Principles and Characteristics of an Acute Frailty Service for Same Day Emergency Care

Contents

Summary

This document has been developed by the Acute Frailty Sub-Group of the Same Day Emergency Care (SDEC) Programme Board, NHS England and NHS Improvement as part of a series of publications supporting system leaders, commissioners and providers to deliver acute frailty services. It has been produced in response to NHS providers requesting clearer direction on how to establish acute frailty services that will support identification and management of people with various grades of frailty who present in a crisis and need a rapid response. It incorporates factors to consider around COVID-19.

Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) was asked to provide acute frailty services for at least 70 hours a week. They will work towards achieving clinical frailty assessment within 30 minutes of arrival. This document sets out suggested practical approaches to achieving this ambition.

Whilst linking this system of care to community services is important, this document does not cover the types of frailty care that would be addressed by the urgent community response.

For further information, tools and resources readers can visit the Same Day Emergency Care webspace here https://future.nhs.uk/SDEC_CommunityofPractice/grouphome

1. Introduction

Although important before, it is now even more of a priority (with COVID-19) for hospital teams to develop and adapt their services for vulnerable adults, such as older people living with frailty. This requires early and appropriate assessment to identify those who need hospital admission and those whose needs may best be met by SDEC with or without linked primary care and community support. Succeeding in this should minimise patients' risk of exposure to COVID-19, along with other hospital associated risks such as deconditioning. This is particularly important for people aged over 65 years, who are more likely to present with symptoms of frailty. If treated as a priority, it is less likely these patients will need to be admitted to hospital. This is already happening. The British Geriatrics Society have identified that many acute and community services have altered the way they provide care for older people, with more frailty focused patient pathways for patients requiring hospitalisation and or community services.

SDEC aims to minimise and remove delays in the patient pathway, allowing services to care for patients within the same day, as an alternative to hospital admission. SDEC is based in the acute hospital, but its success depends upon prompt and reliable provision of care by other parts of an integrated health and social care system.

Over recent years, SDEC has moved from a small to a significant element of hospital acute care and is acknowledged to improve both patient experience and flow for both admitted and non-admitted patients.

In many areas of the country a large proportion of people attending Emergency Departments (ED) are over 65 years of age. With any acute illness, including COVID-19, individuals in this population are more likely to present with or subsequently develop frailty syndromes which requires early recognition and direction to treatment at the right place, in the right time. Poor or late recognition of frailty or associated syndromes increases the likelihood of being admitted to hospital, having a longer length of stay in hospital and generally experiencing poor long-term health outcomes.

2. Why frailty matters?

People living with frailty have reduced resilience to illness, injury, surgery or other setbacks, so are at increased risk of adverse health outcomes or death.

The grade of frailty that a person lives with is as good, and sometimes better, predictor of clinical outcomes than the severity of a single illness.

People living with frailty are more likely to:

- need health services when they become ill
- be admitted to hospital if they attend the ED
- develop new problems in hospital
- experience a long stay in hospital
- need prolonged rehabilitation
- need admission to a care home
- be readmitted to hospital sooner

However, early identification of frailty prompts different clinical decisions and treatments, providing better care with better outcomes and the creation of shared plans for anticipated future illness or events.

This document helps to identify grades of frailty, how to factor this into the overall clinical assessment and how this then helps decide the best care. In short this is about how to establish a hospital acute frailty service which can work in your context. In each section it defines the **principles** a team would aim to achieve, and the **characteristics** a team needs to consider when establishing their acute frailty services

It also includes an algorithm/flow chart that illustrates the key assessments and judgements which can help achieve patients with various grades of frailty getting to the right services, at the right time. Summary Chart be accessed via https://future.nhs.uk/SDEC_CommunityofPractice/view?objectID=22744848

3. Acute Frailty services: national perspective

Acute Frailty services should be seen (and planned) as part of a wider programme of re-orientating healthcare to meet the needs of increasing numbers of people living with various grades of frailty. These individuals currently access large volumes of urgent and emergency care.

Proactive and acute reactive healthcare services both need to adjust to become “frail-friendly”, to incorporate the identification, assessment and appropriate care of people living with various grades of frailty. The pro-active work of primary and community services impacts the need for urgent and emergency care. The capacity of the health and social care system to respond to acute changes in a person’s health and functioning impacts the need for these changes to be met by hospital-based emergency care. So, the scope of acute frailty services can be wide, encompassing both community and hospital provision. This document focus’ on the hospital-based provision but the future need for how it develops and how well it succeeds is closely linked to the performance of the system as a whole.

Particular interdependencies include:

The Ageing Well programme and establishing the 2hour2day standards by 2023/24, including:

- Crisis response services within two hours of referral to avoid unnecessary hospital admission and support SDEC
- Reablement care within two days of referral to enhance recovery and reduce unnecessary hospital stays

4. Integrated referral pathways

Principles

Ensuring patients receive integrated care across hospital departments, services, and the community means that hospital teams are more likely to work together, the patient's care is less likely to be fragmented or delayed and they are less likely to miss out on important elements of care. This is essential for improving the experience and outcomes of patients' care.

Characteristics

- First responders (including those in primary care and ambulance services) understand the roles of, and have access to, a range of urgent and emergency care responses for patients seeking acute care.
- Over time, the 2hour2day Urgent Community Response will increasingly become an option for suitable patients.
- Where suitable community facilities exist, ED and SDEC staff and hospital acute frailty teams have clear criteria, access and logistic arrangements to secure home support for patients with frailty whose clinical needs do not require hospital admission.
- Hospital and community services have mechanisms for predictable and reliable two-way access to advice and care for patients.
- There will be systematic sharing of performance data, patient experience feedback and staff reflections across disciplines and agencies to help improve care and satisfaction.

5. What is an acute frailty service?

The definition is:

> "An acute frailty service routinely and systematically identifies and grades frailty in people who present acutely to Urgent and Emergency Care services.
> These services then consider the personalised needs of individuals living with frailty, considering their grade of frailty and degree of illness, supported by clear reliable pathways into and out of hospitals aligned to the grade of frailty identified."

5.1 What is a hospital acute frailty service?

Principle

An acute frailty service is an integrated approach involving most staff working in an ED and urgent care services. It is not simply a unit, and it is not just a team. Depending on the local context details will vary but the essential purpose and principles are constant.

Characteristics

- It is a shared responsibility, with active support or participation of leaders and staff of multiple teams and departments.
- There is a specialist multidisciplinary (MDT) acute frailty team which has a dedicated space for the in-depth assessments but not all patients with grades of frailty will need access to this team.
- Roles and responsibilities of the various service components – ED, acute medicine teams, acute surgical teams, dedicated SDEC staff, the acute frailty team - are agreed and mutually understood.
- There may be a single multidisciplinary team which provides both SDEC and short stay frailty services with focussed decision-making on patient flow.
- At each stage, staff will ensure that the patient knows who is making clinical decisions and who they can turn to for information and discussion.

5.2 What is the acute frailty team?

Principles

Multidisciplinary acute frailty team members have clinical and communication skills suitable for working with older and other patients with frailty, including dementia skills, plus their family/carers and other providers. The MDT should be available 10 hours a day, seven days a week. The team includes one or more senior clinical decision makers, available in person.

Characteristics

- Geriatricians are suitable team members and leaders.
- Other senior professionals (doctors, nurses, pharmacists and AHPs have, or can acquire, the necessary skills to contribute to, and/or lead a frailty team.
- A senior clinical decision maker in this team will need Tier 3 level of capabilities ("Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty").
- The team will usually include senior nurses, physio or occupational therapists and pharmacists.
- Other AHPs including dietitians and speech and language therapists should be available on request.

5.3 How big should the Acute Frailty team be?

To determine the size of your acute frailty team, you will need access to patient data to inform you. This information will be available in a number of forms e.g. simply estimates of numbers of patients with various grades of frailty will have been made by applying a frailty score to a consecutive series of attending patients and observing the care pathway they take, including those discharged and admitted. This helps understand what happens as opposed to as imagined.
Other important sources of patient data are the Emergency Care Data Set (ECDS) and **Frailty Opportunity Identifier Tool**

The Emergency Care Data Set (ECDS) is an important tool that enables the capture of important information and assists in understanding how and why people access urgent and emergency care. From November 2020 ECDS will have an additional capacity to enter data on the NEWS2 and CFS scores of individual patients. This will be mandatory from April 2021. (See **ECDS latest updates** from NHS Digital here)

Frailty Opportunity Identifier Tool incorporates grades of frailty using the Hospital Frailty Risk Score based on Hospital Episode Service (HES) utilisation data, will enable local services and systems to better understand how patients with various grades of frailty have previously flowed through the hospital.

5.4 Developing the workforce for an acute frailty team

Principles

With information gained from patient data it is likely you will be dealing with increasing numbers of people with various grades of frailty. Meeting the needs of this growing patient group will require a general upskilling of many types of staff to support the delivery of frail-friendly services.

Characteristics

- Staff will need to be trained to expand their skills outside of their traditional roles and receive the right training to develop adequate skills and capabilities in order to care for patients presenting with frailty. Traditional staff roles may need to blend to enable a comprehensive approach without multiple staff inputs. A frailty framework can be accessed via https://future.nhs.uk/SDEC_CommunityofPractice/view?objectID=82478565
- The NHS and Health Education England (HEE) have described three tiers of Core Capabilities for working with frail older people.
  - All staff in urgent and emergency care need tier 1 capabilities (a *general awareness of frailty*).
  - Care co-ordinators, who can ensure that senior clinical decision makers are promptly engaged to determine the appropriate next steps for patients identified with various grades of frailty, need tier 2 capabilities. *(Health and social care staff and others who regularly work with people living with*

frailty but who would seek support from others for complex management or decision-making).

- Acute Frailty MDT members will generally need tier 3 capabilities.

GMC Decision making and consent guidance

5.5 Physical infrastructure

Principles

It is the processes and clinical actions that matter not the name of the space. However, assessment and treatment areas should be 'frail-friendly' and equipped for the job. This means that environmental adaptations and equipment is available which will enhance sensory, cognitive and decision abilities.

Characteristics

- The way that acute frailty services develop will be informed by strategic co-production which ensures that people with lived experiences are integral to their development. This ensures that what matters to the patient is captured.
- A dedicated space for assessment of people with moderate or high grades of frailty *(CFS 6-8) may be within or close to "SDEC" related spaces with equal access to investigation and logistic support services.
- Glare light and noise will be minimised.
- Visual and hearing aid batteries and other communication aids will be available.
- Large print signage and information.
- Non-slip flooring and handrails.

**See Chapter 6 for full description of the Clinical Frailty Scale (CFS).*

6. Identification of frailty

Principle

Identifying that a patient is living with frailty is as important as identifying illness severity. Both contribute to immediate and longer-term patient experience and outcomes.

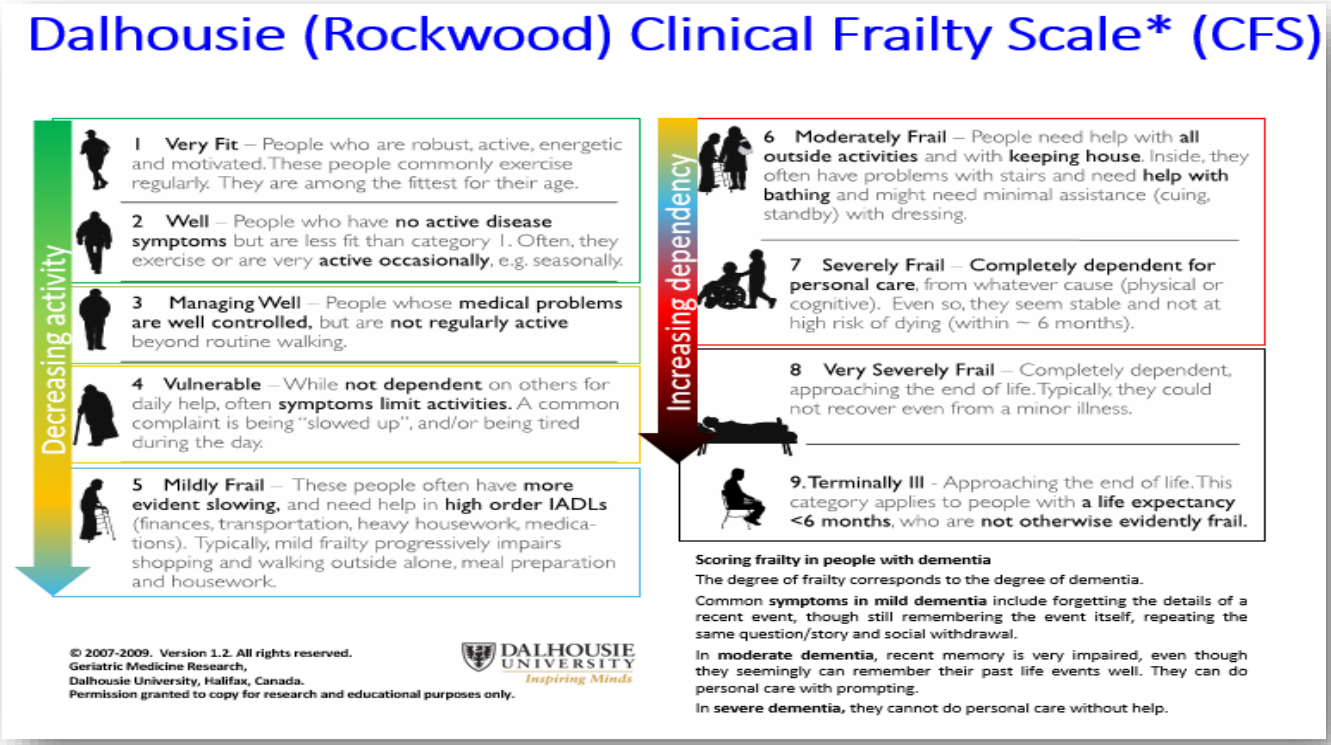
Characteristics

- Identifying grades of frailty should be part of any routine urgent assessment process, such as triage in ED (if it has not already been assessed during conveyance to hospital) and be initiated within 30 minutes of presentation and completed as soon as possible.
- A clear, local protocol defines who, where and when a brief assessment for frailty is performed and for which targeted group of ED, urgent care or SDEC.
- Assessment of frailty may have also been conducted by the GP or other community services.
- This may include paramedic assessments made prior to conveyance decisions.
- The patient group to target for routine assessments will be agreed, but may change iteratively as confidence, experience and capacity increases.
- A possible starting group of patients likely to have higher grades of frailty are people aged 65 years and over who have been conveyed by an ambulance.

6.1 How to identify grades of frailty?

There are several approaches to identify frailty (present or not), or the grade of frailty (e.g. mild, moderate, severe). Tools based on these different approaches produce similar, but not identical results. These different tools require various degrees of expertise and may or may not need equipment and/or a detailed clinical examination.

For general use in urgent care settings, many providers use the Clinical Frailty Scale (the "Rockwood" CFS).



The Clinical Frailty Score (CFS) is based on how the person was when last stable, usually 2 weeks before presentation to urgent care. The updated CFS produces a 9-point score based on symptoms, day to day activities and functional abilities.

(Note that the CFS has not been validated for use with people <65 years: For example, it is not suitable for younger people with disabilities)

6.3 Who assesses frailty?

Frailty identification may be performed by any suitably trained healthcare worker in urgent and emergency care

- For some patients, their grade of frailty may be available from GP clinical records in the form of an electronic Frailty Index (eFI).
- This provides a useful indication of the patient's frailty, but as it does not directly equate to the CFS grade, we recommend performing an assessment using the CFS.

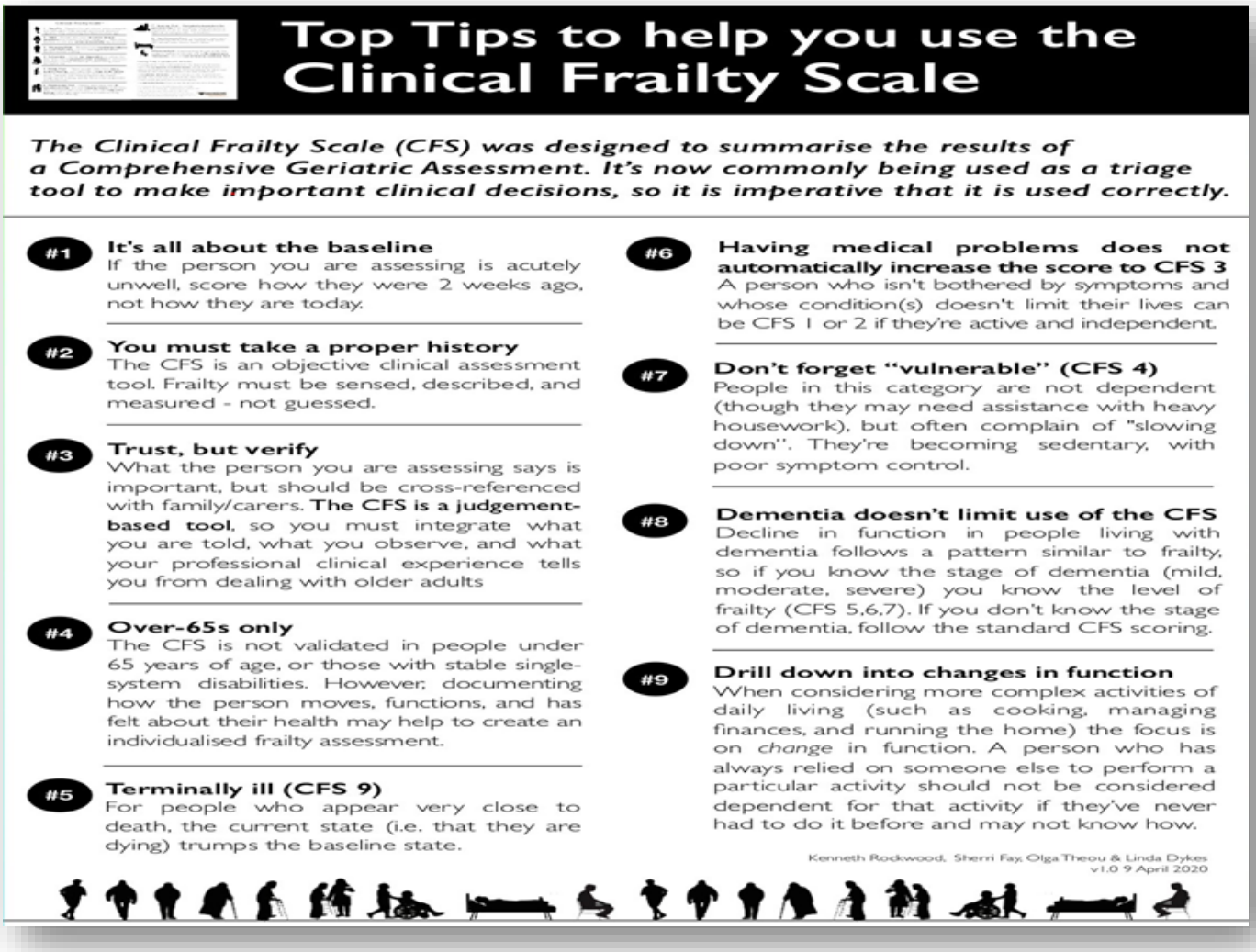
- For some patients conveyed by the ambulance service, the identification of frailty using the CFS may be done by paramedics at their home or on their way to hospital.

- Information about recent health and function may be obtained from primary care or community health staff, if not from the patient or their family and carers.

6.4 Training to use the Clinical Frailty Scale (CFS)

Training on how to use the CFS can be accessed via this link which includes advice about when and who to ask for information and what questions are helpful to obtain the information needed to decide a score. There is also additional advice about how to take dementia into account when deciding a score. The CFS App is available from the App Stores with further guidance on the tool.

6.5 Top tips to help you use the CFS



Top Tips to help you use the Clinical Frailty Scale

The Clinical Frailty Scale (CFS) was designed to summarise the results of a Comprehensive Geriatric Assessment. It's now commonly being used as a triage tool to make important clinical decisions, so it is imperative that it is used correctly.

#1 It's all about the baseline
If the person you are assessing is acutely unwell, score how they were 2 weeks ago, not how they are today.

#2 You must take a proper history
The CFS is an objective clinical assessment tool. Frailty must be sensed, described, and measured - not guessed.

#3 Trust, but verify
What the person you are assessing says is important, but should be cross-referenced with family/carers. **The CFS is a judgement-based tool**, so you must integrate what you are told, what you observe, and what your professional clinical experience tells you from dealing with older adults

#4 Over-65s only
The CFS is not validated in people under 65 years of age, or those with stable single-system disabilities. However, documenting how the person moves, functions, and has felt about their health may help to create an individualised frailty assessment.

#5 Terminally ill (CFS 9)
For people who appear very close to death, the current state (i.e. that they are dying) trumps the baseline state.

#6 Having medical problems does not automatically increase the score to CFS 3
A person who isn't bothered by symptoms and whose condition(s) doesn't limit their lives can be CFS 1 or 2 if they're active and independent.

#7 Don't forget "vulnerable" (CFS 4)
People in this category are not dependent (though they may need assistance with heavy housework), but often complain of "slowing down". They're becoming sedentary, with poor symptom control.

#8 Dementia doesn't limit use of the CFS
Decline in function in people living with dementia follows a pattern similar to frailty, so if you know the stage of dementia (mild, moderate, severe) you know the level of frailty (CFS 5,6,7). If you don't know the stage of dementia, follow the standard CFS scoring.

#9 Drill down into changes in function
When considering more complex activities of daily living (such as cooking, managing finances, and running the home) the focus is on *change* in function. A person who has always relied on someone else to perform a particular activity should not be considered dependent for that activity if they've never had to do it before and may not know how.

Kenneth Rockwood, Sherri Fay, Olga Theou & Linda Dykes
v1.0 9 April 2020

6.6 What to do if the information to complete the CFS is not available?

If the information required to complete a CFS is not available from the patient, family, carers, or care home, keep in mind that the patient's clinical condition and level of functional ability **may be the result of acute illness**.

Nevertheless, a clinical assessment of the patient's immediate vulnerability should prompt urgent action to prevent adverse frailty related events and initiation of a comprehensive assessment. A reliable CFS should be obtained and recorded later.

6.7 Responding to the needs of frail patients outside of the core opening hours

Principles

Older people with frailty identified outside of core hours should not routinely be admitted just because they are awaiting review by the frailty team. Those admitted for clinical reasons should be cared for in a way to maximise recovery and avoid hospital associated harms.

Characteristics

- ED staff have telephone access 24/7 to senior staff to support clinical decisions about discharge home.
- Patients admitted overnight who need input from the acute frailty team should be reviewed by the team by noon the following day.
- The ward accommodation for patients with frailty admitted overnight will be suitable in terms of light, noise, dignity, privacy, orientation and staff skills.
- Usual walking aids and other appliances should be available.
- Staff will have the skills of the enabling approach to promote functional independence from the point of admission to prevent hospital acquired deconditioning.
- Inpatient bed moves will be a few as possible.

7 Holistic management of the patient with frailty

Principles

Clinical judgements about individual patients also require assessments of illness severity or acuity, and mental health. Thresholds or algorithms may be helpful to trigger discussions with the right clinical teams, **but** *c*linical decisions about individual patients are based on all relevant factors. The presence of frailty impacts, but does not rule out, intensive treatment for severe illness such as shock or sepsis.

Characteristics

- Consider frailty along with NEWS 2 for illness acuity and the 4AT screen for delirium. **We call this the triple assessment.**
- Patients with grades of frailty of CFS 6 or above, who are not in need of immediate clinical escalation, may need discussion with the acute frailty team.
- Senior clinical decision makers are needed to determine clinical priorities and best place/processes of care, based on these initial assessments.

7.1 Taking the patient's perspective into account

The idea of being frail is not appreciated by many patients, including those who might appear so to the healthcare professional. Many patients may consider their health to be better than what is implied by terms such as "vulnerable" or "moderately frail". It is important to establish the patients' perspective of their health status early, even when the exact diagnosis or possible treatment is not yet clear. This matters because:

- Patients with a more optimistic outlook on their health, on average, do better when ill. This should be considered in clinical judgements about potential benefits, risks and burdens of treatment.
- If it is clear early on that a patient does not wish to opt for intensive or invasive treatments, then this will impact what is the best place, the best clinical team or the best general approach in the next steps.

- Language matters: it affects the way that the options are discussed and how effectively shared decisions can be made.

7.2 Summary on how a frailty assessment helps

Frailty assessment supports SDEC by helping to distinguish:

- People who were, prior to their urgent presentation, fit or mildly frail and may benefit from SDEC, earlier discharge +/- community rapid response. If they are acutely ill, they may not be suitable for SDEC.
- People with moderate or severe frailty whose hospital care and subsequent community support will need specialist “frailty” input.
- People who are likely to be dying (who then may need end of life/palliative/supportive care).
- It may also support earlier “triage” clinical decisions about if and where a person may need conveying by the ambulance team.

Be careful about differentiating between CFS 6 and 7:

CFS 6 (need help with outdoor activities and some help with basic activities) – all cause mortality during admission to acute hospital = 6%

CFS 7 (completely dependent for personal care) – all cause mortality during admission to acute hospital = 11%

7.3 What should happen next for patients with low levels of illness acuity and any grade of frailty?

Principles

For patients with any grade of frailty, but low levels of illness acuity, consider SDEC if more detailed assessment or investigation is needed to enable a likely discharge home today: alternatively, it may be appropriate to discharge directly from ED.

For patients going home, the grade of frailty should be included in the information for the GP or community health services so that non acute responses can be considered, e.g. to prevent falls.

In any clinical setting, grades of frailty CFS 6 or above will lead to an assessment for frailty associated syndromes e.g. risk of falls, delirium, hospital acquired functional decline, incontinence, using local approaches based on NICE guidance.

Characteristics

- After immediate treatment, clarify goals of care, considering the patient's priorities and the feasible approaches.
- Reliable processes are needed to facilitate access of suitable patients to the acute frailty team.
- The frailty team may be primarily responsible, but the acute medical unit can take responsibility for others.
- Local arrangements should clarify responsibilities, balancing clinical needs with resources in a flexible manner so that "waiting for assessment" is minimised.
- Standardised approaches are used to assess for presence of frailty syndromes as part of the initial clinical assessment.
- The findings will result in clinical responses recorded in the notes and will generally include a medication review.

7.4 What should happen next to patients with moderate or severe frailty (CFS 6 or above)?

Principles

The presence of moderate or severe frailty **does not automatically rule out** intensive management of severe illness such as shock or sepsis, but patients with very severe frailty or who are terminally ill may not benefit from intensive treatments. For people with CFS of ≥7, the patients' priorities should be discussed and agreed in the context of potential benefits and burdens of treatment. Patients with moderate or severe grades of frailty, whose immediate needs are best met by the acute medical or surgical team, may also need access to a "frailty" team. Patients with moderate or severe frailty or frailty-associated syndromes, may benefit from a comprehensive geriatric assessment (CGA).

Characteristics

- Factor in patients' priorities when deciding treatment plans, levels of escalation and the need for end-of-life care (they may have advance care plans which offer guidance or legal directives).
- NICE guidance is available to support decisions about using critical care.
- Put in place agreed protocols of liaison to enable the acute frailty team to support other clinical teams (e.g. in acute medical units or surgical SDEC teams).
- For patients admitted to hospital, this support might be from ED/SDEC based acute frailty team or the hospital geriatrics service.
- E-health records are designed to support inclusion of frailty grade and syndromes and shared access to clinical assessments

7.5 The importance of Comprehensive Geriatric Assessment (CGA)

Principles

CGA is a systematic approach proven to identify problems, set goals and design and initiate the necessary clinical responses including follow up. CGA will be needed for most frail patients potentially suitable for SDEC. For some patients, this may be completed after discharge by suitable community or primary care clinical services.

Characteristics

- Patients with grades of frailty of CFS 6 or above are likely to have a range of problems – physical, mental, functional, social or environmental which will impact the course of the acute illness, the need for rehabilitation and ongoing care.
- CGA covers five domains: medical, functional, social, cognitive or psychological, and environmental.
- Some issues need urgent consideration. Others need longer term primary or community-based interventions to slow, stop or reverse progression of frailty.
- Clinical urgency based on the overall assessment will determine the timing and focus of the CGA but will be started within 2 hours of presentation.

- CGA requires a multidisciplinary team working together in hospital or community/primary care settings with agreed roles and with well-planned interactions such as team meetings.
- CGA findings are recorded and accessible to other hospital and community services.

7.6 Getting a patient with frailty home from SDEC

Principles

Understand patients' needs and their available support, respecting and incorporating the contribution of informal carers and families. Logistics, e.g. transport, should be resourced to support the aims of SDEC bearing in mind that some SDEC patients will be living with various grades of frailty.

Characteristics

A patient-centred approach involves shared (supported) decision making. All elements of the SDEC service (including medical and surgical):

- Need prompt access to suitable allied health professionals (AHPs) and social care professionals to assess needs and facilitate the support at home being set up.
- Need responsive, community-based hospital discharge support teams to operate consistently but flexibly on agreed criteria based on patient need, not on the referring service or team.
- Need system leaders and commissioners to ensure that suitable and timely provisions exist for transport to and from SDEC services.
- Include results of the triple assessment to be shared with community and primary care staff on discharge from hospital, whether this be via SDEC or later.

8.Special considerations for people who may present with symptoms of COVID-19?

- Patients with COVID-19 may present with delirium, fatigue or reduced functional ability without typical respiratory symptoms: this is more common for those with any grade of frailty.
- Older people living with frailty are particularly susceptible to severe COVID-19 related illness, therefore this possible diagnosis must be factored into clinical judgements about older patients for the foreseeable future.
- This will likely impact the pathways and places where assessments take place but does not preclude the option of SDEC.
- Local arrangements will determine where and by whom patients with possible or definite COVID-19 may be cared for.
- National, and if relevant, local guidance should be followed regarding discharge or transfer of care arrangements for patients with possible or definite COVID-19.

9.How to get started?

Principles

Equity requires that the SDEC service supports access to SDEC for patients living with various grades of frailty. Establishing a hospital acute frailty service to support SDEC will be affected by the approaches, capacity and type of services available for patients with frailty in the local primary and community services. Success of the hospital service will also need commitment from both hospital and community health partners. The co-production approach to developing and improving services includes the patient's voice at the core of decision making. This perspective is an enabler of personalised care.

Characteristics

- Analysis of your hospital and/or CCG wide data will help you to understand how your services currently respond to patients with frailty accessing urgent and emergency services.
- This process will include review of data obtained from the emergency care data set (ECDS) and the frailty opportunity identifier tool
- Data from NHS Benchmarking audits and reports from GiRFT (Getting it Right First Time) can also provide useful insights and recommendations.
- If resources are limited, start by putting in place a process to identifying a group of patients most likely to include those living with frailty, e.g. conveyed patients over age 75, and then spread out as processes, capacity and confidence grow.
- Follow the clinical path taken by a group of these patients (in reality, not as imagined) to see what needs changing and who needs training.
- To ensure co-production, consider also using experience-based design to identify problem areas in the current service.
- Identify the right staff and capabilities needed and provide the necessary training and support to develop with the right skill mix in the right places to identify and care for people with frailty.
- If resources are limited, start by putting in place a process to identifying a group of patients most likely to include those living with frailty, e.g. conveyed

patients over age 75, and then spread out as processes, capacity and confidence grow.

- Even with a small start, agree explicit actions by whom and by when and measure to assess progress.

The Acute Frailty Network has developed ten key principles to embedding the approach to acute frailty in urgent and emergency care. For more information please go to www.acutefrailtynetwork.org.uk

9.1 How to develop and improve?

Principles

It is important to understand how well your service is providing care for patients and it will be important to agree how SDEC local activity will be recorded and reported. Make sure there are opportunities for capturing information on the impact of the changes you have implemented and some of this information can be observed via the **Frailty Opportunity Identifier Tool**. You will also want to ensure that you capture measures or are able to retrieve information that describe the impact on your service developments and if there are opportunities for reimbursement.

The co-production approach to developing and improving services includes the patient's voice at the core of decision making. This perspective is an enabler of personalised care

Characteristics

- To manage patient expectations' and those of their family, patients should be informed early in their journey (ideally in ED or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight.
- Small scale cycles of plan, do, study, act (PDSA) with process measures can help develop what is needed next.
- Clear measures must be agreed and monitored to assess the effects of service changes on patient experience, clinical outcomes, and service performance.

- Ensure feedback from patients and carers (Friends and Family Test, complaints, compliments, patient stories) are collected, shared and used to improve services.
- Use the available validated methods to capture patient experience
- Reflecting on routine clinical datasets will enable better grasp of current clinical activities
- System level changes are needed but may take a while so focus on feasible observable measures first.
- Providers must work with NHS England and NHS Improvement commissioners to agree how SDEC activity will be recorded and reported.

9.2 Signals that your acute frailty service is not yet fully established.

- The numbers of patients with identified frailty is low or variable
  - *Consider capacity/culture/over-reliance on specialists*
- Numbers seen by the frailty team is lower than expected
  - *Criteria may be too restrictive or not applied*
- Case mix seen by the frailty team is inconsistent
  - *Referral pathways are unclear, complex or not feasible*
- Patients are “waiting for the frailty team”
  - *Consider any of the above; remember - frailty is everybody’s business*
- Little impact on system performance
  - *Measuring too early – review modelling*
- Volumes too low
  - *Pathways not in place or capacity too small (hospital or community)*

BUT, improving the care of any patient is a positive change, be optimistic!

10. Conclusion

This guidance brings together in one document information to support providers deliver acute frailty services for Same Day Emergency Care. Looking ahead as the NHS Long Term Plan for the Ageing Well programme continues to be implemented this will mean a more proactive approach to care for the elderly and a change in emphasis from hospital to community care, which in many ways has been accelerated as a result of COVID-19. As local services work to meet the *2hour2day* standards, then community services present an alternative to hospital for suitable patients. However, it is important to recognise that many patients will need both community and hospital care. An outcome of COVID-19 has accelerated the urgency for local services to work towards developing patient pathways to facilitate direct access for GPs, paramedic to hospital-based teams including SDEC, and Acute Frailty services.

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