Acute Frailty Network

Frailty improvements contribute to significant cost savings in Portsmouth

Taking a systematic approach to identification of patients with frailty and putting in place early comprehensive assessment can deliver significant benefits, improving the experience of patients and contributing to cost savings.

www.acutefrailtynetwork.org.uk
Introduction

The Queen Alexandra Hospital in Portsmouth sees more than 400 patients over the age of 75 every week in the Emergency Department (ED). Before the hospital joined the Acute Frailty Network (AFN), it had no routine way of identifying frail older patients and no comprehensive assessment processes, although some limited work was in development. Some frail patients were being admitted to hospital unnecessarily and were staying longer than they needed to. This was having a detrimental impact on patients and contributing to patient flow problems for the hospital. Therapy and adult social care support was limited in the ED and Acute Medical Unit (AMU). While there are still considerable pressures throughout the local healthcare system, over the last two years the Trust has shown that having a systematic approach to identification of patients with frailty, early comprehensive assessment and case management, is delivering significant benefits, improving the experience of patients and contributing to savings. This is their story...
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Led by Dr Alison Bartens, Acute Frailty Lead, and Dr Claire Spice, Consultant in Medicine for Older People, the team in Portsmouth Hospitals NHS Trust in conjunction with community provider organisations, set out to improve the effectiveness, safety and experience of care for all patients with frailty, whether or not they were admitted to hospital.

While there have been a number of efforts since 2010 to improve case management of frail older people at the front door of Queen Alexandra Hospital, unfortunately these services were not consistently sustained. Joining the AFN, on the recommendation of ECIP (the Emergency Care Improvement Programme), facilitated the implementation of a sustainable service through a quality improvement approach. The Network provides support and networking opportunities for organisations looking to improve the care of frail patients. It acts as a conduit for sharing best practice and encourages organisations to learn from one another. It is a highly effective approach as it allows organisations to network with colleagues facing similar challenges and enables them to see improvement work in action.

**Identifying frailty earlier**

Portsmouth’s specific aims were to reduce admissions from ED of frail older people, to introduce comprehensive geriatric assessments (CGA) into the ED and AMU, and to case manage patients requiring short hospital stays of less than 72 hours, enabling more patients to be discharged during this timeframe. A review by ECIP noted that identifying patients with frailty earlier in their journey would make a difference to their experience and outcomes.

In the autumn of 2015, the Trust created a frailty group including representation from system partners to begin mapping pathways of care for frail older people. With the support of the transformation team and AFN, they looked at where they were and where they would like to be.

**Executive buy-in**

It was vital at this stage to have executive buy-in to become members of the Network, and the involvement of the transformation lead, Deborah Burrows, proved to be highly effective in achieving this. Claire Spice explained “We needed someone with influence and who understood the potential for improvement. Deborah, with a strategic transformation role, worked alongside us to present the clinical arguments to the executive team and demonstrate why we needed to address the issue of frailty if we were to improve the urgent care pathway. These arguments related both to patient experience and system efficiency”. Dr Bartens adds “We continue to canvas with our executive team the importance of care of frail patients throughout inpatient pathways, including the need for generic competencies for all staff, to include care of frailty”.

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Data to evidence impact

Some years before, the Queen Alexandra Hospital had geriatricians based in the assessment unit for 12 hours a day. The initiative lasted for two years and, anecdotally, was a big success. However, the hospital had no clear impact evidence to back this up. The initiative failed to get ongoing executive buy-in as a result and was unable to secure future funding.

Alison Bartens commented: “Our previous efforts to implement enhanced consultant access was ambitious and not inclusive of all roles of the multidisciplinary team. We continued to have silo working between an existing ED-based admission avoidance team and the medical component. “We learned from this experience. This time around, we took a structured improvement approach. We took baseline measures and were careful to secure the data we needed to demonstrate that what we were doing was working. We collected data from the outset and were able to show the difference each step of the improvement process was making. It was helpful to have input from the AFN with this. Frailty was one of five major workstreams for urgent care improvement in the local area, and the support and visibility of our work was enhanced.”

Robust improvement methodology

As well as taking a structured approach to building data that would evidence improvement, Portsmouth used PDSA (Plan Do Study Act) cycles to test out a proposed tool to screen for frailty among ED patients. They used a paper-based version of the tool and tested how long, on average, it would take for ED nurses to complete it. They found that it would take less than two minutes to screen most patients using the tool. Initially, around 85% of patients over 75 were being screened for frailty in ED. Use of the screening tool is voluntary and, over the intervening months, its use has plateaued at around 65%. Plans to make frailty screening mandatory later this year are expected to drive this figure up again. A frailty screen positive flag has also been introduced on the Bedview patient system. Paramedics are doing some clinical frailty scale assessment for patients before arrival in the hospital.

![Portsmouth Avoided Admissions](image-url)
Frailty and interface team

With the support of partners and commissioners, the hospital formed FIT (the Frailty and Interface Team), consisting of geriatricians, nursing staff from both the community and acute trust, healthcare support workers, physiotherapists, occupational therapists and social workers. The aim was to create a dedicated multidisciplinary team that could work together to improve the care of frail older patients and provide an enhanced response early in the patient’s journey.

FIT holds twice daily frailty board rounds, at 8.30am and 12.30pm. It operates 12 hours a day and has been instrumental in introducing a number of system improvements to date, including creating Standard Operating Procedures, establishing Key Performance Indicators and developing competencies for staff. It has also created an information leaflet for patients and carers, and has introduced education sessions for junior doctors in ED and nursing staff in AMU. Representatives from FIT surveyed staff in ED, AMU and Medicine to establish the levels of understanding and knowledge about frailty and to discover how staff feel about caring for frail older people.

Comprehensive geriatric assessment

At the outset, the hospital carried out an audit of Silver Book Standards and found that the majority of patients were not receiving a complete CGA assessment (including all elements), within the appropriate timeframes. Since June 2016, approximately half of frail older people coming through ED undergo a focused initial CGA by the FIT nurses or therapists. This figure is expected to rise when use of the screening tool for frailty becomes mandatory later this year.

Experience-Based Design (EBD)

The team also used EBD to discover more about the experience of frail older patients coming into the hospital. Patients were surveyed and asked to share their thoughts and feelings about their first three days in hospital – what stood out in their minds, what they would have liked more/less of, and what is important to them and their family. This information was shared with the wider FIT team and used as the basis for improvement. It led to a range of changes including a new leaflet about frailty and the role of the FIT team, changes to the way food and drink are given in ED and improvements to the AMU environment. Patient experience videos are also being developed to be used for training purposes.

Impact

Initially, around 85% of patients were being screened for frailty using the new screening tool. This has dropped to around 65% but is expected to increase when screening becomes mandatory. At the outset, no patients were receiving a full CGA. Now, nearly a half (48%) who are screened positive for frailty in ED go on to have a CGA.

There has been no impact so far on reducing length of stay to 72 hours or less for patients who are admitted to hospital and the team is continuing to review processes in this area. Re-attendances and the amount of time spent in ED by frail older patients have both remained unchanged. A range of different measures have been introduced to improve patient experience in response to feedback.

Portsmouth Hospitals NHS Trust carried out a detailed review of a cohort of patients presenting in ED, who were seen by FIT and subsequently not admitted. Through admissions avoidance and supported discharge the Trust has been able to demonstrate over £1.3m of savings linked to its frailty improvement work. Further details are available in the Acute Frailty Network Portsmouth case study on Return on Investment.
Key success factors
The team in Portsmouth has identified a number of key factors that have played a role in the project’s success:

● Getting staff and executives on board

According to Alison, it is essential to understand the issues from the perspective of staff on the ground, rather than trying to impose a solution on them.

“The local healthcare system of Portsmouth and South East Hampshire has significant challenges across the urgent-care pathway. It is now recognised at executive level that the key to our success is to unlock pathways for frail older patients. This mind-set has been encouraged and enforced by continually sharing the data and enthusiasm for change.

We have observed that by engaging our teams and staff with ideas, encouraging our staff to tell us how they think the pathway should work and ‘giving things a try’ within a PDSA process, they continue to advocate for the patients and keep sharing ideas and feedback. The transformation team and AFN membership have supported this by encouraging our tempo along our frailty journey.”

● Champions

Identifying those people who care about the issue and encouraging them to become champions for change is a great way to drive the improvements forward. According to Claire “These may not always be the first people you think of.” For instance champions may be the paramedic link or ED nurses as well as non-clinical staff such as information service links and ICT colleagues. The frailty champion within ED liaises with patients and carers and is actively exploring opportunities to improve factors such as nutrition and the environment in ED for frail patients. The Trust recognises that there are a group of natural enthusiasts and that there has also been a further opportunity to plant more early adopters by the natural increase in the team’s visibility throughout ED and AMU.

● A new, dedicated team

The Community Emergency Department Team was the forerunner of FIT. Portsmouth built on what was good about the community team but extended the skills mix and encouraged staff to work proactively rather than reactively. Staff expressed concerns initially that FIT would only see frail older patients but its remit extends to all frail patients, including young people. Claire explained:

“Once the new team took shape and staff could see the benefits of assessing for frailty earlier in the patient journey, it became far easier to get any remaining detractors on board. Initially there was a lot of nervousness about changing the Community Team but these have largely been allayed as staff can see what a difference the new FIT team is making to patients. The Matron of ED recognises that, if we can look after frail older people well, who are some of our most vulnerable patients, then all other patients will also benefit.”

● Involving the wider team

Paramedics often gain valuable information about a patient’s frailty levels in their initial assessment. One of the early drivers at Portsmouth was ensuring that mechanisms were in place to capture this information. The screening questions that are used at the point of triage consist of information that paramedic teams will generally have found out already such as the patient’s usual mobility and function and whether they are confused. This is one of the reasons the screening is quick to do. In some cases they may also have done a Clinical Frailty Scale. Because it’s captured at triage it then is much more visible to staff and FIT.

● Acute Frailty Network

AFN has played a key part in Portsmouth’s improvement journey. Alison said:

“Our membership of the Network, in tandem with executive sponsorship and a quality improvement approach, gave us the ideal opportunity to take control of what we could influence within our local frailty pathway. The regular meetings and education ensured that key members of the local team had some time together outside of a clinical setting and were able to focus together and open our minds to the possibilities for our services. We were able to gain system visibility through collaboration with system partners and this was helped by the ability to share our local issues and success nationally through the AFN forum.

We have been able to focus on how we will measure success, both from the initial changes implemented and the longer-term objectives. The focus afforded by Network membership has allowed us to truly be able to describe the journey and how we’ve measured it along the way, and the key changes we have implemented are being felt by patients and staff alike. The general improving awareness of frailty and what’s important to individual patients is palpable and has enhanced our local success with further initiatives such as a local #endpjparalysis campaign.”
What’s next?

Up until now, it has been voluntary for Queen Alexandra Hospital’s ED staff to use the frailty screening tool. The hospital intends to make frailty screening in ED mandatory in the near future, which should drive up usage.

There is an intention to trial the use of the Clinical Frailty Scale in patients admitted through a GP pathway to help focus resources in the right way for maximum gain for patients.

There are plans to improve the frailty pathway further, including developing outreach to non-elderly care wards. Discussions are taking place about whether to establish a specialist frailty unit and, if so, when and where. There is also an aspiration to improve the multidisciplinary case management of patients with a predicted short stay and to introduce ways of measuring the impact of CGA and tracking patient progress.

We continue to keep the profile high for the frail older patients coming to the hospital for acute care. Accessing training opportunities wherever possible, we have also improved links with Portsmouth University and are working with system partners to develop a generic frailty competency framework for staff.

We are continuing to recruit interested professionals to the cause of frailty pathway improvement and have a senior pharmacist engaging with a quality improvement project relating to frail older patients and also links with the Older People’s Mental Health team supporting a further project relating to recognition of delirium at acute presentations.