Additional Information - QI04-22 Specialised Frailty Therapy Support

Please see below with the answer to the following questions:

1. *How will this QI project fully utilise 2x 1WTE members of staff to deliver?*

2. *In order for us to understand the value/ROI of this proposal, how many patients are expected to benefit within the 12-month trial period?*

Based on recent calculations, there are approximately 50 patients at any one time across ACM wards L3-6 with a CFS of 5 & 6. Patients will be able to benefit from the service in several ways, such as assessments, 1:1 exercise, goal-setting and seated activity groups. Below, we have broken down how both the band 7 and the band 3 will work across an average week. This will demonstrate the utilisation of the two members of 1WTE staff but also show how the patients will directly benefit from the service.

- Seated Activity Groups – 0.1 WTE (Band 7), 0.15 WTE (TA) – 3 groups, 6 patients = 18 patients per week (potentially multiple contacts with the same patients – currently learning suggests new patients attend each activity group)
- Patient contact time (e.g. specialist assessments, home visits) – 0.6 WTE (Band 7), 0.6 WTE (TA) – 19 patients per week (some patients may attend the seated activity group as well). One of the goals of the driver diagram is to increase attendance at a community service/group therefore a further 10 patients (approximately 50%) to attend a community service/group through our referral process.
- Non-patient-facing activity (e.g. community referrals, liaising with carers/relatives, admin time) – 0.175 WTE (Band 7), 0.175 WTE (TA)
- Staff Frailty Training (e.g. 1:1 training, drop-in sessions) – 0.05 WTE (Band 7)
- Service Development (e.g. assessing and evaluation progress, data collection) – 0.05 WTE (Band 7), 0.05 WTE (TA)
- Personal Development (e.g. supervision, mandatory training, training course) – 0.025 WTE (Band 7), 0.025 WTE (TA)

As mentioned above, patients will be affected directly through the service via assessments and groups and other patient-facing activities however they will also be indirectly affected due to organised staff training, spontaneous 'on the job' training with staff and provision of information leaflets. Developing staff knowledge and skills in terms of identifying and managing frailty will lead to improvements in the care of our frail patients. We have tried to estimate the indirect benefit of this but understandably this is hard to accurately quantify.

Based on current estimations there are approximately an average of 50 patients concurrently across the four 'L wards' we aim to cover. The service aims to complete assessments on anyone who is appropriate and not solely patients with CFS score of 5 and 6, although this will make the bulk of the caseload. For this reason, we have estimated that the service could indirectly impact patients with a CFS score of 5-8. At the time of writing, this was 71 patients. If we minus patients seen through the service (19 – average length of stay of 15.26 days) we would therefore **directly** reach approximately 494 patients over 12 months. This is worked out as 19 patients stay for approximately 2 weeks

(rounded down for ease of gathering this data). We have therefore multiplied 19 by 26 weeks to gain an estimate.

To work out our indirect benefit, we need to take the same 71 patients (the number of patients on the four wards at present with a CFS score between 5 and 8), but minus the 19 patient we would see directly through the service per week. Therefore, we would estimate that we could have an **indirect** benefit towards a remaining 52 patients per week. Due to their average length of stays of 15.35 days, this would mean over 12 months it would benefit approximately 1352 patients. This is worked out by multiplying 52 with 26 as we have also rounded down the average length of stay to 2 weeks to gain this data more easily.