NCUHT Frailty Service

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Care in the right place at the right time

• 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 #pjparalysis  
  (Gill et al 2004)

• 43% increase in mortality at 10 days following admission through a crowded A & E  
  (Richardson, D.B.) (2006)

• For patients that are seen and discharged from an A & E the longer they have waited to be seen the higher the chance that they will die during the following 7 days  
  (Guttman et Al 2011)

• 48% of people over 85 die within one year of hospital admission  
  (Clarke et al 2014)
Patient in A & E / EAU identified as meeting criteria receives assessment.

Care for the Older Person in A & E:
- Consultant
- Frailty Nurse
- OT
- Physio

- Patient admitted to short term/frailty assessment bed
- Frailty Team
  - Consultant
  - Nurse
  - OT
  - Physio
  - Discharge Navigator

- Patient admitted to care of the older person ward

- Patient admitted to specialist ward

- Patient sent home with appropriate support
Early Specialist Intervention

- In reach to A & E and EAU
- Working with ‘Home First’ & specialist therapists
- Early Comprehensive Geriatric Assessment
- Referral to ‘hot’ clinics
- Admission to Acute Frailty Unit
Acute Frailty Unit

- 12 bedded unit
- Direct admission
- Criteria to admit
- Expected stay of less than 72 hours
- MDT approach with designated therapists
- Mobilising patients as soon as possible, when possible
Frailty Clinics

- ‘Hot’ rapid access clinics with referrals from GPs and ED ‘Home first’ therapists
- Planned/bookable frailty clinics 3 x weekly
- Comprehensive Geriatric Assessment
- MDT approach
- Referral back to GP and community services
GOW – (not GOD)

• Geriatrician on a weekly rota
• Information and advice for GPs, Community Hospitals, core wards
• Support to keep the patient at home
• Direct admission to FAU
• Referral to Frailty Clinic for CGA
Timely Discharge

• Willow A Exemplar ward for SAFER
• Red and green days
• Reduced length of stay
• Proactive therapeutic approach to maintaining mobility e.g. dance recall
• Discharge to Assess
• Discharge Navigator
**Evidence / Results**

**Average Length of Stay (days*)**
*Apr 16 to April 17*

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<tr>
<th>Date</th>
<th>Maple A</th>
<th>Elm A</th>
<th>Average LoS over the Period</th>
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- **Maple A**: 7.6 days
- **Elm A**: 4.5 days

*Additional bed days if 573 completed Elm A ward stays had LoS of 7.6 days*

% change: -41%
In a recent CQC inspection the service was highlighted as an area of outstanding practice:

- ‘There were innovative and progressive Frailty Unit projects at CIC.’
- ‘The implementation of dance related activities for vulnerable patient groups stimulated social interaction, patient involvement, family partnerships, and exercise.’
Patient Experience

Face to Face Survey
Ward Elm A Frailty Unit, CIC, as at 21/04/2017

100% of patients surveyed would highly likely or likely recommend this ward to their families and friends.

Number of respondents 8 (80%)
Number of patients on new medication 6
Ongoing work & Next steps

• Creating links with the local ICCs. Frailty Nurse is now attending weekly frailty meetings with the community teams.

• An ambulatory care bay attached to the unit, with the frailty clinics and frailty unit working closer together

• Assessment and change to the frailty assessment / CGA documentation.
Case Study

• 97 year old gentleman identified at ICC frailty meeting. Direct Admission arranged to AFU. Immediate and ongoing CGA and diagnostic tests. Discharged home within 72 hours, with appropriate follow up.
Positive Outcomes

- Avoidance of ED
- Rapid Admission and CGA
- MDT approach
- No ward moves
- Short length of stay
- Communication with community teams
- Improved patient & family experience
There is much to celebrate in people living longer...

(Growing Old Together. Sharing new ways to support older people, NHS Confederation, 2016)
Questions?