NHS London

London: Unplanned Hospital Care Acute Frailty Service Specifications – Guidance Document

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This document will continue to be reviewed and re-released to reflect new and emerging evidence. Please email england.londoncagsupport@nhs.net to request the most recent version.

This London guide is designed to complement and not replace local guidance and professional judgement. It will be updated to align with other national and regional guidance once published.

NHS
London
Clinical Networks

Unplanned Hospital Care Acute Frailty Service Specifications – Guidance Document

NHS England and NHS Improvement

Prepared by the London Clinical Networks Acute Frailty Workstream

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Background

Frailty is a long-term condition characterised by increasing vulnerability to external and internal stressors. The prevalence of people living with moderate to severe frailty in London is estimated to be 12% to 26% in people aged ≥ 65 (Fusion 48, 2018)[1]. Improving the health and wellbeing of people with frailty requires integrated health and social care services, but care needs to be personalised as frailty affects people in different ways. This is particularly challenging in London, where there is huge diversity in culture, religion, ethnicity, income and social support. It also creates a unique environment in which our health and care services function.

The NHS needs to evolve further to make the shift from models for single diseases to providing care and support for complex multi-morbidity. This is especially so in London where many teaching hospitals have prioritised the provision of tertiary and quaternary care in highly specialist medical areas over general services for their local population. When people with frailty become unwell, they often present with non-specific syndromes. Older people (as a proxy for frailty) have longer waiting times in Accident & Emergency Departments, are more likely to be admitted, and have longer length of stays (Nuffield Trust, 2014) (The King's Fund, 2012). People with frailty admitted to hospitals are at risks of harm such as falls, delirium and pressure sores (Hubbard et al., 2017). To maximise chances of recovery and reduce risk of hospital-acquired harm, it has always been crucial that people living with frailty are managed as close to home as possible where appropriate. This has become ever more pressing since the COVID 19 pandemic.

Same day emergency care services provide same day care for emergency patients who would otherwise be admitted to hospital, by offering rapid assessment, diagnosis and treatment, and discharge within 24hours if clinically safe to do so. Acute frailty services, as part of same day emergency care services, routinely and systematically identify frailty in people who present acutely to urgent and emergency care services. They then consider the personalised needs of individuals, their degree of frailty and severity of acute illness to develop a shared plan, supported by clear reliable pathways into and out of hospitals aligned to the degree of frailty identified.

The NHS Long Term Plan stipulates that all Type 1 Emergency Departments should have an acute frailty service. Service delivery requires an integrated approach involving most staff working in the emergency department. In addition, a specialist acute frailty team ideally within a purpose-built frailty attuned area, clinically led by professionals with advance frailty expertise, is needed for more complex assessments. These services can be accessed as unplanned attendances to the Emergency Department, or heralded by pre-hospital urgent care services (Diagram 1: "Unplanned pre-hospital frailty care pathways"). Acute frailty services belong to a cross sector integrated urgent care system that spans primary care, community

[1] *12% figure estimated from 2017/18 GMS contract data analysis by Fusion48, and assuming diagnosis rate of 60% of expected diagnoses. 26% figure generated from electronic frailty index using Whole System Integrated Care Dataset though caution that this dataset only covers North West London.*

services, ambulance services, social services, voluntary sector and acute hospitals (Diagram 2: “Hospital acute frailty service as part of wider system”). Their success will depend on collaboration with many stakeholders, and need to be supported by commissioning.

This document aims to describe the acute frailty pathway *after* a patient arrives at the hospital, and describes what the service looks like for people living with frailty who are expected to be *in hospital between 4 to 24 hours*, either as walk-in patients, or directed in by GPs or 111/999 services. The intention is to provide guidance on setting up Same Day Acute Frailty Services (SDAFS) in hospitals across London, enabling an older adult living with frailty to experience a consistently excellent level of care whichever hospital front door they enter.

This document should be read in conjunction with the NHS England & Improvement document “Principles and Characteristics of an Acute Frailty Service for Same Day Emergency Care”.

Function of Same Day Acute Frailty Services

The Same Day Acute Frailty Service (SDAFS) should be able to:

- Establish formal links with pre-hospital urgent and emergency care services to offer direct referrals
- Diagnose and manage acute illness in a person living with frailty, refer appropriately if needed to other specialities
- Create a Comprehensive Geriatric Assessment (CGA) to cover the domains of medical, psychological, functional, social and home environmental circumstances
- Create a care plan relevant to the acute and chronic situation considering the views, wishes and priorities of the patient and those close to them including a decision as to whether discharge home is appropriate and what (if any) safety netting is required
- Provide medicines optimisation and link to community pharmacy services
- Have comprehensive knowledge of hospital based and community services relevant to enabling patients to return home with their care needs met whilst living at home rather than requiring hospital admission
- Build on strong links with community services to offer virtual clinics and management where these exist collaboratively.

SDAFS staff will have advanced skills in:

- Medical management of those living with frailty and co-morbidity
- Multifactorial falls risk assessment and management
- Functional assessment with provision of mobility equipment, environmental modification advice and referring/ signposting to community resources
- Assessment and management of delirium and dementia
- Assessment for alcohol, drugs and smoking and provide brief interventions and signposting
- Assessment for depression and anxiety linked to appropriate pathways including Mental Health Services for Older Adults
- Assessment for isolation and links to appropriate services
- Screening for malnutrition and be able to give nutrition advice
- Pressure sore assessment and advice
- Continence assessment
- Advance Care planning
- Mental Capacity Act and Safeguarding adults
- Care Act

Diagram 1: Unplanned Pre-hospital Frailty Care Pathways – A Schematic Diagram

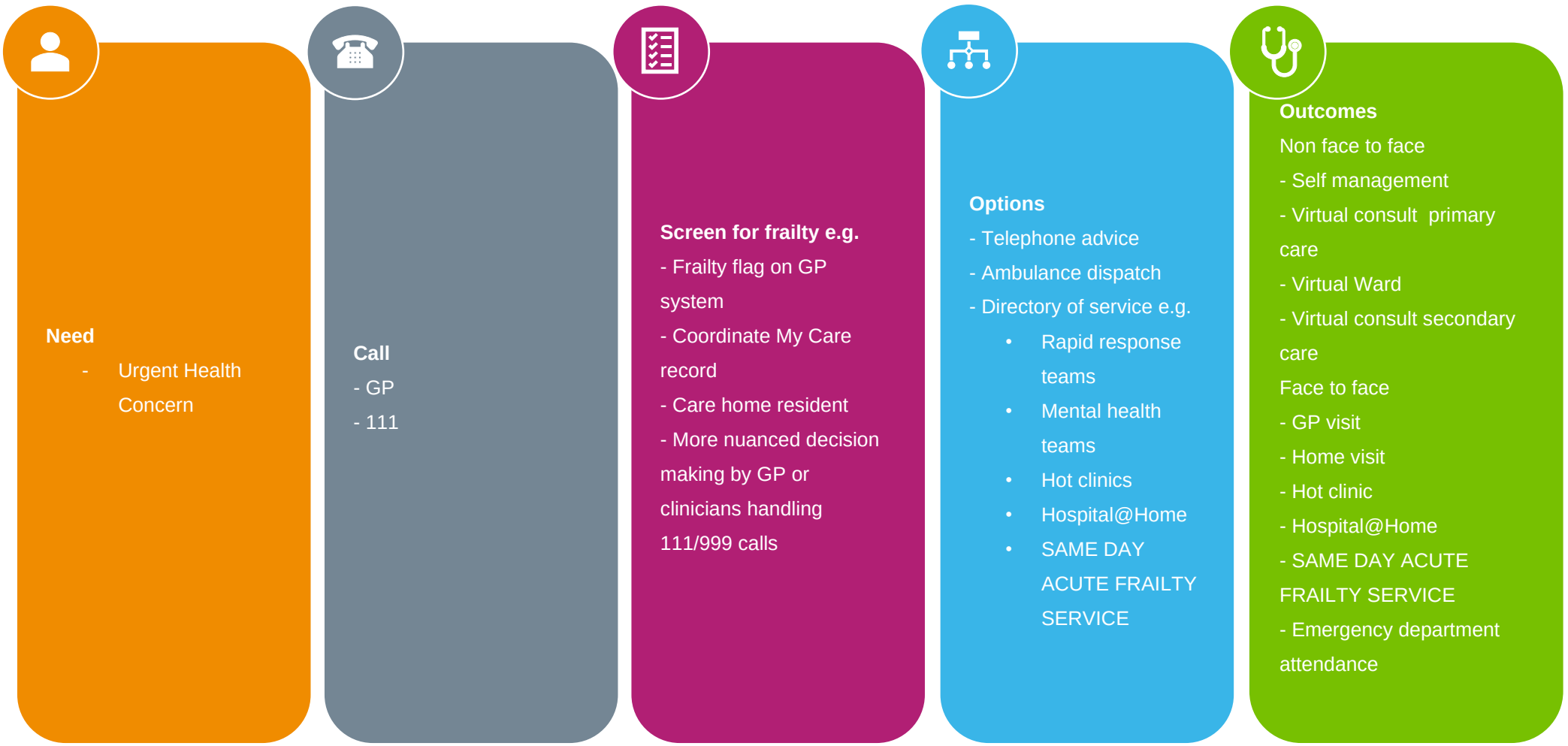
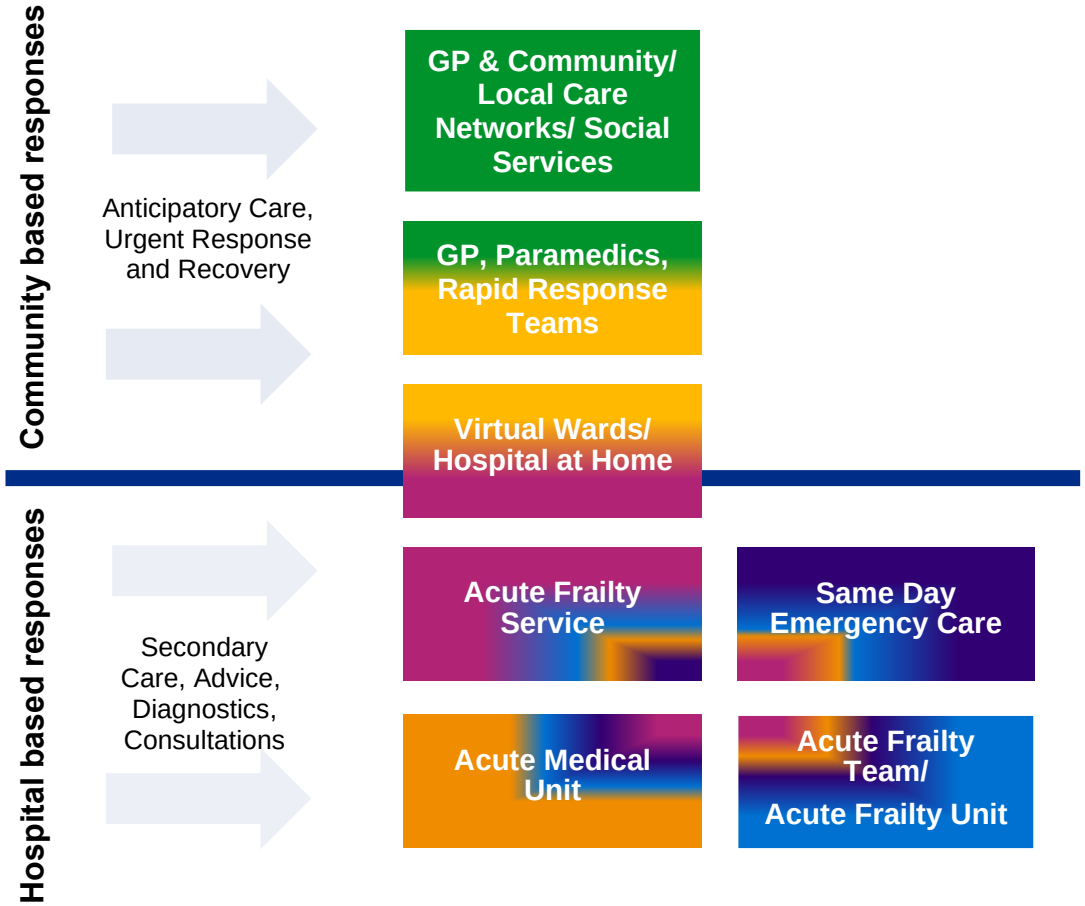


Diagram 2: Hospital Acute Frailty Service as Part of Wider System – A Schematic Diagram



How to Use this Document

People identified as living with frailty arriving at a hospital generally fall into one of three groups according to their acute healthcare issue and medical stability (see Diagram 3):
(A) likely to require admission beyond 24 hrs
(B) likely to go home within 4 hours from emergency department
(C) Potential for same day (within 24 hrs) discharge but unlikely within 4 hrs

Staff in emergency departments are skilled at triaging, but where pathway decision is not clear, senior advice or advice from acute frailty team should be sought early. Same day acute frailty services are directed at patients in category (C), which is the focus of this document.

The guidance starts from screening for frailty on arrival, then describes briefly the expectations for patients who are (A) likely to require admission beyond 24 hours, and (B) likely to go home within 4 hours from emergency department.

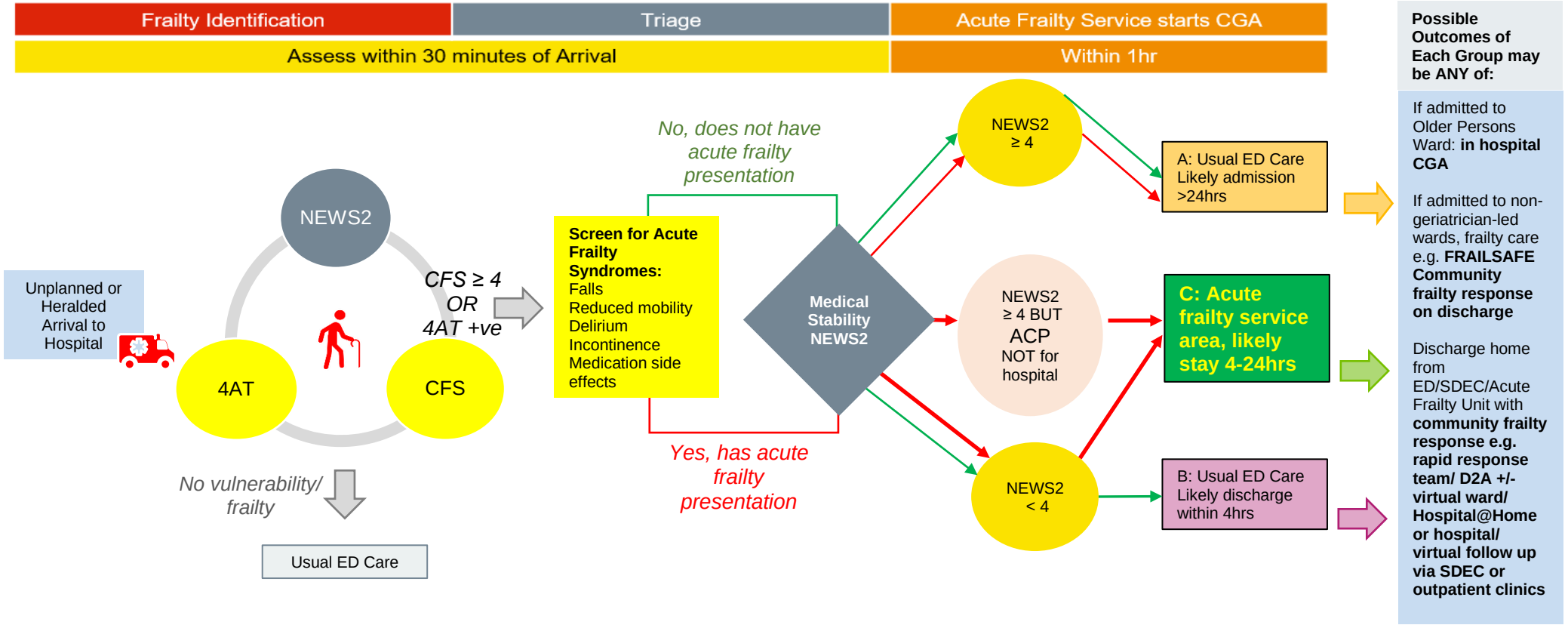
For (C) Potential for same day (within 24 hrs) discharge but unlikely within 4 hrs, the guidance goes on to detail a number of domains:

- Assessment and management
- Multi-disciplinary team
- Stakeholder links
- Infrastructure
- Governance

Each domain is divided into three levels from Bronze (essential) to Gold (exemplar). They are not intended to be prescriptive, but offer a framework for Trusts to self-assess and help to identify areas for improvements. Same Day Acute Frailty Services (SDAFS) in different hospital sites will be at different stages of maturity, and priorities for development will be dependent on local needs and resources.

Diagram 3: Unplanned Care for People with Frailty – A schematic diagram showing how assessment of frailty and medical stability influences onward care pathways

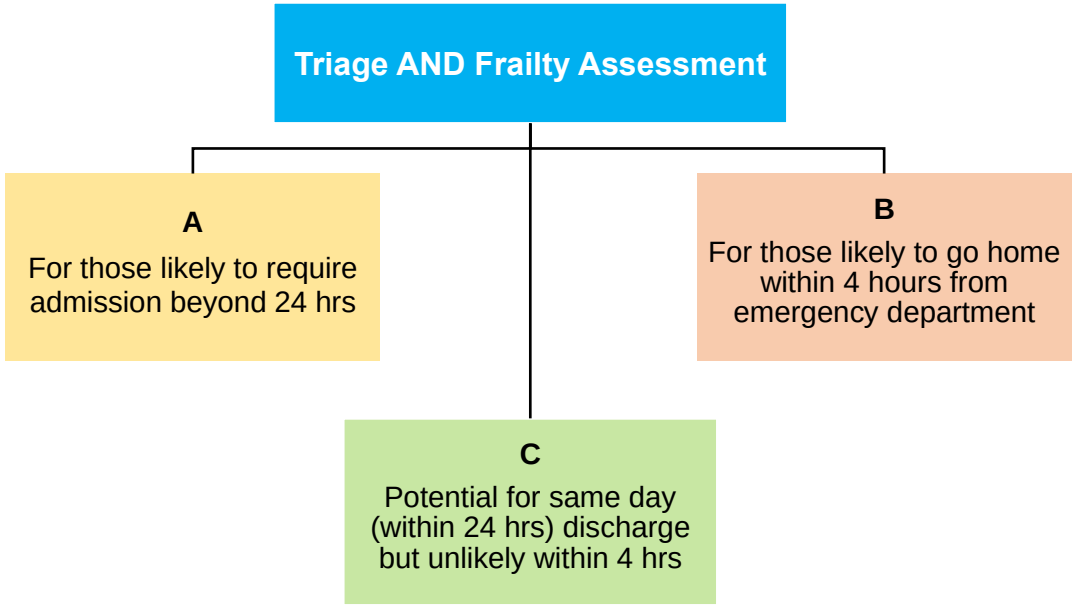
Assessments are not linear and priorities depend on clinical judgement, but should consider frailty along with NEWS2 for illness acuity and 4AT for delirium. Clinical decisions should be based on all relevant factors.



ACP – Advance care plan
CFS – Clinical Frailty Scale
CGA – Comprehensive geriatric assessment
ED – Emergency Department
SDEC – Same Day Emergency Care

Specification

	Bronze	Silver	Gold
On Arrival	Routinely screen adults aged 65+* for frailty using the Rockwood Clinical Frailty Scale (CFS)[A,B] within 30 mins and NEWS2 score completed.	Bronze plus screened for dementia/ delirium using the 4AT[B] within 30 minutes.	Bronze plus screened for dementia/ delirium using the 4AT[B] within 30 minutes.
	Frailty score documented in a place that is visible to all practitioners throughout the patient journey during the hospital episode to inform appropriate pathway of care.	Bronze plus delirium/ dementia score documented in same manner as frailty score.	Bronze plus delirium/ dementia score documented in same manner as frailty score.



** Age 65 as per NHSE/I recommendation*
[A] Rockwood Clinical Frailty Scale as per how the person was 2 weeks prior to hospital presentation
[B] or an equivalent validated screening tool

Determination of Frailty Care Pathway for those with CFS ≥ 4 (Groups A & B have ongoing needs to be addressed in the community)

	Bronze	Silver	Gold
A. • **For those likely to require admission beyond 24 hrs** • **NEWS2 ≥ 4** Typically Medical/ surgical issue requiring hospitalisation for further management e.g. acute myocardial infarction, acute bowel obstruction	Clinical pathway throughout their hospital journey that addresses their frailty needs in parallel with the acute clinical care pathway for the condition that requires hospitalisation e.g. use of tools such as FRAILSAFE in all clinical inpatient areas.	Bronze plus an **"on-referral" geriatrician led frailty team CGA** review wherever the person is admitted to in the hospital.	Bronze and Silver plus **proactive systematic follow up** by a specialist geriatrician led frailty team providing enhanced CGA care wherever the person is admitted to in the hospital.
B. • **For those likely to go home within 4 hours from emergency department** • **NEWS2 < 4**	Care led by emergency department team. Frailty identified, and requirement for CGA communicated to GP/ community teams. Access to a SDAFS for advice.	Bronze plus CGA requirement communicated if dementia/ delirium identified.	Bronze and Silver plus CGA initiated by a tier 2 or above trained practitioner for patients identified as CFS ≥ 4 .

<table>
<tr><td rowspan="2">C.
• Potential for same day (within 24 hrs) discharge but unlikely within 4 hrs
• NEWS2 <4
• OR advance care plan for end of life care at home</td><td colspan="3">Identified for Same Day Acute Frailty Service (SDAFS) in Hospital setting:
A frailty syndrome** presentation + CFS ≥ 4 + Medical stability (NEWS2 < 4)
OR advance care plan for end of life care at home</td></tr>
<tr><td>Bronze</td><td>Silver</td><td>Gold</td></tr>
<tr><td></td><td>Care led by Same Day Emergency Care (SDEC) team supported by SDAFS.</td><td>Bronze plus following identification for SDAFS, patient treated in a defined frailty service area (ideally a unit for persons living with frailty) within 1 hour of arrival.</td><td>Bronze plus following identification for SDAFS, patient treated in SDAFS area within 30 minutes of arrival.</td></tr>
<tr><td colspan="4">Frailty pathways B and C may be delivered in a variety of ways/ models depending on geography, size of the local population aged ≥ 65 with CFS ≥ 4 and recruitment factors. Examples:
• A roaming SDAFS into all areas
• Core Emergency staff trained in frailty for less than 4-hour turnaround patients plus a SDAFS for those staying over 4 hours
• The preferred model - Combination of a SDAFS area for those staying over 4 hours plus a roaming SDAFS into other emergency areas for those staying less than 4 hours.</td></tr>
</table>

** *Frailty syndromes:*

- *Delirium*
- *Recurrent falls*
- *Sudden deterioration in mobility and or function*
- *New or worsening incontinence*
- *Medication side-effects*

Same Day Acute Frailty Service (SDAFS) FOR GROUP C

Assessment and Management		BRONZE	SILVER	GOLD
	Comprehensive Geriatric Assessment	Multi-disciplinary assessment addressing acute needs and starts CGA (as per Silver Book) within 1 hour of arrival. Utilises existing patient information from hospital and community records, accesses Co-ordinate My Care (CMC), and contacts relevant services for information. Ensures information from carers and those close to the patient taken into account in decision making as per mental capacity act principles.	Bronze plus arrangements for rest of CGA to be completed after discharge from acute unit.	Bronze and Silver plus CGA domains of physical medical, psychiatric, functional, environmental, advance care plan (ACP) addressed in a systematic and documented fashion.
	Frailty Documentation	Frailty is coded in hospital records and communicated to GPs.	Bronze plus frailty status is communicated to GPs and relevant community teams involved in patient's care.	Bronze and Silver plus frailty status is recorded in integrated local health and care records.
	Communication	Structured discharge letter to patient on discharge, and to GP within 24 hours.	Structured discharge letter to patient on discharge, and to GP and relevant community teams within 14 hours.	Silver plus letter designed to be read from perspective of patient and those close to them.
	Coordination of Referrals	Have plans in discharge letter for GP to make onward referrals.	Bronze plus all necessary referrals made and detailed in discharge letter.	Bronze and Silver plus have single point of access to services that co-ordinates all onward referrals.
	Advance Care Planning	If CFS ≥ 7, DNACPR discussed and outcome documented in hospital notes and discharge letter.	Bronze but extended to CFS ≥ 4 as appropriate and outcome in CMC.	DNACPR and other advance care plans discussed and recorded in CMC for people with CFS ≥ 7, and where appropriate for those with CFS 4-6.

	Assessment & Management	BRONZE	SILVER	GOLD
	Discharge and Ongoing Care	Knowledge and experience of urgent community response services to enable risk assessment and same day discharge optimisation. Agreed pathways for SDEC/SDAFS review where appropriate (face-to-face or virtual).	Knowledge and experience of urgent community response services to enable risk assessment and same day discharge optimisation. Agreed pathways for SDEC/SDAFS review where appropriate (face-to-face or virtual).	Knowledge and experience of urgent community response services to enable risk assessment and same day discharge optimisation. Agreed pathways for SDEC/SDAFS review where appropriate (face-to-face or virtual).
	In-patient Services	If admitted CGA followed through for patients admitted to specialist Geriatrician led multi-disciplinary team (MDT) care inpatient area.	Bronze plus CGA followed through for patients admitted from SDAFS to non-geriatrician led wards where liaison services provided by specialist Geriatrician led MDT exist.	Bronze and Silver plus all people with frailty admitted to hospital are tracked and reviewed by a specialist Geriatrician led MDT regardless of which acute speciality patient is admitted under.

			BRONZE	SILVER	GOLD
Multidisciplinary Team	**Manager**		Service Lead.	Service lead.	Service lead.
	Medical		Consultant Geriatrician available 5 days per week on site and remote advice on weekends.	Consultant Geriatrician available 7 days per week on site, minimum of 5 days as core member of SDAFS.	Consultant Geriatrician on site as core member of SDAFS 7 days a week.
			Junior Doctor or equivalent support as part of SDAFS team.	Junior Doctor or equivalent support as part of SDAFS team.	Junior Doctor or equivalent support as part of SDAFS team.
	Mental Health		Mental Health Liaison team available remotely.	Bronze plus available daily in person on request.	Mental Health Liaison team for Older Adults member part of SDAFS core team.
	Allied health professionals	**Therapy**	Physiotherapist (PT) or Occupational therapist (OT) with extended scope available for SDAFS operational hours.	PT **and** OT both with extended scope available 7 days per week. Either PT **or** OT as core member of SDAFS 7 days a week.	PT **and** OT both with extended scope available 7 days per week. Both PT **and** OT as core members of SDAFS 7 days a week.
		Pharmacist	Same access to discharge medications as ED.	Bronze plus pharmacist as part of the SDAFS core team 7 days a week. Pharmacist roles include medication reconciliation.	Bronze and Silver plus ability to rapidly turn around medication compliance aids and supporting medication reviews.
		Discharge team	Access to remote support from discharge team.	Discharge co-ordinator (or equivalent) core member of SDAFS 5 days a week plus remote support for the other 2 days.	Discharge co-ordinator (or equivalent) core member of SDAFS 7 days a week.
		Phlebotomy	Phlebotomy service.	Phlebotomy service.	Phlebotomy service.
		Speech & Language Therapist/ Dietician	Access to remote support from Speech and Language, and Dietetics.	Bronze plus available to see patients same day on request.	Bronze and Silver plus see patients same day within 4 hours to enable same day discharge.

	Multidisciplinary Team	BRONZE	SILVER	GOLD
	Nursing	Appropriate ratio of nurses and grades to match numbers and acuity of patients as per Royal College of Nursing guidelines.	Bronze plus nurse with special interest in frailty/ Advanced care practitioner or equivalent.	Bronze plus nurse with special interest in frailty/ Advanced care practitioner or equivalent.
	Social worker	Access to social worker (or their delegate) to provide up-to-date social care plans for patients throughout operational hours of SDAFS. Ability to re-start social services provision same day.	Bronze plus access to a social worker for assessments for same day changes to social care plans 7 days a week and new packages of care assessments (ideally linked to Discharge to Assess pathways).	Bronze and Silver plus social worker is core part of SDAFS team. 7 days a week.
	Third Sector (e.g. Age UK, British Red Cross)	Signposting to appropriate services.	Bronze plus access to care navigator or equivalent to provide additional support and tailored services including social prescribing.	Bronze and Silver plus care navigator or equivalent within core SDAFS team available 7 days a week.

Key Stakeholder Links		BRONZE	SILVER	GOLD
	Urgent Community response services	Direct link with urgent community response services able to start no later than next day and able to provide: medical, psychiatric, nursing, rehabilitative care, functional support.	Bronze plus urgent community response services able to start **same day.**	Bronze and Silver plus **acute overnight** medical and functional support in own home e.g. delirium care, catheter care or end-of-life care.
	GP	Access to GP records.	Bronze plus access to GP led support services.	Bronze and Silver plus access to GP services enabling same day discharge.
	Community and Anticipatory Care Services	Links with Community Multidisciplinary Teams e.g. community matron, palliative care.	Bronze plus access to Community Care records (e.g. district nurses, community dietitian, community mental health teams).	Bronze and Silver plus there is capacity for active retrieval by Community Multidisciplinary Teams that know patient well.
	Social services	Access to up-to-date social care plans for patients throughout operational hours of SDAFS. Ability to re-start social services provision same day.	Bronze plus same day changes to social care plans to enable discharge. New packages of care started same day.	Bronze and Silver plus access to emergency social care interim placement same day.
	Third Sector (e.g. Age UK, British Red Cross, Social Prescribing)	Access to 3rd sector support services.	Access to 3rd sector support services same day 5 days a week.	Access to 3rd sector support services same day 7 days a week.
	Housing	Access to accurate and timely housing information for the patient e.g. from council and housing associations.	Bronze plus same day repairs/ installation services to enable same day discharge e.g. plumbing, including heating, key safe.	Bronze and Silver plus access to emergency housing same day.
	Equipment delivery	Equipment delivered within 24 hours.	Bronze plus same day, 7-day, delivery with access to four-hour delivery.	Bronze plus same day, 7-day, delivery with access to 4-hour delivery.

Infrastructure for SDAFS		BRONZE	SILVER	GOLD
	Operating hours	Provide a 70 hours a week service.	Bronze plus a 7-day service. Process in place for people identified as needing SDAFS arriving out-of-hours for next day early morning review by SDAFS.	Bronze and Silver plus providing a 7-day service more than 70 hours/week.
	Access to senior decision making on frailty (e.g. Consultant geriatrician or Band 8 staff with tier 3 capabilities in frailty)	70 hours a week, with remote advice over weekends.	Bronze plus service hours spread over 7 days.	7-day access more than 70 hours/week, with remote access out of hours.
	Service area	Roaming SDAFS team within Urgent and Emergency Care services.	A dedicated SDAFS unit co-located with Emergency services plus outreach team across other Emergency services areas.	Silver plus overnight provision within SDAFS unit for those going home next day/ those arriving out-of-hours.
	Meeting area	Facilities for multi-disciplinary team meetings face-to-face or virtually.	Facilities for multi-disciplinary team meetings face-to-face or virtually.	Facilities for multi-disciplinary team meetings face-to-face or virtually.
	Environment – frailty and dementia friendly	Welcoming, well lit, calm and quiet area.	Bronze plus good natural light.	Bronze plus good natural light.
		Toilets for patients including toileting facilities for those requiring physical assistance and/ or wheelchair users.	Toilets for patients including toileting facilities for those requiring physical assistance and/ or wheelchair users.	Bronze plus toilets for visitors within the area.
		Wheelchair access. Seats for patients and relatives.	Bronze plus space and seats of different heights and with arms.	Bronze plus space and seats of different heights and with arms.

	Infrastructure for SDAFS	BRONZE	SILVER	GOLD
	Environment – frailty and dementia friendly	Matt floors with a consistent colouring and no pattern. Walls and fabrics also consistent colouring.	Bronze plus handrails throughout the area. Flooring and handrails colour contrasts with the walls.	Bronze and Silver plus noise absorbent surfaces used on floors and walls. Other measures to reduce noise including quiet closing bins and call bell settings.
		Provision of communication aids e.g. small whiteboards/ marker pens, magnifying glasses, alphabet boards, communication boards, induction loop amplifiers, batteries for hearing aids.	Provision of communication aids e.g. small whiteboards/ marker pens, magnifying glasses, alphabet boards, communication boards, induction loop amplifiers, batteries for hearing aids.	Provision of communication aids e.g. small whiteboards/ marker pens, magnifying glasses, alphabet boards, communication boards, induction loop amplifiers, batteries for hearing aids.
		Provision of water/ drinks and food for patients.	Bronze plus access to dietetic supplies including thickener and enteral feeds on request.	Bronze and Silver plus dietetic supplies are stocked in the area.
	Clinical facilities	Variable height examination couches (including very low setting to reduce injury from falls).	Variable height examination couches (including very low setting to reduce injury from falls).	Bronze plus trolley chairs in use to improve patient flow.
		Equipment for observations, examination (e.g. auroscope, ophthalmoscope, Snellen chart, hearing screening device, tendon hammer), ECG machine, venepuncture sets and venflons.	Equipment for observations, examination (e.g. auroscope, ophthalmoscope, Snellen chart, hearing screening device, tendon hammer), ECG machine, venepuncture sets and venflons.	Equipment for observations, examination (e.g. auroscope, ophthalmoscope, Snellen chart, hearing screening device, tendon hammer), ECG machine, venepuncture sets and venflons.

	Infrastructure for SDAFS	BRONZE	SILVER	GOLD
	Clinical facilities	Mobility aids (e.g. frames, sticks, crutches, access to hoist).	Mobility aids (e.g. frames, sticks, crutches, access to hoist).	Mobility aids (e.g. frames, sticks, crutches, access to hoist).
		Access to stock cupboard.	Unit has its own stock cupboard.	Unit has its own stock cupboard.
		Access to a bladder scanner.	Bladder scanner available on same floor as SDAFS.	Unit has its own bladder scanner.
		Equal priority as for other SDEC services for diagnostics, investigations and laboratory results turnaround.	Equal priority as for other SDEC services for diagnostics, investigations and laboratory results turnaround.	Equal priority as for other SDEC services for diagnostics, investigations and laboratory results turnaround.
	Communication	Enough computers and printers not to delay care and completion of discharge letters and referrals etc.	Bronze plus IT that links to GP records and other shared records e.g. through information exchange platforms.	Bronze and Silver plus SDAFS notes/ CGA/ Care Plans digitally transferrable between settings across primary care, community services and secondary care.
		Adequate phones able to dial out of hospital. Access to interpreters. Patient Information available in different languages.	Adequate phones able to dial out of hospital. Access to interpreters. Patient Information available in different languages.	Adequate phones able to dial out of hospital. Access to interpreters. Patient Information available in different languages.
	Transport	Rapid access to transport (ambulances and taxis) to get patients home (same standard as for rest of SDEC services).	Rapid access to transport (ambulances and taxis) to get patients home (same standard as for rest of SDEC services).	Rapid access to transport (ambulances and taxis) to get patients home (same standard as for rest of SDEC services).
		Dedicated porter service to ensure timely investigations and other within hospital moves.	Dedicated porter service to ensure timely investigations and other within hospital moves.	Dedicated porter service to ensure timely investigations and other within hospital moves.
	Facilities for all staff	Toilets within the area.	Bronze plus lockers and coat hooks.	Bronze and Silver plus hot and cold drinks.

		BRONZE	SILVER	GOLD
Governance	**Performance monitoring**	Mechanisms in place to monitor performance of acute frailty service within department.	Bronze plus mechanisms in place to monitor performance of acute frailty hospital pathways within the trust.	Bronze and Silver plus mechanisms in place to monitor performance of acute frailty pathways in the integrated urgent emergency care system involving entire pathway across GP, community and hospital.
	Support	Appropriate administrative/ business management support.	Appropriate administrative/ business management support	Appropriate administrative/ business management support
	Key Performance Indicators (reported to Trust Board and Clinical Commissioning Groups)	% of unplanned care episodes of patients aged ≥ 65 with a CFS recorded.	Bronze plus % of unplanned care episodes of patients aged ≥ 65 with a 4AT recorded.	Bronze plus % of unplanned care episodes of patients aged ≥ 65 with a 4AT recorded.
		% of unplanned care episodes of patients aged ≥ 65 with CFS ≥ 4 managed and discharged same day.	% of unplanned care episodes of patients aged ≥ 65 with CFS ≥ 4 OR 4AT ≥ 4 managed and discharged same day.	% of unplanned care episodes of patients aged ≥ 65 with CFS ≥ 4 OR 4AT ≥ 4 managed and discharged same day.
		Satisfaction survey on patients/ those close to them e.g. Friends and family.	Bronze plus more in-depth satisfaction survey.	Bronze and Silver plus evidence of change implementation.
		7-day re-attendance and re-admission to hospital.	7-day re-attendance and re-admission to hospital.	7-day re-attendance and re-admission to hospital.
		Total occupied bed days of patients aged ≥ 65 with CFS ≥ 4.	Total occupied bed days of patients aged ≥ 65 with CFS ≥ 4.	Total occupied bed days of patients aged ≥ 65 with CFS ≥ 4.
		30-day mortality.	30-day mortality.	Bronze plus follow up outcomes at 3 months and 12 months e.g. mortality, remaining in usual place of residence.

	Governance	BRONZE	SILVER	GOLD
	Training	Practitioners in the SDAFS should have Tier 2 and Tier 3 training, as per their roles, of the Frailty Core Capabilities Framework published on behalf of Health Education England in 2018.	Bronze plus staff in Emergency Department, General Medicine & Acute Medical Unit to receive training.	Bronze and Silver plus staff pan-hospital to receive training.
	Quality Improvement Projects (QIP) and Research	No participation in research.	Site centre for recruitment to research projects in other centres.	Silver plus principal investigator/ co-applicants on research projects as part of a research group involved in primary research.
		Local QIPs including local mortality, re-presentation and frequent attenders with completed cycles.	Bronze plus a wider programme of QIPs (e.g. falls etc.) with completed cycles.	Bronze and Silver plus participation in multi centre and pathway QIPs involving external stakeholders with completed cycles.
		Environmental Audit of SDAFS area; Kings Fund environmental assessment tool “Is your hospital dementia friendly?” Scores lower than 5s with a plan for improvement.	Environmental Audit of SDAFS area; Kings Fund environmental assessment tool “Is your hospital dementia friendly?” Scores lower than 5s with a plan for improvement.	Bronze plus consistently scores 5s across the audit areas.
		Participation in pan-London and National benchmarking.	Participation in pan-London and National benchmarking.	Participation in pan-London and National benchmarking.

Suggested Metrics

Metrics should cover impact, balancing measures and process/ activity e.g.

- Number of emergency bed days used
- Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/ rehabilitation services
- Patient experience
- Staff experience
- Safety incidents in department
- Unplanned re-attendance in 7 days

Please also refer to suggested metrics in the following document:
Same-Day Acute Frailty Services
Published by NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network May 2019

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