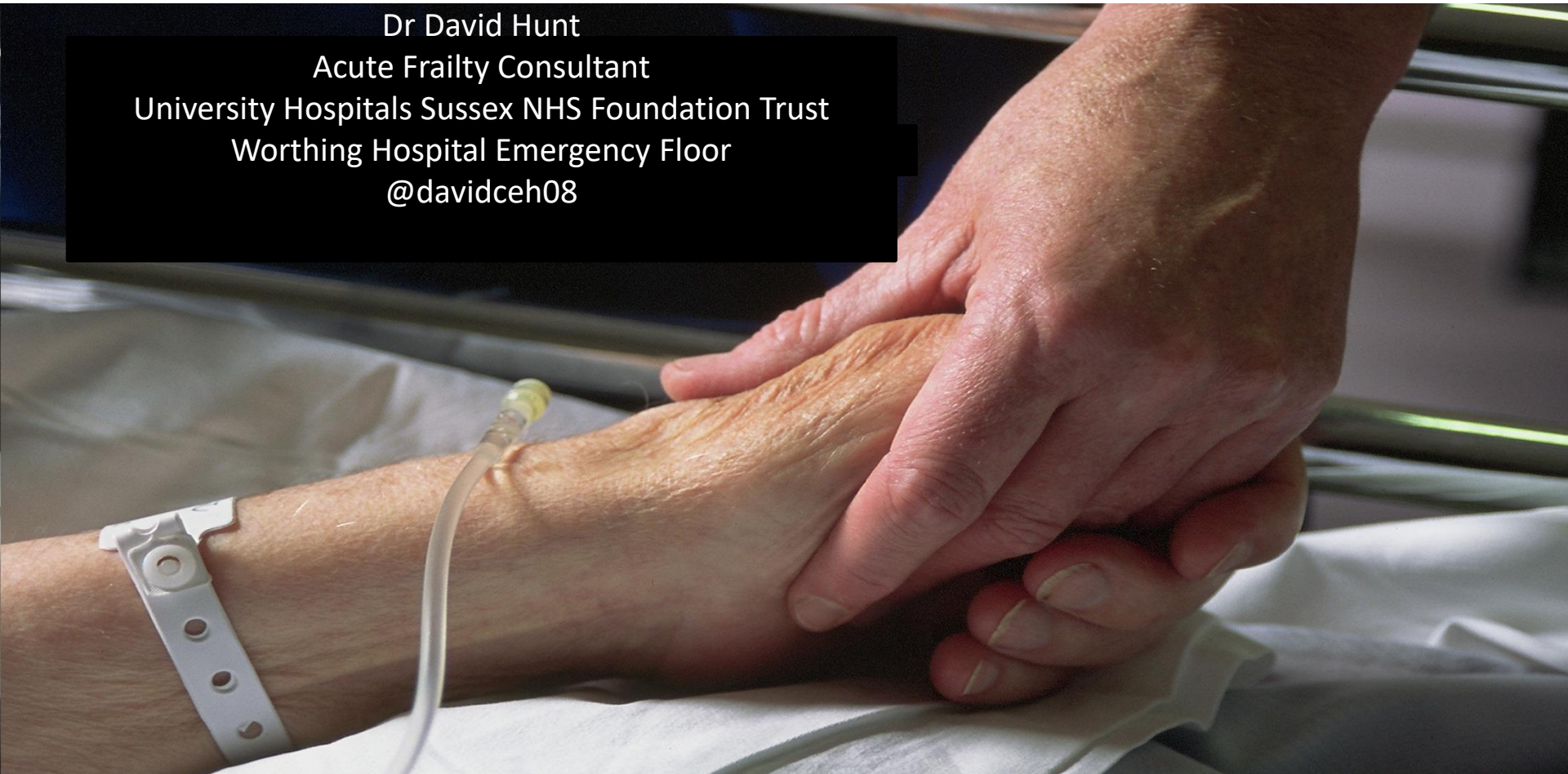
Changing care systems and delivering an acute frailty improvement programme



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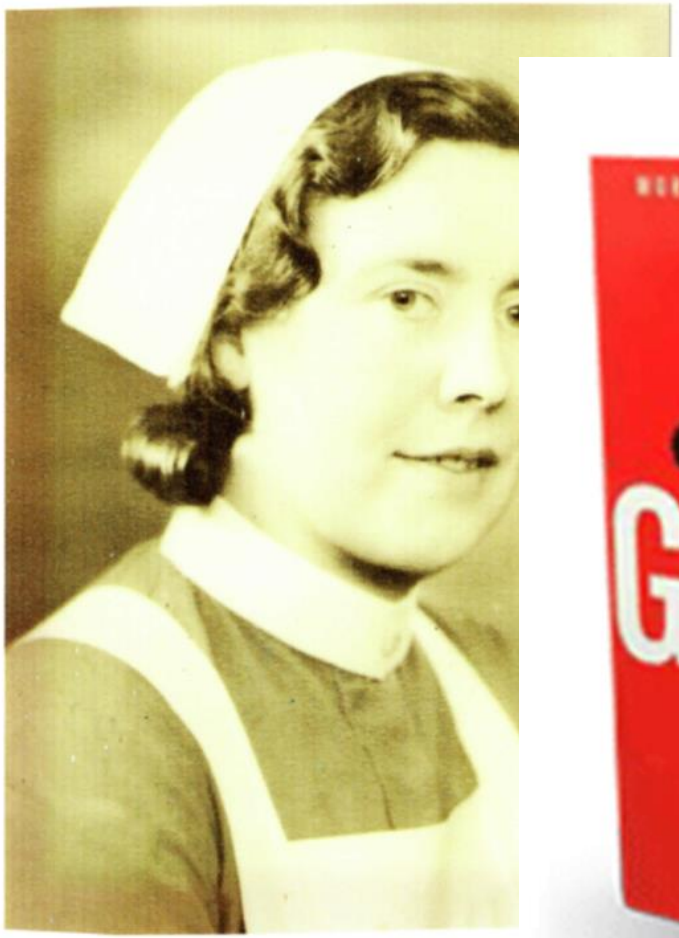
Content

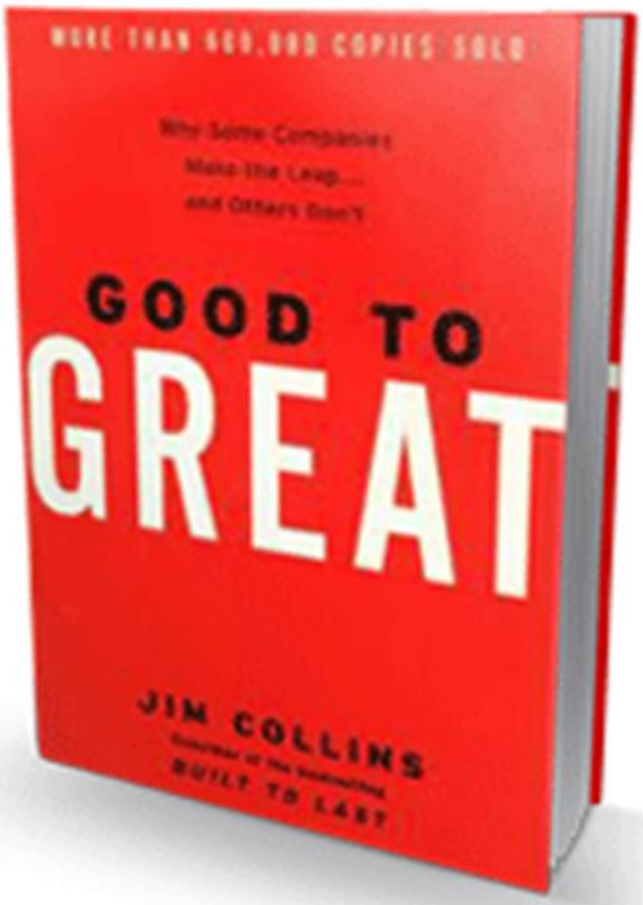
- Frailty: national update and understanding prevalence
- Implementing frailty assessment at the front door
- Provide practical resources for you to use

Disclaimer

- With thanks:
  - Prof Adam Gordon
  - Prof Finbarr Martin
  - Prof Martin Vernon
  - Prof Simon Conroy
  - Michael Azad
  - GIRFT
  - NHS Elect – AFN/SCFN
  - NHSE/I –SDEC AFN
  - BGS
  - SAM
  - WSHFT
  - Coastal West Sussex CCG



mother



Who motivates to provide a Outstanding service?

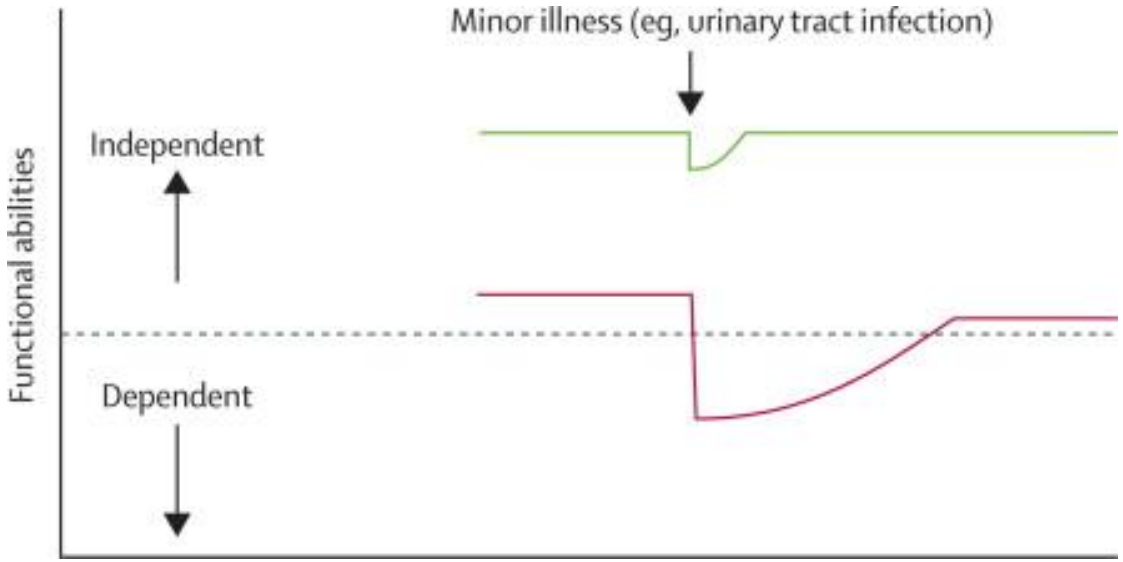
Demographics

- By 2031:
  - 66% increase in over 65s
  - 77% increase in over 75s
  - 131% increase in over 85s
  - More people >65 than <18
- In next 20 years those >100 will quadruple

- 8% of the population >75 years old, but account for 30% of emergency admissions

- >65 year olds account for
  - 40% of hospital bed days
  - 65% of NHS spend
  - 60% of social care spend

British Geriatrics Society
Department of Health



THE LANCET

Frailty in elderly people

Andrew Clegg, John Young, Steve Iliffe, Marcel Olde Rikkert, Kenneth Rockwood

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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

Prevalence of Frailty

- Prevalence increases with age
- 3.2% of 65-70 year olds
- 9.5% of 75-79 year olds
- 25.7% of 85-89 year olds

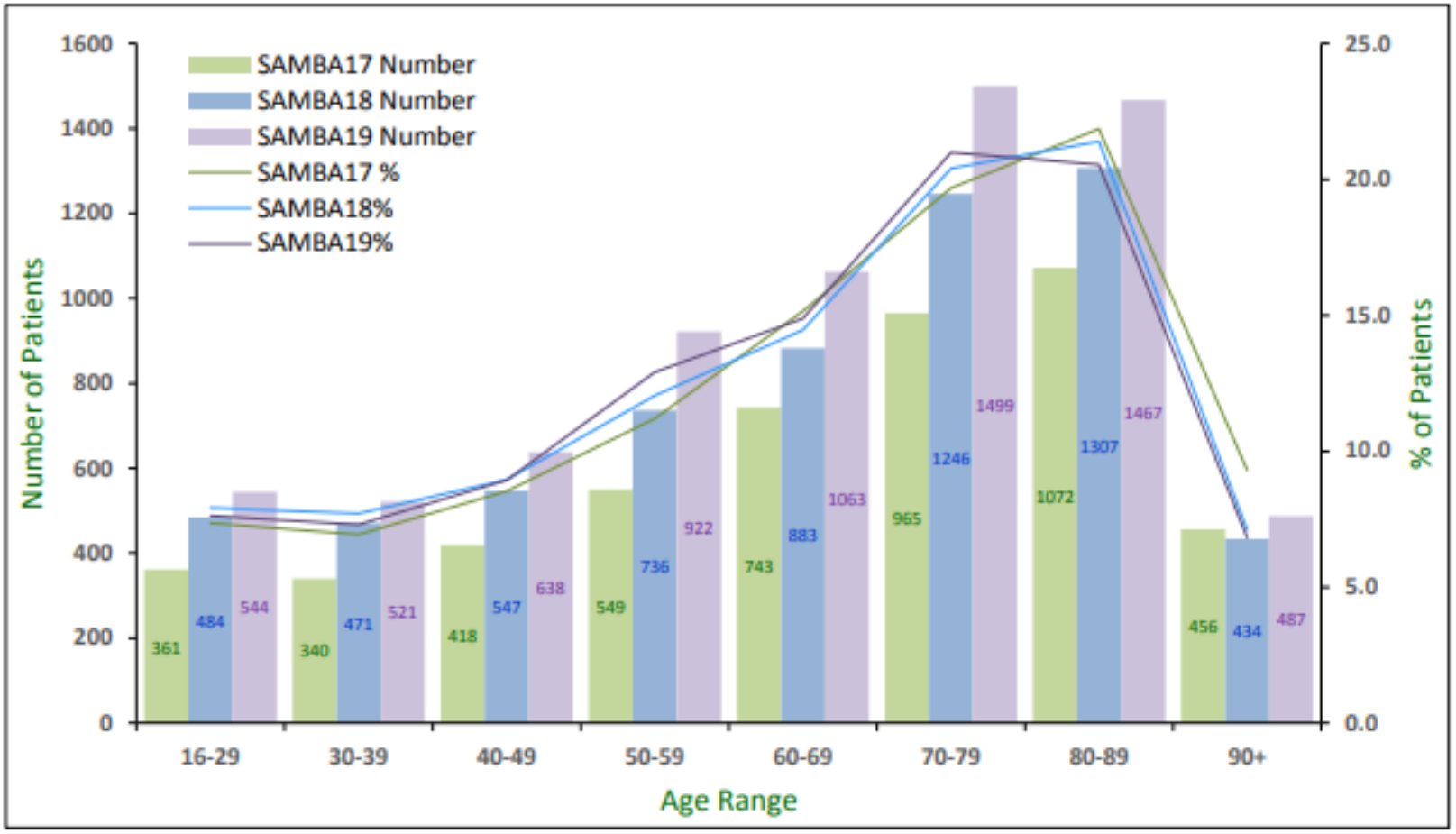
- Hospital inpatient prevalence much higher

- Women almost twice as likely to be frail

British Geriatrics Society
Department of Health

Society for Acute Medicine Benchmarking Audit SAMBA19 Report

Figure 8 Age distribution of SAMBA17, SAMBA18 and SAMBA19 patients*

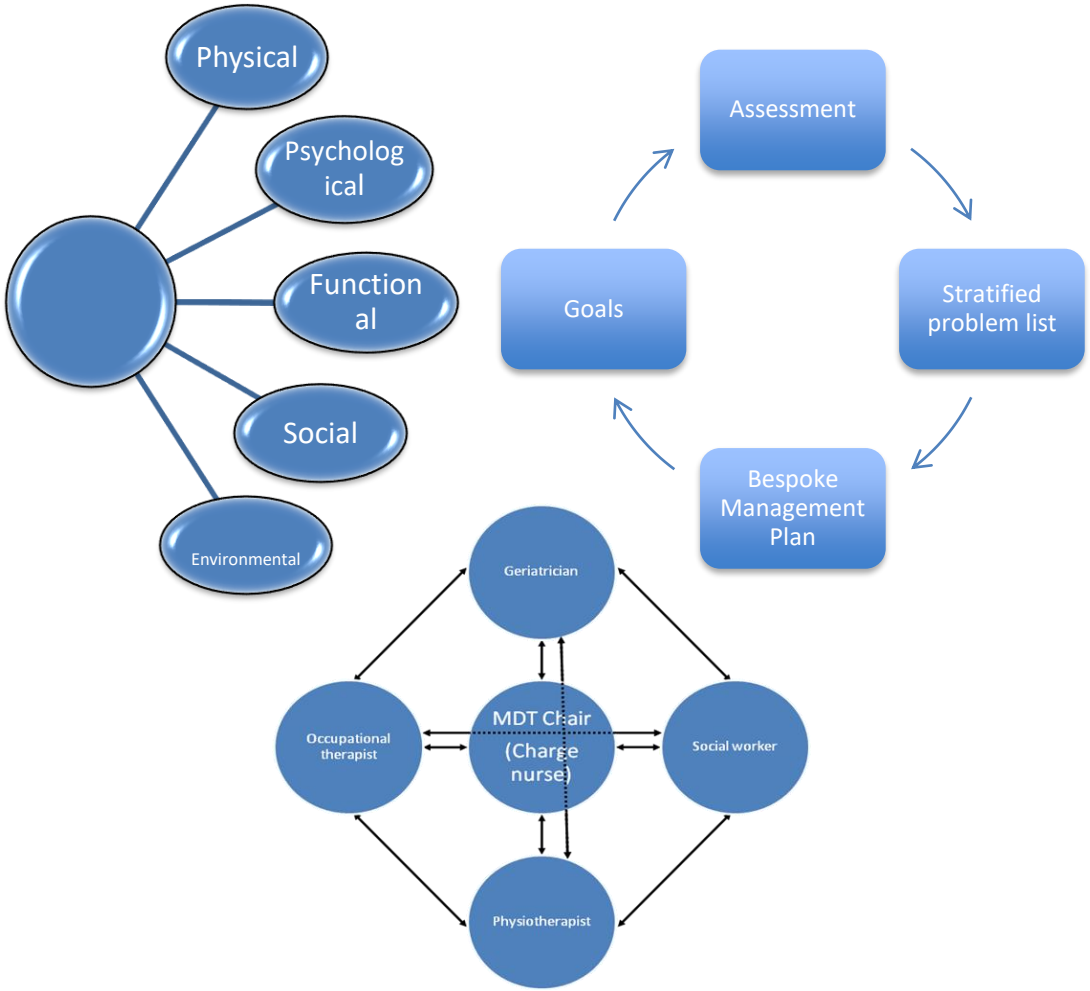


* The denominator populations are SAMBA17 4904 patients, SAMBA18 6108 patients and SAMBA19 7141 patients.

NHS Long Term Plan ambition

Milestones for urgent and emergency care

- In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online.
- All hospitals with a major A&E department will:
  - Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20
  - Provide an acute frailty service for at least 70 hours a week. They will work towards achieving clinical frailty assessment within 30 minutes of arrival;
  - Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020
  - Test and begin implementing the new emergency and urgent care standards arising from the Clinical Standards Review, by October 2019
  - Further reduce DTOC, in partnership with local authorities.
- By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.


Physical
Psychological
Functional
Social
Environmental
Assessment
Stratified problem list
Bespoke Management Plan
Goals
Geriatrician
Occupational therapist
MDT Chair (Charge nurse)
Social worker
Physiotherapist

What is the evidence base for this CGA?

Type	Mortality	Living at home	Readmission	Physical function	Cognitive function
Institutional	**0.78 (0.62-0.97)**	**1.19 (1.01-1.39)**	0.85 (0.70-1.03)	1.22 (0.84-1.78)	1.79 (0.73-1.46)
Non-institutional	0.91 (0.77-1.07)	**1.26 (1.10-1.44)**	0.89 (0.78-1.01)	0.99 (0.77-1.27)	1.03 (0.73-1.46)
Combined	**0.86 (0.75-0.98)**	**1.26 (1.10-1.44)**	**0.88 (0.79-0.98)**	1.06 (0.86-1.30)	**1.41 (1.12-1.77)**

Stuck, A.E. et al., 1993. Comprehensive geriatric assessment: a meta-analysis of controlled trials. The Lancet, 342(8878)

The Same Day Emergency Care (SDEC) programme

The same day emergency care (SDEC) programme is part of the NHS England and NHS Improvement urgent and emergency care (UEC) transformation team.

The national SDEC programme team supports and facilitates the implementation of the NHS Long Term Plan SDEC objectives. The key work streams for this programme are:

- Same day emergency care (SDEC)
- Surgical same day emergency care (SSDEC)
- Acute frailty
- SDEC emergency care data set (SDECDS)
- Commissioning for quality and innovation (CQUIN)

Same-day acute frailty services

Published by NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network

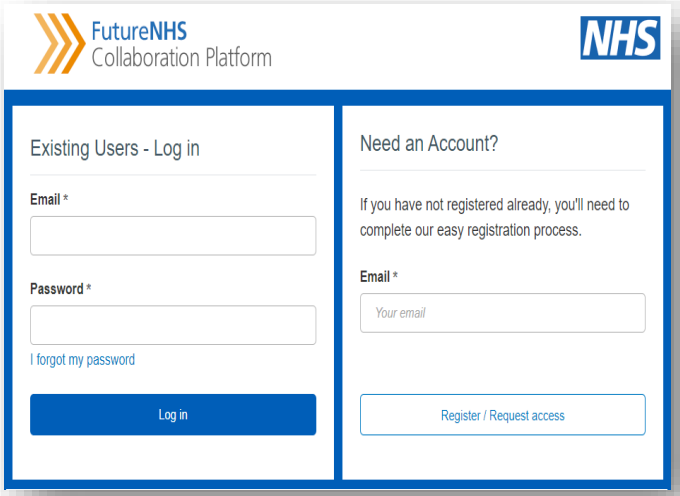
May 2019

NHS England and NHS Improvement

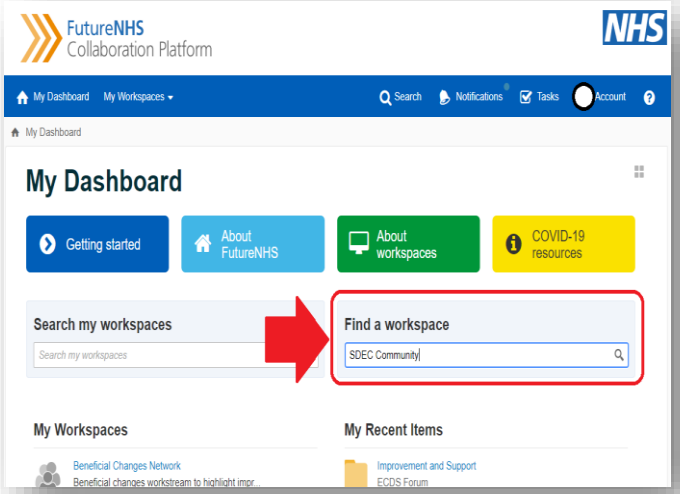
Principles and Characteristics of an Acute Frailty Service for Same Day Emergency Care

How to join the FutureNHS Collaboration Platform and SDEC Community Space to access Acute Frailty Service resources

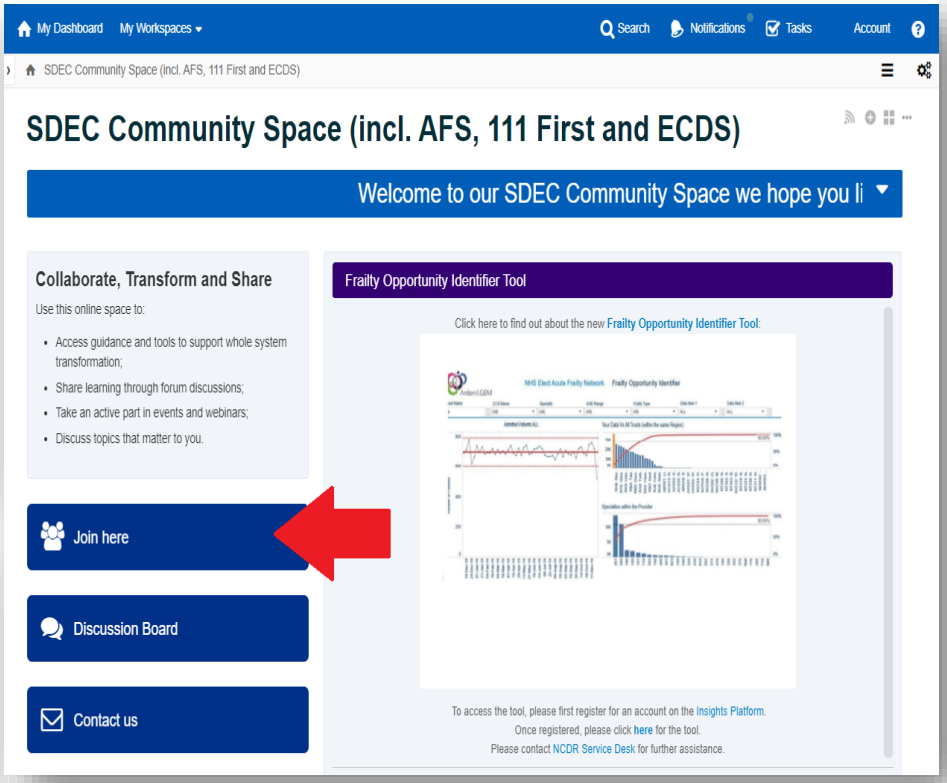
Step 1 – Register to the FutureNHS Collaboration Platform https://future.nhs.uk/system/home



Step 2 – Search for SDEC Community in find a workspace box



Step 3 – click 'Join here' https://future.nhs.uk/SDEC_CommunityofPractice/grouphome



What is an Acute Frailty Service?

An acute frailty service routinely and systematically identifies and grades frailty in people who present acutely to Urgent/Emergency care services. These services then consider the personalised needs of individuals living with frailty, considering their grade of frailty and degree of illness, supported by clear reliable pathways into and out of hospitals aligned to the grade of frailty identified.

Although important before, it is now even more of a priority (with COVID-19) for hospital teams to develop and adapt their services for vulnerable adults, such as older people living with frailty.

Acute Frailty Service in SDEC setting

The Hospitals Same Day Emergency Care model for Acute Frailty supports people living with frailty who are in need of urgent care, to be treated by skilled multidisciplinary teams in a timely manner in order to be discharged to their usual residence sooner if hospital admission would offer no benefit.

Succeeding in this should minimise patients' risk of exposure to COVID-19, along with other hospital associated risks such as deconditioning.

The national ambition

The drive from the NHS Long Term Plan is that all hospitals with a 24 hour A&E (type 1 providers) will provide an Acute Frailty service at least 70 hours a week with an aim to complete a clinical frailty assessment within 30 minutes of arrival in the ED/SDEC unit. We will support providers to develop and enhance acute frailty service in their hospitals under SDEC.

Acute Frailty Service Outcomes

- **Improve patient experience**: by removing delays, provide appropriate assessment to support shared decision making about priorities of care and treatments
- **Improve patient flow (beneficial changes)**: patients can be seen in the right place and assessed accurately at first time (ED/SDEC triple assessment recorded (CFS,NEWS2,4AT), enabling more appropriate clinical processes early on and identify patients who may benefit from specialist Acute Frailty team input
- **Reduce reliance on traditional referral pathways**: **SDEC by default: *Reduce reliance on admission*:**patients are discharged home to their usual place of residence as default with the SDEC approach rather than acute admission by default
- **Enhance clinical engagement:** workforce upskilling as appropriate for better workforce planning to support early decision making/intervention
- **Increases collaboration:** a system-wide approach to providing care across boundaries

What are we trying to achieve?

Frail and acutely ill	Admission is probably useful and necessary • Identify geriatric syndromes that will impact the next few days eg delirium • Build in a CGA approach to maximise function • Anticipate discharge and post acute needs
	Admission is probably NOT useful • Identify palliative needs: ? end of life care
	Admission might be useful but is not necessary • Discharge to competent service for medical and other interventions and support • Liaise with hot clinics /CGA
Frail + not acutely ill	Discharge +/- urgent functional support • Rehabilitation to increase reserve and resilience to future events

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Frail + not acutely ill	**Discharge +/- urgent functional support** • Rehabilitation to increase reserve and resilience to future events

SDEC

Frailty is everyone's business

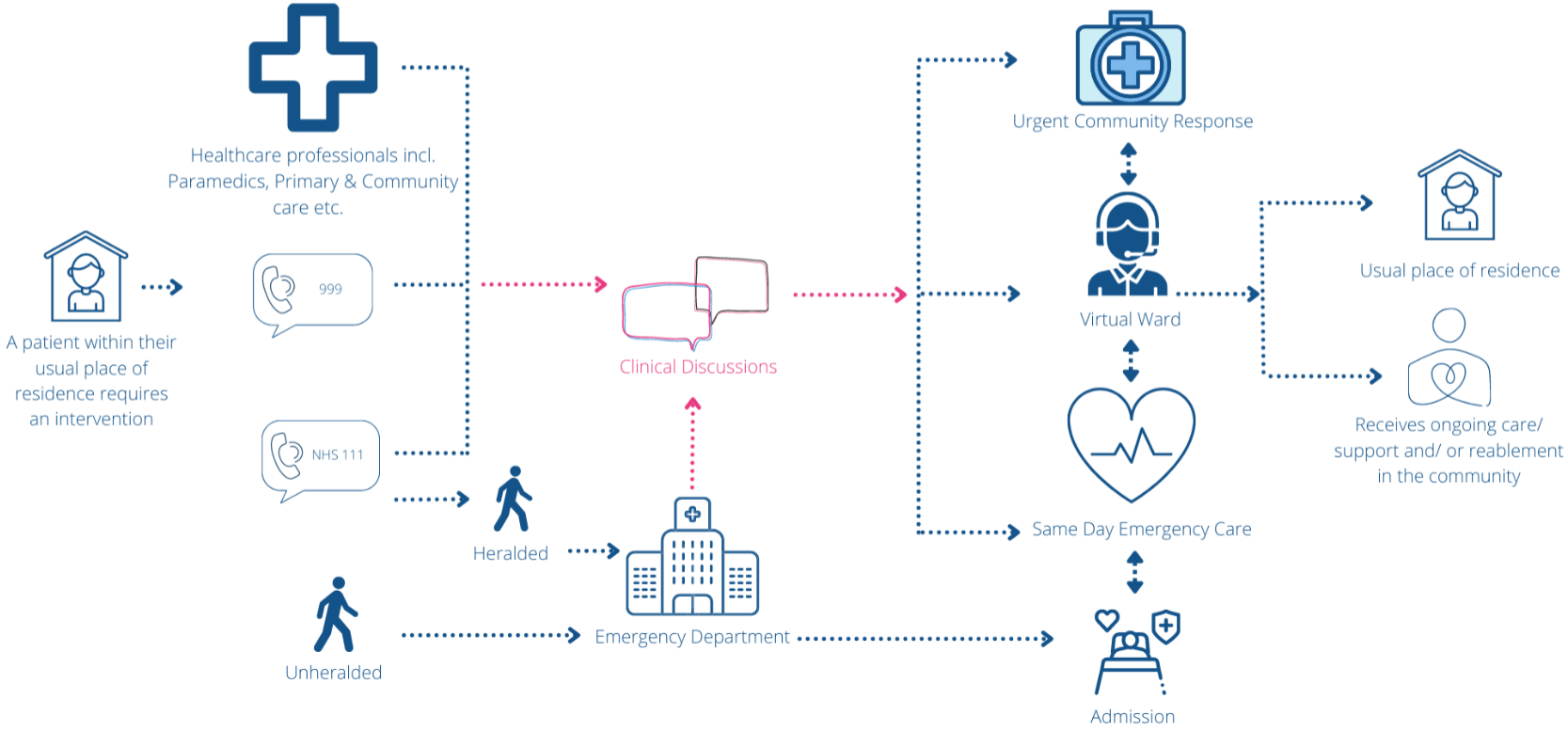
NHS England

Ongoing care within the community, but a decision has been made that an intervention is needed

A clinical discussion with the relevant service to provide rapid support

All services have the opportunity to refer to other services to support ongoing care

Patient remains within community or if within secondary care, aim to discharge same day



NHS Benchmarking Network

Same Day Emergency Care
Final Bespoke Report
2021

SD000 - NHS Benchmarking Network

Appendix: participants

Organisation Name	Organisation Name
Ashford and St Peter's Hospitals NHS Foundation Trust	Northumbria Healthcare NHS Foundation Trust
Barking, Havering and Redbridge University Hospitals NHS Trust	Nottingham University Hospitals NHS Trust
Barnsley Hospital NHS Foundation Trust	Oxford University Hospitals NHS Foundation Trust
Barts Health NHS Trust	Portsmouth Hospitals University NHS Trust
Bedfordshire Hospitals NHS Foundation Trust	Royal Berkshire NHS Foundation Trust
Bolton NHS Foundation Trust	Royal Cornwall Hospitals NHS Trust
Bradford Teaching Hospitals NHS Foundation Trust	Royal Devon and Exeter NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust	Royal Surrey NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust	Royal United Hospitals Bath NHS Foundation Trust
Chelsea and Westminster Hospital NHS Foundation Trust	Salisbury NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust	Sandwell and West Birmingham Hospitals NHS Trust
Croydon Health Services NHS Trust	Sheffield Teaching Hospitals NHS Foundation Trust
Dartford and Gravesham NHS Trust	Sherwood Forest Hospitals NHS Foundation Trust
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Shrewsbury and Telford Hospital NHS Trust
Dorset County Hospital NHS Foundation Trust	Somerset NHS Foundation Trust
East and North Hertfordshire NHS Trust	South Tees Hospitals NHS Foundation Trust
East Cheshire NHS Trust	South Tyneside and Sunderland NHS Foundation Trust
East Lancashire Hospitals NHS Trust	South Warwickshire NHS Foundation Trust
East Suffolk and North Essex NHS Foundation Trust	St George's University Hospitals NHS Foundation Trust
East Sussex Healthcare NHS Trust	St Helens and Knowsley Teaching Hospitals NHS Trust
Epsom and St Helier University Hospitals NHS Trust	Surrey and Sussex Healthcare NHS Trust
Frimley Health NHS Foundation Trust	Tameside and Glossop Integrated Care NHS Foundation Trust
Gateshead Health NHS Foundation Trust	The Dudley Group NHS Foundation Trust
George Eliot Hospital NHS Trust	The Hillingdon Hospitals NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust	The Newcastle upon Tyne Hospitals NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust	The Princess Alexandra Hospital NHS Trust
Guy's and St Thomas' NHS Foundation Trust	The Queen Elizabeth Hospital, King's Lynn. NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust	The Rotherham NHS Foundation Trust
Homerton University Hospital NHS Foundation Trust	The Royal Wolverhampton NHS Trust
Hull University Teaching Hospitals NHS Trust	Torbay and South Devon NHS Foundation Trust
Imperial College Healthcare NHS Trust	United Lincolnshire Hospitals NHS Trust
James Paget University Hospitals NHS Foundation Trust	United Lincolnshire Hospitals NHS Trust
Kettering General Hospital NHS Foundation Trust	University Hospital Southampton NHS Foundation Trust
King's College Hospital NHS Foundation Trust	University Hospitals Birmingham NHS Foundation Trust
Kingston Hospital NHS Foundation Trust	University Hospitals Bristol and Weston NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust	University Hospitals Coventry and Warwickshire NHS Trust
Lewisham and Greenwich NHS Trust	University Hospitals Dorset NHS Foundation Trust
Liverpool University Hospitals NHS Foundation Trust	University Hospitals of Leicester NHS Trust
London North West University Healthcare NHS Trust	University Hospitals of North Midlands NHS Trust
Maidstone and Tunbridge Wells NHS Trust	University Hospitals Plymouth NHS Trust
Manchester University NHS Foundation Trust	University Hospitals Sussex NHS Foundation Trust
Medway NHS Foundation Trust	Walsall Healthcare NHS Trust
Mid Yorkshire Hospitals NHS Trust	Warrington and Halton Hospitals NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust	West Hertfordshire Hospitals NHS Trust
North Bristol NHS Trust	West Suffolk NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust	Whittington Health NHS Trust
North Middlesex University Hospital NHS Trust	Wirral University Teaching Hospital NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust	Wrightington, Wigan and Leigh NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust	Yeovil District Hospital NHS Foundation Trust
Northern Devon Healthcare NHS Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust
Northern Lincolnshire and Goole NHS Foundation Trust	

Acute frailty overview

Given that the *NHS Long Term Plan* ambition is that there should an acute frailty service available at least 70 hours per week, it is interesting to note that the mean hours per week open is 61 hours with 46% of units achieving the 70 hour ambition. Currently (September 21) 97% of patients are seen face to face.

NSHE recommend that robust inter-professional standards should be in place to support specialty in-reach into SDEC. 77% of organisations that reported not having a separate frailty unit have an acute frailty in-reach service into the medical SDEC unit.

	Percentage responding yes (0% – 100%)	Group % yes	SD000
Do you have a separate SDEC 'Unit' for Acute Frailty patients?		25%	...
If 'No', is your Acute Frailty SDEC Service combined with the SDEC Unit which includes Medical patients?		39%	...
If 'No', do you provide an Acute Frailty SDEC Service elsewhere in the hosptial?		39%	...
If not a separate Acute Frailty unit, does the trust have an Acute Frailty IN-REACH service which provides specialist input to the SDEC Unit which includes Medical patients?		77%	...
If you provide a separate 'Acute Frailty Service' is it open for 70 hours per week?		46%	...

FRAIL

within the SAME DAY strategy

NHS England

F	R	A	I	L
Focus on the acute problem	**Refer**	**Assess**	**Identify needs**	**Leave**
Patients upon arrival should be assessed and treated for the acute condition they have presented with. Complete a clinical frailty assessment within 30 minutes of arrival.	Refer to the Multi-Disciplinary Acute Frailty Service if needed. Liaise with other key services to support Same day discharge	A Comprehensive Geriatric Assessment (CGA) should be completed in order to further assess the patient	Aim to personalise needs and support a patient centred approach	Discharge the patient Same day, with a discharge summary linking in to other key services to deliver ongoing care

FRAIL is not independent from the SAME DAY strategy, instead both should be used together to support the implementation or review of Same Day Emergency Care (SDEC) services

Priority 1. (F)ocus on the acute problem

Overview

- Patients upon arrival should be assessed and treated for the acute condition they have presented with remembering Frailty co-exists with the presenting acute complaint.
- Age is a factor when considering Frailty.
  - The Clinical Frailty Score (CFS) is not validated for use in under 65s
  - Anyone can have frailty markers regardless of age.
- We advocate a triple assessment is used when supporting the identification of frailty and initial assessment of the acute problem:
  - National Early Warning Score (NEWS) 2
  - Clinical Frailty Score (CFS) (for patients aged 65+)
  - 4AT (Rapid clinical test for Delirium)
- Patients who present to acute settings should receive a clinical frailty score assessment within 30 minutes of arrival into secondary care.

Actions at provider level

1. Develop protocols to implement a SDEC by default approach.
2. The Acute Frailty service should provide support for front door assessment of appropriate patients – this could be an Advanced Clinical Practitioner and a physio therapist as long as there are links to other members who provide the Acute Frailty Service
3. Promote a fit to sit philosophy at the front door

Actions at ICS level

1. Work with system partners to advocate the clinical frailty assessment taking place prior to hospital. Often completing this within the patients own surroundings is easier, quicker and more reflective rather than in a secondary care setting.
2. Shared records across health and social care is vital to support the initial assessment and should be made available.

Priority 2. (R)efer

Overview

- Access should be made available for all professionals including Primary and Community Care, NHS 111 and 999 services including paramedics on scene. This should also include Urgent Community Response (UCR) services.
- A multi-disciplinary team (MDT) is required to provide a holistic assessment and meet the needs of the patient.
- The multi-disciplinary team should be available at least 10 hours a day, 7 days per week.
- A senior decision maker should be available to accept the patient into the Acute Frailty service and offer onward advice to enable same day care
- Referrals to other services to support the patient in their usual place of residence should be made. These include (but not limited to)
  - Virtual Ward Monitoring e.g. Heart failure
  - Hospital at Home e.g. I.V antibiotics,
  - Third Sector/ Voluntary Sector organisations e.g. British Red Cross, AGE UK and other local organisations.
  - Social Care (including recommencement of care after an admission)

Actions at provider level

1. Training for Advanced Level Practitioners (ALP) so they are confident and comfortable in being part of the senior decision making team.
2. The Acute Frailty service should also include a “pull” mechanism to ensure rapid assessment of the patient.
3. It is imperative that the Acute Frailty service has both clinical and executive sponsorship to ensure the services success.

Actions at ICS level

1. Open access routes to Acute Frailty services and be clear who can refer i.e. all Health Care Professionals including ambulance technicians.
2. Referral routes to other services to support a same day approach should be made available to secondary care and be clearly mapped across the ICS to support decision making.
3. Development of ICS workforce plans across community settings to enable delivery of care at home.

Priority 3. (A)ssess

Overview

- The team should have the skills and equipment to undertake a Comprehensive Geriatric Assessment (CGA) at the same time of management of the ongoing acute problem.
- Frailty is everywhere and everyone's responsibility and as such dedicated Acute Frailty units are not always required. Instead being co-located with other services (such as Medical) can help collaboration and increase identification of frailty.
- Community SDEC models are also another way in which an Acute Frailty service can be embedded to support patients.
- Rapid access to diagnostics is vital to ensure a SAME DAY approach can be achieved.
- Point of Care Testing (POCT) devices can support immediate review, assessment and treatment for patients.

Actions at provider level

1. Every patient who from the CFS scores 6 & > should have access to CGA.
2. Ensure that Same Day Emergency Care services have the same diagnostic turn around times as the Emergency Department.
3. Consider where the frailty service is sited within the organisation
4. Determine the senior decision maker within the Acute Frailty service to ease contact by Primary & Community Care, Ambulance services etc.

Actions at ICS level

1. CGAs already completed should be made available to all to reduce duplication and prioritise on treatment plans.

Priority 4. (I)dentify needs

Overview

- Patient and carer needs are taken into account and they are supported to:
  - Understand the care, treatment and support options available and the risks, benefits and consequences of those options
  - Make a decision about a preferred course of action, based on their personal preferences and, where relevant, utilising legal rights to choice.
- Using the personalised care model patients have proactive, personalised conversations which focus on what matters to them
- Support those patients who have a frailty score of 7 or > with Advanced Care Planning (ACP).
- Patient experience should be used to continually assess the service and where improvements should be made.
- No patient should stay within the Acute Frailty Service and/or Same Day Emergency Care service longer than 8 hours.
- Patients should be assessed as a fit to sit patient

Actions at provider level

1. Work with third sector/ voluntary organisations to support patients and their carers needs and reduce admissions for social reasons.
2. Advocate that other specialised teams should be involved in the patients management at this stage e.g. diabetes, oncology, tissue viability etc.
3. Advocate staff training with the personalised care institute https://www.personalisedcareinstitute.org.uk/

Actions at ICS level

1. Work with primary care and community teams to ensure that patients with cancer or who are palliative and at end of life are aware of how to access appropriate services when they have an acute problem

Priority 5. (L)eave

Overview

- The SDEC service will need to provide a summary of the attendance within 24 hours of discharge so that the patient's primary and community care providers become actively involved in the ongoing care needs.
- Patient transport is a key factor that should be considered within SDEC. The immediate provision of transport for those who require it should be made available to enable them to return to their place of residence on the same day.
- Discharge planning should be thought about at the start of the patient's journey at initial assessment by the Frailty service to include practicalities such as whether the patient has access to their home.

Actions at provider level

1. Consider a role within the service who can link into Primary & Community services (such as access into GP records) to help with assessment and discharge planning.
2. Consider the measurement of success e.g. - reduction of admissions, patient and staff experience etc.
3. Work with commissioners to address any patient transport concerns to ensure that a same day approach is optimised.

Actions at ICS level

1. The Acute Frailty Service should work with their Integrated Care System (ICS) to ensure that services are integrated. E.g. UCR/ VW services linked with Acute Frailty Service.
2. Ensure that the reablement offer for all patients is consistent.
3. Nursing and residential homes should ensure they are able to receive patients back into their setting including during out of hours (including weekends)

Appendix A – Resources & Guidance

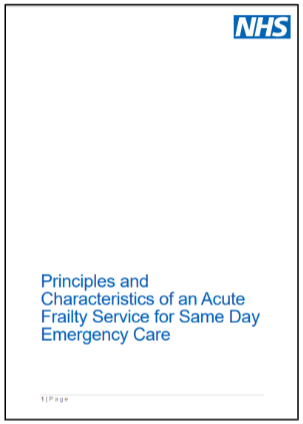
NHS England

GENERAL INFORMATION

- Frailty SDEC online homepage
- Acute Frailty (SDEC) NHS Futures online collaboration platform

HOSPITAL PROGRAMME RESOURCES

- Principles and Characteristics of Acute Frailty Same Day Emergency Care
- Guidance to support Early Identification of Frailty in Urgent & Emergency Care
- The way forward for Acute Frailty Same Day Emergency Care
- Acute Frailty Same Day Emergency Care Case Studies

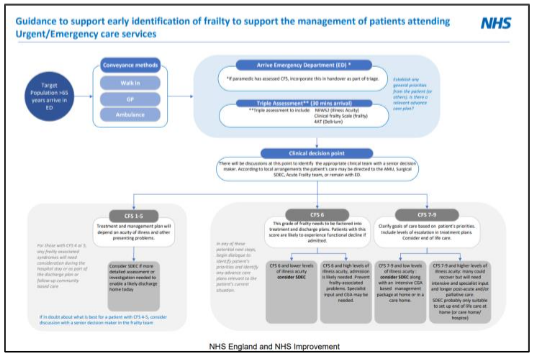


ASSESSMENT RESOURCES

- 4AT Rapid Clinical Test for Delirium

STAKEHOLDER LINKS

- Guidance on frailty Hospital-at-Home
- Top tips in using the Clinical Frailty Score
- AGE UK – Understanding Frailty
- NICE Guidance – Advanced Care Planning
- Resources to help understand the Comprehensive Geriatric Assessment
- British Geriatrics Society Comprehensive Geriatric Assessment toolkit for Primary Care
- British Geriatrics Society – Recognising Frailty
- British Geriatrics Society – Silver Book
- The Kings Fund – Tools in developing a dementia friendly environment



Frailty Opportunity Identifier Tool

AFS Counting Activity

Frailty Opportunity Identifier Tool

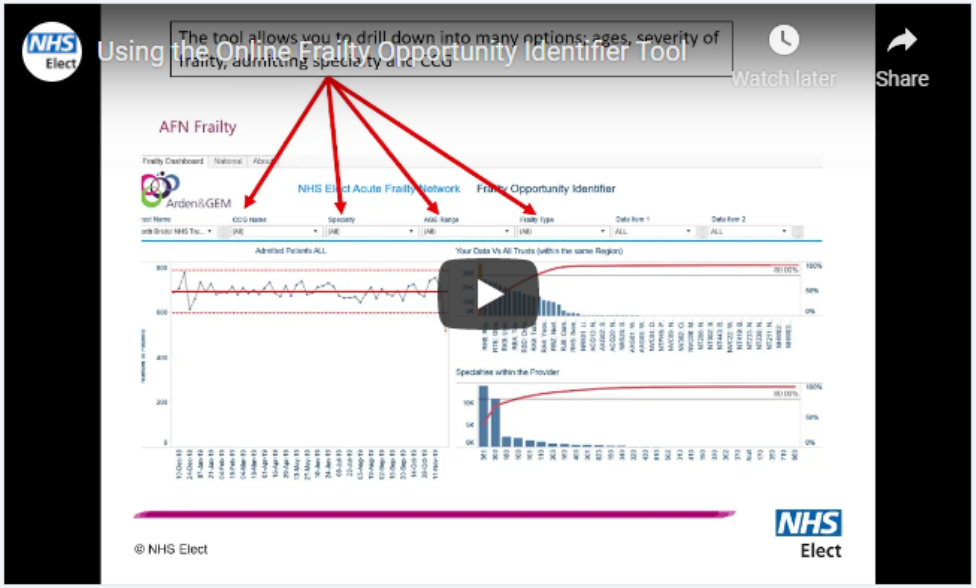
The Hospital Frailty Risk Score (HFRS) algorithm was developed and validated through an NIHR-funded research project. HFRS is a case-mix descriptor that potentially enables better understanding at system level of the flows and demand for NHS services from a group of high using individuals who we know benefit from a more frailty attuned approach.

Development of the Frailty Opportunity Identifier Tool

We have integrated the validated HFRS into a measurement for improvement interface, to create an online tool that analyses HES data to identify opportunities to improve pathways of frail patients in secondary care. The tool is also helpful for capacity planning.

Read more

How to use the Frailty Opportunity Identifier Tool



To access the tool, please first register for an account on the Insights Platform
Once registered, please access via the NCDR summary report page **here** and click on "Ac

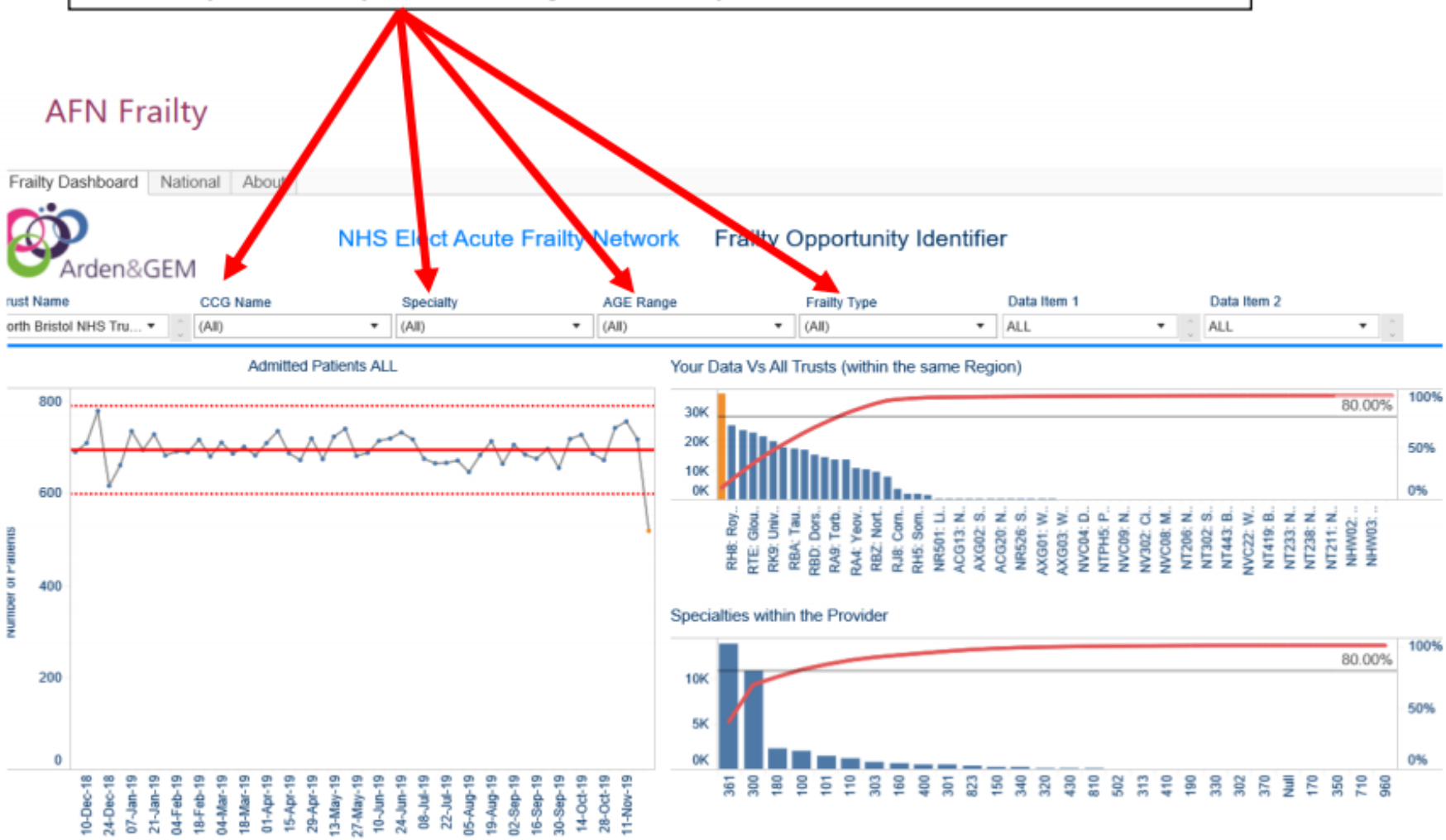
Support

Please contact NCDR Service Desk for further assistance

09:58
06/03/2021

[Using the Online Frailty Opportunity Identifier Tool - YouTube]

The tool allows you to drill down into many options; ages, severity of frailty, admitting specialty and CCG



NHS Elect

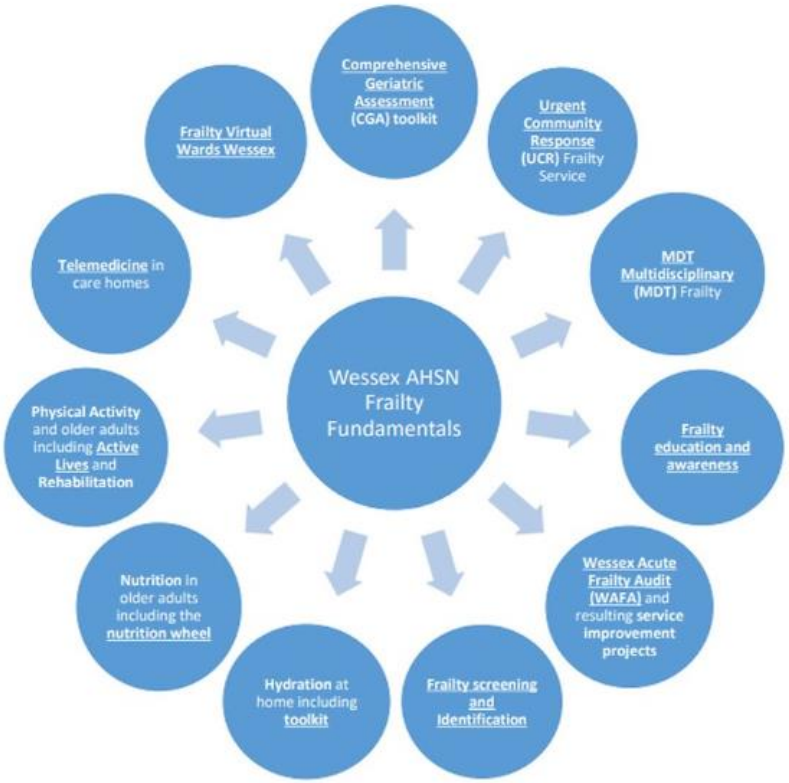
What are the Frailty Fundamentals?

Wessex AHSN in collaboration with frailty experts across Wessex have developed a simple, interactive dashboard to take you straight to our suite of frailty resources and toolkits. Comprising of key resources to support health and social care professionals and those delivering care to individuals living with frailty.

The Frailty Fundamentals includes:

- Comprehensive Geriatric Assessment (CGA) toolkit
- Urgent Community Response (UCR) Frailty Service
- MDT – Multidisciplinary MDT in Frailty
- Frailty Education and awareness
- Wessex Acute Frailty Audit (WAFA)
- Frailty Screening and Identification
- Hydration at home including a toolkit
- Nutrition in older adults including the nutrition wheel
- Physical activity and older adults including active lives and rehabilitation
- Telemedicine in care homes
- Frailty virtual wards

Click the wheel for the Frailty Fundamentals



2023/ 2024 Identification of Frailty CQUIN

The CQUIN

Description

- Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

Numerator

Of the denominator, the number of patients who have a documented assessment against the clinical frailty scale (CFS) with:

- The result recorded in ECDS
- Appropriate response where moderate-severe frailty (CFS score of 6 or more) is identified, including:
- initiation of a comprehensive geriatric assessment (CGA), and/or
- referral into the acute frailty service (AFS).

Denominator

- Total number of patients attending A&E/SDEC aged 65+

Want access to the full guidance materials?

For the full guidance on the CQUIN indicators and to also find out more information around the payment for CQUINs click here.

2023/ 2024 Identification of Frailty CQUIN

Thresholds, Payments and Data Collection Tool

Thresholds

- A minimum of 10% and up to a maximum of 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

Payment

- Payment will be based on the entirety of the relevant period.
- For this indicator this is Q1-Q4 in 2023/24.
- The performance will be calculated by averaging the four quarterly performance figures (average of 1/4s) to produce the scheme performance for the indicator

Quota Sampling

- A sample of 100 records is required each quarter to assess compliance.
- The results should be documented within a data collection tool

Data Collection Tool

- A data collection tool has been developed to support submission. To access this tool click here
- It is an example data collection tool that can be used for data collection and includes all the data fields required for submission on a quarterly basis
- This is then used to help calculate the achievement for that quarter.

2023/ 2024 Identification of Frailty CQUIN

British Geriatrics Society
Improving healthcare
for older people

Definition of Initiating the CGA

Definition *(endorsed by the British Geriatrics Society)*

The initiation of the CGA includes discussion with the patient to capture the following information as a minimum:

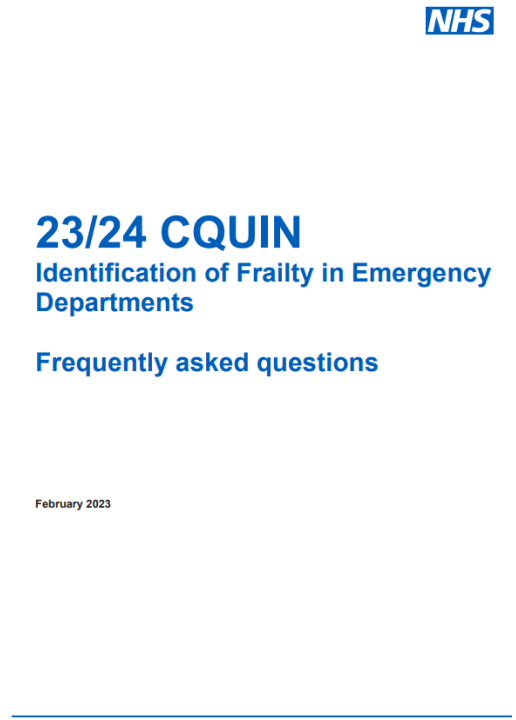
1. Current functional ability on assessment in ED/SDEC area - in particular basic activities of daily living (BADLs) (such as mobility, gait, risk of fall, use of mobility aids, dressing, washing, toileting, feeding)
2. Functional ability when last well and prior to assessment in ED/SDEC (approx. 2 weeks ago) - basic activities of daily living (BADLs) and instrumental activities of daily living (IADLs) (such as managing finances, shopping, cooking, housework)
3. Social circumstances prior to assessment in ED/SDEC area (such as type of accommodation, lives alone, level and frequency of formal/informal care support, loneliness and/or social isolation)
4. Medication review
5. Cognitive assessment (i.e. 4AT, Abbreviated Mental Test Score)

Capturing this information will support determine the onward management plan.

Sharing of information

This information should be included with Primary and Community teams as appropriate to aid onward care in the patients journey whether in the acute or community.

2023/ 2024 Identification of Frailty CQUIN



https://apps.apple.com/gb/app/clinical-frailty-scale-cfs/id1508556286

Mac iPad iPhone Watch TV Music

App Store Preview

This app is available only on the App Store for iPhone.

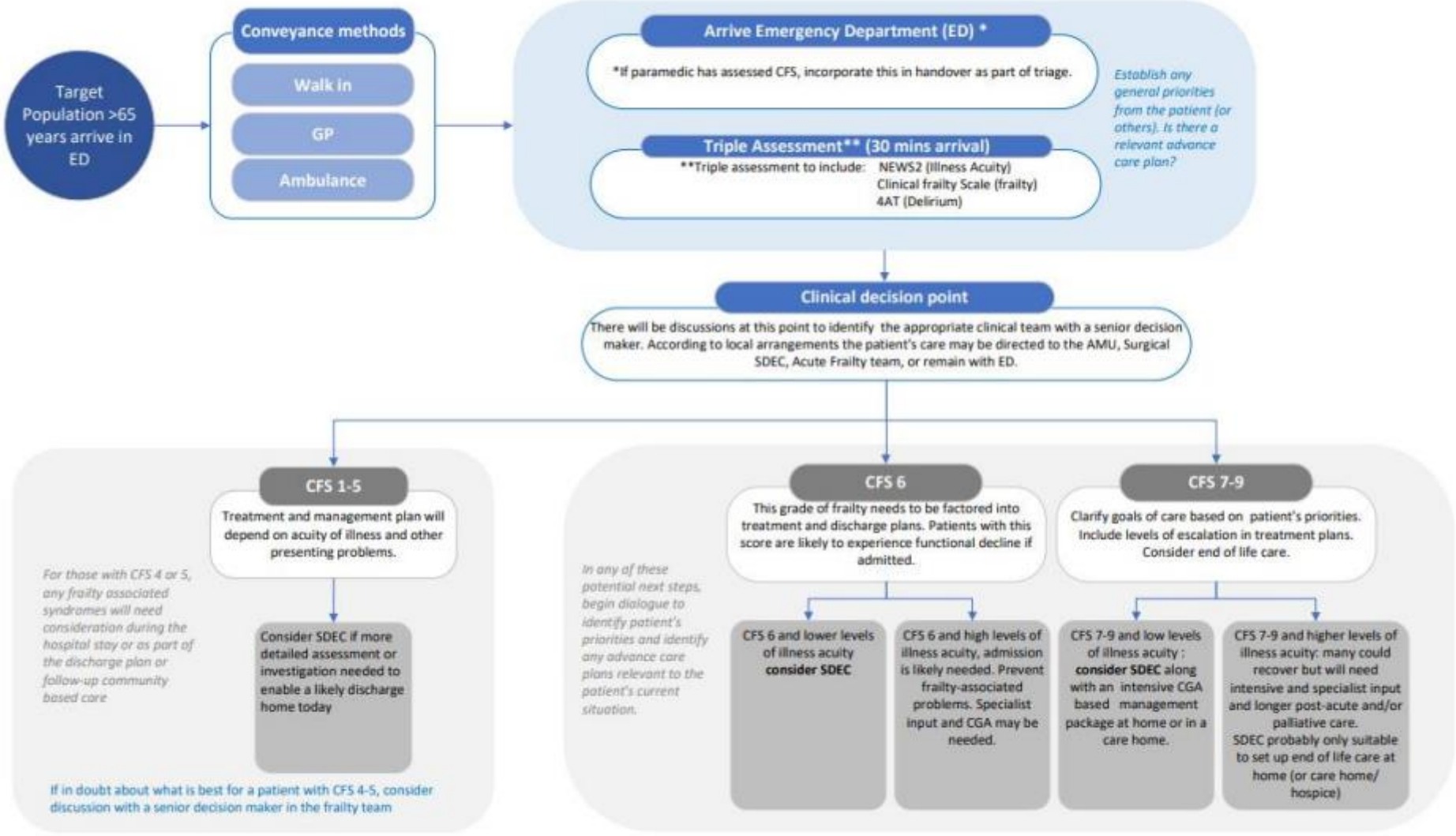
Clinical Frailty Scale (CFS) 12+

NHS Elect

★★★★★ 4.8 • 20 Ratings

Free

Guidance to support early identification of frailty to support the management of patients attending Urgent/Emergency care services



NHSE/I Acute frailty SDEC workstream 2020

NHS England and NHS Improvement

4AT

(label)

Patient name:

Date of birth:

Patient number:

Assessment test for delirium & cognitive impairment

Date: Time:

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE ☐

Emergency Care Data Set (ECDS)

2017: version 1

2021: version 3 CFS, NEWS2, Ambulance

Chief Complaint, Acuity, Diagnosis, Demographics, Disposition (NH / RH / WCF etc)

Next steps: Embed and evaluate CFS

ECDS v4: SDEC, 4AT

Ambulance Data Set

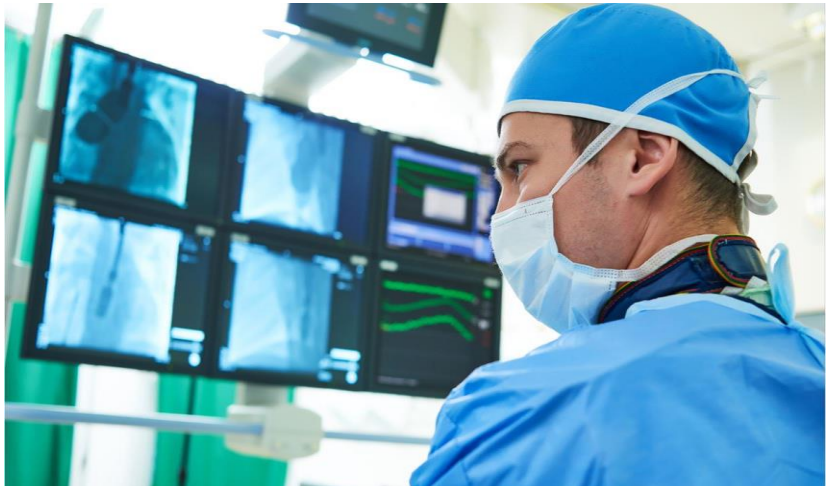
The key changes made in ECDS version 4.0 include:

- Recording of Virtual Care (including virtual consultations)
- Recording Same Day Emergency Care (SDEC) activity
- Recording of Hot Clinics (Pilot)

GETTING IT RIGHT FIRST TIME

Getting It Right First Time

Clinically-led programme, reducing variation and improving outcomes



GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust, NHS England and NHS Improvement

What do GIRFT say?

- Assess all older patients for frailty in the emergency pathway
- Mobilise early to prevent worsening frailty
- Appoint accountable officers for frailty
- Provide basic frailty training
- Look for and manage delirium
- Focus on removing barriers to discharge
- Integrate frailty across health systems

GETTING IT RIGHT FIRST TIME

https://www.bgs.org.uk/virtualwards

NHS RightCare

NHS RightCare: Frailty Toolkit

Optimising a frailty system

Increasing numbers of people are at risk of developing frailty. People living with frailty are experiencing unwarranted variation in their care.

This toolkit will provide you with expert practical advice and guidance on how to commission and provide the best system wide care for people living with frailty.

June 2019
Gateway ref: 000513

age UK
Love later life

GIRFT
GETTING IT RIGHT FIRST TIME

Informed by relevant NICE recommendations
NICE National Institute for Health and Care Excellence

https://www.england.nhs.uk/rightcare/products/p

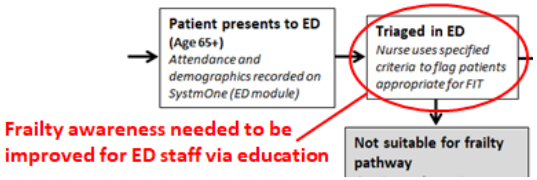
What does an Acute Frailty Service look like?

Or what to do about acute presentation of older people with frailty?

Intervene to improve overall physical, mental and social functioning and to avoid injury, hospitalisation and institutionalisation using goal-orientated rather than disease-focused approaches.

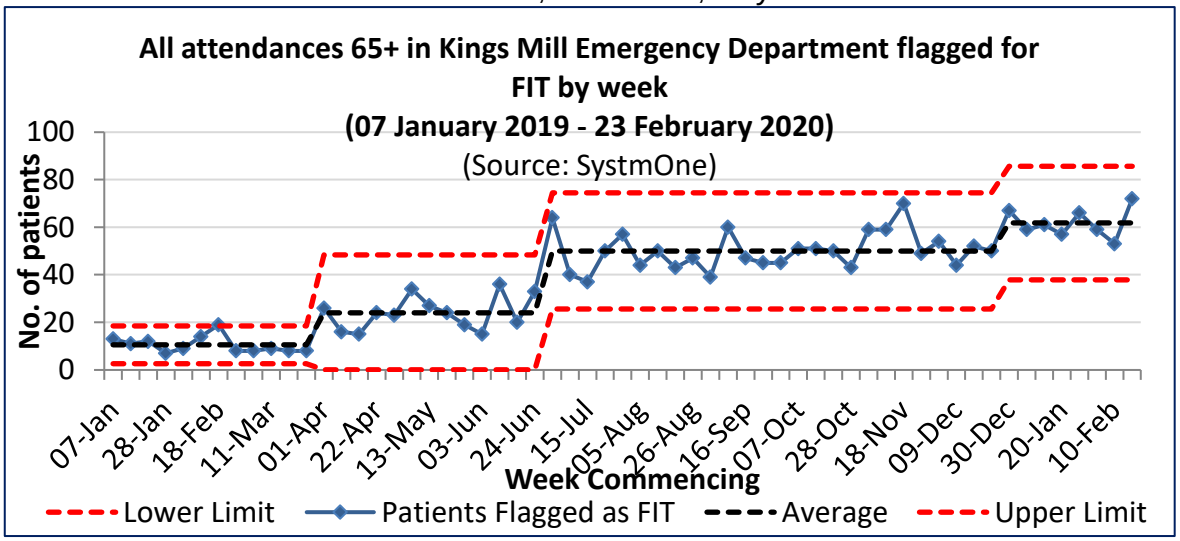
Acute Care for Frail Older People Toolkit

Process – Frailty Flagging



Flagging patients for the Frailty Intervention Team (FIT)

- Frail patients to be flagged for FIT by triage nurse on ED system
- Further education to increase FIT awareness for this process to be consistent
- Communications involvement – 'Think FIT before you admit'
- Posters, flashcards, lanyards etc.



These data show that more patients are being flagged for FIT so awareness of the team is improving.

Various models

University Hospitals of Leicester NHS Trust Acute Frailty Unit

Acute Frailty Network

Wirral University Teaching Hospital NHS
NHS Foundation Trust

SPECIALIST NURSES FOR OLDER PEOPLE (SNOPs)

- 4 New posts
- Senior nurses from the community

- In-reach into ED / AMU
- CGA commenced within 1 hour
- Pull patients through to OPAU
- Co-ordinate prompt senior review
- Liaison with community teams to assist with complex discharges
- Data collection

- Importance of defining job description

UK's first Older People's Emergency Department to be introduced at NNUH

Back to News

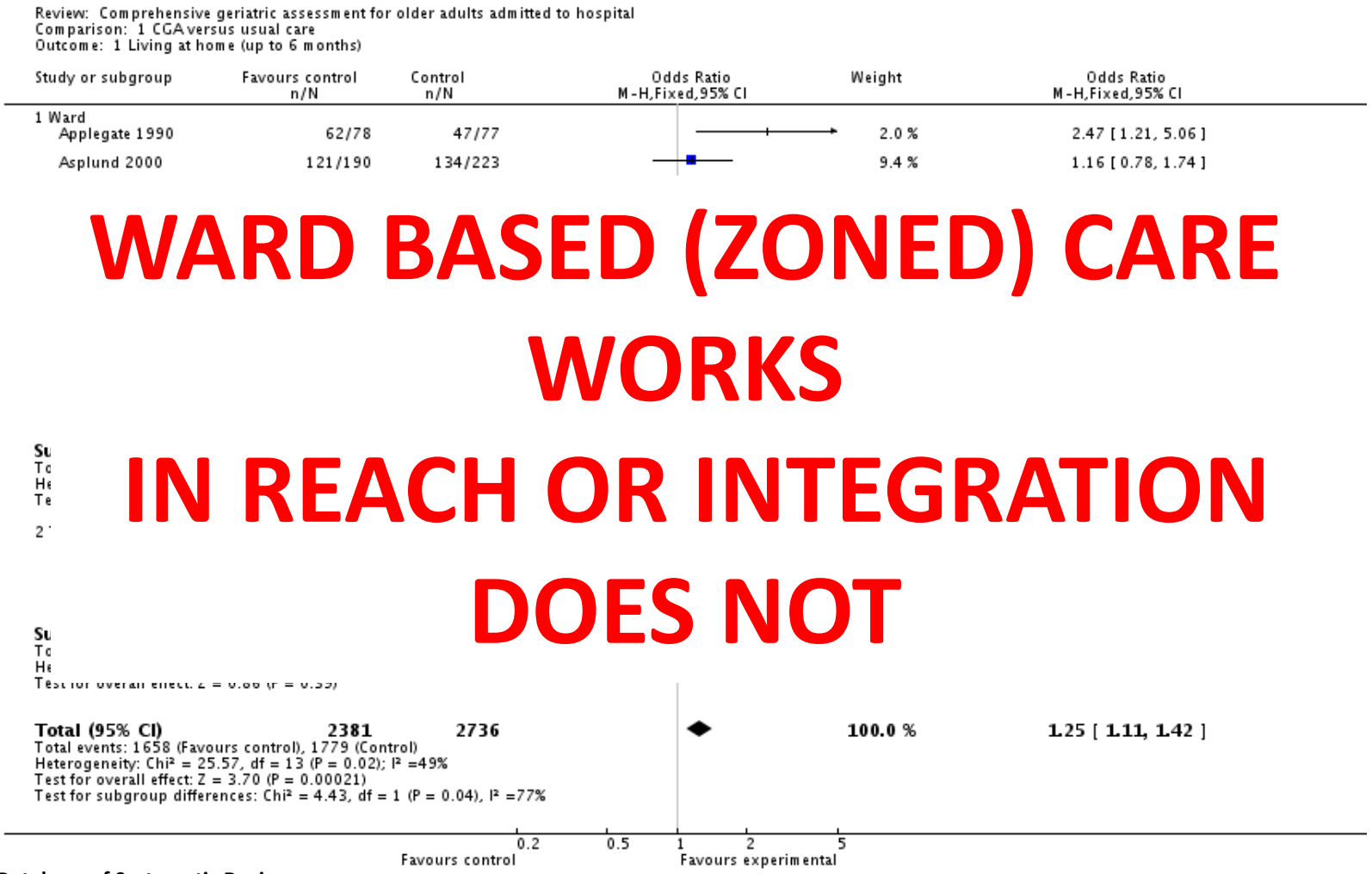
UK's first Older People's Emergency Department to be introduced at NNUH

The Norfolk and Norwich University Hospital (NNUH) has announced innovative plans to transform the way it delivers emergency care by introducing the UK's first Emergency Department that is entirely dedicated to patients over the age of 80. As well as a new Older People's Emergency Department (OPED), NNUH will also be relocating the Paediatric Emergency Department and tripling its size to improve the experience of its youngest patients.

This significant expansion, as well as other improvements to the main Emergency Department, will be completed at the end of November, with further work planned for early in the New Year.

Over the last year, there have been many changes to the care available for older patients at NNUH. Older People's Ambulatory Care (OPAC) allows many older patients admitted as an emergency to receive a comprehensive assessment and be discharged much earlier than previously. A second new service, the Older People's Assessment Service (OPAS) now allows GPs direct access to a booked appointment with a specialist geriatrician within 48 hours of referral. This replaces the traditional outpatient clinic appointment, as well as the traditional long wait for that to happen. Now, when a patient over 80 years old arrives at the NNUH emergency department, they will go straight to OPED, where there will be a multi-disciplinary team consisting of Emergency Department Consultants, Consultant Geriatricians, Emergency and Older People's Medicine Nurses waiting to provide care for them. Patients who require a longer admission will still then be admitted directly to one of the specialist older people's wards. But for other patients, these new services should have a significant impact.

Comprehensive geriatric assessment for older adults admitted to hospital



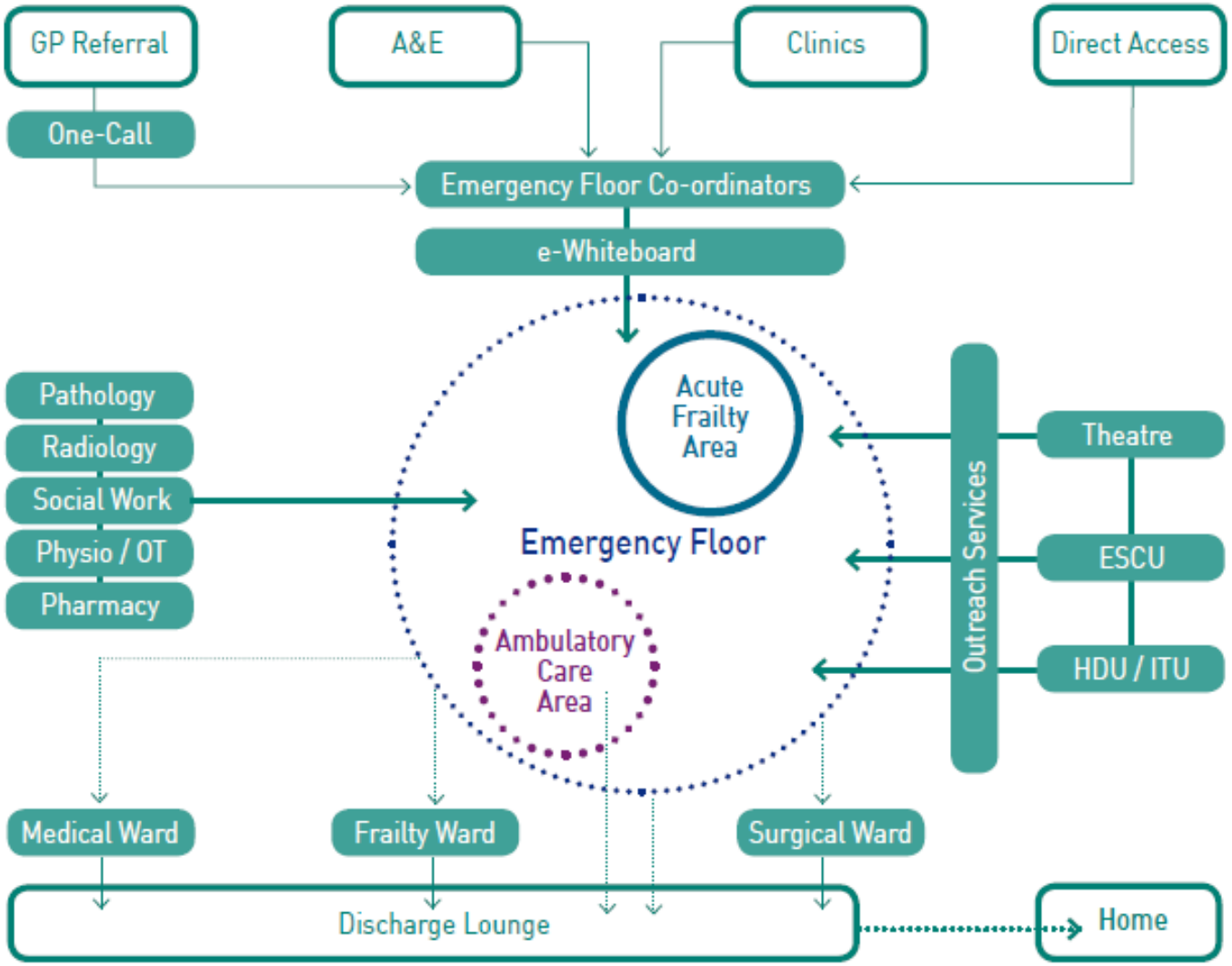
WARD BASED (ZONED) CARE WORKS

IN REACH OR INTEGRATION DOES NOT

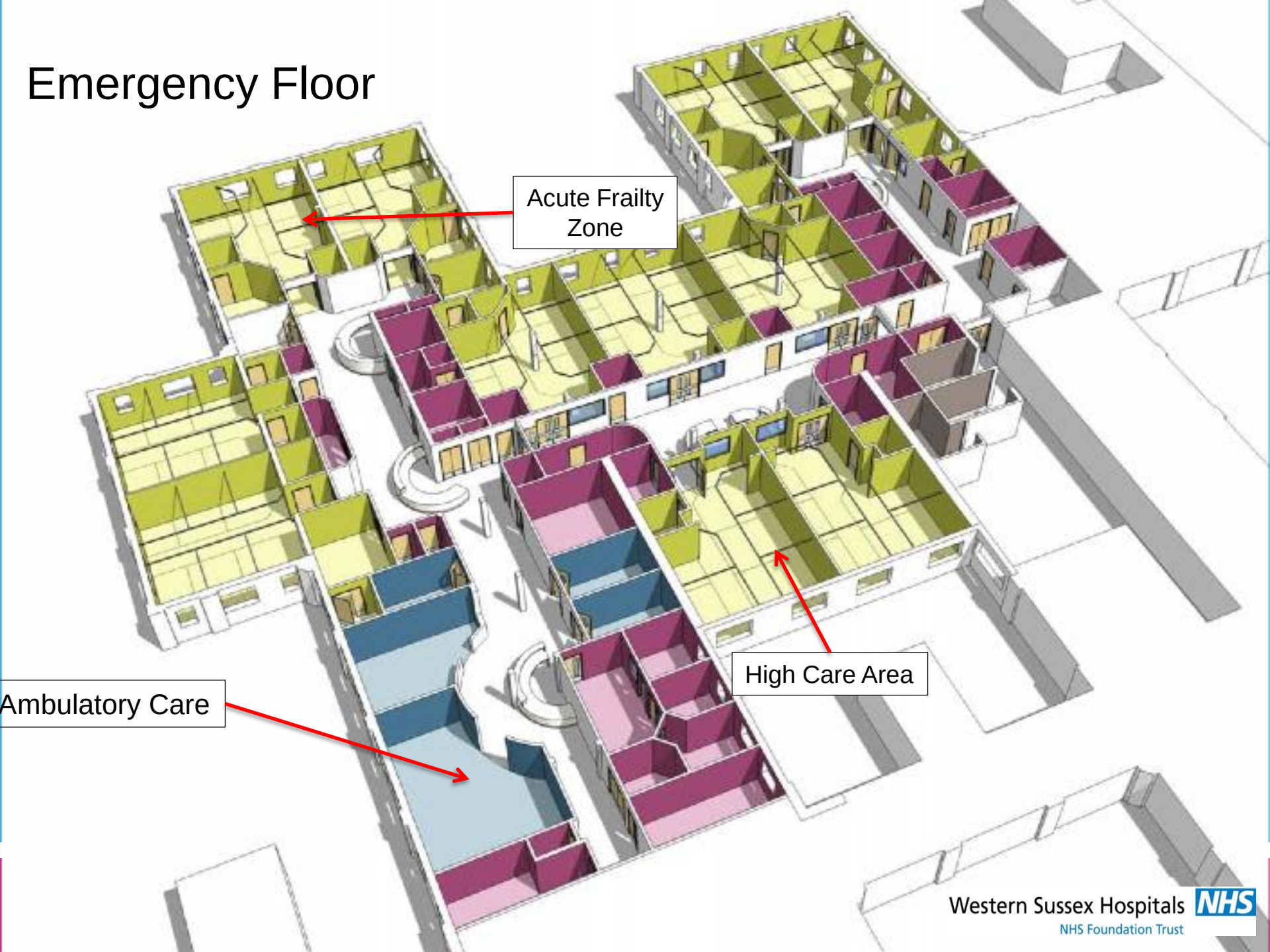
Cochrane Database of Systematic Reviews
6 JUL 2011 DOI: 10.1002/14651858.CD006211.pub2
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006211.pub2/full#CD006211-fig-00101

Emergency Floor Patient Pathway

Existing Building + Constraints



Emergency Floor



Western Sussex Hospitals NHS
NHS Foundation Trust

Frailty core skills

Western Sussex Hospitals NHS Foundation Trust

What core capabilities are needed to care for older people?

Applicable to [*everyone*]:

- Health, social care and other employers
- Employees
- People living with frailty, carers, the public
- Educational organisations which train future workforce

Framework describing core capabilities 2018

Core: common & transferable across different types of service

Capabilities: underpinning knowledge, skills & behaviours leading to competency a (the outcomes of education, training or experience)

Tier 1: Those requiring general awareness of frailty
Tier 2: Health & social care staff and others regularly working with people living with frailty but who seek support from others for complex management or decision-making
Tier 3: Health, social care & other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for older people

https://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework

Additional guidance eg on ACPs

- Society of Acute Medicine (SAM) " AHPs working in AMU competencies Version 4 2017"

- "Multi-professional Framework for Advanced Clinical Practice in England" 2017
  - Clinical Practice
  - Leadership and Management
  - Education
  - Research

  - **Training Needs Analysis completed with funding for 3 year programme**

THINK FRAILTY:

How using the frailty score improves patient outcomes

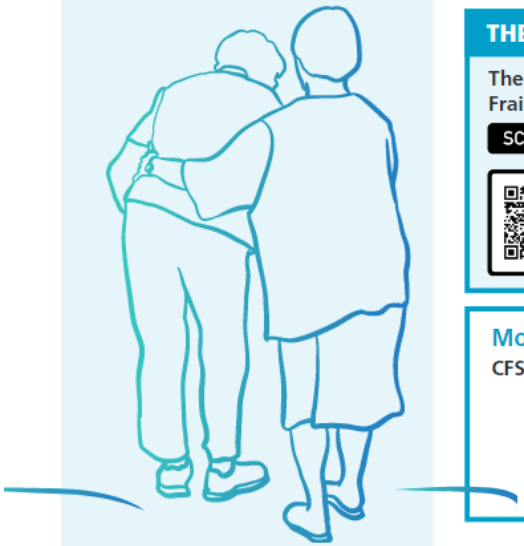
NHS England

Why look for frailty?

Around 10 per cent of people aged over 65 years have frailty and this rises to between 25-50% for those aged over 85.

Frailty should be identified with a view to improving outcomes and avoiding unnecessary harm.

When older people present to Urgent and Emergency Care services, early identification of frailty with scoring supports prediction for clinical outcomes along with presenting illness.



Why is this important for you?

Identifying that a patient is living with frailty is as important as identifying illness severity.

Both contribute to immediate and longer-term patient experience and outcomes.

Being frail at hospital admission is a risk factor for deconditioning, long hospital stays, functional decline at hospital discharge or admission to a care home.

What action can I take?

identifying grades of frailty should be part of any routine urgent assessment process, such as triage/ initial assessment in ED (if it has not already been assessed during conveyance to hospital or by the patients GP) and be initiated within 30 minutes of presentation - and completed as soon as possible.

THE KEY TOOLS YOU NEED

The Rockwood Frailty Score

SCAN ME

Top tips on using the Rockwood Frailty Score

SCAN ME

More information and local contacts

CFS 6 & above? – Call the frailty team on:

Want to know more about Worthing?

tinyurl.com/westernafn

- PFIS

tinyurl.com/westernEF

- WRG EF

WEST SUSSEX HAS THE ENGLAND DEMOGRAPHIC FOR 2035:
"Go and see" the future..

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