Acute Frailty Network
Patient Centred, Holistic Approach to Assessing Older People with Frailty and Urgent Care Needs

University Hospitals of Leicester NHS Trust
**Context**

Since about 2000, UK health policy has promoted the concept of acute medicine - the early, rapid assessment of people accessing acute care, typically in discrete Acute Medical Units. The early acute medical services tended to operate upon a medical model of care, without significant focus on the care of frail older people or explicit attempts to deliver comprehensive geriatric assessment (CGA) for frail older people within the acute medical unit setting. Services tended to be integrated and offered generic acute care provided by a range of hospital physicians working ‘on-call’. In the year following attendance and discharge from an acute medical unit, older people with frailty experienced high rates of readmission and other adverse outcomes. This prompted the search for more effective and efficient models of care for older people with frailty in urgent care settings.

**Over Arching Principles**

During the course of our service developments and evaluations, we have identified a number of principles that seem to be associated with better outcomes for older people with frailty and urgent care needs, many learnt by trial and error, some derived from research or understanding of best practice from elsewhere. The key principles that we think are associated with better outcomes for older people with frailty are:

1. Identify older people with frailty and urgent care needs at the earliest possible point in their urgent care journey

2. Adopt a patient centred, holistic approach to assessing older people with frailty and urgent care needs

3. Ensure that the needs of older people with frailty are addressed using interdisciplinary approaches

4. Adopt a whole system perspective building upon a shared common vision - quality care for older people across the whole patient pathway (acute and community settings)

5. Embed evidence based care (Comprehensive Geriatric Assessment - CGA)

6. The delivery of CGA should not just be about Geriatricians, but competency driven
7. The importance of avoiding pilotitis

8. Risk sharing across all settings - clinical and financial

We cover each of these principles in more detail in the sections below.

**Identify Older People with Frailty and Urgent Care Needs Early**

Hospitalisation of an older person can be a sentinel event that heralds an intensive period of health and social care service use. This is especially the case for ‘older people with frailty’, a distinctive late-life health state in which apparently minor stressor events are associated with adverse health outcomes. Depending upon definitions, the setting and local service configuration, about 5-10% of all emergency department (ED) attendees and about 30% of patients in Acute Medical Units are older people with frailty. The purpose of focusing on older people with frailty is that they represent a relatively small proportion of all those accessing urgent care settings, but an increasing proportion of those at risk of harms and high resource use as they progress from admission onto inpatient care.

However, there is limited evidence for the discriminant ability of frailty scales in the urgent care context: although most scales perform better than chance in predicting a range of poor outcomes, none of them performed adequately for individual clinical decision making, and most perform either poorly or very poorly\(^2\). Until more accurate tools become available, simple clinically acceptable criteria can be used to identify a large proportion of older people who are frail (sensitivity) but without good enough specificity to exclude some older people without frailty. Examples include:

- **Age 65+ AND** presenting with one or more frailty syndromes (confusion, Parkinson’s Disease, presenting with fragility fractures and/or falls, care home residents) **OR** people aged 85+

**AND/OR**

- Moderate or severe frailty (grade 6-9) using the Canadian Frailty Scale

We are currently undertaking work to look specifically at a number of commonly used scales to ascertain which are easiest and most acceptable for use by busy ED teams. Interestingly, 40% of Geriatricians surveyed at the Edinburgh Frailty Conference felt that frailty identification should take <1 minute, but the majority felt it should take ≥5 minutes - whereas ED clinicians felt the process should take <1 minute.
Adopt a Patient Centred, Holistic Approach to Assessing Older People with Frailty

General medical care principles apply as much to older people with frailty as anyone else - Early Warning Scores, timely diagnostics, early assertive case management, early goal setting and so on. For example, an older person with a Modified Early Warning System (MEWS) of ‘0’ at admission has a very low probability of death (OR 0.14, 95% CI: 0.08-0.24).

But there are important differences common in older people with frailty that make their care more ‘interesting’. Typically, nonspecific presentations with geriatric syndromes such as falls or delirium may cause diagnostic uncertainty. Communication barriers necessitate involvement of carers and families. Coexisting problems including multimorbidity make assessment and management complex.

To help address these issues, we strongly encouraged the use of ‘problem lists’, and have made these a core part of our assessment documentation. The focus on problems rather than diagnoses helps avoid pathway driven care, towards more patient focussed issues and problem solving. Importantly, the assessment booklets are multidisciplinary, making it easier to synthesise the full range of issues that need to be addressed in order to provide holistic care.

Ensure That the Needs of Older People with Frailty are Addressed Using Interdisciplinary Approaches

Interdisciplinary Working

A cornerstone of Comprehensive Geriatric Assessment is interdisciplinary communication and coordination. These have been traditionally been delivered using Multidisciplinary Team (MDT) meetings - typically on a weekly or occasionally daily basis. Clearly this frequency is not well-adapted to the urgent care setting, so alternative mechanisms are necessary.
In some settings, it might be possible to bring the team together for rapid MDT discussion about patients - for example in ‘observation units’; such meetings should be at a fixed time every day and for a fixed duration so that expectations for attendance and duration are clear to all team members. On average, each patient discussion should be for no more than 1 minute, and it might be helpful to structure the discussion using the domains of the Comprehensive Geriatric Assessment - physical/medical issues; functional/mobility issues; cognition/mood; social support networks and environment (home setting).

We found that having all the members of the team come together in real-time urgent care settings improved communication. In Leicester, this is achieved most efficiently by frequent brief MDTs highlighting actions and progress (see https://vimeo.com/132073531). We have used Quality Improvement methods to drive up the consistency and frequency of MDT meetings.

In the main area of the ED (‘majors’), coordination and communication can be more difficult, as it will be unusual to be able to have multiple staff involved with the same patient at the same time. In this scenario standardised documentation, again based on the principles of CGA, can help staff more easily navigate the issues that have been addressed, and identify where value can be added. Even in a busy and noisy majors area it is possible to bring most clinicians together every hour or two for a quick run through of the patients. In addition to addressing the domains of CGA, it is useful to consider situational awareness issues in this context.

**Delivering Comprehensive Geriatric Assessment**

It can be challenging to carry out CGA in urgent care settings because of constraints of time and place or because of the priority of urgent medical treatment (e.g. for septic shock) or resuscitation. But even then, elements of CGA are needed as factors such as mobility, cognition and patients’ wishes at the end of life have an important impact on clinical management. So challenging as CGA in urgent care might be to deliver, it is important, and urgent care services must adapt to meet this challenge, just as they have adapted to meet the urgent needs for stroke thrombolysis or...
coronary angioplasty.

In Leicester we have addressed this through two main strategies:

1. Embedding geriatric services within the ED
2. Spreading the influence through education and training

**Embedding Geriatric Care in the ED**

We established an Emergency Frailty Unit, which essentially offers ambulatory care for frail older people (it’s just that many of them are not very mobile!)

In January 2011, the University Hospital of Leicester merged two acute medical services (Leicester Royal Infirmary and Leicester General Hospital) onto one site (Leicester Royal Infirmary). This allowed a team to be freed up from delivering conventional acute care in the acute medical units to support the development of the Emergency Frailty Unit (EFU). The EFU was allocated between 8-12 beds on a day by day basis, according to demand. From March 2011, the service moved to complete coverage by geriatricians, 08:00-18:00, seven days a week. A standardised integrated proforma was developed, along with care pathways guiding the care of frail older people within the main emergency department. In addition to a daily ward round of patients admitted overnight, the geriatricians also fulfilled an in-reach function to the major receiving area of the ED. Additional efforts were made to integrate geriatric medicine and emergency medicine through shared clinical assessments and decisions making, joint governance meetings and joint education and training meetings. The EFU continued to focus its efforts on older people who were likely to be discharged home within 24 hours, with standard acute medical care being provided elsewhere within the hospital for those patients who required it.

In addition we work closely with our Emergency Department colleagues, supporting them clinically on the ground, through in-reach into the majors area, by ‘Primary Care Coordinators’, essentially gerontological nurse specialists.

The geriatricians are also learning from the ED team about trauma and other issues in older people, which is refreshing!

**The EFU Team!**

- **Medics**
  - ED
  - GER
- **Nurses**
  - Staff Nurses
  - Primary Care Coordinators
  - Physiotherapists
  - Occupational Therapists
- Healthcare Assistants
- Administrative Staff
- Porters
Embedding Geriatric Care in the AMU

In the Acute Medical Unit we first tested a liaison or Older Persons Assessment and Liaison (OPAL) type model (of course we had to call ours something different - FOPAL!), but this was not very efficient in terms of time per patient, and not always effective as advice was not always followed, in keeping with the broader literature on geriatric liaison. So we developed our Acute Frailty Unit (similar to the Sheffield model); this essentially replicates the processes described in the EFU above, but with more of a focus on acute care than ambulatory care, although both are possible.

Adopt a Whole System Perspective Building Upon a Shared Common Vision

A key enabler for any of the changes described above was the involvement of the whole system on the journey. This started out with a small collaboration between geriatric medicine, emergency medicine, public health and community services agreeing a vision and the steps needed to deliver that vision. We then engaged with a wide range of stakeholders (CCGs (previously PCT Leads), mental health, acute and community care colleagues) to spread awareness, prior to starting the project off. We maintained awareness through regular communication, including email, stakeholder meetings, WhatsApp groups and sharing success narratives e.g. http://www.nhselect2.org.uk/aec/afn_leicester_afu3.php. Importantly, we were able to measure the impact of the service developments and adjust according to effectiveness, for example, maintaining the EFU based on evidence of impact, but evolving the FOPAL service in light of the apparent inefficiencies.

It is not always easy, and there were many challenges, but the initial broad base of support helped maintain energy, focus and commitment, not least thanks to the support of senior clinical and non-clinical leaders in the system, backed up by evidence.

Embed Evidence Based Care (Comprehensive Geriatric Assessment - CGA)

Throughout our journey our focus was not just upon avoiding admissions, (although to be clear, the business model was based upon bed-day efficiencies), but on quality care for the whole of the patients’ episode. Aware that quick fixes at the front door were insufficient, we tried hard to ensure that early decisions were holistic, coordinated and well communicated, and most importantly linking into community services.

The existing care pathways between secondary care and primary and/or social care were further developed and strengthened. There was an emphasis on vertically integrated care...
pathways for frail older people, including for example, permitting the acute frailty assessment to act as the admission assessment and management plan in community rehabilitation facilities.

The Delivery of CGA Should Not Just be About Geriatricians...

We were well-aware that this was not just about geriatricians, and set about establishing education and training fellowships that enhanced geriatric competencies in other specialities, for example, Emergency Medicine trainees and foundation doctors. These fellowships allow clinicians to develop their knowledge of geriatric medicine and the services that they might need to access, improving their skills in assessing older people, especially those with cognitive impairment, and change attitudes and behaviours, e.g. by working in the community setting to breakdown the potential silo mentality that can exist. Clearly we cannot train everyone, well at least not yet, but those that were ‘frail-friendly’ can also act as ambassadors elsewhere in the system. For example one of our early GEM fellows went on to set up a frail friendly ED elsewhere.

We also recognise that geriatricians have much to learn from Emergency Medicine (EM), and our current Geriatric Emergency Medicine (GEM) fellow is a geriatrician learning more about EM. So this is about creating a social movement and a passion to improve. Twitter, web blogs, awards and praise for those willing to change to improve care for older people are all very important.
The Importance of Avoiding ‘Pilotitis’

All too often the NHS is brilliant at having good ideas and implementing them (more or less effectively), but is not so good at evaluating and sustaining them. We think we did this differently in Leicester, by working hard to develop the services as much as possible before carefully evaluating the impact. This way we ensured that we evaluated ‘mature models of care’ rather than the early ‘storming and forming stages’. For example, the EFU took about six months to really settle into the ‘norming and performing’ phase before eventually becoming normal practice. This is difficult as the appetite for quick wins is rife in the NHS, so there is something about managing expectations early on, and agreeing prospectively some of the parameters and timings for evaluation.

It was also interesting to observe the focus on data for judgement, rather than measurement for improvement - see the IHI Thinking (http://www.ihi.org/resources/pages/howtoimprove/scienceofimprovementestablishingmeasures.aspx) about this!

Risk Sharing Across all Settings

Whole systems approaches are required to modify urgent care use, in particular systems that align primary and secondary care (vertical integration), despite which governance, budgets, line management and information systems rarely cover the whole patient pathway.

We do not have a solution for this, but some areas have been more successful at devising shared ownership and accountability, which can sometimes be helped by organisational integration, though the latter should always be driven by the patient pathway, not organisational priorities.

Summary and Reflections

We have not got everything right in Leicester, we still struggle and we still have the embarrassment of people waiting to access the ED in ambulances, in keeping with much of the NHS in 2016. But we have experimented and tried and tested different ways of working. Importantly through careful evaluation, albeit having to use service data rather than patient reported outcomes (that’s another journey to follow!).
we have got a service in place that offers quality care for most older people with frailty, most of the time.

We still have a long way to go to make our whole hospital frail-friendly, but what else is there to do for the next 25 years?!

References

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www.acutefrailtnetwork.org.uk
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