Acute Frailty Network
Holistic Care for Frail Older Patients in the North Midlands

University Hospitals North Midlands NHS Trust
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The first 72 hours are critical in the care of frail older patients. Evidence shows that they can begin to deteriorate (decondition) rapidly after this time and the chances of them being discharged home decrease with each day they spend in hospital. Ten days in hospital produces the equivalent of 10 years’ ageing in the muscles of people over 80.

The Acute Frailty Network was established to support hospitals to improve the care of these vulnerable patients. Based on the recommendations of The Silver Book, which proposes new models of care to reduce admissions and give frail patients a better experience, the Network provides one-to-one support, national events and the opportunity to learn from other trusts facing similar challenges.

Amongst the first cohort of trusts to join the Acute Frailty Network was University Hospitals North Midlands (UHNM). This is their story...

University Hospital North Midlands (UHNM) manages a high number of frail older people and had already made significant improvements in the care of these patients when it signed up for the Acute Frailty Network in 2015. UHNM was one of the first sites in England to introduce a dedicated Frail Elderly Assessment Unit in October 2010 and is nationally recognised as a pioneering site in the care of frail older patients. Despite this, UHNM was keen to learn from others facing similar challenges and to hear from experts in the care of frail older people on how it could improve its services still further.

A Change of Focus

An initial assessment visit by the Acute Frailty Network’s improvement team revealed that some significant improvements could be made, as Improvement Lead, Simon Griffiths explains:

“At the time of our visit, UHNM’s focus was on developing a new rehabilitation ward for acutely ill frail older patients who also had dementia. While this was, undoubtedly, a positive step we knew that it would not make any difference to the crucial 72-hour period after admission, when there is the greatest potential to make a difference to patient outcomes. For this reason, we proposed a change of direction, which the hospital readily took on board. Their focus moved to admission avoidance, improving patient flow into the unit from the Emergency Department and the community, limiting deterioration and facilitating early discharge.”
Support at the Highest Level

UHNM’s Chief Operating Officer, Helen Lingham, became executive sponsor for the Acute Frailty project and took a hands-on approach to improvement work within her own trust. She explains why:

“This work is important because if we can get it right for frail older people, we will get it right for virtually all patients. I took on the role of executive sponsor for this project with the Acute Frailty Network because I believe that a supportive national infrastructure like this which fulfils such a valuable role, deserves executive level input to raise its profile, to provide support and to offer healthy challenge.

“Our aim in joining the Network was to improve both patient outcomes and experience; to manage patients in the right environment with the right team thereby reducing the need for unnecessary transitions of care; to minimise delays that can lead to deconditioning; and to reduce admissions where ever possible. It was vital to us that patients that could and should be managed in the community were not admitted to hospital.”

Helen believes that being part of the Network delivered multiple benefits for the Trust:

“The Acute Frailty Network provided us with a mix of practical expertise, access to experts in the care of older people and an understanding of proven approaches to improving frailty services. We gained confidence from their support and that of our peers and developed robust metrics to enable us to measure impact. They were also able to facilitate partnerships with local organisations to support implementation. It was particularly helpful to us that they flagged up that we needed to change our focus from developing a Shared Care Ward at the end of the pathway to what we are doing to manage frailty more effectively in the first 48-72 hours.”

What They Did...

UHNM’s Frail Elderly Assessment Unit is led by a Geriatrician with full multidisciplinary team support. GPs and community teams can refer patients directly into the unit, thereby avoiding admission to the Emergency Department, and patients remain on the unit no longer than 48 hours. As a result of its involvement in the Network, the Trust made the following important changes to the care of frail older people.

1. Redefine Frailty

Since its launch, the Frail Elderly Assessment Unit has used the Bournemouth Criteria to determine frailty. It is currently reviewing its admission criteria to encompass a broader...
definition of frailty, based on recent evidence, so that no patient who could benefit from the service is overlooked.

2. Develop Comprehensive Geriatric Assessment

UHNM is developing a Comprehensive Geriatric Assessment (CGA) process for Advanced Nurse Practitioners to use in the Medical Assessment Unit. CGA is a multidisciplinary diagnostic process that is designed to determine a frail older person’s medical conditions, mental health, functional capacity and social circumstances. It allows staff to develop a holistic plan of care based on individual need.

3. Streamline Processes and Manage Discharge

The Trust is taking steps to reduce transitions of care and tackle delays using The Exemplar Ward programme, which all of its elderly care wards have been implementing. Exemplar Ward is a proven approach for streamlining processes and managing the patients’ exit from the hospital more efficiently. One of the principles of Exemplar Ward is to adopt a Discharge to Assess model. This means that, rather than waiting in a hospital bed to undergo an assessment of their ongoing care needs, patients are discharged and either assessed at home or brought back into the hospital for assessment at a later date. The hospital forecasts that, over a 12-month period, this approach could result in the decommissioning of 11 beds.

4. Renewed Focus on Early Geriatric Input

There is a renewed focus on early therapy intervention to minimise deconditioning and improve care, as Advanced Nurse Practitioner, Amanda Futers explains:

“We have shown that earlier Geriatrician input and a more holistic approach to the care of frail elderly patients has a dramatic impact on their experience while they are in hospital. Length of stay has dropped from around 35 days a few years ago to as little as 15 days and now is around 9 days. Patients’ mobility and independence is being maintained in more cases and they are being discharged sooner with, if necessary, an appropriate package of support. The savings for us as a Trust are in the region of £700,000.

5. Limit Direct Access to the Unit

At the time of its launch, the Frail Elderly Assessment Unit took patients from all of the emergency portals - A&E; the Medical Assessment Unit (MAU); GPs and short stay units. However, the volume of patients from MAU meant that, within a very short time, the unit was overwhelmed and unable to take patients from A&E. In
light of this, it adjusted its admission routes and now only patients from A&E or GPs have direct access to the unit. If there are frail older patients in MAU, an Advanced Nurse Practitioner and a Consultant Geriatrician will visit them to assess them, initiate CGA and ensure that a care plan is put in place to address their holistic needs. From MAU, older patients are now moved directly onto the elderly care wards without going via the Frail Elderly Assessment Unit. Today, roughly 70% of admissions onto the unit come from A&E and the remaining 30% come from GPs.

### The Impact

Measurement metrics demonstrate that UHNM has succeeded in reducing the number of stranded older patients.

Stranded patients are patients that have a length of stay in hospital greater than 10 days. Overall length of stay for frail older patients has also reduced, thereby decreasing the likelihood of deconditioning. NHS benchmarking data shows that an average length of stay on elderly care wards of 14.6 days. UHNM is well below this at just 8 days.

The proportion of direct admissions from GPs and ED to the Frail Elderly Assessment Unit is increasing and the number of frail older patients in AMU decreased between March and November 2015. Overall, frail patients are experiencing fewer transitions of care and early Geriatrician input.
Last year (2015/16), as part of the Trust’s Improvement Programme, the improvements in the care of frail elderly patients saved more than £700,000, as well as reducing length of stay and increasing throughput.

**What’s Next**

UHN is in the process of introducing a frailty flag, which will automatically flag up patients on the IT system who identify with the revised frailty criteria. This will make it easier to track these patients and to build a more comprehensive picture of their care. The Trust also plans to introduce system-wide shared records and create a comprehensive outreach service to avoid unnecessary admissions.

An Advanced Nurse Practitioner (ANP) with expertise in the care of older patients visits AMU daily to support clinical decision-making and help to develop frailty care plans. The ANP sees between 10 and 20 patients a day with the aim of avoiding unnecessary admissions and signposting patients to alternative services.

**Frailty is Everyone’s Business**

The team has identified a number of challenges that UHN needs to address if improvements are to continue to be made. Frailty is not always identified early enough and it is seen by some areas as “not our business”. The Comprehensive Geriatric Assessment process needs to start at the front door in order to improve patient outcomes, reduce length of stay still further and limit deconditioning.
“Times change and you have to change with them,” says Amanda Futers. “The national standard framework for elderly care is now 16 years old. People are living longer and they require geriatric input at a later age. A perception still persists within the hospital that everyone over the age of 65 is geriatric and needs to come onto the unit to be treated for acute conditions. Our message is that frailty is everyone’s business. Just because someone is frail doesn’t mean that they should automatically be referred to the unit. Other specialities need to recognise and know how to respond to the needs of frail older people.”

UHNMs Key Success Criteria

1. Executive Support

Chief Operating Officer, Helen Lingham, played a key role as executive sponsor for the Acute Frailty Network, offering support and challenge and lending credibility to the service. She also took a hands on approach to improvement work within the Trust:

“I was able to offer healthy challenge to the team here and unblock things when any blocks appeared. It was a really positive experience. I learned a lot about how we were doing things and how we might be able to make things even better.”

2. Early Mobilisation of Patients

With frail older patients, there are often multiple comorbidities and UHNMs recognises that it needs to adopt a holistic approach to their care. If they only address the acute condition and the patient can begin to deteriorate rapidly in other areas. As well as treating their acute condition, the hospital ensures that patients are mobilised to avoid deconditioning. This is now being addressed. Dr Amit Arora, Clinical Lead for Elderly Care Services at UHNMs and Co-Chair of Elderly Care Clinical Network in Staffordshire says, “early mobilisation where appropriate should be a key objective for all units caring for frail older people. All older people should be encouraged to actively participate in activities of daily living while they are in hospital. We should be encouraging and helping patients to regain maximum possible independence in activities of daily living, this is the responsibility of all clinical staff and not just restricted to therapists.”
3. Early Intervention

Advanced Nurse Practitioner, Amanda Futers, says:

“The Frail Elderly Assessment Unit provides the opportunity for Geriatricians to assess patients at an early stage and gain a detailed understanding of the full extent of their care needs. We can then ensure that they are receiving the most appropriate treatment to maintain their mobility, cognitive ability and independence, at the same time as addressing acute care needs.”

4. Tackling Patient Flow and Capacity Issues

Tackling flow problems is a priority for the Trust and staff on the unit are also proactive in identifying when spikes in demand might occur. On a Monday morning, for example, there is, generally, a high number of patients waiting to come into the unit. Multidisciplinary teams from other parts of the hospital are mobilised to tackle capacity issues and staff from the unit are also proactive in visiting MAU to support the care of frail elderly patients who have not come onto the unit.

5. Discharge Planning

One of the major challenges for staff on the Frail Elderly Assessment Unit is in ensuring prompt discharge. Patients there are assessed by a multidisciplinary team and a decision is made about whether they require admission to the hospital or discharge. A high proportion of patients require some form of continuing care once they are discharged and these care packages are commissioned externally. The SPEED (Single Point Early Effective Discharge) Team carry out an initial assessment within 24 hours and, if required, patients can be discharged to a local community hospital bed to await further assessment or implementation of support plans. The SPEED Teams consist of complex health assessment nurses, therapists and social workers who mobilise to the wards to support exit plans for medically stable patients for transfer to alternative care settings.

6. Education and Training in the Community

In order to promote a greater understanding of the care of frail older people, the Trust provides an education and training programme to junior doctors and nursing students at a local university. A new Masters course of Fraility and Integrated Care starts in May 2016 with Keele
University to encourage local GPs and other health professionals to upskill in care of older people. This GP Fellowship Programme will enable GP fellows to work alongside Consultant Geriatricians in the local hospital and cascade their learning to colleagues in the community. The aim is to increase understanding and build confidence in managing patients in their own home whilst also addressing the national shortage of doctors with expertise in care of older people. Dr Amit Arora, who with his CCG colleagues and the British Geriatrics Society, has been instrumental in designing and developing this course, said this course will provide excellent opportunities to develop a clinically sound interface between acute and community care.

7. Restricting Direct Access

Restricting direct admissions onto the unit has ensured that it can continue to meet demand from the Emergency Department. More importantly, it has enabled more admissions directly from the community going into the frailty unit rather than waiting for hours in a crowded A&E environment, which is not always the best place for frail older people. To ensure needs of those patients not admitted to the Frailty Unit are met, staff from the unit visit MAU on a daily basis to provide proactive support to frail elderly patients there, enabling them to be transferred directly onto elderly care wards.

Dr Arora, who also helped develop quality standards for frail older people in the West Midlands says:

“We were in the process of transforming the care of older people and incidently AFN came at the right time. Working with experts from AFN has been a brilliant experience and so much has changed for the better. There is a new found enthusiasm amongst all staff who changed the way we work, achieved positive results and have demonstrated that good quality care is achievable within current available resources.”

He is very pleased with the results but quoting Robert Frost, he says:

“But I have promises to keep, and miles to go before I sleep, and miles to go before I sleep.”

For more information contact:
Dr Amit Arora, Clinical Lead amit.arora@uhns.nhs.uk
Amanda Futers, ANP Amanda.Futers@uhns.nhs.uk
Helen Lingham, Chief Operating Officer Helen.Lingham@uhns.nhs.uk
To find out more about Acute Frailty please go to:

www.acutefrailtynetwork.org.uk
or email frailty@nhselect.org.uk