



**Problem statement:**

The current model for providing proactive care to older-age adults living with frailty (OALW) involves completing a Comprehensive Geriatric Assessment (CGA) at home, followed by referrals to other professionals as needed. This model, however, presents several challenges:

**Delays due to complex referral processes:** The web of referrals and multiple handovers results in delays, impeding timely care delivery.

**Low priority of frailty in complex care nursing:** Proactive frailty is given the lowest priority, further contributing to delays and inefficiencies in care.

**Unclear referral criteria for non-housebound patients:** There is ambiguity in the referral criteria for non-housebound patients, creating gaps in care for those who are moderately to severely frail but not confined to their homes.

**SMART aim:**

To pilot a multi-disciplinary team (MDT) ambulatory frailty clinic at EMHC, providing CGAs for 20 moderately to severely frail, non-housebound patients by August 2024, enhancing coordinated, patient-centred care, identifying existing care gaps and enhancing overall care quality.

**Measures to track improvement:**

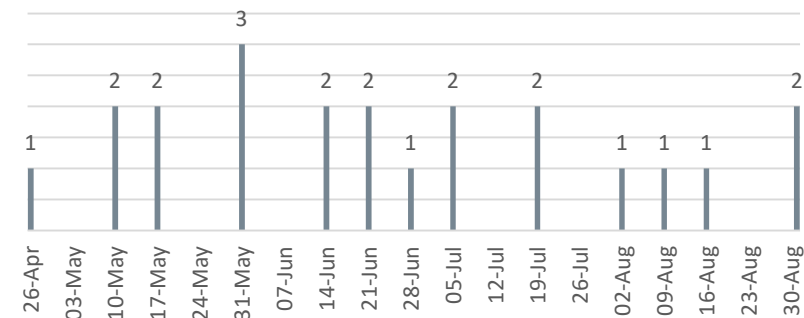
- Number of assessments completed
- Length of wait for community CGA
- Pre-screening and 30 day post CGA using patient identified meaningful measures, EQ5D (quality of life measure) and loneliness score
- Colleague survey and patient stories .

**Data:**

Between 26 April and 23 August 2024, 13 clinics have been held and 22 patients assessed.

"I feel motivated and stronger since my time at the clinic" patient feedback

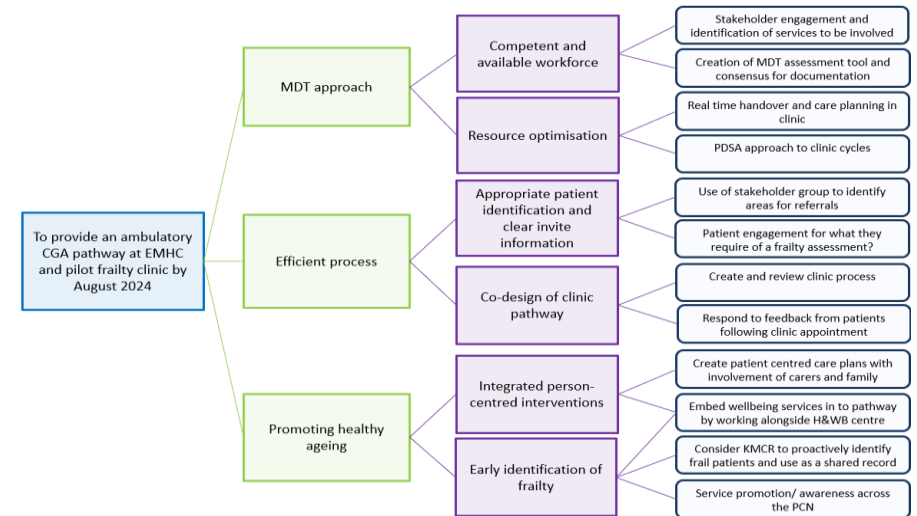
Patients assessed by Ageing Well Clinic April to August 2024, n=22



**Tests of change:**

Patient engagement to increase patient voice in co-design. Key themes included:

- Accessibility and transportation
- Reliance on family support
- Communication preferences
- Social interaction and wellbeing
- Desire for simplification and efficiency
- Need for comprehensive support



**Results, what we learned and what's next:**

The MDT frailty clinic has saved an average of 3.5 clinician hours per patient, reducing costs by £86 per case and providing timelier assessments compared to domiciliary CGA's. Early outcomes indicate improved quality of life, prompt support and a strong patient preference for the personalised, trust-based approach, particularly among those with cognitive difficulties. Patients report feeling more "important" and "empowered," while staff experience high satisfaction from positive team dynamics.

The pilot highlights the success and benefits of an ambulatory MDT frailty assessment clinic at EMHC for patients, our trust and the broader health system.

Next steps include further developing referral streams, continuing data analysis to support the service as it goes "live" in September and ensuring clear clinical and senior leadership .

