

# Acute Frailty Network **A Compilation of “Best Practice” Case Studies**

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Nurses and therapists across the network have worked with us to compile this collection of case studies, sharing their experiences and stories of improving services for frail older people.



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Kettering General Hospital NHS Foundation Trust had no dedicated frailty service in 2012. The hospital – a medium-sized district general with 574 beds - is based in Northamptonshire, which already has a greater percentage of older people than many other regions and is facing a 19% increase over the next 10 years. The number of over 85s is expected to rise the fastest.

### Pilot project

A baseline audit showed poor quality data collection for frail older patients. The hospital began a three-month nurse-led pilot to explore ways of improving the identification and management of frailty. It developed a comprehensive geriatric assessment (CGA) process using the Royal College of Physicians' acute care toolkit and the Silver Book. The team identified particular frailty markers to identify suitable patients, including falls, confusion (acute or known), dehydration and patients in receipt of care packages. It began carrying out CGAs in urgent care wards, conducted by a single nurse working fixed times.

### Nurse-led frailty team

After three months, the pilot scheme demonstrated a 40% reduction in length of stay for patients who met its frailty criteria. This was enough to convince the hospital to create a full-time Acute Frailty team. The team began as one full-time post (Lauren Rothwell, a former deputy sister in urgent care). Between 2013 and 2017, four former urgent care nurses joined the Acute Frailty team, as well as a senior nurse.

One of the factors that made this such a successful project was the fact that it was nurse-led and that all of the nurses had previous urgent care experience. Lauren explained:

*"We already had good relationships with the acute physicians. In common with many hospitals, we have a shortage of geriatricians so the clinicians were very appreciative of our support and open to our input. In return, we adopted a very purposeful, collaborative approach. We all had a willingness to challenge assertively but from a place of professional enquiry; we respected their perspectives and they respected ours. We have built on these good relationships from the start and encouraged a collaborative mentality between our team and the teams we work with."*

## Easy-to-use CGA

The CGA process was reviewed at the end of the pilot programme and amended in response to nurse and therapist feedback. The layout was amended to make it easier to use and they added new sections relating to medical reviews and functional assessments. This process of reviewing and refining has continued since the CGA was introduced. Lauren added:

*"We are now up to version 12 but, despite adding more sections and making revisions, we have kept the documentation to the same five-page format. Any longer becomes unmanageable for staff. We've avoided duplicating any information that is already gathered during our emergency department (ED) clerking process. Our aim is for every patient over 75 to have a CGA when they come through the front door and to get them where they need to be as quickly as possible. It is vital that the form is short and easy for nurses to use."*

## An expanded team

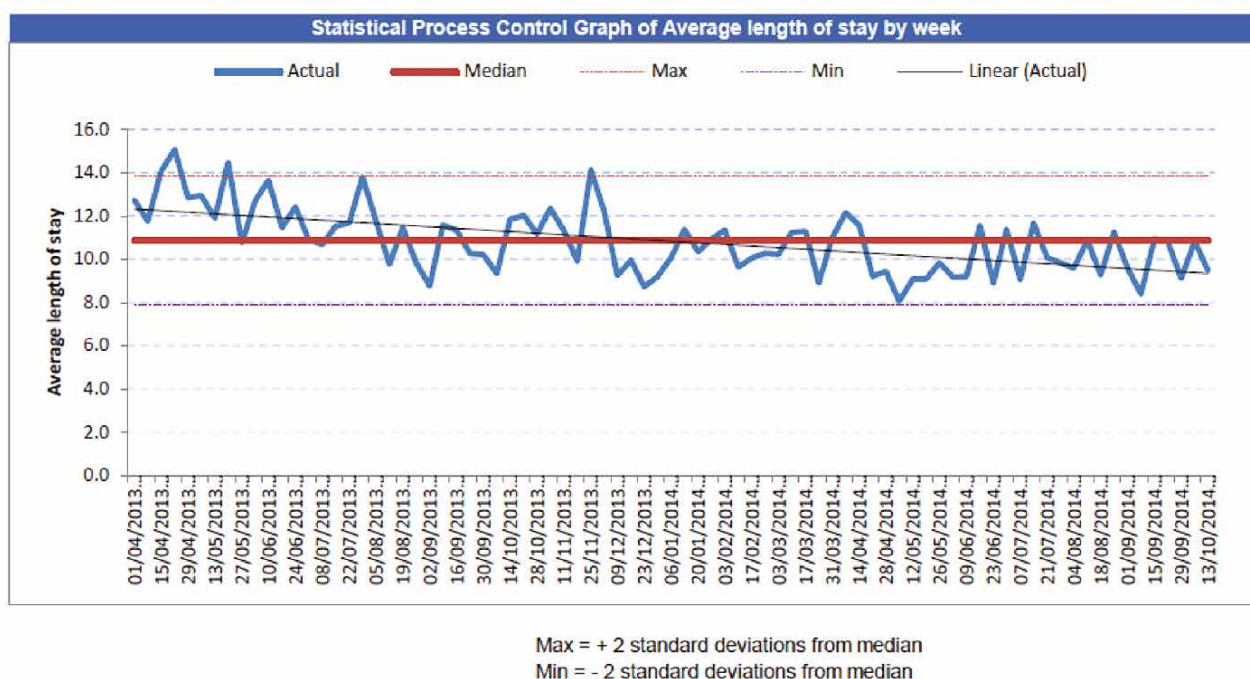
The Acute Frailty team, with the support of the Trust Therapy Lead, expanded in 2016 to include dedicated therapy time. At the same time, it moved into ED. This proved to be a pivotal moment in the development of the service as Lauren explained:

*"Originally we were based in urgent care but this meant patients had already been admitted by the time we saw them. Relocating ourselves into ED means we see patients earlier in their journey and even these few hours can make all the difference. We have reduced length of stay still further since moving into ED."*

Nurses within the team are developing their skills by undergoing Advanced Practitioner and Clinical Assessment training. Such is the relationship between the Acute Frailty team and ED colleagues that Advanced Clinical Practitioners from ED provide mentoring support to Acute Frailty nurses undergoing training.

## 'Look for the Lilac'

The Acute Frailty team launched an awareness-raising campaign called 'Look for the Lilac' to coincide with the expansion of the team in 2014/15. All of our frailty documentation has lilac-coloured branding," said Lauren, "we created a poster campaign and attended forums and MDT meetings across the hospital to let people know about the Acute Frailty service and to encourage them to look out for our documentation which contains a wealth of information on caring for frail patients. The Acute Frailty service's credibility and awareness has been boosted by sharing within the Trust the regional and national recognition it has received.



## Improving safeguarding

The Acute Frailty team has made a positive impact on the number of frail patients being admitted and length of stay. It is also impacting patient safeguarding through closer examination of psychosocial circumstances. Lauren said:

*“One of the areas we are making a difference is in assessing treatment plans. We have time to gather more information about a patient’s history and background than staff in other areas of the hospital and this helps us to improve patient safety. For example, in this way we have identified patients who have been put on IV fluids due to suspected acute kidney injury, but they actually have chronic kidney disease and the presenting results are normal for them. We have liaised with clinicians to ask for the patient’s treatment to be amended. It is not about apportioning blame, it is all about working together to provide the best possible care for the patient.”*

## Frailty Assessment Unit

Kettering recently opened a new 10-bedded Frailty Assessment Unit, open 24 hours a day, seven days a week with lengths of stay of up to 72 hours. It has also recruited a registrar and geriatrician.

This project is no longer being funded by the clinical commissioning group, but it still has access to the Intermediate Care Team, through referral, for community-based reablement.

## Challenges

The biggest challenge for Kettering General Hospital was a lack of sufficient resources to support the kind of Acute Frailty service it aspired to. Executives were keen to create an Acute Frailty Unit earlier in the process but without the geriatricians to support it, it proved too challenging at that time. “There was a risk of staff becoming disengaged at the start because we simply didn’t have the resources to deliver what was being asked of us. But rather than give up we decided to do what we could do with the resources we’d got. That would be my one piece of advice to other organisations doing similar work to us “work with what you’ve got, don’t wait”. We have achieved a lot with very few resources,” said Lauren, “and now a few years down the line more resources are being made available to us.”

## Success factors

The main factors that were identified as contributing to the success of the Acute Frailty service in Kettering were:

- There were good working relationships between the Acute Frailty team and other teams in the hospital. The Acute Frailty team’s collaborative mentality and an approach based on assertively challenging helped to strengthen these relationships.
- The Acute Frailty team had good credibility as it was staffed by nurses with urgent care experience. The team has built on this by upskilling nurses and expanding to include more therapists and geriatricians. Other teams in the hospital have witnessed the difference the Acute Frailty team makes to patients, which further strengthens the team’s credibility.
- The CGA model was created by the Acute Frailty’s lead nurse, senior Physiotherapist and Occupational Therapist, general manager (a nurse by background) and a geriatrician. They used gold standard documentation from the Royal College of Physicians and the silver book. The model has been reviewed and refined many times but the team has kept it short, succinct and manageable.
- The Acute Frailty team ran a ‘Look for the Lilac’ campaign to raise awareness of its services to staff across the hospital.



# Meaningful activities for patients with dementia



Nearly a quarter of older people in acute hospitals suffer from dementia. University Hospitals of Leicester NHS Trust has taken proactive steps to improve the wellbeing of dementia patients in its hospitals, typically around 120 people a day. Such patients are vulnerable to illness, accidents and falls, all of which can impact on their wellbeing and extend length of stay.

For all frail older patients admission to hospital can be detrimental, leading to a loss of everyday skills and mobility. However, for patients with dementia this deconditioning can be irreversible as they may be unable to relearn lost skills. While in hospital they may struggle to eat and drink, and the loss of routine, change in environment and other medical causes can trigger delirium.

In 2013, Leicester ran a pilot project to deliver meaningful activities to patients with dementia. These activities ranged from simply chatting, which helps both to calm patients and provides hospital staff with an opportunity to find out about them and their likes and dislikes, through to music, arts and crafts, and support with eating and drinking. Different wards have different environment so facilitators adapted accordingly. For example, on the wards with larger day rooms, one facilitator created a homely environment and invited patients to come in as though it were a sitting room. On the smaller wards, activities took place at the patient's bedside. All facilitators hosted 'posh' tea rounds, with china cups and saucers, which proved popular with patients.

## Routine and sense of identity

Meaningful Activities Team Leader, Charlotte Leeds explained:

*"Offering cognitive stimulation to patients with dementia supports their physical, sensory and psychological wellbeing. In milder cases, Meaningful Activities facilitators can help to alleviate the boredom of a hospital stay through talking, reading books or giving a hand massage. For those with more advanced dementia, we may be able to offer support with eating and drinking, reassurance or providing a sense of routine that can help to maintain their identity and skills, and prevent delirium. Maintaining a dementia patient's routine and sense of identity can assist in reducing length of stay and creating better outcomes. For example, patients are supported at mealtimes to eat and drink as independently as possible using different techniques such as mirroring, verbal and gestural prompts, as well as something as simple as making lunchtime a social experience."*

The pilot, which was funded through the Leicester Hospitals Charity, creating three band 3 Meaningful Activities Facilitators. These were experienced Health Care Assistants who had worked in the acute setting with people with dementia, or with older people. They also had additional experience in arts, music and activity coordinating and possessed qualities such as empathy and patience.



## Expanding the service

The funding from Leicester Hospitals Charity lasted for almost three years and during this time the team grew to a total of 10 facilitators and a team leader. In June 2016, the funding for the service was taken over by the Trust.

*"Feedback from patients, their families/carers and staff suggests that Meaningful Activities plays a significant role in improving patient wellbeing, particularly in managing challenging behaviour," said Charlotte. "Our facilitators offer reassurance and help to calm patients, which can be helpful when there are essential investigations that need to take place. There was one instance when a lady with dementia was admitted over a weekend but refused to allow hospital staff to carry out any diagnostic tests. On Monday, the Meaningful Activity Facilitator visited her to talk and play music. She discovered the patient loved Elvis and by playing the music she loved while she underwent the tests, the lady was happy to comply. It is very difficult to quantify the impact that the service has but this example alone shows how we can make a difference to patient flow and shorter lengths of stay."*

## Positive impact

In the year 2016/17, the Meaningful Activity service in Leicester supported 2,134 patients in total, 2,019 of whom had a diagnosis of dementia or a possible dementia. Relatives or carers for 517 of these patients took part in activities. The service is reviewing its data but early indications suggest it is having a positive impact on malnutrition, dehydration, falls and fractures, delirium and challenging behaviour.

## Educating staff

One of the challenges for the service is in conveying to staff exactly what Meaningful Activity Facilitators do.

*"As with any new role, there is a need for education to convey to ward staff exactly what we do. There can be a tendency for ward staff to think we just do craft activities with patients but actually our role is far broader than that," said Charlotte. "Our activities include improving nutritional intake for patients who are refusing to eat or drink, reducing agitation, supporting 'safe wandering', providing support with procedures such as cannulation, x-rays and blood taking, improving functional abilities and engaging with carers/families. We attend board rounds, multidisciplinary team meetings and ward sisters' meetings to let people know what we do and feed back about the care of patients. We also use publicity material to make ourselves as visible as possible across the hospital."*

## Positive impacts on behaviour

Feedback about the Meaningful Activities service from 2016/17 shows:

- 78% of patients referred were either assisted or prompted with their nutritional intake during or as part of an activity
- 94% of those referred to the service, had a positive change in wellbeing and behaviour noted after being involved with meaningful activity
- The multidisciplinary team received direct support in looking after 84% of these patients, through reassurance when having essential investigations, personal care or assessments.

# Nurses and therapists champion improvement in Norfolk



Nurses and therapists have championed frailty improvement at Norfolk and Norwich University Hospitals NHS Foundation Trust. According to Senior Operational Manager, Jo Walmsley, it is logical for them to take a leading role in this work:

“Nurses and therapists are acting as early implementers and are helping to raise awareness of frailty for us here in Norfolk. They are often the staff who meet the patient first and have the most on-going contact with them so they are critical to identifying frailty, and understanding its impact and the risks associated with hospital admission. Nurses and therapists play a vital role in early mobilisation and early discharge planning. They are often better placed to gain a detailed social history of a patient than the medical teams.”

### A focus on frailty

Improving the care of frail older patients is a key priority for Norfolk and Norwich. The region has a higher than average number of older people and the hospital admits an average of 850 patients to its Older Peoples Medicine (OPM) Directorate every month. Norfolk and Norwich NHS Trust works with five local CCGs and one Local Authority. A Memorandum of Agreement is in place setting out their strategic partnership and work plan. Frailty is one of its key strands. Richard Parker, Norfolk and Norwich's Chief Operating Officer and executive sponsor for the project explained why:

*“Focusing on frailty is an essential part of the system response to the challenge of the demographic profile, with an increasing population of older people over the next 10 years.”*



## Awareness raising

At the start of the project, only a small number of clinicians were engaged in identifying and managing frailty at the front door of the hospital. The Acute Frailty improvement team wanted all staff to be aware of frailty and to know how they could contribute to improving the care of frail patients.

The project was launched with a creative thinking event in Older People's Medicine. There was unanimous agreement that frailty is everyone's business and the team initiated a program of awareness sessions to spread the word. Improvement Manager Cat Cole said:

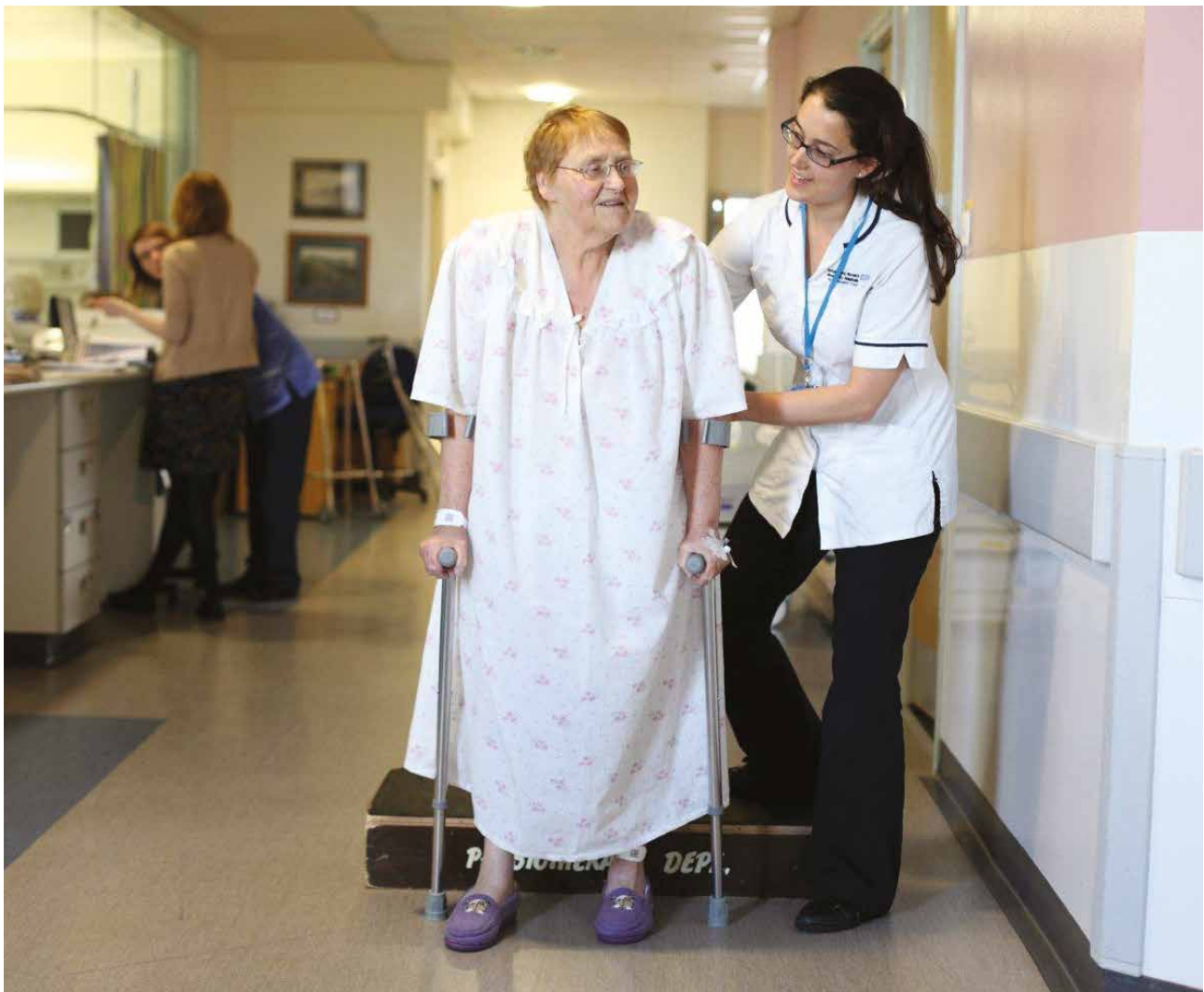
*"We held 'Raising Awareness' events in busy staff areas, such as outside the staff restaurant. These didn't prove as successful as we'd have hoped e.g. staff were often on their lunch break and did not want to stop and talk. However, they did produce helpful staff feedback and we got invited to other meetings as a result of being there and being visible. We then went from specialty to specialty, beginning in the emergency department (ED), talking to staff about frailty. We used a video telling an individual patient's story as a way of engaging staff and driving home the message."*

## Tailored cascade training

The team introduced staff training, delivered by the Older People's Medicine (OPM) Advanced Nurse Practitioner, OPM Ward Managers and Matrons, the OPM Consultant and Frailty Lead and therapy staff. The team attended team meetings and training was cascaded to all staff. Jo Walmsley, Senior Operational Manager explained:

*"It is important for staff to receive information about frailty that is specific to their role and supports them to deliver whichever aspects of frailty care they are responsible for. We devised a different training package for different staff groups with content that is directly relevant to them. For example, ED staff training focuses on the importance of early identification of frailty and supportive discharge; ward based staff are reminded of the importance of adopting a multidisciplinary approach to the comprehensive geriatric assessment (CGA) and discharge teams are made aware of the importance of communicating frailty to teams outside the hospital. The emphasis for pharmacy team training is on the STOPP/START tool and supporting medication reviews."*

The training was extended beyond its original remit to include ambulance paramedics, volunteers, and the practice development team, all of whom play a crucial role in identifying and managing frail patients.



## Frailty inbox

To prevent readmissions, the Acute Frailty team identified the need for an additional pathway for frail patients who are discharged from ED. Improvement Manager Cat Cole explained:

*"There is not always enough time during an emergency admission to carry out a comprehensive assessment of frail patients and we identified that some patients would benefit from having a follow-up with the OPM team. We developed something called a frailty inbox whereby clinical teams in ED send the casualty cards for discharged frail older patients to a central inbox managed by the OPM team. The team then reviews individual cases and invites some patients (currently around 8%) to return to an OPM outpatient clinic. At these clinics we can discuss any concerns, review medication, introduce the concepts of DNA CPR and Advanced Care Planning (ACP) and signpost patients and families to additional community support. Patients who are not offered a follow-up appointment receive a phone call or are invited to discuss any concerns with their GP."*

## Frailty CQUIN

Norfolk and Norwich agreed a local frailty CQUIN with commissioners. Its aims were:

- **To increase the number of patients screened for frailty.** The hospital implemented a simple screening tool, starting with ED and the acute medical unit (AMU) and progressing onto the medical wards. The team developed a frailty mnemonic to make it easier for staff to remember. The tool is applicable to patients who are living in a care home or who are aged 80 years+ with one or more of the following:

<b>F</b>	<b>Falls</b> (history of)
<b>R</b>	<b>Reduced mobility</b> (from usual)
<b>A</b>	<b>Altered cognition</b> (confusions/memory problems)
<b>I</b>	<b>Incontinence</b>
<b>L</b>	<b>Lots of medication/care from family, friends or professional carers</b>

The screening tool was tested and modified using Plan Do Study Act (PDSA) cycles. As a result, this initial assessment has now been added as a mandatory field on ED IT systems.

A yellow primrose PAS icon was introduced, to alert staff to patients with frailty. The next step will be to link the PAS 'alert' with the electronic Ward View system which all of the wards have. This link will then be able to create auto-referrals to Occupational Therapy, Physiotherapy and Memory Matters. The frailty icon will also be added to electronic discharge letters which will be visible to GPs.

- **To increase the number of patients who received a CGA.** The frailty improvement team is working to identify opportunities within existing processes to provide early CGAs, for example, as part of ward and board rounds, Red to Green work and the SAFER bundle.
- **To increase the number of frail patients discharged to their usual place of residence.** Awareness raising, education and early liaison with ward teams is playing a key role in better discharge planning.
- **A reduction in conversion rate from attendance in ED to an admission.** The OPM team educates and supports ED colleagues with clinical decision-making and assessment of risk regarding the discharge of frail patients. The development of a frailty inbox is also playing a key role in admissions avoidance. The hospital has also set up a dedicated phone line that staff can call for advice from a geriatrician. It currently operates between 9am and 5pm but the hospital is planning to extend it from 8am to 8pm.
- **To perform advanced care planning for 90% of frail patients.** This deliverable posed a considerable challenge and the hospital has yet to achieve it. Jo Walmsley commented:

*"We see many patients who are admitted from care homes with long-term conditions who could benefit from advance care planning delivered in the pre-hospital setting. Although we have not yet achieved our goal of 90%, we are committed to improvement in this area. We have increased the number of patients who are discharged with an electronic discharge letter (eDL) that contains information about their resuscitation status or makes recommendations for ACP to be considered by community teams. The Acute Frailty team is liaising with other teams in the hospital to look at the use of the Resuscitation Council's RESPECT document."*

## Impact

The impact over the last year has been positive. The conversion rate from attendance in ED to an admission has reduced in this age group and the quality of information being shared with the patient and their carers/families has improved, helping patients to feel more involved in their care. The changes to the eDL have had benefits for GPs and other care providers.

Work will be ongoing to make further improvements with a focus on more ambulatory care, combined with robust CGA for all eligible patients.

# A multidisciplinary team approach in Portsmouth



Portsmouth Hospitals NHS Trust sees approximately 55 patients over the age of 75 in the emergency department (ED) each day. When the Trust joined the Acute Frailty Network (AFN) there was no system in place for identifying frailty and no structured way of managing frail older patients. Large numbers of frail patients were admitted and faced a potentially long length of stay and the risk of deconditioning. Once in hospital, there was limited therapy and adult social care support available to them.

Portsmouth has introduced a range of measures to improve the care of frail older patients, with nurses and therapists playing a pivotal role in the frailty improvement journey.

### What they did:

#### A new frailty and interface team

They brought together two existing teams - a Community ED Team and an Older Person's Nurse Specialists Team – to create a new team with a frailty focus. The Frailty and Interface Team (FIT) includes social workers, therapists, community nurses, older persons' specialist nurses and administrative support. The FIT role is to proactively assess patients with frailty in ED and the Acute Medical Unit (AMU), and provide a more structured care pathway. It is led by a Band 7 Therapy Lead and Physiotherapist, Lucy Elloway and Band 7 Older Person's Specialist Nurse, Debbie Cartmell.

Lucy explained:

*"Nurses and therapists have been pivotal to the development of FIT. With the backing of consultants and senior managers, we established the team, got staff on board and led the frailty improvement work. It is important for staff to understand what frailty is, why frail patients need different support from other patients, and what can happen if their needs are not met. I think because we were friendly, familiar and non-hierarchical, staff felt comfortable engaging with us and came on board with the frailty improvements we were proposing."*

The FIT team began operating in the ED and AMU in early 2016. They introduced a range of improvement measures including:

### A frailty identification tool

At the start of the improvement journey there was no system in place for screening patients for frailty. The team used PDSA (Plan Do Study Act) cycles to develop a frailty screening tool. Lucy said:

*"PDSA cycles allowed us to try things, even if they were only minor changes, to see if they made a difference. We would implement something for a set time period and then assess the impact it had made. If necessary, we would then refine the change or abandon it. When it came to implementing changes, we knew that they would achieve the aims we wanted to achieve."*

Older person's nurse specialists were involved in designing and testing the frailty screening tool which was then implemented and further tested by ED staff.

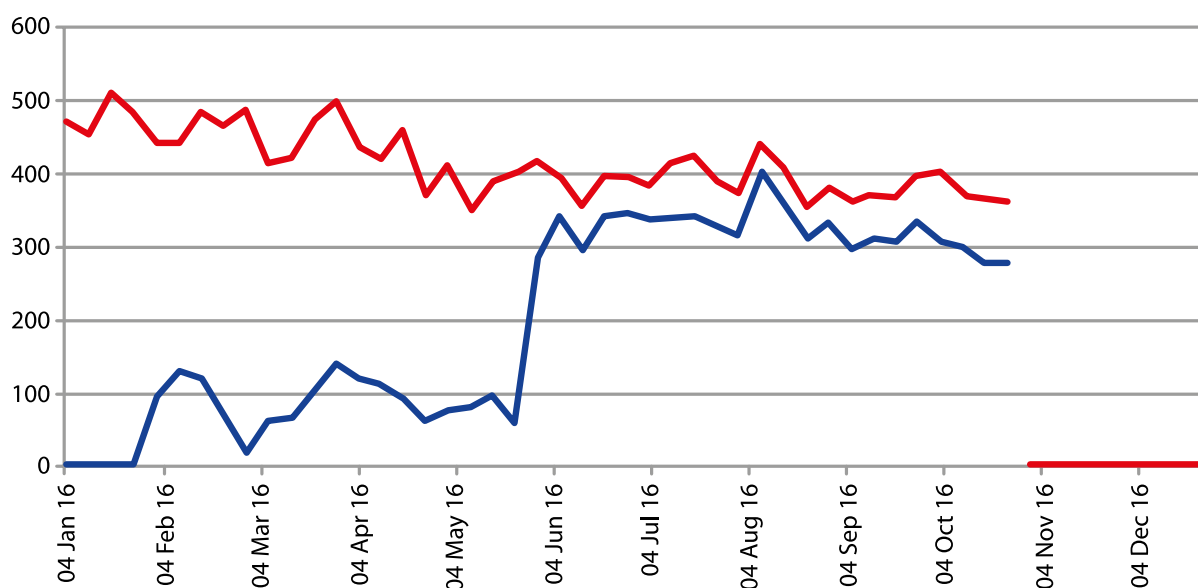
*"It was introduced as an optional tool that ED staff could use to test for frailty," said Lucy. "Initially around 85% of eligible patients were being screened for frailty but over time this dropped to 65%. ED is a busy place with its own targets and competing demands on staff time. The fact that screening was not mandatory meant that, over time, fewer staff were doing it. We are intending to make frailty screening mandatory over the coming months and are liaising with the ED Matron about this."*

### Comprehensive geriatric assessment

Portsmouth also used PDSA cycles to develop a comprehensive geriatric assessment (CGA) process which is used by the FIT team to assess patients who are flagged as frail using the frailty screening tool. "One of the benefits of the CGA is that we only have to question patients once," commented Lucy. "We use a definitive questionnaire which provides all of the information we need for that patient's care. This is better for patients, who are not being asked the same questions again and again, and better for us as it is more efficient, eliminating duplication and improving patient flow."

The FIT team operates from 8am to 8pm so there will, inevitably, be some patients who do not receive a CGA. Currently, 30% of patients aged 75+ who are screened for frailty receive a structured review from the FIT team. This is from a starting point of zero.

Number screened for frailty & Number attending ED aged 75+  
Weekly totals from 4 January 2016  
Portsmouth Hospitals NHS Trust



Number screened for frailty    Number attending ED aged 75+    Number screened for frailty



## Sharing skills and building competencies

Alongside improving the way frail patients are identified and assessed, FIT has introduced a programme of education to increase staff and patient awareness about the care of frail patients.

*“Nursing staff are often asked to work beyond their normal scope of experience, for example they might be required to carry out basic mobility assessments or stairs assessments before handing over to one of the therapists for a more in-depth assessment. We developed a set of competencies that would provide nurses with basic therapy skills,” explained Lucy. “We have done a lot of skill sharing within the team so everyone has a good idea of each other’s skills and roles. We have also had other clinicians come in to talk to us, for example one of the consultants spoke about dementia and delirium, so we have as complete a picture as possible about the care of frail patients.”*

## Outcomes

Work is still ongoing in Portsmouth but the number of frail patients who are admitted to hospital is falling. (The model for flow of expected GP patients changed in March 2016 so that GP expected patients came to AMU directly, rather than via ED, which may have impacted conversion rates). The number of patients admitted for more than 72 hours has remained unchanged and the team is reviewing processes to try to increase the proportion of patients with a shorter length of stay.

## Return on investment

The Trust carried out an analysis of its frailty improvement work and identified a return on investment of approximately £1.3 million.

## Key success factors

Portsmouth’s model of frailty improvement has the potential to be scaled up to other NHS trusts although the FIT team acknowledges that every ED is different and there is no ‘one size fits all’ approach. The Trust believes a number of factors have contributed to its success:

- Creating a multidisciplinary team with a shared skillset ensures a good level of understanding of the needs of frail patients and consistency of care.
- Frailty screening identifies frail patients early in their care journey, allowing the teams to provide proactive care, which improves outcomes.
- CGA ensures a detailed understanding of the patient’s needs.
- Using PDSA cycles allowed the team to try out and refine improvement processes before implementing them.
- Placing the development of FIT in the hands of nurses and therapists meant that the service was devised by the people who would deliver it and also helped to ensure greater buy-in from staff.

# Small scale tests of change lead to system transformation



Three previously unsuccessful attempts to establish an acute frailty pathway and Acute Frailty Unit did not deter the team at Royal Cornwall Hospitals NHS Trust in Truro from trying again. This time however, there were some important differences that, ultimately, produced very different outcomes. In January 2016, Royal Cornwall joined the Acute Frailty Network (AFN). Its aim was to create an effective acute frailty pathway with a view to setting up an Acute Frailty Unit.

### Senior leadership

Consultant Nurse for Older People and Associate Chief Nurse, Frazer Underwood led an inter-professional project team, comprising a consultant geriatrician, commissioners, community partners, nurses, therapists, GPs and the local ambulance service. Crucially, the project secured executive sponsorship from the then Chief Operating Officer. Membership of the AFN helped to secure this vital senior level backing, as Frazer explained:

*"The AFN assisted in raising the profile of frailty within the hospital and securing support at the highest level for our improvement work. This made all the difference. We made the case to our executive sponsor that correctly identifying and streaming frail older patients would support the hospital's wider aims of tackling overcrowding and addressing patient flow problems. The proportion of older people here in Cornwall is 12% higher than the national average. We are also subject to wide variations in the frail elderly population due to high visitor numbers to our region. As a Trust, historically we have not been particularly good at co-ordinating acute frailty care but we were committed to making the necessary improvements to bring about sustained and lasting change."*

## Project aims

The hospital's aims were:

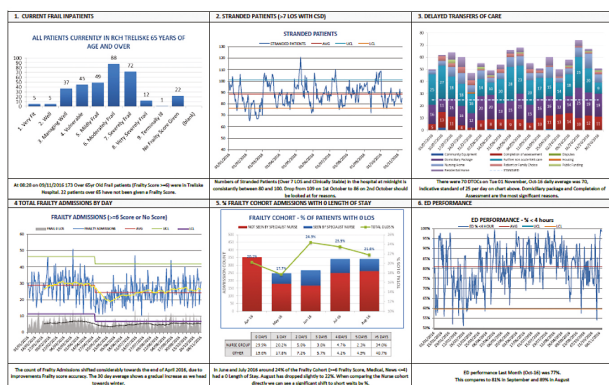
- To bring the frailty team closer to the front door to reduce admissions.
- To establish an Acute Frailty Unit to improve treatment of frailty.
- To create early supported discharge pathways to streamline discharge.

The hospital's Chief Operating Officer, Richard Best commented:

*"Having an effective and efficient acute frailty pathway in place across our hospitals is so important. Acute hospitals play an important role for a small number of frail older people, but for many it is not the best place for them. We are all too aware of deconditioning and other harms that being stranded in an unfamiliar hospital environment can cause. We are committed to making sure we have a responsive, highly skilled and frailty focused workforce supporting early assessment and care co-ordination of these patients through our frailty pathway."*

## Using data to inform improvement

From the outset, the Acute Frailty project team realised that using data effectively would be vital to create a high quality frailty service. The hospital had begun collecting frailty data in 2015, measured against the Rockwood clinical frailty scale. The project team worked with hospital analysts to turn this into something that would be useful and meaningful for staff. For 12 months, the Acute Frailty project team met fortnightly. It presented live data at every meeting which provided an accurate picture of what was happening in the treatment of frailty and the impact that improvement work was having.



The Cornwall Improvement Dashboard

## Sharing patient information

*"To be able to make a difference to frail patients, we need to identify them early and make decisions quicker," said Frazer. "We believed that having access to the patient information systems of other organisations, such as mental health and social services, would enable us to build a more detailed picture of the patient quickly. I had been trying to get access to external information systems for over a year but the support of our Chief Operating Officer and our new-found sense of urgency, helped by joining the AFN, meant we were able to make it happen."*

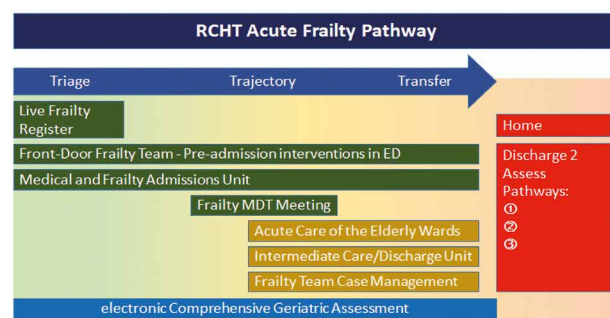
## Small scale tests of change

The Royal Cornwall believed that taking small, deliberate steps would help it to achieve its larger project ambitions. Frazer explained:

*"My advice would be don't go for the big project ambitions. Instead, take small, incremental steps, test out the impact and refine them if necessary before moving onto the next thing. This builds confidence and enables you to share your successes. Taking this approach – using PDSA (Plan, Do, Study, Act) cycles – meant we could progress apace and keep people engaged with us every step of the way. Not only did we feed progress back to the staff who were working with us but also to the executive board who were keen to hear about what we were doing."*

## Frailty nurses at the front door

The Royal Cornwall believed that moving its Acute Frailty nurses closer to the front door would help it to reduce admissions. In 2016, they were relocated to the emergency department (ED) and the impact on zero length of stay has been significant: "Every month we are seeing an average of 26 more frail patients with zero length of stay. The Acute Frailty nurses currently operate in ED from Monday to Friday, 8am to 4pm. Their input gives ED staff greater confidence to discharge frail older patients rather than admitting them to hospital."



The Acute Frailty pathway at Royal Cornwall

## Correctly identifying more frail patients

Acute frailty work in Cornwall has been entirely clinically-led with no programme management support. "Frailty and ED nurses were pivotal to the entire project. At the start there appeared to be some discrepancies in the accuracy of frailty scoring so we worked with ED nurses to develop some small scale tests of change for measures to improve accuracy. 12 months on we have achieved 83% accuracy for correctly identifying frail patients based on the Rockwood criteria. The data has also showed us where there are still some inaccuracies and we have been able to target these areas accordingly. We now have more confidence in our frailty data as an organisation and this allows us to make better decisions," said Frazer.

The project team also worked with the ambulance service to help them improve the accuracy of their frailty scoring and to increase the percentage of frailty screening carried out (continuing to improve from a baseline of just 30%).

## Frailty register

All of the frail patients in the Royal Cornwall Hospital are now recorded on a live frailty register. This allows the frailty team to track where frail patients are in the hospital in real time, how long they have been in hospital and what levels of support are available to them when they are discharged. They can also track where patients have come from and, if necessary, offer preventative education to care homes to avoid readmissions.

## Advanced care planning

An audit in May 2016 by a Community Consultant Nurse looked at readmissions of 83 frail older people who had presented more than four times at the hospital in the last year. It showed that more than 80% were in their last year of life but only 8% had a case manager. Delirium and UTI were common triggers for people to be admitted to hospital.

In response to this audit, the hospital added a column to the frailty register which shows readmissions and allows the Acute Frailty team to identify these at risk patients. They are using this information to prompt for advanced care planning, identifying where they can achieve quick wins by allocating a community matron to frail patients at risk of readmission. The hospital recently recruited two Advanced Nurse Practitioners (ANPs) who are working with GPs to identify high risk patients and improve advanced care planning and treatment escalation plans. Frazer commented:

*"We used the frailty register to identify our top 50 patients across the county who are most at risk of admission and we are working with our colleagues in the community to put in place effective admission avoidance strategies."*

## Community-based admissions avoidance

The Acute Frailty team developed an electronic comprehensive geriatric assessment (CGA) form for use in the community. As with its other frailty improvement initiatives, this was tested and refined using PDSA cycles. It also relaunched personalised care plans for use in the community and developed a summary front sheet for the electronic patient care notes showing the individual's preferences and normal tolerances and highlighting admission avoidance strategies. This information will help emergency services to make better decisions about whether or not to admit a patient with frailty syndromes. The hospital recently began receiving information from the Mental Health Trust's dementia register which will provide additional information about vulnerable patients.

## Success factors

The Royal Cornwall Hospital has taken a thorough and comprehensive approach to improving the care of frail older patients. Among the factors contributing to the project's success are:

- **Accurate, well-presented data** which has enabled them to target their efforts where they will be most effective.
- **Senior leadership support** from the Chief Operating Officer and lead geriatricians which gave the project credibility and helped to tackle any challenges that arose.
- **Commitment** from everyone involved in the project. This has ultimately been the most important factor in bringing about effective and sustained change. The project team met every two weeks for a whole year to constantly assess progress and drive forward change. "No extra time or resources were allocated to the project but everyone involved, from commissioners to clinicians, has been totally committed to pushing it forward," said Frazer. "People are interested and committed because they believe it is the right thing to do for patients. We have achieved a notable level of inter-professional working and inclusivity which has contributed hugely to our success."
- **Acute Frailty Network** support which proved invaluable and helped to keep the project focused and on track.



## Wirral University Teaching Hospital

# Courage and commitment with a human touch



Specialist Nurses for Older People (SNOPs) are helping to prevent at least a quarter of all frail older patients from being admitted to Wirral University Teaching Hospital NHS Foundation Trust.

Wirral has been one of the leading lights in improving the care of frail older people over the last few years. It was one of the earliest participants in the Acute Frailty Network (AFN) and was featured as a best practice case study after adopting all ten of the Network's key principles for improving the care of frail older people. The hospital developed the role of the SNOP to spearhead care of frail patients.

### Specialist Nurses for Older People

The SNOPs approach to frailty is to assess at the front door and to turn around frail patients wherever possible rather than admit them. They in-reach into A&E and the acute medical unit (AMU) to identify suitable patients, initiating comprehensive geriatric assessments (CGAs) within the first hour of patients arriving at the hospital. They then liaise with therapy teams to arrange appropriate treatment so they can get people home as quickly as possible. The service is available from 8am to 8pm, 7 days a week

## Home first mindset

Dr Deb Lowe is Consultant Geriatrician & Stroke Physician and Clinical Director for Medicine at Wirral. She said:

*"The dynamic that exists between our SNOPs, our A&E sisters, our matrons and our senior co-ordinators on the Older Person's Assessment Unit is fundamental to the success of our frailty improvement work. People share the same vision and understand why it's important for us to care for our most vulnerable patients well. Staff in the Trust 'get' frailty. Our SNOPs help to keep the flow of patients moving by in-reaching into A&E. Therapists have a 'home first' mindset and everyone works creatively to get patients out of hospital as quickly as possible with all the support they need"*

## Old fashioned nursing

Audrey Fisher was one of the first SNOPs in Wirral. She explained:

*"We are old fashioned nurses with old fashioned qualities and values. Essentially, it is about bringing the human touch to the care of frail older people. The care that we role-model is hands-on, one-to-one care that is focused on meeting the needs of the frail older patient whenever and wherever they need it. If a patient needs toileting or we need to check for pressure ulcers, that takes priority over everything else. We lead the way and normalise one-to-one care in A&E."*

Audrey describes the SNOPs' role as being like a 'bridge' between A&E, the Older Person's Assessment Unit and Primary Care.

*"We have earned the trust of our colleagues across the hospital. This allows us to break triage protocol, to interrupt the normal activities of the ward so we can prioritise reviews and facilitate rapid discharge, all in the interest of high quality patient care."*

Deb added "The care of frail older people is complex but, since the introduction of SNOPs and our structured improvement programme, there is far less fear among staff. They have seen that it is possible to turn a patient around at the door without causing them harm. We have built confidence and we are all sharing the same vision."

## An open and honest culture

There has been a huge shift in the mentality of A&E staff in relation to frail older patients. Deb described how, historically, the default would always have been to admit:

*"We have challenged this way of thinking by asking staff what they expect to achieve by admitting frail patients. We point out to them that, inadvertently, they could make that person's situation a whole lot worse by bringing them into hospital. We make them aware of the community services that are available that could keep the patient out of hospital. It is all about being honest. Honesty is such a good place to start. We only admit patients if there is no other option. Our SNOPs are patient-focused and are not afraid to challenge. There is no hierarchy, we have built an open and honest culture."*

## Challenging red tape

Such a culture has not come about by accident and Deb has played a key role in helping to build it.

*"Historically there was plenty of red tape that kept patients in hospital when they didn't need to be here," she said. "I challenge that red tape and I am not afraid to get myself into trouble by asking why it's there and pointing out that the patient would be a lot better off at home. How the service runs when you are not there is the acid test and I know that when I am not around, the team provides the same fantastic level of care for frail older people. Our SNOPs are gritty, confident individuals who are motivated by the same vision. Some people will use 'risk' as a potential obstacle to change. The only risk, as far as I can see, is not providing the optimum level of care for patients."*

It is this way of thinking that enables Wirral to send frail older patients home within hours, whereas previously they may have spent days in hospital. Such rapid treatment can make a significant difference for older patients, as Deb explained:

*"One patient who was nearing the end of life was given a terminal diagnosis, a care pathway put in place and essential equipment delivered to her home and an extensive package of care put in place - all within four hours of her coming into the hospital. This meant she could be back home with her family when it mattered most."*

## Nothing is impossible

Deb describes the SNOPs and Older Person's Assessment Unit as being like a dam. "Patients only get past the dam if they really need to be here. We work together to keep them out of hospital. The team are brave and entirely patient focused. And we don't think that anything is impossible."



AFN at NHS Elect  
Suite 2, Adam House  
7-10 Adam Street,  
London, WC2N 6AA

Tel: 020 7520 9088  
Email: [frailty@nhselect.org.uk](mailto:frailty@nhselect.org.uk)  
[www.acutefrailtynetwork.org.uk](http://www.acutefrailtynetwork.org.uk)

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