NHS
Specialised Clinical
Frailty Network

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Leeds empowers frail patients on its colorectal cancer pathway

Introduction

Leeds Teaching Hospitals NHS Trust is one of the largest centres for colorectal surgery in Europe. It is a tertiary referral centre and centre of excellence for the treatment of advanced and recurrent colorectal cancers. Previous analysis suggested that around 30% of its colorectal patients were aged over 75 years but the pathway made no specific provision for identifying, assessing or optimising frail patients. In January 2020, the Trust joined the Specialised Clinical Frailty Network (SCFN) with the aim of identifying frail colorectal patients early on. It wanted to develop a Care of the Elderly clinic that would support shared decision-making and promote optimisation prior to surgery. This is their story…

The rates of colorectal cancers are higher amongst the over 65s and, as people are living into their 80s and 90s, surgery is becoming increasingly common among frail older people. However, it may not always be the best option as surgery may lead to a risk of deconditioning or poor outcomes and, in some cases, the drawbacks may outweigh the benefits.

Rising demand

Leeds has seen a significant rise in demand for care from frail patients on the colorectal cancer pathway in recent years. In 2018-19, the team cared for 253 patients over the age of 75 years. However, in the first five months of 2020 alone - during the period of this frailty improvement project - 217 patients over the age of 75 years received care from its colorectal cancer services.

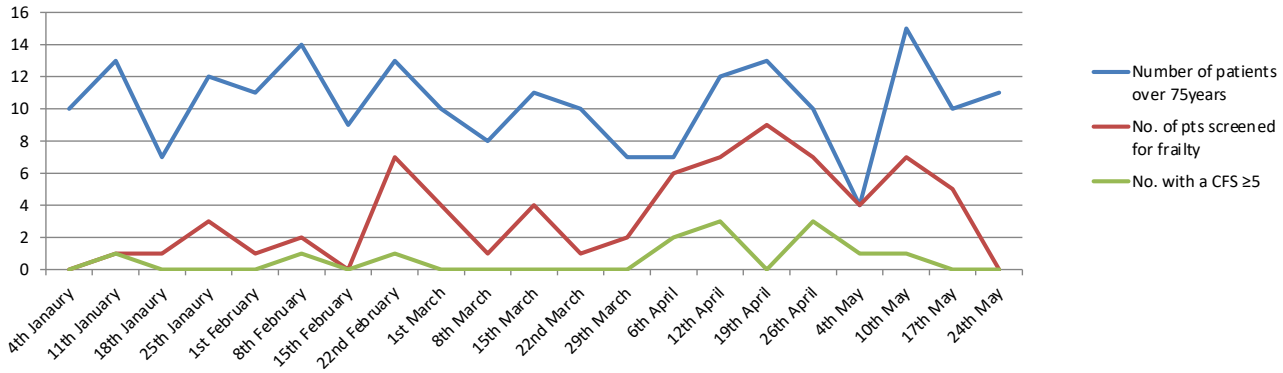
Baseline

Just 22% of patients from January to December 2018 had a clinical frailty score and for the vast majority, scoring was completed post-operatively, which meant that it was not used to inform treatment decisions or to support optimisation prior to surgery.

Frailty improvement team

Leeds joined the SCFN in October 2020 in the midst of the coronavirus pandemic, which created huge challenges from the outset. Despite this, the improvement team was determined to push ahead with the work. It was led by Dermot Burke, Consultant Colorectal Surgeon and Sophie Blow, Clinical Operational Lead for Perioperative Optimisation. Also part of the team were: Sherena Nair, Consultant Perioperative Medicine and Research Lead, Julie Hemingway, Clinical Nurse Specialist Lead Nurse, and Liz Gombocz, Business Manager Abdominal Medicine. The Executive Sponsor was Chief Medical Officer and Deputy Chief Executive, Phil Wood.

The story so far

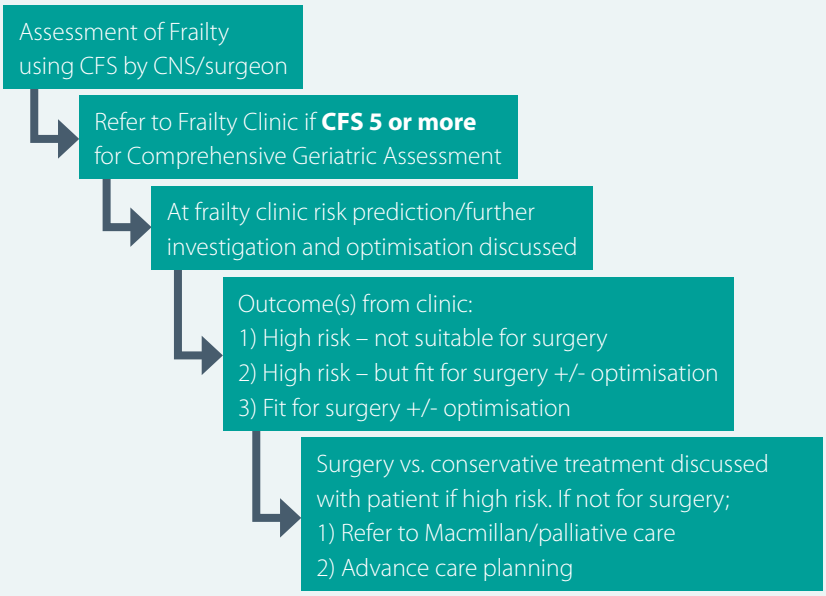


Aims and objectives

The aim was to ensure that patients who are frail or have signs of frailty are identified earlier on the colorectal cancer pathway so conversations can take place that support shared decision-making and optimisation in the event of surgery.

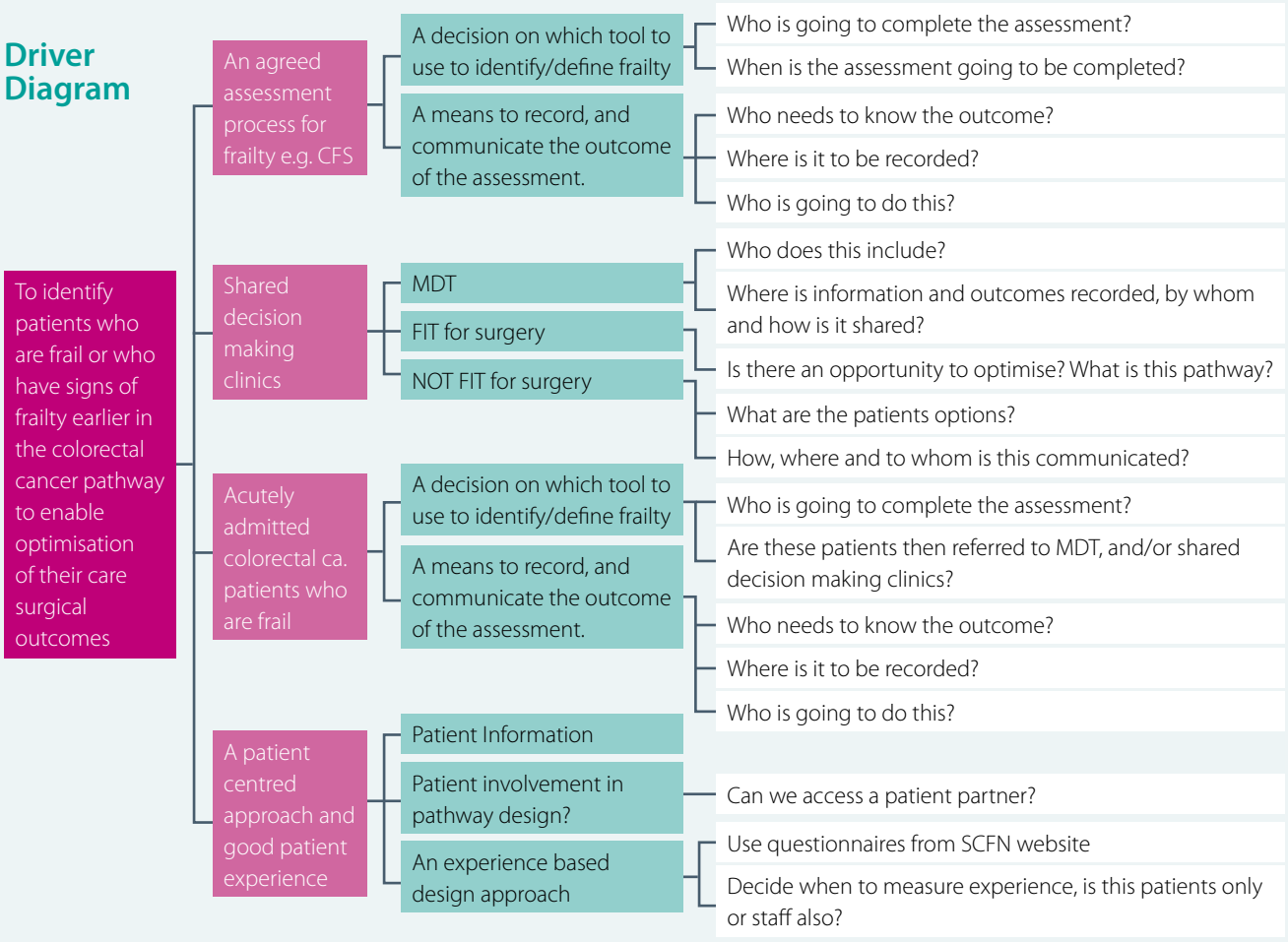
The team mapped out the referral pathway taken by frail patients undergoing care for colorectal cancer.

Colorectal Surgery: referral pathway for patients with frailty



Next, it created a driver diagram setting out what it intended to do. In the first instance, it wanted a mechanism for identifying and determining the extent of a patient's frailty. Multidisciplinary shared decision-making clinics would be created to help determine which patients were and were not fit for surgery and, if surgery was going ahead, these clinics would support the patient to optimise them before surgery, ensuring the best possible outcomes. Overall, the team was keen to adopt a patient-centred approach and deliver a good patient experience.

Driver Diagram

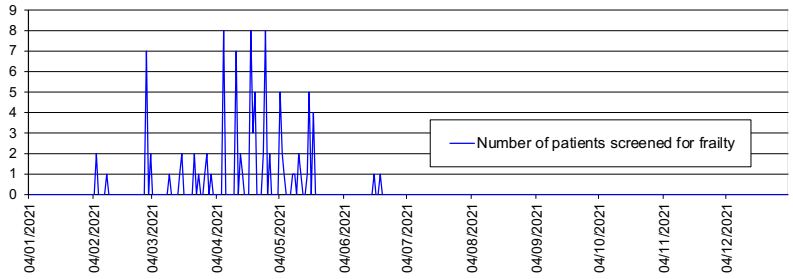


What they did

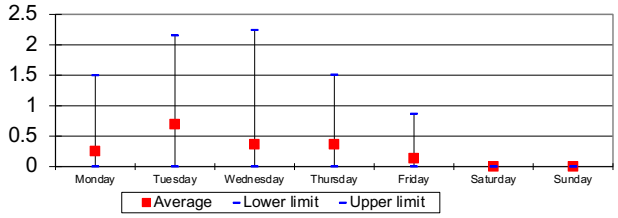
1. Baseline measures

They analysed the data to obtain baseline measures for patients on the pathway for colorectal cancer. These included the number of patients screened for frailty, and what happens to patients who are identified as frail.

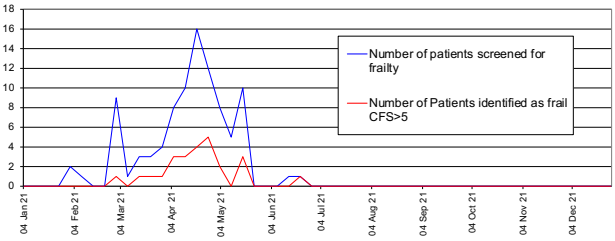
Number of patients screened for frailty between 4 January-30th June 2021 Leeds Teaching Hospitals NHS Trust



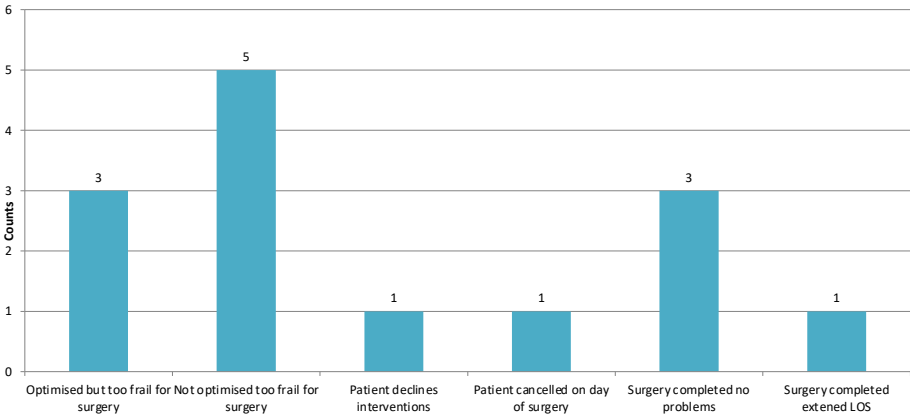
Number of patients screened for frailty – day of week summary Leeds Teaching Hospitals NHS Trust



Number of patients screened and the number of patients identified as frail between 4 January - 30th June 2021 Leeds Teaching Hospitals NHS Trust



What happens when patients are identified as frail?



2. Clinical frailty scoring

Leeds Teaching Hospital introduced clinical frailty scoring for patients on its colorectal cancer pathway. At first, this was challenging as nurses saw it as an additional task to add to their already heavy workload. Sophie said "It was a real benefit to have Julie, our Clinical Nurse Specialist Lead, as part of the team. She was able to meet with her nursing colleagues and explain why we were doing this and the difference it would make to patients. Once the nurses could see where this was going and that clinical frailty scoring meant they could refer patients to the Care of the Elderly Team for advice and support, they had a good feeling about it and really got on board. It's important to have a mix of specialties as part of your improvement team so you can get everyone engaged."

3. Shared decision making

Any patient with a clinical frailty score of five or above is invited into the frailty clinic to meet with a Care of the Elderly doctor who carries out a holistic review of their health, frailty status and other health conditions. Dermot said "This is a comprehensive geriatric assessment (CGA) that takes into account all of their bodily systems not just the colorectal condition for which they have been referred. The Care of the Elderly team looks at anything that might impact the patient's response to surgery, such as whether they are asthmatic or have atrial fibrillation. They talk to the patient and their relatives about their individual risks and what these mean to them. For example, a frail patient might have an increased risk of developing delirium or of being unable to live independently after surgery. They have frank discussions about what to expect and what the risks and likely benefits of surgery might be. If a patient has cognitive impairment they involve their family or advocates in these conversations.

It is all about what is important to the individual and what might change in their life if they go ahead with surgery. Sometimes patients choose not to have surgery following these discussions as they decide it may adversely affect their quality of life. In these cases, the multidisciplinary team (MDT) works closely with them to ensure they have the support they need to remain comfortable and living well for as long as possible."

4. Patient optimisation

If a patient does decide to go ahead with surgery, the MDT looks at ways to optimise them beforehand. For example, they may be anaemic and require an iron infusion or they may benefit from nutritional support to help them to build up fat and muscle mass to protect them during and after surgery. The team will also review any drugs that they are on to ensure they are taking the optimum combination and dosage.

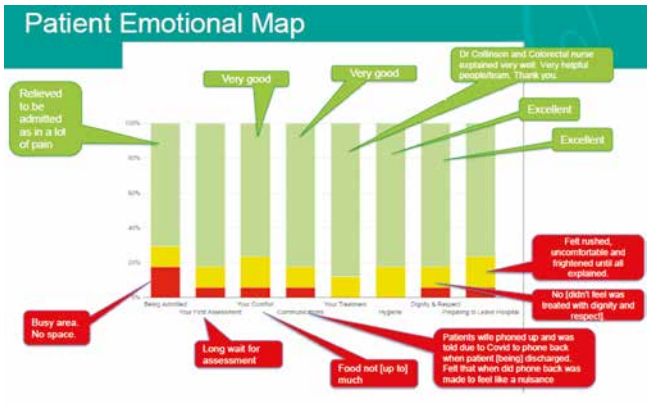
Dermot said "We need to act quickly on the cancer pathway so we may not have very long to optimise the patient, but the team does what it can in the time we have and this makes a difference to patient outcomes. In some cases, we may recommend delaying surgery for a week or two to increase their chances of making a good recovery. We may also put in place post-surgical support if someone is very frail."

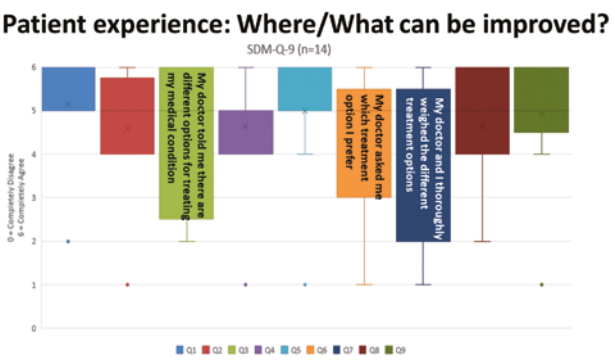
5. Experience based design

The frailty improvement team was keen to hear from patients how it felt to be part of the colorectal cancer pathway and used the Experience Based Design (EBD) questionnaires developed by the SCFN to obtain patient feedback. The nursing team spoke to patients in the outpatient clinic and on the wards, explaining what the questionnaire was all about and why they were using it. In total, 17 patients and their families participated, sharing their feelings and experiences at different touchpoints along the pathway. The team then created a patient experience map, identifying potential areas for improvement.

Sophie said "The feedback was very positive about the staff but there were one or two points where we could do better. Patients noted that it can be stressful when the wards are very busy. Our aim is always to provide the best care for our patients so it is good to know how work pressures impact them and to consider what we can do to improve their experience."

One of the improvements that has emerged from this EBD work is the creation of a leaflet explaining the different elements of the pathway using patient-friendly language. The team is using the Trust's Quality Partners panel, which includes patient representatives, to help it develop the leaflet which it hopes will support even more informed decision-making.





Impact

Prior to the frailty improvement work, only 22% of patients over the age of 75 had a clinical frailty score while on the colorectal cancer pathway and, for the majority, this happened post-operatively. In just five months, the team increased this to 37% and all these clinical frailty scores were completed prior to admission and as part of the decision-making pathway.

Of the patients who had a completed clinical frailty score on the colorectal cancer pathway, 21% were referred for Care of the Elderly support and optimisation. More than half (62%) of these patients chose not to proceed with surgery, either because their frailty levels meant the risks were too great or because they felt surgery was not the right choice for them as it might adversely impact their quality of life.

As well as improving the care of patients, a greater focus on shared decision making has had operational benefits. There has been a reduction in on-the-day surgical cancellations and an associated fall in lost surgical time. If patients decide not to proceed with surgery, further investigations are cancelled creating increased availability of CT scans for other patients.

Sophie said "At the heart of patient-centred care is empowering patients so they are fully informed and active participants in their own care. If a patient decides not to proceed with surgery, we respect and support their decision and assist them in whatever ways we can to have the best quality of life going forward. It also means that any further investigations can be stopped, preventing unnecessary discomfort and reducing the amount of time spent in or travelling to the hospital."

Chief Medical Officer and Deputy Chief Executive, Dr Phil Woods praised the frailty improvement team, saying "The improvements they have achieved are truly remarkable, and demonstrate the importance of the work in ensuring true patient-centred care and genuine shared decision-making. The programme serves as an outstanding exemplar of how integrated pathways that provide an individualised patient approach can ensure that patients and families can be true partners in their treatment and care choices."

Benefit of being part of Specialised Clinical Frailty Network

Being part of the SCFN enabled the team in Leeds to learn from other sites, including what worked and what didn't work so well. Sophie said "We had a lot of different webinar sessions to choose from and it was encouraging to know that others were facing similar challenges to our own including, of course, dealing with COVID-19. Hearing the experience of other people helped us to identify small wins which were important in keeping the team motivated. It was also useful to have support with using and analysing the data."

Dermot commented "It was difficult to be fully engaged at times, with everything that we were dealing with at the time, but when I was able to participate fully I found it very helpful to listen to different perspectives and see the bigger picture in all of this."

Challenges

The greatest challenge for Leeds Teaching Hospital's frailty improvement work was the unprecedented impact of coronavirus. Dermot said "It was hard to keep going at times, there were so many changes to our working life. We almost gave up, but Sophie was great and encouraged us to keep going. Everyone involved in any kind of improvement work needs a 'Sophie'. We hung on by our fingernails but eventually things got a bit easier and the impact has been worth it."

The team foresees another looming challenge, which is keeping surgeons engaged. Dermot said "Surgeons are very focused on surgery and this is not surgery, it is an entirely different approach to patient care. Our nurses have been great at understanding the importance of taking a holistic approach and why this is so beneficial for patients. With our surgeons (we have 11 in our team), I anticipate we will have to keep having the conversations. It is about winning over hearts and minds and that takes persistence."

Learning

One of the key learning points for Leeds has been the importance of diversity in its improvement team. Having the Clinical Nurse Specialist on the team helped with engaging nurses and they have also recently discussed involving oncology colleagues. Sophie said "To anyone undertaking a similar project I would say make sure you have the right people involved. You need a mix of interested people representing different parts of the clinical team. My advice would be start small – with one team or one surgeon's clinic – and don't be afraid of getting things wrong. It's good to test out your idea and if it's not quite working to adapt it or try something else. Once it's working well you can expand it and involve more people."

Key Contacts

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