Same-day acute frailty services

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The NHS Long Term Plan says that when organisations work together they provide better care for the public. That is why on 1 April 2019 NHS Improvement and NHS England united as one – our aim, to provide leadership and support to the wider NHS. Nationally, regionally and locally, we champion frontline staff who provide a world-class service and constantly work to improve the care given to the people of England.

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1. Introduction

This guide to acute frailty services has been developed by NHS England and NHS Improvement in collaboration with the Ambulatory Emergency Care Network (delivering same-day emergency care) and the Acute Frailty Network as part of a series of recent publications supporting secondary care providers to deliver same-day emergency care (SDEC), including *Same-day emergency care: clinical definition, patient selection and metrics*, *Managing increased demand from winter illness* and *Guide to reducing long hospital stays*.

'Acute frailty services' in this document refer to those services that identify and respond to the needs of frail, usually older people presenting to urgent and emergency care (UEC) services.

The need for acute care service redesign, including that for acute frailty, is crucial for the delivery of high quality, sustainable healthcare. With rising patient demand across UEC services, the increase in admissions is negatively impacting on patient flow in emergency departments (EDs) and bed occupancy and, where there is a lack of capacity, the number of outlying patients across a hospital. Patient outcomes and experience will inevitably worsen and length of stay increase. Trusts need support to improve the quality, effectiveness and productivity of their care pathways for frail patients.

Background

Between 5% and10% of all those attending EDs and 30% of patients in acute medical units (AMUs) are older and frail.[1] Frailty is 'a state of vulnerability to poor resolution of homeostasis after stressor events'.[2] It limits a patient's capacity to recover and is a consequence of cumulative decline in many physiological systems over a lifetime. Even small challenges such as a minor infection or a change in

[1] Conroy S, Dowsing T (2013) The ability of frailty to predict outcomes in older people attending an acute medical unit. *Acute Med* 12(2):74–6.
Basic D, Shanley C (2015) Frailty in an older inpatient population: using the clinical frailty scale to predict patient outcomes. *J Aging Health* 27:670–85.
Ferguson C, Woodard J, Banerjee J, et al (2010) Operationalising frailty definitions in the emergency department – a mapping exercise. *Age and Ageing* 39(S1):i7.
[2] Clegg A, Young J, Iliffe S, et al (2013) Frailty in elderly people. *Lancet* 381:752–62.

medication can have a disproportionate, sometimes catastrophic, impact on a frail person.

Not all older people are frail but patients with moderate to severe frailty account for most issues in (eg falls, delirium, disability, hospital readmission and care home admission) and use of resource by older people.[3] About 20% of patients account for 80% of events (including patient deaths) and bed day use in the over 75 age group.[4] Identifying and targeting this high risk cohort provides an opportunity to improve quality of care and optimise patient and service outcomes for a vulnerable population.

Patient presentation

People with frailty may present differently from other patients. They often have non-specific signs and symptoms, such as delirium, reduced mobility and a history of falling, and not the 'textbook' diagnostic indicators of a particular condition. Their condition should not be interpreted as lacking seriousness or urgency because of this – it relates to the underlying pathophysiological processes emerging across several body systems simultaneously and to communication challenges. Both the underlying medical conditions and the presenting syndrome (see below) need attention.

Frail older people may prioritise outcomes differently, with some favouring functional recovery and others comfort over cure. Preferences should be documented and influence how a patient is managed.

[3] Clegg A, Young J, Iliffe S, et al (2013) Frailty in elderly people. *Lancet* 381:752–62.
Fried L, Tangen C, Walston J, et al (2001) Frailty in older adults: evidence for a phenotype. *J Gerontol Medl Sci* 56A(3):M146–56.
Boyd C, Xue Q, Simpson C, et al. (2005) Frailty, hospitalization, and progression of disability in a cohort of disabled older women. *Am J Med* 118(11):1225–31.
Covinsky KE, Pierluissi E, Johnston C (2011) Hospitalization-associated disability: "she was probably able to ambulate, but I'm not sure". *JAMA* 306(16):1782–93.

[4] Romero-Ortuno R, Wallis S, Biram R, et al (2016) Clinical frailty adds to acute illness severity in predicting mortality in hospitalized older adults: An observational study. *Eur J Intern Med* 35:24–34.
Wallis SJ, Wall J, Biram RW, et al (2015) Association of the clinical frailty scale with hospital outcomes. *QJM* 108(12):943-9.
Gilbert T, Neuburger J, Kraindler J, et al (2018) Development and validation of a hospital frailty risk score focusing on older people in acute care settings using electronic hospital records. *Lancet* 391(10132):1775-82.

Frail patients with acute care needs are especially vulnerable to harm from delays in diagnosis and to 'deconditioning' while in hospital.[5] For example, a patient whose delirium is not identified may not be very mobile or drink enough and the ensuing dehydration and pressure sores will add to the complexity of their care and chance of a poor outcome.

Frail patients should be seen by a senior clinical decision-maker as soon as possible to avoid their unnecessary admission, improve care decisions and outcomes, and minimise the time they spend in hospital.

Patients should be managed holistically and proactively and transferred back to the community as soon as it is clinically safe, so they do not lose the ability to care for themselves. Wherever clinically appropriate, SDEC should be provided for frail older patients.

Acute frailty service provision – the mandate

As part of the 2018/19 ambitions set by NHS Improvement, by 31 December 2019 we expect all trusts with type 1 EDs to be providing an acute frailty service for at least 70 hours per week. This service requires input from physiotherapists, occupational therapists, case managers (typically a nurse specialist), doctors with geriatric expertise (but not necessarily a geriatrician) and pharmacists for multidisciplinary assessment.

[5] Platts-Mills TF, Owens ST, McBride JM (2014) A modern-day purgatory: older adults in the emergency department with nonoperative injuries. *J Am Geriatrics Soc* 62(3):525–8.
Carter EJ, Pouch SM, Larson EL (2013) The relationship between emergency department crowding and patient outcomes: a systematic review. *Journal of Nursing Scholarship* 46(2):106-15.
Bernstein S, Aronsky D, Duseja R, et al. (2009) The effect of emergency department crowding on clinically oriented outcomes. *Acad Emerg Med* 16(1):1–10.
Pines J, Pollack C, Diercks D, et al (2009) The association between emergency department crowding and adverse cardiovascular outcomes in patients with chest pain. *Acad Emerg Med* 16(7):617–25.
Gill TM, Allore HG, Holford TR, et al (2004) Hospitalization, restricted activity, and the development of disability among older persons. *JAMA* 292(17):2115–24.
Kortebein P, Symons TB, Ferrando A, et al (2008) Functional impact of 10 days of bed rest in healthy older adults. *J Gerontol Biol Sci Med Sci* 63(10):1076–81.

2. Identifying frailty

Looking for frailty must become an embedded part of the acute assessment of people aged over 65, to enable earlier targeted assessment and intervention using comprehensive geriatric assessment (CGA; see below). As frail patients can be found across a hospital, this is an issue for all clinical teams.

Clinical frailty scale

The clinical frailty scale (CFS) is a quick and simple tool that identifies degree of frailty based on symptoms and functional status. Patients who score:

- **1** are fit, active and independent with an aggregated risk of death of 2% during their hospital admission
- **4–6** are vulnerable but have an aggregated risk of death of <6% during their hospital admission
- **7** are severely frail and completely dependent with an aggregated risk of death of 11% during their hospital admission
- **8** are very severely frail and completely dependent with an aggregated risk of death of 24% during their hospital admission
- **9** are terminally ill with a life-expectancy of less than six months.

Such scores can help with identification and risk stratification but are not precise enough for individual prognostication.

Table 1: Suggested CFS uses in clinical and care pathway decision-making

Category	CFS score	Clinical considerations	Care pathways
Robust	1–3	Usual treatments, including specialist care referrals if indicated	Driven primarily by primary presenting problem
Mild-moderate frailty	4–6	Look for geriatric syndromes, refer if identified (usually as outpatient)	Consider case management in discharge planning to reduce the risk of readmission
Severe frailty	7–9	Geriatric syndromes prevalent, ensure holistic care available, end-of-life scenarios common	Services able to deliver CGA (in hospital or at home)

3. Assessing frail patients

Frail older people usually present with a range of issues, not just medical, and require a thorough, multidisciplinary management plan. Isolated medical interventions cannot alone optimise outcomes for these people – a more holistic, multidimensional care model is required.

Comprehensive geriatric assessment (CGA) is a structure for the thorough assessment and management of a person's medical, psychological, functional, social and environmental circumstances and needs. It improves patient and service outcomes,[6] and increases the likelihood that patients survive and are back home 3 to 12 months after discharge.[7] CGA is no longer the province of geriatricians only: acute and emergency physicians are increasingly developing geriatric competencies.

Geriatric syndromes

Geriatric syndromes are clinical presentations that are particularly common in moderately to severely frail people: for example, the combination of falls, immobility, delirium, dementia, depression and incontinence. These syndromes must be managed proactively from the start to prevent worsening morbidity, prolonged hospitalisation or even the patient's death.

Focus on function

Older patients will often present with pre-existing functional impairment that is further affected by an acute illness, particularly if their presentation to ED is delayed and after enforced bed rest. An enabling approach in hospital preserves function and a period of rehabilitation is often needed, ideally in the patient's home.

[6] Baztan JJ, Suarez-Garcia FM, Lopez-Arrieta J, et al (2009) Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis. *BMJ* 338:b50.
Silvester KM, Mohammed MA, Harriman P, et al (2014) Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources. *Age Ageing* 43(4):472–77.

[7] Ellis G, Gardner M, Tsiachristas A, et al (2017) Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database of Systematic Reviews* 2017(9):CD006211.

STOPP–START criteria

The screening tool of older people's prescriptions (STOPP) is used in older people to identify the potential for medication-related harm, which is several fold more likely in patients with frailty. These patients are more likely to have long-term conditions or multiple comorbidities and to be prescribed multiple medications (polypharmacy), raising the iatrogenic risk of adverse interactions between the different drugs.

The screening tool to alert doctors to the right treatment (START) identifies potential errors, omissions or underutilisation of medication.

Always consider opportunities to reduce a patient's medication. For this you may find the STOPP/START criteria useful as:[8]

- STOPP criteria medications are significantly associated with harm, eg adverse drug events.
- STOPP/START criteria assessment should be done at least once during admission/hospitalisation for an acute illness. This will significantly improve medication appropriateness.
- STOPP/START assessment within 72 hours of admission significantly reduces adverse drug reactions (ADRs) (absolute risk reduction 9.3%; number needed to treat 11 – that is, for every 11 patients assessed and managed using the tool, one ADR will be avoided). It also reduces average length of stay by three days in hospitalised older people with acute illness.

As well as frailty making a person vulnerable to minor stresses, their altered regulation of body functions is likely to affect their ability to metabolise drugs. When introducing new medications, 'start low, go slow'.

Same-day acute frailty metrics

(for patients with moderate to severe frailty, CFS 7–9)

The following metrics should be introduced to measure effective acute frailty service provision:

[8] O'Mahoney D, O'Sullivan D, Byrne S, O'Connor M, Ryan C, Gallagher P (2015) STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age Ageing* 44(2):213–8 https://academic.oup.com/ageing/article/44/2/213/2812233

- **Metric 1: Identification.** Frailty in older people (65+) who arrive at acute services (ED, AMU, SDEC) by ambulance should receive a geriatric assessment within 30 minutes of arrival.
- **Metric 2: Response to identification.** Frail older people (65+) presenting to acute services should be assessed for the presence of geriatric syndromes within an hour of being identified as having a CFS of 7 or above; documented consideration of end-of-life care should also be routine.
- **Metric 3a: Action response during core hours.** A multidisciplinary team (MDT) capable of assessing and managing geriatric syndromes should be available 10 hours a day, seven days a week. This availability will promote same-day emergency care and reduce time spent in hospital.
- **Metric 3b: Action response outside core hours.** Frail older people presenting and admitted outside acute frailty service hours should be reviewed by the frailty team by noon the following day.
- **Metric 4: Decision-making.** The MDT input should be recorded in the clinical management plan, incorporating all five domains of the CGA (medical, cognitive/psychological, functional, social and environmental problems).

4. Service redesign

Assessment and treatment areas should be ‘frail-friendly’. Environmental adaptations should include:

- non-glare lighting
- access to visual and hearing aids and large print signage and information
- non-slip flooring and handrails
- wherever possible, a calm environment with reduced background noise
- staff trained and geriatric medicine champions appointed to promote gold-standard care.

5. Next steps

We want this guide to develop and reflect best practice nationally – please share your examples by contacting us at: nhsi.sdec@nhs.net

6. Further information

The British Geriatrics Society has developed:

- a **commissioning guide** to support the design of services, which can be found on its website.
- an **interactive service-level self-assessment toolkit** available soon on its website.

More information on frailty is available from:

- Acute Frailty Network: www.acutefrailtynetwork.org.uk
- British Geriatrics Society: www.bgs.org.uk

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