julia Rogers
Isabelle Wisenbach
Dr Salman (NPT)
Dr Jenna Williams (NPT)

Job Plans

In order to deliver this broad range of services for older people living with frailty variety of job plans will be required.

These are likely to follow the following board areas:

- Consultant Geriatrician with a interest in Community Geriatrics (4 posts)
- Consultant Geriatrician with a interest in Intermediate Care/Rehabilitation Medicine (4 posts)
- Consultant Geriatrician Emergency Frailty Unit/Older Peoples Assessment Service
- Consultant Geriatrician Acute Frailty Unit
- Consultant Geriatrician with an Interest in Orthogeriatrics (2 posts)
- Consultant Geriatrician with an Interest in Surgical Liaison

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Con 1	Inpatient ward & Cluster											
Con 2	Inpatient ward & Cluster											
Con 3	Inpatient ward & Cluster											
Con 4	Inpatient ward & Cluster											
Con 5	Inpatient ward & rehab											
Con 6	Inpatient ward & rehab											
Con 7	Inpatient ward & rehab											
Con 8	Inpatient ward & rehab											
Con 9	Emergency Frailty Unit											
Con 10	Acute Frailty Unit											
Con 11	Outpatients, Referrals and Back cover etc.											
Con 12	Acute Clinical Team Swansea											
Con 13	ACT Consultant NPT											
Con 14	Orthogeriatrics											
Con 15	Orthogeriatrics											
Con 16	Perioperative Medicine /Surgical Liaison											

The Consultants could rota through roles in inpatient work although this would need to be discussed in departmental job planning.

A sample rotas may look like this:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Con 1	Inpatient ward & Cluster				EFU	AFU	Inpatient ward & rehab				ACT	X
Con 2	X	Inpatient ward & Cluster				EFU	AFU	Inpatient ward & rehab				ACT
Con 3	ACT	X	Inpatient ward & Cluster				EFU	AFU	Inpatient ward & rehab			
Con 4	IPR	ACT	X	Inpatient ward & Cluster				EFU	AFU	Inpatient ward & rehab		
Con 5	Inpatient ward & rehab		ACT	X	Inpatient ward & Cluster				EFU	AFU	Inpatient ward & rehab	
Con 6	Inpatient ward & rehab			ACT	X	Inpatient ward & Cluster				EFU	AFU	IPR
Con 7	Inpatient ward & rehab				ACT	X	Inpatient ward & Cluster				EFU	AFU
Con 8	AFU	Inpatient ward & rehab				ACT	X	Inpatient ward & Cluster				EFU
Con 9	EFU	AFU	Inpatient ward & rehab				ACT	X	Inpatient ward & Cluster			
Con 10	IPC	EFU	AFU	Inpatient ward & rehab				ACT	X	Inpatient ward & Cluster		
Con 11	Inpatient ward & Cluster		EFU	AFU	Inpatient ward & rehab				ACT	X	Inpatient ward & Cluster	
Con 12	Inpatient ward & Cluster			EFU	AFU	Inpatient ward & rehab				ACT	X	IPC
Con 13	ACT Consultant NPT											
Con 14	Orthogeriatrics											
Con 15	Orthogeriatrics											
Con 16	Perioperative Medicine /Surgical Liason											

Additional sessional cover and back fill will be required for annual leave and study leave.

Conclusion

Significant investment and expansion of the Consultant body is required to fully integrate medicine for older people across the Health Board set out in the introduction.

There is a compelling evidence to support the benefits of comprehensive geriatric assessment for older people living with frailty where ever they present.

In order to deliver this model for an Integrated Department of Medicine for Older People with dedicated posts/sessions in community geriatrics, acute frailty services, the Acute Clinical Teams and support for geriatric surgical liaison teams in orthopaedics and general surgery it is envisaged we will need at least 6 additional consultant posts.

The Older People's Assessment Service (OPAS) and the Integrated Care of Older People's team (iCOP) have illustrated the benefits of CGA at the front door. Further modelling work is required to describe in detail the benefits extending these services at scale might have on unscheduled care.

A substantial consultation and periods of group job planning will need to take place to align current job plans with those envisaged in this document.

Not all doctors will have transferable skill sets to all of these areas and some will have a significant commitment to a particular service.

This paper only sets out the Consultant cover required to lead the services described. Medical services for older people need to be multidisciplinary and additional multidisciplinary support will be required to deliver the fully integrated person-centred co-ordinated care aspired to.

Most people over 65 presenting acutely to hospital have impairments in performing their activities of daily living and many have not returned to baselines levels of mobility or functional dependence on discharge from hospital.

All initiatives to improve patient flow and expedite discharge will depend on accessible re-ablement and rehabilitation services. Any strategy to improve medicine for older people is predicated on increased capacity in our hospital to home services. This is critical in allowing more older people to return to their own homes, reduce delayed transfers of care and reduce excess bed days in acute hospital.

Appendix 1: CONSULTANT GERIATRICIAN with an INTEREST in Community Geriatrics

PROVISIONAL JOB PLAN WARD 3 MONTHS (may be subject to alteration)

NPTH – Neath Port Talbot Hospital, SH – Singleton Hospital, MH – Morriston Hospital, CCH – Cefn Coed Hospital, COM – Community setting

	Sessions	Hours	Location	Type of Work
Monday AM	1	3.5-4.0	MH	Board Round and Ward Round Acute Geriatric Ward
Monday PM	1	3.5-4.0	MH	SPA
Tuesday AM	1	3.5-4.0	MH	Hot Clinic
Tuesday PM	1	3.5-4.0	Community Session	Cluster or Virtual MDT
Wednesday AM	1	3.5-4.0	MH	Board Round Acute Geriatric MDT
Wednesday PM	1	3.5-4.0	SH	SPA
Thursday AM	1	3.5-4.0	Community Session	Cluster Virtual Ward or MDT
Thursday PM	1	3.5-4.0	Community Session	Cluster Falls Clinic
Friday AM	1	3.5-4.0	MH	Board Round and Ward Round Acute Geriatric Ward
Friday PM	1	3.5-4.0	MH	In patient care/Family meetings
On Call			MH	

Appendix 2: CONSULTANT GERIATRICIAN with an INTEREST in Acute Emergency Frailty

PROVISIONAL JOB PLAN AMAU POST

NPTH – Neath Port Talbot Hospital, SH – Singleton Hospital, MH – Morriston Hospital, CCH – Cefn Coed Hospital, COM – Community setting

	Sessions	Hours	Location	Type of Work
Monday AM	1	3.5-4.0	MH	ED Frailty
Monday PM	1	3.5-4.0	MH	SPA
Tuesday AM	1	3.5-4.0	MH	ED Frailty
Tuesday PM	1	3.5-4.0	MH	Hot Clinic
Wednesday AM	1	3.5-4.0	MH	ED Frailty
Wednesday PM	1	3.5-4.0	MH	Hot Clinic
Thursday AM	1	3.5-4.0	MH	ED Frailty
Thursday PM		3.5-4.0	MH	SPA
Friday AM	1	3.5-4.0	MH	ED Frailty
Friday PM	1	3.5-4.0	MH	Hot Clinic
On Call			MH	

Appendix 3: CONSULTANT GERIATRICIAN with an INTEREST in Acute Frailty (AMAU Post)

PROVISIONAL JOB PLAN AMAU POST

NPTH – Neath Port Talbot Hospital, SH – Singleton Hospital, MH – Morriston Hospital, CCH – Cefn Coed Hospital, COM – Community setting

	Sessions	Hours	Location	Type of Work
Monday AM	1	3.5-4.0	MH	AMAU Patient Reviews & MDT
Monday PM	1	3.5-4.0	MH	Family Meetings
Tuesday AM	1	3.5-4.0	MH	AMAU Patient Reviews & MDT
Tuesday PM	1	3.5-4.0	MH	Undergraduate Teaching (SPA)
Wednesday AM	1	3.5-4.0	MH	AMAU Patient Reviews & MDT
Wednesday PM	1	3.5-4.0	MH	SPA
Thursday AM	1	3.5-4.0	MH	AMAU Patient Reviews & MDT
Thursday PM				Hot Clinic
Friday AM	1	3.5-4.0	MH	AMAU Patient Reviews & MDT
Friday PM	1	3.5-4.0	MH	In patient care
On Call			MH	

Appendix 4: CONSULTANT GERIATRICIAN with an INTEREST in Rehabilitation/Intermediate Care

PROVISIONAL JOB PLAN WARD 3 MONTHS (may be subject to alteration)

NPTH – Neath Port Talbot Hospital, SH – Singleton Hospital, MH – Morriston Hospital, CCH – Cefn Coed Hospital, COM – Community setting

	Sessions	Hours	Location	Type of Work
Monday AM	1	3.5-4.0	MH	Board Round and Ward Round Acute Geriatric Ward
Monday PM	1	3.5-4.0	MH	Hot clinic
Tuesday AM	1	3.5-4.0	SH/NPT	Rehab Ward round
Tuesday PM	1	3.5-4.0	MH	Specialist Interest Session
Wednesday AM	1	3.5-4.0	MH	Board Round Acute Geriatric MDT
Wednesday PM	1	3.5-4.0	MH	SPA
Thursday AM	1	3.5-4.0	SH/NPT	Rehab ward MDT
Thursday PM	1	3.5-4.0		SPA (Undergraduate teaching)
Friday AM	1	3.5-4.0	MH	Board Round and Ward Round Acute Geriatric Ward
Friday PM	1	3.5-4.0	SH	In patient care/Family meetings
On Call			MH	

CONSULTANT GERIATRICIAN with an INTEREST in Orthogeriatrics

PROVISIONAL JOB PLAN WARD 3 MONTHS (may be subject to alteration)

NPTH – Neath Port Talbot Hospital, SH – Singleton Hospital, MH – Morriston Hospital, CCH – Cefn Coed Hospital, COM – Community setting

	Sessions	Hours	Location	Type of Work
Monday AM	1	3.5-4.0	MH	Trauma meeting & Ortho-geriatric Ward Round
Monday PM	1	3.5-4.0	MH	SPA
Tuesday AM	1	3.5-4.0	MH	Trauma meeting & Ortho-geriatric Ward Round
Tuesday PM	1	3.5-4.0	SH/NPT	Rehabilitation MDT
Wednesday AM	1	3.5-4.0	MH	Trauma meeting & Ortho-geriatric Ward Round
Wednesday PM	1	3.5-4.0	MH	SPA
Thursday AM	1	3.5-4.0	MH	Trauma meeting & Ortho-geriatric Ward Round
Thursday PM	1	3.5-4.0	SH/NPT	Rehabilitation WR
Friday AM	1	3.5-4.0	MH	Trauma meeting & Ortho-geriatric Ward Round
Friday PM	1	3.5-4.0	MH	In patient care/Family meetings
On Call			MH	

**CONSULTANT GERIATRICIAN with an INTEREST in Perioperative Medicine
/Surgical Liaison**

PROVISIONAL JOB PLAN WARD 3 MONTHS (may be subject to alteration

NPTH – Neath Port Talbot Hospital, SH – Singleton Hospital, MH – Morriston Hospital, CCH – Cefn Coed Hospital, COM – Community setting

	Sessions	Hours	Location	Type of Work
Monday AM	1	3.5-4.0	MH	Surgical Liaison Ward Round
Monday PM	1	3.5-4.0	MH	SPA
Tuesday AM	1	3.5-4.0	MH	Surgical Liaison Ward Round
Tuesday PM	1	3.5-4.0	SH/NPT	Rehabilitation MDT
Wednesday AM	1	3.5-4.0	MH	Surgical Liaison Ward Round
Wednesday PM	1	3.5-4.0	MH	SPA
Thursday AM	1	3.5-4.0	MH	Surgical Liaison Ward Round
Thursday PM	1	3.5-4.0	SH/NPT	Rehabilitation WR
Friday AM	1	3.5-4.0	MH	Surgical Liaison Ward Round
Friday PM	1	3.5-4.0	MH	In patient care/Family meetings
On Call			MH	

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