Healthcare Improvement Scotland

Developing hospital front door frailty services

Tuesday 20 August 2024

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

Welcome

Healthcare Improvement Scotland

Dr Lara Mitchell

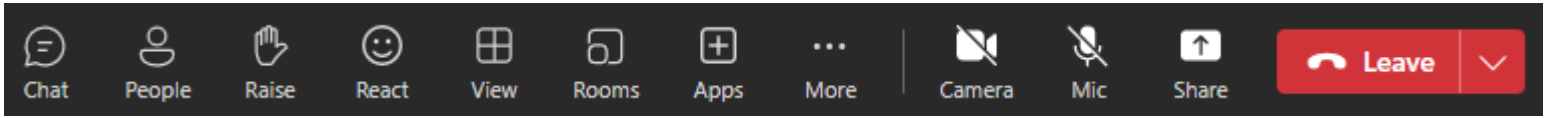
National Clinical Lead for Acute Care,
Healthcare Improvement Scotland

Housekeeping

Use **Chat** to introduce yourself, raise any questions you may have for the speakers and also post comments.

React to others contributions with emojis.

Press **leave** at the end of the webinar**.**



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Troubleshooting

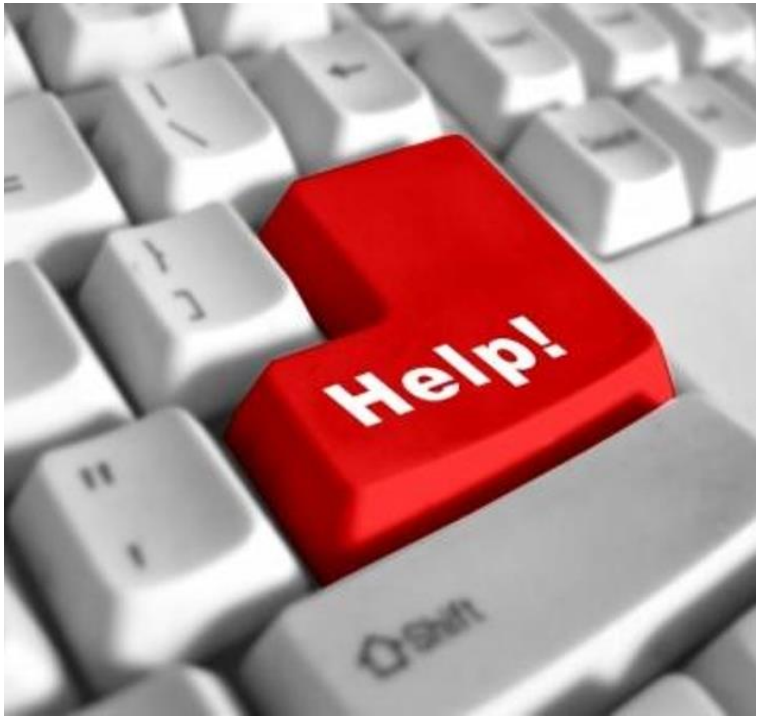
Healthcare Improvement Scotland

Any technical issues please contact:

Gemma Rehill

MS Teams chat @GemmaRehill

Email: gemma.rehill@nhs.scot



Healthcare Improvement Scotland

This webinar will be recorded.

The webinar recording and outputs will be shared on our webpage following the session.

Agenda

Time	Topic	Lead
13:00	Welcome and introductions	Dr Lara Mitchell, National Clinical Lead for Acute Care, Healthcare Improvement Scotland
13:05	British Geriatric Society principles for establishing front door frailty services	Dr Elinor Burn, Senior Geriatric Medicine Registrar, Leicester Royal Infirmary
13:35	Identification and assessment of frailty and comprehensive geriatric assessment huddles	Dr Laura Duffy, Consultant Geriatrician, and Erin Walker, Advanced Practice Physiotherapist in Frailty, NHS Greater Glasgow and Clyde, Glasgow Royal Infirmary
13:45	Multidisciplinary team working, leadership and community connections	Hazel Gilmour, Frailty NMAHP Consultant, NHS Lanarkshire and North Lanarkshire HSCP
13:55	Q&A	All
14:10	Evaluation and close	Dr Lara Mitchell, National Clinical Lead for Acute Care, Healthcare Improvement Scotland

Healthcare Improvement Scotland

Dr Elinor Burn

Senior Geriatric Medicine Registrar

Leicester Royal Infirmary

Healthcare Improvement Scotland

Developing front door frailty services

Dr Elinor Burn

Geriatric Medicine Registrar
Flexible Portfolio Trainee – QI Theme
University Hospitals of Leicester

Contributions from Dr Amy Armstrong
Emergency Medicine Consultant, Edinburgh

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

What we will cover

British Geriatrics Society
Improving healthcare for older people

BGS

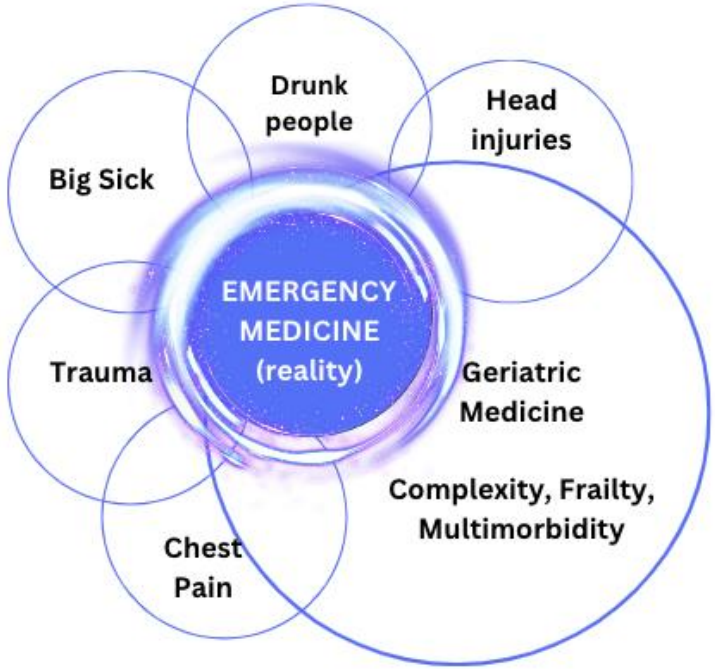
- BGS Mapping the UK landscape survey
- BGS fellow role
- BGS Advice on setting up services principles
  - Prioritise development
  - Prove your need
  - Map your organisation and consider intervention points
  - Identify frailty and trigger CGA
  - Build relationships and plan the workforce

Front door frailty: Advice on setting up services

Use one word to describe your frailty service

How did this work start?

- Frailty, multi-morbidity and complexity is a huge part of ED take
- Recognise harms of hospitalisation and long ED waits. Is there an alternative?
- Lack of practical advice available for setting up these services

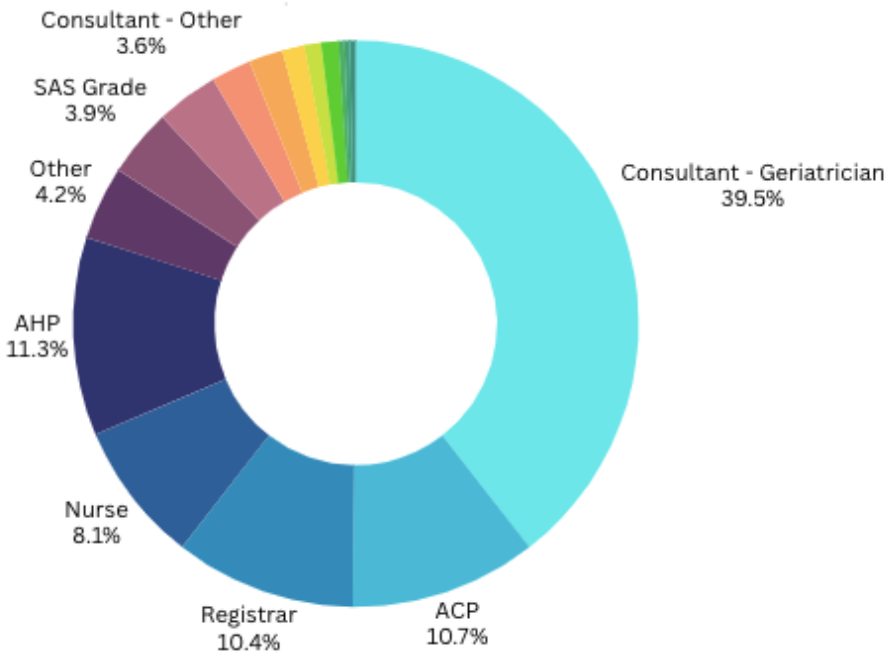


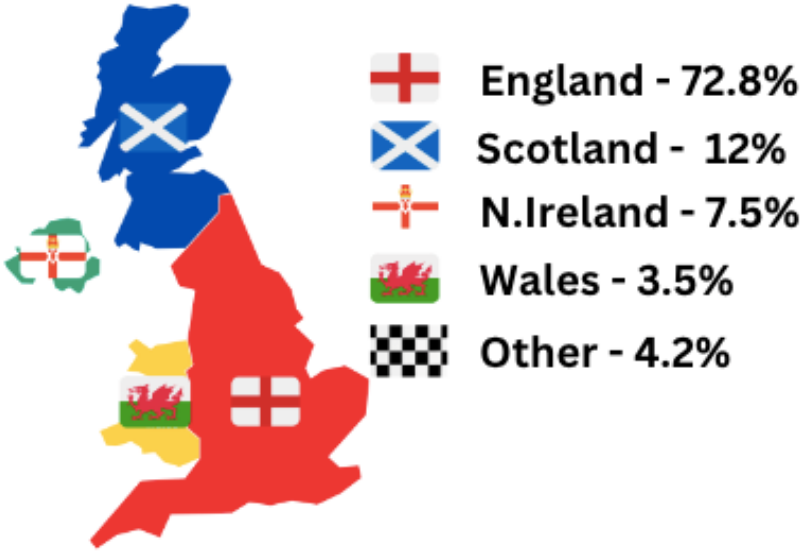
BGS Survey

- “Help the Frailty in Urgent Care Settings SIG understand the existing front door frailty systems in the UK”

- 8 questions
- Emailed to SIG members
- 309 responses, 200 datasets

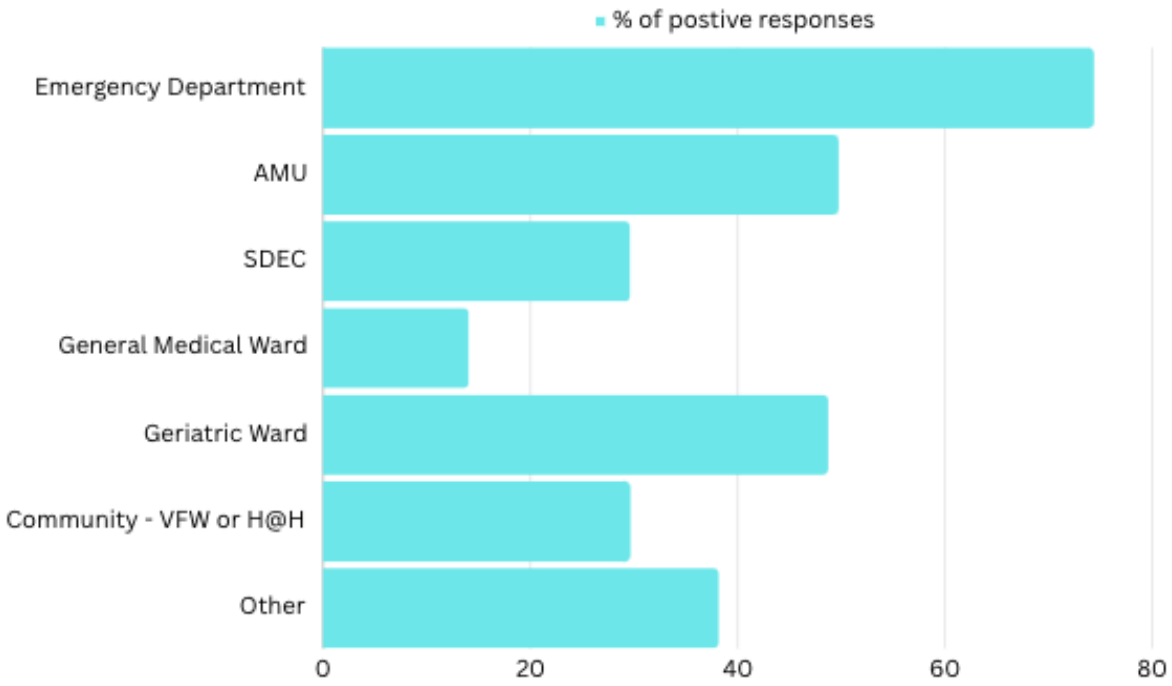
Demographics





Where is frailty identified/screened for routinely in your hospital?
(tick all that apply)

- Early identification key…if it results in a change to patient journey!
- New frailty CQUIN 23/24 encouraging screening in NHSE
- ‘Inconsistently’ was free text impression!



Other: GP practices, surgical wards/POPS services, orthogeriatric settings and major trauma wards, acute frailty assessment/admission units, care homes, Day Hospital, ambulance services and stroke wards

England targets

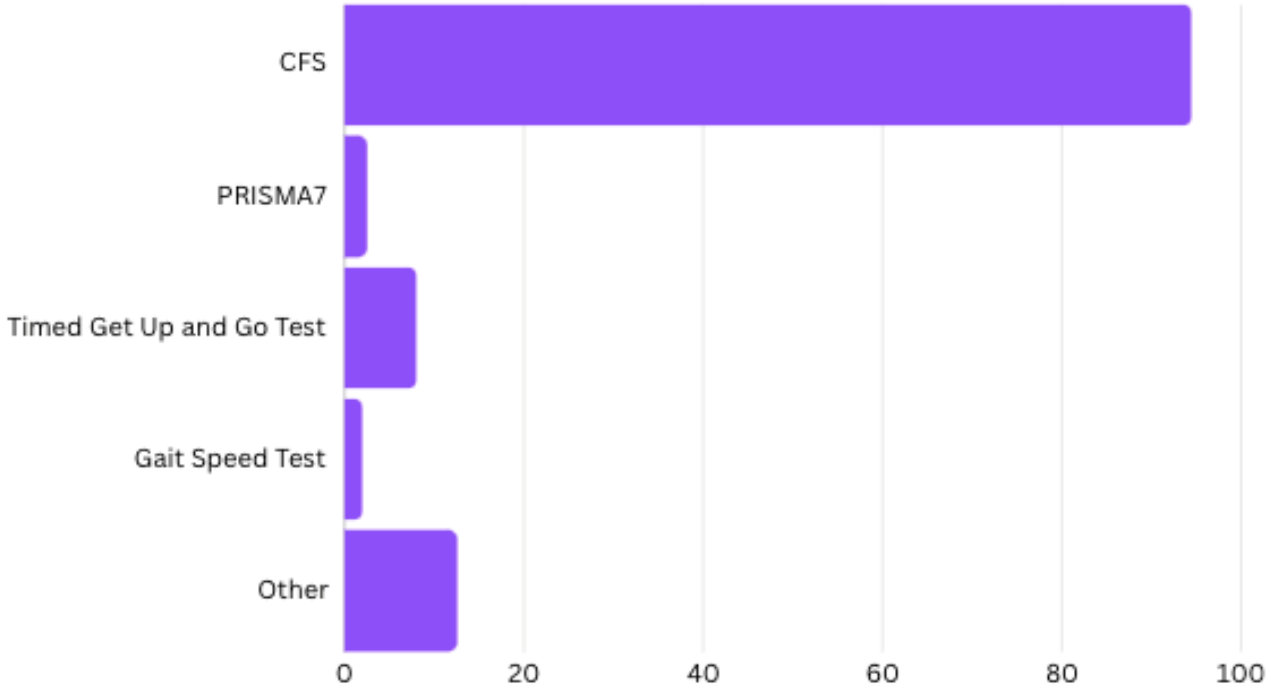
CQUIN05: Identification and response to frailty in emergency departments

Description	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

FRAIL is a mneumonic for the 5 key principles of an acute frailty service:

- **F**ocus on the acute problem:
  - assess patients on arrival and treat the acute condition they have presented with
  - complete a clinical frailty assessment within 30 minutes of arrival
- **R**efer:
  - refer to the multidisciplinary acute frailty service if needed
  - liaise with other key services to support same day discharge
- **A**ssess:
  - initiate a Comprehensive Geriatric Assessment (CGA) to further assess the patient
- **I**dentify needs:
  - aim to personalise needs and support a patient-centred approach
- **L**eave:
  - discharge the patient on the same day, with a discharge summary that links the patient into other key services for ongoing care

Please describe which tool(s) are used for frailty screening in your receiving area



Android

Apple app store

[Clinical frailty scale app]

Others: EFI, HIS THINK frailty tool, Edmonton or Fried's models (lots of people naming Rockwood)

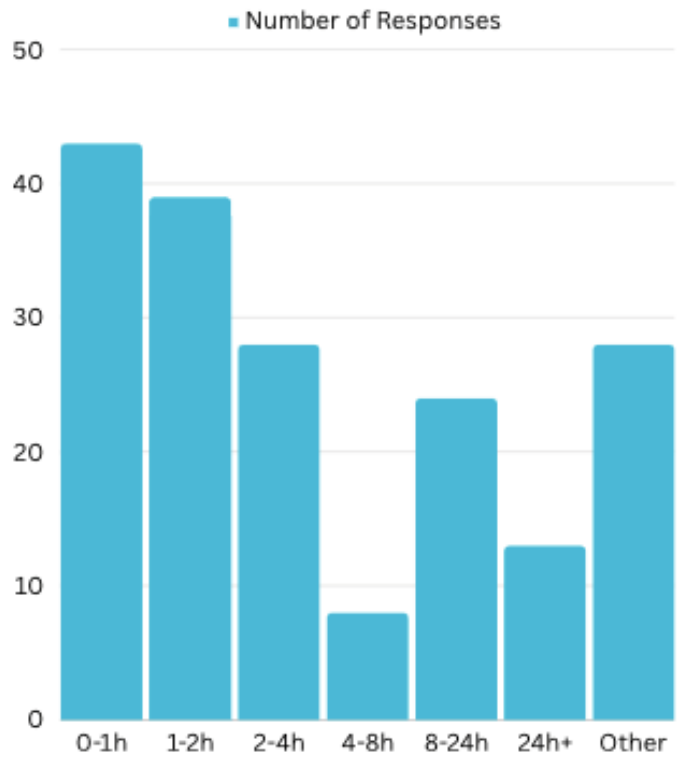
How long on average does it take for a patient to receive clinical frailty screening following their arrival to hospital or care setting ?

VARIABLE

- Probably early peak in EDs/AMU in first 4 hours (or frailty specific equivalent)

THEN

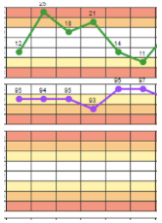
- Later peak >8 hours e.g. in-hours when on geriatric ward or reviewed by geriatric wider MDT team member



Please describe the main patient cohorts or referral guidelines/criteria that the Acute Frailty Service in your organisation sees.

AGE

NEWS



CARE HOME RESIDENTS

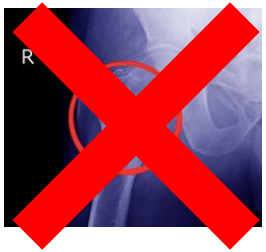
DISCUSSED WITH TEAM

FRAILTY SYNDROMES/ ‘GERIATRIC GIANTS’

CFS

CLINICAL FRAILTY SCALE

ESTIMATED LOS<72H



NEEDS OTHER SPECIALTY INPUT

Survey conclusions

1. Frailty identification and screening is increasing
2. Clinical Frailty Score is the most widely used tool
3. Time to screening and frailty identification is variable
4. Criteria for what ‘Front Door Frailty’ is varies widely

British Geriatrics Society Fellowship

- Part time
- Two months
- Supervision from BGS Policy Manager
- Virtual working post
- Concept defined, but the final piece of work was developed organically

BGS

FRONT DOOR FRAILTY

Advice on setting up services

British Geriatrics Society
Improving healthcare for older people

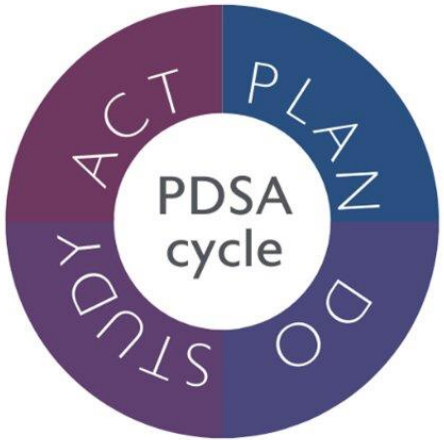
BGS

Front door frailty: Advice on setting up services

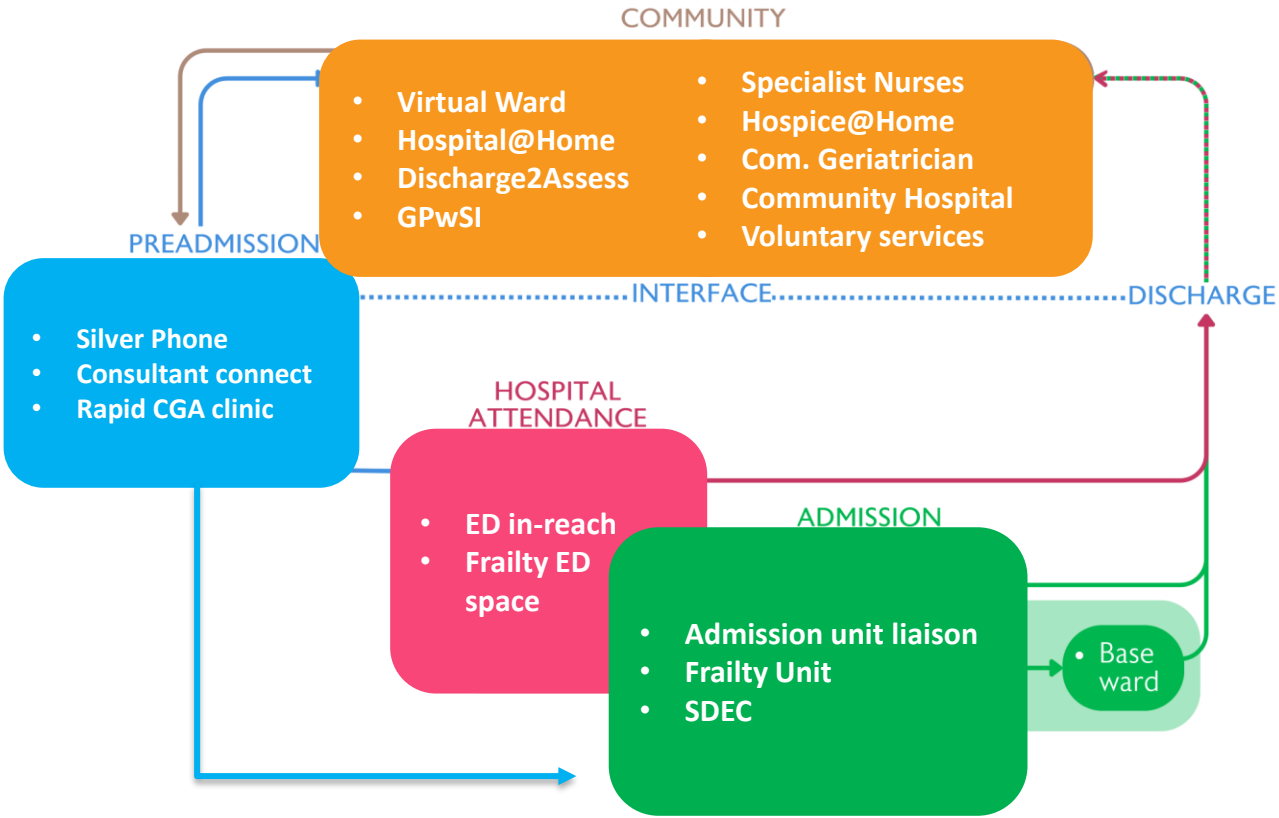
- FDF services have a positive impact everywhere that they have been implemented effectively
- There is no perfect recipe to create a FDF service
- Here is a compendium of advice and experiences from established services

1. Prioritise the development of the service

2. Prove your need



3. Map your organisation and consider intervention points



4. Identify frailty and trigger the start of CGA

5. Build relationships and plan the workforce

CFS

Conclusions

- Start somewhere, start small
- Perfection is the enemy of progress
- Find your tribe
- Person dependant processes may be needed initially

- Raised many questions and scope for further work
  - National dataset for FDF work
  - How to share resources with emerging FDF sites
  - How to facilitate full collaboration with healthcare services across all sectors
    - BGS networks
    - Future NHS Collaboration Platform

FutureNHS Collaboration Platform

Frailty is everyone's business

BGS British Geriatrics Society Improving healthcare for older people

BGS FRONT DOOR FRAILTY

Advice on setting up services

Dr Laura Duffy

Consultant Geriatrician

NHS Greater Glasgow and Clyde, Glasgow Royal Infirmary

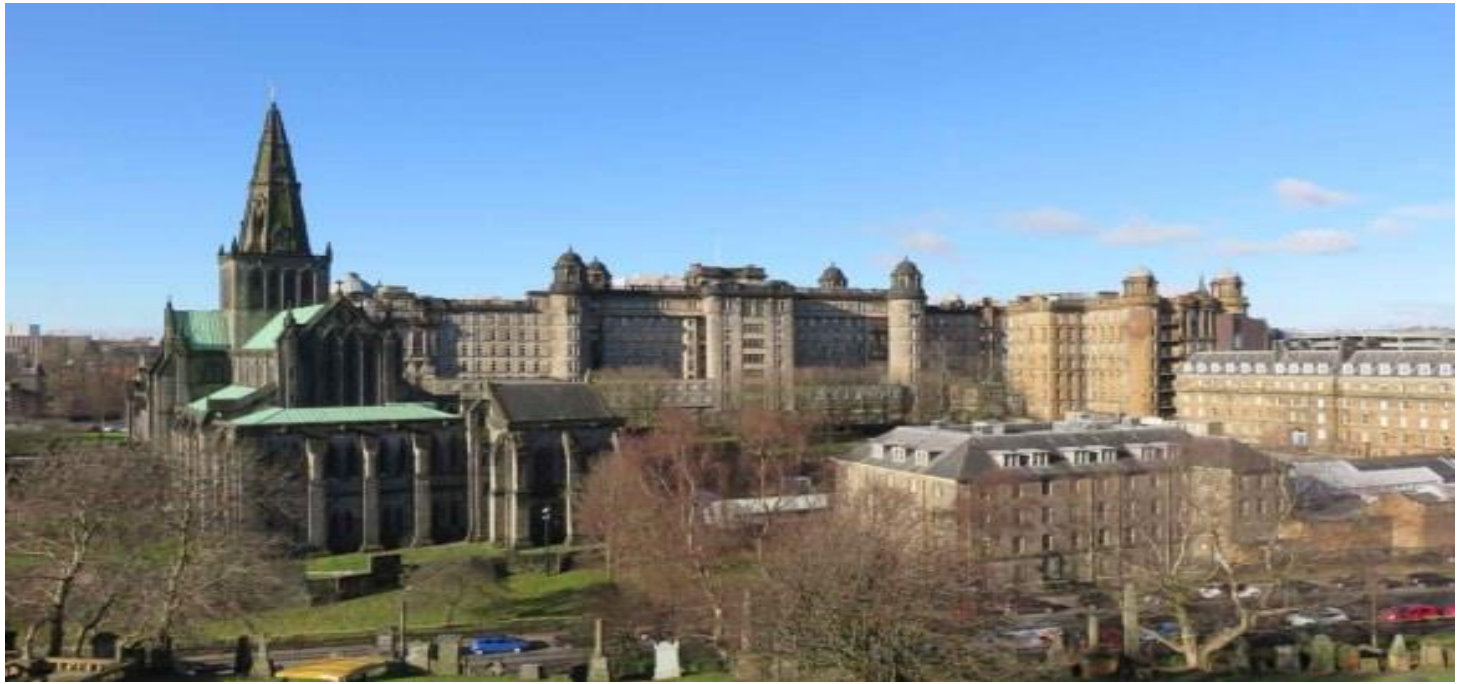
Erin Walker

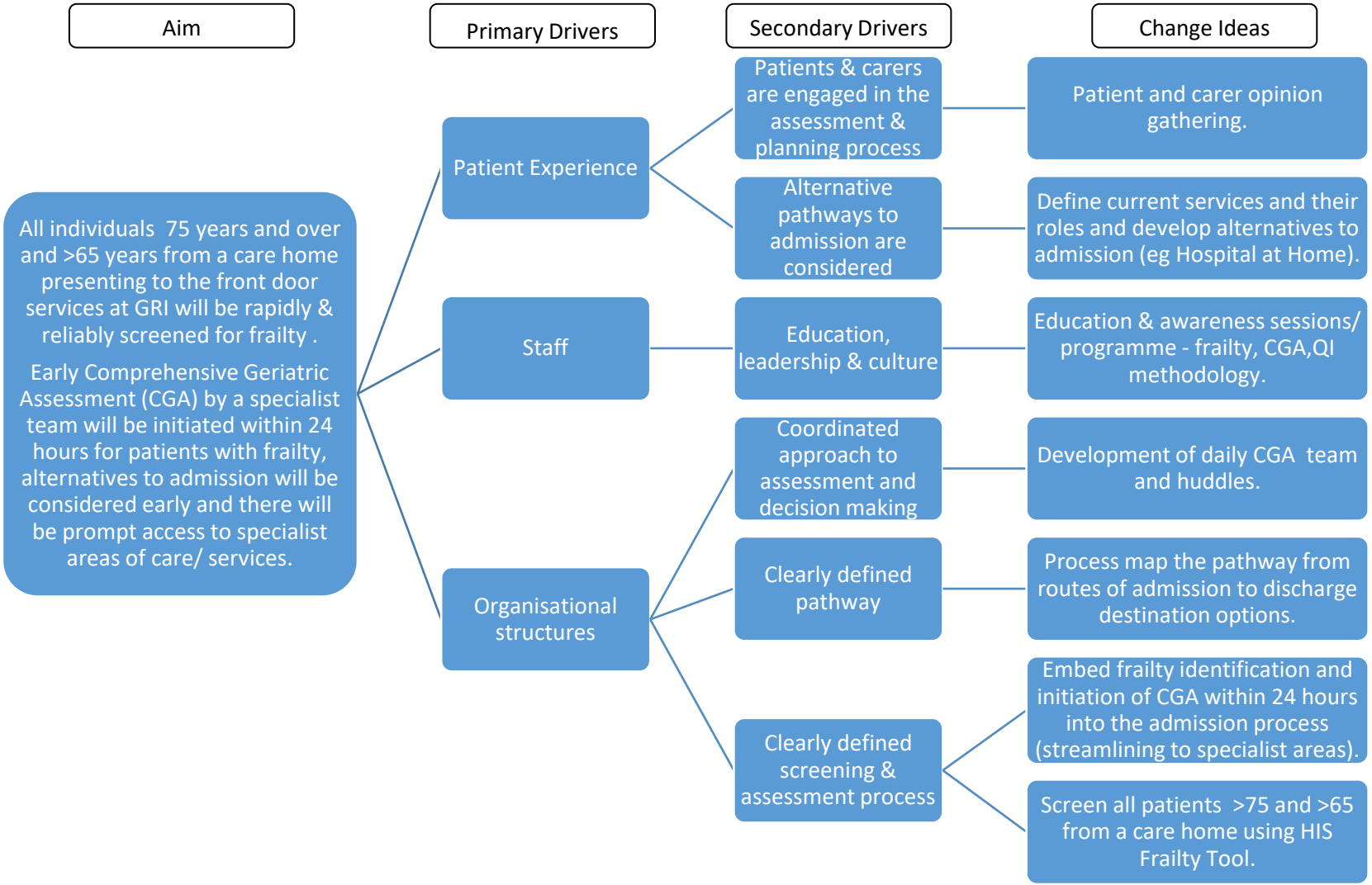
Advanced Practice Physiotherapist in Frailty

NHS Greater Glasgow and Clyde, Glasgow Royal Infirmary

Focus on Frailty GRI

August 2024




Aim
Primary Drivers
Secondary Drivers
Change Ideas
All individuals 75 years and over and >65 years from a care home presenting to the front door services at GRI will be rapidly & reliably screened for frailty .
Early Comprehensive Geriatric Assessment (CGA) by a specialist team will be initiated within 24 hours for patients with frailty, alternatives to admission will be considered early and there will be prompt access to specialist areas of care/ services.
Patient Experience
Staff
Organisational structures
Patients & carers are engaged in the assessment & planning process
Alternative pathways to admission are considered
Education, leadership & culture
Coordinated approach to assessment and decision making
Clearly defined pathway
Clearly defined screening & assessment process
Patient and carer opinion gathering.
Define current services and their roles and develop alternatives to admission (eg Hospital at Home).
Education & awareness sessions/ programme - frailty, CGA,QI methodology.
Development of daily CGA team and huddles.
Process map the pathway from routes of admission to discharge destination options.
Embed frailty identification and initiation of CGA within 24 hours into the admission process (streamlining to specialist areas).
Screen all patients >75 and >65 from a care home using HIS Frailty Tool.

Building blocks for change

Frailty services identified as key departmental priority.

Frailty session with Senior Leadership Team

(review of previous work).

Member of national collaborative (HIS Focus on Frailty).

Education sessions with key groups (e.g. AHPs, ECANs, ED, bed management).

Key stakeholder group established.

Meetings schedule and MS Teams page.

Process mapping of the identification of the patients with frailty within ED & AAU.

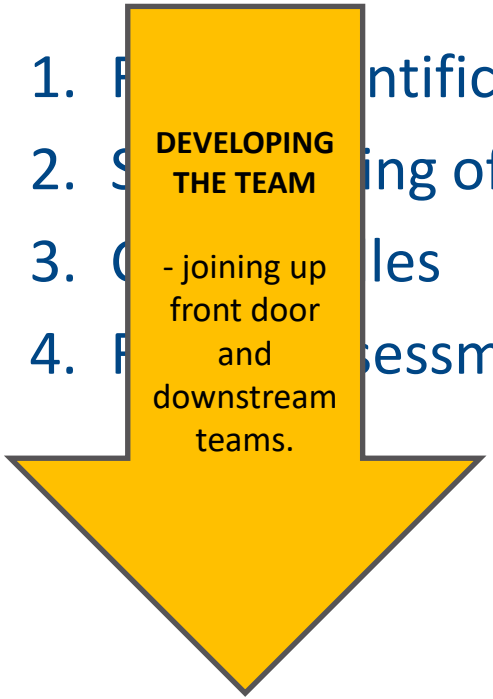
Process mapping of the patient journey through ED/ AAU and the initiation of CGA.

Key phases

1. **Frailty identification**
   - patients 75 years and over (and 65 years and over from care home) screened for frailty
   - electronic version of HIS Frailty Assessment tool.
2. **Streamlining to initiate early CGA**
   - OPS receiving area (ward 53)
   - specialty downstream wards.
3. **CGA huddles**
   - Frailty Assessment Proforma.
4. **Frailty Assessment Area** (or similarly named) and development of **alternatives to admission**.

Themes

1. R ntification
2. S ing of patients with frailty to specialist area(s)
3. C les
4. R sessment Unit (or similarly named).



Themes

1. R ntification
2. S ing of patien ailty to specialist area(s)
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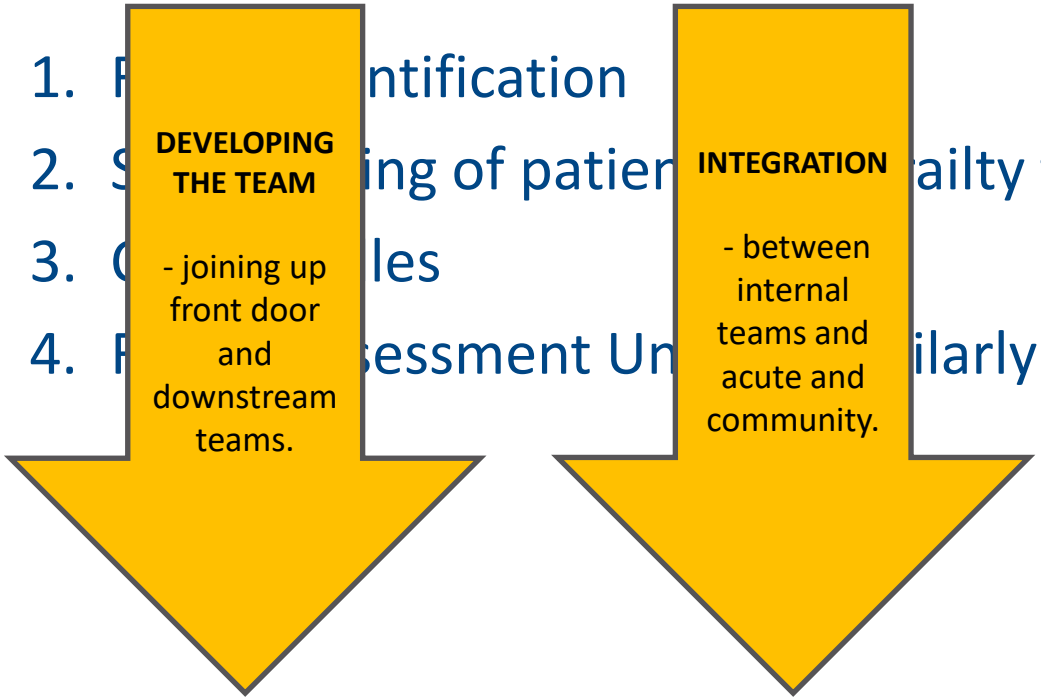
4. R sessment Un ilarly named).



Themes

1. R ntification
2. S ing of patien ailty to spec (s)
3. C les
4. R sessment Un ilarly named

DEVELOPING THE TEAM

- joining up front door and downstream teams.

INTEGRATION

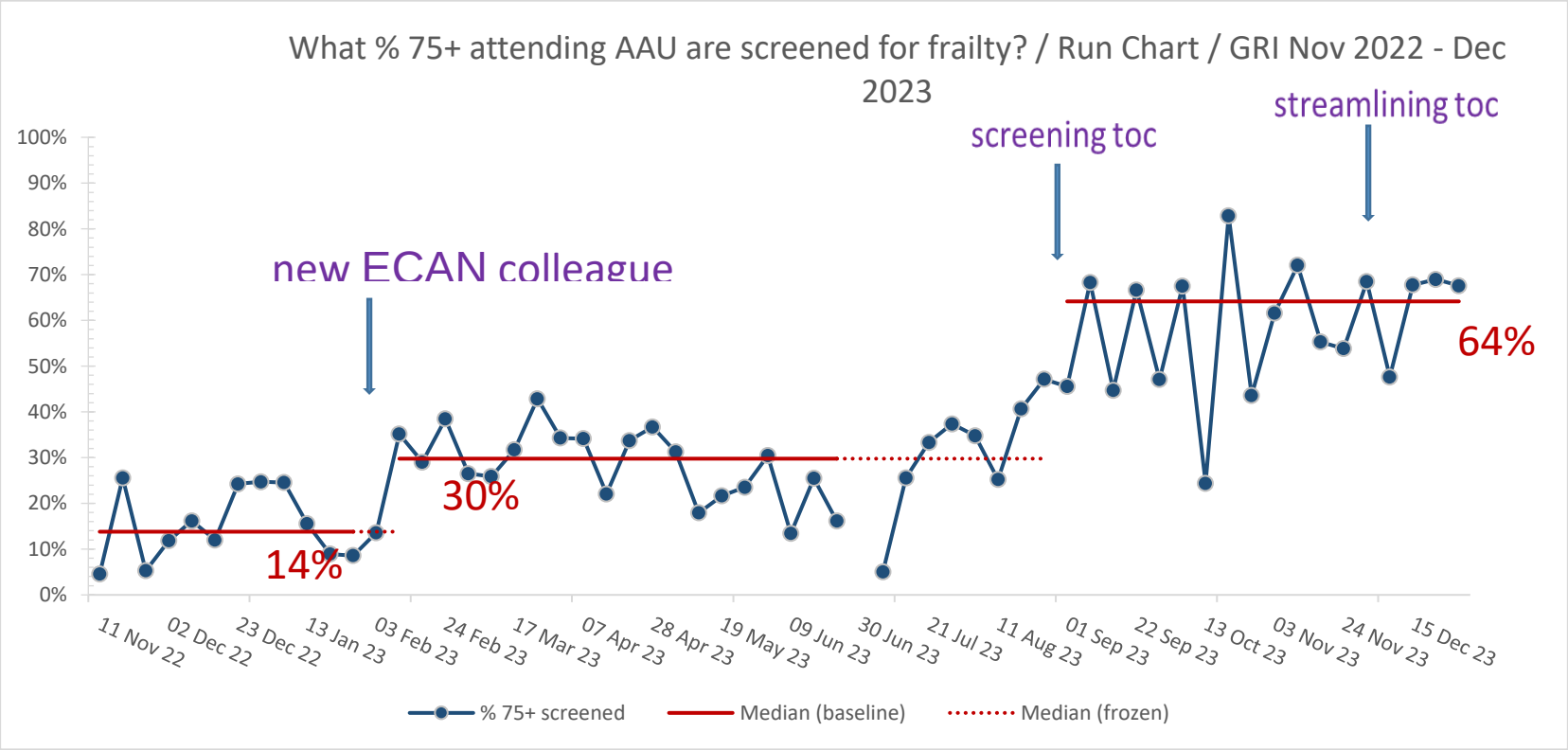
- between internal teams and acute and community.

EDUCATION

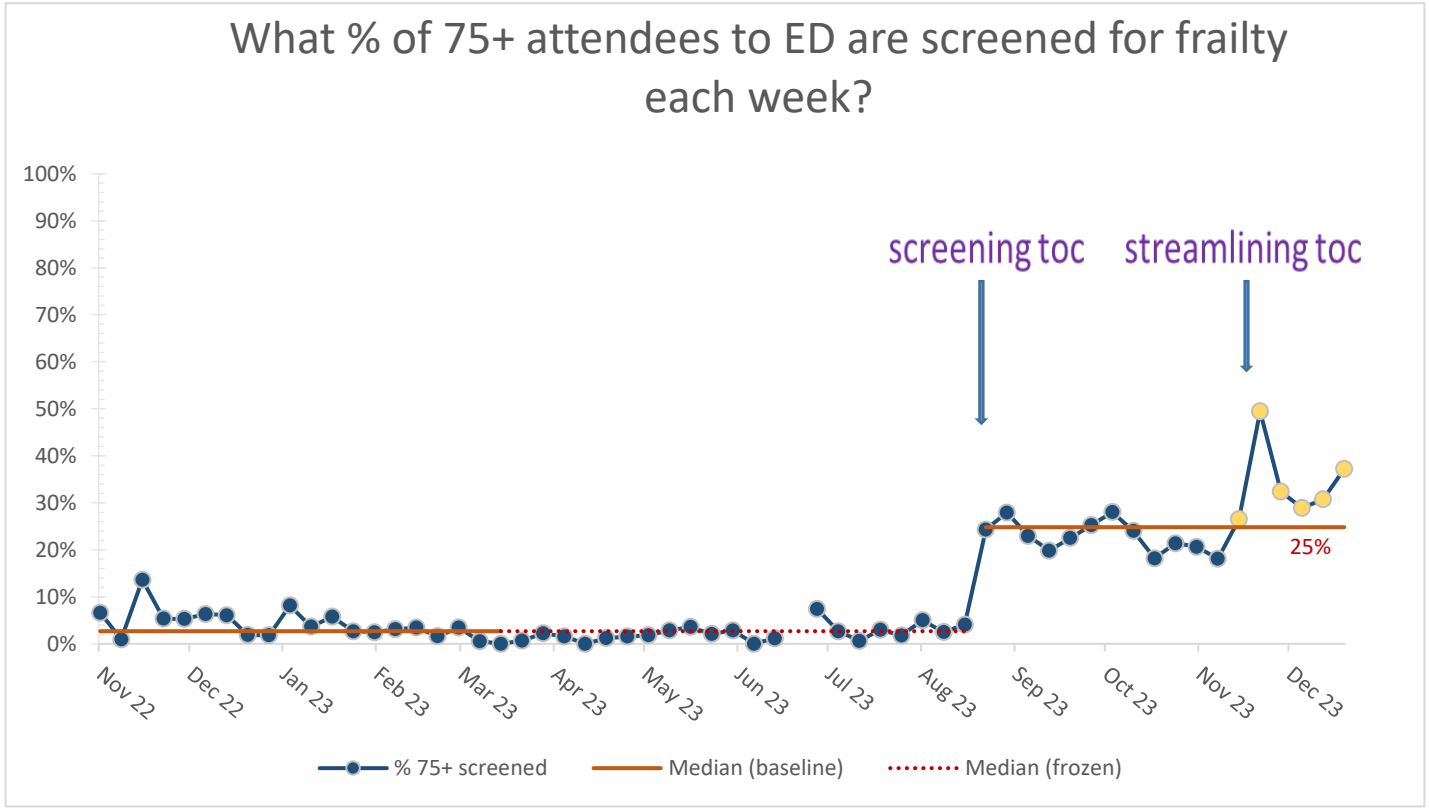
Testing change – frailty identification

- 4th September 2023
  - Patients 75 and over who were being admitted screened for frailty in AAU and ED at the point of the SBAR completion.
    - HIS Frailty Assessment Tool completed at point of SBAR completion (medics in ED, nurses in AAU).
    - ECANs began doing ‘sweep’ of AMRU and AAU at 7am and 3pm.

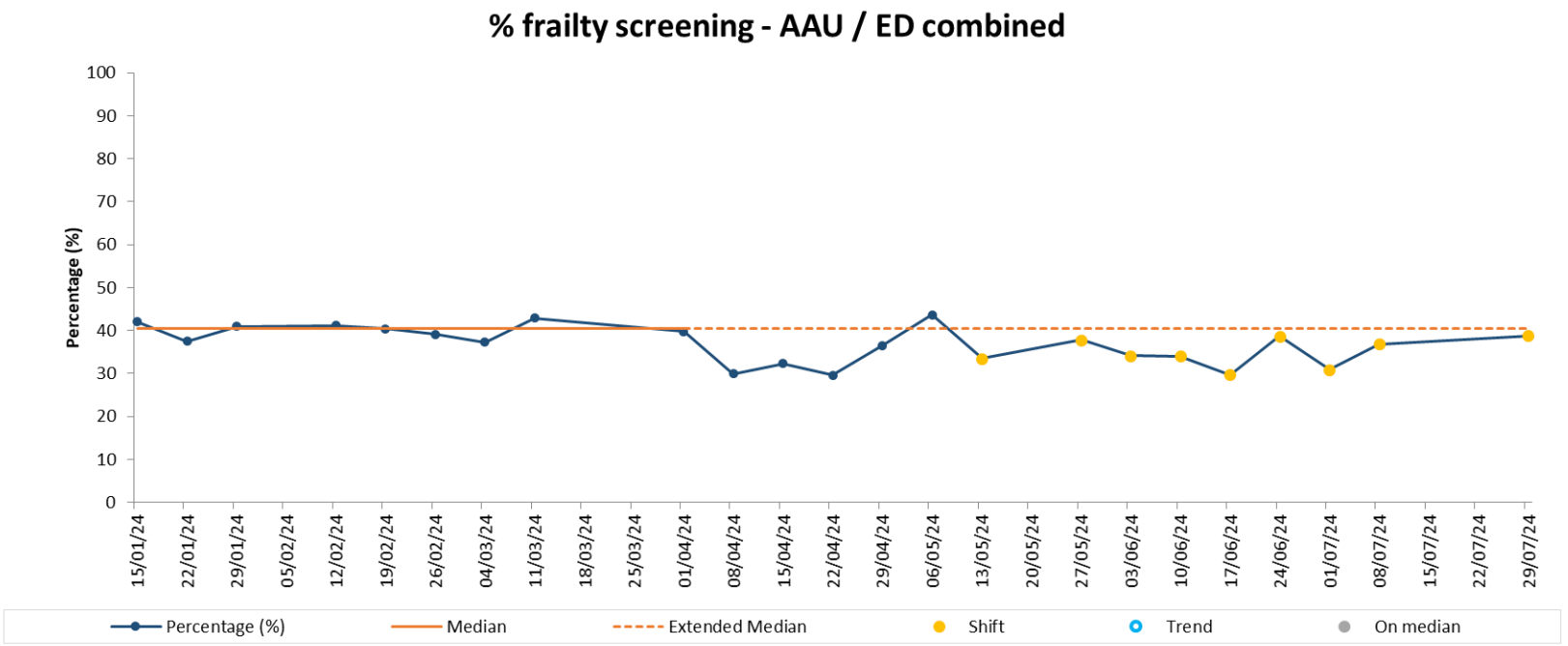
Frailty identification - AAU



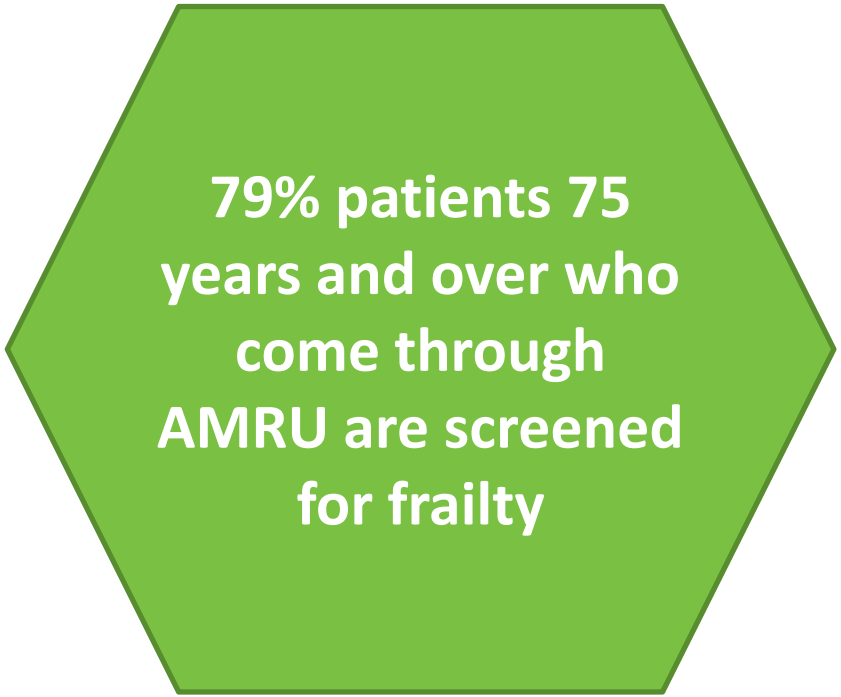
Frailty identification - ED



Frailty identification – ED/AAU



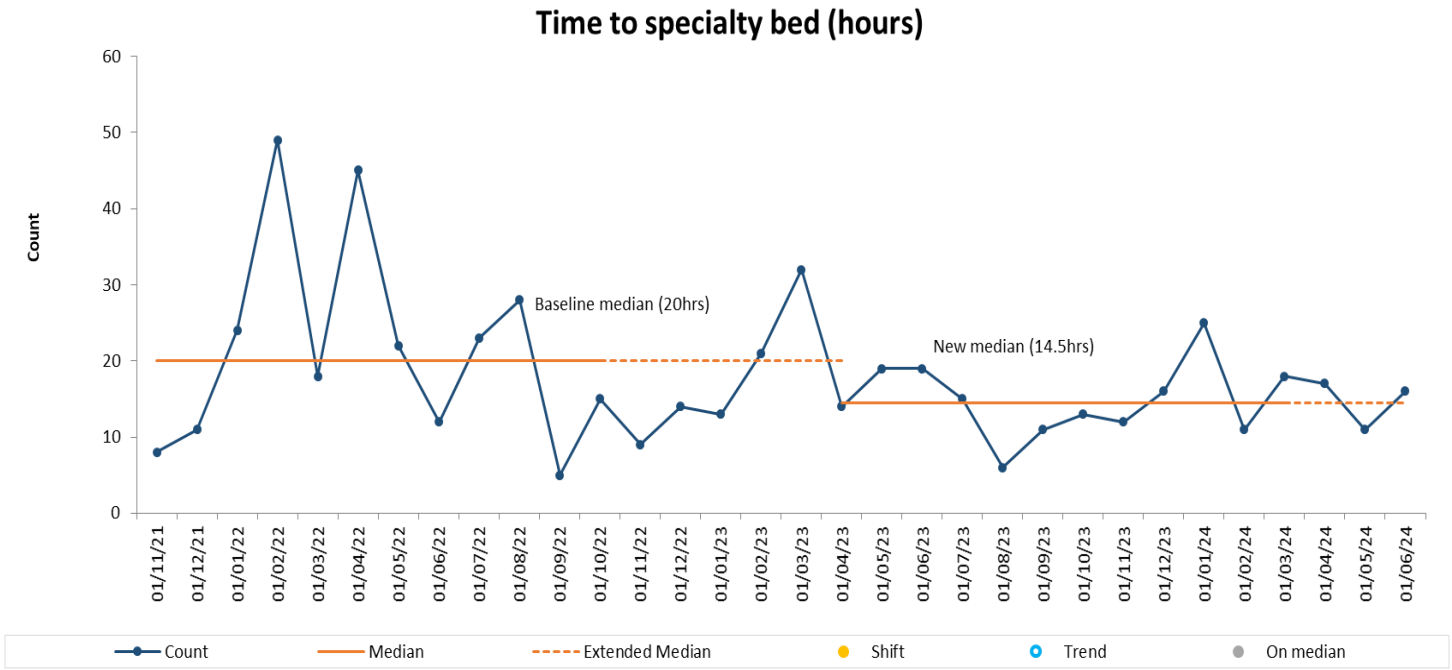
Frailty identification – AMRU



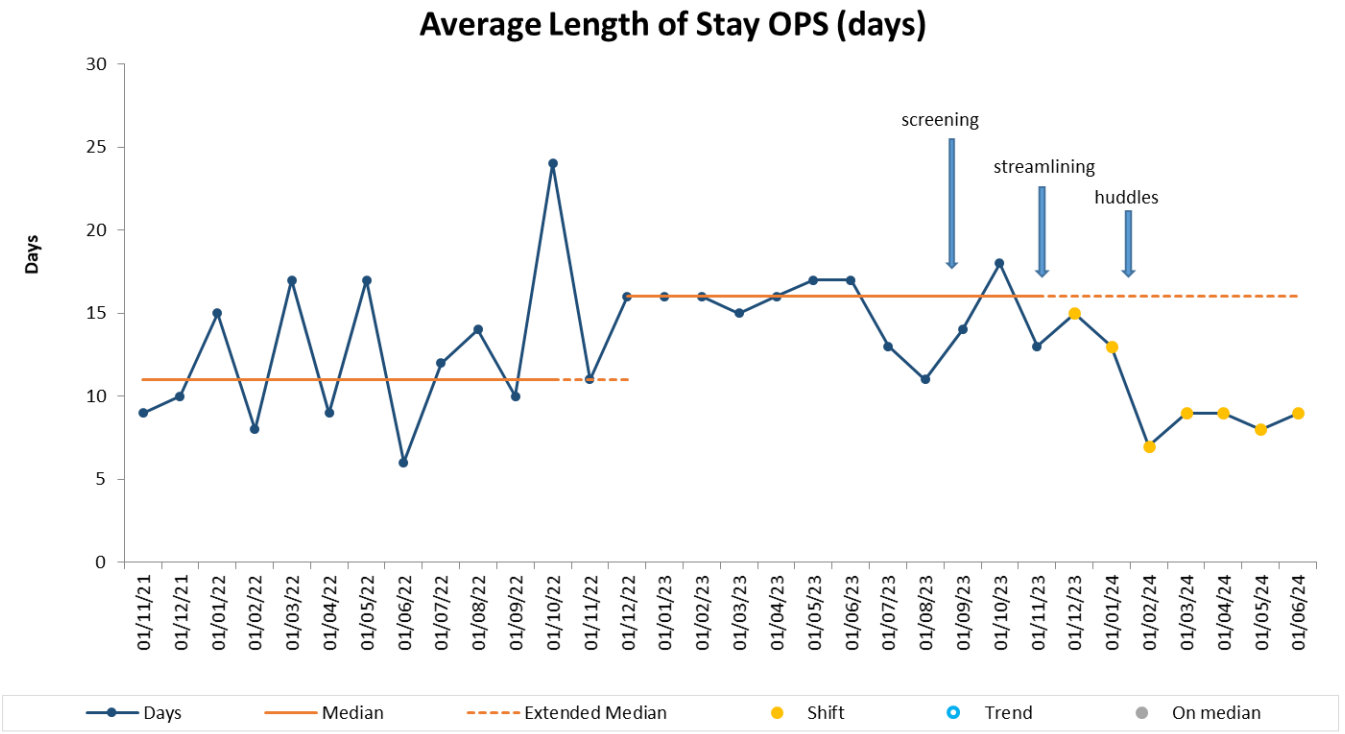
Testing change – streamlining to specialty area(s)

- 21st November 2023
  - Test of change to streamline patients with frailty to specialty beds/ specialty receiving area (ward 53)
    - operational guide developed.

Prompt specialty care



Worth getting it right!



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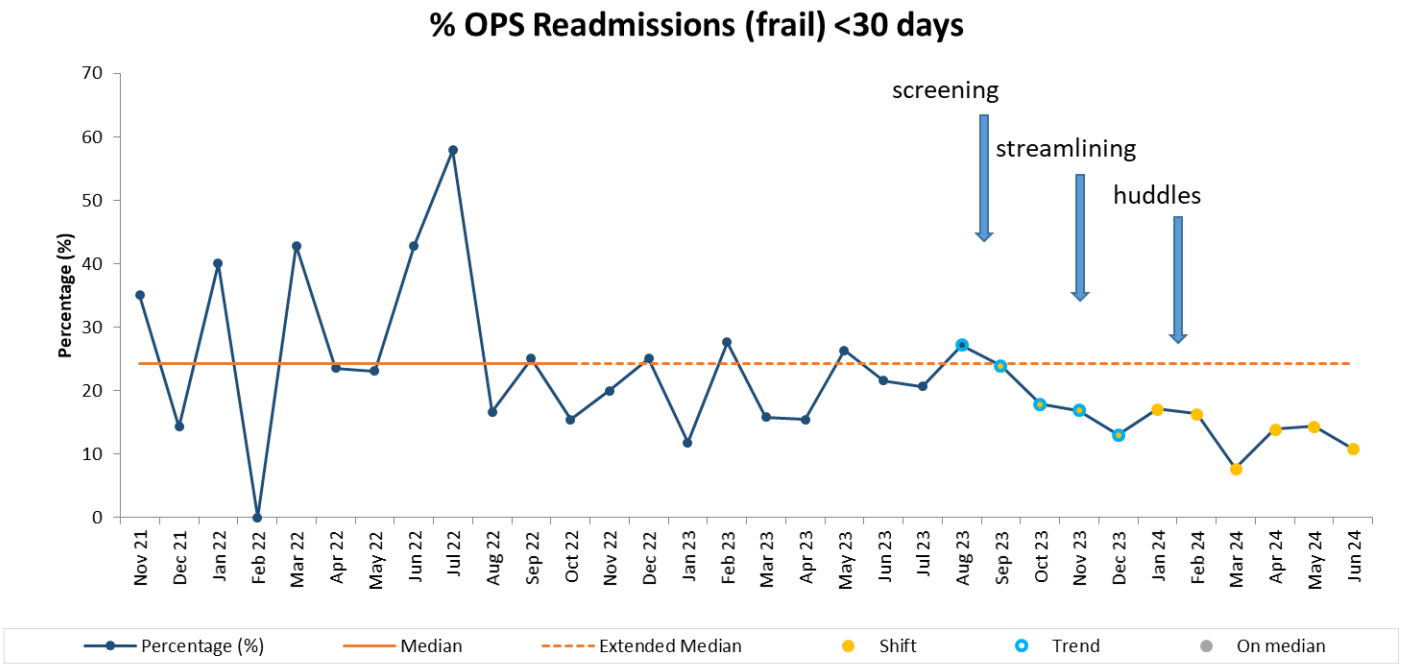
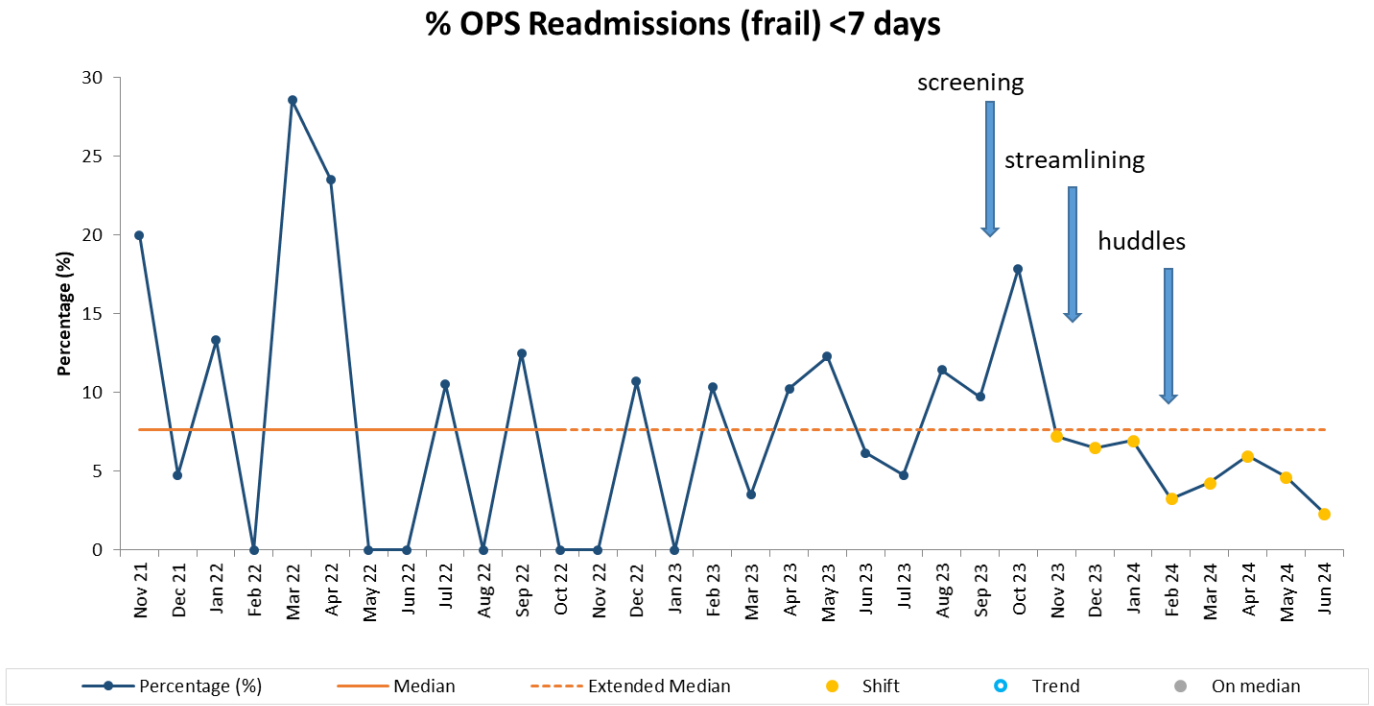


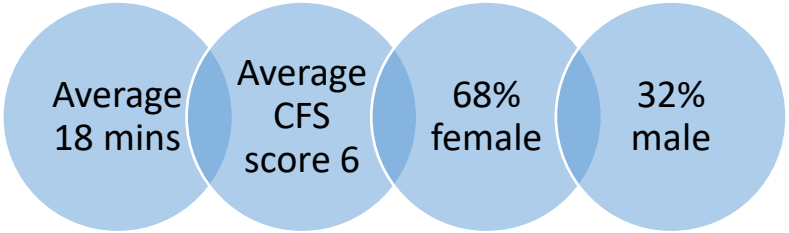
Worth getting it right!

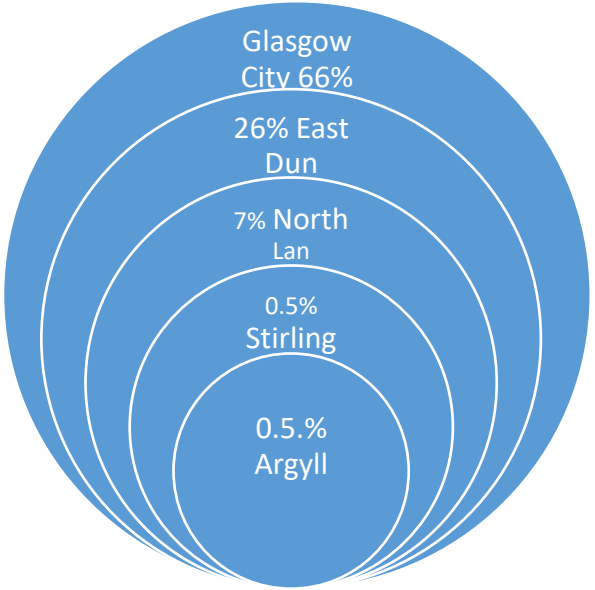


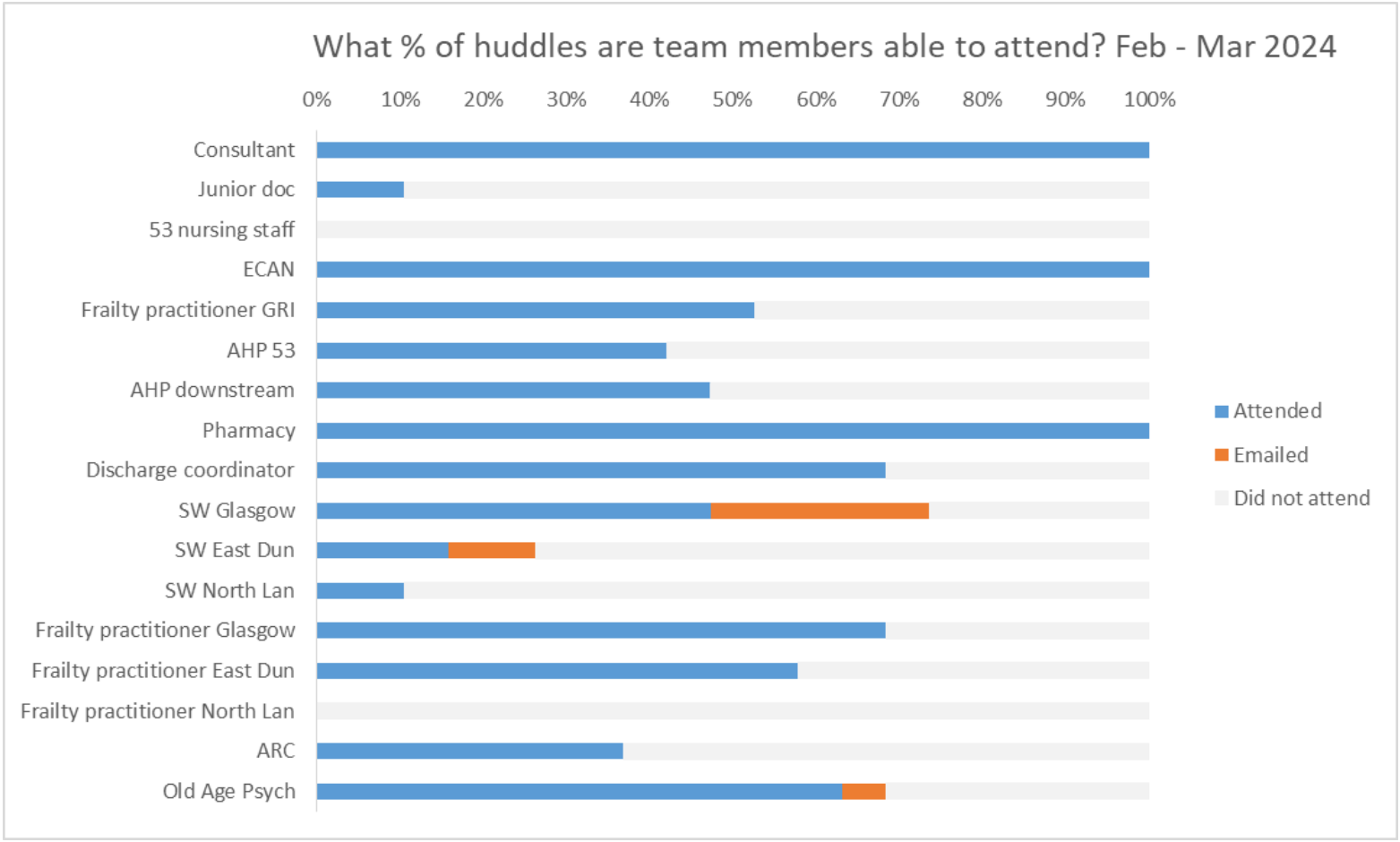
Testing change – CGA huddles

- First 10 patients with frailty.
- List e-mailed out at 9am.
- After post take ward round at 12 midday (in-person and on MS Teams)

- Increase in the number of discharges from 53
- Key relationships building.






What % of huddles are team members able to attend? Feb - Mar 2024
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Consultant
Junior doc
53 nursing staff
ECAN
Frailty practitioner GRI
AHP 53
AHP downstream
Pharmacy
Discharge coordinator
SW Glasgow
SW East Dun
SW North Lan
Frailty practitioner Glasgow
Frailty practitioner East Dun
Frailty practitioner North Lan
ARC
Old Age Psych
Attended
Emailed
Did not attend

What has changed for the patients?

Timely CGA/Proactive AHP and ECAN Ax

In ward 53 mean time to AHP assessment is 1.3 days compared with 2.3 days in downstream OPS wards and 6.5 days for frail patients in medical wards

Increased numbers of AHP assessments and discharges from ward 53

Increased numbers of AHP assessments and steady numbers of patients discharged from ward 53 over recent months

Early Carer/Relative Communication

Where appropriate contact is made with carers/relatives to establish collateral Hx and identify issues early and offer support where necessary

Proactive Early Onward Referral/Signposting

Where required early onward referral can be made e.g. social work, orthotics, podiatry, homecare

Expedited Homecare Access and Equipment Provision

Largely due to our proactive input and improved communication with community rehab teams

Improved communication/team working

- within ward 53 team i.e. between medical staff, AHPs, ECANs and nursing staff
- between hospital and community

Ward 53 - Patient Story

BACKGROUND

Patient: June McIntosh*
Age: 80
Presenting Condition: admitted with dizziness of unknown cause
Social History: Mary lived with her husband - she is his main carer. She had distant support from extended family. She had recently felt that she was requiring additional support with extended ADLs. She was normally independently mobile.

Timely CGA and AHP assessment

Proactive onward referral and signposting

Expedited homecare access and equipment provision

WHAT HAPPENED?

The patient was assessed by the AHP team in ward 53 following assessment by the geriatrician and stroke team.
She underwent a Dix-Hallpike procedure to assess for BPPV and had an assessment of her mobility and function.
She was slightly off her normal functional level and a POC was discussed and agreed on to assist in the short term.
She was provided with a walking aid and a commode for use overnight.
On discussion she was desperate to return home to look after her husband but it was clear she was experiencing carer stress from looking after her husband so a social work referral was made and she was also signposted to some carer support resources. With her consent this was all discussed with her son.
She was able to be discharged home that day with follow-up at the syncope clinic to complete her medical investigations as an outpatient.

SO WHAT?

1. Timely CGA and AHP assessment Early identification of issues relating to the patient and allowed the team to establish plan and ultimately expedite discharge home rather than requiring transfer to a downstream ward.

2. Proactive onward referral and signposting
The patient was able to be referred to social work and homecare services for additional support and was signposted to other community services such as carer support to help to support her discharge from hospital. She was also able to be referred for urgent medical follow up for her remaining medical investigations.

3. Expedited homecare access and equipment provision
The ward team were able to order homecare and provide equipment to support function at home

Learning along the way

Healthcare Improvement Scotland

Hazel Gilmour

Frailty NMAHP Consultant

NHS Lanarkshire and North Lanarkshire HSCP

Whole System Approach to Frailty

Hazel Gilmour

Frailty NMAHP Consultant

20/08/2024

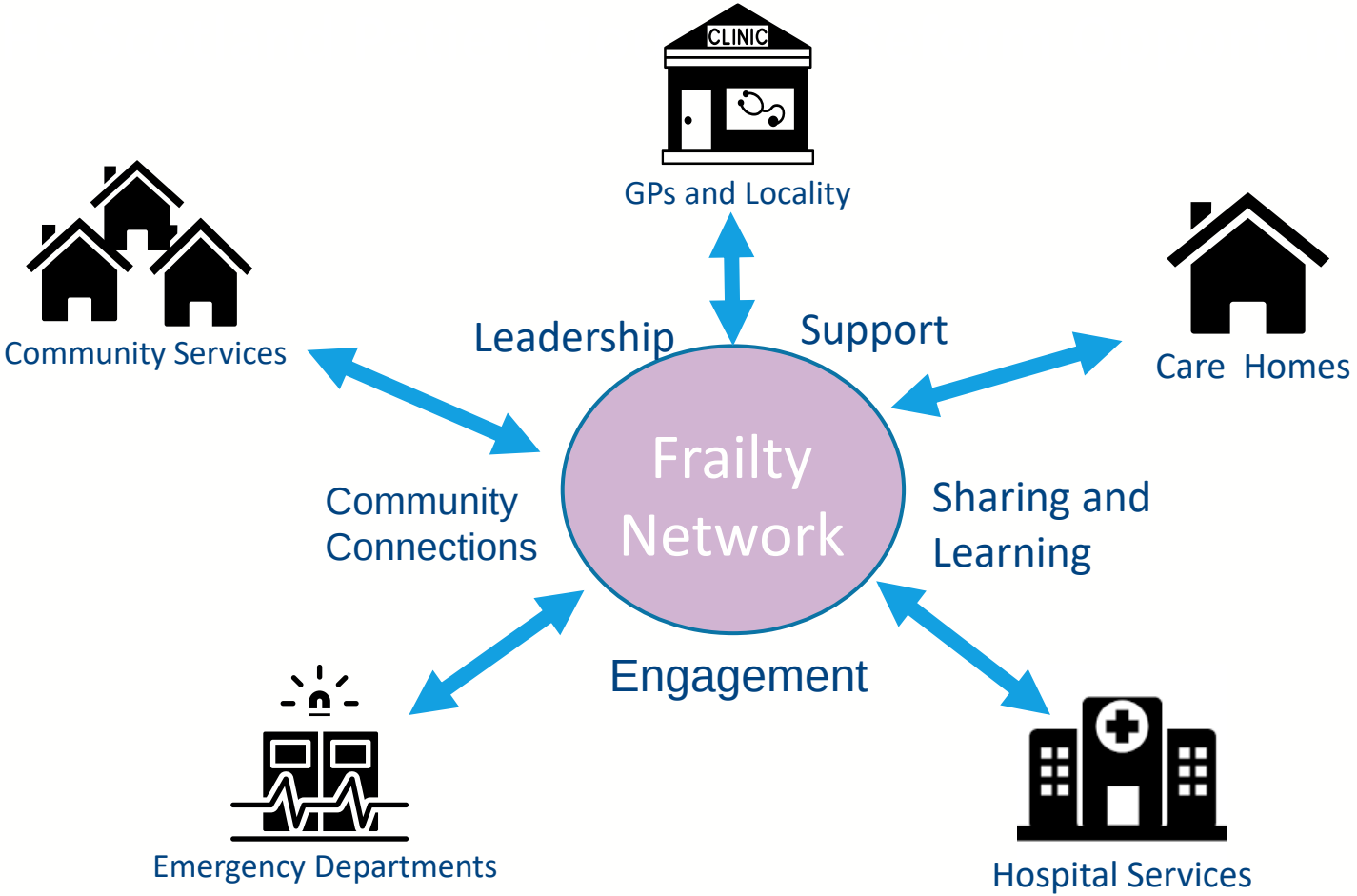
HIS Frailty Learning System Webinar
Developing Front Door Services

What is the Frailty Network?

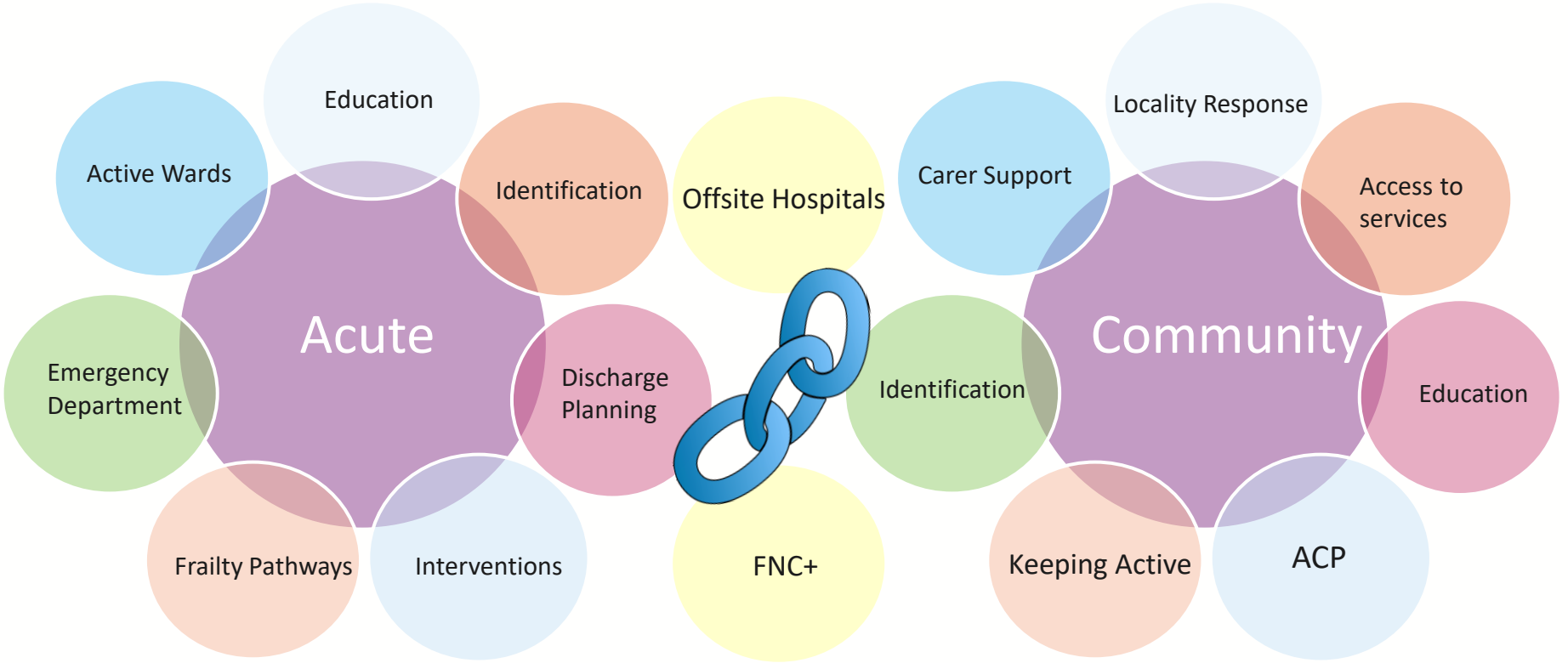
The Frailty Network was established in November 2023

Aims-

- Enhance care for frail patients through multidisciplinary collaboration across acute and community settings.
- Create partnerships with Health and Social Care teams, GPs, district nurses, and third sector organisations.
- Strive to provide realistic and patient-centric improvements in Lanarkshire.
- Proactive, personalised, and coordinated support to help frail older adults maintain independence and well-being.
- Encourage, Engage and Empower teams to improve our systems together.


CLINIC
GPs and Locality
Community Services
Leadership
Support
Care Homes
Community Connections
Frailty Network
Sharing and Learning
Engagement
Emergency Departments
Hospital Services

Whole System Approach to Frailty



Ongoing New Ways of Working

NHS Lanarkshire

Highlighted Areas for Improvement

- Improving Identification Systems
- Understanding our data and Measurements
- Discharge Planning
- Anticipatory Care Planning
- Right Care, Right Place
- Increasing CGA Access
- Reducing Deconditioning
- Access to Services

Ongoing New Ways of Working

- Interface Division
- FNC+
- Virtual Bed Capacity
- Rehabilitation Coordinators
- Offsite Bed Pharmacist
- Advanced AHP ED
- Frailty Units & Pathways
- Increasing CGA at the front door
- Active Wards
- ReSPECT documentation in NH
- Hospice Frailty Coordinator
- DN Frailty Scoring
- Locality Response

Understanding our Systems

- Hospices
- District Nurses
- Carers Academy
- Mental Health
- Front door pathways
- Medical Pathways
- Offsite Pathways
- Surgical Pathways
- Orthopaedics
- Frailty Pathways
- GPs
- Pharmacy
- 3rd sector
- Home Care Teams

Strategy for Preventing and Managing Frailty 2023 – 2028

NHS Lanarkshire

getting it right for everyone

HSCPs: Heads of Health, medical, nursing and AHP representation

Acute: Clinical Leads COTE, Hospital at Home, operational and nursing leads;

Corporate: Public Health, Health Improvement, planning leads, staff-side, EDI lead

Community & Third sector representatives including older people and carer advocacy

Local Authority representatives

Community Reprentatives

Frailty Strategy Implementation Group

- Place and Wellbeing - prevention and proactive support
- Integrated planned care
- **Integrated Unscheduled care**
- My Health, My Care, My Home framework for adults living in care homes
- Education and training

*It will help different parts of the health and social care system to **work together** and **share information**. We have invited people from our communities to **share their experiences** through group discussions and activities to guide our pathfinder project(s).*

Delivery of the Frailty Strategy

Promoting Health and Wellbeing

- Build social capital, community assets and create inclusive, compassionate age and dementia-friendly communities.
- Public messaging on healthy ageing and wellbeing in later life.
- Systematic identification of frailty in all care settings.
- Enhance digital inclusion and use technology to support older people to remain independent, at home.

Tackling Inequalities

- All people experiencing frailty can access the right care, at the right time, in the right place.
- Co-design services with older people and families.
- Involve carers as equal partners, and support carers to remain well.
- Comprehensive person centred assessment relevant in all care settings.

Delivering Sustainable Healthcare

- Scale up proactive future care planning and support for people with frailty in each locality.
- High-quality emergency care attuned to the needs of older people with frailly – specific focus on first 72 hours.
- Urgent community response in all localities will be well aligned with goal oriented reablement, intermediate care and rehab.
- All hospitals will plan for discharge from admission, reduce deconditioning/delirium and work with community partners to reduce LOS and improve transition of care.

What are our challenges?

- Resource & Staffing
- Technology
- Expectation
- Burn out
- Data & Measurement

Thank You

Questions

Evaluation form

Healthcare Improvement Scotland

Webinar evaluation form

Next frailty learning system webinar

Healthcare Improvement Scotland

Medication reviews for older adults living with frailty

03 October 2024, 13:00 - 14:00

Via MS Teams

Register here

Keep in touch

Email: his.frailty@nhs.scot

Frailty learning system: MS teams channel

Twitter: @online_his

Web: healthcareimprovementscotland.org

Blog: blog.healthcareimprovementscotland.org