Norfolk and Norwich University Hospitals NHS Foundation Trust was struggling to meet the four-hour A&E performance standard and often it was frail older people who bore the brunt of those breaches. The region has a higher than average number of older people than other regions, admitting an average of 850 patients a month to its Older Peoples Medicine department.
A focus on frailty

Determined to improve the care of its most vulnerable patients, and incentivised by the National Frailty CQUIN, the Trust made frailty one of its key improvement strands. Chief Operating Officer, Richard Parker, who acted as executive sponsor for the frailty project, said:

“Focusing on frailty is an essential part of the system response to the challenge of the demographic profile, with an increasing population of older people over the next 10 years.”

Norfolk and Norwich joined the Acute Frailty Network (AFN) so it could learn from other organisations facing similar challenges and receive expert support for its improvement work. Dr Sarah Bailey, Clinical Lead for Frailty and Governance Lead for Older Peoples Medicine (OPM), explained some of the particular challenges that their region faced:

“Geographically we cover a wide area and much of the region is rural. Many younger people tend to move away so it can be difficult for us to liaise with families about vulnerable older patients as they often live some distance away. When this improvement work started, we didn’t have the Rockwood clinical frailty scale to help us establish a baseline, so we were struggling to find an effective, consistent way for staff to identify frailty.”
Cultural change
Not only was the hospital facing problems identifying and managing frail patients, but culturally there was a perception that frailty was primarily the responsibility of a small number of geriatricians at the front door of the hospital. Consequently staff tended to think it was someone else’s problem.

One of the first tasks of the Acute Frailty Improvement Team was to change this by encouraging buy-in and making all staff aware of their role in identifying and caring for frail patients. A brainstorming event in OPM produced unanimous agreement that frailty is everyone’s business and the team agreed to hold a series of awareness-raising sessions to spread the word. They held events where staff tend to congregate, such as outside the restaurant, and visited each specialty to talk to staff directly about frailty. A video telling an individual patient’s story helped to drive home the message.

A simple screening tool
Once staff were on board with the concept of frailty and could see its relevance to them, the next task was to create a simple tool that would enable them to identify it easily. They devised a simple stage one screening tool, as Advanced Nurse Practitioner Rachel Burridge explained: “It needed to be something easy and memorable that everyone could remember and use day-to-day. We came up with the idea of a mnemonic using the letters of the word FRAIL.”

The tool is applicable to patients who are living in a care home or who are 80 years old and over with one or more of the following:

- Falls (history of)
- Reduced mobility (from usual)
- Altered cognition (confusions/memory problems)
- Incontinence
- Lots of medication/care from family, friends or professional carers

The tool was tested and modified using Plan Do Study Act (PDSA) cycles. The tool was initially introduced as an optional screening device but the hospital hopes to have it added as a mandatory field very soon.

Comprehensive geriatric assessment
This simple mnemonic proved highly effective in identifying patients who were potentially frail and flagging up the need for a more in-depth comprehensive geriatric assessment (CGA). The hospital aims to carry out a CGA within 72 hours. At the start of the process, no patients were consistently receiving a CGA within 72 hours. In quarter two, 65% (source CQUIN audit) of patients identified as potentially frail were receiving a CGA within 72 hours. Quarter three increased to 71% and quarter four to 73%.

Redefining the concept of ‘frail’
Not only was the hospital keen to increase the number of potentially frail patients receiving CGAs, but it was also keen to sharpen up on the definition of frailty. There was a tendency to regard frail as synonymous with geriatric. Dr Bailey said: “We spoke with colleagues in medicine, as well as nurses and members of the multidisciplinary team, to explain that just because someone is in their 70s it doesn’t mean that they’re frail. Conversely, if someone has a diagnosis of frailty it doesn’t necessarily mean they are older. Frailty is not age-determined, it is about what that patient needs.”

Refining the diagnosis of frailty helped to reduce the workload for wards as no longer was every older patient automatically regarded as frail.

Frailty alert
A yellow Primrose PAS icon was introduced, to alert staff to patients with frailty. The next step was to link the PAS ‘alert’ with the electronic Ward View system which all of the wards have. This link was then able to create auto-referrals to Occupational Therapy (OT), Physiotherapy and Memory Matters. The GPs are informed if a patient is Frail via the electronic discharge letter (EDL) and the outcomes of the CGA are also added.
Electronic discharge letters
These letters were introduced to improve channels of communication with GPs. It was important to make GPs aware of the outcomes of the CGA but without creating lots of extra work for hospital staff. The EDL uses simple, quick, dropdown boxes. EDLs are available for anyone involved in that patient’s care at any time and provide a useful and comprehensive resource.

Frailty inbox
One of Norfolk and Norwich’s primary aims was to ensure that emergency department (ED) colleagues felt sufficiently confident to discharge frail patients from ED without admitting them to the hospital. This meant educating them on how to recognise frailty and why hospital is not always the right setting for frail patients. However, the Acute Frailty team was keen to build a failsafe to the system to take pressure off ED staff and provide a safety net for patients. They devised the frailty inbox. All information concerning frail patients is automatically sent to the inbox to be assessed by someone on the OPM team. If necessary, patients are followed up by OPM.

Improvement Manager, Cat Cole explained:
“The team reviews individual cases and invites some patients (currently around 8%) to return to an OPM outpatient clinic. At these clinics we can discuss any concerns, review medication, introduce the concepts of DNACPR and Advanced Care Planning (ACP) and signpost patients and families to additional community support. Patients who are not offered a follow-up appointment receive a phone call or are invited to discuss any concerns with their GP.”

Tailored cascade training
The Acute Frailty team created a frailty training programme, delivered by the OPM Advanced Nurse Practitioner, OPM Ward Managers and Matrons, OPM Consultant and Frailty Lead and therapy staff. The Acute Frailty team attended other departments’ team meetings and training was cascaded down to all ward staff. Jo Walmsley, Senior Operational Manager explained:
“It is important for staff to receive information about frailty that is specific to their role and supports them to deliver whichever aspects of frailty care they are responsible for. We devised different training packages for different staff groups, with content that is directly relevant to them. For example, ED staff training focuses on the importance of early identification of frailty and supportive discharge; ward based staff are reminded of the importance of adopting a multidisciplinary approach to the CGA and discharge teams are made aware of the importance of communicating frailty to teams outside the hospital. The emphasis for pharmacy team training is on the STOPP/START tool (see below) and supporting medication reviews.”

STOPP:
Screening Tool of Older People’s Potentially Inappropriate Prescriptions

START:
Screening Tool to Alert Doctors to Right (i.e. appropriate, indicated) Treatments

The training was extended beyond its original remit to include ambulance paramedics, volunteers, and the practice development team, all of whom play a crucial role in identifying and managing frail patients.
The frailty CQUIN
Norfolk and Norwich agreed a local frailty CQUIN with commissioners. Many of the CQUIN's aims have already been achieved, whilst others are in process:

1. To increase the number of patients screened for frailty
   The hospital implemented a simple screening tool using a mnemonic to make it easier for staff to remember. The tool was introduced to ED and the acute medical unit before being rolled out to the medical wards.

2. Increase the number of patients who receive CGA
   The Acute Frailty Improvement Team is working to identify opportunities within existing processes to provide early CGAs – for example, as part of ward and board rounds, Red to Green work and the SAFER bundle.

3. Increase the number of frail patients discharged to their usual place of residence
   Awareness raising, education and early liaison with ward teams is playing a key role in better discharge planning.

4. Reduction in conversion rate from attendance in ED to an admission
   The OPM team educates and supports ED colleagues to assess the risks of discharging frail patients. The frailty inbox provides a failsafe. The hospital has also set up a dedicated phone line that staff can call for advice from a geriatrician. It currently operates between 9am and 5pm but the hospital is planning to extend it from 8am to 8pm.

5. Perform ACP for 90% of frail patients
   This deliverable posed a considerable challenge and the hospital has yet to achieve it. Jo Walmsley commented:

   “We see many patients who are admitted from care homes with long-term conditions who could benefit from ACP delivered in the pre-hospital setting. Although we have not yet achieved our goal of 90%, we are committed to improvement in this area. We have increased the number of patients who are discharged with an EDL that contains information about their resuscitation status or makes recommendations for ACP to be considered by community teams. The Acute Frailty team is liaising with other teams in the hospital to look at the use of the Resuscitation Council’s RESPECT document.”

Impact
Data for OPM patients aged 80 and above (Data source: NNUH IS)

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<thead>
<tr>
<th></th>
<th>April to March 2016</th>
<th>April to September 2017</th>
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<tbody>
<tr>
<td>Conversion rate of patients admitted from ED</td>
<td>61.1%</td>
<td>53.6%</td>
</tr>
<tr>
<td>Patients discharged by OPM Consultants to usual place of residence</td>
<td>70.2%</td>
<td>73.4%</td>
</tr>
<tr>
<td>LOS – Average stay in calendar days (ordinary admission only) discharged by OPM Consultant</td>
<td>Mean Average 9.8</td>
<td>Median Average 5</td>
</tr>
<tr>
<td>Readmissions within 30 days - discharged by an OPM Consultant on first admission</td>
<td>20%</td>
<td>*18%</td>
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*please note data relates to readmissions up to 26 September as 30 days had not passed from end of September at time of writing.

Since introducing processes to highlight potential frailty in older patients and by working more closely with colleagues in ED, the conversion rate for this group has improved, as has the number of patients returning to their usual place of residence following a hospital spell.

Although there was concern that changing processes would impact negatively on the length of stay, it has remained stable and due to more comprehensive communication with GPs, the readmission rate has also improved.
Next steps
Norfolk and Norwich opened an Older Person's Assessment Area on one of its short stay wards in July 2017. The area will provide a more conducive environment for carrying out CGA and will also be used for physio and OT appointments. Staff will actively pull patients from ED onto the assessment area.

The hospital has plans to extend the hours that acute frailty staff are located in ED once sufficient resources can be found and it has also completely redesigned the outpatient service so that frail patients can be seen more quickly within 48 hours. There is an ambition to offer next day appointments to provide peace of mind to patients and staff.

Key learning
Norfolk and Norwich believes the key to admission avoidance for frail patients is giving staff in ED the confidence to discharge them. To achieve this, it has implemented a multi-pronged approach including:

- education and training so staff are more familiar with the concept of frailty and how to respond to it
- visible support from frailty consultants in ED who can provide expert input
- simple tools to help staff identify frailty easily
- the frailty inbox as a failsafe to reassure staff

Changing mindsets has been one of the keys to success. Firstly, this was about conveying to staff that frailty is everyone’s business and making it relevant to them in their speciality. “Not all frail patients are older patients,” said Dr Bailey. “A younger person with respiratory disease can also be frail. We did a lot of work to change the perception of frailty.”

Secondly, it was about educating people to think twice before admitting frail patients. “We want them to think twice about bringing vulnerable people into hospital,” explained Rachel. “We did this through case studies and by presenting the evidence about the impact of admission on frail patients. For example, we showed them the Mrs Andrews video, which charts a patient journey that goes wrong.”

The hospital adopted the motto ‘think twice, ask twice’ for staff who are considering admitting frail patients. It provided a helpline for paramedics, offering advice on alternatives to bringing patients into the hospital.