Making sense of the information collected during CGA: An MDT approach within the rapid access frailty service

"The Isle of Wight NHS Trust has a Community division that developed a Rapid Access Frailty Service during some of the changes to estates and services during Covid-19. The principle was to quickly assess patients in their own home when that person was rapidly deteriorating such that the referrer was worried that escalation of care to a hospital/acute setting might be required. The service was provided from existing resources of the crisis response team with additional advanced clinical practitioners (ACPs), a specialty doctor and some dedicated time per week from one of the hospital Care of the Elderly Physicians. The service was managed by the Consultant Nurse in Frailty.

We noticed that during the MDT discussions via Microsoft Teams, there was a tendency for the output from the CGA to provide a problem list which was worked through, without easily being able to bring it all together in a way that was useful and had meaning for the different professions attending the meeting. For example, if there was a very low serum vitamin D level the doctors would be satisfied with knowing it was going to be replaced, but by putting it into the context of helping with symptoms of weakness and reducing falls as a reason for doing it, it became more relevant for the wider team. As senior clinicians we also realised that sometimes the reasoning behind decisions that included some risk taking were not easy to describe, particularly if the context in which a decision was made changed. We wanted to try and provide a framework that allowed us to include all the relevant information that we had included in decision making such as the levels of frailty or the burden of additional illness that person was living with.

The framework detailed below has four categories to work through after a person had undergone a CGA by any member of the team. Typically, we would meet weekly to talk through the cases, but ad hoc discussions also took place at other times during the week when required – the same approach was used at those times as well. Outputs from these discussions were documents in the patients' notes.

Feedback from the different members of the team state that that it is easy to use and provides a way of keeping on track with the relevant issues; It is very easy to get lost in a list of small actions to do with the blood results and not give consideration to the bigger picture – this tool helped ensure we were consistently considering all the domains. It has made sure the conversations remained relevant to us all and encouraged the use of non-jargon language which was then useful when taking discussions back to patients and families."

Dr Sarah Gladdish, Consultant Physician, Isle of Wight Trust

If you would like to trial the approach within your team/organisation and feedback, please contact: sarah.gladdish@nhs.net for further details

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Pillars	What were we trying to achieve and how did we approach it?
Reducing Uncertainty (now)	**Aim: The immediate requirement was to get enough information to be as confident enough as we can that we have identified the potential reasons for a person's rapid change in function; the aim being to reduce the clinical uncertainty about what was going on so that the person could more confidently be managed outside of an acute setting.** The team would discuss whether we felt we had obtained enough information from the patient, family other sources to be clear about the problem and possible causes. We would confirm that a proportionate approach to investigation had been taken, explicitly including the need to be clear what we were expecting to find/exclude with the test and whether that was going to actually change the treatment options open to the patient. This would include discussions about the person's wishes, capacity to consent (and who was the decision maker in that situation) and the anticipated 'burden' of investigation on the patient balanced against the result being likely to change management options.
Assessment of Reversibility (this week)	**Aim: To quickly and effectively work through the information, in the context of the individuals situation and previously expressed wishes, to identify those problems that we could reasonably expect to manage and improve in order to reduce risk of unplanned admission where appropriate.** The team would discuss the results of history, examination and proportionate investigation to identify what interventions we could put in place at that time and whether there were additional (less urgent) considerations that could be communicated to the GP practice for review if needed and consideration of onward referral as necessary. We would discuss how likely/how quickly the interventions might make a difference and how much it would impact on the referral symptoms/problems. The focus for the team was concentrating on the interventions that were most pertinent to the referral issue that was putting the person at risk of further deterioration and admission.
Assessment of Recoverability (next week)	**Aim: to ensure the degree of frailty and co-morbidities that the person is living with are explicitly included in our planning and are discussions with the person/family about prognosis and likelihood of recovery.** This step allowed to team to take a step back from the more task orientated outcomes above and to ensure we were being honest and realistic in those plans and discussions with the person about the likely improvement and/or any complications; what they should expect going forward and whether there were non-medical issues they needed to plan for. As well as the Rockwood CFS we would use other relevant tools like NYH heart failure classification as an example, to illustrate why a person may take a long time to recover and indeed, might not recover to how they were before.
Assessment of Survivability (& beyond)	**Aim: To use the information above to plan with the person their future care wishes as appropriate.** The team found that often the discussions around frailty and other co-morbidities triggered discussions about future care wishes. The reason for including this as a separate step was to make sure those conversations were captured and relevant documentation could be completed if needed or communicated to where other staff could revisit the conversation at a later date. From the team's point of view it was also useful to look at the case history in the context of population data. While we did not do it for every patient, on occasions we used data (such as predicted survival after a fracture neck of femur, myocardial infarction, stroke, and age-adjusted expected life expectancy) to better understand if the person was likely in the last 1000 days of life – this reinforced the need to have those conversations about planning for the future.