The Implementation of a Frailty Assessment and Support Mechanism Within a Satellite Radiotherapy Department - The Christie at Oldham

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Introduction

Frailty is strongly linked to poor patient outcomes[1,2] therefore consideration needs to be given to this in order to both better support patients and improve outcomes.

A **Phase 1** project conducted in November - December 2019 audited the implementation of a basic frailty tool within the Radiotherapy department at The Christie at Oldham. The aim was to quantify and identify frail patients within the centre, assess the implications on workflow and establish sustainability and compliance. The prevalence of frailty within our patient group was 28%.

Phase 2 of this project aimed to;

- Identify a threshold on the Rockwood CFS (Clinical Frailty Scale) for patient referral for an in-depth frailty assessment (CRANE) thus offer further support.
- Establish a referral pathway within the department via the on-site Cancer Care Co-ordinator (CCC) team.
- Assess the integration of this pathway into departmental workflow.
- Quantify the number of referrals to compare with phase 1.

Methodology

A total of 187 patients who started their radiotherapy treatment between 1st July – 31st August 2020 were assigned a CFS score by Radiographers as part of a mobility assessment on their first treatment appointment.
Patients scoring 4 or above were referred onto the CCC team for a CRANE frailty assessment. The CCC team performed this assessment alongside the patients Holistic Needs Assessment (HNA).
All data for the 2 month period was recorded along with assessment outcomes.
A questionnaire was also completed by the Radiographers to assess their perception of the impact on workload as a result of this change.

Results

Overall compliance was 98.9%, with only 2 patients not receiving frailty screening. Of the screened patients, 75.1% had a CFS score of 1-3, and 24.9% scored 4-9. 41 patients required referral for a CRANE assessment (*Table 1*). Of these, 68.3% had a CRANE assessment alongside their HNA appointment.

73.7% of staff responded to the questionnaire. Results demonstrated that integrating the frailty assessment alongside the mobility assessment presented no issues in terms of workflow for 100% of these staff members.
Compliance for the CFS screening has remained stable throughout phase 1 and 2 (97.9% vs 98.9%) thus showing the successful integration of this within the department.

	CFS Scoring										
	1 Very Fit	2 Well	3 Managing Well	4 Vulnerable	5 Mildly Frail	6 Moderately Frail	7 Severely Frail	8 Very Severely Frail	9 Terminally Ill	Not Scored	Total
Number of Patients	11	65	63	22	14	7	3	0	0	2	187
% of New Patients	5.9	34.8	33.7	11.8	7.4	3.7	1.6	0	0	1.1	100
% of Patients Assessed	5.9	35.1	34.1	11.9	7.6	3.8	1.6	0	0	---	100

Table 1. CFS scores for patients assessed in phase 2.

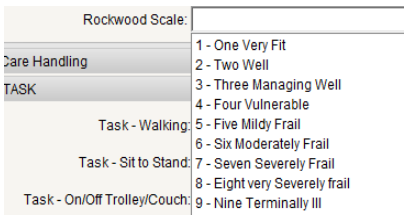

Figure 1. Rockwood scoring tool added to Mosaiq software to record patient CFS score.

Departmental Pathway

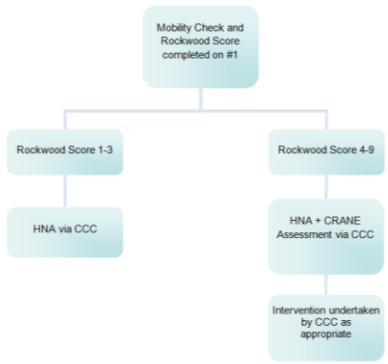

Figure 2. Frailty Referral Pathway at The Christie at Oldham.

In May 21 the CCC role funding ceased and this provision was no longer supported. A further registered audit (**Phase 3**) was completed to assess the impact of removal on both patients and the service.
On average, 25% of patients across each of the three phases classified as frail. During phase 3 no patients received a HNA or CRANE assessment, compared to only 2 patients not receiving a HNA in the 18 months prior.
37/189 patients received additional support in some form .
Additional support was provided by the onsite team (B5-8). Time taken was 49.67 hours. Financial impact calculations have identified that a potential saving of £17,119 would be made if a CCC was in post.
Over 90% of staff found it harder to further support patients and stated that it had affected the provision of personalised care.
Funding has now been made available to support the post for a further year.

Recommendations

We have been able to establish, via these audits, a basic understanding of the prevalence and severity of patient frailty within our department, whilst successfully implementing a frailty support pathway which does not appear to affect current workflow.

Through the use of this pathway we have been able to efficiently triage and identify those patients in need of further support under the care of our CCC team. Due to the prevalence of frailty and the correlation between frailty and patient morbidity we should continue to use this pathway within our department in order to best support our patients and improve outcomes. This was vindicated by phase 3.

We must also consider that patient frailty status can change. Therefore, in the future those patients that are border line in their CFS screening (a score of 3) and show any signs of deterioration, require a repeat assessment and appropriate action should be taken as per the pathway based on their most recent score.

Frailty Outcomes

Support patients received included;

- OT, GP and CNS referrals
- Help obtaining mobility aids
- Referrals to benefits advice
- Counselling & local support groups
- Help with breathlessness
- Diet and Exercise information
- Carer's support
- Points of contact such as CNS, Palliative Care Team and community support.

A number of patients already receiving appropriate support voiced they were grateful for the contact.

Learning Points

We must appreciate that due to the nature of the CFS, scores may be somewhat subjective and to an extent may vary slightly from one assessor to another. However, measures such as training have been put in place to prevent disparity.

Although frailty is very complex and may be a challenging assessment to make within a busy clinical setting, this frailty pathway has shown to be beneficial in highlighting and triaging those patients that require more support with regards to frailty, without overwhelming the department and affecting workflow.

References
1. Gregorevic KJ, Hubbard RE, Katz B, Lim WK. The clinical frailty scale predicts functional decline and mortality when used by junior medical staff: a prospective cohort study. BMC Geriatrics. 2016. June 16:117
2. Kahlon S, Pederson J, Majumdar SR, Belga S, Lau D, Fradette M, Boyko D, Bakal JA, Johnston C, Padwal RS, McAlister FA. Association between frailty and 30-day outcomes after discharge from hospital. CMAJ. 2015. August;187(11):799-804