DORSET FRAILTY TOOLKIT

A model for the identification, assessment and care planning of frail patients

Version 1. November 2017

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Introduction

Frailty is defined by the British Geriatrics Society (BGS) as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.'

Over recent years, frailty has been increasingly recognized as a long term condition and it is of particular concern because individuals living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after even apparently minor events. However there is evidence that individuals with frailty can have improved outcomes and potentially reduced hospital admissions if a person-centered, goal-orientated comprehensive approach is taken. This is summarized in the BGS document 'Fit for Frailty' published in 2014.

In October 2016 the Weymouth & Portland Locality were successful in a bid to receive a year's funding from Health Education Wessex to develop and implement a model that would enable us to provide proactive interventions for patients increasing in frailty.

This toolkit explains the process of ongoing identification of 'at risk' patients using different information sources. It complements and enhances the requirements of the current GP contract relating to frailty (July 2017) and ensures that the right, often unknown patients are identified. It also supports the goals of Integrated Community and Primary Care Services ensuring a joined-up approach, reducing duplication and enhancing patient care.

It is intended as a practical guide; formalising the structure of the Multi-Disciplinary Team (MDT) process with step by step guidance on risk profiling, The Dorset Care Plan (DCP) and an introduction to the Comprehensive Geriatric Assessment (CGA).

This model is recommended to be delivered at a locality level to enable strong links between Dorset HealthCare University Foundation NHS Trust (DHC) and Primary Care, but can be adapted to be used within individual practices.

GP Practice - MDT Meetings

MDT meetings are recommended to be run monthly with an identified list of patients from risk profiling and patients of concern put forward by clinicians.

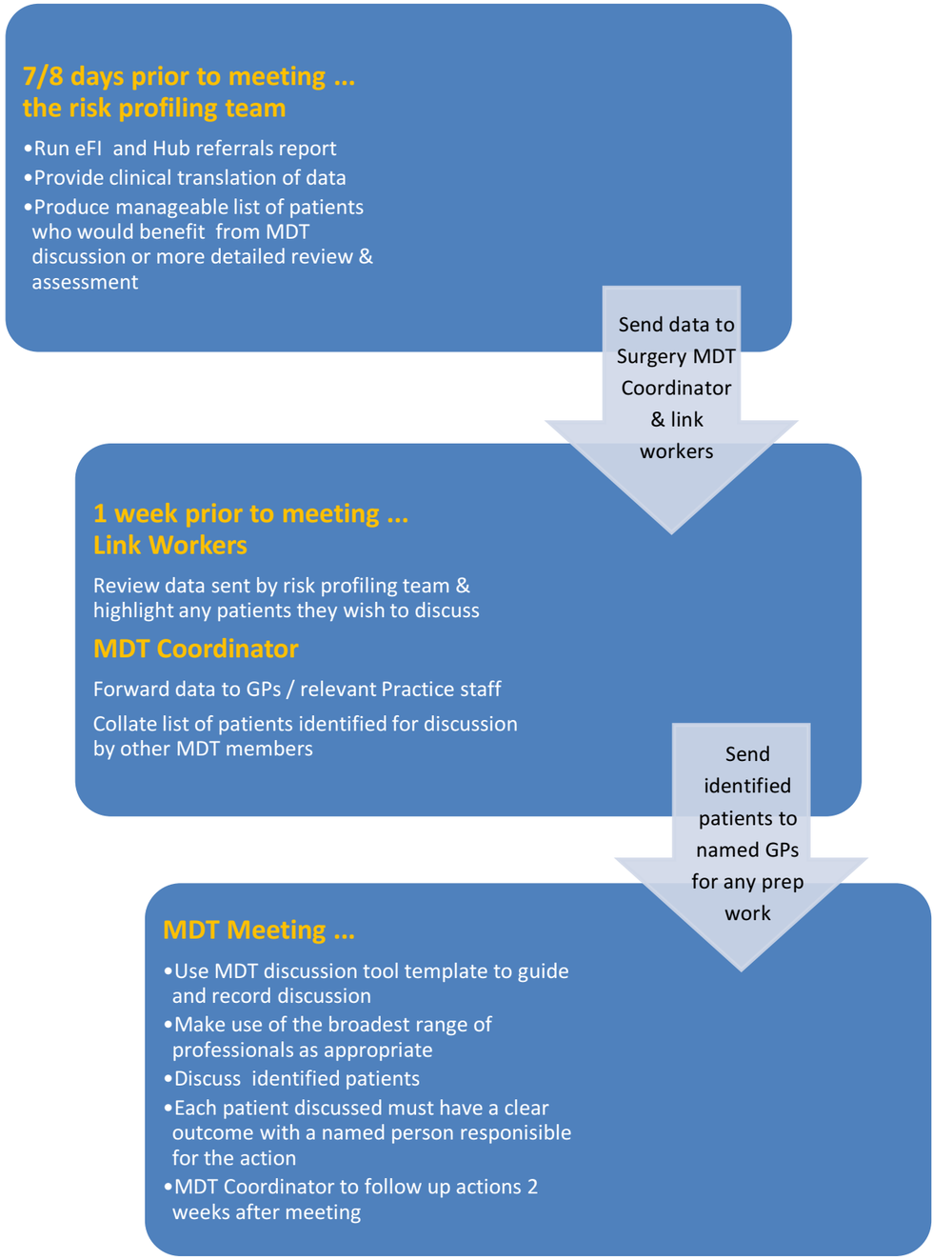
Structure of an MDT

To ensure an MDT meeting is set up to enable all team members to contribute, the following are recommended:-

- A suitable sized room to seat all MDT members
- GP System access available in the meeting
- A projector to enable all MDT members to view GP system and relevant records
- An up to date list of all link workers attending the surgery MDT representing their service
- MDT dates agreed a year in advance to ensure all link workers plan their diaries and guarantee attendance
- The risk profiling data should be sent to GP practices and link workers a week in advance of the MDT to allow adequate time to gather any background information that may be helpful to the discussion
- All attendees must sign a confidential declaration
- The MDT terms of reference should be sent to all link workers
- All surgeries should have an MDT coordinator
- A nominated scribe must be available in the meeting to record the relevant points on the MDT discussion tool - This should not be the chair of the meeting
- The Chair can be a GP or a competent alternative

MDT Process Chart

The following chart demonstrates the process from risk profiling to MDT outcome



Primary Care MDT - Terms of reference

The purpose of the MDT meeting is:

- To provide a multi-disciplinary forum for the discussion and management of relevant patients
- To ensure that the patient is at the centre of the MDT decision making process
- To ensure that the discussion around each patient covers all relevant points, which can be facilitated by the use of a MDT discussion tool template
- To maintain communication between all organisations making up the multi-disciplinary team in order to promote best practice and to ensure timely, holistic individualised care
- To agree a plan of action based on intended outcomes for the patient.

Attendance:

• GP s • Nurse Practitioners / ECP's • Community matrons • District nurses • Health & Social Care Coordinators (H&SCCO) • Palliative care nurses	• ICRT members – physiotherapy / OT • CMHT – adult and older peoples • Social Services • Administration staff/MDT Coordinator • Third sector representative for appropriate parts of the MDT (They should not be in attendance when discussing patients not on their caseload)

Expectations of the chairperson:

- The chairperson may be a clinical or non-clinical team member
- To ensure the meeting commences and finishes on time
- To have collated and reviewed in advance of the meeting all relevant data sources including (but not exclusively): palliative care patients, admissions data, frailty and hub reports provided by the H&SC Coordinator and identified patients from any of the multi-disciplinary teams members
- To review previous action plans from the last MDT meeting
- To effectively manage the meeting, taking into consideration time constraints, preventing repetition and ensuring that team members remain focused, succinct and relevant to MDT working
- To relay any relevant information to the wider team on behalf of any persons unable to attend
- To ensure that any actions given to absent team members are conveyed to them in a timely and clear manner
- To summarize the decisions and action plan and ensure they are recorded accurately.

Expectations of attendees

- Members are expected to attend and be prepared to contribute both actively and constructively to the meeting
- Presentation of patients should clearly and concisely specify the main issues to enable constructive discussion to take place. Discussion should be presented with objectivity, brevity and with clear purpose
- Members who are unable to attend should send their apologies and an update to the administrator/chairperson prior to the meeting
- To show respect for others knowledge and value equally the input of all in attendance
    - Only one group member to speak at a time
    - To be mindful of language used when describing patients, their significant others and other professionals
    - To not interrupt inappropriately
    - To listen
    - To promote a supportive environment
- To be responsible for the safe keeping of any identifiable information printed for the purpose of the meeting, and if not required, to be handed back to the administrator/chairperson for confidential disposal
- Laptops / hand held electronic devices are allowable only if they are necessary for informing the meeting
- Agencies should be willing and able to accept referrals directly from the MDT
- Attendance from services will be monitored.

Record keeping:

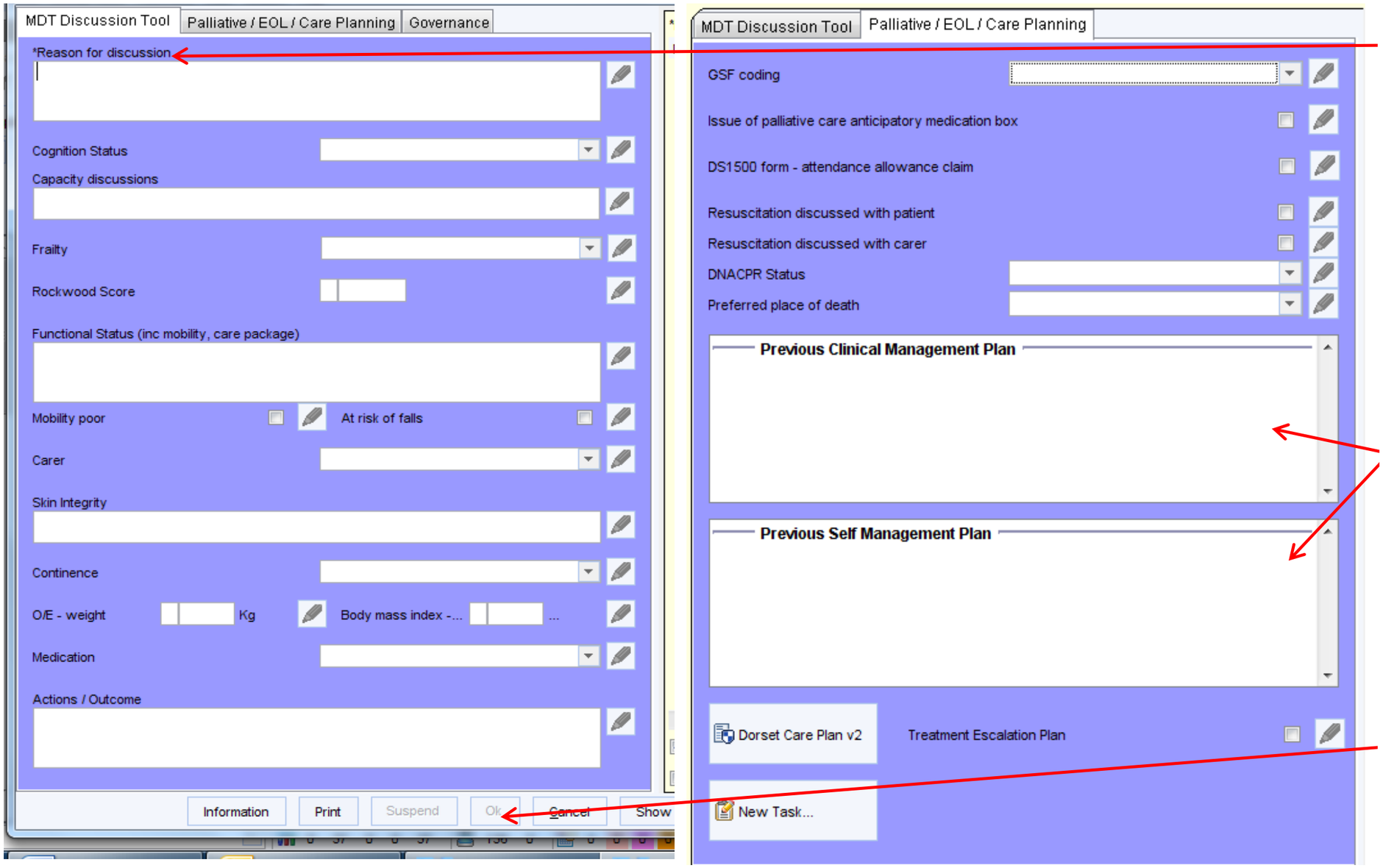
- A nominated admin support person will circulate meeting dates prior to the meeting and will circulate all relevant documentation to all members of the MDT at least 48 hours before the meeting
- Ensure a register of attendees is kept along with relevant confidentiality declaration
- To record the discussion in an appropriate format in the patients records and by use of e.g. MDT discussion template
- To record the decisions and action plan as summarized by the chairperson
- To record the nominated professional(s) to complete the action plan.

Processes:

- MDT meetings will take place monthly, the duration to be decided by the individual surgery
- Preparation for the MDT meeting will take place as per the MDT processes flowchart
- Patients for discussion will be submitted to the surgery MDT administrator or chairperson at least 24 hours in advance of the meeting
- The chairperson will determine the order of discussion inviting relevant multi-professional team members to present their identified patients.

MDT Discussion Tool

The MDT discussion tool is recommended to be used during the Primary Care MDT discussion to enable the conversation regarding the patient to be recorded directly into their notes. It offers a guide to steer the MDT discussion ensuring actions and outcomes are recorded.



Reason for discussion box is the only one that is required to be filled in during discussion; the rest of the template can be used as necessary. Actions should be recorded following patient discussion.

If a Dorset Care Plan has been completed then the clinical & self-management plans will be visible here.

Use 'Suspend' to come in and out of template to speed things up.

Risk Profiling

Risk profiling is a process of identifying patients through a structured method; ensuring patients who are at risk due to an increase in their frailty scoring are highlighted.

The Electronic Frailty Index (eFI) is an evidence based tool recommended by the BGS to be used to identify frailty in an identified population. The eFI uses a set of 36 deficits that may indicate factors which increase a patient's chance of frailty, based on Read codes recorded in a GP practice.

The eFI is the minimum standard required for risk profiling your population. To enrich this process we recommend you also risk profile using admission data from your secondary care services, this data analysis will also assist community teams to satisfy the CQUINN target of 'Supporting proactive and safe discharge' which aims to reduce length of stay to under 7 days for over 65s. Admission data also allows you to look for specific conditions that represent 'frailty syndromes' identified in 'Fit for Frailty' as falls, immobility, delirium, new/worsening incontinence and susceptibility to side effects of medication. Data from referrals to locality hubs/virtual ward can also be used to add value to GP MDTs. Instructions on how to do this are included in the toolkit.

GP practice responsibility

From the 1st July 2017 the General Medical Service's contract will require practices to routinely identify moderate and severe frailty in patients aged 65 years and over. The NHS Five Year Forward View identifies older people living with frailty as one of the areas where the NHS faces particular challenges. Practices will be required to use an appropriate tool and record the appropriate diagnosis of moderate or severe frailty in the patient records.

This risk profiling process is not designed to generate an entire frailty register. It is a method of identifying patients who are increasing in risk and may require input to implement proactive, preventative care than may reduce, or in some cases, reverse their frailty deficits.

Risk Profiling Team

The following guidance will provide information for Health & Social Care Coordinators or other appropriate practice based staff member on how to run the necessary reports to risk profile a population. In addition to this it provides guidance for Community Matrons or other identified clinicians to translate the data which adds value to using an electronic tool and brings clinical review into the process as no risk profiling tool is 100% sensitive.

The risk profiling team (RPT), depending on your chosen approach of locality or practice level coordination should be made up of the following team members:

Locality team	Surgery team
• Health & Social Care Coordinator (RPT administrator) • Community Matron/Other Clinician (RPT Clinician) • Surgery MDT Coordinator	• GP/Practice Advanced Nurse Practitioner (RPT Clinician) • Surgery MDT Coordinator (RPT administrator)

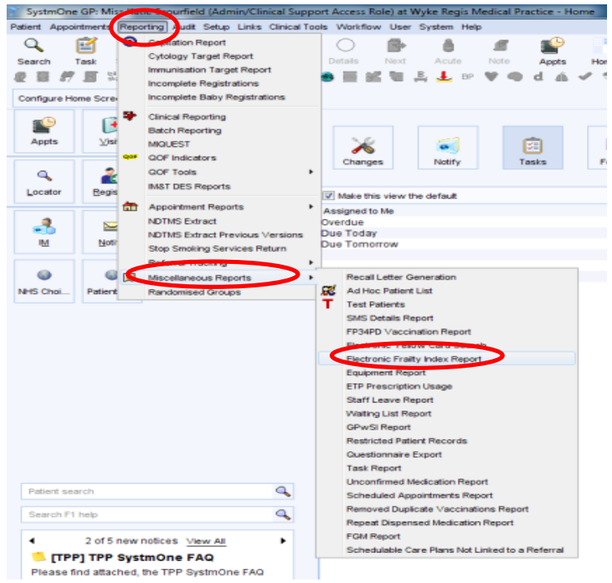
EFI

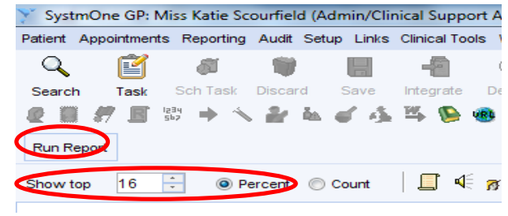
Risk profiling instructions for RPT Administrator – EFI tool

SYSTMONE:

To find / run the Electronic Frailty Index report….

- Open the required GP Practice SystmOne
- Select 'Reporting'
- Select 'Miscellaneous Reports'
- Select 'Electronic Frailty Index Report'
- Go to 'Show top' type in percentage of population you wish to search and ensure that 'Percent' is selected *(for risk profiling you will need to include all patients with a score of 0.13 or above – this can be achieved by searching for 100% of population and discarding those not required or by working out approximate 'frail' populations for your Practices)*
- Select 'Run Report'
- Once the report has been populated right click on any patient, select 'Table' then 'Open as CSV' which will export the table to an Excel Spreadsheet allowing data to be manipulated.
- Once document has opened scroll down to bottom of EFI list and delete any patients with a score below 0.13.
- Do not close the Practice SystmOne as you may need it again later
- ***If you have a GP S1 that serves multiple Practice MDTs you will need further instructions***



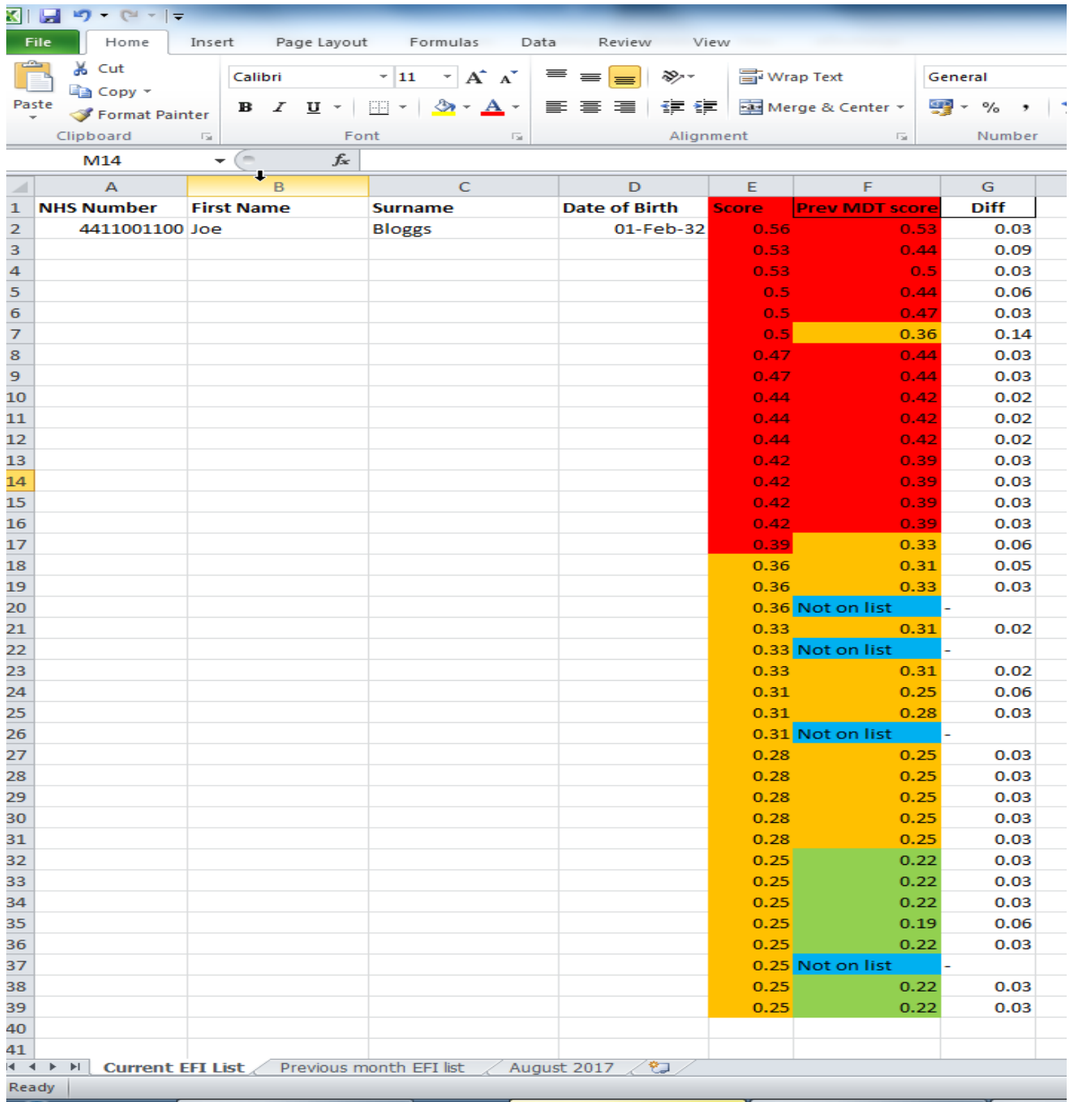


SystmOne EFI score guidance:

- Fit 0 – 0.12
- Mild frailty 0.13 – 0.24
- Moderate frailty 0.25 – 0.36
- Severe Frailty > 0.36

EFI SPREADSHEET EXAMPLE / INSTRUCTIONS

You will be provided with a spreadsheet that your eFI list can be transferred into that will identify patients with an increased eFI score using the VLOOKUP function and utilises conditional formatting to colour code scores according to frailty categories. It can also be set up to identify patients with care plans / in care homes etc.



	A	B	C	D	E	F	G
1	NHS Number	First Name	Surname	Date of Birth	Score	Prev MDT score	Diff
2	4411001100	Joe	Bloggs	01-Feb-32	0.56	0.53	0.03
3					0.53	0.44	0.09
4					0.53	0.5	0.03
5					0.5	0.44	0.06
6					0.5	0.47	0.03
7					0.5	0.36	0.14
8					0.47	0.44	0.03
9					0.47	0.44	0.03
10					0.44	0.42	0.02
11					0.44	0.42	0.02
12					0.44	0.42	0.02
13					0.42	0.39	0.03
14					0.42	0.39	0.03
15					0.42	0.39	0.03
16					0.42	0.39	0.03
17					0.39	0.33	0.06
18					0.36	0.31	0.05
19					0.36	0.33	0.03
20					0.36	Not on list	-
21					0.33	0.31	0.02
22					0.33	Not on list	-
23					0.33	0.31	0.02
24					0.31	0.25	0.06
25					0.31	0.28	0.03
26					0.31	Not on list	-
27					0.28	0.25	0.03
28					0.28	0.25	0.03
29					0.28	0.25	0.03
30					0.28	0.25	0.03
31					0.28	0.25	0.03
32					0.25	0.22	0.03
33					0.25	0.22	0.03
34					0.25	0.22	0.03
35					0.25	0.19	0.06
36					0.25	0.22	0.03
37					0.25	Not on list	-
38					0.25	0.22	0.03
39					0.25	0.22	0.03
40							
41							

- Open the EFI spreadsheet
- You will notice that cells F & G on Current EFI list tab are already populated **DO NOT** amend these cells as they contain formulae which make your job much easier!
- Please note that the first time you run the EFI you will only need to copy and paste your S1/Emis list into 'Current EFI list' tab
- Select 'Previous month EFI list' tab and clear contents of previous EFI
- Select 'Current EFI list' tab (ensure that 'Diff' column filter is removed) select columns A-E, copy and paste into 'Previous month EFI list' then clear contents
- Go back to your spreadsheet that contains your newly populated EFI list and copy and paste into 'Current EFI list' tab you will notice that the columns F & G have populated themselves
- Always check that the formulae are correct - please refer to the formula document in *Appendix 1*
- Filter 'Diff' column and deselect '0' and any minus scores then click 'OK'
- Copy and paste the patients into a new tab and rename it to reflect MDT month. You will only need to include patients with a 'severe' or moderate' score
- You now have a table that only shows patients where there has been a change since the last MDT
- Save document.
- **If you have a Virtual Ward SystmOne and MDT caseloads …**
    - Register patients
    - Select 'Other' as Referral source
    - Select 'MDT – Frailty' as Primary Referral in Reason
    - Select appropriate Practice MDT as Caseload
    - When completing Info Gathering & Referral Screening template ensure that you record Increased EFI score as reason for referral and include if the patient has a care plan, what frail category they are in and whether they have increased by category
    - Inform RPT clinician once patients are registered to S1 and ready for clinical input.
- **If you do not have a Virtual Ward SystmOne …**
    - Inform RPT clinician that EFI spreadsheet is complete and ensure that they have access to document so they are able to record their clinical input.

It is recommended that the RPT administrator EFI input is completed 8 days prior to MDT. Following clinical translation of data the next day RPT administrator to run Hub referrals report.

Clinician Guidance on translating data

Allocating time for risk profiling – The identified clinician will need to allocate time within their day these points are guidance on how this can be done

- Keep a record of all risk profiling preparation dates and your link surgery MDT dates
- Block out time in your diary to complete the data analysis on the preparation day
- The administration member of the risk profiling team (RPT) will ensure you have the data in your inbox the day before
- Aim to return the data completed to administration member of the risk profiling team by midday on the same day.

How to translate the data/risk profiling for Efi If you are NOT using hub module

Monthly

1. The administration member of the RPT will have provided you with a list of data for you to translate drawn from the Electronic Frailty Index (Efi)
2. The data includes patients who have 'risen' or are 'new' on the list. It is broken down into mild (green), moderate (yellow) and severe (red) frailty categories. The colour coding will help identify patients who have 'jumped' up a category or who have 'risen' within their category
3. Access the GP modules for your practices and look up the patient
4. Look in the tabbed journal to establish any contact over the past month
5. Identify any admissions, infections, falls, delirium, exacerbation of LTC, deterioration in condition or increased frailty
6. Review medications to identify risk of polypharmacy, identify weight loss, new diagnosis, increase in care needs
7. Check if a Dorset Care Plan requires completing or updating. This should include a clear escalation plan and description of patients baseline
8. Review any letter from a specialist that provides information which may add to the current picture
9. Highlight if a Rockwood score needs to be completed
10. Record anything significant in the appropriate column on the data sheets
11. Highlight patients that have significant changes that would benefit from being discussed at the surgery MDT.

How to translate data via the hub module in SystmOne

1. You will receive an email from the administration member of the RPT telling you your Efi caseload is ready to view on the hub module
2. Log into the hub module
3. Click on caseloads
4. Look under the MDT caseload for your surgery – here you will find the list of patients who have increased in frailty over the past month (see point 2 in the section above)
5. Work down the list and retrieve the records for each patient
6. The Admin RPT member will have recorded in the patient notes if they are 'moderate' or 'severely' frail, if they have jumped a category, if they have a Dorset Care Plan (or not) and if they are an in-patient

7. Look in the tabbed journal to establish any contact over the past month
8. Identify any admissions, infections, falls, delirium, exacerbation of LTC, deterioration in condition or increased frailty
9. Review medications to identify risk of polypharmacy (specify meds to review if relevant), identify weight loss, new diagnosis, increase in care needs
10. Check if a Dorset Care Plan requires completing or updating. This should include a clear escalation plan and description of patient's baseline
11. Review any letter from a specialist that provides information which may add to the current picture
12. Highlight if a Rockwood score needs to be completed
13. Record anything significant by clicking on 'hub dashboard' followed by 'quick note' and summarise your findings
14. If the patient **does not** require an MDT discussion – Save, admin template, end referral, usual place of residence, treatment completed then save and refresh list
15. If the patient **does** require an MDT discussion, save, admin template then save
16. When you have looked through the whole list, you will have one shorter list of patients that require MDT discussion
17. Email RPT admin member to notify that this task has been completed
18. They will then compile an email with the names of patients to be discussed along with the complete list of patients who have been raised that month due to their Efi, an admission or referral to the hub. This will be attached to information sent to the Practice. the GP practice information.

Hub referrals / MDT data

Hub referrals / MDT instructions for RPT Administrator- You will need access to the Locality Hub SystmOne module and be able to access Clinical Reporting

Please note if you do not have access to Hub S1, you will not be able to complete this stage and instead will need to send your Efi & admissions data to GP Practice and link workers.

To create an MDT Hub referrals report …

- Select 'Reporting'
- Select 'Clinical Reporting'
- Select 'Local Reports'
- Select 'New'
- Name your report and create new category called MDT
- Open the 'Registration' folder
- Select 'GP' then 'Registered GP practice at time of event' and search for the Practice required.
- Select 'Registration Status' and ensure that 'Deceased' 'Active' and Deducted' are all ticked
- Open the 'Clinical' folder
- Select 'Event Dates' then 'Event date' and enter the appropriate time period
- Select 'Referrals In' then 'A referral in exists' and ensure that 'Both new and re-referrals' and 'Limit to referrals to here' are ticked
- Select 'Ok' at bottom of screen and your report has been created

To find/run the MDT Hub referrals report ….

- Open Hub SystmOne
- Select 'Reporting'
- Select 'Clinical Reporting'
- Select 'Local Reports' and click on the triangle to the left-hand side
- Select 'MDT'
- Right click on the appropriate Practice report and select 'Amend'
- Scroll down to 'Event Dates' and change the event date to 'After' the date the previous report ended
- Change the name of the report to reflect the time period it now shows (report will only include date recorded before 5pm the following day)
- Select 'Ok'
- Right click on your report and select 'Run'
- Once green tick has appeared next to report it is ready to view (if this is taking a while then click on 'Refresh')
- Right click on your report and select 'Breakdown Results'
- Drop down 'Referrals In' list and tick 'Referral ID' & 'Reason for referral' then drop down 'Registration' list and tick 'Registered GP (GMS)'
- Select 'Refresh' and then 'Close'
- Right click on your report and select 'Show patients'
- Select 'Save all pages to CSV' which will open a spreadsheet
- Open MDT data document
- Open and rename a new tab to reflect the MDT month you are working on.
- Copy and paste relevant information from your 'Show patients' spreadsheet into MDT data document
- If a patient appears on list more than once, condense information into one row.
- Highlight patients identified as needing further discussion in red. (Patients identified will be those left in Hub MDT caseload or sent to you by Community Matrons)
- Send MDT data to GP Practice and link workers

Daily Admissions

Risk profiling admission data ensures patients admitted due to frailty syndromes are being identified in a proactive timely way. The following criteria is based on acute admission data between April to March 2015/16 & 2016/17 and focuses on the top reasons for admission that relate to frailty **See Appendix 2*

Risk Profiling Criteria:

- Over 65 and one of the following:
- Admission for a fall or UTI
- 2 or more admissions in the past year

Risk profiling instructions for RPT Administrator – Daily Admissions

You will need to have access to daily admissions alerts email, acute hospital system and the Hub S1 to complete this task. (If you do not have a Hub s1 then you can still carry out task but will need to create a spreadsheet to keep your data)

- Open daily admissions alerts email and enable editing (save as required)
- Select 'Data' tab and click on 'Sort' button then select Sort by DOB and ok
- Only over 65's need to be included so all other patient rows can be deleted. In 2017 a 65 y/o would have been born in 1952
- Select Column C then select 'Conditional Formatting', 'Highlight Cell Rules', 'Duplicate Values' then 'OK'
- Delete duplicate NHS numbers only – do not delete entire row
- Filter 'Admissions previous yr' column and deselect '0' & '1'
- Register patients to S1
    - Select 'Other' as Referral source
    - Select 'MDT – Frailty' as Primary Referral in Reason
    - Select 'Admissions' as Caseload
- Go back to daily alert sheet and un-filter 'Admissions previous yr' column
- Filter 'Initial Complaint' column and select 'FALL' and/or 'UTI'
- Repeat above steps for these patients, they do not need to be registered twice if already on for 2+ admissions
- Open and log in to acute hospital system to find relevant information to be recorded in Info Gathering & Referral Screening template ensuring that you record the admission criteria as reason for referral.

This data will be analysed daily by the risk profiling team.

- If the patient is still an in-patient the ward is contacted to see if: - the hub can facilitate discharge, to add information already know about the patient or to identify reason for ongoing admission
- A link is established with our service and the ward and requested that we are kept updated if an ongoing admission is required
- If the patient is already at home the RPT clinician will review discharge letter and contact patient/carer to ensure patient is recovering well and arrange a visit within 48 hours if appropriate to review or as urgent if required

The Dorset Care Plan

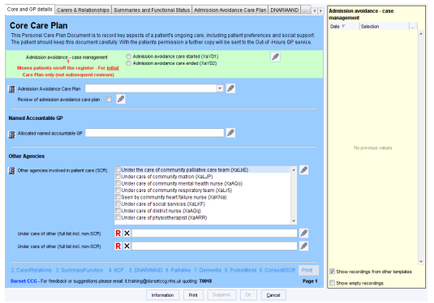
The Dorset Care Plan (DCP) is a detailed template which can allow recording of a comprehensive management plan and background history for any patient (although it is particularly relevant to frail or complex patients). It was developed to allow a standardised approach to admission avoidance/advance medical care planning and it can include any or all of the following information: the patient's priorities for care, a summary baseline for that patient, an advance care plan, a treatment escalation plan and self-management advice. The fields closely link to the enhanced summary care record (highlighted on the template) allowing it to be shared easily with other HealthCare professionals using different IT systems.

Things to think about when considering whether a patient is suitable for a Dorset Care Plan:

- Does this person have complex needs where a DCP would help an external person manage those needs?
- Does this person need instructions to help them manage long term conditions in the form of a shared care plan?
- Is this person's condition likely to deteriorate or change quickly and it is important that baseline information is known?
- Is there a clear non escalatory plan that is essential to share?

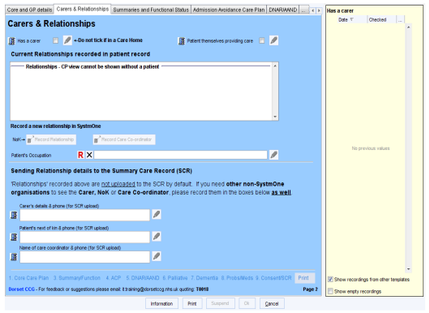
When completing a Dorset Care Plan, by clicking in any of the fields, it is possible to see what data has already been entered linked to that code (in the window on right side of screen). This allows different health-care team members to complete different parts of the care plan. If the last entry on the right hand side is complete and accurate, there is no need to re-enter this information in the care plan. If the last entry is incomplete or has changed – either re-enter all new data or right click on the entry and press ctrl+C. Then click in the data entry box and press ctrl+V – the entry will be copied across and can then be amended as required. Remember that the marked read codes link to the eSCR and every entry is visible. Only re-enter data if there is a change or new information. The printable care plan generated at the end of the template will pull in the last entry into it regardless of when it was added.

The page numbers and screen shots refer to the Primary Care SystmOne version of the Dorset Care Plan. However this is available for Primary Care EMIS systems and for Dorset Health Care Community SystmOne modules. The descriptions and examples are relevant to all versions.



PAGE 1: Core Care Plan

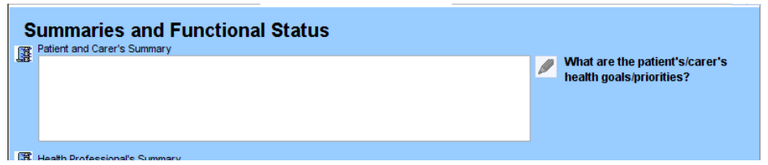
Record named GP, admission avoidance care and reviews, other professionals involved.



PAGE 2: Carers & Relationships

Carers, occupation and next of kin details

PAGE 3: Summaries and Functional Status



Patients/carers perspective

Record the views of that patient and/or carer – what are their priorities and how would they describe their health? Their priorities may be non-medical. Do they want all treatments aimed at prolonging their life regardless of outcome, or is their priority comfort and quality of life?

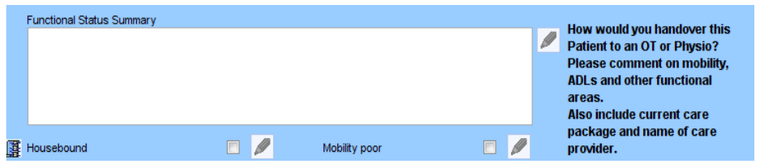
e.g. Bob feels that although he does get severe chest infections at times, his quality of life is good in-between these and he is still able to do most of the things he wants to do. If he becomes severely unwell he would want admission to hospital for any intensive treatment aimed at prolonging his life.

PAGE 3: continued

Health Professionals summary

A brief description of the patient – where do they live, how much support do they need to meet their care needs (if any), what are the main risks to deterioration of health?

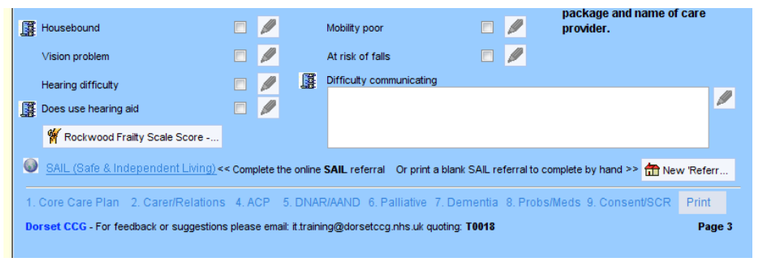
e.g. Bob lives in his own bungalow with the support of his daughter who helps with shopping, cleaning and collecting medication. He is still managing to complete all other ADLs independently but this is getting harder and he may need a small care package in the next few months. He has COPD and has been admitted to hospital twice in the last year with exacerbations, despite prompt treatment with his rescue medication. Early treatment does however prevent some admissions.



Functional Status

Use this box to describe the patient's ability to self-care – consider any/all of the following areas - mobility, continence, ability to wash and dress, ability to self-feed, skin integrity

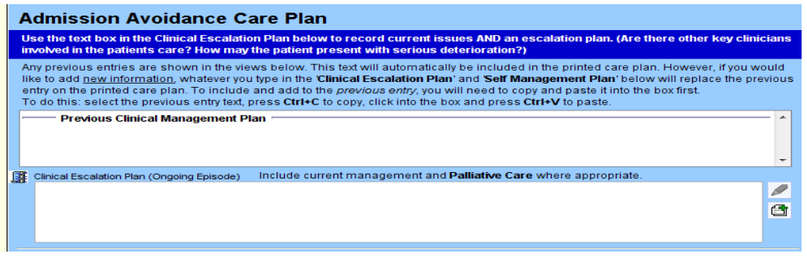
e.g. Bob is independently mobile with one or two sticks, he is fully continent. He is independent with showering and dressing, but is starting to find this quite difficult and is considering that he may need a carer to assist him. He eats a normal diet and is able to reheat ready meals, but not to prepare a meal himself.



Further information – tick boxes & click on pencil to record further information

*Rockwood frailty score (**Please note this is not on the DHC version**)* Click on this box and the Rockwood scoring (and guidance) will pop up – choose rating 1-9 and if appropriate mild/moderate/severe frailty from drop down box.

PAGE 4: Admission Avoidance Care Plan (**Please note pages 4 & 5 are on the same page on the DHC version)**



Clinical escalation plan

This can take a variety of forms depending on the patient and the risks. Consider giving guidance related to chronic health problems and suggested actions. Consider likely scenarios for deterioration (including but not exclusively – stroke, MI, infection, fall, sudden unexpected deterioration in health, poor oral intake) and the level of care a patient would want in that situation. You could use the following categories of care – Intensive (all acute interventions including intensive care if necessary), Hospital (admission to hospital for any interventions apart from ITU/HDU), Home (care in the home only including any treatments that are possible in the community), Comfort (palliative management rather than active treatment). Consider major health problems that may need intervention.

e.g. Bob prefers to be treated in his home when safe to do so, but he is accepting of hospital admission if it is clinically necessary and appropriate.

He is at risk of chest infections/infective exacerbations of COPD. He is aware of signs of deterioration (increased cough/sputum, increased shortness of breath). These sometimes respond well to oral Amoxicillin and a short course of Prednisolone, however sometimes he deteriorates rapidly and will need consideration of hospitalisation if his sats drop (his usual sats are 93-95%) or if he shows signs of sepsis. He is agreeable for treatment with intravenous antibiotics and consideration of non-invasive ventilation support if this is necessary and appropriate.

He has occasional falls (related to postural hypotension & residual weakness from a previous CVA). If he falls and can't get up, he has a Careline. Suspected fracture/wounds will need assessment and appropriate treatment in A&E.

He has had a CVA previously resulting in mild residual right sided weakness. He would want hospital admission for a further CVA, although he would not want artificial feeding and has an advance directive to refuse treatment relating to this scenario.

Atrial fibrillation – rate is controlled with low dose bisoprolol and he is anticoagulated – at present the benefits outweigh the risks, but this may need reconsidering if falls increase in frequency/result in severe injury.

In the event of a sudden unexpected deterioration in health – hospital admission would be accepted if he could not be safely investigated or treated at home.

Hyponatraemia – previous episode of symptomatic hyponatraemia secondary to omeprazole. Consider checking U&Es urgently if he develops signs of recurrent hyponatraemia.

PAGE 4: continued

Self-management plan

This is guidance from HealthCare professional to the patient/carers. What symptoms/signs should they look out for, what should they do if a particular symptom starts. When should they call for help and who should they call?

e.g Bob – Exacerbation of COPD – if you develop your usual signs of a chest infection (increased cough/sputum/breathlessness) – then start your emergency antibiotics and prednisolone. Re-order from GP surgery. If not improving as usual or your symptoms are worse than usual then make an emergency appointment with GP/request visit/out of hours call 111.

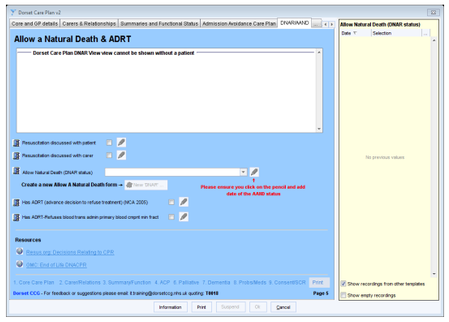
For any other urgent health problems - make an emergency appointment with GP/request visit/out of hours call 111

For routine health problems – make a routine appointment with your GP

If you have a severe symptom and feel your life may be at risk from it, then call 999 or press your Careline buzzer

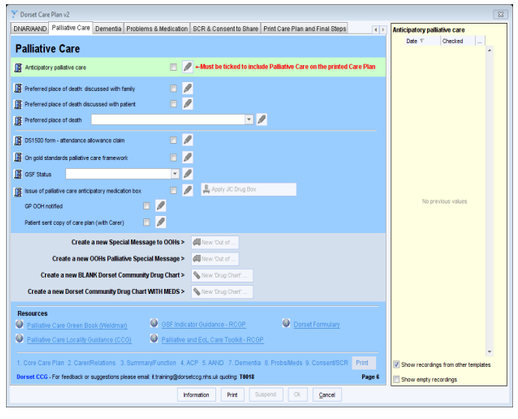
If you fall and can't get up, then call 999 or press your Careline buzzer.

What is their preferred place of care? (drop down box)



PAGE 5: Allow a Natural Death decisions & ADRT

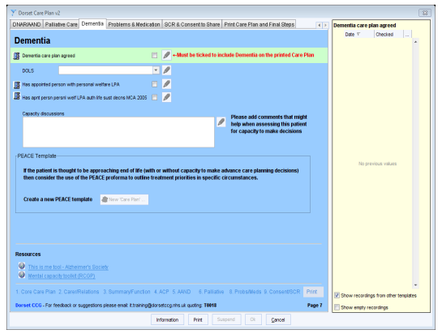
Options to record decisions relating to resuscitation and advance directives to refuse treatment.



PAGE 6: Palliative care

To ensure that the palliative care section is added to the completed Care Plan document, tick this 'anticipatory palliative care' box highlighted.

Options to record GSF status, preferred place of death, links to create palliative care drug charts, special message forms for out of hours/ambulance service, prescribing for anticipatory medication.



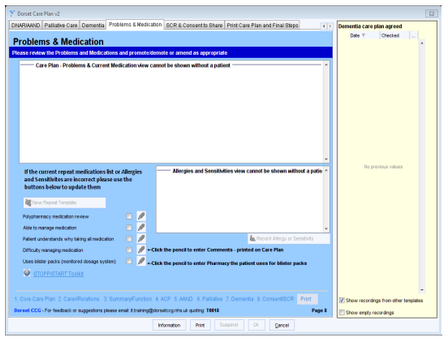
PAGE 7: Dementia

You must tick the 'dementia care plan agreed' box to include this in the completed document

Record details about DOLS, Power of attorney & capacity here

(**Please note the PEACE information is not on the DHC version**)

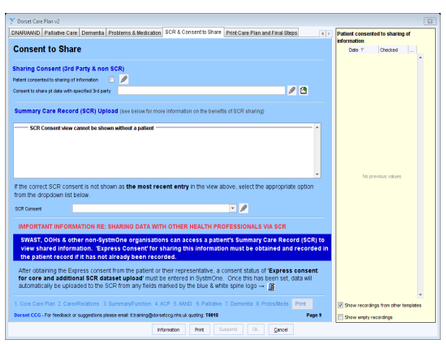
Link to PEACE form (thresholds of care for patients in care homes with and without capacity – a lot of this information could be recorded in the clinical escalation plan, but it is also includes helpful guidance notes for care home re: Intensive/Hospital/Home/Comfort thresholds of care and how to achieve Home and Comfort options). This is a useful document for a nursing home and gives structure to decisions, however it does not upload or link to the enhanced Summary Care Record.



PAGE 8: Problems, medication

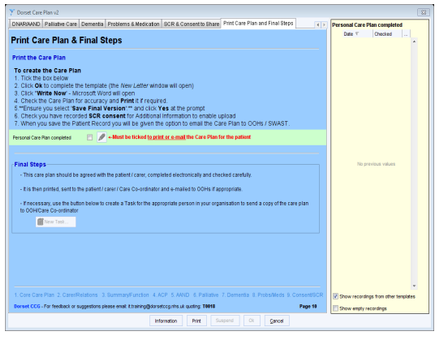
An opportunity to review medication and problem list – medications can be altered from this screen and problem list can be edited if some problems need to be moved e.g major active to major inactive

Record details about ability to manage medication



PAGE 9: Consent to Share

Coding page for consent to share and consent (or dissent) for core and enhanced summary care record



PAGE 10: Print Care Plan & Final Steps

Final page to allow creation of a personalised Dorset Care Plan document (by ticking the box)

Please note on the DHC version there will be an additional box to tick to state consent has been gained for the patient's records to be shared on the enhanced summary care record. There will also be an automated task sent to the GP when the DCP has been amended or completed in the community setting as the GP is the only professional who can change a patients consent settings

Throughout the care plan template there are options to open up additional forms for completion when relevant and extra guidance

e.g SAIL form, STOPP START tool

**Please see Appendix 3 for further examples on how to complete the Dorset Care Plan*

Comprehensive Geriatric Assessment

The gold standard for the management for frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). It involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings (BGS June 2014)

Not all patients require assessments from every member of the multidisciplinary team and onward referrals may be required following the process. The assessment is commonly built up over a period of time with input from different members of the multidisciplinary team and this is why a shared template across the various HealthCare services is ideal to achieve this and to reduce duplication.

The outcome of the CGA process is the formulation of a patient-centred list of needs and issues to tackle (an action plan) and an individualised care and support plan (e.g the Dorset Care Plan) and a recommendation for frequency of review.

Components of a CGA

- Physical Symptoms
- Mental Health symptoms
- Level of function in daily activity for personal care and life functions
- Social support networks currently available (formal and informal)
- Living environment
- Level of participation and individual concerns/anxieties – what is important to them
- Compensatory mechanisms and resourcefulness the individual uses to respond to having frailty.

Outcomes of a CGA

- Formulation of a patient-centred list of needs and issues to tackle including medication review (an action plan)
- Individualised care and support plan (e.g the Dorset Care Plan)
- Recommendation for frequency of review.

Fit for Frailty (BGS 2014) recognises that resources would not allow all patients with frailty to have a full CGA assessment, but suggests that all patients with frailty should at least have a holistic medical review by their GP based on the principles of CGA with the same outcomes as a full CGA (action plan and Dorset Care Plan in this model).

Outcome Measures

Aim

The aim of this work is to reduce unplanned admissions for patients over 65 identified as being moderate or severely frail

Process Measures – These measures define the process implemented to achieve the intended outcome

- Patients identified as mild/moderate and severely frail
- Rockwood score
- CGA
- Dorset Care Plan

Outcome measure – These outcome measures can be collected by running reports on the GP system or from daily acute admission date from secondary care

- Number of unplanned admissions
- Length of stay
- Preferred place of care achieved
- GP/OOH Contacts
- To allow for quantitative data friend and family audits can also be included

Mild Frailty / E-Learning

Although the British Geriatric Society advises against population screening for frailty due to lack of evidence of positive outcomes, we need to be mindful of the early warning signs of developing frailty and be able to achieve the goal of 'assessing individuals for frailty at every HealthCare encounter.'

Dorset HealthCare has a frailty module that is recommended to be completed by all staff and can be accessed by the E-hub. It provides a basic level of information to increase the knowledge of all staff members who come into contact with patients who are potentially increasing in frailty.

This module has now also been made available on the CCG intranet, GP practices are encouraged to promote the completion of this module by all reception/admin and clinical staff. This can be accessed by https://intranet.dorsetccg.nhs.uk/localities/frailty-elearning.htm.

We have provided a series of leaflets on living with frailty, assessing for frailty (using a validated tool called PRISMA 7) advance care planning and early self-help. These patients can be well supported by third sector early help and of course exercise and balance classes are the only intervention that has shown a definite ability to partially reverse or slow the progression of frailty.

We hope that these tools will give you some additional resources to help develop practice and locality specific support and identification of the mildly frail. ** Please see Appendix 4*

Case Study

NHS England. “Now we have help” https://www.youtube.com/watch?v=Y9hYaD201rI

Acknowledgements

Authors

Dr Laura Godfrey – Weymouth Elderly Care Service

Emma Winterburn – Community Matron/Project Lead

Katie Scourfield – Health & Social Care Co-ordinator

We would like to extend our thanks to Dorset HealthCare University Foundation Trust, Dorset Clinical Commissioning Group, Two Harbours HealthCare, the Weymouth & Portland Frailty Project Team and Health Education Wessex for their support and contribution.

To download Frailty Tool Kit please visit: www.dorsetccg.nhs.uk/frailty

References

British Geriatrics Society. Fit for frailty - consensus best practice guidance for the care of older people living in community and outpatient settings.
www.bgs.org.uk/press-3/resources/campaigns/fit-for-frailty/fff-guidance-download

Oxford academic. Development and validation of an electronic frailty index using routine primary care electronic health record data.
https://academic.oup.com/ageing/article/45/3/353/1739750/Development-andvalidation-of-an-electronic

NHS Employers. Technical requirements for 2017/18 GMS contract changes.
www.nhsemployers.org/gms201718

NHS England. Five Year Forward View.
www.england.nhs.uk/five-year-forward-view

Appendix 1 – eFI formulae

If there is ever a problem with any of your formula please check this sheet so you can correct any errors that may have occurred.

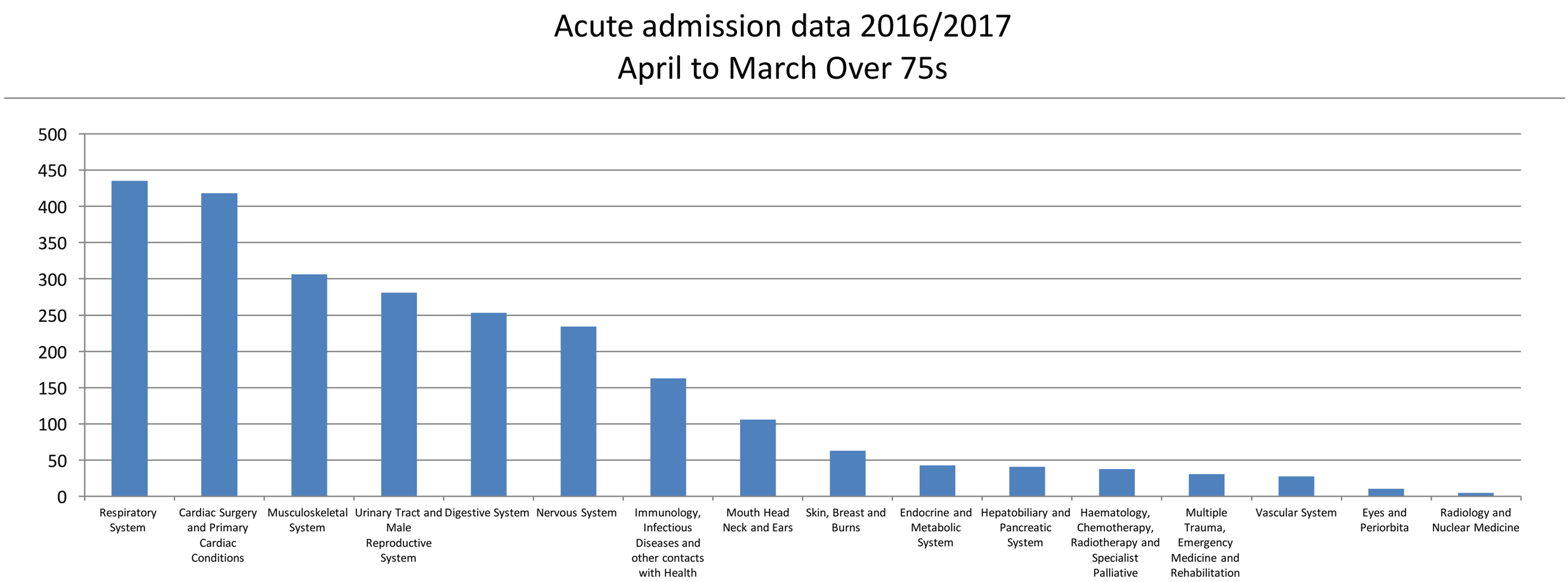
Please note that highlighted cell number may not always be A2 – it will be whichever cell contains the first NHS number in your list

If you need to amend formula make sure you drag the formula down so it amends all cells necessary

Prev MDT score =IFERROR(VLOOKUP(A2,'Previous month EFI list'!A:E,5,FALSE),"Not on list")

Diff =IFERROR(SUM(E2-F2),"-")

Appendix 2 –Pareto chart



Appendix 3 – DCP additional examples

Patients/carers perspective

e.g. Jill has advanced dementia and she never wanted to become as unwell as she now is and would have been very upset to have been unable to manage her own hygiene needs. She strongly dislikes hospitals and taking medication. The priority is maintaining her comfort and dignity in the familiar surroundings of her care home and ensuring that hospital admission is avoided.

Health Professionals summary

e.g. Jill has advanced dementia and moved into a nursing home in January 2017 when it became too difficult to meet her care needs at home. She needs all nursing care. She can become agitated and aggressive with inter-current infection and she experiences recurrent UTI. If she needs any medication then it should be liquid or dispersible formulation due to swallowing difficulties.

Functional Status

e.g. Jill has no active mobility and needs hoisting for transfers. She is doubly incontinent and needs 2 carers to manage personal care, washing and dressing. She needs to be fed and needs stage 1 thickened fluids and a pureed diet. She is at risk of pressure sores and needs regular changes of position to avoid this.

Clinical escalation plan

e.g. Jill has advanced dementia and in general her care needs are best met in a familiar setting with familiar carers. A best interests decision in discussion with her next of kin has agreed that whenever possible her care should be managed in the nursing home with support from her GP surgery or out of hours service. The only exception would be trauma or if symptomatic control could not be achieved in the community.

She is at risk of UTI and chest infections. These usually respond to oral antibiotics (liquid formulation). Any infections should be treated in the nursing home setting only with oral antibiotics when she is able to swallow. If she becomes unable to swallow then management should be palliative.

Dementia – she has advanced dementia and can display some behaviours that challenge relating to aggressive behaviour with interventions. These can be managed with behavioural strategies generally. If there is a change to behaviour then consider reversible causes e.g. pain, infection, constipation. Manage deterioration related to dementia in the nursing home with the priority being symptom control. No current CMHT involvement.

Falls risk is low due to her immobility. If there is trauma then assess in A&E only for suspected fracture or unmanageable wounds and return to nursing home as soon as possible.

Heart failure – symptoms currently controlled with diuretics, these may need adjustment if she develops worsening peripheral oedema or shortness of breath.

In the event of any sudden deterioration in health e.g. CVA – manage in the nursing home symptomatically with support of GP surgery / out of hours service.

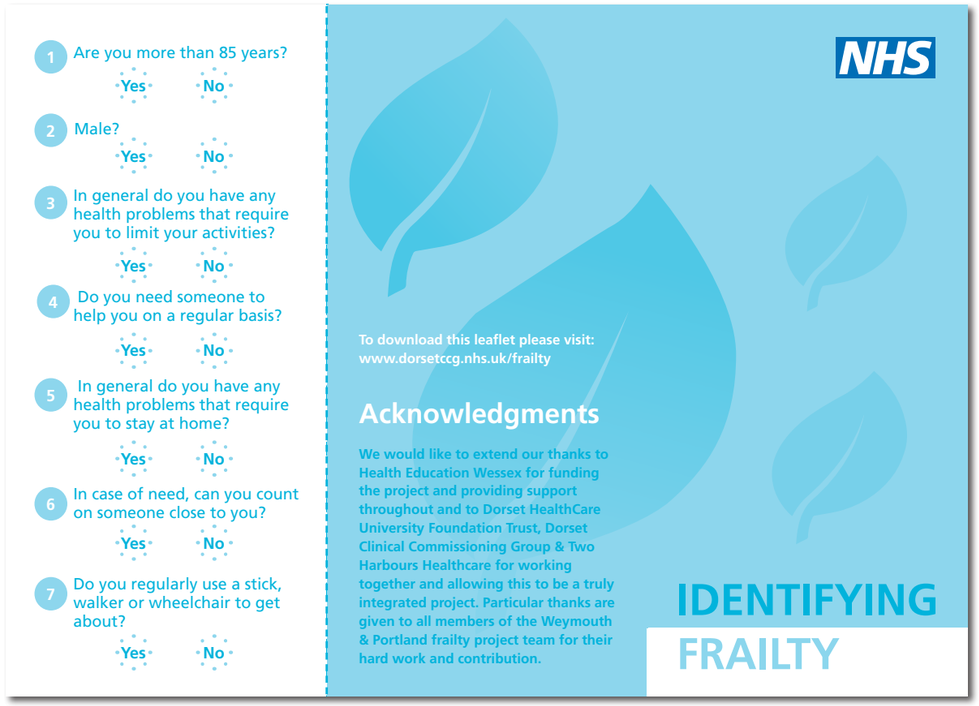
Self-management plan

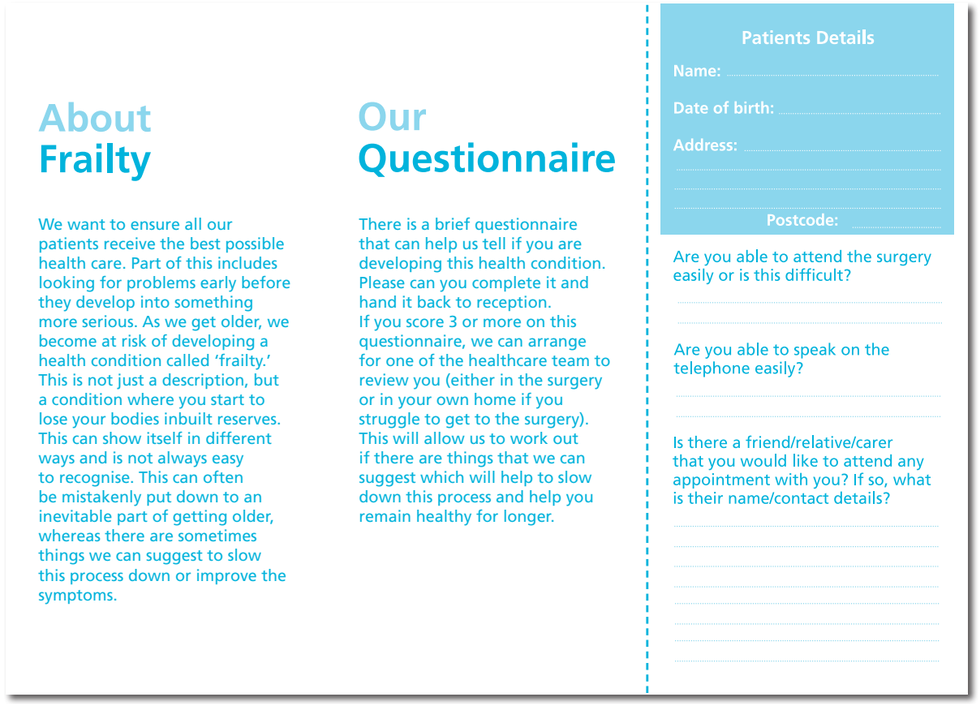
e.g. Jill - The aim is for management in the nursing home, so for any unexpected deterioration in health then contact GP surgery / out of hours service to advise / review.

For any non-urgent problem then await routine weekly GP surgery visit

999 only for trauma or a severe distressing symptom that cannot await GP advice/assessment.

Appendix 4 – Frailty Leaflets





Appendix 4 - Frailty Leaflets

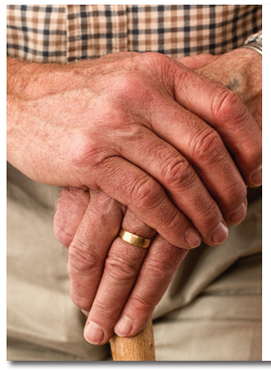
NHS

To download this leaflet please visit:
www.dorsetccg.nhs.uk/frailty

Acknowledgments

We would like to extend our thanks to Health Education Wessex for funding the project and providing support throughout and to Dorset HealthCare University Foundation Trust, Dorset Clinical Commissioning Group & Two Harbours Healthcare for working together and allowing this to be a truly integrated project. Particular thanks are given to all members of the Weymouth & Portland frailty project team for their hard work and contribution.

Planning for your future care



What would happen if...

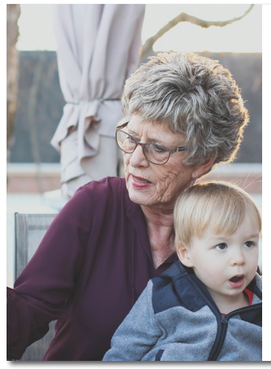
Have you ever thought about what would happen if you or a relative became seriously ill or disabled?
Regrettably we often fail to address these issues until it is too late to do anything about them.
For example, if you (or a relative) lost the ability to make decisions about your finances or health – do you know what would happen?
Another situation is resuscitation – lots of people have quite clear views that, when the time comes, they want to be allowed 'to go naturally' – however if this not clearly documented then resuscitation will always be attempted.
These are difficult subjects to think and talk about for many people, and that is both completely understandably and acceptable.
If however you do want to think about this, then we've listed some areas to consider, and some helpful links too.

Dorset Care Plan

For certain of our frailer patients or patients at high risk of hospital admission, we can complete a Dorset Care Plan. This not only gives you a chance to tell your GP what your wishes are, but allows a record of these wishes and plans to be available to the out of hours services and paramedics too.

These are in addition to the documents listed below, but could contain information from any or all of them. If you feel that you should have a care plan and do not yet have one, then don't hesitate to let your GP know.
For an overview of advance care planning and all it entails please visit

http://www.nhs.uk/planners/end-of-life-care/documents/planning-for-your-future-care.pdf



Lasting Power of Attorney

This is a legal document that lets you nominate one (or more) people to make financial or health decisions for you, if you loose the ability to do so. This is particularly relevant for people who develop dementia, but can apply in other situations too.

This has to be completed whilst you still have the 'capacity' to do so. So it's never too early to think about it. And remember, no matter how early you make this, the people you nominate can only make decisions for you if you no longer can.

https://www.gov.uk/power-of-attorney/overview

Advance Care Plan

This is a booklet that you can fill in to let other people know what your wishes are in certain situations e.g. if you got very poorly, whether you would want to go into hospital or be cared for at home.

We have copies of these available in the surgery, or you can download a copy at:

http://www.dorsetccg.nhs.uk/Downloads/aboutus/CCP/Cancer%20and%20end%20of%20life/201309_Dorset_Advance_Care_Planning_Guide.pdf

Advance decision to refuse treatment

It is possible to make an advance decision to refuse a specific treatment, in specific circumstances e.g. if you had a stroke and were unable to eat/drink – you could refuse to have a feeding tube fitted.

http://www.ageuk.org.uk/money-matters/legal-issues/living-wills/advance-decision/

'Allow a Natural Death'

If you have a clear view that you would not want resuscitation to be attempted, then you can discuss this with your GP, who can complete the relevant form.
Please remember that making a decision to allow a natural death does NOT mean that your regular medical treatment will stop. Your healthcare team will continue to ensure that you get the highest level of care regardless of this decision.

Appendix 4 - Frailty Leaflets

To download this leaflet please visit:
www.dorsetccg.nhs.uk/frailty

Acknowledgments

We would like to extend our thanks to Health Education Wessex for funding the project and providing support throughout and to Dorset HealthCare University Foundation Trust, Dorset Clinical Commissioning Group & Two Harbours Healthcare for working together and allowing this to be a truly integrated project. Particular thanks are given to all members of the Weymouth & Portland frailty project team for their hard work and contribution.

National Sources Of Help

My Life My Care

'visit Age UK for help, information and advice'.

They are able to provide advice, enable independence e.g. exercise classes, and combat loneliness e.g. befriending services

0800 678 1174
www.ageuk.org.uk

Citizens Advice Bureau

'Information, advice and support to help you find a way forward whatever the problem' Includes benefits, income maximization, debt, housing, employment. Health & care, family & relationships, legal, immigration, consumer, education, tax.

0344 2541219 (any queries)

0845 4900042 (Macmillan support – living with cancer)

01929 775500 (energy advice)

www.citizensadvice.org.uk

NHS

SELF HELP AND EARLY HELP RESOURCES

Help To Keep Your Independence

There are many different options available to help maintain your independence and allow you to live in your own home for as long as possible. However it is sometimes difficult to know what options are available, whether there is a cost, if help with costs is available and where to go for advice.

This leaflet includes a list of local and national options available to help you to work out what you need. Some of this information you can find yourself online, some services can be contacted by telephone or email to access advice that way or to arrange face to face meetings. All of these services are free to contact and access, although some of the services they may be able to guide you to may have a cost.

Local Sources Of Help

Dorset Popp Wayfinders

'Wayfinders are individuals who live and work locally who are able to meet you and provide information and signposting to support and services for adults in their local community'

'They work primarily with any adults who have an identified need or a concern that is reducing their ability to maintain their independence or quality of life whilst living in their own homes for as long as they wish to'

01305 548111
www.helpandcare.org.uk

My Life My Care

'if you find it difficult to live safely and independently in your own home, you can find help here. Our solutions offer information and advice to help you make informed choices about living the life you want'

01305 221016
www.mylifemycare.com

My Health My Way

'access free support with your health... helping you cope and feel more confident living with a health condition'

0303 303 1053
info@myhealthdorset.org.uk
www.myhealthdorset.org.uk

SAIL - Safe And Independent Living

'SAIL offers Dorset residents a wide range of free support, services or information to help keep people safe and independent in their own homes'

Health professional to complete
0800 0382323
'Safe and Well' advice line

Complete online
www.mylifemycare.com/Safe-and-independent-living

Appendix 5 – Frailty Poster

DEVELOPING FRAILTY SERVICES IN DORSET

NHS

INTRODUCTION

In October 2016 Weymouth & Portland received funding from Health Education Wessex to focus on developing services for frailty.

The aim was to support the goals of Integrated Primary and Community Services ensuring a joined-up approach, reducing duplication and enhancing patient care.

ABOUT FRAILTY

- Frailty is a spectrum condition that spans from mild to severe.
- For people living with frailty the state for an individual is not static; it can be made better and worse.
- Frailty is not an inevitable part of ageing; it is seen as a long term condition in the same way as diabetes or Alzheimer's disease

TOOL KIT INCLUDES

- Recommended structure for MDTs
- Terms of Reference
- MDT discussion tool example
- Instruction on how to risk profile using the Efi, Admissions and hub data
- Detailed instructions on completing a Dorset Care Plan
- Introduction to CGA
- Recommended outcome measures
- Information on the E-Learning frailty Module
- Patient leaflets – Planning future care, self & early help resources and Prisma 7 questionnaire/mild frailty

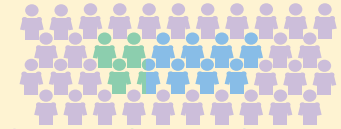
OBJECTIVES

- To agree a standardized approach to the identification and stratification of frailty across health and social care services within the Weymouth and Portland Locality
- For patients identified as frail - to develop a frailty framework, underpinned by a standardized assessment approach
- To develop a training and education package to enable the above to be consistently delivered, reviewed and monitored across Dorset.

LOCAL CONTEXT

In Dorset about 17,000 people would fall within this definition. Of Dorset's estimated population of 765,700 some 173,000 are aged 65 and over. Of these around 6,200 are 85 or over; a figure which is said to rise to 9,300 in the next 25 years.

The pilot for this project focused on Weymouth and Portland and developed an integrated model with excellent GP and Community services engagement. A toolkit was designed to enable the model to be rolled out to other localities



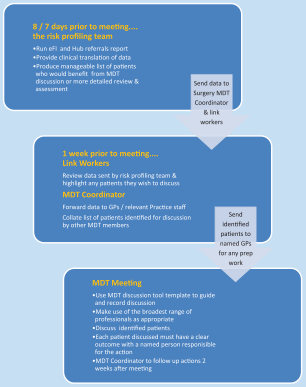
The Dorset Care Plan (DCP)

The Dorset Care Plan was developed in Weymouth & Portland in primary care to encompass the patient's priorities for care, admission avoidance including treatment escalation and advanced care planning.

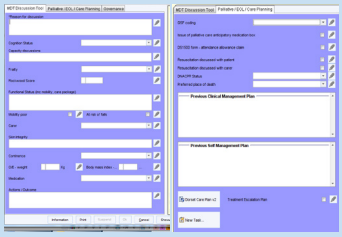
The DCP links with the enhanced summary care record providing OOH/ Paramedics with this valuable information. As part of the frailty project Dorset HealthCare have developed an equivalent version enabling Community and Primary care to input into a shared document ensuring the patients records are up to date and accurate and completed by the most appropriate clinician at the time.

MULTI-DISCIPLINARY MEETINGS IN GP PRACTICES

The Toolkit provides a step by step guidance on how to get the best value out of a GP MDT.

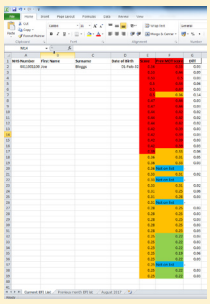


Risk profiling of frail patients using the Electronic Frailty Index and admission data is analysed prior to MDTs to ensure the patients who are in most need are discussed. The MDT discussion tool is used in the meeting to help guide the discussion and formulate a clear action plan.



To monitor the engagement and uptake of the model the following process measures have been implemented:-

- COMPLETED DORSET CARE PLAN
- COMPLETED CGA
- PATIENTS IDENTIFIED AS MILD/ MODERATE AND SEVERELY FRAIL
- COMPLETED ROCKWOOD SCORE



THE ROLL OUT

The model and toolkit has been adopted by Dorset HealthCare and the Dorset Clinical Commissioning Group. It is being rolled out as the gold standard of frailty work to be implemented in all localities over the next year

What next?

We plan to create a shared Comprehensive Geriatric Assessment (CGA) template between primary and community services to reflect and enable the following:-

- The gold standard for the management for frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA)
- Holistic, multidimensional, interdisciplinery assesment of a individual by a number of specialists of many disciplines in older peoples health

The CGA has been demonstrated to be associated with improved outcomes in a variety of settings (BGS June 2014)

The following Outcome Measures will be used to measure the impact of this project:-

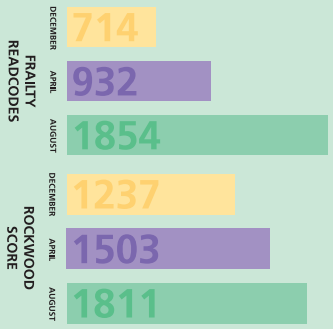
- Number of unplanned admissions
- Length of stay
- Preferred place of care
- GP / OOH contact

RESULTS

Use of Dorset Care Plan has remained consistent but there has been a marked improvement in the detail recorded and the template is now also available to community health services.

Use of both the Rockwood score and the frailty readcodes has continued to rise throughout the project. Note that significant increase in use of frailty readcodes between April and August will have in part been due to the GP contract requirements of July 2017.

No results recorded on the use of CGA as this is still in development.



Education

Whilst the rollout of the Dorset Frailty Toolkit provides the bulk of the projects education, other developments have been made. Dorset HealthCare had a pre-existing frailty e-learning module that has now, through the work of the frailty project, been made available to the Dorset CCG providing a basic level of information to increase the knowledge of all staff members who come into contact with patients who are potentially increasing in frailty. A series of leaflets on living with frailty, assessing for frailty & advance care planning and early self-help were also developed during the project.

REFERENCES

British Geriatrics Society. Fit for frailty - consensus best practice guidance for the care of older people living in community and outpatient settings. www.bgs.org.uk/press-3/resources/campaigns/fit-for-frailty/fff-guidance-download

Oxford academic. Development and validation of an electronic frailty index using routine primary care electronic health record data. https://academic.oup.com/ageing/article/45/3/353/1739750/Development-andvalidation-of-an-electronic

NHS Employers, Technical requirements for 2017/18 GMS contract changes. www.nhsemployers.org/gms201718

NHS England. Five year forward view. www.england.nhs.uk/five-year-forward-view

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