Making frailty a priority – bridging the gap

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Aims

Historically, the approach to care provision for frail patients in Coventry has been a siloed model of working involving multiple agencies including acute, primary, community, social and voluntary sectors. The care tends to focus more on the patient's medical conditions and is usually delivered in response to a medical or social crisis. Analysis of the patient cohort for frailty highlighted a number of performance challenges, including increased length of stay, delayed transfers of care, prolonged wait in emergency department (ED) and higher readmission rates. Could an innovative general practitioner (GP)-led cross sector, cross provider multidisciplinary team (MDT) model-based solution work within an acute trust?

Methods

Business case-funded presence of GPs, therapists, care navigators (Age UK Coventry), social workers, community matrons and a care coordinator.

Established daily GP-led MDTs in acute wards at hospital, discussing all frail patients as identified by therapists and/or clinicians.

Mandatory follow up at 7 and 30 days post discharge. The focus being on initial troubleshooting when back in own environment and then looking at longer term readmission prevention. Bespoke early or more frequent follow up if needed.

Effective use of MDT resource to allocate follow ups to most appropriate individuals.

Collaboration and building relationships with colleagues in emergency departments, acute medicine, REACT (therapy and discharge team), social care, gerontology, and community services.

Concurrent service design and delivery – therefore organic evolution of a service which is patient-centred, clinician and MDT driven.

Implementation of frailty identification tool within patient tracking software at 'front door' to allow patient referral to be generated, stored, MDT notes to be added and follow ups to be fed back to daily MDT.

Development of frailty clerking paperwork with shared notes for medical/nursing/therapy.

Establishment of a 'front door frailty' service providing a GP and therapist 12 hours a day 7 days a week to assess and manage frail patients, initiating comprehensive geriatric assessment.

Joint continuing professional development sessions held weekly in the 'Frailty Hub' to share knowledge, learn about each other's work, promote relationship building creating a sense of team and a shared ethos for the service.

Results

Results for the period January – June 2017.

- Trust average length of stay for over 75s with frailty syndromes is 11.9 days with a readmission rate of 22.5%
- 1,330 patients went through the GP led ward MDTs
- Average length of stay was 7.04 days
- 73% discharged directly from MDT-led ward with an average length of stay of 4.37 days
- 27% went to a different ward with average length of stay of 14.2 days
- 28 day readmission rate 17.2%
- 1,181 frail patients seen by 'front door frailty' service
- 36.3% turnaround without admission
- Turnaround rate has increased from 30% to over 50% over the past 6 months.

This may correlate with a move of 'front door frailty' from ED majors to a frailty assessment area based within the medical decisions unit. This is a smaller, quieter area with more consistent staffing and resources which supports GPs and therapists in delivering a focused assessment.

- 28-day readmission rate 17.2%.

Conclusion

This early data suggests that a MDT with primary care and community involvement, providing early follow-up and feedback to the medical teams, reduces length of stay and readmissions. Front door frailty data suggests that initial assessment of frail patients in an appropriate environment and with MDT input can increase the proportion of patients that are discharged without admission without negatively impacting re-admission rates. ■

Conflict of interest statement

No potential conflict of interest.

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