NHS Fife

6 ESSENTIAL ACTIONS Unscheduled Care

NHS Fife: Getting it Right for Our Most Vulnerable Patients

Healthier Scotland
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6 Essential Actions – Fife Frailty

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According to The Cochrane Review, receiving a Comprehensive Geriatric Assessment increases the chances of frail older patients still being alive and in their own home 12 months after an emergency hospital admission. The review evaluated more than 10,000 patients in six countries[1] and its findings make a compelling case for service change.

It was one of the factors that influenced the team at The Victoria Hospital in Fife to undertake frailty improvements. Numbers of frail patients were high, particularly frail older patients, and the hospital recognised that traditional models of care did not meet these patients' needs effectively. The hospital used the 6 Essential Actions for Improving Unscheduled Care, Capacity and Patient Flow Realignment model to support its frailty improvement work.

Recognising and Responding to Frailty

NHS Fife Chief Operating Officer, Scott McLean explained:

"At any one time between 50% and 70% of our patients have frailty syndromes. These are not just older patients – we see some 90-year olds who are healthier and fitter than some 50-year olds. Frailty is a syndrome or set of syndromes that are not exclusively linked to ageing, although a high proportion of frail patients are over the age of 65. It is crucial that we do whatever we can to minimise the time frail patients spend in hospital to avoid doing them harm. This means not waiting until they fall or become confused before intervening."

1 Twenty-two trials evaluating 10,315 participants in six countries were identified. Patients in receipt of CGA were more likely to be alive and in their own homes at up to six months (OR 1.25, 95% CI 1.11 to 1.42, P = 0.0002) and at the end of scheduled follow up (median 12 months) (OR 1.16, 95% CI 1.05 to 1.28, P = 0.003) when compared to general medical care. In addition, patients were less likely to be institutionalised (OR 0.79, 95% CI 0.69 to 0.88, P < 0.0001). They were less likely to suffer death or deterioration (OR 0.76, 95% CI 0.64 to 0.90, P = 0.001), and were more likely to experience improved cognition in the CGA group (OR 1.11, 95% CI 0.20 to 2.01, P = 0.02). Subgroup interaction in the primary outcomes suggests that the effects of CGA are primarily the result of CGA wards.

Left to right: Jodie Kirk (OT), Louise Kellichan (Team Lead) and Joy Reid (Nurse Consultant)

Getting it Right for Vulnerable Patients

Nurse Consultant for Older People, Joy Reid added:

"We knew that identifying frailty earlier in the process and ensuring that frail older people had access to Comprehensive Geriatric Assessments would provide better outcomes and help us to improve patient flow. Getting patients to be seen by the right person in the right place at the right time meant creating the right conditions for this to happen. Without this, GPs would default to sending patients into the hospital, where it is likely that they would be admitted. There was significant buy-in from senior managers for frailty improvement work; we believed that getting it right for our most vulnerable patients meant we would get it right for everyone."

Back to Basics

The decision to embark on a frailty improvement programme was triggered by the amalgamation of Fife's Victoria Hospital with Queen Margaret Hospital. Bringing together two emergency teams with two separate ways of doing things created challenges, but also provided an opportunity to go back to basics and redesign the service in a way that frontline staff believed would work best. The hospital formed a working group consisting of representatives from across the multidisciplinary team.

"There was strong leadership, honesty and a commitment to creating a clear vision for the treatment of frail older patients," said Joy. "We invited representatives from the two existing teams to come and join us at a service redesign and team-building day, where teams were asked to describe their

Left to right: Mark Alcock (Specialist PT), Gordon Ellis (Frailty ANP), Joy Reid (Nurse Consultant), Louise Kellichan (Team Lead), Lorna Brocklesby (Specialist OT) and Rhona Lyttle (Frailty SN)

ideal service model. One of the things that emerged as a common theme was the need to introduce Frailty Advanced Nurse Practitioners (ANPs) to support the decision-making process. As a result of this, two new ANPs were recruited onto the team and a Band 5 Nurse was upskilled. Physiotherapy Team Lead, Louise Kellichan was recruited to the role of Frailty Team Lead to drive the improvement process and oversee the implementation of improvements identified by the working group." Dr Kirsty Rodger, Geriatrician lead for Front Door Frailty Service was successfully appointed 1 year on which has further enhanced the delivery of older peoples care at the front door.

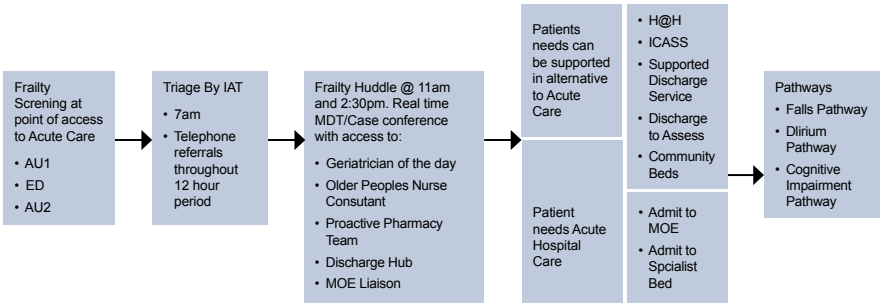
The Integrated Assessment Team (IAT)

The newly formed Integrated Assessment team consists of a team lead physiotherapist, specialist frailty nurse practioners, static specialist occupational therapist and physiotherapists, frailty staff nurses and Assistant Frailty Practioners. The pioneering post of the assistant frailty practioners has been a great success of the improvement work and this new role can support all professions within the team and is generically trained.

Key successes are the team's enhanced service delivery which has enabled a seven-day service for all front door areas which is available from 7.00am until 7.30pm, 365 days a year, and is inclusive of all public holidays.

The hospital created a new pathway to identify frailty at the front door.

Frailty @ Front Door Pathway



The Integrated Assessment Team was located in the 40-bedded Medical Assessment Unit (MAU) and developed a process of frailty screening in MAU, the Emergency Department and the Surgical Assessment Unit. Nurses within both the assessment units now screen all patients regardless of age for frailty syndromes including: reduced mobility; falls; cognitive impairment and delirium. Patients that are flagged up as having potential frailty indicators are referred to the Integrated Assessment Team for a Comprehensive Geriatric Assessment (CGA). Each morning Monday to Friday the IAT will triage the patients screened positive for Frailty and identify 10 patients to be seen by the Consultant Geriatrician doing the Frailty Ward Round. Priority is given to patients with delirium, patients from Nursing/Care home, and patients likely to be suitable for early supported discharge with Hospital at Home. It is well recognised that the earlier CGA is started the better the outcomes for patients and by introducing the Frailty Ward round these patients are seen by a Consultant Geriatrician as early as possible in their admission and a comprehensive plan is made. We are able to take a holistic approach with our specialist skills to ensure the correct pathways for patients that would otherwise be different or delayed if seen instead by colleagues from other medical specialities first.

6 Essential Actions – Fife Frailty

Back Row (L to R): Gordon Ellis (Frailty ANP), Karen Goudie (Nurse Consultant), Alex Bann (Frailty ANP), Rona Young (Frailty SN), Rhona Lyttle (Frailty SN), Nicola Weir (Assistant Frailty Practitioner)

Front Row (L to R): Loretta Comer (OT), Ailsa Williams (Specialist OT), Lauren Stenhouse (Specialist PT), Louise Kellichan (Team Lead)

Within the Emergency department, the screen sits on TRAKCARE (our IT system) and is carried out by both the medical and nursing team for patients over 65 years. Using the model for improvement the team has carried out a number of PDSA cycles to bring this process to triage where by the team is alerted to the patient at the earliest time possible in their journey.

A response time of **30** minutes is adhered which enables the specialist team to guide the decision-making to optimise patient care and lead referrals to the established community teams. This enhanced service has opened up referral routes for patients which enable the team to ensure the right care at the right time, for example discharges with Fife's established Hospital @ Home services. Previously these patients would have been admitted, but can now often be discharged directly home.

The team provides liaison advice to all front door areas which is hugely valued and the nurse consultant supported by the Frailty NPs provide outreach delirium support and advice.

On average, the team sees 20 patients a week within the ED and 75% of these are discharged directly home. If patients attend ED out with IAT team times they will be frailty screened and if positive an out-of-hours referral is completed which the team

triage next working day and identify appropriate follow up e.g. Day hospital, MOE clinic, Hospital@Home and community rehab teams. The team receive on average 20-30 Out of Hours (OOH) referrals each month.

The feedback from the ED teams includes:

"From the ED perspective, it is very useful getting patients seen in the period from 4-7pm".

"Referring to IAT is streamlined – phone referrals are accepted with professionalism and grace without millions of questions".

"IAT have a quick response time in coming to see patients".

"The extended service provides a rapid response, and does aid the ED in discharging patients that might otherwise have been admitted".

"IAT team members work together to optimise outcomes for patients".

Additionally, Dr Andrew J Kinnon who is consultant and Clinical Lead in Emergency Medicine (NHS Fife) reports "The frailty IAT team have become an integral part of the ED team. They provide expertise in assessing those patient groups who may not need admission but need additional support or would benefit from specialist clinic follow up in the community. They can also access hospital at home if needed. The team is available to us seven days a week. They will follow up on ED referrals that were made during the OOH period on patients who were deemed fit for discharge overnight from the ED but may need some frailty input. The team members are approachable and always willing to offer support and advice in a timely fashion. They work with us to help achieve the governments and hospitals targets".

Mix of Competencies

Frailty Team Lead, Louise Kellichan explained:

"Comprehensive Geriatric Assessments look at the whole picture – physical and mental health, as well as social and environmental factors. This is so important and it has been shown to make a significant difference to patient outcomes."

Prior to the formation of the Integrated Assessment Team, The Victoria Hospital had created a therapy and acute care of the elderly team to manage the admission of older patients. The teams were particularly effective at skill sharing, developing a diverse mix of competencies in each team member to equip them to care for frail older people. The new Integrated Assessment Team has continued with this approach, creating a matrix of compulsory training for all members of the team.

Joy commented:

"Frailty is a significant component of urgent care. Roughly seventy per cent of people who exhibit frailty symptoms are over the age of 65. If we can get it right for these vulnerable patients, we get it right for everyone."

Frailty Team Lead, Louise Kellichan pointed out that having the data to support the change process was important for obtaining executive and staff buy-in. The 6 Essential Actions provided a valuable framework for our improvement process as it encompassed patient rather than bed management, seven-day services and using data to support and monitor improvement, all of which were key elements we aimed to deliver.

Monitoring the impact of service changes enabled the team to demonstrate to staff, particular detractors, that their work was making a real difference to patients.

Highest standards of care

As a way of improving understanding of frailty, the frailty working group held a two-day educational event for representatives from across the hospital. It looked at the quality of care provided for frail older people, how clinicians communicate and what could be done to reduce harm. “By default, we knew this process would improve patient flow, but this was not our primary objective,” explained Louise, “what we actually wanted was to provide the highest standard of care for frail older patients.”

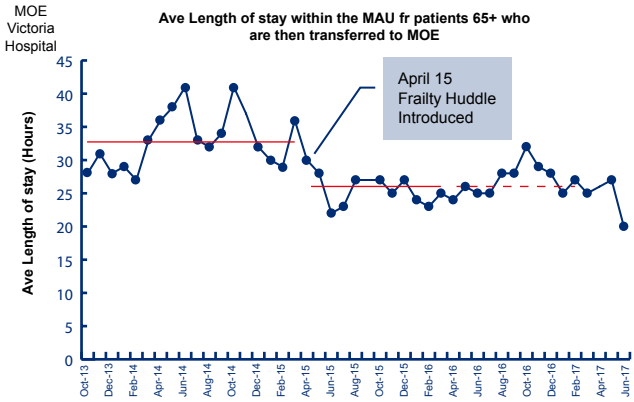
Frailty huddle

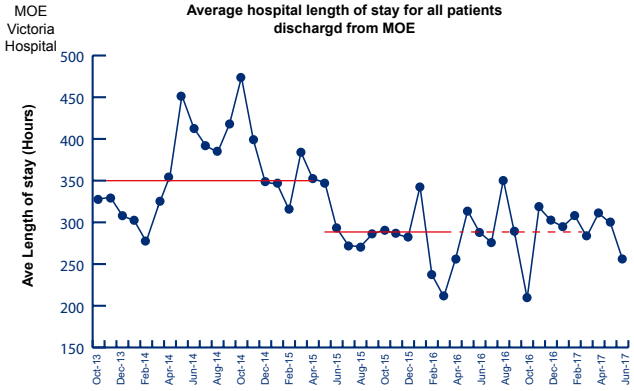
In Spring 2015, the hospital introduced a daily frailty huddle in the Medical Admissions Unit. “It is a very busy unit with lots of different professionals working shoulder to shoulder,” said Joy, “we run the risk of a lack of co-ordination in the care of our frail older patients, with potentially harmful consequences. The daily huddle brings together all of the people involved in their care to discuss these patients, what matters to them and how their care should be delivered to achieve the best outcomes”.

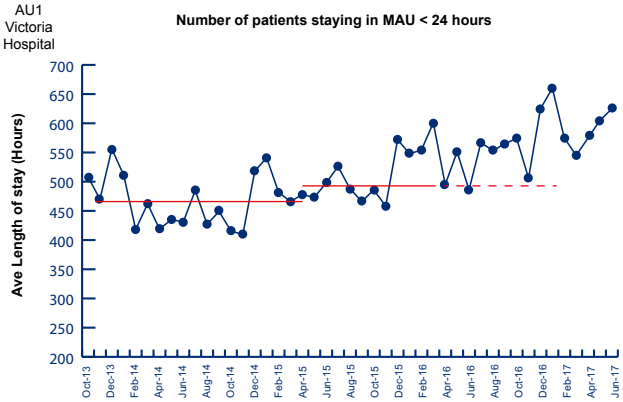
The ethos of the frailty huddle is clear, “it is not about bed management and is clinically driven”, it is led by the team and the nurse consultant. In attendance is the geriatrician of the day who sees all frail patients in MAU, the pharmacy team, the clinical co-ordinator and a senior member of the MAU nursing team. Feedback from other boards includes that this is a very inclusive approach, where all members are valued and where there is clear collaborative working from all professionals.

Pulling Patients out of MAU

The Integrated Assessment Team works to improve care of frail older patients at the front door by getting frail patients to the right place at the right time. A success of the huddle is the strongly formed relationships between the team and the Medicine for the Elderly teams. As soon as a decision has been made for inpatient specialist care, the team communicates this need and the receiving team creates capacity at the earliest opportunity. This joint partnership has made a difference to the length of time that patients are waiting on MAU which, in turn, contributes to shorter length of stay on the Medicine for Elderly ward. “By getting patients onto the ward quicker, we can begin treating them quicker which helps them to recover sooner and reduces length of stay,” explained Joy.







“By getting patients onto the ward quicker, we can begin treating them quicker which helps them to recover sooner and reduces length of stay,” Joy Reid

Short-Term Discharge Support

The hospital recently piloted a programme with a private care organisation that provides early short-term support with personal and domestic care when patients are first discharged from hospital. “Previously, these types of patients would have had to remain in hospital because there was no access to immediate, short-term care support,” explained Louise. “The 16-week pilot showed that providing this type of support to roughly 90 newly-discharged patients cut bed days, resulting in savings of approximately a quarter of a million pounds. Patients were also at less risk of infection or institutionalisation. The Short-Term Discharge Support Service was recently commissioned for a further two years.”

Creating the conditions for change

Scott McLean added:

The change process was not without its challenges. There was a certain amount of apprehension towards change, particularly extending the Integrated Assessment Team's hours from 8am to 4.45pm Monday to Friday to 7am to 7.30pm with some weekend cover. However, data showing the impact of improvements, coupled with patient feedback and high-level support for the programme has helped to overcome this resistance with the team now driving forward and working collaboratively with a shared vision.

Scott McLean said:

"It costs very little to make improvements like this. You don't need a frailty department or a grand plan, all you need is a couple of brave people to lead the change, backed by support from the top and a determination to bring about a change of mindset. We created the conditions for this improvement programme to happen, unlocking the barriers and politely encouraging people to do what needed to be done. Clinical teams with different views can produce awkward compromises and we didn't want that."

Typical patient comments about the Integrated Assessment Team include: "I arrived in a state of panic but soon felt calm" and "I feel positive about my future as everything has been better explained to me." The team is aspiring to provide seven-day cover in the near future.

Contemporising the concept of frailty

Scott McLean commented:

"History shows us there is always "*the next big thing*". Frailty doesn't feel like that. It is really important that the concept of frailty becomes mainstream, although not so mainstream that we become complacent about it. Managing frailty will always be a challenge but we are making good progress here in Fife.

This improvement work has changed the way we do business. If we trust and respond to the evidence-base we cannot help but improve patient outcomes. It is encouraging to hear speciality doctors and surgeons talking about frailty in a way that they never would have done about geriatrics. In a modernised healthcare system, it is not about young or old, it is about what is right for individual patients.
The concept of frailty is starting to contemporise and patients are benefiting as a result."

Key Lessons Learned

- Identification of frailty should happen at the earliest opportunity.
- Frailty screening at front door areas highlights patients requiring CGA early and with the right rapid response from an MDT can facilitate early discharges and prevent inappropriate admissions to acute in-patient areas.
- Huddles don't cost anything and allow invaluable decision-making and pathways are set which are truly patient-focused and centred on reducing harm and improving patient experience.
- Multi-professional approach to frailty provides the best outcomes.
- Advanced practice and senior decision-making are essential to drive complex discharges from door areas and ensure smooth transfer to community teams.
- Rapid response times are required for assessment of the older adult at the front door, especially to the ED.
- When redesigning services plan for seven days and extended length of day.
- Multiple changes through service re-design are exciting and can naturally and spontaneously eliminate barriers/issues.
- Involve key players and partners from the outset. This works well when clinicians delivering new service are leading the changes.

Key Lessons Learned

- Timely feedback of new processes is essential to refine and embed. Encourage staff to challenge and have a solution-focused approach.
- It is important for staff to understand data and quality improvement at every level and recognise that new ways of working are enhancing patient experience and making system improvements.
- Don't worry about making mistakes or things not going according to plan. These are valuable learning opportunities so build upon them.
- Empower staff to deliver the change.
- Working across health and social care partnerships is essential for front door areas to develop effective care pathways for patients.

Acknowledgements

We would like to thank everyone who has contributed to this case study. By openly sharing your experiences, your challenges and your learning, you are helping to spread best practice and drive system-wide improvement.

These stories serve to inspire others and celebrate the hard work of individuals who are omitted to making things better for patients. In particular we would like to acknowledge:

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- Karen Goudie, Nurse Consultant for Older People
- Louise Kellichan, Integrated Assessment Team Leader, NHS Fife
- All staff at NHS Fife
- Case Study writer, Kate Philbin, and the National Unscheduled Care Team

If you are inspired to share your improvement story, we would love to hear from you. Please get in touch at: UnscheduledCareTeam@gov.scot

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