Acute Frailty Network

A Frailty service built on solid foundations

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In 2016, admission bed modelling showed that the number of frail older patients coming into the emergency department (ED) was increasing. Many frail patients with relatively minor problems – falls, minor infections or an inability to cope at home - were being admitted and kept in hospital for an extended period, despite having low acuity levels. The average length of stay was five to seven days. The hospital was concerned about the impact of this on frail patients, as well as on its own infrastructure. Two thirds of Nottingham’s inpatient beds were occupied by patients over the age of 65.
Acute Frailty Network

To address this, Nottingham joined the Acute Frailty Network (AFN) in September 2017. The AFN supports hospitals to improve services for people with frailty and urgent care needs to get home sooner and healthier. The Network provides one-to-one support, information, events and networking opportunities with other organisations to share best practice.

To help structure pathway improvements, the AFN has developed a toolkit of ten principles, that are key for effectively managing frail older people with urgent care needs. The first of these is early identification of people with frailty and the second is to initiate a comprehensive geriatric assessment (CGA) within the first hour of frailty being identified.

AFN principles for managing frail older patients in an acute care setting

1. Establish a mechanism for early identification of people with frailty
2. Put in place a multi-disciplinary response that initiates comprehensive geriatric assessment within the first hour
3. Set up a rapid response system for frail older people in urgent care settings
4. Adopt clinical professional standards to reduce unnecessary variation
5. Develop a measurement mindset
6. Strengthen links with services both inside and outside hospital
7. Establish appropriate education and training for all staff
8. Identify clinical change champions
9. Patient and public involvement
10. Identify an executive sponsor and underpin with a robust, sustainable, project management structure

Initial improvements

Prior to joining the AFN, in 2016 the hospital had applied for winter resilience funding to develop an eight-month pilot project to improve frailty services. The aim was to capture frail patients earlier in the process and avoid admissions where clinically appropriate. The £3.2 million project, which started in September 2016, improved services in the community and developed an acute frailty pathway in ED and an older persons assessment unit (OPAU).

The 12-bedded OPAU, located close to ED, was staffed by a robust multidisciplinary team (MDT), including a consultant, registrar, senior house officer (SHO), lead nurse, discharge co-ordinator, integrated discharge team with social care and dedicated pharmacy support. Staff could be called into A&E to carry out CGAs as needed. There were additional community beds commissioned as well as community and mental health teams attached to the project. An MDT with members of various professions, including members of social services, made joint decisions for these patients.

The project achieved a reduction in length of stay of two to three days. Frail older patients were discharged from OPAU on average within three to four days. After the unit opened, metrics demonstrated that the hospital was saving 14 net bed days daily, equivalent to closing half a ward. This equates to around 5,110 days over a 12 month period. This also led to a reduction in the number of outliers for the Health Care of Older People (HCOP) team.

Going further

While the hospital was pleased with these results, geriatricians were convinced that they were still missing a significant number of frail older people because there was no dedicated frailty service based in A&E.

Size of opportunity

The opportunity for improvement was significant. Of the 36,024 adult A&E attendances between September 2016 and March 2017, an estimated 3,605 were patients identified as frail.

Around 10% of people over 65 have frailty, rising to between a quarter and a half of those aged over 85. Frailty usually presents in crisis with any of the frailty syndromes (including new or worsening confusion, reduced mobility and falls). In Nottingham, this equates to between 35 and 45 patients a day who could benefit from an improved frailty pathway.

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Moving closer to the front door

Following the initial site visit from the AFN team, Nottingham's HCOP team recognised that the lack of a frailty service at the front door was an issue.

The team set out to create a dedicated frailty area close to the front door of the hospital. They started small initially, with a simple assessment area and a handful of staff. However, when the Emergency Medical Services team vacated a six-cubicle area in A&E in November 2017, it was too good an opportunity to miss. Despite having no furniture, no computers and not even a drinks trolley, the team moved in and the frailty unit in A&E was born.

“We set up everything after the frailty unit opened because it was needed and nothing was going to stop us,” said Consultant Geriatrician, Dr Aamer Ali. “By sticking our heads above the parapet and moving closer to the front door where patients undergo their initial assessment, we knew we would be able to intervene quicker and prevent unnecessary admissions, which is what these patients needed.”

A&E was often crowded with up to 20 patients waiting on trolleys for hours, many of them frail older patients. This made it easy to obtain high-level support for the work. “It was not a difficult sell to get divisional support for our plans,” said HCOP General Manager, Peter Allsopp. “Whatever you need, let’s make it happen” was the message from the Executive team. The team in A&E was helpful and supportive, too.

The frailty unit in A&E

The frailty unit in A&E has seating for up to 12 people, three large cubicles with beds or trolleys and three smaller cubicles with recliners. Emergency physicians and geriatricians work alongside one another to provide rapid CGA at the front door. Within four hours, frail patients are seen and assessed by the team and either discharged or admitted onto the frailty pathway. The integrated discharge team reviews patients both in the frailty unit and in A&E as a whole.

Staffing

The service is open Monday to Friday from 8am to 5pm and staffed by a multidisciplinary team including: an advanced clinical practitioner (ACP), a physician associate (PA), a GP trainee, a registrar and a nurse. A consultant is available on site for reviews and assessments. PAs are trained in general medicine and have a two-year postgraduate degree. They can perform assessments and a range of procedures including venepuncture, cannulation and catheterisation. ACPs carry out CGAs and help to identify patients suitable for the frailty pathway.

Social care

The team had twice daily MDT meetings on OPAU which were attended by members of social services to facilitate early transfers from the unit. A significant proportion of the funding was used to enhance care packages to people in their own homes in the community and open extra community bed capacity.
Integrated discharge team

An MDT, consisting of physios, occupational therapists (OTs), nurses and B4 assistant practitioners, is employed by the community to in-reach into A&E and front door assessment areas and bring community specialist knowledge.

The integrated discharge team works alongside clinicians to support the transfer of patients to the most appropriate place.

Gemma Hirons, Supported Transfer of Care Senior Clinical Lead and Team Manager said: “This often involves advocating community services as well as arranging appropriate wrap around services to support the patient discharge.

We explore health and social care needs as well as carers’ needs and signpost to services to avoid a readmission. Our mantra is right place, right time, no delay. We aim to support the home first, discharge to assess model.”

All of the integrated discharge team are holistically trained and upskilled in other disciplines in addition to their primary one. For example, a physio by profession will have OT, nurse skills to Band 4 level and social care knowledge. The team works with any patient over the age of 18.

Overcoming challenge

Despite broad ranging support, setting up this frailty unit wasn’t completely without its challenges. It was a change for A&E to have someone else assessing their patients. However, the teams in the frailty unit and A&E took care to establish trust between them. At first, patients were jointly assessed by an A&E nurse and a member of the frailty unit team. After a while, the team from A&E was happy for assessments to be carried out by frailty unit staff alone.

“It was also about changing hearts and minds,” said Aamer. “We needed to work together in developing expertise at the front door and to improve access to CGA for this group of patients.”

Strong relationships

To cement the strong relationships that were created between A&E and the frailty unit, the teams came together to train one another in their areas of expertise. This has meant not only improved integration between the two teams but also a good understanding of frailty among A&E staff and an appreciation of the pressures of A&E among frailty unit staff.

Aamer describes the frailty unit as “prime A&E real estate” and says that there is sometimes pressure to use the space for non-frail patients. However, the fact that A&E colleagues understand the important role played by the area makes this much less likely to happen. The frailty unit team is also mindful and shares its impact data widely so everyone understands the difference this pathway makes to the care of frail older patients.

The importance of good working relationships cannot be understated, according to the team in Nottingham. Right from the outset, Aamer spent time in the department, getting to know people on first name terms. He joked: “They call me Frailty Ali. Staff don’t have to email me, they don’t have to phone me, and they can just come and talk to me. There is no us and them, it is all us, a team approach.”

A “us” mindset

This “us” mindset has contributed to the success of the project. Pete said: “Most A&Es have a wall around them, metaphorically speaking. Ours has undergone so much improvement over the years and so many changes that the mindset here is very different. The team in A&E saw that we were offering to help them to tackle some of their problems by creating a dedicated service for frail patients. It was obvious that this was the right thing to do for patients and, consequently, we met very little resistance.”

Metrics to drive improvement

Metrics have proved an important way to monitor impact and drive continuous improvement. The teams have a refresh button that they can click daily to see the very latest performance data.

Pete said: “It is vital to be able to review progress in real time. It is one thing to put a system in place but it is another to keep it working at an optimum level. You have to keep monitoring and refining.”
Staff feedback
They also discovered that it is important to have a mechanism for staff to feed back to service managers what is and isn’t working. Initially, the frailty unit team held a weekly huddle but this was dropped because managers thought the system was working well and it was no longer needed. In hindsight, Pete admits that they may have been overhasty. The weekly huddle has just been reintroduced to provide a mechanism for staff to feed back and discuss any issues before they escalate.

The difference it has made
Moving frailty services closer to the front door has improved both patient and carer experience. The HCOP pathway is suitable for and responsive to patients with frailty, and length of stay continues to improve (currently down to 9.2 days on average). Outliers have reduced and discharge rates are up by 20%. The frailty unit succeeds in discharging 41% of patients, many of whom would previously have been admitted to hospital.

Readmission rates for the frailty service stand at 3.1% after seven days and 17% after 28 days – below the geriatrics department as a whole. Improved relationships with specialties via the geriatrics liaison service is supporting further reductions in length of stay as well as reducing risk by increasing awareness of frailty.

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Patient impact

And, what about the impact of the new service on the patients themselves? The figures speak volumes.

Between November 2017 and May 2018, the service saw 1,244 patients. Forty one per cent were transferred back to primary care, compared with just 10-15% before the service opened. Patient satisfaction rates have soared. Average length of stay has dropped by four days over the last two years.

Over and above the statistics, are the individual experiences. Aamer described how the daughter of one of the older patients came to him in tears explaining that she had been in the hospital with her mother every few days for a period of many weeks. After her first assessment in the frailty unit, the daughter told Aamer that she fully understood, for the first time, what was wrong with her mother and what the treatment plan looked like, and she was delighted.

Aamer said: “It is moments like this that illustrate why we are doing this. If we can make a difference to one patient, one concerned relative, then it is worth it. Actually, we make a really big difference. Since we opened there have been hundreds of patients through our doors and we have sent 41% of them home, with a plan that works.”

John Gladman, a professor in community geriatrics who helped to champion the HCOP programme from the outset said: “This is what I have preached my whole life and now I am practising it.”

Patients were asked to share their feelings at each stage of their journey and to provide comments about the service. More than a third said they felt happy after their treatment by the frailty service compared to just 0.9% who felt worried. Patient comments included: “Excellent hospital, food, staff, everything…” and “It has completely changed my opinion of this hospital” and “Can’t fault it”.

Next steps

The frailty unit is working well but there are ongoing adjustments and improvements to be made. While frail older people tend to present at hospital in the morning during the winter months, in the spring and summer it is different. With frail older people turning up at A&E throughout the day during these months, the need to extend the frailty unit’s opening hours became clear.

The plan is to move to 8am to 8pm opening Monday to Friday in the next few months. However, within the next 12 months, the service will be open seven days a week. Discussions with staff have already begun and, while the extended opening will undoubtedly present a challenge to working patterns, there is a widespread sense that this is the right thing to do for the patients and, on this basis, there is a greater willingness to share the burden.

Much of the work in Nottingham has concentrated on the front door (admissions). With A&E about to undergo a £2.3 million front door redesign, a work stream has been created to consolidate this work. Next, the hospital will begin looking at the back door (discharge) to see how services can be streamlined for frail patients to ensure that, once admitted, they get home faster.

Keys to success in Nottingham

● Great clinical leadership with strong management support
● Divisional backing for the project
● Discharge to assess – assessment for re-enablement, packages of care and care home placements are not done in hospital setting.
● Building trust between the frailty unit and ED
● Sharing impact data widely so people understand the value of the frailty unit
● A physical presence in ED
● Providing a forum for staff to feed back regularly
● Starting the service with limited infrastructure “because it could not be delayed”
● Using metrics to refine and improve the service

Emoji responses shown as percentages

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