Acute Frailty Network

Acute Frailty on the AMU: the challenges

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Acute Frailty Network Faculty
@DocMattThomas
• The challenge

• A structured solution
  • Early identification
    • Pre hospital, ED, AMU, Frailty unit
  • Early CGA
  • Ambulate
    • Clinic
    • On the ward
  • Discharge to assess, not assess to discharge
  • Liaison
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• Challenge
  • Numbers
  • Deconditioning
Figure 4: Average number of beds available by category, 1987/8-2016/17

Source: NHS England 2017a

Note: The drop in bed numbers between 2009/10 and 2010/11 is likely to be attributable to a change in data-recording methodology between these years. This means comparisons across the period are subject to some uncertainty.
English hospital activity per 1,000 people, general & acute specialties, 2009/10 to 2016/17

- A&E attendances (all types of A&E) 7.7% rise
- Non-elective (emergency) admissions 6.7% rise
- Elective admissions (overnight admissions and daycases) 15.7% rise
- First outpatient attendances 15.1% rise
Figure 1: Attendances at, and emergency admissions from, major A&E departments (2003/4=100)
Figure 2: Per cent of attendances at a major A&E department resulting in an admission
Figure 7: Total admissions into hospital care, Department of Health funding and English population aged 85 and older (2003/4=100)

We have chosen all hospital admissions, including all non-elective admissions, as a proxy for all hospital activity, given this represents the bulk of cost.

Projections are shown as dashed lines. The NHS England projection of unmitigated demand for acute services assumes that the measures in the Five Year Forward View have no effect on reducing demand and that admissions will increase at the same rate as activity in the rest of acute care.
Figure 3: Emergency admissions from A&E, monthly data

Data source: A&E attendances and emergency admissions www.england.nhs.uk
Figure 5: Delayed transfers of care: total number of days delayed each month

Data source: Acute and non-acute delayed transfers of care, total days delayed, 2016/17 [www.england.nhs.uk](http://www.england.nhs.uk)
NHSBN Older People’s Care in Acute Settings 2016

- 3% of Consultant workforce are Geriatricians
- 52% of Trusts have a frailty unit
- 89% of frailty units use CGA
- 45% of nursing staff on older people wards are unregistered
- 14% of pay costs spent on bank & agency across the pathway
- 83% of delayed transfers of care were attributable to people age 65 and over
- 12 days average length of a delayed transfer of care
- 56% of patients included in the service user audit have had a hospital admission in the last 12 months
- 74% of organisations set estimated discharge dates within 24 hrs of admission

SAMDA 2018
Fast facts about deconditioning

- 10 days of bed rest in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 (Kortbein et al 2004 J Gerontology)
- One study showed 60% of immobile older patients had no medical reason that required bed rest (Graf 2006 Am J Nursing)
- A 50% increase in walking while in hospital was associated with a 6% shorter length of stay (McCullough et al 2006, Phys Measure)
- 48% of people over 85 die within one year of hospital admission (Clark et al 2014 Palliat Med)
- The application of #EndPJparalysis in Ward C4, Trauma & Orthopaedic Unit, Nottingham University Hospitals, led to
  - 37% reduction in falls
  - 86% reduction in pressure injuries
  - 80% reduction in patient complaints
  - Spot audit showed reduction in length of stay of 1.5 days
- 47 per cent of delayed transfers of care in one study related to deconditioning (Lim et al 2006)
Consent Form 1
Patient agreement to investigation or treatment

Patient details (or printed label)

Surname
First name
Date of birth
Male ☐ Female ☐
NHS Number

Responsible consultant
Job title
Special requirements (e.g. other language, communication method)

Name of proposed procedure of course of treatment
Include brief explanation if medical term not clear

Admission to hospital because it is safer than going home

Statement of health professional
To be filled in by health professional with appropriate knowledge of proposed procedure as specified in consent policy

I have explained the procedure to the patient. In particular, I have explained:
The intended benefits: Possibly early investigations: Not falling or collapsing with nobody there to help; having time to arrange better social circumstances/care

Serious or frequently occurring risks: Loss of confidence; loss of muscle power; loss of mobility; loss of sleep; increased confusion; increased risk of falling; risk of hospital acquired infection; not getting back to your own home... ever.

Any extra procedures which may become necessary during the procedure
☐ Blood transfusion
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Frailty in elderly people

Andrew Clegg, John Young, Steve Iliffe, Marcel Olde Rikkert, Kenneth Rockwood

Frailty is the most problematic expression of population ageing. It is a state of vulnerability to poor resolution of homoeostasis after a stressor event and is a consequence of cumulative decline in many physiological systems during a lifetime. This cumulative decline depletes homoeostatic reserves until minor stressor events trigger disproportionate changes in health status. In landmark studies, investigators have developed valid models of frailty and these models have allowed epidemiological investigations that show the association between frailty and adverse health outcomes. We need to develop more efficient methods to detect frailty and measure its severity in routine clinical practice, especially methods that are useful for primary care. Such progress would greatly inform the appropriate selection of elderly people for invasive procedures or drug treatments and would be the basis for a shift in the care of frail elderly people towards more appropriate goal-directed care.
**Figure 1:** Vulnerability of frail elderly people to a sudden change in health status after a minor illness

The green line represents a fit elderly individual who, after a minor stressor event such as an infection, has a small deterioration in function and then returns to homoeostasis. The red line represents a frail elderly individual who, after a similar stressor event, undergoes a larger deterioration, which may manifest as functional dependency, and who does not return to baseline homoeostasis. The horizontal dashed line represents the cutoff between dependent and independent.
Development and validation of an electronic frailty index using routine primary care electronic health record data

ANDREW CLEGG¹, CHRIS BATES², JOHN YOUNG¹, RONAN RYAN³, LINDA NICHOLS⁴, ELIZABETH ANN TEALE¹, MOHAMMED A. MOHAMMED⁵, JOHN PARRY⁶, TOM MARSHALL³

¹Academic Unit of Elderly Care and Rehabilitation, University of Leeds, Bradford, West Yorkshire, United Kingdom of Great Britain and Northern Ireland
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⁶Address correspondence to: A. Clegg. Tel: (+44) 01274 383440; Fax: (+44) 01274 382766. Email: a.p.clegg@leeds.ac.uk
Figure 1. Five-year Kaplan-Meier survival curve for the outcome of mortality for categories of fit, mild frailty, moderate frailty and severe frailty (internal validation cohort).
Figure 2. Relationship between age, electronic frailty index score and mortality (internal validation cohort).
Clinical Frailty Scale*

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.

3. Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs walking outside alone, or doing.

6. Severe Frail – Completely dependent for personal care from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though repeating the

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ORIGINAL PAPER

Association of the clinical frailty scale with hospital outcomes

S.J. Wallis\textsuperscript{1,2}, J. Wall\textsuperscript{2}, R.W.S. Biram\textsuperscript{1} and R. Romero-Ortuno\textsuperscript{1,3}

From the \textsuperscript{1}Department of Medicine for the Elderly, Addenbrooke’s Hospital, Cambridge, UK, \textsuperscript{2}School of Clinical Medicine, University of Cambridge, Cambridge, UK and \textsuperscript{3}Clinical Gerontology Unit, Department of Public Health and Primary Care, University of Cambridge, Cambridge, UK

Address correspondence to Dr R. Romero-Ortuno, Department of Medicine for the Elderly, Box 135, Addenbrooke’s Hospital, Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ, UK. E-mail: roman.romero-ortuno@nhs.net
Figure 1. ROC curves for the prediction of in-patient mortality. AUC with 95% CIs were: CFS: 0.72 (0.69 to 0.75, \( P < 0.001 \)), Charlson Comorbidity score: 0.67 (0.64 to 0.70, \( P < 0.001 \)), age: 0.59 (0.56 to 0.62, \( P < 0.001 \)), history of dementia and/or current cognitive concern: 0.53 (0.50 to 0.56, \( P = 0.079 \)).
Figure 2. ROC curves for the prediction of transfer into core DME ward (from non-DME ward), LOS ≥ 10 days and 30-day readmission. AUC with 95% CIs for DME transfer were: CTS: 0.86 (0.81 to 0.90, P < 0.001), Charlson comorbidity score: 0.58 (0.56 to 0.61, P < 0.001), age: 0.62 (0.59 to 0.65, P < 0.001), history of dementia and/or current cognitive concern: 0.62 (0.59 to 0.65, P < 0.001). AUCs for LOS ≥ 30 days were: CTS: 0.63 (0.58 to 0.64, P < 0.001), Charlson: 0.56 (0.56 to 0.58, P < 0.001), age: 0.58 (0.56 to 0.60, P < 0.001), history of dementia and/or current cognitive concern: 0.59 (0.55 to 0.63, P < 0.001). AUCs for 30-day readmission were: CTS: 0.54 (0.52 to 0.56, P < 0.001), Charlson: 0.54 (0.52 to 0.56, P < 0.001), age: 0.54 (0.51 to 0.56, P < 0.001), history of dementia and/or current cognitive concern: 0.52 (0.50 to 0.55, P < 0.001).
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RESEARCH

Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials

Graham Ellis consultant geriatrician and honorary senior clinical lecturer, Martin A Whitehead consultant geriatrician, David Robinson consultant geriatrician, Desmond O’Neill associate professor of gerontology, Peter Langhorne professor of stroke care

1Medicine for the Elderly, Monklands Hospital, Airdrie, North Lanarkshire, Scotland, UK; 2Medicine for the Elderly, Wishaw General Hospital, Wishaw, North Lanarkshire; 3Mercy’s Institute for Research on Ageing, St James’ Hospital, Dublin, Republic of Ireland; 4Department of Medical Gerontology, Trinity Centre for Health Sciences, Adelaide and Meath Hospital, Tallaght, Dublin 24, Dublin; 5Academic Section of Geriatric Medicine, University of Glasgow, Glasgow, Scotland
Comprehensive Geriatric Assessment (CGA)

“a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person’s medical conditions, mental health, functional capacity and social circumstances in order to provide a coordinated and integrated plan for treatment and follow up.”

Brittish Geriatric Society (BGS)2015
Conclusions

Significantly more older patients are likely to survive admission to hospital and return home if they undergo comprehensive geriatric assessment while they are inpatients. Fewer will die or experience deterioration and more will have improved cognitive functioning. These effects of acute geriatric medicine programmes are consistently shown in trials of geriatric wards but are not replicated in trials of geriatric consultation teams on general wards. These benefits might be cost effective.
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• Ambulatory care
  • Not just the ambulant
  • For all whose function has not changed from baseline
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Are YOU looking after an older person?

Ageing can cause:
- reduced bone mass
- reduced muscle strength
- problems with blood pressure control
- hearing and visual impairment

Older patients are vulnerable
When an older person comes to hospital...
we often put them in a hospital bed which restricts their mobility which can result in...

- increased confusion
- functional incontinence
- deconditioning and muscle weakness resulting in further immobility
- an increase in falls
- reduced appetite and increased risk of aspiration
- this is made worse by multiple medications, sensory impairment, constipation, dementia and their current illness

Stand up for INDEPENDENCE
and ask yourself the following...

- Does my patient know who I am and where they are?
- Does my patient need the IV fluids?
- Does my patient need to be in bed with the cot sides up?
- Does my patient need the catheter?
- Is my patient constipated?
- Could my patient sit out in a chair?
- Does my patient need help with eating and drinking?
- Does my patient need their glasses or hearing aid to help them communicate?
- Have my patient’s medications been reviewed?

By asking yourself these questions you can:
- Increase the chance of your patient going back to their own home
- Help them recover more quickly and reduce the need for ongoing support
- Reduce the risk of harm from falls, infection, delirium (acute confusion) and blood clots
PREVENTING DECONDITIONING AND ENABLING INDEPENDENCE FOR OLDER PEOPLE IN HOSPITAL

Older people in hospital can be more at risk of:
- Reduced bone mass and muscle strength
- Problems with blood pressure control
- Reduced mobility
- Constipation due to changes in environment
- Demotivation

...and lies in bed, it can affect their wellbeing and physical function

When an older person comes to hospital...

THIS IS KNOWN AS ‘DECONDITIONING’

Increased risk of falls due to muscle weakness
Increased confusion or disorientation
Further immobility due to inactivity

Constipation and incontinence
Lying in bed can affect appetite and digestion
Increased risk of swallowing problems leading to pneumonia

Prolonged bed rest in older people can lead to substantial loss of muscle strength and physical activity

Assess

A Comprehensive Geriatric Assessment should be completed to determine normal capabilities

A risk assessment should be completed

Glasses and hearing aids should be accessible

Support

Are there appropriate mobility aids available

Walking to the toilet helps to prepare for going home

Sitting out of bed helps (when possible)

Encourage

Feed or take fluids independently

Wash and dress independently

Keep moving, arms and legs even in a bed or chair

Thinking about how to support and encourage movement helps to:
- Reduce the risk of falls, infection, clots and delirium
- Reduce length of stay in hospital
- Reduce the likelihood of having an increase in future care needs

Sit up... Get dressed... Keep moving...

YOUR MUSCLES / YOUR STRENGTH / YOUR ABILITIES - USE THEM OR LOSE THEM

SAMDAM 2018
#EndPJparalysis 70 day challenge

17th April 2018 - 26th June 2018

"Time is the most important currency in healthcare" Prof. Brian Dolan

Did you know, 46% of people aged >85 die within 1 year of admission to Hospital? (Clark et al 2014)

Deconditioning in hospitalised older patients, can cause serious harm

Aiming for 1 million patient days dressed in own clothes & moving in 70 days. Let’s help our patients get home back to loved ones

If you had 1000 days left, how many would you want to spend in Hospital? That’s why EVERY DAY matters

FACT: Reduces mobility
FACT: Loss in strength
FACT: Loss of independence
FACT: Longer stay in hospital
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The two most common reasons for DTOCs (across all DTOCs) reported were “awaiting further non-acute hospital care” at 23% and “awaiting a care package in own home” at 18%.
There is established good practice

Joint working with primary, social and community care

Patient pathway

GP referral

Hospital attendance

Accident and emergency (up to four hours)

Short stay assessment unit (up to 48 hours)

Ward

Discharge

Priorities for older patients

Early identification of needs to determine the most appropriate care for older patients

Maintaining momentum to ensure older patients do not spend any longer in hospital than they need to

Assessment and rehabilitation at home, wherever possible, where older patients can make more effective decisions about their long-term care

Patient / family involvement in decisions about their care, treatment and discharge
Variation in practice - admission avoidance (1)

**Variation in admissions:** There is significant variation across hospitals in the percentage of older people attending A&E who are admitted (37% to 61% - 10th and 90th percentile)

**Risk appetite:** We heard in a number of case studies that geriatricians were more willing to make decisions to discharge patients early than general ward staff who had a more risk averse culture. Our survey results showed that only 34% of trusts felt they had enough geriatricians.
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• Acute Frailty Network
**NOW**

- The frail Elderly
  - Late Crisis presentation
    - Fall, delirium, immobility
  - Hospital-based episodic care
    - Disruptive & disjointed

**FUTURE**

- ‘An Older Person living with frailty’
  - A long-term condition
- Timely identification preventative, proactive care supported self management & personalised care planning
- Community based person centred & coordinated
  - Health + Social +Voluntary+ Mental Health
• Establish a mechanism for early identification of people with frailty
• Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour
• Set up a rapid response system for frail older people in urgent care settings
• Adopt clinical professional standards to reduce unnecessary variation
• Develop a measurement mind-set
• Strengthen links with services both inside and outside hospital
• Put in place appropriate education and training for key staff
• Identify clinical change champions
• Patient and public involvement
• Identify an executive sponsor and underpin with a robust project management structure
Acute Frailty Network

- Breakthrough series collaborative
- Focus on:
  - Frail older people
  - CGA
  - First 72 hours
  - Quality improvement
Acute Frailty Network metrics

Macro-level
External comparisons – AFN sites vs. rest of NHS to determine benefits over & above usual care; using Nuffield & HES based algorithms to standardise assessment of frailty across the NHS

Meso-level
Internal service metrics based on HES data (age, conversion rates, bed-days; internal progress, local commissioners & benchmarking)

Micro-level
Internal service development metrics aligned to specific aims
AFN internal evaluation

- Reaction
  - The structured site interviews indicate high levels of satisfaction with the network, especially site visits, site support, national events to network, measurement support and meetings, validity given by being part of AFN, Executive level support.

- Some themes about AFN needing to develop a more MDT and less geriatrician led approach, need for a ‘clinician day’ rather than a ‘nursing/ therapies’ day, focusing less on first 72 hours and more on whole pathway, usefulness of sustainability tool, and not knowing about venues until too late.
AFN internal evaluation

• Learning
  • 7 more sites reported implementing frailty related training for staff, to varying degrees.
  • 9 out of 12 sites improved their sustainability scores during the programme,
  • Trusts reported critical success factors as being bravery, frailty identification, measurement, winning over hearts and minds, MDT approach, someone with a vision, time for key team members to commit, working together.
AFN internal evaluation

• Behaviours
  • 8 more sites now identify frailty than at the beginning of the programme
  • 6 more sites now have a rapid response system for frail older people in urgent care settings, including increasing the MDT available at the front door, better in reach in ED / MAU, relocation of services with fewer beds and more clinics. Future plans include 7 day services, developing more integrated working with partners
  • 6 more sites now adopt clinical standards to reduce unnecessary variation
  • 6 more sites believe they now have a measurement mind set
  • 3 more sites identify clinical change champions. Portsmouth has focused on ward accreditation
  • 8 more sites report having identified an executive sponsor for frailty services. For most, this has made a huge difference in raising profile and tackling ‘blocks’
The Acute Frailty Pathway at Medway NHS Foundation Trust

Outcome

In March 2016 the new medical model was introduced to the trust, which provided a greater continuity in care.

Two AAU’s (Acute Assessment Units) were opened; one male ward, one female ward. From this point Consultant Geriatricians directly manage and assess Frail patients admitted to the hospital. By the Consultant Geriatricians taking full management of Frail patients the stranded patient rate applied as the new process was embedded and the patients still admitted under the previous medical model were assessed and discharged, this then dropped hitting more often than not below the lower limit average this then began to rise slightly then from August 2016 the stranded patient rate massively dropped and has stayed significantly below the lower limit consistently, resulting in less patients staying in hospital for over 7 days.

Proving that managing Frail patients by Consultant Geriatricians from Day 1 of admission impacts hospital length of stay.
Increase in early discharges has been essential to improve flow

**Bournemouth ROI Calculations**

<table>
<thead>
<tr>
<th></th>
<th>Weekly</th>
<th>LOS reduction</th>
<th>Discharges</th>
<th>Days saved (a week)</th>
<th>Based on Audit commission data (£59)</th>
<th><em>Based on Bed day rate (</em>£171)</th>
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<tbody>
<tr>
<td>Using Averages</td>
<td>4.05</td>
<td>88.50</td>
<td>358 bed days</td>
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<td>Using UCL</td>
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<td>127.66</td>
<td>470 bed days</td>
<td>£27,730</td>
<td>Not Available</td>
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</table>

**Annual**

<table>
<thead>
<tr>
<th></th>
<th>Based on Audit commission data (£59)</th>
<th>*Based on Bed day rate</th>
</tr>
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<tbody>
<tr>
<td>Using Averages</td>
<td>£1,098344</td>
<td>£3,187115</td>
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<tr>
<td>Using 80% Variation</td>
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<tr>
<td>Using UCL</td>
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*Bed day rate: Provided by Bournemouth, but only as an average figure*
The Impact on Cohort 2

This infographic highlights the outcomes from the evaluation of AFN Cohort 2. The evaluation was designed to analyse the effectiveness of the AFN programme against its stated objectives and identify opportunities for improvement.

**REACTION:** Improved engagement and commitment

- **326** attendees attended the four national events
- **90%** of sites rated the programme as good or excellent
- **25%** more sites now involve partners and members of the public
- **80%** of sites reported improved partnership working

**LEARNING:** Increased awareness and knowledge

- **75%** improved their ability to realise benefits from complex projects
- **43 more sites trained in Experience Based Design**
- **Some sites nearly tripled their sustainability score**

**BEHAVIOUR:** Enabled sites to do things differently

- **70%** more sites now identify frail patients
- **Rapid Response**
  - **90%** more sites have a rapid response team in place for frail people in urgent care settings
- **60%** Nearly 60% more sites now have an inter-disciplinary response including comprehensive geriatric assessment (CGA) for frail patients

**RESULTS:** Improved outcomes for patients

- **Better Care**
  - Reduced the number of patients aged over 75 staying in hospital for over 7 days from 129 to 70 per day
  - Reduced the number of readmissions within 30 days by nearly 100% from 200 per week to 110
  - Have increased their early discharges essential to improve flow from 19 per day to 34 per day and reduced their length of stay from 10.26 days to 7.78 days
  - Have also achieved an annual saving / return on investment of between £1m - £3m (depending on financial rates saved) and saved around 400 bed days per week
Of course, as with other age groups, many elderly patients will be admitted as acute patients at the request of their general practitioner; but this is not the characteristic pattern of admission to a geriatric unit. The key to this is assessment, a process which looks at the patient’s whole life situation, taking in his physical, mental and social circumstances. It attempts to define the need for treatment, the scope for rehabilitation, and the ultimate prognosis from the earliest contact with the patient. Frequently it starts in the patient’s own home before admission. Although it may be mainly done by a domiciliary visit by a consultant in geriatric medicine it is essentially a multidisciplinary affair, involving social workers, occupational and physiotherapists as well as the general practitioner and hospital doctors.

After admission the process of assessment continues concurrently with treatment and rehabilitation. It
Acute Frailty Network

‘getting older people home sooner and healthier’

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