Acute Fraility Network

Improving the care of people with frailty at Frimley Park Hospital

www.acutefrailtynetwork.org.uk
In March 2017, consultant geriatrician Dr Lucy Abbott took on the brief to set up an Acute Frailty unit and team at Frimley Park Hospital. Knowing that frailty is a priority for the organisation, she went to the Director of Operations and asked for funding for membership of the Acute Frailty Network (AFN). The Trust had been successful as a member of the Ambulatory Emergency Care (AEC) Network and the funding was made available to enable Lucy to tap into the AFN’s expertise, tools and resources.

The AFN provided support for the project. They held workshops to help the Trust gain skills such as measurement, undertaking quality improvement, managing change and supporting experience based design (EBD) with patients. The organisation continues to use AFN tools and templates to make and monitor improvements. The AFN facilitator assigned to support the site has been a great help and checked in with the local project team every two weeks throughout the project. Following completion of the 12month programme, the organisation is about to appoint its own project manager to carry on the work.

Lucy feels that membership of the AFN has raised the profile and increased the credibility of the project, both within and outside the organisation.
How did the project start?
The project started off by engaging with hospital and community partners to spread the message about the change and educate staff. The first AFN event took place in May 2017, to set the vision and aims for the project. The AFN team undertook their first site visit in June.

Identification of the person with frailty
The first improvement, ‘frailty identification in A&E’ was launched in August 2017. Frailty identification for all people over the age of 75 years is now mandatory. Every patient over 75 with frailty now receives a frailty flag, which is recognised throughout the organisation and beyond.

The Older Persons Short Stay Unit
The Older Persons Short Stay Unit was launched in October 2017. Thought was put into the title of the unit to manage people’s expectations of length of stay. The use of the words older person was also intentional, as people do not like to be called elderly or frail.

The ward was originally a 22 bedded elderly care ward. With the AFN’s help, Lucy and the team developed it into the new unit. The unit now has a robust multidisciplinary team, with physiotherapists, occupational therapists (OTs), social care practitioners, pharmacists and in-reach practitioners amongst the team.

The Short Stay Unit holds board rounds every day at 8.30am, and in the afternoons. A community integrated care team member attends. The whole team is flexible. For example, an OT who works on the bank at the weekend, elects to come to the Monday morning board round to tell the team about her patients. Sometimes, in-reach GPs attend board rounds too.

Length of stay on the unit is expected to be less than 72 hours. The reality is occasionally different, especially in winter. However, length of stay continued to reduce over the winter period 2017/2018 by 0.9 days. Overall, length of stay has reduced by 1.8 days since the launch of the OPSS Unit, with no increase in readmissions.

There are still 22 beds, which is more than is needed for short stay and as a consequence there are some longer-stay patients. Due to patient’s cognitive problems, staff do not want to move them unnecessarily. This accounts for some longer stays.

At the beginning, it was difficult to ensure that the appropriate patients were admitted to the Older Persons Short Stay Unit. Some patients may have been able to go home from the front door, rather than be admitted. This indicated the need for a front door frailty team.
Creating the Integrated Frailty Liaison Team

The organisation put in a bid to NHS England for winter pressures funding with their partners. The intention was to create an integrated frailty team with mixed community and acute services at the front door of the hospital. The organisation received six months of funding to create the team, allowing them to be in post by April 2018. Other team members, such as in-reach GPs, were funded by the CCG.

As well as working in ED, the Integrated Frailty Liaison Team go out to other medical and surgical patients in the hospital if required. The Team currently consists of:

- A Band 7 nurse
- A consultant geriatrician every day
- A Band 8 frailty nurse consultant
- A Band 6 community OT
- An SHO
- In-reach GPs.

This current team will be expanded to meet the demands of providing a seven-day a week, 10 hours per day, service, now funded by the Frimley Health and Care Integrated Care System.

The frailty team also support community frailty pathways, so rather than being reactive in hospital, comprehensive geriatric assessment (CGA) happens proactively in the community. This has the potential to prevent frailty crisis and avoid admission to hospital. The project has been supporting integrated care teams for people living with frailty. This means that patients are often already known to the acute team when admitted and community team when discharged. Farnham and Surrey Heath are two areas that have already established frailty MDTs and are spreading practice out to the other integrated teams.
How was the improvement measured?

The project measured the impact of each improvement on a set of criteria using AFN tools. It is difficult to analyse the impact of the outreach part of the frailty team, as many different factors come into play. However, there is good qualitative feedback from wards and the number of stranded patients has reduced as shown by graph 1.

As a result of the improvements to the frailty pathway, the time spent by patients with frailty in ED has reduced (graph 2) and the length of stay and mid-day occupied bed days on the OPSS unit has continued to decrease (graph 3).

To calculate the financial saving associated with improvements made by the frailty team, 50 patients whose admissions were avoided by the team were reviewed. Based upon the non-elective (NEL) tariffs that would have been incurred had the patient been admitted, the average saving per avoided admission could be determined. By multiplying this average cost by the number of avoided admissions per week, an average annual saving of £557,336.00 was calculated.

In addition to financial benefits, a patient experience story using a frail older person who had recently been admitted to Frimley Park Hospital describes excellent feedback surrounding the frailty team and their overall hospital experience. The focus on patient centred care for frail older people from the very start of the pathway resulted in a positive and high quality experience for both the patient and their family. To read the full return on investment and patient experience case studies, please visit www.acutefrailtynetwork.org.uk.
**Are the changes sustainable?**

Frimley Health has its own integrated care system - one of the most developed in the country - so draws down funding for the care system as a whole. Because Frimley Health had frailty as one of its five key priorities, the organisation was keen to support the concept of the hospital’s front door team. Lucy went to the Integrated Care System Transformation Board to obtain a further six months of funding to enable a seven day service to run until spring 2018. The allocated funding is about to run out, but because the improvements have generated demonstrable good results, it is expected that long term funding will be guaranteed to continue the work.

The future depends on the availability of long-term funding, so assuming that this is agreed, then the changes are sustainable. The team are using the AFN sustainability questionnaire; the score has increased over time and is rated quite highly.

The team has a regular Frailty Delivery Group meeting, which is now co-chaired by the new nurse consultant and Lucy. This means that there is no longer a need to cancel meetings if Lucy is unavailable.

Securing longer term funding will allow the frailty team to deliver the metrics outlined in the national document; Ambulatory emergency care guide; Same day acute frailty services by NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network, published in June 2018.

**How well is the unit functioning now?**

The unit is performing well, although Lucy would like to add some services, such as increased pharmacy input and more capacity is required in community intermediate care services. The team are on a continuous journey of improvement.

**Is there anything that stands out as a key benefit? What would make Lucy want to do it all over again?**

The main thing is the beneficial impact on the patients and the ability to manage the perceived risks associated with earlier discharge home. It feels like the team are now supporting what matters most to the patient as well as their relatives and carers, identifying what the patient wants to achieve, and improving quality of life.

The team took a leap of faith in starting the service, taking on the new and unknown. They have been well-received by patients and staff, and it really feels like they are making a difference.

**What communications mechanisms are being used?**

The team has a Twitter feed at #frimleyfrailty. This works well. They have given numerous educational presentations to acute and community services, published articles in the newsletter and trust magazine and weekly bulletin, as well as presenting posters at the British Geriatrics Society and AFN national conference. The service was also featured as demonstrating best practice in a recent CQC publication “Under pressure: safely manging increased demand in emergency departments”

Evidence-based training and education has been put together in the form of a degree-level module which covers the Level 3 competencies from the Frailty Core Capabilities Framework, and online training is being developed to cover Level 1 and 2 competencies. This will be available to all health and social care professionals within the integrated care system.
What’s next?

The team has ambitions to continue improving and spreading good practice;

1. Wexham Park is Frimley’s sister hospital; the team will be implementing the same changes there.
2. Maintain long term funding
3. Seven-day service across both hospitals
4. Planned publishing of research
5. Integrated care provision and proactive approach to continue
6. Education and training will improve, with an MSc degree module Living with Frailty aimed at acute and community staff to start with, then social and primary care.