Frailty Pathway System Update

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Strategic Plans

- **Health and Wellbeing Strategy Priorities for Older People** (2017 -2022)– Improving outcomes for older people

- **Better Care Fund –** 2017-2019 and subsequent updates

- **South Integrated Care Partnership Frailty Pathway** – (2018/19)

- **Frailty iCARE (Involve, Consider, Assess, Respond, Evaulate)** – (2019) Regional approach to supporting people presenting with frailty

- **Ageing Well** – (2020) Urgent care community response, Enhanced Health in Care Homes and anticipatory care

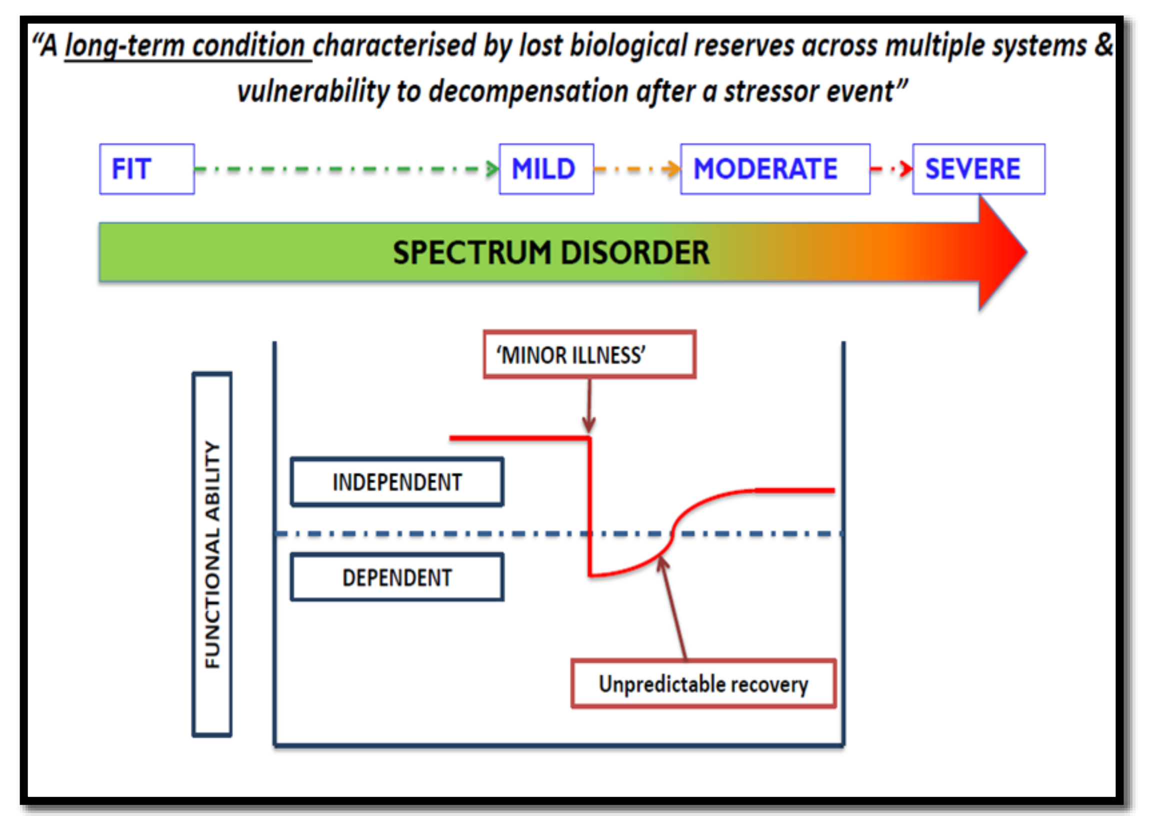
Frailty Priorities

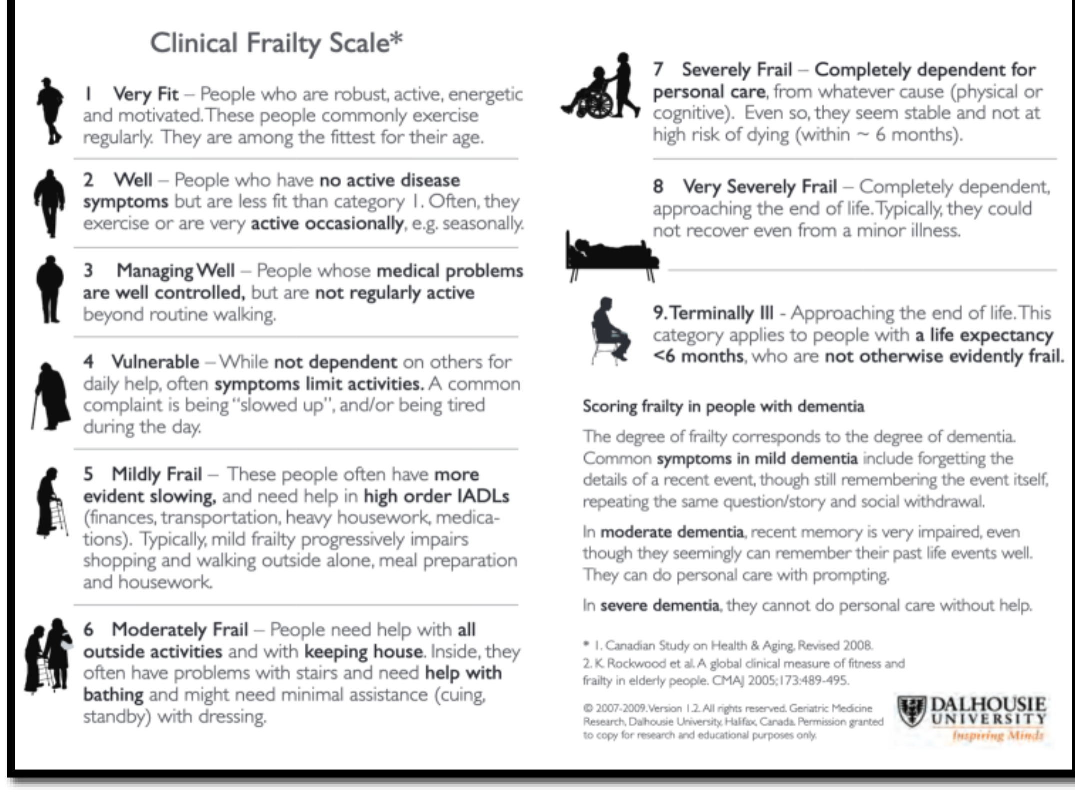
- **Strategic Outcomes**
  - Prevent avoidable admissions of the frail and elderly
  - Optimise the quality of care for people admitted to hospital
  - Ensure patients are discharged home, or as close to home as possible, when they are medically optimised

- **Transformation ambitions**
  - Integration and Collaboration of Community Services - Responsive Integrated Assessment Care Team (RIACT) to support people presenting with frailty
  - Front of House Frailty Team, Darlington Memorial Hospital – Acute Hospital
  - Improved Discharge Pathways, ensuring people are discharged with the right support, reducing the risks of deterioration and readmission to hospital

What do we mean by Frailty?

Frailty -'Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10 per cent of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85'





Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Inspiring Minds

Responsive Integrated Assessment Care Team (RIACT) to support people presenting with frailty

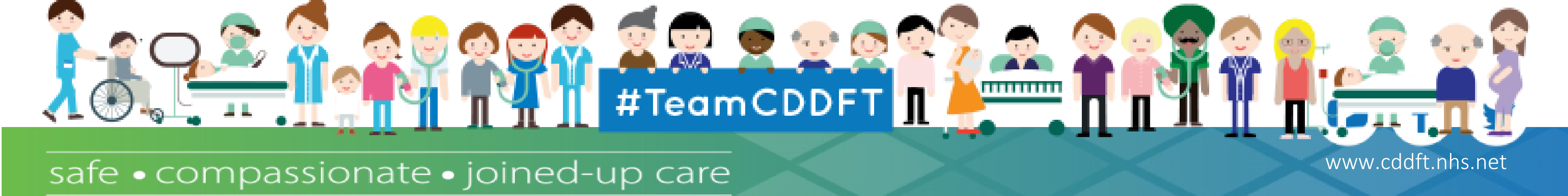
- Developments continue in relation to the Hundens Lane based health and social care Integrated **Single Point of Access (iSPA)** for hospital discharges, intermediate care and urgent community crisis
- Urgent community response - **Responsive Integrated Assessment Care Team (RIACT service)** and other community teams to offer more joined up approach based on patient need
- Ageing Well funded pilot for admin support has released 30% more patient facing time for clinicians and has supported 80% increase in nurse activity supporting the **Multi Disciplinary Team Meetings** in care homes CDDFT Community Services have developed a dedicated 'Care Home Team'
- New proposals between the Care home team and Primary Healthcare **Darlington's Enhanced Health in Care Homes (EHiCH)** team will drive improved outcomes for care home residents

Social care prevention - RIACT & Wider Social Care support – Frailty Support

- The aim is to ensure an MDT approach and that interventions happen at an early stage rather than admit to hospital
- Health and Social Care work together to support for individuals that would benefit from a short term Reablement intervention.
- If longer term support is required, social work professional support and guidance is offered with a range of options- preferably within the person's home
- Prior to the transformation of Adult Social Care services the teams supported with community offer to prevent hospital admission.
- The social care teams assist in speedy return home with support, operating an 8am-8pm social work assessment service, within a 4 hour response and a 7.30-10pm in house
- Reablement service supported by access to private sector reablement & Rapid Response support including some overnight support.

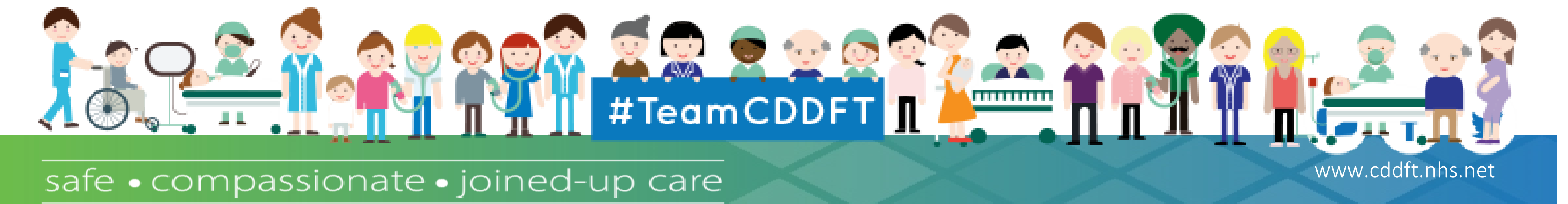
Acute Frailty development DMH

- Mandated through NHS improvement, NHS Rightcare, 5 year plan and Royal college/professional body best practice
- Priorities acute frailty clinical strategy 2020:-
  - Acute frailty team 7 days a week in acute admitting hospital
    - Business case approved Oct'20
    - 7 days/week 8am until 8pm from April 2021
  - Developing Acute Multi-Disciplinary Team working in keeping with Comprehensive geriatric assessment with expansions of in-patient therapy resource
  - Acute complex frailty and specialist units for more complex, prolonged admissions and consultant expansion
  - Surgical liaison and orthogeriatrics service expansion
  - Enhancement of Parkinson's service to meet growing demand



Acute Frailty Team and unit development

- 8am-8pm 7 days/week Darlington Memorial Hospital; 8am-6pm 7 days/week University Hospital of North Durham
- Urgent Comprehensive Geriatric Assessment (CGA) delivered by a specialist multi-disciplinary team
- Standard Operating Procedure – Acute Medical Unit, Emergency Department and SDEC (same day emergency care)
- Enhance acute patient assessment and care
- Improve diagnosis and initial management
- Evidence base + patient centred
- Try to get right patients the right care in the right place
- Enhanced MDT support and consultant recruitment into specialist wards



Flow and length stay outcomes patient's with frailty DMH

% Frail Pts Discharged from AMU

	%
JAN-MAR 2020: GIR	5%
MAR-APRIL 2021: AFT	14%

Average length of stay in hospital (days)

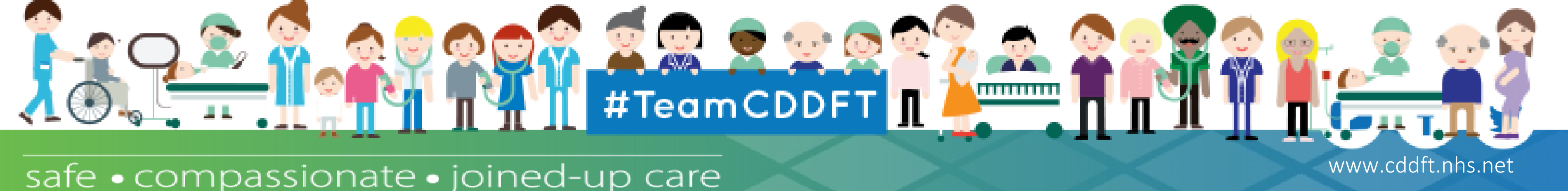
	Days
JAN-MAR 2020: GIR	10.2
MAR-APRIL 2021: AFT	7.8

% Discharged within

	JAN-MAR 2020: GIR	MAR-APRIL 2021: AFT ACUTE FRAILTY TEAM
24 hrs	6%	14%
48 hrs	12%	22%
72 hrs	18%	28%
1 week	47%	58%

% Re-admission within 30 days

	%
JAN-MAR 2020: GIR	23%
MAR-APRIL 2021: AFT	16%



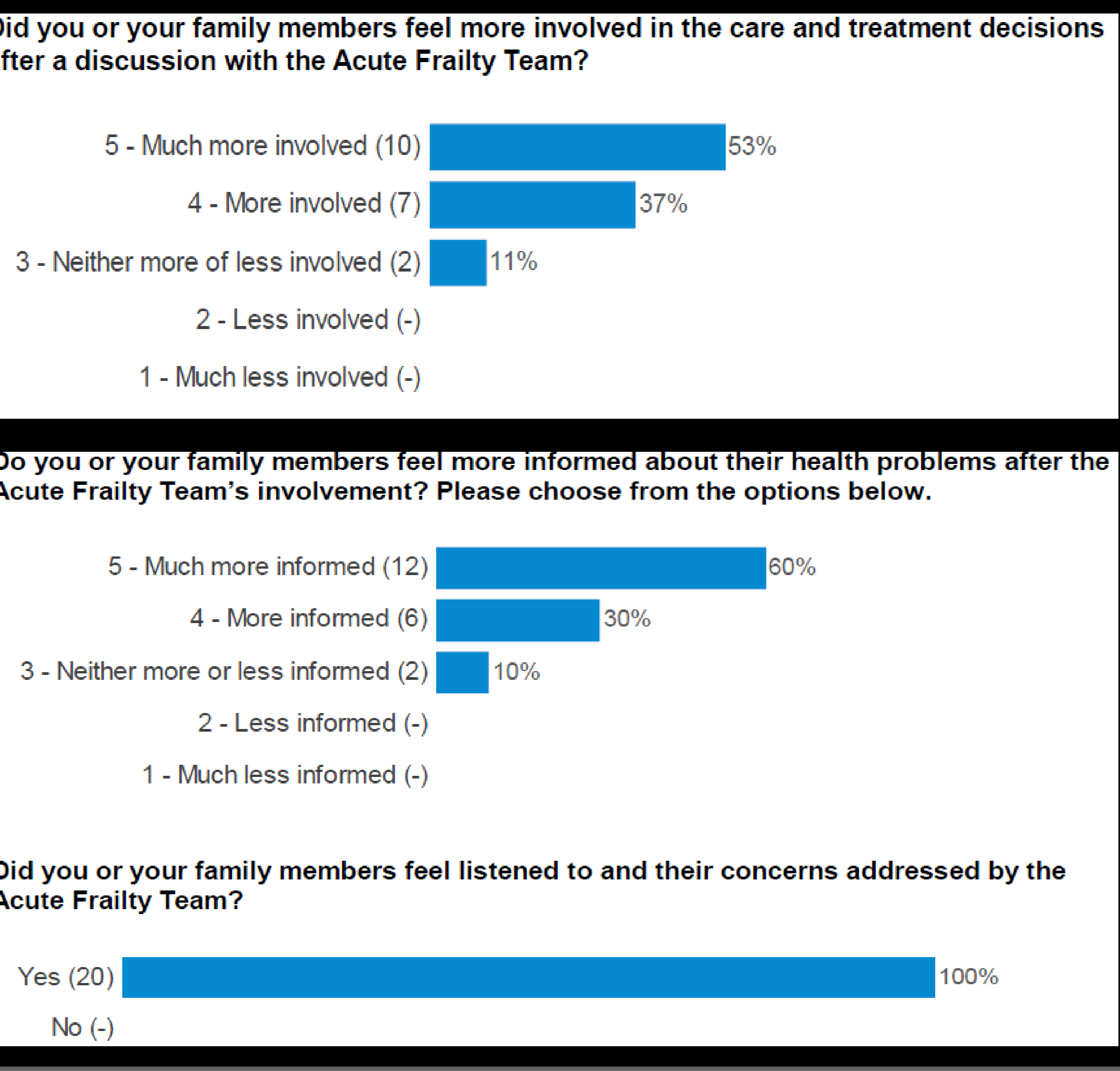
100 FRAIL PTS IN BOTH COHORTS	JAN-MAR 2020: GERIATRICIAN IN REACH	MAR-APRIL 2021: ACUTE FRAILTY TEAM	CHANGE
pts with a CFS score documented	**31%**	**100%**	**Identification of frailty improved**
pts with a 4AT score documented	27%	91%	**Delirium screening improved**
pts Discharged from AMU	**5%**	**14%**	**Less frail pts admitted from AMU**
% pts admitted who occupy COTE/REHAB/COMMUNITY BED during inpatient stay	41%	54%	**More frail pts accessing COTE/rehab/community beds**
Average length of stay Acute site stay Total bed days	**10.2** **8.8** **1018**	**7.8** **6.4** **758**	**Reduced length of stay** **Reduced bed days/occupancy**
Discharge in: **24 hrs** **48 hrs** **72 hrs** **1 week**	 **6%** **12%** **18%** **47%**	 **14%** **22%** **28%** **58%**	**Quicker turn around of patient discharge from hospital**
% pts who see a therapist in: 24 hrs 48 hrs 72 hrs	 28% 38% 52%	 69% 81% 88%	**Improved access to early therapy assessment and input**
Discharge to new 24 hr care	**21%**	**9%**	**Less pts discharged to new 24 hr care**
Discharge to own home	72%	82%	**More pts discharged to own home**
Re-admission within 30 days	**23%**	**16%**	**Reduced re-admission**
Died in hospital	7%	9%	**Slightly increased number of deaths (not significant)**

>2000 referrals seen by Acute Frailty Team from April 2021- Oct 2021

Frailty identification improved (>80%)

Increased screening for delirium with >400 patients with delirium identified to date

>650 patients seen by a therapist before 11:30 am of the first morning of admission to Acute Medical Unit



Patients said….

I think they were brilliant, first class

Felt listened to and they understood my situation

Very professional and felt that they cared and listened and also included my daughter in my treatment plans

Very professional and polite

I met the frailty team this morning and felt more informed about my care and planning

The person that came to see me was very nice and made me feel at ease

Kind and caring staff, felt listened to

Hospital discharge

Discharge to Assess/Home First (D2A)

- The Adult social care team have been progressive in developing and operating a discharge to assess model, working with colleagues in health to ensure discharges are safe, timely and have the relevant professionals involved with the individual.
- Where care is needed the social work assessment is undertaken in the home environment on discharge, via the Responsive Integrated Assessment Care Team(RIACT) service. This strength based rehabilitation model utilised a functional assessment and any necessary care given as the assessment is undertaken. The team also provide a quick turnaround to prevent hospital admission.

Trusted Assessment/Collaboration

- Reflects good relationships in health and social care in Darlington
- Trusted Assessment is about health and adult social care working together so the most appropriate person gathers the information about a given individual and this is accepted by all colleagues involved in delivering care therefore minimising duplication

Delayed Transfers of Care (DToC)

- The adult social work teams continue to work with health colleagues to maintain effective flows with virtually no delays in transfers of care.

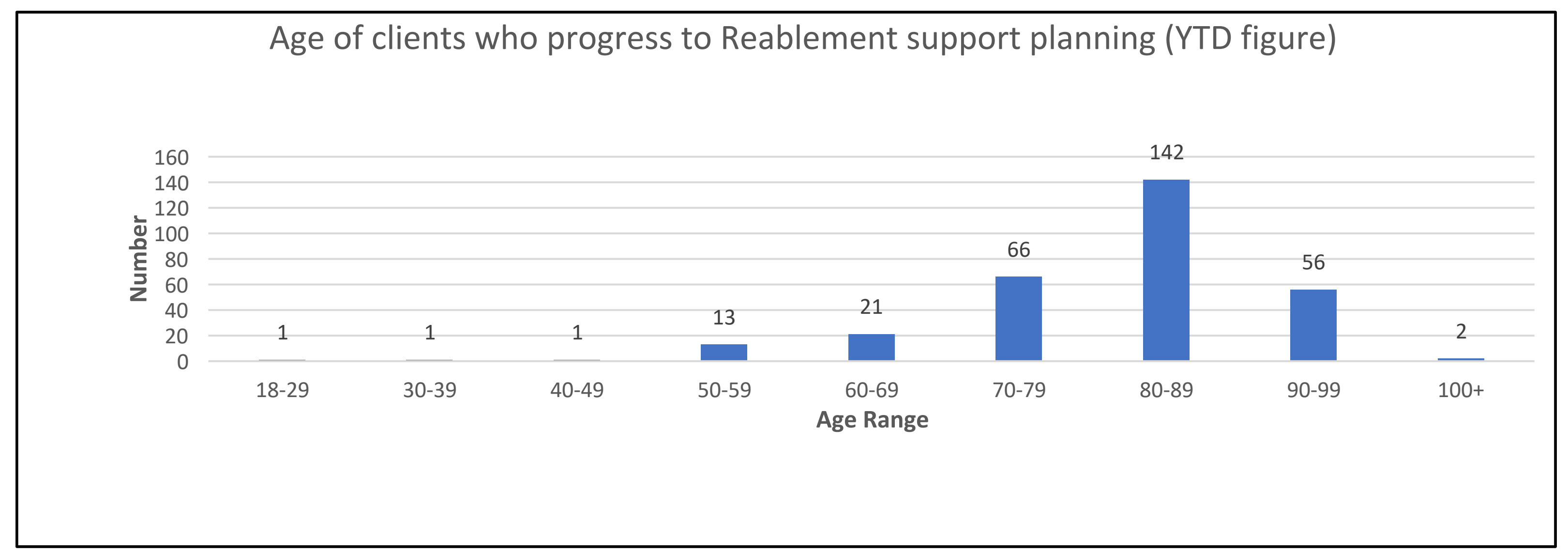
Covid Funding/Continuing Health Care (CHC)

- Government funding to support discharges from hospital has been highly assistive in supporting the system, along with transitioning CHC assessments in the community. The social work teams have been highly responsive to facilitating the CHC assessments in a timely way.

Hospital discharge

Reablement

- Client age profile



- As you can see Reablement is across the whole range of the adult spectrum. The main age range is 70-89.
- Amongst this cohort we have seen improvements in independence, well over 50% see an improvement significant increase in levels of independence following reablement

Future Plans

Ageing Well National Strategy

- 2 hour urgent crisis/community response
- Enhanced Health in Care Homes
- Anticipatory Care

Refreshed Health and Wellbeing Board Priorities

- Continue to focus on the Ageing Well Agenda
- Workforce development
- Prevention and well being

Challenges

- Workforce and the COVID affect – impact on delivery, recruitment and retention

- Skill mix to meet needs of increasingly frail and complex population

- System wide working, advantages and challenges, especially when the whole system is under pressure

- Winter pressures, which are no longer only winter pressures- ongoing resilience across the whole sector