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Leaflet for health and care professionals

Welcome to the new Leeds virtual ward (frailty)

Hello my name is Graham Sutton, Consultant at Leeds Teaching Hospitals NHS Trust and lead geriatrician for the virtual ward (frailty) and hello I'm Lucy and I'm David, we are both Community Matrons.

We know many of you will be familiar with the concept of a virtual ward, but for those who aren't we hope this guide helps. Our virtual ward (frailty) is a collaboration between NHS organisations in the city (primary, community and secondary care), Leeds City Council Adult Social Care and the Leeds Oak Alliance (Third Sector consortium).

Graham Sutton

David and Lucy, Community matrons

What are the aims of this virtual ward?

This virtual ward provides rapid assessment and wrap-around care to people in their own home who become suddenly unwell and would normally be admitted to hospital or are already under the care of Leeds Teaching Hospitals and who's needs can be safely managed at home. For a person with moderate or severe frailty, a virtual ward improves outcomes and experience by reducing disruption to people's lives including their carers. The virtual ward provides an alternative to hospital admission as well as supporting a speedier discharge, improving outcomes and reducing the risk of hospital acquired adverse events including deconditioning. The virtual ward will work alongside and communicate with existing providers if the person already receives homecare or other support in the home and ensure a good plan post input.

How does the virtual ward (frailty) work?

The diagram on page 3 shows the typical pathway for the virtual ward (frailty). If someone becomes suddenly unwell at home and meets the criteria for the virtual ward:

- A referral can be made via SPUR on **0113 376 0369** - select option 2 (new referral); between 8am-4pm; 7 days a week.
- They will be seen and assessed by a community matron or associate community matron within two hours of receiving a referral.
- Following this initial assessment which can involve rapid blood tests, they will be accepted on to the virtual ward and overall responsibility for their care will transfer to the team and a consultant geriatrician.
- 'Length of stay' - they can be on the ward for up to seven days as they recover and once discharged from the ward, overall responsibility for their care transfers back to the GP. There is no charge for any additional care package that a person may require for this seven day period.
- Service operating hours – 7 days per week, 24 hours a day, taking referrals between 8am-4pm. We will continue to monitor whether there is a need to extend referral times past 4pm.

What do we mean by virtual?

The virtual ward is a consultant led service that supports people experiencing medical problems in their own home. There is rapid access to diagnostics (e.g. pathology / radiology) and treatments that can be safely delivered at home (e.g. intravenous medicines). However because it is a multiagency team including social care colleagues people also get rapid access to increased care packages and therapy services where required. People can be supported at home with multiple visits through the day and care overnight if needed. Their care plan will be reviewed daily by the virtual ward MDT meeting.

Where is this operating?

As of 21st September 2020, the virtual ward (frailty) is operational citywide.

The referral criteria:

- People who are registered with a Leeds GP
- People who have been seen by a referrer / healthcare professional. Due to COVID-19, we are also currently accepting referrals of patients who have had a telephone or video consultation with the referrer
- People who are aged 70 and above
- People whose needs can be managed safely at home, see exclusion criteria below, i.e. NEWS2 less than 5 (with the exception of single score of 3 in one parameter) dependent on the person's baseline NEWS2 score[1]
- People who have been identified as Moderately or Severely Frail using the electronic frailty index (eFI) and/or Rockwood score of 5 or more see page 4
- People **NOT** displaying signs of an acute medical / surgical emergency, e.g. overdoses / poisonings, alcohol withdrawal / intoxication, sepsis, seizures, allergic reactions, eye conditions / change in vision, suspected significant injury after a fall / trauma, diabetic ketoacidosis or hyperosmolar hyperglycaemic state, stoke / TIA, venous thromboembolism (VTE) and myocardial infarction

Examples of people who could be eligible for referral to the virtual ward (frailty)

- People will mild delirium of an unclear cause who can still be managed at home and when a change in environment may make the delirium worse
- People with mildly deranged blood tests that need short-term monitoring e.g. mild acute kidney injury
- People with cellulitis not resolving with oral therapy - these are typically people who would be admitted for probable IV antibiotics

Case study

77 year old gentleman with laryngeal and prostate cancer, who had been discharged from St James' Hospital five days prior to his referral to the Virtual Ward (Frailty). Diagnosed with acute kidney injury, a chest infection and a low potassium due to his PEG feeds. Presented to the VW(F) with lethargy and diarrhoea and his potassium level was lower than when he had been discharged from St James' - which could have precipitated a readmission to the hospital.

Outcome: Admitted to the VW(F), given potassium supplements and his fludrocortisone stopped. Discharged from the VW(F) after three days when his potassium level returned to normal with an onward referral to the community dietician.

Who can refer?

Referral needs to be from a clinician who has seen (virtually, by phone or face to face) the person and uses either the EFI or Rockwood score to determine their frailty score. The following services are listed, accepting that for some, they may need a clinician such as a GP to facilitate the referral.

- Primary care (GPs, Advanced Nurse Practitioners (ANP's) and Physician Associates (PA's))
- Yorkshire Ambulance Service 999 (paramedic) and 111 (via GP out of hours)
- Neighbourhood Teams and Leeds Community Healthcare NHS Trust's specialist teams
- Leeds and York Partnership NHS Foundation Trust intensive home treatment teams and intensive care home teams (mental health) via GP
- Community care beds
- Care homes (both residential and nursing via GP or registered nurse)
- LTHT clinician following review by consultant geriatrician

It is a condition of referral that the referrer has seen the patient face to face to be clear about their assessment of potential suitability to be cared for on the virtual ward.

1 NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

What are the benefits of a virtual ward to a person?

The virtual ward (frailty) aims to reduce length of hospital stay or avoid admission in the first place, which leads to quicker recovery and reduces disruption to patient's lives. This means we can proactively manage people living with frailty at home, through support from a wider care team, which improves patient's experience and outcomes.

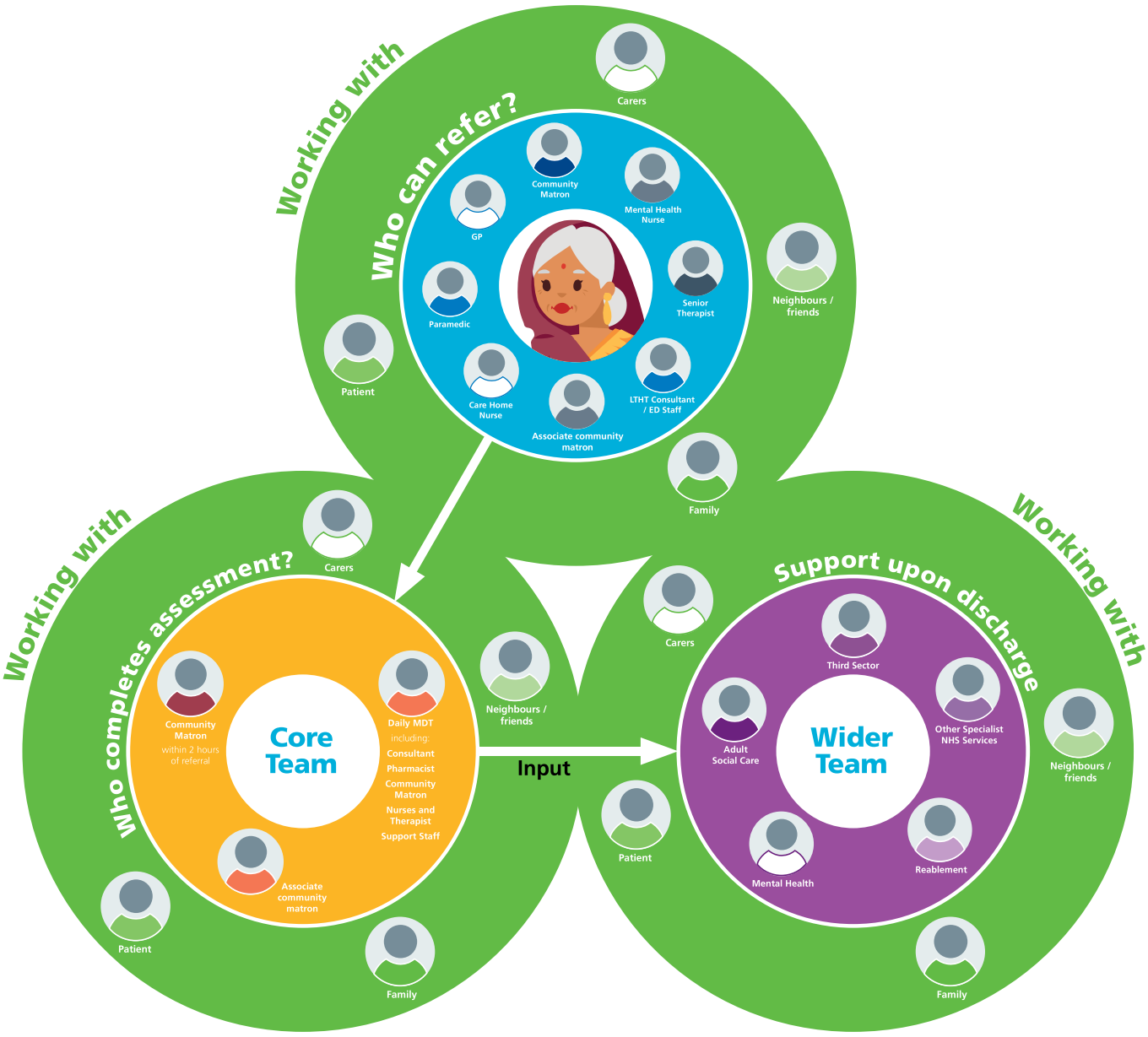
How the virtual frailty ward pathway works?

The figure below gives a summary of the health and care professionals who would support people who are on the caseload for the virtual ward (frailty).

Is this the first virtual ward for Leeds?

No, in Leeds there's already a well established virtual respiratory ward which has helped us develop the virtual ward (frailty). The virtual respiratory ward is a multi-disciplinary team offering more intensive support to people experiencing an acute exacerbation of specific respiratory conditions to avoid an unnecessary admission to hospital and support earlier discharge when a patient has been admitted. In instances where people will benefit from either ward, there is a process in place to ensure that all involved in a person's care can collaborate, led by a consultant.

Appendix 1 - Typical pathway



Appendix 2

Assessing frailty - electronic frailty index or Rockwood score

The electronic frailty index (eFI) uses the existing information within the primary health care record to identify populations of people aged 65 and over who may be living with varying degrees of frailty. The eFI helps predicts who may be at greatest risk of adverse outcomes in primary care as a result of their underlying vulnerability. The eFI uses existing electronic health records and a 'cumulative deficit' model to measure frailty on the basis of the accumulation of a range of deficits. These deficits include clinical signs (e.g. tremor), symptoms (e.g. vision problems), diseases, disabilities and abnormal test values. It presents an output as a score indicating the number of deficits that are present out of a possible total of 36, with the higher scores indicating the increasing possibility of a person living with frailty and hence vulnerability to adverse outcomes.

The Rockwood Clinical Frailty Scale is a way to summarise the overall level of fitness or frailty of an older person after they have been assessed by a clinician experienced in looking after older people. It is a nine point scale that is easy to use and administer in a clinical setting.

Clinical Frailty Scale

1. Very Fit
People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well
People who have **no active disease symptoms** but are less fit than category 1. Often they exercise or are very **active occasionally** e.g. seasonally.

3. Managing Well
People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.

4. Vulnerable
While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being 'slowed up', and / or being tired during the day.

5. Mildly Frail
These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail
People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail
Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within 6 months).

8. Very Severely Frail
Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill
Approaching the end of life. This category applies to people with **a life expectancy <6 months** who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question / story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

For more information on the virtual ward (frailty)
please contact the project team:
virtual.frailty@nhs.net