NHS
Manchester University
NHS Foundation Trust

Frailty in Trafford General Hospital: Briefing Paper for Scrutiny Committee

Prepared by Helen Hurst Consultant Nurse Jan 2018

Background

It is now widely acknowledged that recognising frail older people admitted to hospital is an area of practice that needs to be addressed. Not only recognising this cohort of patients but providing a comprehensive assessment that will affect outcomes by improving care, reducing length of stay and working more closely with community services. It has prompted many published articles including systematic reviews and standards from the Royal College of Physicians and British Geriatric Society. Many Trusts and organisations have developed different ways of working and introduced teams that specifically focus on frail older people admitted through the emergency departments and the acute medical units.

Project to Date

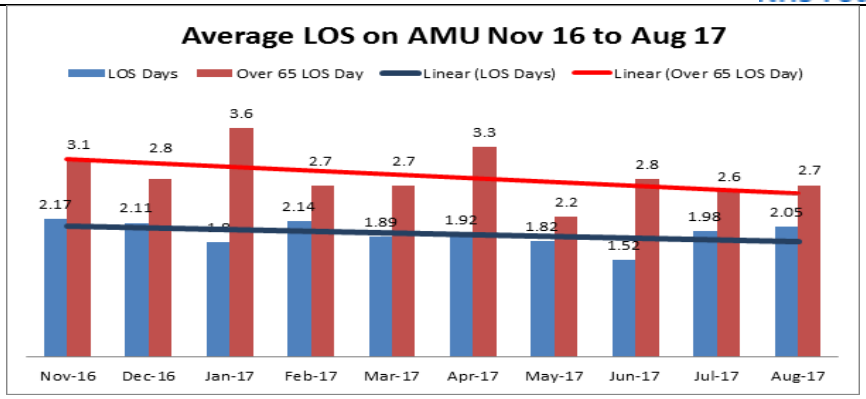
At Trafford General Hospital (TGH) a pilot week in June 2016 led by a Consultant Geriatrician prompted a review of how best to implement a frailty pathway into the acute medical assessment unit (AMU). It became clear that to continually improve required leadership and organisational changes. The Consultant Nurse was employed in November 2016 to enable this transition and introduce a frailty pathway within the AMU. Visits to other hospitals was also undertaken to understand how teams and services are being provided. It is clear that often this can take 2-3 years to achieve successes and have a stable and sustainable service. KPI's identified early on related to workforce planning, IT to support frailty screening and comprehensive geriatric assessments (CGA) and building links to community services. Over the last few months many achievements have been realised but there is still a need to plan for the next 12 months and beyond. Part of the early work involved a partnership event with Pennine Care and other providers. This event was held at TGH and was an opportunity for community and hospital teams to discuss and plan services. Understanding what's available within the community is always challenging for secondary care and building those relationships is crucial.

Below is a summary of the work so far.

- There were identified gaps in the workforce for therapy services, with no therapy service based. Historically therapy input had been commissioned via Pennine Care and in place until the practitioner resigned in 2016. Working closely with the therapy lead and Pennine Care it became clear the

money for these posts had been redirected into the community enhanced therapy services. The provision of therapy from Pennine Care and service criteria was too limiting and did not enable therapy assessments on in-patients. The criteria set was patients had to be in hospital for < 5 days and medically optimised for discharge. An agreement was made to introduce a physiotherapist and occupational therapist into AMU funded by TGH for a three-month pilot period. This was successful and although the posts are now vacant, funding has been agreed and posts are about to be advertised. Provision of therapy services from Pennine Care continues within their criteria.

- Education has been provided to both medical and nursing staff through presentations and a successful animation of an ideal service, funded by the transformation team at MFT.
- The screening for frailty was agreed to be done by nurses at the point of admission and since March 2017 a frailty screening tool was added to the nursing assessment tool. Compliance has gradually increased.
- The CGA was first tested in the nursing/observation tool but was not successful and is now included in the electronic patient record system. The electronic CGA was introduced in July 2017 and is still undergoing some changes to enable the assessment process to be multidisciplinary. IT system development is currently limited due to the merger of three hospitals and the need for an integrated system across all sites. The GCA assessment should really follow the patient into community for the GP and other providers.
- The functioning of the board round on the AMU and the safer standards document has also been the focus and through PDSA cycles has now an agreed format. This still requires leadership and direction.
- Stronger links with community and different trials of in- reach with community teams have happened over the months. There was no benefit demonstrated with the community enhanced therapy team coming in daily to board rounds. No additional patients were identified for discharge as per the criteria described above. The next steps now are to secure a therapy service within AMU and to then review the referral criteria that has been set by Pennine Care and examine different ways of working to enhance discharge processes. This will include trusted assessments to allow easier discharge and follow up.
- Evaluation and data collection has also been part of the project and results to date are encouraging with a reduced length of stay (see graph below). Further in-depth data is currently on going.



Next Steps Vision

Many models of frailty within secondary care have been published to share and demonstrate good practice. The most common processes and models are the development of teams to provide a minimum 5-day service at the front door in secondary care for frail older people. With the merger of three/four hospitals, standards of care need to be agreed so that every patient is expected to receive the same care and service wherever they are admitted. Current strategic plans and meetings are taking place across Manchester to examine this in detail.

TGH Next Steps

- To enhance and consolidate the frailty team requires a business plan and funding which has been put forward to the appropriate management team. This includes a frailty assessment model so patients are referred direct from GP's, UCC and community teams.
- Continue to build links with community teams and look at ways of cross over working bringing expertise out into community and community expertise into the hospital.
- To have another partnership event to examine success and challenges for the next 1-2 years. This includes working with NWAS to assess patient flow and try to ensure patients are transferred to the most appropriate urgent/emergency care facility; the aim being to reduce patient movement between hospitals within the first 48 hours.
- A strategic alliance between Manchester Foundation Trust and Manchester Metropolitan University has been formed to bring together experts including clinicians and academics to address three key areas relating to frailty: education, clinical practice and research. The alliance includes all hospitals and representatives in the new configuration to align frailty pathways and standards.