UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 24 MARCH 2016

Title:	**DEVELOPMENT OF THE ORTHOGERIATRIC MEDICINE SERVICE AND THE PROVISION OF NAMED CONSULTANT COVER FOR 12 GERIATRIC MEDICINE BEDS ON WARD 518**		
Responsible Director:	Cherry West, Chief Operating Officer		
Contact:	Steve Cumley, Director of Operations, Division C, Ext 13640 Ian Sharp, Divisional Director, Division C, Ext 14789		
Purpose:	To seek the support for the development of the orthogeriatric medicine service and to provide named consultant cover for 12 acute geriatric beds on Ward 518		
Confidentiality Level & Reason:	Confidential - Staff		
Annual Plan Reference:	Aim 1: Always put the needs of the patient first Aim 2: Maintain our reputation and position at the leading edge of performance quality		
Key Issues Summary:	1. To provide a quality service that supports all aspects of care for elderly trauma patients. 2. To achieve best practice tariff for hip fracture patients 3. To provide named consultant cover for 12 acute geriatric medicine beds on Ward 518 4. To reduce waiting times for patients referred into the falls clinic		
Recommendations:	The Board of Directors is requested to: **APPROVE** the proposed appointments		
Approved by:	Cherry West	Date	15 March 2016

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THURSDAY 24 MARCH 2016

DEVELOPMENT OF THE ORTHOGERIATRIC MEDICINE SERVICE AND THE PROVISION OF NAMED CONSULTANT COVER FOR 12 GERIATRIC MEDICINE BEDS ON WARD 518

PRESENTED BY CHIEF OPERATING OFFICER

1. Purpose

The purpose of this paper is to seek the Board of Directors' support for the development of the orthogeriatric medicine service and to provide named consultant cover for 12 acute geriatric beds on Ward 518.

2.0 Orthogeriatric service

2.1 In July 2015, Divisions C and D jointly presented a business case to CEAG to develop the orthogeriatric service to support patients managed by the Trauma and Orthopaedic team.

2.2 Most older trauma patients have complex medical problems and benefit from input from a geriatrician with expertise in older adult trauma. The current orthogeriatric service is limited in capacity and focuses on patients with hip fracture. The proposed service development would enable UHB to provide a high quality service to all older orthopaedic trauma patients.

2.3 UHB treats over 400 patients with hip fracture each year and a further 874 inpatients aged 75+ with other orthopaedic trauma. The number of patients is increasing as a consequence of population ageing, as well as changes in the effective catchment area for trauma, particularly since the trust was designated a Major Trauma Centre. 363 patients were treated for hip fracture in 2010-11, rising to 447 in 2014-15 (equivalent to a 5.3% increase per annum).

2.4 There is evidence that older orthopaedic inpatients benefit from geriatrician input, with the best evidence being in hip fracture patients. Such a service should improve the quality of medical care; reduce morbidity, mortality and increase the proportion of patients that are able to return to their pre-admission residence. Orthogeriatric input is estimated in studies to reduce mortality by 20%.

2.5 There are strong clinical and financial drivers for high quality hip fracture care: Standards for care published by NICE (Quality Standard 16, 2013) and by the British Orthopaedic Association (The care of patients with

fragility fracture, 2007) make specific reference to the benefits of geriatrician involvement in care of such patients, the BOA recommending that all hip fracture patients are seen by a geriatrician pre-operatively. The Best Practice Tariff for hip fracture includes a requirement for each hip fracture patient to receive a senior orthogeriatrician review within 72 hours of admission, with a financial incentive of £1335 per patient. There are no equivalent drivers for non-hip trauma in older people but it is considered good practice (An age old problem, NCEPOD, 2010) that such patients should receive proactive geriatrician input.

2.6 There has been an orthogeriatric service at UHB for over 15 years. Initially, the service consisted of 1-2 sessions per week on orthopaedic wards identifying those patients for transfer to a rehabilitation ward at West Heath Hospital with occasional advice on medical issues. In 2004, a ward at Selly Oak Hospital was designated an orthogeriatric rehabilitation ward and this has continued since the move to the new QEHB, albeit with fewer orthogeriatric beds despite an increase in demand.

2.7 In 2009, approximately a quarter of hip fracture patients were seen within 72 hours of admission and none were seen pre-operatively. 30-day mortality was 11%, higher than the then national average. Since 2009, the orthogeriatric service has evolved such that there are now two consultant geriatricians, each with 2 PA's, providing clinical sessions on trauma wards. This provides for 3 ward sessions (Monday, Wednesday and Friday mornings) and leadership of one ward multidisciplinary discharge planning meeting on ward 410. Currently, geriatrician input is such that approximately a half of all hip fracture patients are seen pre-operatively and 92% are seen within 72 hours. This is reflected in improved 30-day mortality such that QEHB is one of 11 trusts with case mix-adjusted mortality significantly below the national average of 8.35% (National Hip Fracture Database 2014). HSMR for hip fracture has reduced from 115 in 2011-12 to 80 in 2014-15.

2.8 Medical input to non-hip fracture trauma patients and further reviews of hip fracture patients are provided on an ad hoc and reactive basis. Currently, less than a quarter of older (75+) orthopaedic trauma patients are seen by a geriatrician during their inpatient stay, with very few seen pre-operatively or during the first 72 hours of admission. This is felt to be inequitable, as older trauma patients receive different levels of orthogeriatric input depending on diagnosis and not clinical need.

2.9 It should be noted that much of the expansion in the service over the last 5 years has been informal and is not felt to be sufficient or sustainable in its current form. There is no contingency for prospective cover in the existing job plans and there has been considerable good will from the existing consultants to provide a service above and beyond contracted sessions.

2.10 To provide high quality care that is both safe and effective, the service requires significant expansion. It is proposed to adopt an

"orthogeriatrician of the day" model (Monday to Friday) in a similar fashion to the Stroke service. This would require a minimum of 5 ward sessions per week, including prospective cover, as well as additional clinical time for afternoon availability. There are related developments that are felt to be desirable to provide a wider service to older trauma patients: The service should support the two other inpatient MDT meetings (Ward 412 and Major Trauma Service). It is also intended that the new service will support the weekly bone infection MDT meeting and the monthly orthoplastic clinic. Current (unfunded) input has been provided on a trial basis and has already helped to identify and manage medical problems in these complex patients, with the aim to optimise patients prior to undergoing major surgical reconstruction, anticipating reduction in operative complications and improved clinical outcomes.

Drivers for change

2.11 Quality – The principal driver for change should be clinical quality. There is little doubt that older patients benefit from the involvement of a specialist in geriatric medicine and this should be the norm. There will be tangible benefits, such as reductions in early post-operative mortality and morbidity, and better management of medical comorbidities and complications. However, many of the benefits in terms of care quality are harder to measure. Complaints are relatively infrequent and there are currently no PROMs that relate specifically to older trauma patients.

2.12 Equity – The current service is predicated on the provision of services for hip fracture. This means that older non-hip trauma patients receive an inequitable service, potentially to their detriment.

2.13 Best Practice Tariff for hip fracture care – This requires that there is evidence that several indicators are met for each patient, including surgery within 36 hours and senior geriatrician clinical review within 72 hours of admission. The current BPT uplift is £1335 and UHB achieved this in only 52% of patients in the year 2013-14, improving to 58.4% in the year 2013-14. Nationally the average is 63%, with two trusts achieving BPT in over 90% of cases, namely Boston Trust and Eastbourne. The main cause for loss of this BPT income at UHB is the time to surgery, which is achieved in 64% of cases (nationally 74%). Some of this delay is due to a perceived need for pre-operative medical optimization and it is anticipated that some delays would be prevented by more regular pre-operative geriatrician input. Regarding geriatrician review within 72 hours - this element is achieved in 92% of UHB patients but this level is unsustainable and is likely to fall in future years as a result of increasing admissions and other competing pressures.

2.14 Major Trauma Centre – The MTC saw 237 patients aged 75+ in the year 2014-15. Most of this constitutes activity above pre-MTC levels. By definition, most of these patients are multiply injured and many have significant medical comorbidity, or the physiological consequence of trauma. All such patients could benefit from proactive geriatrician-led

medical input.

2.15 Sustainability – The current service is not thought to be sustainable by the two consultants that provide it and there is no leeway in existing job plans for increased activity or even for prospective cover. With the ageing population and rising elderly trauma admissions, the service is far from future-proof.

2.16 Length of stay – There are many factors that affect length of stay, particularly in frail older adults. Geriatricians are best placed to understand and influence both medical and social factors and reduce length of stay, where possible. There is evidence that orthogeriatric teams can reduce length of stay following hip fracture. UHB currently has a greater length of stay than the national average for hip fracture and even a modest reduction of 1 days could be an opportunity to make savings, however for this case, this is not a main driver for change.

3. Ward Cover on 518

3.1 The need has arisen to release a consultant from their two timetabled sessions on Ward 518 where they currently have ongoing responsibility for 12 inpatient beds and allocated medical outliers. This will allow them to take up two newly-funded research sessions.

3.2 The sessions on 518 will need to be picked up by another consultant but existing consultants within the department are unable to accommodate this sessional time within their own Job Plans. These sessions therefore need to be taken on by a new consultant appointment.

3.3 In order to release the consultant ahead of any new appointment, the sessions on 518 are currently being undertaken by a locum consultant.

4. Falls Clinic

4.1 The department runs a falls clinic that is accessible to GPs through Choose & Book. Patients attending this multidisciplinary clinic are jointly assessed by a consultant geriatrician and physiotherapist to ascertain the cause(s) of their falls. The clinic takes place in the physiotherapy gym.

4.2 Referrals into UHB's falls clinic are currently 20% greater than available capacity and patients are currently waiting up to 17 weeks to be seen. The department has needed to undertake a number of waiting list initiative clinics to keep waits below 18 weeks.

4.3 An additional alternate-weekly clinic will be sufficient to reduce waiting times and ensure that all referrals can be offered appointments through Choose & Book.

4.4 A business case was presented to CEAG in November 2015 to gain support to appoint consultant time to deliver the sessions on Ward 518 and an additional alternate-weekly falls clinic.

5. Options

5.1 Do nothing (including terminating the contract of the locum covering the 12 beds on 518). The orthogeriatric service will not be extended and the improvements to the quality of patient care described above will not be delivered. There will be no consultant cover for the 12 beds on 518 and there will be no reduction in waiting times for patients attending the falls clinic.

5.2 [Preferred option] Appoint orthogeriatric consultant sessions to deliver an extended orthogeriatric service, provide consultant support for the beds on 518 and reduce the waiting times for the falls clinic. There is the opportunity to make a joint appointment with the University of Birmingham with the remaining Pas being offered to an additional appointee.

6. Financial appraisal of the preferred option

	£
EXPENDITURE	
PAY	147,888
TOTAL EXPENDITURE	**147,888**
INCOME	39,889
SURPLUS/ (DEFICIT)	**(108,000)**

The income is derived partly from improved attainment of the hip fragility best practice tariff and partly from the new falls clinic. Commissions are aware of this new outpatient activity. The service anticipates a 5% increase in achieving BPT by having an increased input into pre –operative review; this will be reflected in the job plans for the clinicians. This would reduce the "medical" reason for delay to theatre which currently is on average 6.68% of cases that are cancelled for this reason.

7. Risks

7.1 The main risk is non-recruitment. This would result in the service remaining at its current level with no opportunity for expansion to meet growing need or development to extend to existing unmet need. It would also result in an inability to release the consultant from their current commitments on 518. Waiting times for patients referred into the falls clinic would remain high. It is expected that this post would be attractive to both new CCT's and established consultants looking to work in a successful department in a high-quality teaching hospital. Previous recruitment to geriatric medicine consultant posts at QEHB in the last 5

years has not proved difficult.

7.2 A very unlikely risk would be that the post is funded and filled but that there is an unexpected reduction in orthogeriatric patient activity. Given the ageing population and continual upward trend in admissions, it is not anticipated that this would happen. Despite the investment in Fracture Liaison Service aimed at reducing fragility fractures, it will be some years before this has a significant impact in elderly trauma admissions.

8. Anticipated Outcomes and Post-Implementation Review

Anticipated Outcome	**Milestone**	**Lead Manager**	**How will it be measured?**	**Initial Review Date/ Mechanism**	**Future Review**
Maintenance of geriatrician input to BPT target	>95% of hip fracture patients reviewed within 72h of admission	Group Manager, T&O, Division D	National Hip Fracture Database	Meeting held with Audit clerk and contracts dept. to ensure correct data captured	Monthly
Improved rate of pre-operative assessment of hip fracture patients	>70% of hip fracture patients seen pre-operatively	Group Manager, T&O, Division D	National Hip Fracture Database	Information is submitted onto data base via audit clerk	Monthly
Geriatrician support to orthopaedic MTS patients (age 75+)	In year one, measure the baseline % of patients seen by a geriatrician within 72h of admission (this has not previously been measured). Aiming for achievement of >95%	Group Manager, T&O, Division D	MTS Register (requires new data fields)	Information will be recorded on national data base (TARN)	Monthly

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Anticipated Outcome	Milestone	Lead Manager	How will it be measured?	Initial Review Date/ Mechanism	Future Review
Geriatrician support to non-hip, non-MTS orthopaedic trauma patients (age 75+)	In year one, measure the baseline % of patients seen by a geriatrician within 72h of admission (this has not previously been measured). Aiming for achievement of >95%	Group Manager, T&O, Division D	New local trauma register	Data base to be developed.	Monthly
Consultant ownership of 12 inpatient beds on 518	2 consultant ward rounds per week on 518	Clinical Service Lead, Geriatric Medicine	Consultant's Job Plan	Job Plan review following appointment	Annual
Sufficient falls clinic capacity	Waiting time for new patients <8 weeks	Deputy Director of Operations, Division C	Outpatient waiting list	8 weeks following consultant appointment	Weekly

9. Recommendation

The Board of Directors is requested to **APPROVE** the proposed appointments