The Frailty at the Front Door Collaborative

Impact report

December 2019
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Foreword

Older people are the single biggest users of hospital beds with more than 60% of Scottish hospital beds used by the over 65s. Older people living with frailty are arguably the most vulnerable in that group. They have the highest mortality rate, the highest rates of falls, pressure ulcers, hospital acquired infections and delirium in hospital. They are overrepresented in delayed discharges with 75% of delayed discharges being in the over 75s age group. In addition, it is estimated that between 30% and 56% will experience a reduction in their functional ability between admission and discharge. For many adults this can mean the difference between returning home and being placed in nursing home care.

The good news is that for those older people with frailty who require to be in hospital, organised and coordinated specialist care (known as Comprehensive Geriatric Assessment or CGA) has been shown to reduce death or nursing home admission. CGA is not a single action but an iterative multidisciplinary care approach that is specialist led and most effective when delivered in specialist units.

We know that the population is ageing and with that the prevalence of frailty is increasing. This consistent increase is having an effect on hospital care with increasing numbers being admitted every year. Meeting that demand within available resources represents one of the biggest challenges to hospital care. We need to enable older people with frailty to access specialist input and where appropriate a specialist bed. This requires us to identify these patients at the earliest opportunity and address their multidimensional needs as early in their hospital admission as possible. Doing so improves care and reduces harm, wasted time, inappropriate bed rest, functional decline and ultimately poorer outcomes.

Building on their experience of large scale change, the ihub’s Acute Care portfolio hosted the Frailty at the Front Door collaborative as a bold attempt to help hospitals improve care co-ordination and build systems fit for the needs of older people. It brought together teams from five Scottish hospitals to wrestle with how to improve their patients’ experience. Each hospital built teams, created engagement, tried, failed and tried again. Their successes are very much their own and this collaborative was in many respects designed and delivered in collaboration with them. We have adapted, learned and looked for feedback and this evaluation is an opportunity to explore whether the collaborative has added significant value to patient care and has shaped our thinking going forward.

Professor Graham Ellis,
National Clinical Lead for Older People and Frailty,
Healthcare Improvement Scotland
Executive summary

Purpose of this report

This report provides an evaluation of the impact of phase one of the Frailty at the Front Door collaborative. The Frailty at the Front Door collaborative commenced in December 2017 and ended in May 2019. The evaluation report describes lessons that have been learned and summarises the next steps for this work.

Background

Improving experience and outcomes for older people is a priority for health and social care in Scotland.

There are approximately 560,000\(^{1}\) people living with frailty in Scotland - just over 10% of the population. Of this

- 355,000 people are living with mild frailty,
- 151,000 with moderate frailty, and
- 50,000 with severe frailty.

Growing numbers of older people are being admitted to hospital in an emergency and some of those admitted will deteriorate further or experience a delay in returning home due to being frail.

Evidence shows that delivering early and effective Comprehensive Geriatric Assessment (CGA) for people living with frailty has potential to improve their outcomes and experience of care.

The collaborative

The Frailty at the Front Door collaborative is part of the Acute Care portfolio within Healthcare Improvement Scotland’s improvement hub (ihub). The collaborative was launched as an 18 month improvement programme in December 2017, working with five NHS boards to test potential approaches to improving care co-ordination for people living with frailty who present to unscheduled acute care services. The overarching aims were to improve their outcomes and experience by:

- Identifying frailty on presentation to acute services using a validated screening tool,
- delivering rapid assessment of frailty using CGA, and
- co-ordinating the needs of people living with frailty using structured, focused frailty huddles to determine the most appropriate pathway of care.

Teams from the following NHS boards participated in the collaborative:

- NHS Forth Valley – Forth Valley Royal Hospital
- NHS Lothian – St John’s Hospital
- NHS Lanarkshire – University Hospital Monklands
- NHS Greater Glasgow and Clyde – Queen Elizabeth University Hospital
- NHS Dumfries and Galloway – Dumfries and Galloway Royal Infirmary

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\(^{1}\) based on calculations from the e-Frailty index produced by Living Well in Communities, Healthcare Improvement Scotland
Prior to participation in the collaborative, each team were at varying stages of their work on frailty. Some of the participating teams had established temporary or permanent frailty provision in the form of dedicated clinical staff and/or short stay frailty beds, while others had no such provision. This variation in the starting position meant it was important for them to develop a deeper understanding of their readiness for change and identify the contextual factors required for successful improvement.

**Improvement support**

To achieve the aims of the collaborative, participating teams were required to make changes in both processes of care and ways of working. The Acute Care portfolio used a range of approaches to support teams including:

- Quality improvement tools and training to support tests of change in, for example, care processes for screening for frailty, communicating through frailty huddles and delivery of CGA,
- support for systems diagnostics including pathway walks and value stream mapping,
- networking to support collaborative learning, and
- measurement support including a measurement plan, data reporting and feedback.

![Figure 1- Approaches to support](image)

**Impact**

In order to measure the impact of this collaborative, a dual approach was used to evaluation

- A measurement plan was produced to support reporting of process, outcome and balancing measures.
- Case studies were undertaken with each participating team to explore key contextual factors affecting implementation and identify key learning points to inform the next phase of this work.
The impact of this approach can be seen in:

- changes to the way clinical teams and services are organised,
- improved methods of communication and care planning,
- improvements in identification of people living with frailty,
- an increased proportion of people discharged within 24 hours of admission, and
- reduced length of hospital stay in geriatric medicine.

Figure 2: Impact of approach

Lessons learned

The case studies identified a number of factors that underpinned the achievements of the teams who participated in this collaborative, including the importance of:

- leadership at both an operational and strategic level for the project,
- strategic support across hospitals and integrated joint boards to fully realise the benefits,
- an effective multi-disciplinary team to plan and undertake tests of change,
- support from experienced quality improvement practitioners and project managers,
- a clear reporting structure within organisations that tracks progress,
- achieving consensus on how frailty is defined,
- a communication strategy within organisations, and
- support to access and use data that informs the project.

Next Steps

Phase two of the Frailty at the Front Door collaborative will be delivered between September 2019 and March 2021, working with four new hospital teams from:

- NHS Ayrshire and Arran – University Hospital Ayr,
- NHS Greater Glasgow and Clyde – Inverclyde Royal Hospital,
- NHS Lothian – Western General Hospital, and
- NHS Tayside – Ninewells Hospital.
The lessons learned from this evaluation have informed the development of phase two of the collaborative including:

- revision of the driver diagram, change package and measurement plan,
- amendments to the collaborative timeline to facilitate pre-work, and
- providing a platform for ongoing shared learning for phase one and two teams.
Introduction

Improving experience and outcomes for older people is a priority for health and social care in Scotland. The Scottish Government’s Health and Social Care Delivery Plan (2016) states an ambition that:

‘Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. Care also needs to be integrated with a focus on prevention, anticipation and self-management. Furthermore, when acute care is no longer required, people should be able to return home as soon as appropriate with minimal risk of readmission’.

Frailty is a form of complexity, associated with developing multiple long-term conditions over time leading to low resilience, physical and emotional crisis and functional loss leading to gradual dependence on care.

There are approximately 560,000 people living with frailty in Scotland - just over 10% of the population. Of this:

- 355,000 people are living with mild frailty,
- 151,000 with moderate frailty,
- 50,000 with severe frailty.

Growing numbers of older people are being admitted to hospital in an emergency and some of those admitted will deteriorate further or experience a delay in returning home due to being frail.

There is compelling evidence to support the benefits of early and effective Comprehensive Geriatric Assessment (CGA), re-enablement and intermediate care for people living with frailty. The benefits for people and organisation include:

- improved care experience,
- a reduction in the need for hospital care by consideration of a range of care options,
- people who are more likely to be supported in their own home with the appropriate level of care, and
- shorter periods of time in hospital if admission is required.

Healthcare Improvement Scotland’s improvement hub (ihub) have two programmes that aim to address the needs of people living with frailty across their pathway of care. These are:

- The Acute Care portfolio – Frailty at the Front Door
- Living Well in Communities – A collaborative launched in May 2019 to support improvement in identification and support for people aged 65 years and over to live and die well with frailty in the community.

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4 based on calculations from the e-Frailty index produced by Living Well in Communities, Healthcare Improvement Scotland
5 https://www.cochrane.org/CD006211/EPOC.comprehensive-geriatric-assessment-older-adults-admitted-hospital
Aims of the collaborative

In order to support NHS Scotland hospitals to realise the benefits of reliable identification and care co-ordination for people living with frailty, the Acute Care portfolio launched the Frailty at the Front Door Collaborative as an 18 month programme in December 2017. The portfolio worked with five NHS boards to test potential approaches to improving care co-ordination for people with frailty who present to unscheduled acute care services. The overarching aims were to improve outcomes and care experience by:

- reliably identifying frailty on presentation to acute services using a validated screening tool,
- deliver rapid assessment of frailty using CGA, and
- co-ordinate the needs of people living with frailty using structured, focused frailty huddles to determine the most appropriate pathway of care.

Three main evidenced based principles, described in figure 3, were tested by the collaborative teams.

**Figure 3 – Evidence based principles**

- Early identification of frailty on presentation
- Comprehensive Geriatric Assessment initiated within 24 hours
- Early multi-disciplinary/multi-agency discussions to support decision making
Set up of the collaborative

The collaborative was underpinned by the Breakthrough Series Collaborative method\(^6\) which is a short-term, structured learning system that brings together teams who are seeking improvement in a focused topic area. Teams sent up to eight of its members to attend four learning sessions over the course of the collaborative and were supported during the action periods in between these events. See Appendix 2 for the collaborative’s timeline.

Teams were recruited via a national advertising campaign using the ihub’s established networks. Successful applicants were expected to demonstrate:

- an understanding of their current system,
- an awareness of the potential challenges in delivering the aims of the collaborative, and
- clear executive support to demonstrate local investment from senior leaders.

Five teams were recruited to the first phase Frailty at the Front Door Collaborative.

**Figure 4: NHS boards and test sites**

\(^6\) [http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx](http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx)
Prior to participation in the collaborative, each of the participating teams were at varying stages of their work on frailty as described in table 1 below.

**Table 1**

| Forth Valley Royal Hospital | • Age related provision of CGA in downstream wards  
| | • November 2016 – Pilot for one week testing frailty at the front door principles, supported by Acute Care portfolio, which provided learning but no sustainability plan  
| | • Asset mapping work with Falkirk Health and Social Care Partnership |
| Queen Elizabeth University Hospital | • Established frailty provision delivering CGA  
| | • Extended funding for one physiotherapist and one occupational therapist for CGA team  
| | • Temporary funding for a short stay frailty unit |
| University Hospital Monklands | • Established frailty provision delivering CGA  
| | • Established Hospital at Home service |
| St John’s Hospital | • Newly established Hospital at Home and rapid assessment services  
| | • Focus on frailty screening  
| | • No existing provision to deliver CGA |
| Dumfries and Galloway Royal Infirmary | • Moved into new hospital December 2017  
| | • No existing provision to deliver CGA in acute care |

It is important to note that, while some of the participating NHS boards had established temporary or permanent frailty provision in the form of dedicated clinical staff and / or short stay frailty beds, others had no such provision. In addition to this, the number of routes into the hospital front door varied, as did the specific provision for older adult beds. This variation in the starting position of the teams meant it was important for each team to develop a deeper understanding of their readiness for change and identify the contextual factors required for successful improvement.

The MUSIQ (Model for Understanding Success in Quality) tool was used by each team at the launch event in December 2017 to assess their readiness for change. The tool defines 25 key contextual factors within the microsystem, organisation and environment that may influence quality improvement success in healthcare. The tool helped teams identify contextual factors that they needed to adjust to optimise their chances of success.

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7 [https://qualitysafety.bmj.com/content/21/1/13.short](https://qualitysafety.bmj.com/content/21/1/13.short)
Improvement Support

To support teams to meet the aims of the collaborative, the Acute Care portfolio developed and published a driver diagram, change package and measurement plan to guide tests of change\(^8\). These tools provide direction for teams’ improvement activity and include suggested interdependent changes in both care processes and systems of working.

**Care processes**

1. **Screening for frailty**
   Screening for frailty when people first present to unscheduled care helps to:
   - identify the proportion of the frail population using unscheduled hospital assessment and treatment,
   - rapidly identify patients who are frail, and
   - facilitate delivery of co-ordinated care.

   The Acute Care portfolio developed a screening tool which is in the process of being tested and validated in collaboration with seven NHS boards and the University of Glasgow. The purpose of developing this tool was to simplify the process of screening for frailty and support clinical decision making regarding the optimal pathway of care.

   Teams were supported to test either the screening tool developed by the Acute Care portfolio\(^9\) or the Rockwood Clinical Frailty Scale\(^10\) to screen for people aged over 75 for frailty on attendance to unscheduled care services.

2. **Frailty huddles**

   Frailty huddles were a key intervention of the collaborative as a tool to bring together all of the people involved in the care of people with frailty to support communication and care planning. While the huddle membership may vary depending on the hospital it should include representation from health and social care and individuals with the autonomy to make senior care decisions such as decision to discharge or admit to a specialty ward.

3. **Delivering Comprehensive Geriatric Assessment (CGA)**

   Evidence shows that older people are more likely to be alive in their own home at follow up if they receive CGA on admission to hospital\(^11\). CGA is a process of care that supports specialist co-ordinated care to address a person’s medical, social, mental health, and physical needs with the help of a skilled multi-disciplinary team. In hospital, CGA is carried out on a geriatric ward, or on a general ward that is visited by a specialist geriatric team and aims to maximise recovery and to return patients to previous levels of function when possible.

\(^8\)https://ihub.scot/frailty-at-the-front-door/resources-and-downloads/
\(^10\)https://ihub.scot/media/2190/rockwood-clincal-frailty-scale.pdf
However, reliable and timely delivery of CGA requires processes for effective communication and multi-disciplinary working by teams who have appropriate roles, working patterns and skills. This often requires changes to systems that will facilitate effective teamwork and communication.

**Understanding pathways of care and changing systems of working**

In order to support teams to make the changes set out in the driver diagram, the Acute Care portfolio undertook a range of on-site diagnostic work.

1. **Walking the patient pathway**

Initial visits to each test site were used to conduct a walkthrough of the frailty pathway from hospital front door assessment to discharge or admission to a downstream or specialty bed. This facilitated awareness and discussion about location, context, teams and multi-disciplinary working and communication across the pathway.

2. **Value stream mapping**

Value stream mapping is an improvement tool which helps teams to visualise each step of the older person’s pathway of care and to identify where waste can be reduced and improvements implemented. Building on the initial pathway work and teams’ understanding of their contextual factors, value stream mapping offered the opportunity for each team to gain a stronger understanding of their current systems and processes of care to identify opportunities for improvement. The Acute Care portfolio team facilitated this mapping with each test hospital’s project team, involving their clinical and management teams in this exercise.

Common findings during value stream mapping are described in figure 5.

**Figure 5 – Common findings during Value Stream Mapping**

<table>
<thead>
<tr>
<th>Duplication</th>
<th>Co-ordination</th>
<th>Variation</th>
<th>Delays</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Screening in more than one place by multiple professions.</td>
<td>• Lack of co-ordination and communication</td>
<td>• Pathways different at night creating bottlenecks</td>
<td>• Decision making</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Access to specialty bed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Discharge planning</td>
</tr>
</tbody>
</table>

The value stream mapping exercise undertaken with each team helped them to gain support from a broad range of stakeholders, a better understanding of their system and clarity of purpose. As a result, a range of changes have been tested and implemented according to local context as described in figure 6.
Learning system

A critical element of collaborative activity is to support participating teams to learn how to use improvement methodology to advance their work and provide opportunities for them to learn from each other’s successes and challenges. This is vital in providing the motivation, inspiration and peer support that is necessary for their active participation. The collaborative used two methods to deliver this objective.

1. **Steering groups**

   Teams were supported through quarterly structured steering group meetings which incorporated project surgeries. These enabled the teams to share data, progress and challenges with each other, plan next steps and maximise opportunities to learn from one another.

2. **Learning sessions**

   Four learning sessions were hosted by the Acute Care portfolio to promote the sharing of learning between teams. External speakers were invited to offer a deeper understanding of frailty services elsewhere in Scotland and the UK, and to provide learning on topics requested by the teams as described in figure 7.

   ![Figure 7 – Learning requested from teams](image)
Data reporting, assessment and feedback

Teams were expected to submit data and progress reports using the definitions set out in the collaborative measurement plan. They were supported by the Healthcare Improvement Scotland’s data and measurement team to make links with their local data analysts to facilitate access to relevant data that would inform their tests of change and enable reporting. The Acute Care portfolio provided feedback to each team on their data submission.

Responsive support

In addition to structured site visits, additional visits and calls took place with each of the teams to build relationships, offer support and to develop greater understanding of their unique context and needs. This activity was often based on data submissions and was central in enabling the Acute Care portfolio to understand and provide the right type of support required by each team.
Impact

Methods for evaluating impact

To evaluate this collaborative, the Acute Care portfolio used qualitative and quantitative data to understand the impact on service delivery in participating hospitals and outcomes for people their care.

To achieve this we used a dual approach to evaluation.

1. **A measurement plan** was produced to support reporting of process, outcome and balancing measures as described in table 2. Teams were supported to identify measures that fulfilled two criteria
   - measures that were useful in their context to inform their improvement efforts, and
   - outcome and balancing measures that could be readily accessed from existing systems.

<table>
<thead>
<tr>
<th>Process measures</th>
<th>Outcome measures</th>
<th>Balancing measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people over 75 years old who are screened for frailty on arrival to front door</td>
<td>Average time to specialist geriatric bed</td>
<td>Number of people over 75, discharged from specified ward/unit, who have re-attended within 7 days</td>
</tr>
<tr>
<td>Percentage of people who meet the criteria for CGA who have CGA initiated within 24 hours</td>
<td>Percentage of people over 75 years old discharged from specified ward/unit within 24 hours</td>
<td>Number of people over 75 years old, discharged from specified ward/unit, who have re-attended within 30 days</td>
</tr>
<tr>
<td>Average time to initiation of CGA</td>
<td>Average length of stay for people admitted to specialist inpatient geriatric bed</td>
<td></td>
</tr>
</tbody>
</table>

2. **Case studies** were undertaken in each of the participating teams to:

   - Identify and explore key contextual factors affecting implementation relating to:
     - readiness for change and improvement,
     - team working,
     - what activities supported improvement and in which contexts,
     - enablers and challenges to improvement including relationships with executive sponsors,
     - culture and system change,
     - how teams use data for improvement, and
     - implications for downstream wards and community care as well as the hospital front door.

   - Explore whether, and in what ways the collaborative has achieved its aim, specifically:
     - whether a national collaborative can support measurable improvement within an 18 month timeframe,
     - which collaborative activities and national support did teams value most, and
- the impact of the collaborative in sharing good practice and supporting staff.
  - Identify key learning points to inform phase 2 of the collaborative.

Appendix 1 provides a summary of the case studies for each of the participating teams which include details of the changes they have tested and implemented. The full case studies can be accessed on the [ihub website](https://ihub.scot/)¹².

**Findings of evaluation**

Improvements made to service delivery and processes of care by teams include

- new professional roles across nursing, medicine and allied health professionals,
- an increase in the number of people screened for frailty,
- implementation of frailty huddles,
- establishment of frailty units,
- decreased length of stay for people over 65 years, and
- increased discharge of people over 75 years within 48 hours of admission.

**Data from participating teams**

In order to reduce the barriers to progress, teams in this first phase of the collaborative were encouraged to collect, use and report data that could be accessed from existing systems. This identified a challenge that is common to hospitals in NHS Scotland, namely that there are a number of data systems in use across and within NHS boards. Therefore, while all teams were successful in accessing and reporting measures related to the collaborative, there is a lack of consistency of measures reported across participating teams. The extent to which this issue can be resolved will be explored in the next phase of this collaborative.

¹² [https://ihub.scot/](https://ihub.scot/)
Dumfries and Galloway Royal Infirmary

Figure 8: Average Length of Stay (hours) in the Combined Assessment Unit (CAU) for patients over 75 identified as frail. Data source: Local data system. Data from Dumfries and Galloway

Demonstrates a signal of improvement in reduction in average length of stay (hours) in CAU (this has not been sustained).

Forth Valley Royal Hospital

Figure 9: Percentage of patients over 75 who are discharged from the Combined and Acute Assessment Units within 24 hours. Data source: Local data system

At Forth Valley Royal Hospital, more people are being screened for frailty on arrival to hospital. There are now more people over 75 years old being discharged directly home from assessment units within 24 hours of admission.
University Hospital Monklands

**Figure 10: Frailty Unit average length of stay. Data source: Local data system.**

The frailty unit within University Hospital Monklands has shown 9 weeks of sustained shorter stays for patients in that unit.

St. John's Hospital

**Figure 11: Percentage of patients who were discharged home within 48 hours of admission to hospital, displayed by those over 65 and over 75. Data source: Local data system.**

There are signals of an increased percentage of patients who were discharged home within 48 hours.
Queen Elizabeth University Hospital (QEUH)

Figure 12: Average length of stay for patients admitted to Geriatric Medicine in QEUH (any episode, excluding stroke). Data source: ISD Scotland SMR01 & SMR01E.

There was a decrease in the length of stay for patients in geriatric medicine (excluding stroke) at Queen Elizabeth University Hospital. On average, patients admitted to geriatric specialist beds are now in hospital 1.8 days less than before.

The economic impact of the collaborative

The data reported by participating teams indicates that the Frailty at the Front Door collaborative shows potential in terms of its ability to reduce hospital activity and costs and improve the value of health care provision.

Reductions in average length of stay in geriatric medicine associated with improved provision for specialist beds

NHS Greater Glasgow and Clyde and NHS Lanarkshire hospitals showed a reduction in average length of stay in geriatric medicine. It is notable that both of these hospitals provided increased provision of specialist beds for people who are living with frailty. This reflects findings in literature where studies compared CGA with routine care for patients over 65 years old who were admitted to hospital. Most trials evaluated CGA that was provided on a specialised hospital ward or across several wards by a mobile team. The review shows that older people who receive CGA rather than routine medical care after admission to hospital are more likely to be living at home and are less likely to be admitted to a nursing home at up to a year after hospital admission\textsuperscript{13}.

Increased proportion of people over 75 years old discharged within 24 and 48 hours

NHS Forth Valley and NHS Lothian hospitals showed proportionate increases in the number of patients over 75 years old discharged within 24 and 48 hours.

\textsuperscript{13} https://www.cochrane.org/CD006211/EPOC_comprehensive-geriatric-assessment-older-adults-admitted-hospital
A promising use of this intervention is in being able to stratify early those patients who do not need to stay in hospital, enabling them to be discharged faster. Faster discharge for patients who do not need to stay in hospital can have benefits beyond reducing inappropriate care and the resources used. This is because avoiding unnecessary hospital stays reduces the risk that a patient develops a hospital acquired infection or experiences a subsequent deterioration in their health and/or a delayed discharge.

**Improved person centred care**

The participating hospitals described improvements in screening people over 75 years old for frailty and the establishment of frailty huddles. These are critical steps for delivery of CGA which is a multidimensional holistic assessment of an older person that considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person and their family and carers\(^{14}\). This aligns with the aims of Realistic Medicine\(^{15}\) as it puts the person receiving health and care at the centre of decision-making and creates a personalised approach to their care.

**Caveats to data interpretation**

Length of stay data can be highly skewed by a small number of patients who experience extremely long hospital stays, particularly in Care of the Elderly specialties where extensive rehabilitation may be required, or the patient experiences delayed discharge if they need to be discharged to a care home, or require home modifications or social care support to return home.

We do not know what would have otherwise happened to the patients who were discharged more rapidly by the intervention, and so we cannot quantify how much the intervention saved in terms of having avoided these risks in addition to any reduced or avoided length of stay. However, since the bed day cost of a delayed discharge is £234 (price year 2016-17)\(^{16}\) and the annual cost to the NHS is of nursing home care is over £13,000\(^{17}\) it will be pertinent for future work to further explore these additional potential efficiencies in addition to looking at data on average length of stay.

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\(^{14}\) [https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-02-08/BGS%20Toolkit%20FINAL%20FOR%20WEB_0.pdf](https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-02-08/BGS%20Toolkit%20FINAL%20FOR%20WEB_0.pdf)


\(^{17}\) [https://www.sehd.scot.nhs.uk/publications/CC2019_01.pdf](https://www.sehd.scot.nhs.uk/publications/CC2019_01.pdf)
Overview of findings from case studies

Each of the five test hospitals are working in very different contexts, and are at different stages in developing improvements to the way in which frailty is recognised and co-ordinated at the front door of acute care. During the case studies, participants described common achievements and learning across the dimensions of systems, teams and processes of care.

Systems

Collaborative participants described the following achievements at system level:

- A better understanding of the system components including role definition and service configuration, which are required to support people living with frailty who present to acute care.
- A better understanding of alternatives to hospital admission.
- The use of system level data to inform the development of a business case for additional resources and changes to ways of working.
- Improved system wide recognition through the use of frailty markers in administration systems.

The following were identified as important lessons for system level improvement in relation to frailty:

- The importance of effective strategic leadership that unblocks barriers and creates the conditions for sustainable improvement including
  - access to data that enables understanding of the current system and informs improvement plans,
  - support to redefine roles and reconfigure services where appropriate,
  - building effective strategic links across and beyond acute care services,
  - creating opportunities for system wide communication and awareness raising, and
  - supporting a clear strategic reporting structure for the project.
- Data can also be effectively used to inform staff throughout the system, including downstream wards and community teams, about the impacts of the improvement project, and through this develop buy-in for frailty work across the system.
- E-health support is vital to access system data and develop a frailty marker or icon that supports ongoing awareness of frailty and access to useful data.

Teams

Collaborative participants describe the following achievements at team level:

- Raising awareness of the needs of people living with frailty within and beyond the initial project team.
- Using QI methods, including data, to identify opportunities for improvement, test and implement changes.
- Achieving culture change at the front door of the hospital which impacts across the hospital and community.
- Establishing effective multi-disciplinary working that includes medicine, nursing and allied health professionals.
Collaborative participants identified the following lessons for teams undertaking this work:

- The importance of clinical leadership that builds engagement within and beyond teams.
- Early establishment of the multi-disciplinary team that includes QI and project support.
- Identification of dedicated time to support the project, including data collation.

Processes of care

Collaborative participants describes the following achievements in care processes:

- Testing and implementing processes for
  - screening for frailty,
  - communication and planning through frailty huddles, and
  - delivery of CGA.

Collaborative participants identified the following lessons relating to care processes:

- The importance of achieving consensus and shared understanding, firstly on how frailty is defined, and secondly in relation to the data that are needed, and can be practically collated.
- A key lesson from all sites is to ‘Just Do It’. Recognising and co-ordinating effective care for frail people is a whole system challenge which can feel overwhelming. Teams in this collaborative reflected on the importance of early and rapid testing to build momentum, confidence and learning.

Participating teams experience of the Frailty at the Front Door Collaborative

All five test hospitals were clear that they wanted to develop work on recognising and co-ordinating frailty at the front door, and that if they hadn’t already started work on it, they would probably have started to work on this whether or not as collaborative participants. However, they all considered that the collaborative had provided the focus and momentum to make improvements happen. The regular reports on change ideas and tests required by the Acute Care portfolio provided a very effective impetus to the work. The learning facilitated through the collaborative, both during the learning sessions and steering group meetings, combined with site visits, data feedback and responsive support, helped to support development and maintained focus.

Senior, credible clinical involvement in the Acute Care portfolio team was important in supporting the project within the test hospitals, in particular where the operational team lead was not clinical. All sites welcomed the support in facilitating their understanding of where frailty sits across the whole system through value stream mapping.

“I’ve found HIS and the Collaborative really affirmative. Their leadership and mentorship have been really invaluable.”

Lara Mitchell, Consultant in Medicine for the Elderly and Clinical Lead, Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde
Specific areas for the Acute Care portfolio to consider for the ongoing development of the Frailty at the Front Door Collaborative are:

- Twice yearly events to review ongoing improvement, and
- disseminating explicit metrics for frailty

The Acute Care portfolio can develop its support for future test sites by:

- being more prescriptive and proactive in ensuring that the strategic and operational teams outlined in the application to be a test hospital are in place, and working effectively,
- more strongly facilitating links across the hospitals in the collaborative, for example, by facilitating the sharing of email addresses,
- providing resources to support leadership of the work at the local level, and
- considering the timing of programmes, for example, start new improvement projects in the summer before the winter challenges.
Conclusion

During the 18 month collaborative, five participating teams worked together to test approaches to improve care co-ordination for people living with frailty. This report has collated their achievements and learning over the duration of the collaborative.

The teams participating have achieved a range of measurable improvements including:

- new roles to support delivery of screening and care co-ordination for people living with frailty,
- new frailty teams and specialty beds that deliver CGA,
- increased discharge within 24 hours of admission for people over 75 years old, and
- decreased length of stay for people over 75 years old.

To achieve their aims, teams were required to make changes to both processes of care and systems of working. This, in turn, necessitated improvement support to test new care processes, understand their current system, diagnose problems and generate ideas for improvement.

There are key contextual factors which impacted on each team’s progress including:

- their existing system for caring for people with frailty and their readiness for change,
- the interactions and relationships between teams and their wider systems,
- a stable team that meets regularly and includes clinical leadership, project management and executive support, and
- access to data and support to use it to track their progress.

The participating teams valued support from the collaborative to:

- act as a driver for change in their system,
- provide credible clinical expertise and leadership,
- better understand their system and identify opportunities for improvement,
- provide opportunities to learn from peers with similar ambitions, and
- access and use data that supports their efforts.

There are important lessons that the Acute Care portfolio has learned from this phase of the work including a need to:

- be more prescriptive about the constitution of teams,
- support teams to address any gaps in their assessment of readiness for change,
- be more pro-active about team reporting,
- use a standard reporting template for data, acknowledging that in some cases, the desired measures are not accessible from current systems,
- facilitate more peer support, and
- provide a secure online platform for the sharing of learning and tools.

The Acute Care portfolio acknowledges the important input from the participating teams to the development and delivery of the Frailty at the Front Door collaborative. Their input to shaping the aims and interventions has been critical to the learning presented in this report and has certainly had a positive impact on the care and experience for people in their care.
Next Steps

Frailty at the Front Door Collaborative – Phase Two

Building on the learning from this evaluation and the experience of Phase one, Phase two is being delivered between September 2019 and March 2021 by:

- providing a revision of the driver diagram, change package and measurement plan,
- recruiting new teams to participate in phase two,
- amending the collaborative schedule to facilitate pre-work, and
- providing a platform for ongoing shared learning for phase one and two teams.

Revision of the driver diagram, change package and measurement plan

These improvement resources were developed for phase one of the collaborative and have been an important resource in shaping the collaborative and providing direction to participating teams. They will be reviewed in light of the learning from phase one and used as before for phase two.

Recruiting new teams to phase two

The Acute Care portfolio has recruited four new teams to participate in phase two of the collaborative which launched in September 2019.

Amendments to the collaborative schedule

The case studies have identified an opportunity to better prepare teams for the scale and pace of change required. To address this, there was a period prior to the launch of Phase two where visits to each of the recruited teams were undertaken to:

- clarify expectations through a partnership agreement,
- assess readiness for change using the MUSIQ tool,
- address any issues of readiness,
- address issues of data access, and
- undertake an initial walk of the patient pathway.

Providing a platform for ongoing shared learning of phase one and two teams

It is important that the experience and learning from phase one is available to new teams and that both sets of participants have the opportunity to share their successes and challenges. In addition to the revision of the driver diagram and change package, is being facilitated by:

- Phase one teams were invited to present key lessons at the launch of Phase two in September 2019,
- a number of online events will be hosted that are open to phase one and two teams, and
- facilitating peer visits involving phase one and two teams.
Appendix 1 – Case Studies

Dumfries and Galloway Royal Infirmary - Case Study

Context

There are 149,520 people living in Dumfries & Galloway (D&G). 24.7% of these people (36,907) are aged 65 years old or over. The current population is substantially different from the overall Scottish population profile, with a larger proportion of older people and a markedly smaller proportion of young people. D&G has the highest proportion of men of pensionable age (23.7% aged 65 years old or over) and the third highest proportion of women aged 60 and over (33.0%) of all local authorities in Scotland.

The new Dumfries and Galloway Royal Infirmary (DGRI) opened in December 2017. It has a fully integrated Emergency Care Centre including Emergency Department (ED) and Combined Assessment Unit (CAU) which cares for both medical and surgical patients.

DGRI joined the Frailty at the Front Door collaborative when it was launched in December 2017, just as the new hospital opened. A new model of care at the front door was implemented, aligning frailty work with unscheduled care and overarching improvement work. All General Practitioner referrals go directly to the CAU, missing the ED completely. Patients from the ED also flow through to the CAU.

The Frailty at the Front Door Improvement Project

Prior to the opening of the new DGRI and the launch of the DGRI Frailty at the Front Door project, there was no agreed frailty screening tool, no routine frailty screening and no frailty pathway for people attending unscheduled care.

The Frailty at the Front Door collaborative provided DGRI with the opportunity to redesign their model of care to provide coordinated care for frail elderly people that would avoid admission where possible, improve flow and the experience for patients, carers and staff. The team at DGRI identified a specific aim at the time of joining the collaborative.

By May 2019, 95% of people aged 75 years old or over (or 65 years old or over from a care home) presenting for healthcare at DGRI are screened for frailty using a recognised tool and where frailty is identified, a co-ordinated pathway of care is provided.

Governance and management of the project

The DGRI application to join the collaborative was led by the Patient Safety & Improvement Team, and the clinical lead was a Medicine for the Elderly (MoE) consultant, but it became clear that the project needed to be led by a member of the acute management team. In June 2018, project management changed from the Patient Safety & Improvement Manager to the Acute Service Improvement Manager. This person worked with the MoE consultant and established a steering group, chaired by the Associate Director of Allied Health Professionals (AHPs), and an operational group for the Frailty at the Front Door work.
The steering group was chaired by the executive sponsor for the project (AHP Director), and was comprised of a lead nurse from community, a lead social worker, and a nurse manager from acute services, a site director from acute services, a service manager, a consultant geriatrician and data support.

The operational group comprised of the MoE consultant, physiotherapist, occupation therapist, nurse manager from medicine, senior charge nurse from CAU, senior charge nurse from a Care of the Elderly ward, an acute physician, the flow co-ordinator, a social work care co-ordinator, a data analyst and an improvement manager.

By February 2019 the operational group had widened to include community partners, the rapid response team, the reablement service and representatives from mental health.

The Frailty at the Front Door team included an occupational therapist, a physiotherapist, a pharmacist, an acute physician, social work input and the Short Term Assessment and Reablement Service (STARS) which offer alternatives to admission or early supported discharge. Two trainee advanced practice older people’s nurses were also involved.

**Engagement in the project**

The MoE consultant wrote a blog about frailty at an early stage in the project for NHS D&G. This stimulated a lot of interest, and led to the establishment of the Frailty Interest Group in October 2018 which is open to anyone in NHS D&G. The group had interest from all aspects of the service including community, mental health, anaesthetists and pre-assessment, and highlighted that recognising and addressing frailty is a whole system concern, spanning scheduled as well as unscheduled care.

**What the project did**

1. **Improvements to recognition of people living with frailty**
   The frailty screening tool was agreed by May 2018 and testing by nurses in CAU started in July 2018, using PDSA methodology. By October 2018 this process was included in nurse triage paperwork, and a frailty identifier was established on the patient management system (Cortix). The frailty icon supported both data collection and raised awareness of frailty across the hospital. Despite these successes, the team identified some early challenges with appropriate identification of frailty which they addressed through ongoing education and stakeholder engagement.

2. **Improved multidisciplinary communication**
   Multidisciplinary huddles were tested from October 2018 with increasing frequency and increasing specialty involvement. By December 2018 medical, AHP, social work and pharmacy were involved. In February 2019 it was agreed to test the huddle every day for a week from 5 March 2019.

3. **Improved delivery of CGA**
   In October and November 2018, the CGA proforma was designed and tested using PDSA methodology. By December 2018, the proforma was agreed, including a decision that it should be printed on coloured paper to raise awareness. These became available in March 2019 and were launched with a communication plan to continue raise awareness. IT provided a dedicated section/folder within the clinical portal for the CGA.
4. Role development
It was agreed to pursue funding for a frailty nurse Band 6, 1 WTE in May 2018. This post was agreed by October, and filled by April 2019.

5. Quality Improvement Data
The operational team, with the support of HIS, developed project measures to quantify progress. These were:

- **Outcome measures:**
  - The number of patients getting to a specialty bed within 24hrs of admission
  - The percentage of people >75 years old discharged home within 24/48hrs
  - The number of people admitted to specialist inpatient geriatric bed whose length of stay is longer than 7days

- **Process Measures:**
  - People over 75 years old who are screened for frailty on arrival to the front door
  - People who meet criteria for GCA who have it initiated within 24hrs

- **Balancing:**
  - Number of people over 75 years old, discharged from specified ward who have reattended within 7 and 28 days

The DGRI team had strong links with information services and health intelligence to support the collation of required information/data and the analysis of this. Over the course of the project, there were staff vacancies within information services which directly impacted on access to system data.

**Key achievements**

As a result of the move to a new hospital in 2018 and changes to operational management of the project, the DGRI team were aware that, by March 2019 they were not in a position to demonstrate any measurable improvement in process or outcomes related to the project. However, they are proud of their achievements in establishing the required foundations for this work including:

- raising awareness and engagement with clinical teams in receiving areas,
- establishing a process for frailty screening in CAU,
- developing a process for the delivery of CGA to the people who will benefit,
- improving communication through regular frailty huddles,
- making a successful case for support from a specialist nurse for frailty, and
- building the frailty icon into IT systems to support sustainability and spread.

**Key lessons**

1. **The right team and dedicated time**
The experience of the team at DGRI reflects on the importance of bringing together people with the right knowledge and skills at the start of the project. They particularly identified that an individual with dedicated time and project management/QI skills as vital to bring structure and momentum to the project and provide links with strategic leaders.
2. Timing
The team at DGRI were particularly challenged due to a move to a new hospital at the start of the project which was immediately followed by severe winter pressures. This led to several months of delay in testing any changes.

3. Winning hearts and minds
The team at DGRI were relatively new in the organisation which necessitated a significant effort in building the case for change with clinicians so that they understood the benefits of the change to patients and the people who care for them.

4. Time for the project
As with other teams in the collaborative, the team at DGRI were challenged to secure clinical time to support the project.

5. Supporting staff, education and communication, including using data
The team at DGRI have found it essential to provide education on frailty and ongoing communication about the project to ensure staff have the right information and knowledge to apply screening criteria successfully. The resource they have secured for a specialist nurse will support this.

6. Capability for QI work
The team at DGRI have recognised a gap in their skills to use the model for improvement effectively to support their efforts. They felt they would have benefited from team training on QI skills.

7. Overcoming challenges
This team have had some unique operational challenges which have led to setbacks and delays. They recognise the tenacity and resilience required to drive these projects forward and the importance of operational and strategic leaders in driving and supporting this agenda.

The team’s experience of the Frailty at the Front Door collaborative

The DGRI team valued being involved in the collaborative, in particular they recognised:

1. The focus and momentum the collaborative provided:
The team found that participation in the collaborative supported them to have an organisational focus on frailty. The requirement to submit regular self-assessments and data acted as a forcing function for reflection and adjustment in their approach.

2. The learning and support from teams on other sites:
The team at DGRI found the opportunity to learn from others through open and honest discussion about progress and challenges. This helped them to make progress with their project.

The team also has suggestions for improvements:
- stronger facilitation in building links across the hospitals in the collaborative,
- more local clinical engagement, for example, having access to a frailty nurse specialist to provide more regular on-site support for collaborative teams, and
- resourcing for clinical lead session for collaborative teams.
The future

The DGRI team are confident that they can build on the foundations they have laid and the vision they have established to continue their work. They have established an effective team, the support they need to extract data to guide them and engagement from important stakeholders. They have ambitions to spread this work across the pathway of care by engaging with community teams.

People engaged in the development of information to inform the case study:

- Amy Conley, Consultant, Geriatric Medicine
- Cara Hammond, Clinical Development Fellow in Geriatrics and ScotGEM
- Dawn Carson, Physiotherapist
- Gillian Burgess, Pharmacist
- Jackie Nicholson, Nurse Manager for the Medical Directorate
- Lynne Mann, Service Improvement Manager
- Rebecca Queen, Social Worker (hospital based)
**Forth Valley Royal Hospital - Case Study**

**Context**

NHS Forth Valley is located in central Scotland serving a population of 304,480, 24,255 of whom are over 75 years old. In addition to the NHS board there are two Integrated Joint Boards (IJB), four community hospitals, one acute hospital with an emergency department (ED), and 52 General Practices (GP). There were 65,127 attendances to the ED during 2016/17. The average number of admissions per day is 75 of which two thirds are people presenting with a medical condition.

**The Frailty at the Front Door Improvement Project**

In November 2016 Forth Valley Royal Hospital (FVRH) ran a week-long test, screening all patients at the front door who were over the age of 75 years old (or 65 years old if from a care home) for frailty. This involved a multidisciplinary team, including advanced nurse practitioners (ANP), geriatricians and allied health professionals (AHPs). It was a very intensive week, however, it produced good data which helped to inform the application to join the Frailty at the Front Door collaborative. Overall the test was considered to be significant in creating the conditions for change and demonstrated that a multi-partnership approach was needed to support patients with frailty.

At the start of the project the FVRH frailty at the front door service operated during normal working hours Monday to Friday. By January 2019 the service was extended to 12 hours, 7 days a week. It is delivered by a core Comprehensive Geriatric Assessment (CGA) team comprising of a lead Frailty Intervention Team (FIT) Nurse and two other FIT Nurses who play a key role in identifying frail patients, consultant geriatricians and AHPs from the Fastrack team.

The ambition of the local project team was that all patients identified as frail receive early CGA from a specialist team within 24 hours of admission to hospital.

**Governance and management of the project**

Through the test in November 2016, NHS Forth Valley and its associated IJBs had already identified the development of pathways for people who are frail as a priority for improvement, and had established the governance structure for this work. There is a Programme Board for Frailty at the Front Door which meets monthly, represents all key partners, and is chaired by the head of Nursing for the Medical Directorate. Both the NHS board and associated IJB’s local delivery plans have committed to developing the service for frail people.

The Programme Board for Frailty at the Front Door has both a strategic role, reporting to the joint NHS FV and IJBs Unscheduled Care Board, and an operational role. Its membership comprises of the people who were involved in developing the application to join the Frailty at the Front Door collaborative: Service and AHP manager for acute and rehabilitation, Head of Nursing, Medical Director, FVRH general manager and consultant geriatricians. A senior quality improvement facilitator was invited to join the Programme Board when the collaborative started and there is representation...
from the FIT team. This team is tasked with operational management and delivery of the Frailty at the Front Door project.

The Clinical Director for Ageing and Health provided the strategic medical leadership for the improvement project, together with a consultant physician in Ageing and Health. The senior quality improvement facilitator provided the project management. Staff from the Health and Social Care Partnerships welcomed their inclusion in the Frailty at the Front Door operational team.

**Engagement in the project**

In December 2018, the team began to run education sessions with staff to raise awareness of the Frailty at the Front Door work so that staff understand their role and expected response regarding frailty screening and assessment and the available range of care options offered locally across community, intermediate care and social care. It is expected that this awareness raising will help to take the frailty work beyond the front door, and get the buy-in of staff on downstream wards.

**What the project did**

The team at FVRH undertook a number of tests of change

**Test of change 1: March 2018**

In the Acute Receiving Unit, the call handler screened all GP referrals over 75 years old for frailty for the period of Monday to Friday 9.30am-5.30pm. The call handler used an adapted version of the HIS Think Frailty screening tool and asked GPs the questions when they phoned through a referral. The team concluded from this test that screening over the telephone was not the most reliable way of identifying those who are frail. It was decided to recruit a Frailty Intervention Nurse for a test period of three months who would be responsible for screening patients and identifying those who are frail. By April 2018 the nurse was in post and started screening patients who were over 75 years old. All patients over 75 years old (or over 65 years old from a care home) were screened between Monday and Friday before 8am using an adapted version of the HIS Think Frailty screening tool. By May 2018 there had been an increase in the number of patients screened for frailty, however as the nurse was only screening patients between 7am and 8am Monday to Friday, not all patients over 75 years old were being screened.

**Test of change 2: May 2018**

A daily multi-disciplinary CGA huddle was established to discuss patients identified as frail. The huddle is attended by the core CGA team, and communicates with a wider CGA team with representatives from hospital, community, and social care settings to support early diagnosis and holistic planning for treatment, rehabilitation, and long term follow up. The huddle is generally led by the FIT Nurse, with a script being developed to enable any member of the huddle to lead it in the absence of the lead FIT Nurse.

Some of the services who attend the huddle are not based at FVRH which makes travelling to attend a 20 minute meeting impractical. The team use teleconferencing to enable these services to participate.

In September 2018 a clinical development fellow started seeing patients who had already been seen on admission by the consultant geriatrician, working with the CGA multidisciplinary team to expedite plans put in place. In October 2018 there had been a noticeable increase in the percentage of patients identified as frail who were being discharged home directly from receiving areas, and discharged within 24 hours and 48 hours of admission to hospital.
In particular, social and community care staff welcomed their involvement in the frailty huddles as they helped to build relationships between hospital staff and community staff.

**Test of change 3: June 2018**
The team started undertaking CGA for all patients identified as frail through the screening process. The CGA is initiated by the FIT nurse or one of the AHPs depending on capacity, using a locally developed CGA proforma to obtain a complete history from patients, relatives and carers and other health and social care staff involved in the person’s care.

Additional funding through winter monies in 2018-19 provided additional occupational therapy and physiotherapy staffing who supported the FIT nurse in carrying out CGAs. This increased the number of CGAs completed. The team borrowed the idea of printing the CGA documents on to a different colour of paper to make them more visible.

Feedback from ward staff, including nursing and AHPs, regarding the CGA process has been overwhelmingly positive. They report benefits of patients arriving to them with a clear plan that directs people to the correct pathway of care.

In February 2019, FVRH took the decision to screen all patients at the front door for frailty.

**Key achievements**
The team at FVRH is very proud of its achievements, in particular:

- new processes for frailty screening, communication and care co-ordination,
- specialist roles that are supporting a new model of care for people living with frailty,
- data that demonstrates increased numbers of patients discharged directly from receiving areas, and
- the development of an all age frailty service.

**Key lessons**
In addition to developing **good data on the impact** of the improvement project, the following were identified by the team at FVRH:

1. **Leadership**
   Executive leadership to provide support and oversight has been important to maintain momentum and unblock barriers.

2. **Getting buy-in at all levels**
   Support from various levels of hospital management and across clinical professions has been critical to the team’s progress.

3. **Get consensus on how frailty is defined**
   This team has worked hard to achieve consensus on the definition of frailty across all ages. Anecdotally, they believe they are seeing more patients who can benefit from CGA and less who will not. The data they are now able to access and use will help them quantify the impact of this development.

4. **Have quality improvement support**
   This has been important to drive the project and support tests of change.
5. Have a clinical development fellow
Securing the services of a clinical development fellow for this project provided significant support with tests of change and allowed the lead consultant to devote time to service planning.

The team’s experience of the Frailty at the Front Door collaborative

The team at FVRH described value in the participation in the collaborative in relation to:

1. Support to undertake essential developments
While the team reported that they would have addressed the issue of frailty, they described the collaborative as an important factor in the speed of the changes they have made.

2. The opportunity to learn from others
This team found significant benefit from learning from and collaborating with the other participating teams. They carried out a visit to the team at the Queen Elizabeth University Hospital and took away a number of ideas for testing and have identified an appetite for ongoing opportunities to maintain this network.

3. Maintaining momentum
The team describe benefit from the reporting requirements of collaborative participation and how this provided a project structure and pace to test improvements.

The future

The FVRH is optimistic about the future development of the frailty service, with clear ambitions to:

- embed the new system as business as usual,
- consider development of an ambulatory care area for frail people,
- explore the potential to replicate this model in community hospitals, and
- further develop the FIT team in relation to their autonomy.

People engaged in the development of information to inform the case study:

- Lisa Bremner, Senior OT
- Claire Copeland, Clinical Director Ageing & Health
- Sarah Henderson, Consultant Physician in Ageing and Health
- Deborah Lynch, Senior QI Facilitator
- Patrick Rafferty, Head of Nursing
- Jude Rooney, Service Manager Emergency Care
- Rachel Sinclair, Senior Community Care Worker
- Suzanne Thomson, Programme Manager (HSCP)
- Janice Young, Interim Programme Manager (HSCP)
University Hospital Monklands - Case Study

Context

University Hospital Monklands (UHM) serves a population of 260,000, within the localities of Airdrie, Coatbridge, Bellshill and Cumbernauld which is largely a significantly deprived urban area. The North Lanarkshire Health and Social Care Partnership (HSCP) provides the integrated community services for the people within the UHM catchment area. The hospital has 410 beds, with three Care of the Elderly (CoE) wards, comprising of 72 beds, and one Stroke ward which comprises of 19 beds. One of the CoE wards (ward 20) now includes a 12 bedded Frailty Unit. There are three offsite rehabilitation wards which receive patients aged 65 years old and over. Emergency admissions are increasing each year.

The Frailty at the Front Door Service

NHS Lanarkshire was the first area in Scotland to introduce specialist nurses within emergency admission areas for frailty, focusing on screening and access to specialist Comprehensive Geriatric Assessment (CGA). This included the development of the Allied Health Professionals (AHP) team to support decision making at the front door of the hospital.

At UHM, a number of distinct professional groups work at the front door to identify, assess, and manage people with frailty. This includes:

- for assessment of mobility and function, there is a physiotherapist and occupational therapist. 85% of their work addresses the needs of people over 65 years old.
- pharmacists within the receiving ward areas to support medication review and management.
- a discharge facilitator, working within the discharge hub team, supports facilitation of early discharge planning across the hospital.
- community teams are available to support patients on discharge to provide social care, community nursing, rehabilitation, and a range of community supports, and
- a Hospital at Home service has been established for seven years. This provides an alternative to admission for frail older people, and facilitates support for any ongoing medical needs on discharge from hospital.

The Frailty at the Front Door Improvement Project

The older people’s team at UHM and North Lanarkshire HSCP has a track record in delivering quality improvement projects. It was the first to deliver a Hospital at Home service and has developed team-based working with older people. Despite this, at the point of application to join the Frailty at the Front Door Collaborative, UHM still had significantly longer waits than it wanted for older patients to reach specialty beds. In addition, frail people were experiencing a significant number of bed moves, with most moving ward three times before they reach a specialty bed.
Prior to joining the collaborative, the focus of improvement work had been on downstream wards and discharge including the Hospital at Home service. This had reduced patients' length of stay and admissions to hospital.

The project aimed to:
- deliver a safe, effective and person-centred frailty pathway throughout UHM.
- embed a robust process for frailty screening for all people over 65 years old.
- deliver timely CGA for people identified as frail at initial assessment.
- following initiation of CGA, ensure a ‘Home First’ approach for frail people, avoiding admission to hospital if appropriate, and
- work with the HSCP to develop a Discharge to Assess Model.

**Governance and management of the project**

The improvement project had executive support from both the Director of Acute Services and the North Lanarkshire HSCP Chief Operating Officer. This was to support both a focus on the first 24 hours in an acute hospital and access to specialist beds and to consider pathways back to community settings.

The leadership of the project was the responsibility of the Medical Service Manager until January 2019, when a service manager for CoE was appointed.

At the point of application to join the collaborative, it was anticipated that operational delivery of the project would be supported by the

- Clinical lead for Older Peoples service/ consultant geriatrician
- Service manager for Older Peoples Services
- AHP rehabilitation consultant for Older People
- Associate Director of Nursing North HSCP
- Head of Adult Services North HSCP
- NHS Lanarkshire quality improvement team

This group reports to UHM Unscheduled Care group, which has frailty as one of its four work streams.

The team at UHM reflected on the positive impact of having the support of a service manager who has dedicated time to lead improvements in their specialty, particularly in relation to communication with clinical staff, co-ordination of meetings and actions, and supporting access to data that would inform their plans.

**What the project did**

1. **More robust screening for frailty in the Medical Assessment Unit (MAU)**

The project supported the development of robust screening for frailty within the MAU which was undertaken by the Acute Care of the Elderly (ACE) nurses. However, during the course of the project there was significant sickness absence in the ACE nursing team.

2. **Frailty Assessment Unit in CoE department**

The Frailty Assessment Unit was set up mid 2018 as a 12 bed frailty unit within a 24 bed general CoE ward (Ward 20).
By October 2018 a frailty team was in place, comprising of an experienced senior charge nurse and a charge nurse, a CoE consultant providing clinical leadership, and ACE nursing and AHP input. In due course, the CoE consultants’ working patterns will be reconfigured to accommodate the requirements of the unit.

3. Revised pathway of care for people identified as frail in receiving areas

By February 2019, the improvement project supported the development of a revised flow of people identified as frail in the Emergency Department (ED) or the MAU. This changed their pathway to direct admission to the frailty unit, rather than going from MAU to the Acute Medical Receiving Unit (AMRU).

4. Frailty huddle

Following a test of change in June 2018, a daily frailty huddle was established in MAU. In October 2018 daily frailty huddles were introduced in the frailty unit. Reflection from the team concluded that this works well when there has been capacity in the system.

5. Increased staffing

The improvement project showed that there was a need to address the capacity of the ACE nursing team, both in relation to staff numbers, and in supporting the development of ACE nurses. There were also issues with sickness absence in the CoE consultants.

By March 2019 the sickness absence in the ACE nursing team and in the CoE consultants had reduced and plans were in place to support the development of the ACE nurses in to advance practitioner roles.

6. Data

Lack of clear leadership at the start of the improvement project exacerbated the issues around data collection, which was already challenging because of workforce gaps and staff sickness. A further challenge for the team was in collating the right data that would help them focus their tests of change. By March 2019, the team was sufficiently confident to re-think what data would be useful to collate.

7. IT

From the start of the project, it was hoped that frailty screening at triage through the IT infrastructure would be implemented with a paper on this submitted to the TrakCare Board in October 2018. This is unlikely to happen until the end of 2019. When implemented it will support robust data collection and identify frail patients wherever they are within the system. Consequently, during the course of the improvement project, data collection was manual which has limited reliability and is person dependent. This has been a source of frustration to the project team.

Key achievements

Despite their challenges, the team at UHM are proud of their achievements through the collaborative. In particular, the establishment of a defined unit for frailty is supporting their ambitions for the future.
Key lessons

The challenges that this team experienced provide helpful lessons to other hospitals considering how best to develop approaches for improving care co-ordination for people with frailty at the front door.

1. Have clear and dedicated leadership
The experience of the team at UHM reflects that of others in the collaborative in that having the right person to lead, co-ordinate and communicate the work is critical to gaining and maintaining momentum.

2. Establish a clear and focused multi-disciplinary team from the beginning
The team at UHM recognised the importance of the early involvement of the wider multi-disciplinary team in the project.

3. Start new improvement projects in the summer before the winter challenges
This team expressed an opinion that starting this type of work in the summer would have been beneficial to give them more time to explore and understand the challenges before winter pressures set in.

4. Understand the data that you need and can access
The team at UHM reflected on their challenges in accessing and using data that was useful in their context.

The team’s experience of the Frailty at the Front Door collaborative

The UHM team valued being involved in the collaborative, in particular they reported that the collaborative helped their progress by:

1. Providing the impetus to start the journey
The team described the collaborative as providing drive and focus to set them in the right direction.

2. Learning from other hospitals
As with other participants, the UHM team placed a high value on the opportunity to collaborate with and learn from others. They identified specific value in the non-technical aspect of their learning such as team building and communication.

3. The value stream mapping
The team identified the value stream mapping exercise as particularly useful in helping them engage widely to consider the entire pathway of people with frailty and develop ideas for improvement.

The future

Now that robust leadership is established, the UHM team is positive about the future, with clear ambitions for developing the frailty work across the system including:

- embedding and expanding the Frailty Unit The unit expanded to 17 beds in June 2019.
- a frailty marker on TrakCare by December 2019
- better communication and links across the system, and
- using this project to inform the design of a new hospital at Monklands
People engaged in the development of information to inform the case study

- Frances Campbell, ACE (Acute Care of the Elderly) Nurse
- Fraser McJannett, Medical Service Manager (including Care of the Elderly up to 7th Jan 2019)
- Jennifer Allan, Service Improvement Manager
- Karen Goudie, Chief Nurse
- Pamela Downey, Information Analyst
- Sekhar Santapur, Physiotherapist
- Susan Wilson, Senior Charge Nurse, CoE (Ward 20)
- Yvonne Fielder, Service Manager, Care of the Elderly
St. John’s Hospital - Case Study

Context

It is estimated that West Lothian’s overall population will increase by 12% from 175,990 in 2012 to 196,664 by 2037. However, increases will not be seen across all age groups. There will be an overall reduction of 11.9% in people aged 25-64, the mid to older working age group whilst there will be increases in the number of younger residents aged 0-15 (7.7%) and 16-24 (1.8%). However, the growth in the older age groups will be the most significant with the 65-74 age groups increasing by 57%, and the over 75 age group increasing by 140%.

The projected increase in the over 65 age group is likely to place particular strain on both the NHS and social care services. Alongside the projected reduction in the working age population, and in particular the 50-64 age group who provide most of the unpaid care, these demographic changes will present a significant challenge for the provision of health and social care.

Unscheduled Care in West Lothian is served by St John’s Hospital Accident and Emergency Department, and the Western General Hospital and Edinburgh Royal Infirmary.

The Frailty at the Front Door Service

Frailty is identified and co-ordinated as part of the normal operating procedure within the Emergency Department (ED). There is a specialist Occupational Therapy (OT) team based at the front door within the ED which provides a Rapid Occupational Therapy Assessment Service (ROTAS) which aims to:

• provide a rapid response to referrals received in the ED,
• prevent unnecessary hospital admissions directly from the ED,
• facilitate safe and timely discharges of admitted patients within 72 hours, and
• provide early interventions to patients ultimately transferred to the medical wards.

The ROTAS service operates seven days a week supporting patients diverted from the ED with OT support at home or as an outpatient. Although this service is not exclusively aimed at frail elderly patients, it is extensively used by frail patients over 65 years old.

A community Rapid, Elderly, Assessment and Care Team (REACT) works to reduce unnecessary hospital attendances at the front door by assessing frail, older people before they reach crisis; but moreover provide a specialist pathway to divert patients and start the Comprehensive Geriatric Assessment (CGA) process to meet their needs.

The REACT Hub comprises of a community Hospital at Home team, rehabilitation Allied Health Professionals (AHP) team and a rapid access clinic which bridges the intermediate care gap between the community and hospital. The Rapid Elderly Assessment and Care in Hospital (REACH) team work in partnership with the REACT community team ‘in real time’ to identify potential patients that would benefit from being diverted to a community pathway and prevent an unnecessary stay in hospital.

Patients who are not diverted from a community pathway are moved to the 30 bed Medical Admissions Unit (MAU) where the REACH team screen all patients aged 65 years old or older for frailty, using the Healthcare Improvement Scotland (HIS) ‘Think Frailty’ Screening Tool. The REACH team currently
consists of two WTE nurses along with OT and Physiotherapy (PT) providing early intervention, supporting earlier discharge and reduced length of stay. The REACH nurses lead the CGA process with patients who are identified as frail, with input from OT, PT, geriatricians and psychiatry.

St John’s Hospital had no specific Care of the Elderly bed provision, so frail elderly patients move to one of three general medical wards.

The Frailty at the Front Door Improvement Project

NHS Lothian’s vision is to increase wellbeing and reduce health inequalities across all communities in West Lothian. In early 2017 a full review of the objectives of the West Lothian Frail Elderly Board (WL FEB) took place and a new team was formed to deliver the programme. The board saw participation in the Frailty at the Front Door collaborative as an opportunity to benchmark with similar services in Scotland to enhance the progression of local plans.

The aim of the improvement project at St John’s Hospital was to introduce early identification of frailty and enable timely interventions leading to improved patient outcomes. The objectives of the project were to:
- systematically identify frail patients as soon as possible after arrival to the observation ward,
- carry out specialist CGA screening, assessment and care planning, and
- ensure patients have timely access to services.

Governance and management – strategic and operational

West Lothian Health and Social Care Partnership (HSCP) established the West Lothian Frail Elderly Board (WL FEB), with representatives from partner organisations, which reports to the Integration Joint Board (IJB). In 2017, the WL FEB launched a Frail Elderly Programme (WL FEP) which aims to
- design a whole system model of care for frail older adults that meets the overall IJB strategic priority,
- reduce hospital admission and readmission and minimise delayed discharge,
- deliver the new model of care within the budget available to the IJB, and
- have in place the number of staff with the appropriate skills required to deliver new models of care.

There are four project strands within the wider WL FEP which covers:
1. Optimising Flow
2. Integrated Discharge Hub
3. Intermediate Care
4. Home First

The Frailty at the Front Door improvement project came under the Optimising Flow WL FEB project strand. In October 2018 Frail Elderly Programme resources were diverted from the operational ‘day to day’ support to frailty at the front door to support the commitment to launch an Integrated Discharge Hub.
What the project did

The St John’s Hospital Frailty at the Front Door improvement project undertook three tests of change:

Test of change 1: February 2018

It was challenging to undertake frailty assessments in the ED due to the rapid turnaround of patients and ongoing ward activity, so this tested having a REACH nurse in the ED Observation Ward from 8am to 4pm for 7 days. The REACH nurse screened patients for frailty, and initiated a CGA and interventions as necessary. During the test of change, approximate 80% of patients screened were identified as being frail – on average, four patients per day. The test concluded that, while there was a clear demand for frailty screening and CGA instigation in both ED and the Observation Ward, there is not enough patient demand in the Observation Ward to require a full time Band 6 Nurse.

Test of change 2: April 2018

This test of change also involved having a REACH nurse in the Observation Ward, limiting their input to 2 – 3 hours in the morning over 7 days, with a bleep response at all other times. This was to enable all patients to be screened in Observation Ward while making more effective use of available staff time. During this test of change, approximately 50% patients were identified as being frail, on average, four patients a day. The test concluded that
- there was enough patient demand in the Observation Ward to require a 2-3 hours a day of REACH nurse resource,
- the REACH nurse facilitated planning earlier at the weekend which provided bed capacity on Monday morning for ED admissions, and
- it was apparent that the limiting factor to discharging patients by the REACH was largely attributed to the lack of current care capacity in the community.

Test of change 3: July 2018

This test of change involved a daily geriatrician led ‘rapid run down’ on one of the acute medical wards with co-ordinated multi-disciplinary input including REACH, with the aim of facilitating timely decision making and proactive discharge planning from the start of the patient’s journey. This test demonstrated a benefit from increased number of discharges from the ward and reduction in length of stay over the test period.

In May 2018 a business case for establishing the REACH team, using data from the tests of change, was submitted to Frailty Programme Board but was unsuccessful.

Key achievements

1. Learning through the tests of change

An important achievement was the successful test of change which identified a need to screen and assess for frailty early which raised awareness and brought buy-in from front line staff.
2. Better understanding of how to divert people from hospital admission to community pathways

The development of the integrated multi-agency discharge hub in December 2018 has co-located staff and enhanced the identification of frail people as soon as they come on to an inpatient pathway.

Key lessons

- Managing the pathway for people living with frailty is essential for improved flow and discharge planning.
- A whole system approach is essential and requires agreed collective priorities.
- Support from hospital managers is essential.

The team’s experience of the Frailty at the Front Door collaborative

The St John’s Hospital Frailty at the Front Door team valued being involved in the collaborative, in particular:

1. The role of the collaborative in helping teams to question their assumptions, for example, how patients are tracked through the system.

2. The Value Stream Mapping facilitating a shared understanding of challenges around patient flow and wider engagement with the project.

3. The networking to understand their progress in relation to others.

The team at St John’s Hospital suggested that it would have been helpful if funding had been available, for example to fund a clinical session to support this work.

The future

The St John’s Hospital team hope to run a test of change to explore expanding REACH screening and assessment functions out with MAU by June 2019. It also hopes to have a more robust CGA with additional consultant input and a better interface with frailty community teams, including through the Integrated Discharge Hub.

People engaged in the development of information to inform the case study:

- Carol Bebbington, General Manager for Primary and Community Services, West Lothian HSCP
- Elaine Duncan, Medical Director West Lothian HSPC
- Jim Forrest, Chief Officer West Lothian HSCP
- Louise McKay, Lead REACH Nurse, St Johns
- Latana Munang, Consultant Geriatrician, St Johns
- Jeanette Whiting, Frailty Elderly Programme Manager, West Lothian HSCP
Queen Elizabeth University Hospital - Case Study

Context

The Queen Elizabeth University Hospital (QEUH), part of NHS Greater Glasgow and Clyde (GGC) is the largest hospital in Scotland. The QEUH serves a primarily urban area in North West and South Glasgow, however, takes admissions from wider area including the West of Scotland for some specialist services. Patients can be admitted into the QEUH via the Emergency Department (ED), or via the Initial Assessment Unit (IAU). Patients referred by their General Practitioner attend the IAU, whereas patients who attend themselves or call 999 are assessed and then admitted via the ED.

As an example of the number of admissions to the hospital, in July 2017:
- 8,677 attendances at the ED
- Resulting in 2,647 admissions into hospital from the ED
- 2,274 admissions into hospital from the IAU
- In total there were 4,921 emergency admissions into the hospital during July 2017

The medical receiving complex at QEUH consists of the IAU (30 beds) and five specialty Acute Receiving Units (ARUs) with ARU being the identified area for geriatric receiving. There is a total of 118 beds on the ground floor for unscheduled care.

The Frailty at the Front Door Improvement Project

QEUH Older People’s directorate had been working to improve the pathway for unscheduled attendance and admission of frail elderly patients since 2016. This included work with Healthcare Improvement Scotland (HIS) since early 2016 on the concept of a ‘Frailty Team’ and how best to implement Comprehensive Geriatric Assessment (CGA) within the QEUH. The work with HIS included developing an updated frailty screening tool and a number of Plan-Do-Study-Act (PDSA) cycles over 18 months, each of which tested out a different approach for staff to work including PDSA cycles relating to how and where the Elderly Care Assessment Nurses (ECANs) worked, what information and assessment tools they used and how nursing and Allied Health Professionals (AHP) worked together.

This work led to the creation of a comprehensive frailty service in June 2017. The impact of this was immediate, with data on the first six weeks after implementation demonstrating a significant reduction in the length of stay (LoS) within the Department of Medicine for the Elderly (DME) and a positive impact on QEUH’s overall LoS and no negative impact on LoS within medical specialties.

The purpose of the frailty team is to assess any patient over the age of 75 years old (or over the age of 65 years old from a care home) for frailty using the HIS Think Frailty Tool. The identification of frailty positive patients then allows the frailty team to commence CGA for that patient. The frailty team was established in March 2017, and provides the service five days a week between the hours of 7:30am and 4:30pm. At weekends, two ECANs are on duty, and focus on the geriatric receiving unit (ARU4), going into other areas as requested.

In November 2017, the General Manager (South Sector) and the Clinical Lead for DME made a recommendation to the NHS board to support making these working arrangements within the frailty service permanent.
The Frailty at the Front Door collaborative provided the QEUH team with the opportunity to develop and support their plans to improve the links between the hospital and Health and Social Care Partnerships (HSCPs) by, for example, looking at how frailty assessments that are carried out in the community can be used by acute services on admission and vice versa.

Additionally, it was hoped that the participation in the collaborative would support the frailty team at QEUH to:

- establish a permanent frailty service and team and provide enhanced nursing leadership for the Short Stay Frailty Ward.
- extend the frailty team working hours. By November 2017 the team had successfully demonstrated that there is a benefit to the QEUH of having the ECANs and a Frailty Team working until 8pm as they were able to discharge patients between 5pm-8pm that would otherwise have been admitted during the test of change.
- enhance the collection of data on frailty work, in particular to collect more data specifically relating to patient outcomes and to work with HSCPs and acute colleagues to explore what data could be shared to build a better overall picture of the service offered to frail people who arrive at hospital. In particular, the team hoped to develop an NHS GGC frailty icon on their patient management system (TrakCare) to allow easier identification and tracking of frail older people through all NHS GGC hospitals.

Governance and management of the project

The general manager for DME provided project management until he left his post in December 2018. The clinical lead for DME provided clinical leadership and drove the project. No project or administrative support was available resulting in the clinical lead attempting to fill this role.

From December 2017, when QEUH joined the collaborative, regular monthly frailty meetings were established, and membership of those meetings was clarified. This was a multidisciplinary stakeholder group and has been well attended over the last few years. Engagement in these multidisciplinary meetings is strong, with attendance by clinical services managers from DME, the ED and medical receiving, lead nurses for DME and ground floor wards, community and social work representation, physicians from Medicine, the IAU, the Short Stay Frailty Ward and the clinical lead for DME.

At the strategic level, NHS GGC Unscheduled Care Group (South Sector) approved the application to join the collaborative. This group includes representation from the four HSCP areas in the South Sector, and the Scottish Ambulance Service.

At hospital level, the Unscheduled Care Governance Programme provides governance for the frailty work.

During the Frailty at the Front Door collaborative all of the presentations delivered at networking sessions were fed back to the NHS GGC Urgent Care and Community Interface Group. This is chaired by the Medical Director for NHS GGC. There was, however, no formal reporting requirements internally.

Engagement in the project

QEUH has found that using data to feed back to teams was an important and effective mechanism to build engagement and maintain enthusiasm in their project. This has included posters on frailty which were displayed in wards and other areas involved in frailty work prior to this project, and during this
project data has been fed back through a variety of presentations and reports to clinicians and organisational leaders.

The frailty team at QEUH ran a survey of all staff to provide information about staff attitudes to frailty and the frailty service. This survey provided useful information on how the frailty service is viewed across the hospital and offered suggestions for improvement.

In August 2017 QEUH anticipated that a member of the NHS GGC Patient Experience and Public Involvement (PEPI) and the Person-Centred Health and Care (PCHC) team would work with the project to support it to engage with community and third sector groups such as patient and carer support groups. It was hoped that this approach would produce information to facilitate engagement with community teams. Unfortunately, neither the NHS GGC PEPI nor PCHC teams were involved with the project. This may explain, in part, why hopes to improve the links between the hospital and HSCPs through the project were not fully realised.

**What the project did**

1. **Extended frailty team working hours**

The team at QEUH have used data to considerable effect to secure funding that supports extended working hours of the frailty team. They have been able to demonstrate the impact of additional support on early discharges, improved numbers of people who are transferred directly to specialist beds and length of stay in DME.

2. **Expanding bed capacity in the Short Stay Frailty Ward**

QEUH has established a Short Stay Frailty ward with a capacity of 12 beds. They have undertaken a test of change to increase this capacity to 18 beds which involved a different working pattern for consultants to support the enhanced consultant review for these patients. The team are currently engaged in a consultation exercise with an ambition to permanently increase bed capacity in this unit.

3. **Quality Improvement data**

Prior to this project, QEUH recorded every patient who came into contact with the frailty team. This included assigning an outcome to the team’s interaction with the patient which enabled them to show, for example, how many frail patients were discharged home from hospital assessment wards. The data was used to:

- inform the planning of PDSA cycles,
- monitor and assess the impact of the changes, and
- support a successful business case for additional resources.

During the project, the frailty team were supported by HIS to develop project measures to show whether a change was an improvement. These measures were:

- total number of patients reviewed by the frailty team
- total number of patients accepted by the frailty service
- total number of patients transferred into a frailty bed
- total number of patients discharged from assessment units by the frailty team
- total number of patients transferred directly to a frailty bed from ED/IAU, and
- time to CGA
4. Sustainability and spread

The TrakCare update in March 2019 supports the use of a frailty icon which is the identifier for data reporting on frailty via an informatics dashboard across NHS GGC. The team at QEUH have worked with the NHS GGC Frailty Group which influences across acute hospitals in the NHS board area to spread their learning from their participation in the collaborative. This included a meeting in early October 2018 with all other care of the elderly teams in NHS GGC to look at how to apply the collaborative measurement plans to their different systems for the management of people living with frailty. These metrics were agreed by NHS GGC in March 2019 which allows for reporting across the NHS board.

Key achievements of the project

The QEUH frailty team is proud of its achievements in this work.

1. The culture change that it has managed to achieve at the front door

The team at QEUH report a palpable and practical improvement in beliefs and behaviours that impact on the management of frail people in receiving areas. Much of this is premised on the developing role of ECANs and the wider frailty team who have been able to demonstrate the support they can offer to clinical teams in management of people living with frailty.

2. The multidisciplinary trust developed

Multidisciplinary work is critical to effective care co-ordination for frail people. The team at QEUH have built on existing good relationships and use their participation in the collaborative to further develop trust in decision making by different professional groups. The team have recognised that effective team working has significantly supported their progress with job satisfaction and role development being a key element of their teams' consistency.

3. Improvements to patients’ experience

Through the use of data, the team at QEUH have been able to demonstrate reduced patient transfers within their hospital.

4. The establishment of a frailty icon on TrakCare and agreement of frailty metrics across NHS GGC

5. Effective tests of change that have been helpful in building the business case for service change

6. Celebrating success

The frailty team won an award at the NHS GGC Celebrating Success 2017 event in November 2018 and delivered a poster presentation at the BMJ Quality Forum in March 2019.
Key lessons

The team at QEUH have overcome significant challenges to maintain momentum and deliver measurable improvements for people in their care. There is learning from their experience that will benefit other teams undertaking similar efforts.

1. **Just do it**
   There is a risk that the size of this change can be paralysing, particularly in the context of a large hospital like QEUH. The team found it was vital to start by building a strong team who agreed on an area to start testing changes.

2. **Get strategic management buy-in**
   In recognition of the importance of strategic buy-in to the success of the project, the team at QEUH shared their reports to HIS with their organisational sponsors.

3. **Building the case for the right team and dedicated time**
   Using data to make the case for team resource has been a critical element in this teams’ success.

4. **A clearly visible presence and brand, including a presence on the overarching electronic infrastructure**
   The team at QEUH found that participation in the collaborative helped them to raise the profile of their work within the hospital. Inclusion of the frailty icon on TrakCare has been a considerable achievement which will support ongoing awareness of frailty and reliable data collection for this population.

5. **Effective links between the hospital and HSCPs/community teams**
   It was important for this team to engage community teams at the outset to support project planning and delivery. Community representatives have brought useful information on available resources to support discharge planning.

The teams’ experience of the Frailty at the Front Door collaborative

The QEUH team valued being involved in the collaborative, in particular

1. **Support and challenge**
   The team valued the leadership and mentorship support they received before and during the collaborative. They described a benefit from an external, expert view that was delivered with confidence and compassion and specifically identified the role of the HIS clinical lead to support this. They also valued the opportunity to reflect on their progress and the challenge offered to their thinking.

2. **Quality Improvement methodology input**
   The team described benefiting from all the improvement tools they had access to and the support to make best use of them. They described Value Stream Mapping as a powerful intervention that helped them build relationships across the hospital.

3. **Developing relationship with other hospitals**
   The team gained and offered significant support to other collaborative participants. This included peer support for all professionals and a number of hospital visits.
The team also had suggestions for improvements:

- They expressed a view that mandatory targets and benchmarking on frailty would be really helpful.
- HIS should be more prescriptive and precise about the nature of the steering group and project support.
- HIS should be more proactive and supportive in asking for regular reports.

The QEUH team expressed a wish to be involved in future networking opportunities on the topic of frailty.

The future

The QEUH team is optimistic about the future development of their frailty service. They know that it will continue to be challenging, requiring ongoing data to make the case for new roles and increased bed capacity. The clinical lead is exploring how the team can better connect with organisational and reporting structures to maintain the profile and momentum of their work.

People engaged in the development of information to inform the case study

- Lara Mitchell, Consultant, Lead Clinician for Geriatrics
- Carolanne O’Neill, Elderly Care Assessment Nurse
- Geraldine March, Interim General Manager (Older People’s Services)
- Frailty Huddle (daily at 12noon)
- Patient on short term frailty ward
Appendix 2 – Timeline

- 2nd site visit – Value stream mapping/diagnostics/progress
- 1st site visit – Pathway follow/support and challenge sessions
- Delivery group progress meeting
- Learning Session 2
- Steering Group
- WebEx – HIS ‘Think Frailty’ tool development

2018
- Launch Event
  - Dec
  - Jan
  - Feb
  - Mar Board Report
- April
  - Apr Board Report
- May
  - June Board Report
- July
  - Aug Board Report
- Sept
  - Oct Board Report
- Nov
  - Dec Board Report
- 2019
  - Jan
  - Feb Board Report
  - March
  - April
  - May

End of collaborative event