Wessex CGA Toolkit: Recommendations

Using the links below, navigate to the section that will help you and your MDT implement the Wessex CGA toolkit recommendations.

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Preparation for introducing the Wessex CGA Toolkit into an organisation

Frailty awareness and knowledge

Before you start to develop or review your CGA approach for your organisation, do your teams understand the importance of recognising frailty and the benefits of commencing a CGA?

Recommended Wessex action	Example of approach
• Download the frailty e-learning into your local training system • Develop a frailty education strategy to further embed this learning into your organisation • Ensure all the members of the MDT undertaken the frailty training e.g. pharmacists, social workers, care navigators etc	• Access free, bite size e-learning for all staff, in all specialities and all setting via the frailty e-learning portal • Utilise the frailty education implementation tools to support implementation of the e-learning into your organisation • Review the Frailty iCARE toolkit developed by North-East and North Cumbria AHSN for applicability within your locality
• Learn more about frailty and comprehensive geriatric assessments	• Access this comprehensive peer - reviewed set of resources to extend your knowledge further: https://wessexahsn.org.uk/img/projects/CGA%20resources.docx www.bgs.org.uk http://frailtyicare.org.uk/frailty-i-care/in-detail/involve/
• Understand what a CGA is, its role and how it links in with other plans	• Review this Wessex AHSN developed visual, describing the interconnections with other planning documentation CGA plan overlap • Use this suite of Wessex wide CGA case studies to help promote the importance of delivering a CGA. Contact healthyageing@wessexahsn.net with your case study examples.
• Access free, downloadable resources to promote the importance of holistic assessments for older people	• **For acute settings**: Download these co produced leaflets and posters describing the importance of holistic assessments in a hospital setting

Domain Recommendations

Peer reviewed by Wessex AHSN Medicine Optimisation Programme 2021

Domains

Medication Review

To achieve a CGA, it is crucial that current medicines are reconciled, reviewed and documented within the plan. Many medicines prescribed for someone now living with frailty may no longer be appropriate due to changes in physiology, treatment goals or disease progression.

Recommended Wessex action	Example of approach
• Complete a full medication history, reconciling all current medication; including prescriptions, 'over-the-counter' medicines, herbal, vitamins, illicit drugs etc	• Review this CQC and NICE QS120 guidance for further information
• Obtain full medical history and ascertain which medicines are to treat which condition, and/or whether any conditions require treatment that is missing	• Review STOPP START
• Complete a Structured Medication Review (SMR)e.g.: In general; e.g., 'do you remember your medicines?/do you have any problems taking/swallowing your medicines?' AND individually – i.e., does each medicine have a valid indication that it is working for? Does the person feel it is working? Do you take this medicine?	• Review Wessex AHSN Medicine Optimisation resources • Review the British Geriatric Society medication review guidance
• Assess for any side effects – both from drug data and patient experience	• Recommended resources include: BNF and SPCs available at www.medicines.org.uk/emc
• Calculate the anticholinergic burden score	• Visit http://www.acbcalc.com/ • Visit https://www.nice.org.uk/advice/ktt18/chapter/evidence-context
• Review each medication – using patient priorities to guide the process • Consider using shared decision making (SDM) approach to ensure patient is fully involved in any changes/additions	• Review the following: Good for you, good for us , good for everybody • Review SIGN Polypharmacy Guidance https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/09/Polypharmacy-Guidance-2018.pdf • Review NO TEARS tool https://www.bmj.com/content/329/7463/434 • Review https://www.nice.org.uk/guidance/ng197

Ensure this review is fully documented, prescriptions are altered, required tests are booked/requested and the information is shared with both the patient and other healthcare professionals

Domain recommendations

Domains

Mental Health/Mood

There is a high prevalence of mental health issues in older people, so a CGA is not complete without addressing this. As part of the holistic assessment, it is vital to assess mood and cognition (3)

Recommended Wessex action	Example of approach
• Completion and documentation of the Geriatric Depression Scale (GDS) score and document in the CGA within a primary/community setting and share across partner organisations ***Please note this may not be appropriate in an acute setting, but collateral history of mood and cognition can be helpful***	• Review British Geriatrics Society resources • Review https://www.stchristophers.org.uk/wp-content/uploads/2015/11/steps_stepfive_geriatric_depression_scale_0915.pdf -
• Consider the spiritual aspects of a persons preferences as part of their CGA, using the BGS spiritual distress assessment tool	• Review spiritualty guidance signposted in these additional CGA resources

Functional assessment

Functional, social and environmental assessment provides context to the other areas of the CGA for the individual and the additional support provided (2)

Recommended Wessex action	Example of approach
• Utilise appropriate tools to measure functional, social and environmental support required for an individual	• Review a wide variety of tools. A number are available including Barthel https://www.blmkccg.nhs.uk/documents/barthel-index-of-activities-of-daily-living-1/ • Consider additional focus and support for individuals at increased risk through frailty such as isolation and support for activities of daily living (ADLS)
• Complete CGA using an MDT approach to ensure best practice approach for the individual is delivered	• Review and implement the best practice from MDT toolkit and frailty toolkit

(3) British Geriatrics Society 2019

Process recommendations

Process

Agreement of a CGA approach within your organisation/system

This is crucial to deliver an optimal CGA . When actions are identified during the assessment, clear recording keeping and sharing of information is key in maximising the potential health improvements for an individual and reduces duplication of data collection.

Recommended Wessex action	Example of approach
• Agree the CGA domains that should be included in your organisations CGA • Agree a CGA template that can be used across all settings and specialities	• Standardise your CGA template within in an organisation • Consider how a systemwide approach in developing an integrated care record that can pull detail from disparate systems into 'one version of the truth' could be achieved. Where possible, agree a system wide CGA – however, it is recognised that this may not be achievable within systems in the short term • Explore with partners, system wide integration of coding for frailty and domains of CGA • Clearly define roles and responsibilities of the MDT and who completes what/when. Be clear who is carrying out the actions, what referrals are being made by whom, and what follow up is required • Review examples of paper CGAs in use across Wessex • Review the exemplar paper CGA from North Midlands Trust included
• Agree with health and social care providers what elements of the CGA are useful to share • Consider what patients/carers/families would like to see • Map, document and share which elements of the CGA are useful with all members of the MDT and colleagues in other settings? • Acknowledge completion of the CGA may differ according to setting	• Obtain agreement across the MDT and wider system as to what key information and CGA domains are required
• Develop a standard operating procedure to ensure that CGA reviews with the integrated MDT team is part of best practice	• Review MDT toolkit and frailty toolkit for an optimal approach

Process recommendations

Process

Delivering transparent and accessible plans (1)

An individual's preferences should be at the heart of any assessment, these preferences should be made easily accessible to individuals supporting care delivery

Recommended Wessex action	Example of approach
• Consider whether all the domains as recommended by the British Geriatrics Society and Wessex AHSN regularly completed and reviewed through audit cycles	• Utilise this CGA audit framework to assess the quality of the CGA carried out, we recommend a case note review of 100 patients per year • Adopt and adapt the audit approach to consider meaningful metrics for your system e.g. number of CGAs completed • Share your findings with the system to identify areas for collective improvement
• Consider your team approach in preparing the individual to discuss their preferences	• Review these resources within your team to identify best practice approaches for your service Helen Associates person centred thinking tools
• Consider your team approach in documenting individuals wishes. • Assess whether in your team the domain What Matters Most been clearly documented and actioned • Assess whether the domain What Matters Most has been regularly reviewed with the patient/client/their carer • Assess whether any changes in the individual's preferences are clearly documented Have these changes been shared with other health and social care colleagues involved in their care • Assess whether there a clear mechanism for updating the individuals anticipatory care plan and/or advance care plans	• Review these resources within your team to identify best practice approaches for your service to develop an audit approach that is suitable for your team What matters to you What matters to me • Visit Implementing a Common Framework - Personalised Care Collaborative Network - FutureNHS Collaboration Platform for emergent examples

Process recommendations

Process

Delivering transparent and accessible plans (2)

Involving the individual, their family and carers in decision making will improve outcomes and experience

Recommended Wessex action	Example of approach
• Assess within your team whether you have a process in place to ensure that a CGA has been completed with the patient/client/their carer • Assess how you describe the purpose of a CGA to your patient/client/their carer and identify areas for development and improvement	• Review involving people in their health and care for best practice approaches
• Reflect on whether as an individual or a team you fully understand the impact the completion of the CGA has had on an individual/carer/their family and where this is captured	• Emergent case studies to be captured
• Review how regularly you obtain patient/client for feedback on the CGA process and where improvements could be made	• Utilise this co-produced questionnaire which can be adapted for local use: CGA Patient Experience questionnaire
• Agree with the MDT how problem lists are generated and shared	• Map process and touch points is key in understanding the mechanisms for sharing

Coding recommendations

Coding

Coding

Identifying individuals who would benefit from a CGA or have an assessment in place, it is important to code appropriately to ensure that the right care is delivered at the right time in the right setting

Recommended Wessex action	Example of approach
• Consider whether you routinely include e-FI scores (if relevant for your settings) to help stratify relevant patients that would benefit from a CGA/and a population health management approach? *Developing an integrated view of frailty scoring will enable conversations with all system partners.*	• Visit https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/ for more information on coding from a population health management perspective
• Adopt the use of the Clinical Frailty Score (CFS) to screen and identify patients living with frailty and clearly documented this in electronic and paper records	• Review and use the resources from these best practice frameworks
• Explore and map the CFS to the level of frailty severity (e-FI) to help with conversations with across health and social care. *This is key in ensuring services meet population demand.*	• Review and use eFI and Clinical Frailty Score mapping tool
• Agree with your IT lead and members of the MDT the relevant SNOMED codes to use within your systems *Consistent use of codes across the system will enable detailed analysis to be undertaken to help shape and understand the local populations' needs.*	• Example to be published

Sharing information and action planning recommendations

Sharing

Sharing CGA information and action planning (1)

Sharing information across health and care settings will ensure delivery of consistent, person-centred care. An optimal approach is to hold all assessments, problem lists, and actions plans centrally, accessible to all.

Recommended Wessex Actions	Example of approach
• Identify how actions from a CGA are presently shared with your team • Consider how you would like to share and communicate information in the future to other members of the MDT, outside of the MDT and with the individual, family members and carers • Identify case workers individual have a case worker identified to support their frailty needs within the MDT	• Review MDT toolkit and frailty toolkit for an optimal approach. MDTs are at the heart of effective communication, daily/weekly teams calls are encouraged • Consider nominating a case worker/link worker to ensure plans are delivered should be considered • Identify administrative support as part of the MDT to support communication of changes to plans and any advance planning decisions • Findings from the 2021 Wessex AHSN Acute Frailty audit will help identify where records are shared and will identify opportunities for improvement
• Identify whether you have one shared electronic care plan that allows: 1. Completion of different parts of the same care plan by different health care team members 2. Updates and amendments to be made easily 3. Sharing across the IT systems of all services involved in the individual's care	**With your IT leads:** • Review what shared electronic systems can offer for example: https://www.graphnethealth.com/solutions/integrated-digital-care-record/carecentric/ • Review the Wessex AHSN digital CGA ingredients for success to start the conversation with your system

Sharing information and action planning recommendations

Process

Sharing CGA information and action planning (2)

Exploring new ways of sharing information will be key in delivering consistent, person centred care

Recommended Wessex Actions	Example of approach
• Identify where IT solutions are presently not in place. • Consider how will this sharing of information be best achieved • Consider how you will ensure digital equity to all for patients/carers/families accessing digitalised plans	**With your IT leads:** • Explore the potential for gaining permission to write on other systems if not integrated, e.g., acute frailty team can write into community CGA. • Consider scanning key document into systems within your organisation/external organisations e.g., could GP letters be scanned and send to the hospital and uploaded onto hospital systems • Can discharge summaries be updated to include all relevant information? • Review the Wessex AHSN digital CGA ingredients for success to start the conversation with your system
• Map potential patient pathways in use/required to support the outputs identified in a CGA	• Review the following materials to help develop your approach within your team Process Mapping Using the community to support frailty
• Review present advice/support services available to support individuals. • Consider whether this needs to be updated or whether additional services need to be explored	
• Review and improve present processes to share any changes in the CGA 1. to review and update frailty problem lists 2. to ensure all planned interventions have been completed 3. to identify and evidence that the patient/client's needs have been acted upon 4. to ensure any changes are also included in any anticipatory/advance care or personalised care plans	• Utilise this CGA audit framework to assess the quality of the CGA carried out, we recommend a case note review of 100 patients per year • Consider utilising the Isle of Wight Making sense of CGAs framework