“The road is long.....
With many a winding turn”

The Portsmouth Acute Frailty Journey

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Portsmouth Hospitals NHS Trust
Overview & Acknowledgement

- Contextualise the local issues
- Describe the journey through the key AFN principles
- Achievements and Challenges through our journey
- Acknowledge team enthusiasm and willingness to try “stuff”
Portsmouth & South East Hampshire
Local Context

A DGH “plus” with tertiary services…
Local Population approx. 750k
Local demographic over 85yo approx. 37,000
Acute Geriatric Medicine Bed base- 137 (+39)
3 CCGs, 2 Community providers and 2 local authorities providing care after hospital
Orthogeriatric Unit (36 beds plus outreach)
Consultant Geriatrician 13WTE
58 (+5) bedded AMU
Poor performance against urgent care constitutional standards
Local Frailty Improvement Journey – Until January 2016 (Prior to Cohort 2 AFN)

- Older Peoples Partnership 2010
- Enhancement of community facing ED team – variable therapy input
- Expansion of community capacity with rapid access clinics and pilot of virtual wards led by Geriatricians (Resource intense)
- Pilot of enhanced Geriatrician working hours in AMU/ED 2010
- Further short term trial of enhanced Consultant presence in ED as part of a pilot of direct admissions 2015 (Not sustainable – ended at 6 weeks)
- System pathway review and blueprint design Sept 2015 – reportable to “System Resilience Group”
Frail Older Person Programme of Work (subject to approval)
Introduction to AFN -

- Timely
- Executive voice through working with Transformation Lead
- Team building – away from acute setting
- Harness passion within the team – early adopters
- Linked to QI fellowship for Dr Claire Spice – released clinical time
- Provided structure for our approach by using the 10 key objectives/principles
AFN Principle 8 – “Develop a measurement mind-set”

- Dashboard Development
- Building relationships with IS support team
- Outcome Measures
- Process Measures
- Balance Measures
- Using measurement in conversation
- Using measurement to influence
- Using measurement for team building/motivation
Principle 1 – “Frailty Identification/Screening”

- Early scoping work in September 2015
- QI approach with small sample testing with ED staff – PDSA cycles
- Pilot of electronic tool
- Addition of electronic tool to ED system (Oceano)
- Decision to make a non-compulsory field at triage
- Relationships with South Central Ambulance Service – Use of Clinical Frailty Scale (CFS) by ambulance crews
- Introduction of CFS in AMU for GP referred patients
Frailty screening – carried out at ED nurse triage (non-compulsory)

<table>
<thead>
<tr>
<th>Week Ending</th>
<th>Screened</th>
<th>Outcome</th>
<th>CFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 Jan</td>
<td>58% 394</td>
<td>29% 115</td>
<td>15% 58</td>
</tr>
<tr>
<td>15 Jan</td>
<td>64% 359</td>
<td>33% 117</td>
<td>19% 67</td>
</tr>
<tr>
<td>22 Jan</td>
<td>69% 404</td>
<td>36% 144</td>
<td>14% 55</td>
</tr>
<tr>
<td>29 Jan</td>
<td>52% 282</td>
<td>24%  67</td>
<td>22% 62</td>
</tr>
<tr>
<td>05 Feb</td>
<td>63% 339</td>
<td>25%  86</td>
<td>27% 91</td>
</tr>
<tr>
<td>12 Feb</td>
<td>55% 304</td>
<td>28%  86</td>
<td>12% 36</td>
</tr>
<tr>
<td>19 Feb</td>
<td>60% 327</td>
<td>26%  86</td>
<td>8% 26</td>
</tr>
<tr>
<td>26 Feb</td>
<td>64% 348</td>
<td>28%  97</td>
<td>16% 54</td>
</tr>
<tr>
<td>05 Mar</td>
<td>61% 340</td>
<td>31% 105</td>
<td>13% 43</td>
</tr>
<tr>
<td>12 Mar</td>
<td>63% 351</td>
<td>26%  90</td>
<td>13% 45</td>
</tr>
<tr>
<td>19 Mar</td>
<td>61% 331</td>
<td>32% 107</td>
<td>14% 45</td>
</tr>
<tr>
<td>26 Mar</td>
<td>58% 314</td>
<td>25%  80</td>
<td>9% 29</td>
</tr>
</tbody>
</table>
Principle 2 – Early Access to CGA
“The Frailty & Interface Team” is born...

Professionals assessing frail older adults in the “Emergency Corridor” before December 2015

Professionals assessing frail older adults in the “Emergency Corridor” 2017

Community ED Team
8.30—19.00
- Community Nurses
- Social Care

Medical/Consultant Geriatrician
8.00—12.00

Older Person’s Nurse Specialist

Therapies

Frailty & Interface Team:
ED/AMU Based FIT Nurses
ED FIT HCSW
Acute Therapies Team
FIT Consultant 7 day, 12 hour service + SpRs
Learning from team development – Successes and Challenges

- 60 minutes is not long
- Multiple snapshot audits
- Introduction of ED PITSTOP
- Team dynamics and resilience
- Unanticipated benefits – basic quality/care markers
- “Spanners thrown from left-field”
“FI&T Team tool kit”:

- Governance Arrangements  
  (Collaborative between two organisations)
- Workforce/Recruitment
- Branding – Orange Paperwork and “Logo”
- CGA Approach and Documentation
- Education & Training
- Board Rounds – Twice Daily
- Remove barriers to discharge process
- Reflection from AFN networking
- Demonstrating success through measurement
- Communication
- Staff experience – “A day in the life”
- Patient experience
- Snap shot audits – access to CGA by discipline, time spent with patients,
- AFN supported site visits x 2 – development of team vision and objectives, identifying glitches
**Principle 3 & 4 – Rapid response system & Silver Phone**

- Yet to develop a formal rapid response approach
- All GP calls come through to consultant led phone service (AMU) – need proof of concept project for frailty specialist involvement
- Community single point of contact in development to support paramedic crews and primary care
- FIT prioritise work in ED according to clinical need and facilitation of discharge
Principle 5 – “Reduce unnecessary variation by adopting professional standards”

- Clear standard for assessment managed through individualised development
- CGA tool and standardised documentation
- Education & Training
- GP referred patients – introducing CFS.
- SOP for FIT
- Board Round Rules
- Align urgent care professional standards
Principle 6 – “Strengthen links in and out of hospital”

- Case management in AMU
- Cross organisational leadership of FIT
- “Frailty Development Group” – system representation
- Case-based discussion meetings to facilitate enhancement of patients with anticipated short stay
- Related work-streams within urgent-care improvement agenda i.e. MFFD and stranded patient work-streams
- Patient experience work
- IT links – website development
- SpR QI Fellowship – improving care of frail patients outside of Geriatric Medicine bed-base i.e. Outreach approach
- Pre-op clinical frailty screening (interested individuals)
**Principle 7 – “Education and training for key staff”**

- Training and experience survey
- System core competencies for frailty in development
- Ad-hoc and opportunistic infiltration of training programmes
- Team away time and case-based learning
- Using patient experience work led by Claire Spice
- SpR QI Fellowship – Outreach Models

“Fit for frailty, fit for all!”
Principle 9 – “Enlist Clinical Change Champions”

Internal:
- ED
- AMU
- FIT
- Speciality
- Consultant
- Executive

External:
- Ambulance Service
- Community Health Partners
- ASC Providers
- CCG
Principle 10 - Identify an executive sponsor and adopt a programme management approach

- Multiple leadership changes provide a challenge
- Identifying performance indicators which were reportable at system level – profile and scrutiny
- Frailty business manager in post
- Meeting structure and governance
- Workbook development supported by KPMG
- Transformation team allocated time
  - differential across the journey
So, how are we doing?

- **Qualitative measures – soft**
  - Patient experience
  - Anecdotal Improvements
  - Perceptions of the team and their work
  - Sustainability questionnaire

### Table 1: Sustainability Factor Scores

<table>
<thead>
<tr>
<th>Factor</th>
<th>Maximum Score</th>
<th>Site Average</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1. Benefits beyond helping patients</td>
<td>8.5</td>
<td>7.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Q2. Credibility of the benefits</td>
<td>9.1</td>
<td>7.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Q3. Adaptable of improved process</td>
<td>7.0</td>
<td>3.6</td>
<td>3.4</td>
</tr>
<tr>
<td>Q4. Effectiveness of the system to monitor progress</td>
<td>6.5</td>
<td>5.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q5. Staff involvement and training to sustain the process</td>
<td>11.4</td>
<td>9.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Q6. Staff behaviours toward sustaining the change</td>
<td>11.0</td>
<td>8.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Q7. Senior leadership engagement and support</td>
<td>15.0</td>
<td>12.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Q8. Clinical leadership engagement and support</td>
<td>15.0</td>
<td>12.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Organisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9. Fit with the organisations strategic aims and culture</td>
<td>7.0</td>
<td>4.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Q10. Infrastructures</td>
<td>9.5</td>
<td>5.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Totals</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall Average Score:** 72.7

**Figure 1: Sustainability Factors Bar Graph**

**Your Score 72.7**
Frailty screening – carried out at ED nurse triage (non-compulsory)
FIT team assessment i.e. what proportion of patients who screen positive for frailty markers are the team reaching? (It is a 12 hour service)

<table>
<thead>
<tr>
<th>Week Ending</th>
<th>Rate</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sun 08 Jan</td>
<td>48%</td>
<td>55</td>
</tr>
<tr>
<td>Sun 15 Jan</td>
<td>47%</td>
<td>55</td>
</tr>
<tr>
<td>Sun 22 Jan</td>
<td>36%</td>
<td>52</td>
</tr>
<tr>
<td>Sun 29 Jan</td>
<td>51%</td>
<td>34</td>
</tr>
<tr>
<td>Sun 05 Feb</td>
<td>51%</td>
<td>44</td>
</tr>
<tr>
<td>Sun 12 Feb</td>
<td>55%</td>
<td>47</td>
</tr>
<tr>
<td>Sun 19 Feb</td>
<td>56%</td>
<td>48</td>
</tr>
<tr>
<td>Sun 26 Feb</td>
<td>48%</td>
<td>47</td>
</tr>
<tr>
<td>Sun 05 Mar</td>
<td>48%</td>
<td>50</td>
</tr>
<tr>
<td>Sun 12 Mar</td>
<td>48%</td>
<td>43</td>
</tr>
<tr>
<td>Sun 19 Mar</td>
<td>31%</td>
<td>33</td>
</tr>
<tr>
<td>Sun 26 Mar</td>
<td>39%</td>
<td>31</td>
</tr>
</tbody>
</table>

**Age Band (KPI)**
- 65-74
- 75+

**FIT Hours**
- In FIT Hours
- Out of FIT Hours

**Frailty Screening Outcome**
- Negative
- Not Screened
- Positive
Performance Metrics – Conversion rate in ED

Percentage (aged 75+ years) who come to the ED who are then admitted
Performance Metrics – Case management of “short stay” patients

Discharges With LOS Less Than or Equal To 72 Hours By Week Ending
System factors

Number of IP's with a LOS greater than 10 Days (Weekly) Stranded Patients

- Stranded Patients ≥10 Days
- Period Average
- UCL
- LCL
What’s next?

- Leadership Changes
- Team development & Sustainability
- Business case agreement
- Frailty screening at point of entry to hospital – develop wide use of CFS
- AMU admission pack to progress routine frailty and delirium screening tools
- CGA approach consolidation
- Frailty Unit (Accelerate short-stay and low clinical need pathways)
- Outreach QI work
- Influence Trust Clinical Strategy
- Tandem LoS work-stream