NHS

How Dartford Gravesham and Swanley Implemented System Change

How do we improve health and social care across the frail population as a whole rather than just focusing our efforts within individual organisations?

That is the challenge now facing the NHS and partner organisations and it is what the System Wide Frailty Network was set up to address. Building on the work of its predecessor, the Acute Frailty Network, its aim is to support partner organisations to work in a more joined-up way to improve the care of patients with frailty across the entire system. Clearly, it is impossible to change the system all at once so the Network supports organisations to prioritise and agree an improvement project to test their approach and embed frailty best practice so it can be refined and then scaled up across the system.

The first cohort of the System Wide Frailty Network, in October 2022, brought together seven integrated care boards from across England and Wales. They received a range of specialist support from Network facilitators including: how to building relationships across different organisations; developing clarity about the nature of the service they provide and the model of care; establishing measurement criteria to assess the impact of improvement work; and agreeing the steps that needed to be taken to improve the service.

Dartford Gravesham and Swanley Health and Care Partnership were part of that cohort. This is its story…

Dartford Gravesham and Swanley is one of four health and care partnerships within NHS Kent and Medway's Integrated Care Board. It has a growing older population and rising numbers of frail patients. A significant proportion of these patients have unplanned hospital admissions. The health care partnership is keen to make sure as many of them as possible can avoid coming into the emergency department unless necessary, as it is not an ideal environment for people with frailty. Dartford Gravesham and Swanley has a mixed demographic that includes some of the most deprived neighbourhoods in the UK.

Unlocking system change

The health and care partnership has named frailty as one of its top priorities. However, although many discussions had taken place about improving the care of frail patient across the whole system, changes on the ground were slow to take off. In early 2022, Tina Cook, Programme Manager for Local Care in the health and care partnership, was working alongside the GP lead for frailty, Dr.Adekemi Osadiya, to drive the agenda forward. They were finding the lack of traction frustrating and couldn't understand what was causing it or how to change it. Tina saw an

advert for the System Wide Frailty Network and thought it might be the key to unlocking system change. She said:

"I felt engagement with the national Network might help to give frailty a higher profile in our system and help us gain the traction we were struggling to achieve."

A personal passion

Improving the care of frail patients was a personal passion for Tina who had previously established a social prescribing project for older people in Dartford Gravesham and Swanley, working with the voluntary sector and local authority, and whose own parents were frail. She explained:

"I could see how hard it was for my mother and father to get the help they needed. Even with me as their advocate, it wasn't easy. I thought about frail patients who don't have family or who are less well-informed about the health and social care system. I want to support people like them and their carers. My father sadly died just before the NHS Elect programme and my mother died during it, so this subject really is very close to my heart."

Programme aim

Dartford Gravesham and Swanley joined the System Wide Frailty Network with the aim of developing a whole system approach that would deliver practical results. Tina said:

"We had a lot of different services working with frail patients, but they weren't properly joined up. Although we were talking as a system about greater integration, it was proving hard to achieve. When we started working with the System Wide Frailty Network one of the first quality improvement objectives was to agree what our aim was. This proved to be quite an undertaking, as everyone had different opinions about it. It took time but, finally, we decided our aim was to make sure frail patients should only have necessary unplanned admissions to our main hospital, Darent Valley Hospital in Dartford."

Project team

Dartford Gravesham and Swanley formed a project team led by Tina. It included: Ageing and Health Lead Nurse Beatriz Lopes and Consultant Geriatrician Dr Rupinder Gill from Dartford and Gravesham Hospital Trust; GP Frailty Lead Dr Adekemi Osadiya and then her replacement, Dr Kevin Tan; Ray Savage, Strategic Partnerships Manager, South East Coast Ambulance Service NHS Foundation Trust; James Cotton, HCP Project Manager for Urgent Care; and Alison Scantlebury, Analytics Manager from the Integrated Care Board, along with representatives from the community health provider HCRG, and the GP Federation, DGS Health.

"There was a core group of us who were really committed to the process," said Tina. "We met monthly via Teams. Meeting online meant more of us – clinical colleagues in particular – could participate as people are so busy they don't really have time to come to face-to-face meetings, although we did meet once at the hospital to visit the Frailty Assessment Unit."

Robust process

Agreeing the programme and specific project aim proved challenging from the outset, but support from the Network helped the team to decide where their focus needed to be. It took several months for them to establish their programme and project aim, but the robust process they followed meant that everyone was on board with it once it was agreed. Tina explained:

"Matt Tite, data analyst from the Network, used the Frailty Opportunity Tool to show us how many frail patients were coming into Darent Valley Hospital and having short-stay admissions (three days or less). The SPC charts he created showed there were high numbers of these and we knew that doing something about this would make a difference to frail patients. This was how we reached agreement on our overall programme aim – to make sure all unplanned admissions of frail patients were completely necessary. From this, we were able to set a project aim – to explore opportunities for ambulance teams to convey frail patients directly to the Frailty Assessment Unit, instead of the emergency department."

Driver diagrams

With support from the Network, the team created a driver diagram, outlining the steps they would need to implement to make sure all unplanned admissions of frail patients were strictly necessary. One of these was to improve the urgent care pathway, and they decided this should be the focus.

Make sure all unplanned admissions are necessary

- Improved pathways: clear, consistent, recognisable
- Coordinated person-centred holistic care
- Comprehensive geriatric assessment: suitable to person
- Shift learning and culture to consider best place for person
- Decisions informed by data and experience
- Front door assessment
- Start discharge planning on admission

SYSTEM WIDE

A direct route into the Frailty Assessment Unit

The next step – agreeing the vision for an improved pathway – proved to be a challenge. Tina explained:

"We held a workshop for a wide range of system partners to map the current pathway and agree the next steps. However, it didn't work as well as we hoped. People didn't really understand the whole urgent care pathway and it proved hard to do this work with such a large group, even with the Network facilitating. What came out of the workshop though, was that everyone agreed the current process is far from ideal. This gave us the mandate for developing a new urgent care pathway for frail patients.

"Working alongside frailty colleagues, we mapped out the current pathway and using NHS England Same Day Emergency Care (SDEC) frailty guidelines and drafted a potential new one and shared this with the project team. It was obvious, from looking at our process maps, that frail patients needed a direct route into the Frailty Assessment Unit that avoided the emergency department altogether. This was a turning point for us.

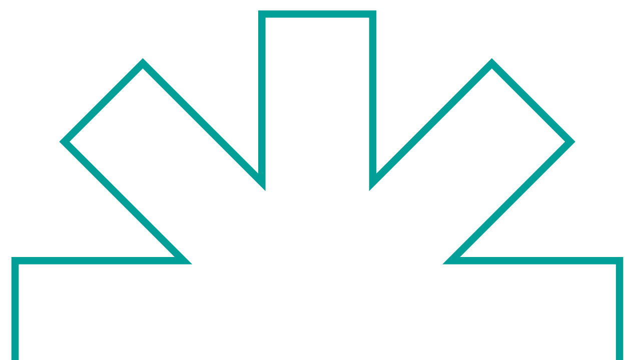
"In hindsight, it would have been better to do the functional mapping exercise sooner and get the conversation moving about how the new pathway could look rather than trying to involve everyone in the development process. The Network also suggested we did a case file review of frail patients in ED. This showed that introducing the concept of a silver phone [see below] and allowing direct conveyances into the Frailty Assessment Unit could make a significant difference."

PDSA cycles

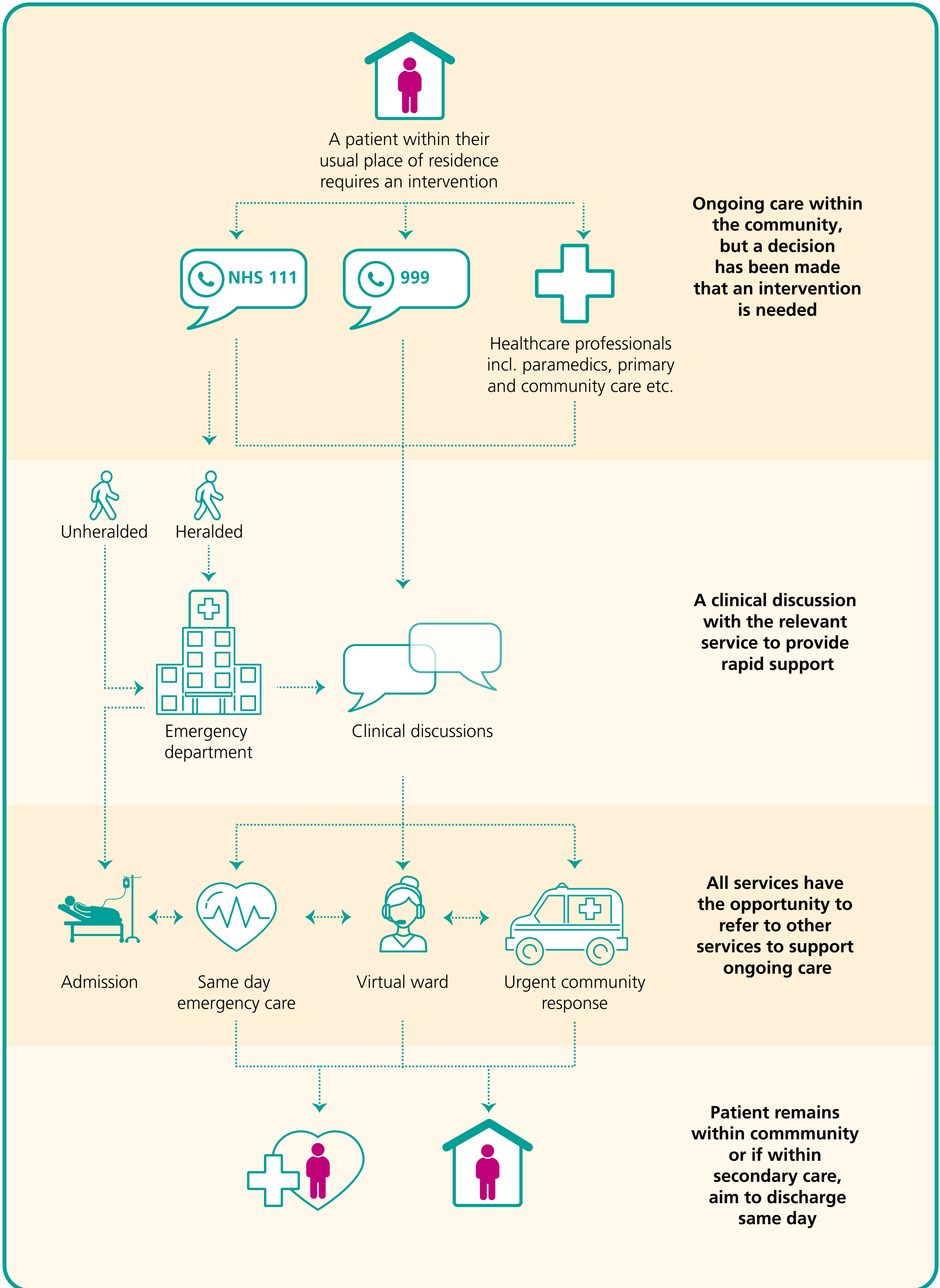
The team began to explore the idea of direct conveyances to the Frailty Assessment Unit via the ambulance service. Tina said:

"I remembered Professor Simon Conroy explaining to us about the 'silver phone' some hospitals use, which allows ambulance and other teams to talk directly to clinicians about frail older patients. The Network introduced us to a geriatrician from the Royal Surrey Community Hospital who'd trialled this idea, with conveyances directly to the frailty service if appropriate. He joined one of our regular team calls. NHS Elect encouraged us to approach this as a PDSA cycle (plan, do, study, act) where you just try something, monitor the results and then adapt the approach if necessary. This inspired our clinicians to trial the idea of ambulance teams being able to convey patients directly to the Frailty Assessment Unit. We held a planning meeting with the Frailty Assessment Unit and ambulance service to check it would be safe to do this and they then implemented the idea for one day. It went well, so the teams made adjustments then trialled it for a week.

"The results were positive, so from the second week of December 2022 onwards, ambulance teams have been able to bring frail older patients directly on to the unit. They can also contact the unit direct and talk to the clinician in charge about the best place to take individual patients, if they need to. In some cases, patients might need to go to the emergency department, where the frailty team will be ready and waiting, but many can come directly on to the unit or some can be treated at home by the community rapid response team."



NHSE SDEC Frailty Strategy Functional Map



The Dartford and Gravesham Ageing and Health Team on the first test of change date – Peter Stone, the Paramedic Practitioner with the red epaulettes, spent the day based at the unit so they could review how it was working together. For the second test of change, Peter came in to the unit for part of the time, so the rest of the week they could test out the process as if it were business as usual. Dr Rupinder Gill, Consultant Geriatrician and Clinical lead , Dept of Ageing and health, Darent Valley Hospital Deputy clinical Director, Dept of Medicine, who has provided outstanding leadership in developing the frailty service at DGS. He is in white. Beatriz Lopez is the lead nurse, third from right, and has shown fantastic commitment to this project – she deserves particular recognition.

Positive impact

The change, which showed positive benefits during the PDSA cycles, means frail patients are not waiting unnecessarily in A&E. They can be seen quickly by a specialist frailty nurse or geriatrician and are less likely to be medicalised. A significant proportion will be able to go home the same day. It is early days, so the numbers are currently quite small, but they are expected to rise in the coming weeks as the process becomes embedded. The change is beneficial for ED colleagues as it helps to relieve pressure in the system and for ambulance crews who can achieve quicker turnaround times. Most of all, it is better for frail patients.

What the data shows

Data showed during December 2022, ED attendances reached unprecedented levels and Frailty Unit activity doubled. 80% of patients seen by the unit went home the same day. Thirteen patients were conveyed directly to the unit by ambulance crews over a three-week period.

Tina said:

"This played a role in supporting patient flow. While these numbers were small, we expect them to increase this year as the pathway is embedded. Positive feedback continues to be received from the ambulance crews and patients conveyed and crews now report they are more aware of frailty."

What the data shows (cont.)

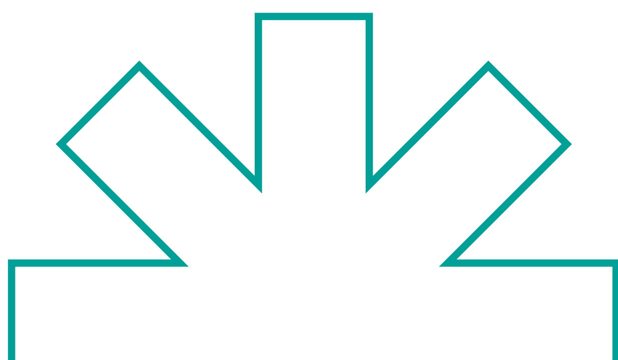
A member of the ambulance service recently wrote to the Frailty Assessment Unit, saying:

"The patient/his family were adamant he was going to A&E, but I explained this was not the place for him. After arriving and instantly being greeted by the receptionist who knew who we were and with the job already printed out, we went straight in and handed over our patient to a doctor. This is a great relief – knowing the support is there for the older patients who sometimes don't need A&E or to be waiting in the corridor for hours with minor or age-related problems. Fantastic service."

Tina said:

"Colleagues from the Frailty Assessment Unit and ambulance service were really proactive in making this happen and the tests of change showed positive results. It was liberating to use a rapid test of change approach like PDSA and the Network also showed us how to audit our last 10 patients to identify the sort of test of change data we might want to capture. This provided a really useful prompt as it will enable us to monitor the impact of our changes."

Recent data shows that half of those seen as a result of direct conveyance were able to go home the same day, and the four/five patients who were admitted were confirmed by the specialist frailty service as clinically appropriate – one was due to lack of appropriate rehab bed capacity. One patient was able to stay home as a result of three way engagement with the community urgent care team. There was a lot of learning about improved processes that have been addressed in preparation for rolling out direct conveyance as part of BAU in February 2023, with plans for the Frailty Team at Dartford Gravesham NHS Trust (DGT) to provide training to the local ambulance crew.



Overcoming challenges

Dartford Gravesham and Swanley has overcome many different challenges during its frailty improvement work and learned many lessons. One of the main ones was how hard it can be to drive change when there are too many stakeholders involved. Although the improvement team was keen to involve partners from different organisations, the process became unwieldy when all of the partner organisations were involved in every step of the process. Instead, they found using visual tools like driver diagrams, SPC charts and process maps with a smaller group helped to focus the conversation and provide a mandate for change. Tools like functional mapping and PDSA cycles proved invaluable in improving pathways and testing out changes quickly.

The team valued being part of the System Wide Frailty Network. Tina said:

"Having external facilitation is really helpful. It gives you the impetus to make progress and provides a structure and focus. The Network introduced us to lots of different quality improvement processes and put us in contact with other organisations who were going through the same challenges as us."

Next steps

The next step for Dartford Gravesham and Swanley is to monitor the impact on frail older patients of direct conveyances by ambulance to the Frailty Assessment Unit. The team used experience based design at the beginning of the programme to identify areas that could be improved and plans to use the tool again to re-assess the patient experience. A frailty study session between the acute team and paramedics is planned to build relationships further, foster shared learning, and increase the numbers of referrals. Tina is supporting a new anticipatory frailty care workstream, which aims to slow deterioration in older people with frailty and help them to stay well for longer. The workstream will include improving dementia diagnoses, falls prevention and end of life planning.

Momentum for system-wide change

Tina believes being part of the System Wide Frailty Network has helped to create real momentum for change across the system and introduced them to many practical ways of driving improvement. She said:

"Our involvement with the Network placed the spotlight on frailty and helped to break through the inertia that you can experience when you're part of a large and complex system. The problems we're facing are complex and the help provided by the Network is multi-factorial in recognition of this. It includes coaching, facilitation, reflection and practical support. It has been helpful to see our frailty challenges through an external lens and with specialist expertise to help us.

"However, none of this would have happened without the fantastic enthusiasm and commitment of the project team, in particular the Ageing and Health Team at Darent Valley Hospital, and SECamb, which was really dynamic and hands-on from the start."

Beatriz Lopes, Ageing and Health Lead Nurse, commented:

"I have been really looking forward to an opportunity like this for a few years to develop the services further, so we grabbed it with all the strength we could. We are indeed very passionate about frailty and want to represent and care for the older population with the respect, comfort and time they deserve. We are committed to continue."

Lessons learned

The main lessons learned by Dartford Gravesham and Swanley.

- Be selective about who you involve. While the whole system has a stake in frailty, you can't involve everyone in every stage of the improvement process. When you have something more concrete to share, people are often more interested and can see the relevance to them.
- Stick to your programme aim and remind people regularly what it is.
- Use visual tools to show people why change is needed and the impact it could have.
- These things take time. Sometimes even agreeing a programme aim can take a long time, so you need to persevere.
- Tests of change allow you to make changes on a small scale and for a limited time to see how they might work if fully implemented.

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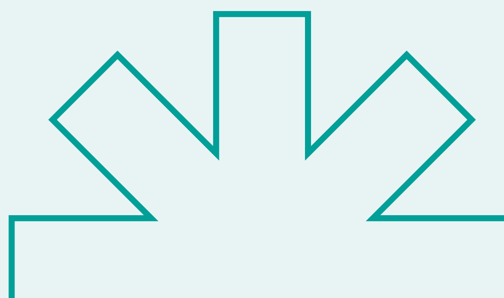

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