Pre-Hospital Frailty Network

Lincolnshire Develops Virtual Frailty Wards to Help Tackle Hospital Patient Flow

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"To provide the right care in the right place for older people living with frailty who have urgent care needs"

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Background

Lincolnshire is a very rural county with significant levels of health deprivation, particularly along its East coast. Life expectancy in some areas is 10 years lower than in other parts of the UK and many patients develop complex comorbidities at a comparatively young age. While national frailty targets tend to focus on the over 65s, in Lincolnshire clinicians can be seeing patients as young as 55 with frailty.

This puts considerable pressure on healthcare services, increasing demand and putting pressure on hospital patient flow. Many parts of its population – particularly frail, older patients - are unfamiliar with using digital technologies which compounds the healthcare challenges.

Lincolnshire hospitals
The United Lincolnshire Hospital Trust has three main sites – two Type One hospitals with major Emergency Departments (EDs) at Lincoln County Hospital and Pilgrim Hospital in Boston, alongside Grantham District Hospital. The North Lincolnshire and Goole NHS Foundation Trust has hospitals in Grimsby, Scunthorpe, and Goole.

Why frailty?
Hospital services in the county are often full, putting pressure on ED and the ambulance service. A key focus for the system is to develop virtual wards across the Lincolnshire Health and Care System. This started with virtual wards for cardiology and COVID-19 respiratory care in early 2022 and has moved on to virtual wards for patients with frailty.

To support this, the Lincolnshire Integrated Care Board (ICB) began working with the Pre-Hospital Frailty Network (PHFN) in December 2021. The Network was set up as a clinically-led quality improvement (QI) collaborative to support clinical teams to improve services for frail patients who access urgent care services. The aim is to work alongside organisations to facilitate care at home for these patients.

Aims
Lincolnshire wanted to make sure that frail older people have a safe and effective alternative to hospital admission. By seeing more patients on virtual wards and by treating them before exacerbation of their health conditions, the ICB hoped to reduce hospital admissions, thereby lessening the pressure on ED and the ambulance service.

Virtual wards were also designed to provide supported discharge so frail older people are able to leave hospital sooner with the relevant support in place. The aim was to embed ‘Home First’ principles across the healthcare system (right care, right place, right time, right service) and to improve capacity in hospitals across Lincolnshire. Improving the experience of frail older people in hospital would result in fewer hospital-acquired infections and less deconditioning.

The virtual frailty ward model
The model for Lincolnshire's virtual frailty wards is to provide step-up and step-down care, with virtual ward teams creating personalised plans and delivering high quality care in the patients' own homes.

Virtual ward patients' step-up from: primary care, Same Day Emergency Care (SDEC), the ambulance service, NHS community teams, care homes, social workers or the third sector. Alternatively, they can also step down from: ED or the Urgent Treatment Centre (UTC), the Frailty Assessment Unit (FAU), therapies, SDEC or from seeing the consultant geriatrician or nurse.

Ian Mills, ICB System Commissioner and Facilitator, and Urgent Care Delivery Manager for Lincolnshire CCG led the improvement project. He explained:

"It can be challenging to move frail patients through the hospital system as there is no linear pathway. With the virtual frailty wards, we are aiming to bring different systems and services together to create a clearer pathway for patients with frailty. Although we are operating both a step-up and a step-down model, we believe the majority of our patients will be step-down. So far, the statistics bear this out, with 74% of patients seen on the frailty virtual wards stepping-down from acute."

What Lincolnshire did

1. Established a PDSA group

Ian Mills headed up the cross-organisational project team, which included representatives from the acute providers, community care providers, ambulance trust, county council and mental health trust. The aim was to work collaboratively on PDSA (plan do study act) cycles to test out proposed improvements. Ian said:

"Historically we have worked in silos. Collaboration was crucial to bring about cross-organisational change, but the culture of organisational sovereignty proved a challenge. I tried to make sure we had the right people in the group and to foster a sense of trust, openness and effective communication. This meant encouraging a 'system mindset' and intervening if people didn't listen or talked over each other. It has been a constant challenge to keep the right balance as people tend to fall back into familiar patterns and ways of thinking and behaving.

Support from the Network helped and so did the Leadership Programme I was participating in. I adopted a mentor role, avoiding chastising people if they disengaged and encouraging those who were actively engaged. The aim has been to move away from 'widget-based management' (how many beds/patients do we have) and instead focus on how well we are managing individual patients and whether staff feel able to deliver the best possible care."

2. Empowered clinicians to lead the improvement work

As project lead, Ian was clear that any improvement work needed to be led not by him but by the clinicians on the project team. He said:

"My role was to facilitate the conversations and remove red tape, but it was down to the clinicians to decide how we could do things differently. We also asked patients to share their experiences – good and bad. We need to learn what is working well and what could be better."

3. Developed a frailty virtual ward

Lincolnshire's first virtual frailty ward was launched in January 2022. Patients are monitored seven days a week using remote monitoring equipment. They have virtual video consultations with clinicians on the ward and receive a daily telephone call. Each day, the virtual ward multidisciplinary team (MDT) – which has clinical frailty expertise - holds a meeting to agree a treatment plan for its patients.

Patients on the frailty virtual ward undergo a comprehensive geriatric assessment (CGA) and assessment of their mobility and functional status. They receive a personalised care plan and any medication they are taking is reviewed and may be de-prescribed, if necessary. Patients can call the urgent care line 24/7. There is rapid access to diagnostics and medical treatments, either at home or through the frailty SDEC, and both the patient and their GP receives a discharge summary. There are plans to offer OPAT (outpatient parenteral antimicrobial therapy) and IV (intravenous) therapies in the future.

Currently, community-based teams refer the majority of patients to the virtual ward but the vision is for the service to be open access, with GPs, patients or family members able to refer themselves. They are not there yet as the full staff team needs to be in place and feel confident that they can cope and not become overwhelmed by an increase in demand.

4. The virtual frailty ward pathway

When a patient is referred to the virtual frailty ward, they are triaged by the Community Care Practitioner (CCP) on duty. If the patient is deemed an appropriate referral, the CCP will visit them or arrange for another practitioner to visit them at home or in the hospital. MDT meetings are held every day at 12.30pm and each patient is discussed and an individualised care plan is developed.

5. Developed a measurement dashboard

An electronic dashboard was created, allowing system users to see a variety of analysis including information on capacity, demand and flow. Mapping technology was also used to incorporate the geography component to the analysis. The tool allows the user to set data parameters for analysis, for example selecting a certain time frame, allowing the tool to be used in the future to understand if any changes/improvement have happened.

6. Funding for staff development

A business case has recently been approved that will enable Lincolnshire to employ more staff for the virtual frailty wards and provide training for existing staff so they can provide county-wide coverage by the end of 2022. Across the system, Lincolnshire aspires to create a system with good career pathways and multiple training opportunities.

Benefits of working with the PHFN

Project lead, Ian Mills, has found working with the PHFN beneficial in a number of ways. He said:

“It was helpful to be able to access their expertise and for the team to know that it wasn’t just me driving things. The team felt empowered by having the Network on board and it gave what we were doing greater credibility as the evidence is there to show that these processes work. The Network also gave the project momentum, helping to keep things on track.”

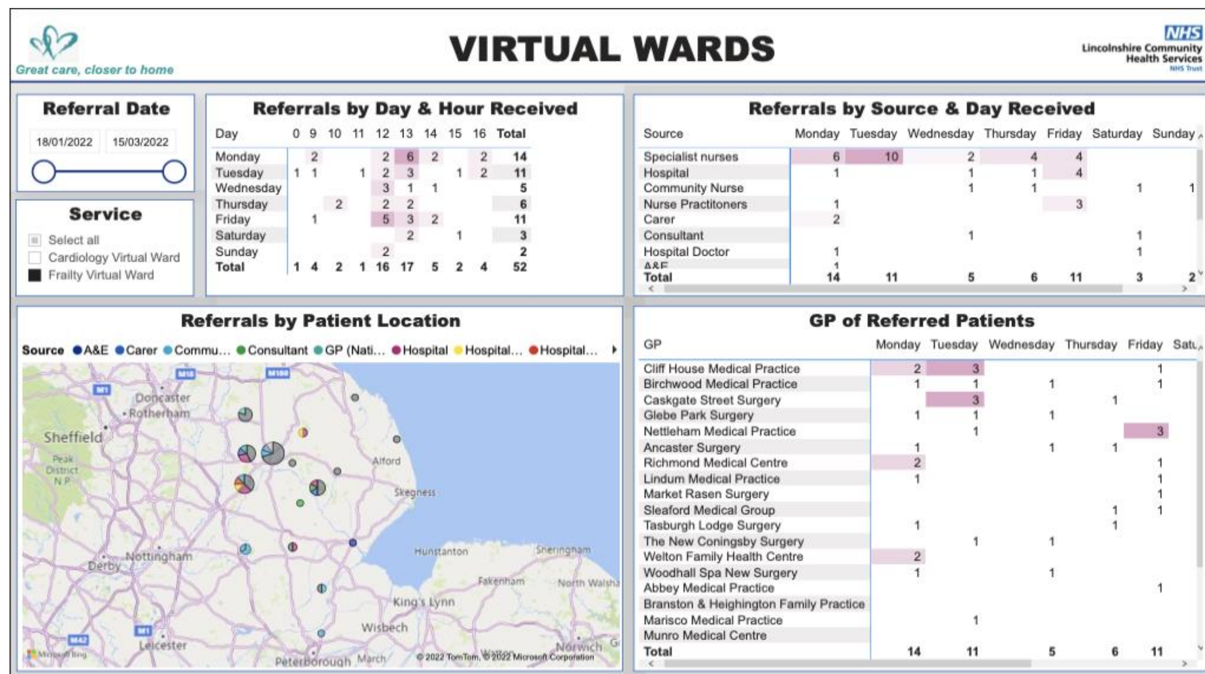

Figure 1 - Dashboard showing referrals by location, source and time.

Challenges

This is an ambitious system-wide project and Lincolnshire have faced a number of different challenges including:

1. Capacity

With OPEL (operational pressures escalation levels) often reaching Level 4, there is a compelling reason to act. However, there is very little capacity within the system to deliver transformational change and the clinicians who need to be involved in these changes have limited availability. This was one of the reasons why Lincolnshire ICB was keen to work with the PHFN. Ian said:

“It is important to have a critical friend who can help you to reflect on what you’re doing, who can offer helpful insights and connect you to others facing similar challenges. The opportunity to discuss some of the key issues within the Network has enabled our clinical teams to look at things through a different lens. It has given them the space to reflect on what they do now and how they might be able to change. This has made such a difference as often they are so overwhelmed with operational pressures that they can’t see how things can be done differently.

Working with the Network has helped us to articulate our vision and to see how others have done it. We’ve had practical conversations and they’ve provided insights to help us to overcome some of our challenges. One of the concerns was that patients going onto the virtual ward might not understand what it is all about and think that they are not receiving care, which could lead to complaints. The Network shared ways that we might be able to mitigate against this, which was very helpful.”

2. Blame culture

Communication between different organisations has sometimes been difficult and the PDSA process has exposed a significant blame culture between different organisations and clinicians. Ian explained:

“This is deeply embedded within the culture of the NHS as a whole. There is a sense that to prove your worth as a clinician you can’t be wrong; and if you show weakness, you’re not a good clinician. It is hard to break this down, but we have encouraged give and take. In the virtual ward setting, the aim is to have as many different lenses as possible on the patient’s needs and outcomes, to recognise the different elements of the patient journey and to value each one of these. This is the foundation for a more compassionate system. We bring people together and share different perspectives. There is no ‘recovery’ from frailty, but we may be able to slow the patient’s deterioration and, so, improve their quality of life. It is about meeting their emotional needs as much as their physical ones.”

3. Loss of momentum

Ian believes that an improvement project like this risks losing momentum if clinical staff have to wait for a business case to be approved before being able to make the changes they want to make. He said:

"You need to empower clinical teams so that when they are ready to make the necessary changes they can do so. We have just had business case approval which means we can push forward with the county-wide roll-out of virtual frailty wards. Along the way, however, we have lost some momentum and we are not as far forwards as we would have liked to be. We now have £1m of system development funding from the national pot of money allocated to support the development of virtual wards. Our next step is to create a sustainable model that will deliver the service going forward."

4. Resistance to change

In any kind of system-wide transformational work, there can be resistance to change. Different organisations don't understand what the changes might mean for them and this can lead to challenge and conflict. Ian sees his role as being to maximise each provider's motivation for wanting to change. He said:

"The challenge is how to engage those people who are too busy or too worn down to want to change. We want everyone's voices to be heard, not just those who are able to articulate their objectives and vision clearly. It is a challenge to deliver a consistently high-quality service across the county and not just in one locality. My belief is it's not about doing it quickly but about doing it fairly. You can focus too much on getting it working really well in one location and inadvertently neglect other areas. We are trying to look at it on a county-wide basis, utilising data well and integrating services into a single point of access."

Next steps

Ian said:

"When we have a business-as-usual service operating, with a core team in place, and where the virtual frailty ward is part of everyone's day job, then we will move into phase two. This will be a rigorous process of engagement and consultation on the service changes so that we can shape the model to make it even better. The patient is at the heart of this process. It is not about doing things to them, it is about asking what would work for them. The virtual ward could be one of the solutions but there might be other things, too."

The team is planning to set up a patient expert reference group so that patients can share their lived experience of the service and help to shape future development. They will consult the group on proposed digital solutions to ask for their feedback and suggestions.

Despite the many challenges, Lincolnshire has made good progress in developing system-wide service improvements for patients with frailty. In time, it hopes to expand its virtual frailty ward model and refine the service in response to feedback from patients and staff. Its achievements are particularly impressive against a backdrop of overstretched services and staff from different organisations who are unaccustomed to working collaboratively in this way.

Key Contacts

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For further information about the Pre-Hospital Frailty Network or how we can support frailty improvements in your local system, please get in touch at:

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