

Augmenting Front Door Frailty Pathways

Queen Elizabeth University Hospital,
NHS Greater Glasgow and Clyde

The Queen Elizabeth University Hospital in NHS Greater Glasgow and Clyde is one of the largest acute hospitals in the UK. The 11 floor building is home to major specialist services such as renal medicine, transplantation and vascular surgery. It hosts state-of-the-art critical care, theatre and diagnostic services. The Frailty Team participated in phase 1 of Frailty at the Front Door working with the ihub at Healthcare Improvement Scotland and have recently carried out further tests of change.

“Everything was wonderful, staff were wonderful and friendly”

Aims

- To increase the number of discharges from unscheduled care of frail older adults from 15 to 25%
- Increase frailty identification and initiation of Comprehensive Geriatric Assessment (CGA)

“My care was perfect was like a ribbon, when I needed something it was there”

Catalysts for Change

Better outcomes are clearly evidenced with the availability of co-ordinated and integrated care planning including the early use of Comprehensive Geriatric Assessment (CGA).

This includes preventing admission, reducing length of stay, re-admission, reducing mortality and enabling the patient, family and all stakeholders to be aware of and involved in the care of the individual.

The time was right

In response to the Covid-19 pandemic, it has never been more important to reduce the need for older people to attend hospital at all, or if they do attend, be able to return home rather than be admitted. If there is a requirement for admission, to limit any stay in hospital and finally to minimise the risk of readmission.



Hospital at Home

The Scottish Government have asked for NHS boards to progress the development of Hospital at Home models following their review of the approach in Lanarkshire.

There is a growing evidence that this approach is beneficial to patients and a significant opportunity to manage the older people pathway.

For the QEUH, this opportunity provides a framework to build a more structured model around existing enhanced community initiatives to support complex cases. It will provide the basis to keep people at home, improve outcomes and reduce unscheduled care activity.

Realistic Medicine

The proposal also offers the opportunity to build on the Realistic Medicine principles to ensure care delivered in the most appropriate setting, in a person centred way and to prevent inappropriate interventions and activity that can at times only cause distress to the individual and family.



Desire to do something different

The Frailty Team at the QEUH participated in the first phase of Frailty at the Front Door in the ihub between 2017-2019 as part of a breakthrough series collaborative.

They demonstrated impact in their length of stay.

In an every changing landscape they were keen to continue their success and use Quality Improvement methodology to further improve their processes



Why do this work?

- Frailty is an independent risk factor for six month mortality and is associated with an increased length of stay
- Access to Comprehensive Geriatric Assessment increases the likelihood of patients being alive and living independently at 12 months
- To strengthen the links between primary and secondary care to provide a service that is safe, effective and person centred supporting people at home where possible, and
- Improving the patient experience by increasing the number of patients discharged from receiving units and the emergency department to be cared for at home in a homely setting



Impact

- **Length of stay** the number of people discharged within 48 hours increased from 15-20% pre tests of change to 33% during test week
- **Comprehensive geriatric assessment** carried out by a multidisciplinary team
- **Person centred discharge**
- **New pathways developed within the Emergency Department and Ambulatory Care** including Consultant connect and rapid access clinic slots
- Urgent **Social Work intervention** /Immediate access to **intermediate care providers** for further assessment and rehabilitation within 48 hours

Planning

- An agreed aim was really important from the outset
- Developing a project initiation plan meant everyone understood the aim and objectives
- Stakeholder engagement with over 180 people who used the service was key
- Buy in from the right people at all levels within the organisation to build the will
- Using a blended approach of both MS Teams calls and face to face supported team members with planning, and
- New standard operating procedures (SOPs) for any new change to pathways



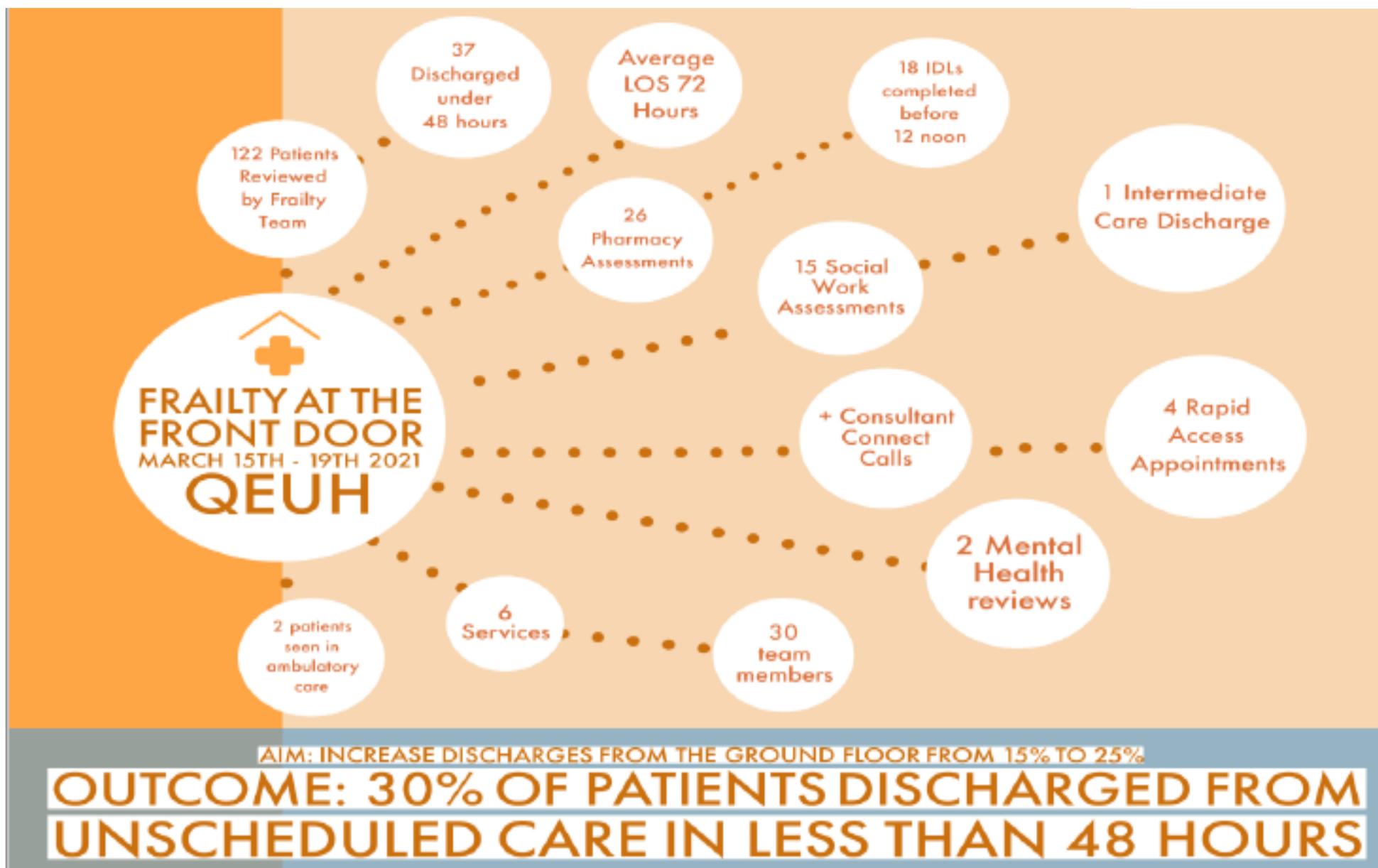
Testing

Enhanced our frailty team by

- 12 hour shifts for AHP in the Emergency Department
- Increased role of key members of MDT e.g. social work, pharmacy, mental health with PDSA cycles with each test of change
- Pharmacy technician/ pharmacy presence
- Mental health input
- Increase in alternative pathways- ED/ ambulatory care/ Consultant connect/ rapid access clinic slots etc. and,
- Maximise expertise and capacity across the whole system – including 3d sector



What did we achieve?



Next steps

- Patient stories will be shared as part of a presentation to demonstrate impact
- Link with emergency department and ambulatory care pathways
- Prioritise links with social work, mental health and community
- Share story at a Frailty ihub Webinar in July 2021, and
- Develop innovation with team roles



Celebrating Success

- The team were so proud of what was achieved working together
- Links with different parts of the system and people all coming together to make care step for change in team working and valuing each other's skills
- Team worked better when everyone was clear on each others skills
- It was clear the difference this made to patients and families accessing the service, and
- The team listened to each other and were flexible and that allowed innovation



Lessons to share

- Be bold, be brave, be proud
- Value each others skills
- Have buy in from senior leaders in the organisation
- Document PDSA tests of change
- Stakeholder engagement with these using the service is key, and
- Patient stories and data together have the biggest impact



Key contacts

- **Dr Lara Mitchell** NHS Greater Glasgow and Clyde @laramitchdr
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- **Laura Walker** Lead AHP
- **Stuart Gaw** General Manager South Sector Older Adult
- **Tricia Moylan** Clinical Director South Sector Older Adult
- **Frailty Team QEUH**
- **Eilidh Gallagher** – Patient Infographics
- **Luisa Fernandes** and **Claire Primrose** – Data



References

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Thank You

The ihub would like to thank Dr Lara Mitchell and her colleagues within NHS Greater Glasgow and Clyde for sharing this case study and their learning with the Frailty team.

 @ihubscot , @ihub_AC, @LWIC_QI , #frailty @NHSGGC

