

Specialised Clinical Frailty Network
Challenging frailty
– the Newcastle approach



Introduction

The Specialised Clinical Frailty Network (SCFN) is exploring how specialised services can improve the way they deliver care and treatment to people with frailty. Standard specialised care pathways may not always be appropriate to the needs and preferences of more vulnerable patients, where there are greater risks of longer hospital admissions and increased mortality.

The Network's collaborative improvement programme, delivered by NHS Elect, helped NHS trusts to improve the way they identify frailty and make better treatment decisions that would improve patient outcomes. The first wave included renal dialysis, complex cardio surgery and interventional cardiology, and chemotherapy. There were up to five trusts in each specialised area.



This is the experience of one of the chemotherapy sites...

The Newcastle upon Tyne Hospitals NHS Foundation Trust wanted to improve outcomes for lung cancer patients with frailty. It believed that implementing frailty assessments early in the patient pathway would enable it to improve decision-making and address the issues of under and over-treatment.

The Trust wanted to look not just at the first presentation but also at transition points in patients' treatment, such as changes in therapeutic regime and admission to hospital. It wanted to create a formal process whereby frail patients could be identified and frailty criteria could be used to determine which types of treatment would achieve optimum outcomes.

Rationale

Early Frailty Assessment Project Manager David Short explained that, in common with other oncology services, Newcastle currently uses patient performance status as a way of determining the best treatment for patients with cancer. Performance Status (PS) is a score that estimates a patient's ability to perform particular activities of daily living without help. These include basic activities like eating, washing and getting dressed and more challenging activities such as household chores and going to work.

David said "Performance status is a recognised method of classifying patients with cancer, but it is not as specific as the Rockwood Clinical Frailty Scale (CFS) and we wanted to explore whether frailty scoring would provide a more accurate way of measuring patients with frailty. We also wanted to determine the extent to which either performance status assessments or clinical frailty scoring were used in making decisions about a patient's treatment.

Our aim was to assess all suspected and confirmed lung cancer patients for frailty, but in particular patients with a PS score of 2 and above (2 means the person is ambulatory for around half of the time but needs occasional assistance). Our question was, could this help us to formalise decision-making and make better decisions about patient treatment?"

Joining the Network

Newcastle joined the first wave of the SCFN.

David said "Our oncology consultant, Dr Alastair Greystoke has a particular interest in frailty and how we make the most appropriate treatment decisions. He was keen to get involved in the SCFN and the Trust fully supported our decision to participate as part of the first wave.

We know that frail patients are more likely to get side-effects from chemotherapy and that frailty is a common problem in lung cancer. We wanted to see whether a simple tool could help us support patients and families into making the best treatment decisions for them."

Executive Chief Nurse, Maurya Cushlow and Medical Director, Andy Welch were keen advocates of the improvement work and attended the initial site visit with representatives from the Network.

Maurya said "The Trust board are fully committed to this improvement work which fits well with our overall priorities on frailty. We are encouraged by what has been achieved so far and confident this project will have a real benefit to patient and their families".

Andy said "Ultimately, objective and dynamic frailty assessments need to occur at pre-assessment, during treatment and post-treatment, and particularly in specialised areas where the frailty scores can change rapidly. This study marks an innovative first step towards that goal."

What they did

Established a core team

Newcastle established a core frailty project team, with David as Project Manager and Alastair as Consultant Lead. It also included Ann Ward consultant respiratory physician, Christine Rushton lung cancer nurse specialist, Jenny Welford specialist OT/research AHP and Louise Duncan, data manager.

The group met fortnightly, starting in March 2018. In addition, it held monthly meetings for the wider multidisciplinary team (MDT), including representatives from pharmacy, oncology, respiratory, social work and management, university and community services.

Assessed all lung cancer patients

David said “Although the acute frailty team had been in place in the Trust for some time, this was the first time we had explored frailty within a particular specialism. We wanted to assess frailty in all patients with suspected or confirmed lung cancer. Decisions were being made to treat or not treat patients based upon clinical picture and performance status, but without any formal measure of frailty. Clinical frailty scoring would enable us to formalise our decision-making processes.”

They began carrying out assessments within the respiratory clinic. The results were discussed and documented at the lung cancer MDT meeting. The idea is for patients to be reassessed in the oncology clinic and again if they are admitted to hospital. Frailty scoring has been made a mandatory field on the MDT proforma.

Re-assessment at transit points

David explained “A person’s frailty levels can change during the course of their treatment. If someone is put on steroids, for example, it might improve their ability to perform everyday tasks that they couldn’t perform before. We wanted to keep checking whenever there were any changes to the treatment plan to ensure that the treatment was the most appropriate for how they were at that time and, if necessary, to adapt it. So, if someone is considered too frail to undergo treatment, we might refer them to a dietician to build up their strength until they are strong enough to start having treatment.”

Secured staff buy-in

It proved relatively straightforward to get buy-in from staff in the respiratory team for implementing clinical frailty scoring, although it has taken a little longer in oncology. The core team took responsibility for driving the process forward and it helped to have a respiratory consultant and oncologist in the core group who could talk peer-to-peer with the consultants who would carry out the assessments.

Occupational therapy and physiotherapy teams based on busy, acute wards across The Royal Victoria Infirmary and Freeman Hospital have high caseloads and found completion time-consuming. This was due to the fact that several copies were required for medical notes, therapy notes and as an electronic send-off to the frailty mailbox.

To remedy this, a number of strategies were adopted including:

- Securing a place to present at the Trust’s Nursing, Midwifery and Allied Health Professional (NMAHP) conference.
- Discussing the practicalities of scoring the clinical frailty scale within Trust-wide occupational therapy and physiotherapy team meetings.
- Providing training directly to individual teams (medicine, surgery, oncology).
- Gaining buy-in from senior members of the AHP leadership team.
- Sending regular email updates regarding data collection.

David said “We held teaching sessions at our MDT study days and explained the difference between the CFS and the performance status that we were already using. We told staff why we were comparing the two, reassured them that this would not take up significant amounts of their time and explained how it might support treatment decisions.”

Adapted the scoring to suit their needs

The team adapted the CFS to suit their particular circumstances and make it as straightforward as possible to use. They added sections to indicate whether this was a new referral, if the patient was an inpatient or outpatient, whether they were involved with OT, physiotherapy or dietetics and what medications that they were on to ascertain polypharmacy. Additional data was collated wherever possible, including details of hospital admissions, treatments received and enhanced supportive care provided. Screenings were conducted across both the Freeman Hospital, where the cancer centre is located, and the Royal Victoria Infirmary in the city centre.

Developed a patient information leaflet

A leaflet has been developed in order to inform patients and their families of:

- what frailty is;
- what pre-frailty is;
- why these issues are important in cancer care;
- who can assess for this; and
- what the team's hopes are moving forward.

A draft of this leaflet will be distributed to waiting areas following the next group meeting and will be submitted to the patient information panel following feedback from families.

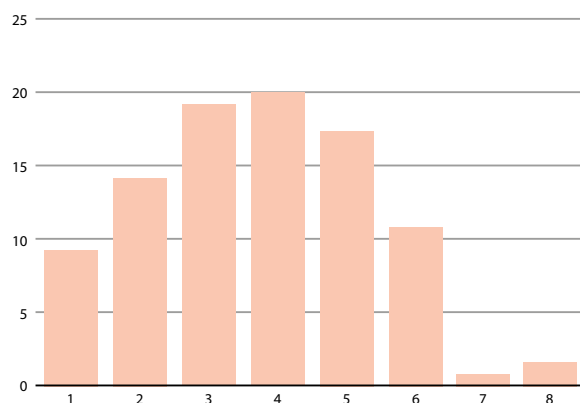
Data analysis

The hospital began building a picture of frailty in lung cancer patients. Between November 2018 and January 2019, 92 patients, ranging in age from 45 to 99, were screened for frailty. The majority (84) were outpatients and most of the screening was done by consultants. The average age of patients was 72.

Most patients had a frailty score of 4 (indicating that they are vulnerable and that their symptoms limit their activities to some degree). Slightly fewer were found to be managing well, while others were rated as mildly or moderately frail.

CFS Scores

Score	1	2	3	4	5	6	7	8
Number of patients	9	14	19	20	17	11	1	2



The team analysed which treatment plan patients were receiving. Unsurprisingly, patients undergoing chemotherapy, immunotherapy and radiotherapy tended to score some of the highest frailty ratings. Patients for whom the approach was 'watch and wait' were also among the most frail.

Treatment plans and associated CFS

Treatment Plan	Best supportive care	Chemo/Rad	Chemo	Immunotherapy	Radiotherapy	Surgery	Monitoring	Watch and Wait	Discharged
Number of patients	2	2	26	4	9	4	9	3	4
Age Range	80 + 90	68 + 73	45-82 mean 67	58, 74, 75, 79	64-90 mean 79	63-86 mean 72	53-86 mean 72	52, 63, 68	54-85 mean 68
CFS Range	6 + 8	1 + 3	2, 3, 4, 5, 6	2, 3, 4	3, 4, 5, 6	1, 2, 3	2-7	3, 4, 5	1, 2, 5

The team also looked at the medications that people were taking (the average number was nine) and compared PS against CFS.

David said "A lot of the data confirmed what we already thought but, in particular, it was interesting to compare the PS and CFS scores. The latter were more detailed and more accurate and gave us a clearer picture of what was actually

going on for the patient. We are still in the relatively early stages with this but the data has provided some helpful insights and we are drilling down further, for example by correlating frailty scores against mortality figures.

Initial data shows that lung cancer patients with a CFS of >6 have a median survival of 26 days, but we need to continue looking at this before we can make conclusions."

Challenges

The team presented its picture of clinical frailty to a meeting of the SCFN in February 2019, at the end of the initial six-month pilot. It was one of a handful of sites chosen to continue for a further six months and its aim was to establish improvement workstreams, focusing on implementing the CFS at first appointment, MDT, protocols and pathways, audit and data, training and the patient prehabilitation programme (which focuses on helping patients to improve their strength and fitness prior to and during treatment to ensure optimum results).

David explained “We had faced a number of challenges since the project began. It was difficult working across two separate sites and with no ring-fenced resources for the improvement work. We also had a period of five months without project management support which is a pivotal role for this kind of project as it cuts across a lot of different disciplines and management structures.

However, during that time we were able to continue and develop the work regarding inpatient assessments which were carried out by AHP colleagues on all cancer patients.”

The other big challenge for Newcastle has been a lack of time and consultant resource, particularly in oncology. David said “Although the assessment itself is not time-consuming to do, using it to support decision-making may be. In the case of lung cancer, decisions have to be made quickly and I believe if we had additional AHP resource to carry out assessments this would help.”

This has been piloted by Jenny Welford the teams OT who has been using the CFS with all patients she comes into contact with on the Sir Bobby Robson Clinical Trials Unit. The scale is used in conjunction with therapy-specific measures and these are re-scored on a regular basis. Most importantly, this work is demonstrating that a real need exists for OT in oncology outpatients. An in-depth functional assessment can shed light on the true capabilities of patients, increasing their quality of life and supporting the MDT when deciding on future treatment. A pilot grant bid has been submitted to a national charity for £25k in order to pilot an OT service for patients with lung cancer and a CFS of >4 .

What's next?

Having established a picture of frailty amongst lung cancer patients, Newcastle hopes to begin using this to inform treatment plans.

David said “We have done a lot of work around identifying patients with frailty and our next focus will be to begin using this data in a formal way to support decision-making. For example, we want to explore whether patients with a high CFS might respond better to treatment if they undergo prehabilitation work first.

A real challenge with this goal is the fact that no standardised model of prehabilitation exists and staffing an MDT programme would be incredible difficult due to a) high costs and b) the fact that our most experienced AHPs in oncology have demanding ward-based caseloads and very few people who could provide cover.”

Experience Based Design (EBD)

The team will also be using the decision regret scale tool to invite patients to share how they feel, in hindsight, about their treatment.

David said “We will be asking them to tell us whether it was the right thing for them and if they have any regrets about it. This will help us to understand more about the experience of patients with frailty. Initially, when we looked at EBD we weren't sure what it would give us anything that we didn't already get from the national cancer survey and lung cancer audit. We didn't want to bombard our patients with questions. But, this feels like a really valuable exercise and we are planning to start soon. Our belief is that if we use CFS in a more formalised way, patients might have fewer regrets about their treatment. We will be repeating this exercise once CFS is routinely being used to support treatment decisions to test out our belief.”

Applying for funding

After recognising how much the work has been held back by a lack of ring-fenced resources, David has put forward a proposal for funding for dedicated time for AHPs. Without this, he believes that progress may continue to be slow.

David said “We are planning to regroup and see where we are at. We want to establish whether CFS is fully embedded in respiratory and oncology services and whether all patients are being reassessed if they get admitted.

We suspect that respiratory and readmission scoring is working well, however it has proved difficult to replicate the systems we have put in place for respiratory services within oncology. This should be helped with the IT improvements taking place within the Trust and we have ensured that the frailty scoring tool is fully electronic. We also want to work more closely with pharmacy colleagues and dedicated funding/resources is essential to move forward.”

Key learning

Despite the challenges it has faced, Newcastle believes the project has been helpful so far. It has identified the following key learning points:

- The role of the core group and project manager are pivotal. Without someone to oversee the project and a team to drive it forward, progress can stall.
- The core team provided the impetus to drive the project forward and are ambassadors for the service. We need now to identify champions within the wider Trust.
- Whilst executive support is essential, without dedicated resource progress can be slow.
- Working across two sites is challenging but not impossible.
- Consultant buy-in is vital and consultants need to be able to see how the CFS will support their decision-making and not slow it down.



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