

Elderly, Intermediate Care, Neurology and Stroke CBU



Getting to know the CBU
March 2021



Bradford Teaching Hospitals

NHS Foundation Trust

Our Team

- * Maj Pushpangadan – Clinical Director & Elderly Care Specialty Lead
- * Awais Habib – General Manager
- * Stuart Maguire – Stroke Specialty Lead
- * Mark Busby – Neurology Specialty Lead
- * Brenda Mosley – Matron Elderly and Intermediate Care
- * Francesca Hill – Matron Stroke and Neurology
- * Andrea Allanach – Lead Advanced Nurse Practitioner
- * Caroline Varley – Business and Performance Support Manager

Our Services



* Elderly Care

- * Wards (Pre Covid) – 3 assessment/admissions , 29, 31 at Bradford Royal Infirmary and F6 at St. Lukes Hospital
- * Facility for acutely unwell older people
- * Hip Fracture Pathway – Orthopaedic Liaison Model

* Intermediate Care

- * Ward F5 at St Lukes Hospital, Westwood Park Community Hospital, Westbourne Green Community Hospital
- * Facility following an acute stay to support rehabilitation and restoration of functional abilities

* Virtual Ward

- * F3, St. Lukes Hospital
- * Enabling multi-disciplinary team to support older people at home.
- * Started as a step-down model with a 'discharge to assess' approach linked to our older people assessment unit. Now also a step up model to avoid admissions and attendances

* Multi Agency Integrated Discharge Team (MAIDT)

- * Health, social care and voluntary care members ensuring patients with complex needs are discharged safely, appropriately and on the correct pathway.

* Stroke

- * Ward 6 – Hyper Acute Stroke Unit, Acute and Rehabilitation at Bradford Royal Infirmary
- * Involved with the Integrated Stroke Delivery Network across the West Yorkshire and Harrogate Healthcare Partnership
- * We are working collaboratively across the Bradford and Airedale health economy to deliver a true single sustainable stroke service across Bradford and Airedale

* Neurology

- * Ward 6 - Acute and Rehabilitation at Bradford Royal Infirmary
- * Lead on Neuromuscular services within the West Yorkshire Network
- * Strong established relationships with Primary Care (GPs with specialist interests) providing comprehensive general neurology, epilepsy and headache services

Covid-19 - Challenges



- * Reduction and relocation of elderly care wards and bed base
 - * Appropriateness of environments for elderly patients i.e. dementia friendly, bay tagging, enabling rehab safely
 - * Nursing skill mix challenges
 - * Hip Fracture pathway – moved to Orthopaedics with patchy geriatric liaison
- * Challenges within social care (homecare packages/local authority beds) due to increase in time for Covid testing and segregation of red and green capacity
- * Reduced workforce/morale – staff sickness, shielding, isolation
- * The CBU recognise a need to understand the psychological/mental health impact on staff and the support they require
- * Lack of visiting for family and friends required increased communication with relatives and support for patients feeling isolated and lonely
- * Changed focus for nursing teams completing patient assessments virtually with social workers as oppose to attending the wards
- * Reduction in face to face outpatient appointments
- * Reduction in outpatient capacity for Stroke and Neurology to support the SWORD (Staff Work Organisational Resource Deployment) ward round rota across the Trust.

CBU Strengths and Successes



- * Collaborative working to support patient management and flow - Medics, nursing, palliative care, virtual ward, MAIDT and Social Care
- * Developed pathways with primary care to avoid admissions (Covid pathways)
- * Staff compliance with training and appraisals albeit staffing and sickness challenges
- * The CBU has recognised teams for their willingness to adapt and be flexible in working across multiple locations (Thank you cards and badges)
- * Increased therapist support over 7 days improving patient rehabilitation
- * Pilot projects with PCNs to enable open access to a MDT/ earlier discharge to a community MDT
- * Integrated pathway with YAS to avoid AED attendances
- * Sustained review of all urgent outpatient referrals (Neurology/Stroke) and continued to deliver follow up capacity virtually
- * Smarter working – introduction of virtual clinics and communication has allowed continued in reach into the community for the virtual ward, communication between teams and virtual consultations for patients across all our specialties maintaining our service provision
- * Ward 29 stepped up from elderly care nursing to level 2 HDU nursing for respiratory non invasive ventilation
- * Our Stroke development project and engagement with the Stroke network has led to an improvement in the latest published Sentinel Stroke National Audit Programme (SSNAP) performance where BTHFT and AGH achieved a B score overall.



We have improved our
Sentinel Stroke National
Audit programme
(SSNAP) score to **B**

Future Developments



* Elderly Care, IMC and Virtual Ward

- * Develop surgical in-reach business case to support CGA approach with general surgery (emergency laparotomy) with a view to expand into further surgical and medical specialties
- * Continue work with Primary Care Networks to establish a Hub and Spoke model
- * Open CAATU (Community Assessment and Triage Unit) F3 SLH - facilitation one stop shop to support frailty using a CGA model of care
- * ACP workforce development-enabling in reach into Blue Zone (medical same day emergency care), Community Hospitals/ developing frailty in reach and surgical in reach
- * Develop further integrated working with YAS- crisis response/ AED admission avoidance
- * Restart inpatient frailty admission and attendance avoidance programme.

* Stroke Service

- * Continue to work with the Integrated Stroke Delivery Network to improve patient pathways across all SSNAP domains
- * Develop business case to address medical staffing DCC shortfall and Psychology input to Stroke
- * Develop comprehensive community based team to address primary and secondary prevention with collaborative initiatives with CCG, PCNs, Stroke Association as part of the Act as One programme.
- * Establish a single clinical lead across AGH and BTHFT

* Neurology Service

- * Complete review of waiting list and develop plan to reduce wait times
- * Business cases
 - * To establish headache and neuromuscular specialist nurse
 - * To increase consultant workforce

* Develop virtual services across the CBU – Discharge to Assess Model

Any Questions?

