Belfast Health and Social Care Trust
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Safety & quality

From Mobility and Beyond

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Introduction to Project & Background

Frailty is a clinically recognizable state of increased vulnerability resulting from aging-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with everyday or acute stressors is comprised (1). The management of frailty should be person-centred, engaging patient and family/carers, using evidence based practice of Comprehensive Geriatric Assessment (CGA) delivered by specialist MDT teams. An older person who receives comprehensive geriatric assessment (CGA) is more likely to be alive and living in their own home 6 months following an acute illness (2)

In response to the development of Older People's Services, the service model has been reviewed in order to deliver a rapid access service for patients who are referred by GPs who do not need admitted and avoid ED attendance but require further CGA assessment.

Aim Statement

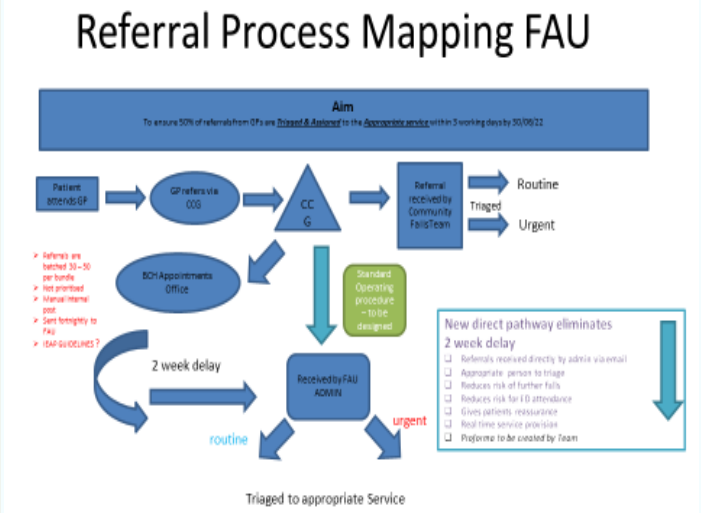
By 30th June 2022 50% of GP referrals to the Frailty Assessment Unit (FAU) will be triaged and assigned to the most appropriate pathway within 3 working days.

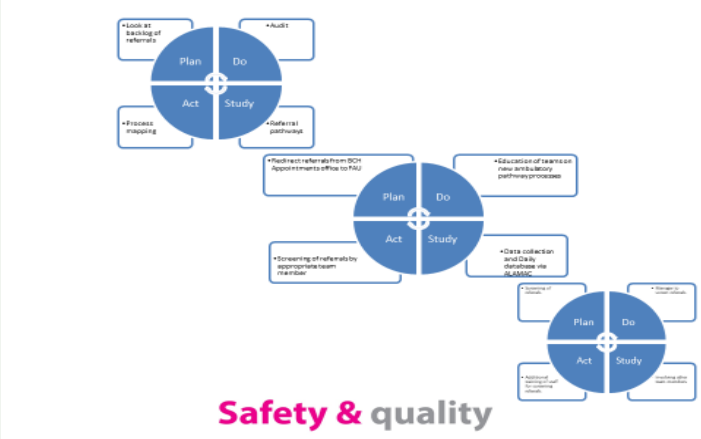
Change Ideas

Our main change ideas were:-

1. Implementing a direct referral option within the GP's electronic referral system (CCG)
2. Developing and testing a standard operating procedure
3. Developing an education process for staff
4. Timetabling various members of the MDT to help with triage.

Process Mapping, PDSA Cycles





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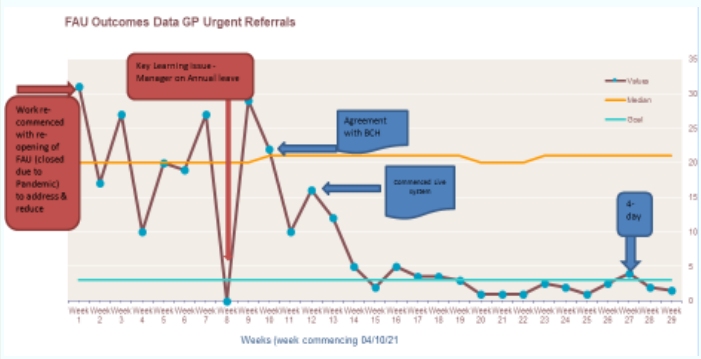
Results



1. Following agreement on procedures there was a significant improvement on appointing GP referrals within 3 days.
2. The goal was first achieve on week 15, however it took until after week 19 for the goal to be maintained for a sustained period.
3. Since then there has only been one week where the goal has not been met.

Achievements

1. We have achieved our aim well ahead of time.
2. A daily referral system with Live Triaging in place
3. Daily Live post Clinic Multi-Disciplinary team meetings
4. GP Referral Waiting list backlog cleared
5. System now being duplicated with the use of PDSA to incorporate Emergency Department referrals

Reflections

1. It was good to be part of the team whose values were aligned with the HSC values of working together, excellence, openness and honesty and compassion.
2. It was learning experience of bringing the team together, laying a strong foundation and building the service together
3. Learning was also in the form of duplicating a success strategy into other dimensions of the service.

Challenges:

1. Patient choice – Patients request appointment allocation outside of aim of 3 working days
2. Additional demands on the Service due to Trust pressures – prioritising alternative pathways
3. Staff availability due to COVID related absences

What next for the project ?

Following the success of overhauling the referral process for the GP's, the Trust is keen that we look at how we can improve the referral process when patients have attended the emergency department but do not need to be admitted, however would benefit from CGA through the frailty hub.

References:

1. Xue Q-L. The frailty syndrome: definition and natural history. Clin Geriatr Med 2011 Feb;27:1-15
2. Ellis G et al. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD006211. DOI: 10.1002/14651858.CD006211.pub3

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