GETTING IT RIGHT FIRST TIME

Geriatric Medicine

GIRFT Programme National Specialty Report

by Dr Adrian Hopper
GIRFT Clinical Lead for Geriatric Medicine

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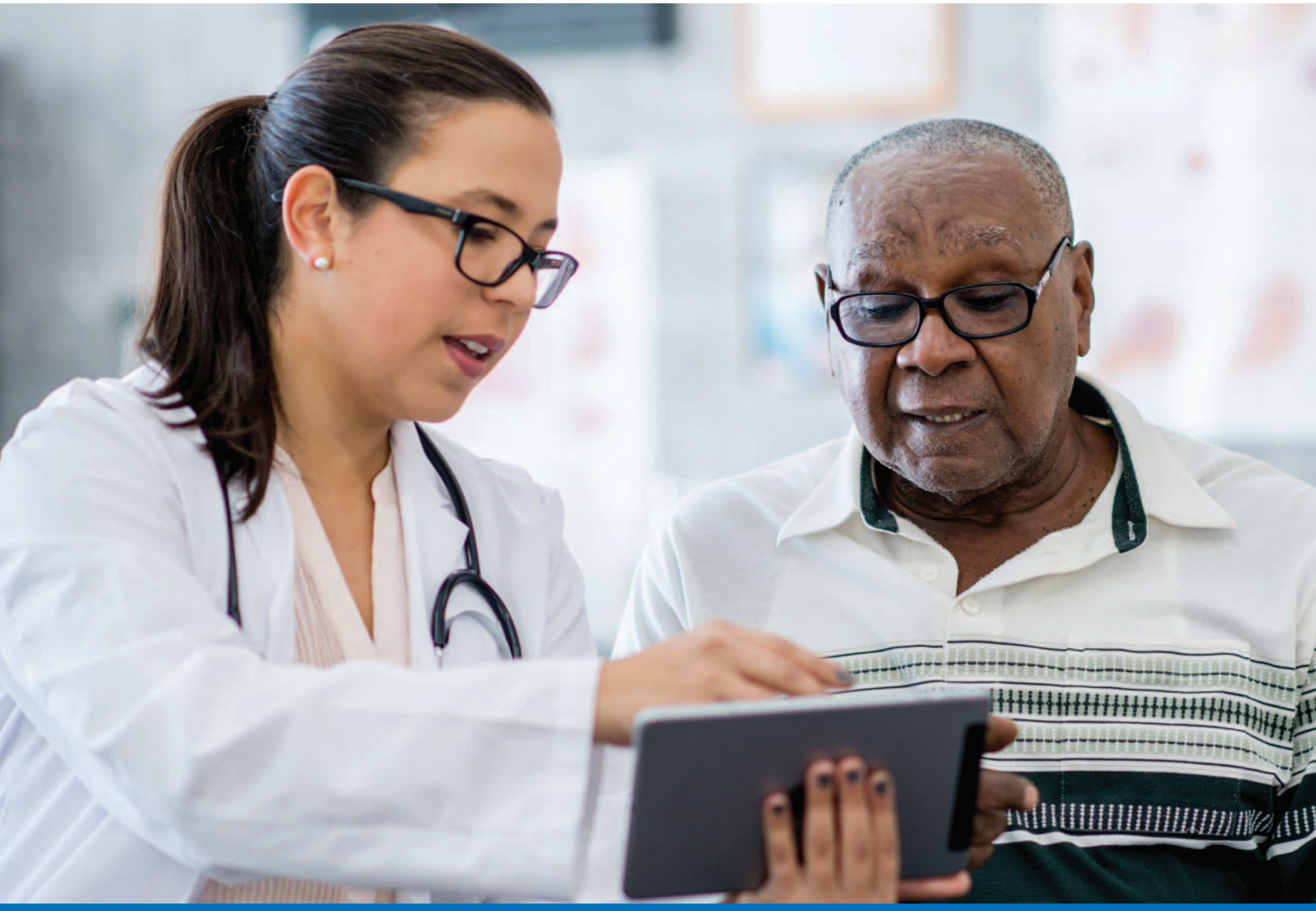

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust, NHS England and NHS Improvement

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Foreword from Professor Tim Briggs

I am delighted to recommend this Getting It Right First Time review of geriatric medicine, led by Dr Adrian Hopper.

This report comes at a time when the NHS has undergone profound changes in response to the COVID-19 pandemic. The unprecedented events of 2020/21 – and the extraordinary response from everyone working in the NHS – add greater significance to GIRFT's recommendations, giving many of them a new sense of urgency.

Actions in this report, such as improving outpatient care by providing alternatives to hospital visits, and removing barriers to safe and effective discharge, can help the NHS as it faces the substantial challenge of recovering services while remaining ready for any future surges, by operating more effectively and safely than ever before.

Adrian has applied the GIRFT approach to his field, geriatric medicine, one of the largest and fastest growing specialties. Geriatric medicine provides treatment and care to the UK's ageing population, many of whom are living with long-term conditions, complex needs or frailty.

The recommendations set out in this report are based on the visits Adrian made to trusts across England, in addition to other data and audits. Implementing these recommendations will help to join up hospitals, care homes and other settings in providing a patient-centred approach to managing frailty, which may help avoid some hospitalisations in the first place. The recommendations in the report are vital to achieving the ambitions of the NHS Long Term Plan to support people to age well and slow the progression of frailty.

It has been encouraging to hear about the enthusiasm and innovation Adrian has seen as he met with colleagues on deep-dive visits. There were many examples of excellent practice, some of which are included as case studies in this report. These are testament to the hard work and dedication of everyone working in the specialty.

That dedication is vital to the GIRFT programme, which can only succeed with the backing of clinicians, managers and everyone involved in delivering care.

My greatest hope is that GIRFT will provide support and impetus for all those involved in geriatric medicine, to work shoulder to shoulder and continue making a real difference to the lives of older people.

Professor Tim Briggs *CBE*

GIRFT Programme Chair and National Director of Clinical Improvement for the NHS

Professor Tim Briggs is Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital NHS Trust, where he is also Director of Strategy and External Affairs. He led the first review of orthopaedic surgery that became the pilot for the GIRFT programme, which he now chairs. Professor Briggs is also National Director of Clinical Improvement for the NHS.

Introduction from Dr Adrian Hopper

When I started as the GIRFT lead for geriatric medicine my first question was about the scope of the review – was it about hospital departments or also community services managed by NHS trusts? What about the ever growing role of geriatric medicine in care homes, in supporting other specialties from orthopaedic surgery to oncology? Was it to cover all conditions prevalent in older patients, or only those specific to older age groups?

The scope could potentially be very far reaching. However, the core purpose of GIRFT is to identify the areas in secondary care where there are unwarranted variations in activity and outcomes, resulting in poor performance and avoidable harms for patients, and where the scope for improvement is greatest.

With that in mind, I have chosen to focus mainly on the care of people living with frailty. Often, these patients are not well served by current pathways. Too many older people with frailty suffer needless harms as a result of unplanned hospitalisation, long waits in A&E, long stays, and poor co-ordination of care. Many are approaching the end of life, when their needs and wishes should be understood and respected, something which has come into sharp focus during the COVID-19 pandemic.

Although the report primarily focuses on care in hospitals, where we have the richest datasets, I have also examined the crucial interfaces between secondary care and primary care, community settings and care homes and how these can be joined up to improve health and care overall. Often, hospitalisation could be avoided in the first place through a more patient-centred approach to managing frailty. I have highlighted some innovative whole-system approaches already in use, some of which have been accelerated by the urgent need to prioritise hospital beds during the COVID-19 pandemic. As a result, many of the recommendations in this report should be seen as calling on trusts and local systems to build on the momentum prompted by the pandemic to accelerate and sustain the progress they are making, for example through the Ageing Well programme.

The hospital is just part of a very complex system, which needs to work effectively as a whole to improve the care of older people. Apparently simple problems may require complex solutions, which need to be applied locally in communities where attitudes towards death and dying, or the role of hospital, may vary, sometimes with added complexity linked to high deprivation. These issues need to be approached with sensitivity as we move towards implementation.

We are lucky to have the wind behind us from the NHS Long Term Plan and some of the successes of the NHS vanguards, such as the Enhanced Health in Care Homes (EHCH) programme, which support a general direction of travel for NHS planning to focus on the prevention of progression of frailty and effective urgent care response.

As part of the GIRFT process I have visited trusts all over England. It has been a privilege to meet so many colleagues, learn from good practice and share our analysis of the data to guide local improvement. I found amazing enthusiasm and innovation on my travels. The report includes many examples of best practice gleaned from deep-dive visits, while also expressing some of the concerns voiced by colleagues on a range of topics.

One observation is that many trusts have developed local systems and change projects, but have been unable to sustain them or measure whether they improve value and outcomes over time. I hope that in the implementation phase of GIRFT we can help trusts to embed good practice and achieve measurable, system-wide improvement that make a real difference in older people's lives.

Our development agenda is challenging and needs to harness the efforts of the whole multidisciplinary team, including a range of health and care professionals working in differing settings. There will never be enough consultant geriatricians and we have to look at what we need to do differently to create more effective, high value, patient-centred care for older people.

Dr Adrian Hopper

GIRFT Clinical Lead for Geriatric Medicine

In addition to his GIRFT role, Adrian works as a geriatrician at Guy's and St Thomas' Trust in London. He was Deputy Medical Director for Patient Safety at Guy's, and Clinical Director for Patient Safety at the Health Innovation Network in South London. He was also the Lead for the Medicine Clinical Academic Group for King's Health Partners. In 2009, Dr Hopper was awarded the NHS Leadership Award (Quality Champion), and in 2010 the BMJ Group Award for Clinical Leadership.

Statements of support

Age UK

To maximise health and wellbeing, it is essential that older people living with frailty can access proactive, joined-up care which is tailored to their individual needs and aspirations. While there are examples of best practice happening across the country, we know that there is inconsistency, leading to poor health outcomes and avoidable admissions to hospital. That's why we at Age UK have long called for better identification, treatment, and management of frailty.

While the recommendations laid out in the Getting It Right First-Time report were needed before COVID-19, they are even more vital now. The pandemic has reduced opportunities for older people to be active, leading to a decline in muscle mass, physical deconditioning, increased frailty, and an increased risk of falls. We must act these recommendations now to support the growing number of older people who are at risk of or already living with frailty.

British Geriatrics Society

The British Geriatrics Society welcomes this GIRFT national specialty report on geriatric medicine that focuses on hospital-based care for older people living with frailty. We endorse the main recommendations and believe implementation of these has the potential to improve quality of care for older people and to help realise the ambitions of the Ageing Well programme.

The BGS supports the approach taken by GIRFT to drive quality improvement and reduce unwarranted variation, through providing detailed reviews of local pathways of care. While this approach has clear advantages, it is equally important to view these pathways in the context of wider health and care systems that support older people to live well and maintain their health and independence. As such, this work demonstrates the need to develop a stronger system-wide understanding of frailty and of potential prevention and management strategies for frailty.

We commend the report for acknowledging the importance of professional leadership in developing well co-ordinated person-centred care across and between primary care, community services, hospitals and care homes. Indeed, it is heartening to see leadership as one of the four main themes, alongside quality improvement within hospitals, quality improvement at the interface with the community and effective use of data that is accessible to frontline professionals.

Within hospitals there is much we can do to improve quality and safety of care for older people living with frailty: ensuring robust approaches to proactive identification of frailty and delirium; providing early access to comprehensive geriatric assessment and interventions to reduce harm and improve outcomes; and facilitating co-ordinated transfers of care to the community. This requires a whole-system approach, with clinicians supported by managers working within Integrated Care Systems (ICSs) and Sustainability and Transformation Partnerships (STPs) to commission person-centred services and support the development of an adequately equipped workforce.

Clearly there is much to be learned from the high-performing services described in the report, but this requires a mechanism for sharing between units. To address this and the implementation and spread of best practice, the BGS has developed the BGS Frailty Hub, consisting of a curated set of evidence-based resources, an e-learning module on frailty and forums for networking and peer support for managers and clinicians from across disciplines. To ensure a person-centred approach, we suggest data collection for future reports is underpinned by the addition of parameters directly related to patient, carer and public perspectives. Similarly, there should be a recognition of the vital role of the voluntary sector in transitions of care, prevention and anticipatory care, and long-term support.

Our understanding of frailty and its interaction with other long-term conditions continues to grow through research, education, training and implementation of best practice across healthcare settings. This report will enrich our knowledge base and provide a strong platform from which to build better pathways and a more integrated whole system for older people living with frailty.

Dr Jennifer Burns

President, British Geriatrics Society

Executive summary

An overview

Our deep dives, and data analysis to support them, identified significant unwarranted variation in the provision of geriatric medicine, care of people living with frailty and a significant opportunity for improvement. Our review has highlighted four core themes – effective use of data, leadership within the new structures, clinical quality improvement within hospital trusts and quality improvement at the interface with the community. Ongoing use of data in this report, along with improvement of the data available, particularly within community settings, will direct much of the improvement we envisage. Leadership is also essential and will be supported by our recommendation for a senior officer for frailty within trusts to lead on safety and quality of care for people living with frailty (see p58). Clinical leaders will need to engage and be resourced to work shoulder to shoulder with managerial colleagues and across multidisciplinary teams. This work will be complex, particularly when developing and then implementing a frailty strategy across ICS/STP footprints which will cover multiple stakeholders (see p29). Importantly, though, there are also priorities trusts can progress immediately, either within their sites or jointly with local partners, including: identification and effective care of frailty and delirium (see p41); liaison with care homes (see p80); safe discharge (see p68); end of life care and learning from case review of re-admissions (see p76). These themes and others are expanded on throughout this report.

A population-based approach to frailty

Older people living with frailty end up in hospital disproportionately. Pre-COVID, Between 5% and 10% of all those attending A&E and 30% of patients in acute medical units were older and living with frailty. There were more than 4,000 admissions daily for frailty, most coming through A&E.

Many of these admissions are for reasons such as falls, minor infections and reactions to medications, that would not require admission without frailty. Once admitted, they are at high risk of longer length of stay, which increases the risk of deterioration, leading to increasing immobility, declining function and reduced life span.

Frailty is a growing challenge that cannot be solved by secondary care alone. It requires comprehensive whole-system solutions that wrap around people, from the home to the care home and the hospital, focused on preventing progression of frailty and supporting people to live well outside of hospital.

What we found: variations in frailty strategy

We found variation in how trusts work together to manage frailty with primary care, care homes and other partners such as local authorities and the voluntary sector. We saw examples of good practice where trusts are working with partners to provide joined up frailty care. These include whole system models being developed to offer alternatives to hospitalisation, such as:

- Community assessment hubs for ongoing assessment and treatment of frailty syndromes.
- Crisis response hubs for rapid response to sudden events, such as falls.
- Multidisciplinary teams (MDTs) working with GPs to support people at home.

However, in some locations, there is little or no engagement. Some of the variation is due to structural reasons. For example, in London, a single trust might have to work with up to six CCGs and several local authorities, making it more difficult to achieve integration. There are also different cultural expectations. In some parts of the country, hospital may be perceived as the right place for older people with frailty to receive care.

Our recommendation: integrate frailty care across health systems

To address the needs and issues outlined above, we recommend that all integrated care system (ICS) and sustainability and transformation partnership (STP) areas should have an integrated frailty system that includes secondary care, primary care, care homes, community services, ambulance services and paramedics, local authorities and the voluntary sector which is centred on patients and their carers and focused on preventing inappropriate hospitalisation and progression of frailty. Since the GIRFT visits began, this work has gathered momentum, and leadership from across the multidisciplinary team will need to be engaged and have time to build on this.

The system should be planned on a population health basis, adapted to the needs and values of local communities, and co-ordinated to avoid duplication of services. It should provide:

- rapid, easy and equitable access to services for people with frailty across a geographic area;
- patient-centred, responsive care, both urgent and non-urgent;
- support and treatment for people with frailty in their own homes where appropriate;
- good pathways for hospital discharge, particularly discharge after short stays.

Identifying frailty early through systematic assessment

As people with frailty are at greater risk of hospital-acquired harms, it is important that their frailty is assessed and identified early and managed through their hospital journey. The standard initial assessment is the Clinical Frailty Scale. According to the NHS Long Term Plan initial assessment should happen within 30 minutes where the person arrives in A&E. If admitted to hospital, patients identified with frailty should be referred for a Comprehensive Geriatric Assessment (CGA).

What we found: variations in frailty assessment

While most trusts have an acute frailty team responsible for assessing and triaging patients, we found variation in their working methods and effectiveness. In some places they are standalone, in others they are part of the A&E department. Often they work 9am to 5pm Monday to Friday, so assessments are not always carried out outside these hours, leading to unnecessary admissions.

In many cases, trusts have established a system for acute frailty assessment but do not monitor its use, measure its effectiveness or review whether it is operating at sufficient scale to improve flow in the emergency pathway. This needs to be addressed. Each trust should develop its own dashboard of metrics for internal review and use them to monitor and measure progress over time.

Delays in assessing patients in A&E

Many initial frailty assessments take place in A&E, where space and facilities are limited. This may be another barrier to effective assessment. We found that some patients have been admitted from A&E while waiting for a frailty assessment, in order to avoid breaching the four-hour target. Our data shows that where the four-hour standard is breached within A&E, adults aged over 75 remain there another four hours on average. In some hospitals, the average additional wait is seven hours, making 11 hours in total, by which time deconditioning may already have begun.

Reducing admissions through early identification

Many people with frailty currently admitted to hospital through A&E are having a short-term crisis, such as a fall or infection, that can be better cared for at home or in the community with support. These people should be identified through the assessment process and re-directed where it is safe to do so. We found this was happening in some trusts but not others – some trusts were admitting more than 60% of all arrivals in this age group. However, the overall trend in A&E conversion rates for over 75s has significantly reduced from 2015 to 2019.

Our recommendation: assess all older patients in the emergency pathway

To address these issues, we recommend that trusts must assess all older people arriving in the emergency pathway using the Clinical Frailty Scale and use this to track them through the hospital if they are admitted. The assessment should be linked to the person's electronic patient record and should follow them outside of hospital as part of the wider frailty system.

Reducing the risk of hospital-acquired deconditioning

Hospital-acquired deconditioning is a major risk for older people with frailty admitted to hospital. Around a third of older people with frailty experience functional decline during their stay. Preventing deconditioning can be as simple as ensuring that all those who are capable get up, get dressed and support patients to mobilise each day, in line with the national End PJ Paralysis campaign.

What we found: variation in mobility support

On our deep-dive visits, we found examples of good practice where trusts are helping older adults avoid deconditioning. These include nurses and healthcare assistants (HCAs) using day rooms to get people moving with support from physiotherapists.

However, we also found many places where this is not happening. Often, this is due to a lack of simple equipment such as appropriate chairs and walking aids, or a shortage of moving and handling equipment, including hoist slings, needed in the early stages of rehabilitation. We heard of patients waiting several days for mobility assessment by a physiotherapist, or for provision of walking aids.

Increased risk of deconditioning above 21 days

The risks of deconditioning increase significantly during longer stays. We found that, on average, people over 75 admitted through the emergency pathway who are in hospital for 21 days (super-stranded) stay an added 19 days, bringing average total stay to 40 days. One reason for these long stays is the lack of weekend cover from liaison frailty teams and services such as physiotherapy.

Our recommendation: prevent moderate frailty from becoming severe

To reduce the risks of hospital-acquired deconditioning, we recommend that trusts should identify patients with mild (CFS 5) or moderate frailty (CFS 6) and prevent them becoming severely frail by providing the mobility support services, equipment and facilities needed to get people moving.

Keeping people with frailty safe in hospital

Older people with frailty are more vulnerable to inpatient harms including those caused by falls, medicine misadventures, nutrition and swallowing issues, pressure ulcers and hospital-acquired infections. It's important that trusts track people's frailty post-admission, checking for these risks and taking proactive steps to prevent them.

Our recommendation: appoint accountable officers for frailty

We recommend that each trust should appoint a senior member of staff who is the accountable officer leading on the safety, and more broadly quality of care, of older people with frailty while in hospital and at the hospital interface with the community. This recommendation will support safety and broader quality priorities within this report, making it key to effective implementation.

Basic frailty training for all patient-facing staff

People with frailty are treated in a range of hospital specialties and in a variety of primary and community care settings. It is important that everyone involved in their care has some basic training to make sure that they understand frailty, spot the risk factors and can take action to prevent deconditioning. We have found variation in the training provided by trusts, with less than half (45%) of trusts having a basic frailty awareness training programme for staff. On our deep-dive visits, some trusts told us they do no frailty training at all.

Our recommendation: basic frailty training

We recommend that all staff caring for people with frailty in and out of hospital should have basic frailty training at level 1 on the Frailty Capabilities Framework.

Improving the dementia and delirium pathways

The dementia pathway is reasonably established in most trusts across England, driven in part by the CQUIN for dementia care which provides incentives for clinical improvement. However, this progress is not matched in delirium, which is a major factor in inpatient falls and linked to longer length of stay.

What we found: variation in delirium assessment

Many older patients who arrive through the emergency pathway are not having an initial assessment for delirium. On our deep-dive visits, we saw examples where the delirium assessment was introduced but its use was not sustained after initial successful implementation. Where patients are not assessed, it's less likely there will be an effective early response to prevent delirium or effective management of symptoms.

Why is delirium assessment not happening?

Patients may be assessed by staff in A&E or other medical or surgical specialties where delirium assessment may not be embedded in pathways and practice. Many acute frailty teams are 9am to 5pm, so patients who arrive out-of-hours or at weekends may not be assessed.

Our recommendation: embed delirium assessment and effective response

We recommend that all trusts should have a clear pathway for delirium that includes assessing all older people admitted as an emergency using 4AT, a system for identifying delirium in elective admissions, and rapid and effective delirium response.

Removing the barriers to safe and effective discharge

During our deep-dive visits, we found that many older adults who were medically fit to return to their usual place of residence after treatment were not being discharged in a timely way. This is bad for their health and wellbeing and adds to pressures on the NHS.

What we found: barriers to safe discharge

We found variation in the level of partnership working between trusts and partners such as care homes, local authorities and carers to support safe and effective discharge. While most trusts had some level of ongoing engagement with partners, the working relationships were often not formalised or embedded in care pathways. Other barriers to safe and effective discharge included:

- Mobility support in hospital: delays waiting for therapists to perform mobility assessments, or because of a lack of facilities, such as chairs, to get out of bed and moving.
- Recuperative rehabilitation: support such as community-based rehabilitation, crisis response, or specialist psychiatric support, was unavailable in some areas.
- Weekend cover: in some areas there were no staff who could assess patients at weekends. There were also problems returning patients to care homes because of reduced staffing.

Our recommendation: implement new NHS discharge service guidance

The need to prioritise beds for people with acute medical needs during the first wave of COVID-19 led to the creation of a new NHS discharge service. This is based on the discharge to assess model in which older adults who present at hospital with a new acute crisis are discharged home wherever possible, with support in place, and then given a CGA to plan their care needs. Key features include:

- a default assumption of discharge home today;
- three pathways for those who need post-discharge support, ranging from basic personal care (pathway 1) to ongoing residential nursing care (pathway 3);
- funded recuperative care and support for up to six weeks at home for those who need it;
- case managers to co-ordinate care packages through a single point of contact.

We recommend that ICS/STPs should work on a multi-agency basis to implement new hospital discharge service guidance for older patients, while also developing targeted strategies to address specific barriers to safe discharge at the weekend and for super-stranded patients.

Reducing readmission rates post-discharge

Early discharge of older adults is only a success if the patient adapts and recovers well in their home environment. From our deep-dive visits, we found that some hospitals with high rates of early discharge of patients over 75 also had high rates of readmission, often within days of leaving hospital.

What we found: high levels of avoidable readmissions

On average 20% of older people with frailty who were admitted as an emergency were readmitted within 30 days of discharge, often because of falls or episodes of delirium. We found that many readmissions were avoidable, often a re-occurrence of their previous admission, and may have been prevented, either by stronger safeguards in the discharge process, or better support post-discharge.

Most trusts offered some post-discharge support but the design and quality of the packages varied widely and some were not effective in reducing readmissions – however this may have changed with the funded support provided through the new NHS discharge service (see above).

Our recommendation: weekly and monthly review of readmissions

Trusts should collect data on the causes of readmissions and whether they could have been avoided to bring about improvements. This should include a patient-focused review of the reasons for early readmissions at seven days and case review at 30 days linked to potential system improvements.

Improving liaison with care homes

More than 400,000 people live in approximately 11,000 care homes in England. A large proportion of them have frailty, or are in the last year of their lives. Many have dementia and are at risk of delirium. Too many of the people experience unplanned and avoidable admissions to hospital – often at the end of life when hospital care may be inappropriate and increase their suffering.

What we found: variation in admissions from care homes

We found wide variation in the proportion of admissions of people over 75 coming from care homes. In some CCG areas, this accounts for up to 9% of cases, while other areas see very low numbers. However, admissions from care homes are high generally, accounting for up to 11% of all emergency admissions for older people in some hospitals. Nationally, numbers have been rising in recent years.

Deaths on admission

We found that an average of 12.5% of patients admitted as emergencies from care homes die during their admission. Of those, 15% died within 48 hours. This suggests that people have been admitted where there may be little benefit to hospitalisation, which can be distressing nearing the expected end of life.

Effective liaison and support

We have seen some good examples of liaison models in which trusts are working with care homes through MDTs, digital hubs and telemedicine services, which are helping to reduce the need for hospitalisation. However, we also found many areas where the level of interface and co-ordination with care homes was poor. In some cases, this related to geography. Implementing an integrated model may be more difficult in locations with a large older population and large numbers of care homes within a single trust footprint.

Our recommendation: implement Enhanced Health in Care Homes

We recommend that all local health systems should implement the principles of the EHCH programme, which has developed a whole-system approach aiming to provide continuity of care for residents, timely medicines reviews, access to hydration and nutrition support, and streamlined referral to out-of-hours services and urgent care.

Providing better end of life care

Older people who are approaching the end of their lives should be recognised by the health system so that appropriate care decisions can be taken. As much as possible patients should be able to die in their preferred place of care and have more choice in how this happens.

What we found: variation in rates of admission nearing the end of life

Data shows that almost a third (30%) of older people in the last 90 days of life experience three or more hospital admissions, often causing unnecessary stress and suffering. End of life admissions of people aged over 75 make up an average of almost 15% of total bed days in NHS hospitals.

One issue is the availability of hospice care. On average, only 30% of this care is NHS funded. The rest depends on the voluntary sector, so it is less sustainable and only able to meet demand from limited categories or people such as those with certain terminal diseases.

Advance care planning

We found good examples of advance care plans (ACPs) being used to plan end of life care. ACPs are discussed and agreed jointly with the older person and their carers, covering key decisions such as treatment thresholds and wishes about hospitalisation. ACPs should be integrated into personalised care plans. Wherever possible this should be a single digital plan that is available to everyone involved in the person's care and linked to the urgent care services.

Our recommendation: help people die in their preferred place of care

We recommend that all local health systems identify older people in the last phase of life and offer them advance care planning, so they can be looked after and die in their preferred place of care wherever possible.

A workforce to meet the needs of the ageing population

As the population ages, the need for specialist geriatric services has risen dramatically. Geriatricians are increasingly called on to manage people with frailty across the hospital, to work in multidisciplinary teams, and for liaison work with surgical and medical departments. Externally, there are also increasing demands to work with community rehabilitation teams and in care homes.

What we found: shortages of key staff

While the scope of practice is increasing, capacity is not matching it. We have found shortages of key staff, including consultants, specialist trainees and advanced practitioners in many areas.

Making greater use of the skills mix

Future demand cannot be met by the existing siloed workforce. New ways of working, with blending of skills and making use of the wider skills mix, need to be part of the solution. We have seen good examples of nurses leading services traditionally provided by doctors, such as continence clinics and fracture liaison services, utilising their skills and expertise through enhanced or advanced practice. Similarly, allied health professions (AHPs), such as pharmacists and therapists, can do more in managing the symptoms of frailty and multi-morbidity.

Our recommendation: extend roles and opportunities for career progression

We recommend that ICS/STPs should develop new ways of working to meet local service needs including extended roles as described above, and more opportunities for portfolio career progression to attract and retain consultants and trainees.

Improving outpatient care

Older people, many with frailty, make up a significant proportion of the number of outpatient appointments in the NHS – around 30% according to Age UK.

What we found: variation in outpatient clinics

On our deep-dive visits, carried out before the COVID-19 crisis, we found wide variation in outpatient clinics. Some trusts had very few clinics, while others had many, in multiple sub-specialties. Many people with frailty were attending as many as eight separate specialty clinics, often for very brief routine assessments that don't require face to face contact.

Outpatient transformation and changes during COVID-19

The need for social distancing, and for older adults to shield themselves from the COVID-19 virus, has accelerated the development of online appointments and virtual outpatient clinics in many hospitals. We think these should become a permanent feature, with appropriate support, including the option of a face-to-face consultation, for patients who may find consultations by phone or video challenging.

Where physical appointments are needed, trusts should aim for a co-ordinated 'one-stop shop' approach, so patients can get everything they need on the same day wherever possible.

Our recommendation: develop alternative models of ambulatory care

We recommend that ICS/STPs should develop and embed alternative models such as virtual clinics, community assessment hubs, out of hours crisis response and same day emergency care and to improve the effectiveness of ambulatory assessment for older adults.

Data and coding

We have found wide variations in how geriatric medicine activity is attributed. Many hospitals allocate the majority of non-elective activity to general medicine main specialty code (300), while activity is also allocated to specialties such as acute internal medicine, respiratory medicine and gastroenterology.

Differing attribution obscures our view of the geriatric medicine specialty and makes it difficult to compare performance and outcomes between trusts. It may also impact directly on patient care. We often can't tell whether people with frailty who are being treated by surgical and medical specialties are receiving the liaison support they need, because this activity may not be coded.

Our recommendation: attribute care of older people to geriatric medicine

We recommend that attribution of specialty should be reviewed to ensure that geriatric medicine activity and the specialty of the person doing it can be identified.

Improving capture of diagnostic codes

We have found wide variation in the rate of identification of key frailty diagnostic codes. For example, the proportion of admitted patients over 75 with ICD diagnoses that map to the dementia/delirium domain ranges from 15% in some trusts to 40% in others, while the rate for falls and fractures ranges between 10-25%. This means that trusts are unable to identify frailty with any accuracy from the ICD diagnostic clinical codes.

Our recommendation: closer co-operation to improve diagnostic coding

We recommend that clinicians and coders should work together to improve capture of frailty-related diagnostic codes to give trusts a clearer hospital-wide data view of frailty.

Medicines optimisation

Rates of medication error are higher in older adults, in care home settings, primary and secondary care and during transfer of care, contributing to high rates of hospital admission among people over 75, especially those with frailty.

What we found

We have found a shift to proactive deprescribing in older patients and those with frailty. In some areas, clinical pharmacists are trained to deprescribe as part of multi-agency structured medication reviews (SMRs) working as part of integrated and multidisciplinary services. We support this work, provided it is based on patient-orientated outcomes, appreciating the complexity of care in older people, and approached stepwise and with regular follow up.

A new system-wide pharmacy service for care homes was developed during the first wave of COVID-19, with remote clinical pharmacy consultations provided for patients. ICS/STPs should seek to build on this and integrate remote pharmacy consultations into system-wide frailty services.

Discharging patients with polypharmacy safely

Due to the complexity of problematic polypharmacy it is important that patient hospital discharge summaries are accurate and include information on what medicines were stopped, trialled and started during the person's hospital stay. Older patients and those with frailty should receive support with their medicines during and after the transfer of care to avoid errors and adverse reactions.

Our recommendation

Local health systems should ensure that patient safety is paramount when addressing older adults prescribing and should link medicines optimisation with case management linked to comprehensive geriatric assessment both in hospital and the community.

Procurement

Geriatric medicine is a low spend high volume specialty. We attempted to look at Spend Comparison Service (SCS) data on spend for items such as walking frames, and chairs that are commonly used by geriatric medicine departments. However this proved difficult as many items used in geriatric medicine are not specific to the specialty and therefore not coded to it. Furthermore, there was not much variation in the prices that trusts pay for this sort of equipment due to the low costs involved.

Our recommendation

We recommend that providers adopt the GIRFT three-point strategy to improve procurement of devices and consumables.

Litigation

Data obtained from NHS Resolution shows that potential estimated clinical negligence claim costs in geriatric medicine rose from £7.6 million to £20.4 million per year over the five years from 2013-18.

We found the national average estimated cost of litigation per admission in geriatric medicine was £8. The best performing provider is estimated to cost £0, while at the other end of the scale, one provider is expected to generate a potential average of £153 of litigation costs per admission.

The two most important clinical themes are falls and hospital-acquired pressure ulcers, which links to our proposal on improving patient safety for frailty. Inpatient falls are often linked to agitation from delirium so improving the delirium pathway, as discussed in *Improving the dementia and delirium pathways*, page 63, can also help to reduce potential claims.

Our recommendation

Reduce litigation costs by application of the GIRFT programme's five-point plan.

Notional financial opportunity

We estimate a total gross notional financial opportunity from implementation of up to £346 million using standard projections, and up to £687 million if target savings are achieved, principally from reduced hospital bed days and associated costs.

Recommendations

Recommendation	Actions	Owners	Timescale
1. Each ICS/STP area should have an integrated system for preventing and managing frailty that includes secondary care, primary care, care homes, community services, ambulance services and paramedics, local authorities, third sector, patients and carers. Priorities should include avoiding inappropriate hospitalisation and progression of frailty, and improvement should be benchmarked with similar local footprints.	**a** GIRFT to support ICS/STPs to embed partnerships in local long term plans.	GIRFT, ICS/STPs	For progress within a year of publication
	b GIRFT will work with local systems and trusts to help them collect and monitor a dashboard of key frailty-related data, including admissions, early discharges, A&E conversion rates and seven-day readmission rates, as well as community measures of how patients are doing at home, and track them continuously over a sustained period to measure progress.	GIRFT, ICS/STPs	For progress within a year of publication
	c GIRFT to support other national bodies to update and extend the eFI to support frailty management outside of hospital and enable population-based and public health approaches to frailty care.	GIRFT, NHSE/I	For progress a year after publication
2. All trusts must assess all older people arriving in the emergency pathway for frailty using the Clinical Frailty Scale and use this to track them through the hospital if they are admitted. Wherever possible this should be an electronic system linked to the electronic patient record and used as part of a system-wide frailty strategy.	**a** GIRFT to support ICS/STPs in implementing the use of CFS in trusts.	GIRFT, ICS/STPs, NHSE/I	A year after report publication
	b Trusts to ensure that a person's CFS score is recorded in the patient record in line with NICE guidelines, is portable and visible to everyone involved in their care, and that trust level data derived from the CFS is available across the wider frailty system.	Trusts, ICS/STPs	Within a year of publication
	c Trusts to communicate the CFS score to the patient and/or their GP following assessment and include it in discharge letters to the GP. This should be accompanied by clear follow up actions for the individual to prevent deterioration and avoid A&E attendance and admissions.	Trusts, ICS/STPs	Within a year of publication
	d Trust to develop dashboard of metrics for internal review and use them to monitor and measure progress within the hospital.	Trusts, ICS/STPs	For progress a year after publication
3. Trusts should identify patients with moderate frailty in all admission wards and take action to prevent them from becoming more functionally dependent. This includes providing space and equipment such as chairs and walking aids for daily mobility support, developing a culture where all ward staff can provide that support and where frailty is everyone's responsibility, and measuring progress against key metrics over a sustained period.	**a** GIRFT will support trusts to use the Clinical Frailty Scale (CFS) to identify those at level 5/6 on the scale and intervene early, and ensure that both the person's CFS score and CGA assessment are available as part of an electronic system linked to their patient record.	GIRFT, ICS/STPs, NHSE/I	Within a year of report publication
	b Trusts to ensure that each patient over 75 identified with frailty has a mobilisation plan within 48 hours of admission.	Trusts, ICS/STPs	Within 6 months of report publication
	c GIRFT will work with Model Hospital to ensure that trusts can benchmark their performance against others.	GIRFT, Model Hospital	Within a year of publication

Recommendation	Actions	Owners	Timescale
4. Each trust should appoint a senior member of staff who is the accountable officer leading on the quality of care for older people with frailty while in hospital, linked to ICS/STPs and local networks. They should report to the board across key frailty safety domains, and use this information to help develop and refine the system-wide frailty strategy.	**a** GIRFT will support trust management to identify accountable officers.	GIRFT, trusts, ICS/STPs	Within 6 months of report publication
	b GIRFT to support trusts to develop a dashboard of key frailty safety metrics including: • deconditioning • delirium response • dementia safety • inpatient falls • nutrition • pressure ulcers • medicines safety • safe discharge • catheter safety using existing dashboards as a base and explore how this can be linked to the Clinical Frailty Scale and/or the Hospital Frailty Risk Score/Frailty Opportunity Identifier Tool.	GIRFT, trusts, ICS/STPs	For progress within a year of publication
5. All patient-facing staff within a local health system should be given basic training in frailty at Level 1 on the Frailty Capabilities Framework.	**a** GIRFT will work local systems to audit their training requirements to ensure all patient-facing staff within an ICS/STP has access to level 1 training.	GIRFT, ICS/STPs	Within a year of publication
6. All trusts should have a clear pathway for delirium that includes assessing all older people admitted as an emergency using 4AT, a system for identifying delirium in elective admissions, and rapid and effective delirium response. Delirium awareness should be embedded in basic frailty training for all patient-facing staff.	**a** GIRFT to support local systems to roll out and sustain the use of 4AT for delirium assessment.	GIRFT, ICS/STPs	For progress within a year of publication
	b GIRFT to work with the NHS England and NHS Improvement pricing and incentives team to explore the viability of a CQUIN for delirium to drive improvement.	GIRFT, NHSE/I	Within two years of report publication
7. ICS/STPs should work on a multi-agency basis to implement the new hospital discharge service guidance to improve outcomes for older adults and optimise flow and discharge rates.	**a** GIRFT to support local systems to implement the new hospital discharge service model, including: • ensuring support packages to help older people remain at home are sustainable and effective • improving data collection on delivery of community rehabilitation services and patient outcomes • developing a multi-agency pathway • benchmarking performance with peers • a review of provision in community hospitals	GIRFT, ICS/STPs	Ongoing
8. ICS/STPs should develop targeted strategies to address specific barriers to safe discharge at the weekend and for patients staying more than 21 days (super-stranded).	**a** GIRFT to support trusts and ICS/STPs to audit discharge barriers for super stranded patients within their footprint.	GIRFT, Trusts, ICS/STPs	For progress within a year of publication.

Recommendation	Actions	Owners	Timescale
9. Review readmission rates on a multi-agency basis to understand the causes and develop interventions to reduce them, including enhanced support for older people with frailty to prevent falls, delirium and multiple admissions, and targeted support for those readmitted within 7 days and 30 days of initial admission.	**a** GIRFT and Model Hospital will support local systems to benchmark discharge performance against other similar systems. This should include a case review by systems to understand local drivers of readmissions.	GIRFT, Model Hospital, ICS/STPs	For progress within a year of publication
	b GIRFT will work with trusts and local health systems to make sure that implementation of the new hospital discharge service model helps to reduce the need for readmissions.	GIRFT, trusts, ICS/STPs	Ongoing
	c GIRFT to support linking of local reviews of readmission rates data with routine recording of frailty	GIRFT, ICS/STPs, trusts	For progress within a year of publication
10. All local health systems should implement the Enhanced Health in Care Homes framework as part of the Primary Care Network (PCN) contractual obligations.	**a** GIRFT to support the continuing roll out and delivery of the Enhanced Health in Care Homes Framework.	GIRFT, NHSE/I	Ongoing
	b Trusts to measure data on admissions from care homes, including admissions in the last year of life and deaths within 48 hours of admission, to enable targeted interventions for the worst performing care homes.	Trusts, ICS/STPs, NHSE/I	For progress within a year of publication
11. All local health systems should have identified older people in the last phase of life and offer them advance care planning, so they can be looked after and die in their preferred place of care wherever possible.	**a** GIRFT and NHS England and NHS Improvement will support local health systems to implement a system to recognise people at the end of life and offer them advance care planning.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress within a year of publication
	b GIRFT to support the use of agreed planning tools such as the PEACE document, Gold Standards Framework, treatment escalation plans, AMBER and Respect.	GIRFT, NHSE/I, Trusts, ICS/STPs Gold Standards Framework, Co-ordinate My Care	For progress within a year of publication
	c GIRFT to work with trusts and other providers to ensure that advance care plans are shared with NHS 111 and 999 emergency services.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress within a year of publication
	d NHS England and NHS Improvement to ensure that palliative care services are available in community settings.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress a year after publication
	e Trusts to monitor data and outcomes on good end of life care.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress a year after publication

Recommendation	Actions	Owners	Timescale
12. ICS/STPs should develop new ways of working to meet local service needs including: extended roles for nurses, allied health professionals, pharmacists and advanced practitioners; a greater role for consultants in acute, general and emergency medicine where capacity allows; more opportunities for portfolio career progression to attract and retain consultants and trainees.	**a** GIRFT to support Health Education England, NHS England and NHS Improvement and professional societies on guidance for extended roles for the geriatric medicine multidisciplinary team.	GIRFT, HEE, NHSE/I, BGS, RCN	For progress within a year of publication
	b Trusts to use the Frailty Capabilities Framework training at levels 2 and 3 to improve skills and help staff to work at top of licence.	Trusts, ICS/STPs	Six months after publication
13. ICS/STPs should develop and embed models such as virtual clinics, community assessment hubs, out of hours crisis response, same day emergency care and patient-initiated follow up to improve the effectiveness of ambulatory assessment for older adults as envisaged in the NHS Long Term Plan.	**a** Trusts to manage duplication of outpatient appointments moving towards a one-stop shop model of ambulatory care.	GIRFT, NHSE/I, Trusts, ICS/STPs	Ongoing
	b Trusts to review the provision of specialist clinics such as falls, memory and continence, to ensure they are at the appropriate scale and linked to a wider pathway.	Trusts, ICS/STPs	Within a year of publication
14. Attribution of specialty should be reviewed to ensure that geriatric medicine activity and the specialty of the person doing it can be identified.	**a** Trusts to attribute all geriatric medicine activity using Main Specialty code 430 or Treatment Function code 430.	GIRFT, Trusts, ICS/STPs	For progress within a year
15. Clinicians and coders should work together to improve capture of frailty-related diagnostic codes to give trusts a clearer hospital-wide data view of frailty. Trusts should be able to see which patients are living with frailty and how severe it is.	**a** GIRFT coding team to work with professional societies to support trusts to improve the quality of clinical coding.	GIRFT, RCP, BGS	For progress within a year
16. Consider how liaison and other shared care services could be recorded and reported more effectively.	**a** GIRFT to work with NHS Digital and NHSE/I to look at how liaison services and other shared care services can be recorded and reported effectively.	GIRFT, NHS Digital	For progress within a year
17. Local health systems should address the prescribing and pharmaceutical care needs of older people to improve safety and optimise adherence.	**a** GIRFT to support NHSE/I and local health systems to implement safe prescribing practices for older people that cover polypharmacy, discharges and deprescribing where appropriate.	GIRFT, NHS England and NHS Improvement, ICS/STPs	For progress within a year of report publication

Recommendation	Actions	Owners	Timescale
18. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.	**a** Use sources of procurement data, such as SCS and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.	GIRFT	Ongoing
	b Identify opportunities for improved value for money, including the development of benchmarks and specifications. Locate sources of best practice and procurement excellence, identifying factors that lead to the most favourable procurement outcomes	GIRFT	Ongoing
	c Use Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.	Trusts, ICS/STPs, GIRFT	Ongoing
19. Reduce litigation costs by application of the GIRFT Programme's five-point plan.	**a** Clinicians and trust management to assess their benchmarked position compared to the national average when reviewing the estimated litigation cost per activity. Trusts would have received this information in the GIRFT 'Litigation data pack'	Clinicians and trust management	For immediate action
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution included in the data set to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk	Clinicians and trust management	Upon completion of 19a.
	c Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support	Clinicians and trust management	Upon completion of 19b.
	d Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI)/patient safety incidents (PSI) and where a claim has not already been reviewed as SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all front-line clinical staff in a structured format at departmental/directorate meetings (including Multidisciplinary Team meetings, Morbidity and Mortality meetings where appropriate).	All trusts	Upon completion of 19c.
	e Where trusts are outside the top quartile of trusts for litigation costs per activity GIRFT we will be asking national clinical leads and regional teams to follow up and support trusts in the steps taken to learn from claims. They will also be able to share with trusts examples of good practice where it would be of benefit.	GIRFT	For continual action throughout GIRFT programme.

What is geriatric medicine?

Geriatric medicine is the specialty that is focused on the health and care and treatment of older adults with complex needs, including those who are living with frailty and multi-morbidity. It is one of the largest specialties in the NHS with more than 1,600 consultants currently employed (some working less than full time)[1].

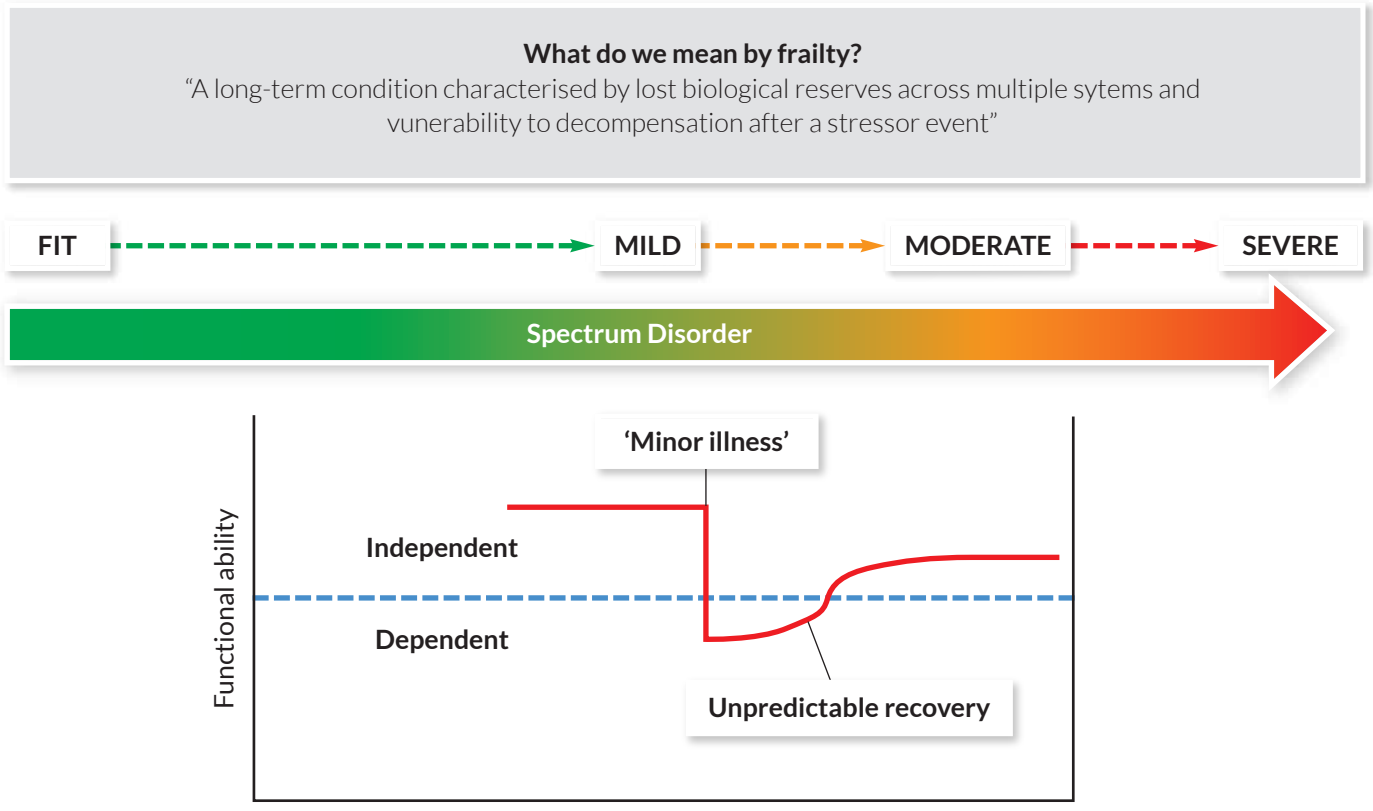
Demand for geriatric medicine specialist care is growing, driven by rising demand for care of older adults generally, as people live longer, often in poor health. Just over half of people aged 65-74 live with at least one long-term health condition, increasing to nearly two thirds of those aged 85 and over[2]. The number of over 85s in England who have higher levels of dependency, such as dementia or multi-morbidity, is projected to almost double from 233,000 in 2015 to 446,000 in 2035[3].

Geriatric medicine in hospitals

Although some older people experience greater morbidity leading to functional dependency, they can be otherwise fit and their care needs no different from people of younger ages. Therefore, geriatricians in acute hospitals tend to focus on people with frailty or multi-morbidity both in their own work and in the interfaces within general hospitals and the community.

Frailty is a condition in which the body's physical and mental systems gradually decline and lose their in-built reserves and ability to respond to stressors. The condition makes people more vulnerable to functional change following illness and results in slower recovery from illness or injury. It becomes more common in older adults, but significant work has been undertaken to understand the health inequalities apparent where frailty occurs earlier in life[4]. Frailty is a spectrum condition, which can progress from mild to moderate and severe. A minor illness such as flu, or a fall, can become a crisis for a person living with frailty, impairing their functional ability and independence, as shown in **Figure 1**.

Figure 1: Diagram of frailty progression and functional dependency that can be triggered by minor illness



[1] *Royal College of Physicians Focus on physicians: 2018–19 census (UK consultants and higher specialty trainees) https://www.rcpmedicalcare.org.uk/developing-physicians/specialties/geriatric-medicine/workforce*

[2] *Age UK Briefing: Health and Care of Older People in England July 2019*

[3] *Andrew Kingston et al Forecasting the care needs of the older population in England over the next 20 years: estimates from the Population Ageing and Care Simulation (PACSim) modelling study Lancet Public Health 2018 http://dx.doi.org/10.1016/S2468-2667(18)30118-X*

[4] *VCSE Health and Wellbeing Alliance (2020) Reducing Health Inequalities for People Living with Frailty: A resource for commissioners, service providers and health, care and support staff*

Management of frailty

Common frailty-related problems include immobility, instability, incontinence, side effects from medicines and delirium, any of which can lead to falls or deterioration, resulting in worsening functional dependency. The core business for geriatric medicine units includes recuperative rehabilitation of patients recovering from these problems, as part of an overall goal to improve functional ability and enable independence.

A majority of people with frailty who present as an emergency to hospital come through the emergency pathway, either directly to A&E or the acute frailty team, or via referral from a community response team or care home. GP hotlines and virtual clinics have become increasingly embedded as a result of COVID-19. Some people with frailty may be at the end of life, with palliative care needs.

Multi-morbidity

Many older adults live with multiple long-term conditions or diseases. This is known as multi-morbidity. Patients who have multi-morbidity have a combination of two or more serious conditions, such as dementia, Parkinson's disease, osteoporosis, diabetes, cancer or stroke, or suffer from conditions with high prevalence such as hypertension, depression and pain. Increased age and deprivation are the leading causes of multi-morbidity .

Often adults with multi-morbidity will have complex health needs, face greater challenges in daily life and have increased risk of disability and poor clinical outcomes. They may also be at increased risk from polypharmacy – the interaction of multiple drug treatments taken concurrently to control their conditions.

Multi-morbidity is correlated with frailty. However, not all people with frailty have multi-morbidity – many have no other long-term conditions. Geriatricians are not solely responsible for the care of older adults with multi-morbidity but contribute to the treatment of these patients in association with colleagues in general medicine and other medical specialties.

Sub-specialisation and areas of expertise

Many geriatricians and other specialist clinicians undertake further training and develop areas of special expertise, reflecting the increasing importance of geriatric medicine and management of frailty in the health and social care system. These include:

- stroke
- orthopaedic and surgical liaison
- movement disorders
- dementia and memory services
- care homes
- continence
- end of life care
- palliative care
- cardiology
- community geriatrics
- oncology liaison
- perioperative medicine for older people.

Service organisation

The level of specialisation in a hospital department largely depends on the size of the unit. In smaller district general hospitals, geriatric medicine departments typically have four or five consultants and concentrate on the acute pathway, including rehabilitation and orthopaedic liaison, particularly focusing on the treatment of fractured neck of femur. Some have no outpatient clinics. Smaller units will also have teaching, training, service development and research functions.

Geriatric medicine may be less defined as a separate unit in some of these trusts and many geriatricians also work as part of general medicine teams. But only one hospital visited by the GIRFT team had no specialist department.

Larger departments may have up to 25 consultants, and offer a wider range of outpatient clinics and specialised services,

as well as taking on the extensive teaching, training, service development and research expected given their size. Most of these trusts manage acute frailty through a multidisciplinary acute frailty team.

Multidisciplinary working

In order to manage frailty and other complex multi-system conditions, care of older adults requires multidisciplinary skills. This may include a range of professionals, including geriatricians, nurses, physiotherapists, occupational therapists, psychologists, old age psychiatrists, dieticians, pharmacists, social workers, and speech and language therapists.

Geriatric medicine multidisciplinary teams (MDTs) often provide an initial assessment for older adults who have presented to hospital as an emergency – often as part of an acute frailty team. They will also provide liaison to other specialties and a range of ambulatory care services including falls and fracture prevention, memory disorders and movement disorders. The scope of MDT work encompasses assessment, treatment, and acute rehabilitation and discharge management.

Skills mix

New models and ways of working have developed in recent years to cope with demand and make use of the wider skill mix. For example, advanced practitioners are increasingly central to the clinical service, particularly within acute frailty teams, and for specialist assessment work such as falls assessment, continence, tissue viability and memory assessment, including assessment and management of delirium.

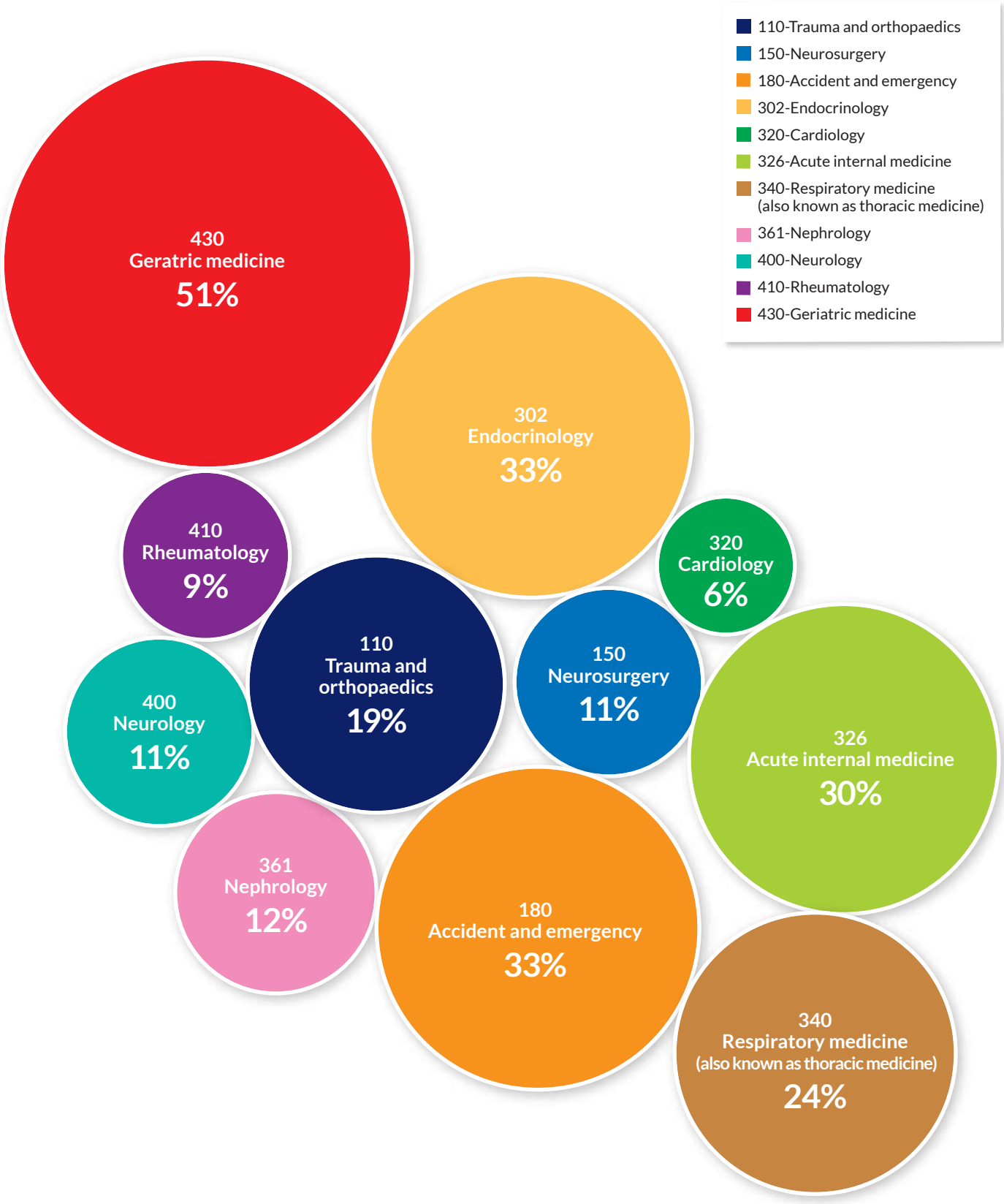
Liaison with other services

Advances in medicine and changing attitudes mean there is no longer an age bar to many surgical and medical treatments. This means that there are older people with frailty treated in all adult specialties – as shown in **Figure 2**.

Geriatric medicine provides a vital liaison role supporting people with frailty in specialties, including general and acute medicine, orthopaedics, respiratory medicine, endocrinology and emergency medicine, as well as palliative care. Many geriatricians also work closely with surgical teams.

The goal is to support patient centred care by assessing multi-morbidity and frailty and, based on that outcome, considering the benefits, risks and burdens of care to enable better goal setting and treatment planning. This is done by applying the principles and methods of Comprehensive Geriatric Assessment (CGA) (see page 42) and linking it to effective treatment often focusing on recuperative rehabilitation and prevention of complications. The breadth of these assessments reflects the scope of an MDT's remit, as described above.

Figure 2: Proportion of admissions of people aged over 65 with frailty to medical and surgical departments (specialties with more than 20,000 admissions and more than 5% frail only included)



Proportion of patients over 65 years who are identified as frail in medical and surgical specialties (specialties with more than 20,000 admissions and more than 5% frail included)

Source: Hospital Episode Statistics 2019-20

Working with partners in community and primary care

Geriatric medicine has a growing role in supporting assessment and treatment for people with frailty at home, in intermediate care, in care homes and in community hospitals and other community settings. Geriatricians and other specialist clinicians also provide specialist expertise to support primary care in general or specialist clinics, for example in falls and movement disorders.

The specialty also plays an important part in supporting the development of integrated care systems, particularly creating effective alternatives to acute hospital care for older adults with frailty (see *A population-based approach to frailty*, page 27).

There has been a strong growth in community-based rehabilitation, falls and fracture prevention, memory services and community palliative care services. Hospital-based geriatricians often work across multiple settings to support this work, including in care homes and with local rehabilitation services.

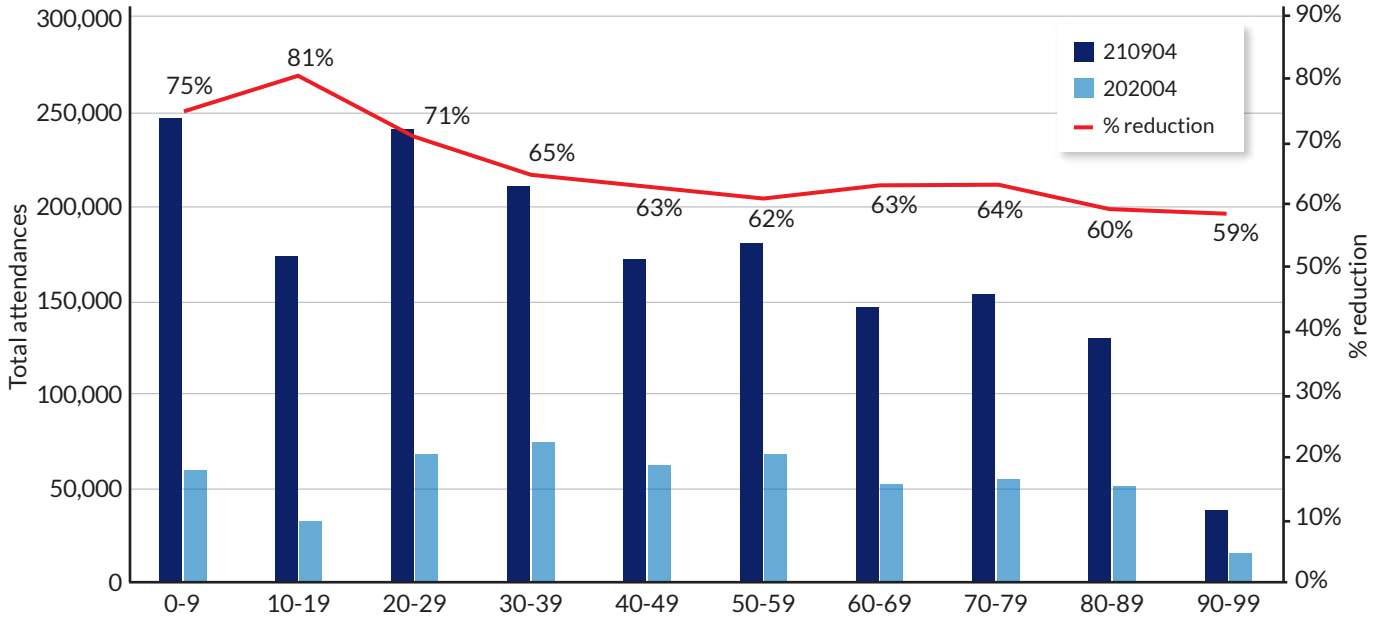
The impact of COVID-19

COVID-19 has had an enormous impact on both the emergency pathway and outpatient services. Many older adults have been shielding, while others have been nervous of coming to hospital. Attendance of older adults at A&E reduced by an average 60% during the first wave of the pandemic – as shown in **Figure 3** – while alternatives to hospital have been accelerated, including virtual alternatives to ambulatory care (see *Improving outpatient care*, page 98).

The need to prioritise beds for those with acute medical need has accelerated the development of a standardised discharge model (discharge to assess), co-ordinated by a new hospital discharge service (see *Removing the barriers to safe and effective discharge*, page 68).

These changes are already feeding into planning decisions over the near to mid-term future and may change how services are organised and delivered over the long term. Also see *Learnings from COVID-19*, page 107.

Figure 3: Percentage reduction in A&E attendances by age group April 2019 vs April 2020



Source: Hospital Episode Statistics 2019-20

About our analysis

Data sources

The analysis we carried out in developing this report is based on the Getting It Right First Time (GIRFT) programme model (see *About the GIRFT programme*, page 116).

First we gathered existing data related to geriatric medicine, including from Hospital Episode Statistics (HES) and looked extensively at data from the NHS Benchmarking Network's Managing Frailty project.

Using these data, we benchmarked providers on key measures which identified variation in practice and outcomes. This included regional benchmarking, comparing trusts to others within their area. A data pack specific to each trust was developed providing insights into the way the department functions.

Then we began to visit trusts to present the data in depth with clinicians, senior management and all those involved in delivering services across inpatient, outpatient and community settings. During the visits we discussed the variation in the data and how the trust stands in relation to their peers, including those in their area, allowing for differences in demography and geography.

Where the data indicated the trust may be underperforming compared to similar trusts, we explored this in more detail to understand the specific challenges they face and consider potential changes to practice.

Where a trust was outperforming its comparable peers, we sought to understand what they were doing differently and how the lessons could help to improve performance across the NHS. These discussions have informed our findings and recommendations.

The data were collected before COVID-19, so do not measure the impact of the pandemic, or changes to services that have happened as a result.

Other sources of data

As well as the HES data, NHS Benchmarking Network's Managing Frailty project and questionnaire data, we have also drawn data from a range of other sources. These include:

- Royal College of Physicians (RCP) Inpatient Falls Audit
- NHS Resolution (litigation)
- NHS RightCare
- NHS Safety Thermometer
- RX-Info Define
- Hospital incident reporting data.

How we used administrative data to identify frailty

Frailty is not reliably recorded as a condition in HES data. To identify frailty for the purposes of our analysis, we used a method derived from the Global Frailty Score (GFS)[5].

We looked for groups of International Classification of Diseases (ICD) diagnostic codes for seven domains of frailty recorded for admissions – dementia and delirium, mobility problems, falls and fractures, anxiety and depression, incontinence, pressure ulcers and dependence and care – with a one-year look back at previous admissions. Where we found codes from two or more of these domains, we classified the patients as frail. This approach therefore depends upon the quality of coding which varies between trusts.

Gaps in our analysis

We faced significant data limitations in completing this report. These included wide variation in the attribution of treatment to the specialty of geriatric medicine between hospitals, which makes it more difficult to form a clear picture of the specialty and the work done by geriatric units – this is discussed further in *Data and Coding*, page 101.

To form a clearer picture for the purpose of benchmarking analysis for the emergency pathway, we have aggregated data on activity related to people over 75 attributed to emergency medicine and general medicine, along with that attributed to geriatric medicine.

[5] *https://bmjopen.bmj.com/content/9/6/e026759*

We refer to NHS Benchmarking Network data throughout the report. This is an ongoing project in which NHS trusts submit detailed data on their acute frailty pathway and delayed transfers of care. Approximately 110 hospital sites submitted data. This gives a good snapshot of current practice in acute hospitals. However, the level of response to some of the questions in the survey is variable and some of the sample sizes for individual measures are therefore small, which limits the evidence that can be drawn from the data. Trusts supplying data for the project were asked if they consented to sharing their data with the GIRFT programme. A small number of participants didn't consent, so the figures in this report may differ slightly from those reported in the NHS Benchmarking Network outputs.

Another issue has been the quality of data covering much of the privately-owned care home sector, which has limited our analysis of care home services and the interface with NHS hospitals. This is a major gap that reduces our understanding of what's happening in the most crucial interface for geriatric medicine. Better data is needed so we can get a clearer picture of how many people are being admitted and readmitted from care homes and why this is happening.

However, we note that the care homes data we have used in this report was collected pre-COVID-19 and we understand that data collection has improved since the start of the pandemic.

Research

We would have liked to include health service research as part of our analysis – in particular, on how effective interventions can be delivered with the highest value for people living with frailty, especially when scaled up into large system change. However, there is a dearth of research available in this area. In making our recommendations, we therefore recognise that the evidence base for some solutions and interventions is limited. We think there is a need for more research and would welcome a renewed effort by grant giving bodies and trusts to initiate studies and enrol patients to help identify and test the approaches that work best to improve effectiveness and outcomes.

The scope of this report

The purpose of this report is to identify unwarranted variations in the provision of geriatric medicine within secondary care and make recommendations for improvement. It has a health and social care professional focus as it was based on the predominant health and social care professional input in deep dives. Future work may benefit from closer exploration of patient experience, utilising input from patients and carers. Such an approach would help further explain unwarranted variation, by more explicitly accounting for patient's perspectives on our pathways for the management of frailty.

It was not within our scope to examine the provision of primary care, community care, social care, or other services involved in the care of older people.

However, care of older people in hospitals interfaces extensively with these services as part of a wider health and care system. Often hospital treatment or assessment is only part of the solution and improvement depends on taking a population-based, whole system approach. We have therefore looked at the potential for joint working and integration between services and, in particular, the importance of good working relationships with care homes.

Many of our recommendations, particularly those linked to clinical quality, will also be relevant to management of frailty in a community hospital setting, and we would encourage colleagues in those settings to consider this report. Equally, notwithstanding data limitations in this setting, the approach of reviewing unwarranted variation would also be useful in principle and merits consideration.

Focus on frailty

As discussed above, the core business of geriatric medicine in hospitals is improving outcomes for older adults by increasing functional ability and enabling independence, for example, by reducing the dependency that can result from falls, serious infections and delirium. These are serious and avoidable harms, primarily associated with frailty, which can be made worse through hospitalisation if the person's frailty and risk of deterioration is not recognised and well managed through the system.

This is the area of geriatric medicine where older people face the greatest risk of avoidable harms, where variation is at its highest and where there is most scope for improvement. We have therefore chosen to focus much of our review and recommendations on the overall management of frailty in older people.

Multi-morbidity and management of specific conditions

Care for older people with multi-morbidity is often led by other specialties such as general medicine, acute internal medicine, or organ-specific specialties, sometimes in conjunction with geriatric medicine. In many cases, treatment may not differ greatly from that of younger patients. We have therefore not focused this review on management of multi-morbidity in detail, except that many people living with frailty may also have multi-morbidity and their care should be designed to meet their wider needs – for example by providing one-stop outpatient appointments to avoid multiple reviews for multiple conditions in multiple settings (see *Improving outpatient care*, page 98).

Likewise, we have not focused on some specific conditions, such as neck of femur fracture, arthritis, stroke and cancer, as the care for these conditions is led by other specialties and they will be covered by other GIRFT reviews.

Age group stratification

In developing our analysis, we have chosen to look at data on people over 75 in most instances, as this enables us to focus on the population which is at greatest risk of frailty and forms the majority of those living with frailty.

We have not used the over 65 age group as most people aged 65-75 do not have frailty and including them in the data would have made the group size very large. This would have obscured our analysis of the impact of frailty, hospitalisation and interventions on those who have the greatest need. However, the solutions we propose will benefit all patients living with frailty regardless of age.

Prevention of frailty

The report is primarily focused on the identification and treatment of people living with frailty treated in secondary care and how it is managed across the wider health system to reduce the risk of progression. This includes prevention of deconditioning, falls, delirium and worsening of all degrees of frailty during hospital admission. The data we looked at was primarily hospital data. We did not look at how frailty might be prevented from occurring within the community in the first place. This is because:

- Prevention often depends on public health approaches such as education and interventions on exercise and nutrition. These were not within the scope of our review and we did not have sufficient data to make any evidence-based recommendations.
- Identification of people at risk of frailty is primarily done in primary care, through clinical assessment and the Electronic Frailty Index (eFI), which enables risk factors to be analysed across a patient group (see *How is frailty identified?*, page 28). Prevention in primary care is now incentivised through the GP contract.

A population-based approach to frailty

An overview of frailty

Frailty occurs when multiple physiological systems lose their in-built reserves. It makes people more vulnerable, less able to overcome daily challenges or maintain usual activities, and reduces their capacity to recover from illness or injury. Symptoms such as falls, immobility, delirium, incontinence and susceptibility to side effects of medicines may suggest frailty.

Relatively minor incidents for someone not living with frailty, such as a fall or an illness such as flu, can become a crisis for someone living with frailty. This can render them immobile or delirious and cause a dramatic deterioration in their mental and physical wellbeing. An example is age-related loss of muscle strength, where people with frailty need to use most of their strength to stand and walk. A stressor, such as an acute infection, can cause older adults to lose some muscle strength and result in immobility.

These factors can lead to high rates of hospital attendance. Between 5% and 10% of all those attending A&E and 30% of patients in acute medical units are older and living with frailty[6].

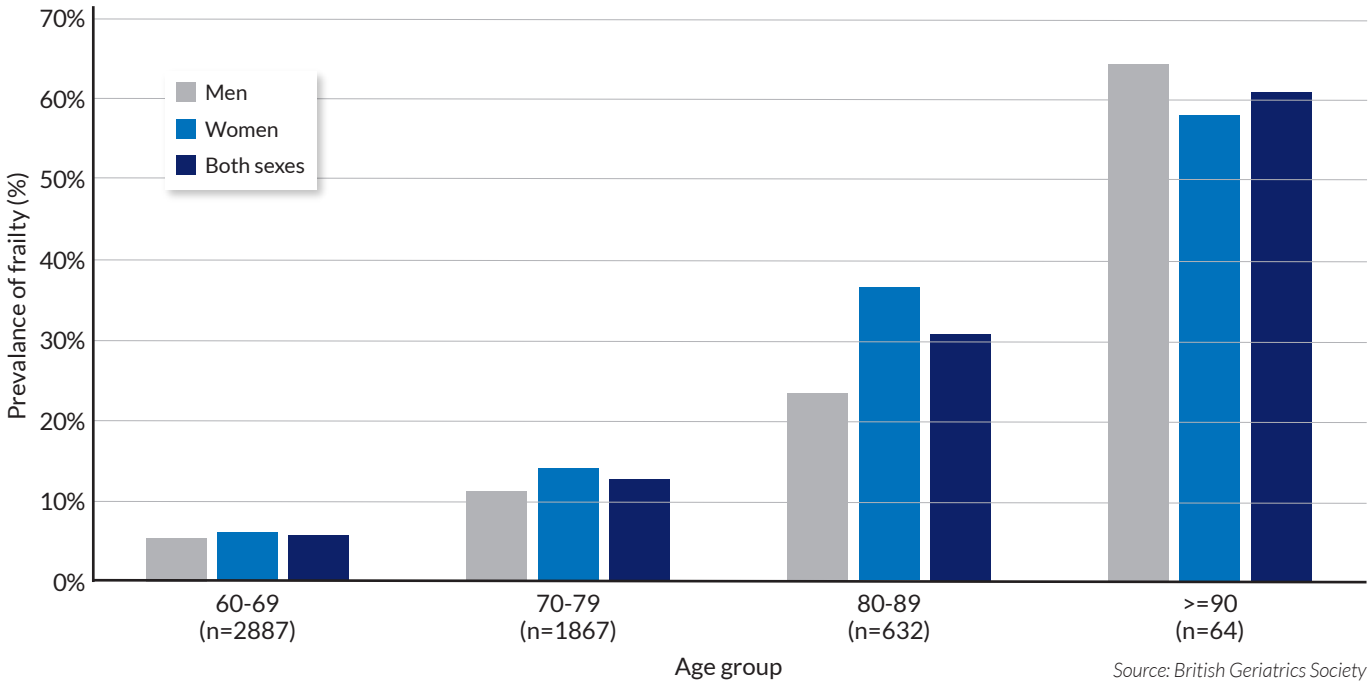
The impacts are worse in deprived areas, with rates of frailty up to twice as high in the most deprived neighbourhoods compared to least deprived[7]. Frailty can therefore be considered as a health inequality and should be a key focus in reducing inequalities among older people across the health and care system.

Improving the care of people with frailty is a major focus of the NHS Long Term Plan[8], which includes commitments to reframe frailty as a long-term condition and reduce the time people spends in long-term ill health in later life through early identification and prevention of progression of frailty.

Stages of frailty

Frailty is a spectrum, ranging from mild to severe. The risk of decompensation of body systems increases as frailty becomes more severe. Approximately 7% of the population over 65 have severe frailty[9]. Frailty is not exclusive to older people but it is linked to the ageing process and is more common in older age groups, as shown in **Figure 4**.

Figure 4: Weighted prevalence of frailty according to age and sex



Source: British Geriatrics Society

[6] *Conroy S, Dowsing T (2013) The ability of frailty to predict outcomes in older people attending an acute medical unit. Acute Med 12(2):74–6*

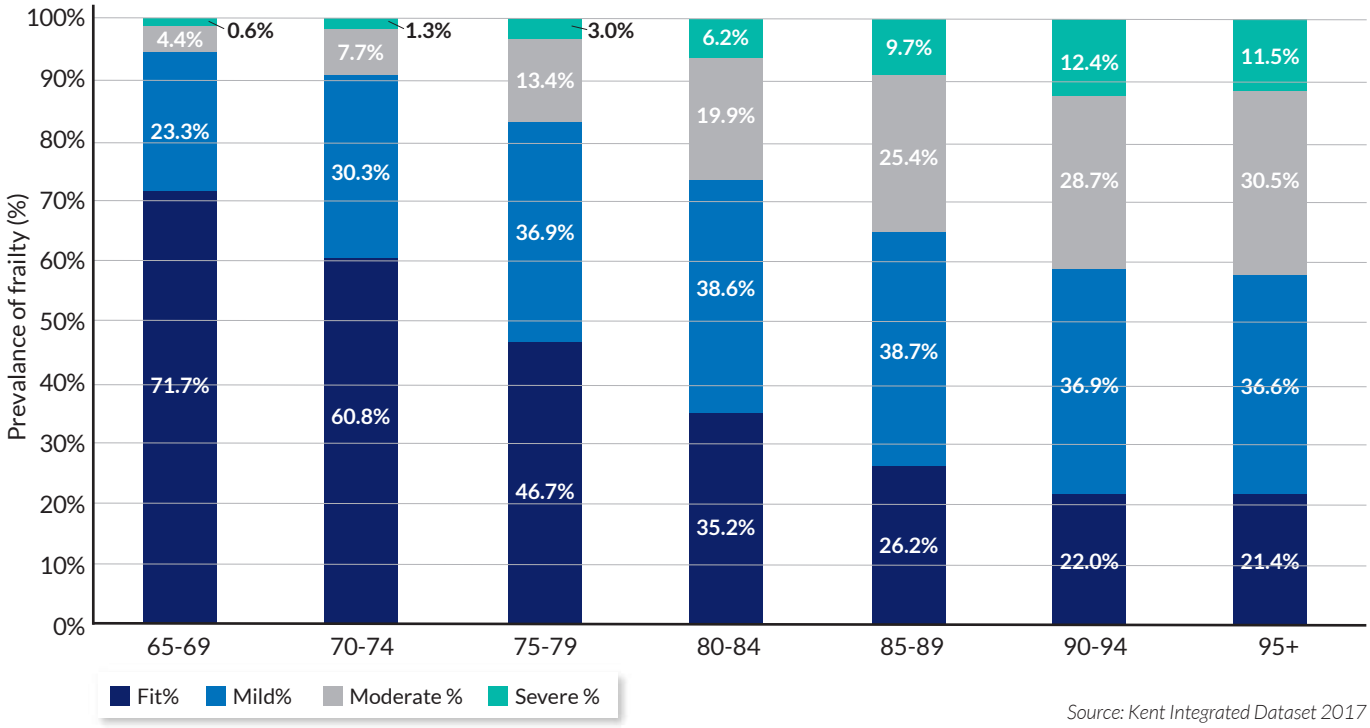
[7] *Lang IA , Hubbard RE , Andrew MK , et al Neighbourhood deprivation, individual socioeconomic status, and frailty in older adults. J Am Geriatr Soc 2009;57:1776–80. doi:10.1111/j.1532-5415.2009.02480.x*

[8] *NHS Long Term Plan page 16-17 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf*

[9] *BGS Frailty: what's it all about good practice guide https://www.bgs.org.uk/resources/frailty-what%E2%80%99s-it-all-about#:~:text=Severe%20frailty%3A,-Average%20practice%20list&text=7%25%20of%20the%20population%20over,about%2027%20patients%20per%20GP*

However, a significant proportion of the population remains fit even in very advanced old age, as shown in **Figure 5**, based on Electronic Frailty Index (eFI) data from the Kent Integrated Dataset[10].

Figure 5: Proportion of older people at each level of frailty (fit to severe) identified using the primary care eFrailty Index



Source: Kent Integrated Dataset 2017

How is frailty identified?

Whether a person is frail, and their level of frailty, can be identified by clinical assessment using tools such as the Clinical Frailty Scale (see *Identifying frailty early through systematic assessment*, page 41). Frailty can also be identified from administrative datasets using systems and tools such as:

- The Hospital Frailty Risk Score (HFRS)[11] and the Global Frailty Score, which analyse International Classification of Diseases (ICD) diagnostic codes in the Hospital Episode Statistics (HES) admissions data for recognised markers of frailty. These tools are used by clinicians in hospitals to identify groups of patients who have frailty or are at risk of frailty for targeted interventions.
- The Electronic Frailty Index (eFI) , used in primary care, which analyses coded data for 36 symptoms, disabilities and disease states. If 12 or more are found, it classifies the person as having severe frailty. The eFI can also be used to segment the older population into four frailty categories: fit, mild, moderate and severe. However the eFI is not a clinical assessment so it needs to be confirmed by clinical validation.

The Frailty Opportunity Identifier tool, hosted by NHS Elect, provides a useful way to access and use the HFRS, combining it with data on admissions, to enable trusts and local health systems to compare performance with other providers, regions and the national picture to drive improvements in pathways for people living with frailty. To register email: Frailty@NHSelect.org.uk

GIRFT frailty data

Where we report frailty data, we have based it on the Global Frailty Score, defined as any patient identified with diagnostic codes from two or more domains of frailty as recorded in HES (see *About our analysis*, page 24, for full details of our frailty data).

[10] *https://www.kpho.org.uk/__data/assets/pdf_file/0004/74146/Kent-Integrated-Dataset-August-2017.pdf*

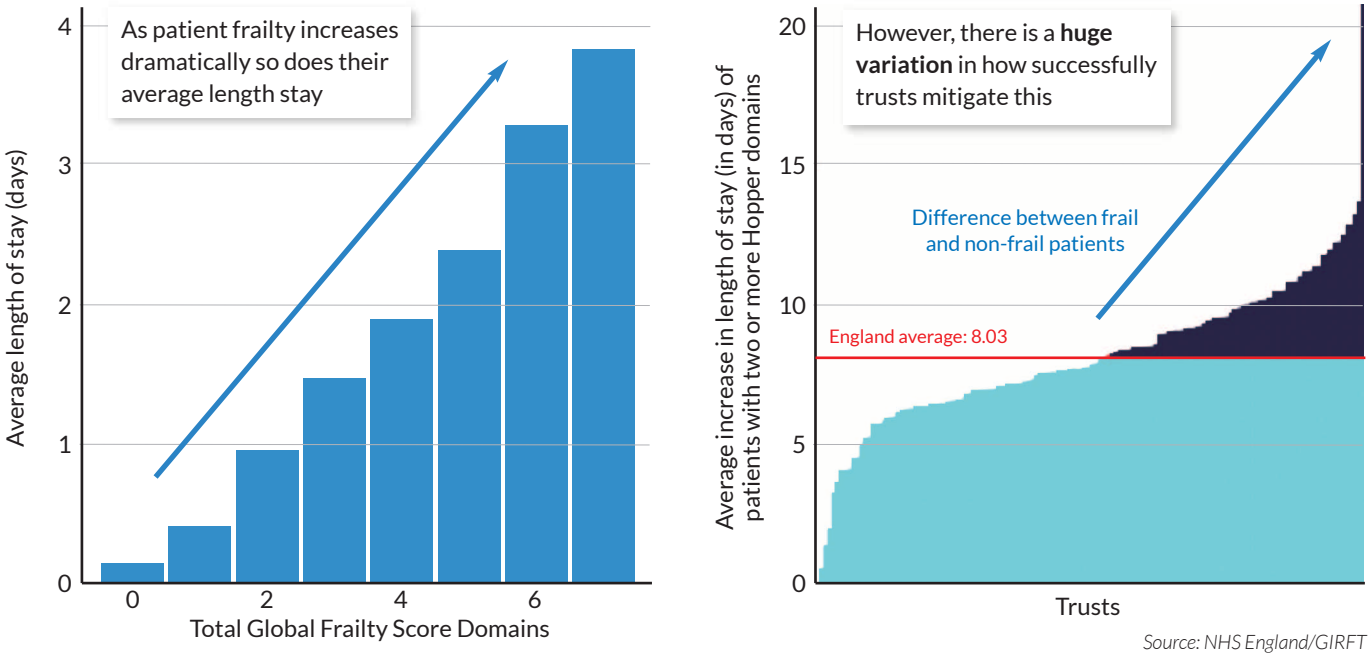
[11] *https://www.nuffieldtrust.org.uk/news-item/the-hospital-frailty-risk-score*

The need for a co-ordinated frailty strategy

Older people living with frailty end up in hospital disproportionately. Pre-COVID, there were more than 4,000 admissions daily for frailty, most coming through accident and emergency[12].

Some people with frailty will need to be admitted due to the severity of their illness or injury. However, many admissions are for reasons such as falls, minor infections and reactions to medications, that would not require admission without frailty. Once admitted, they are at high risk of longer length of stay, as shown in **Figure 6**, which increases the risk of their frailty deteriorating further.

Figure 6: Length of stay vs severity of frailty (all England) and variation between trusts for frail vs non-frail patients

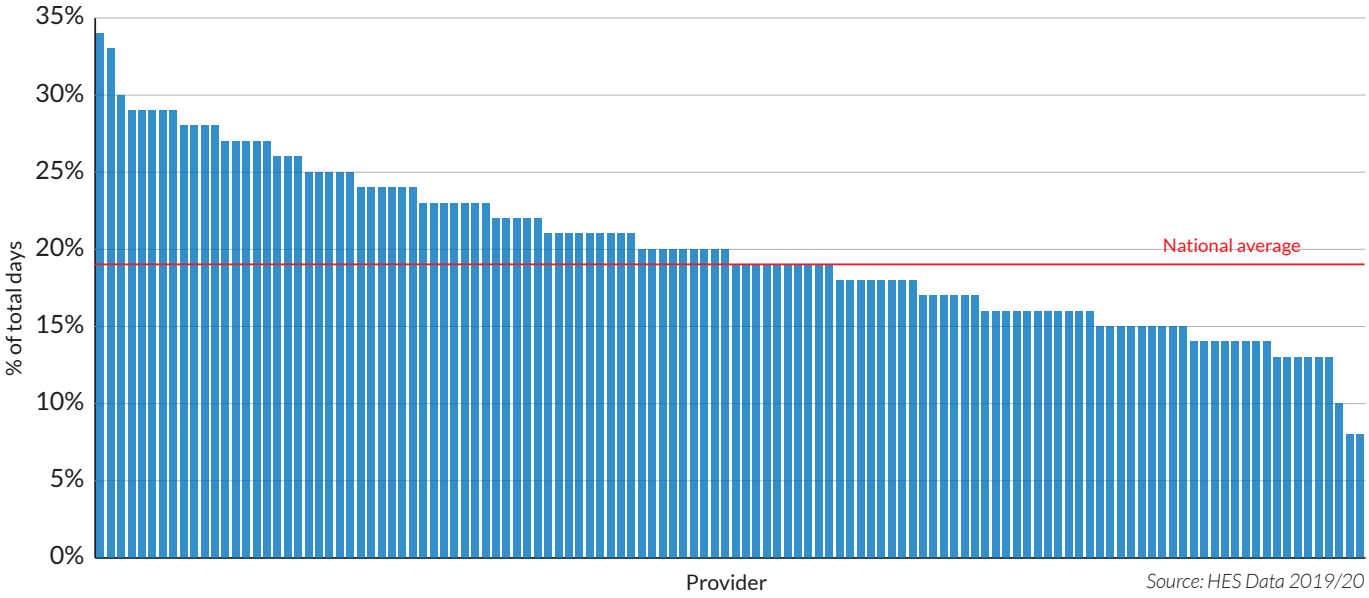


Source: NHS England/GIRFT

[12] *https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/*

Older people with frailty account for a growing proportion of hospital bed days. As shown in **Figure 7**, people with frailty aged over 75 occupy about 20% of all bed days across England. The data show considerable variation between trusts. Patients with frailty over 75 account for a third of bed days in some trusts and less than 10% in others, more than can be explained by variations in local demographics.

Figure 7: Proportion of total hospital bed days occupied by people with frailty aged over 75, elective and non-elective, by provider



Source: HES Data 2019/20

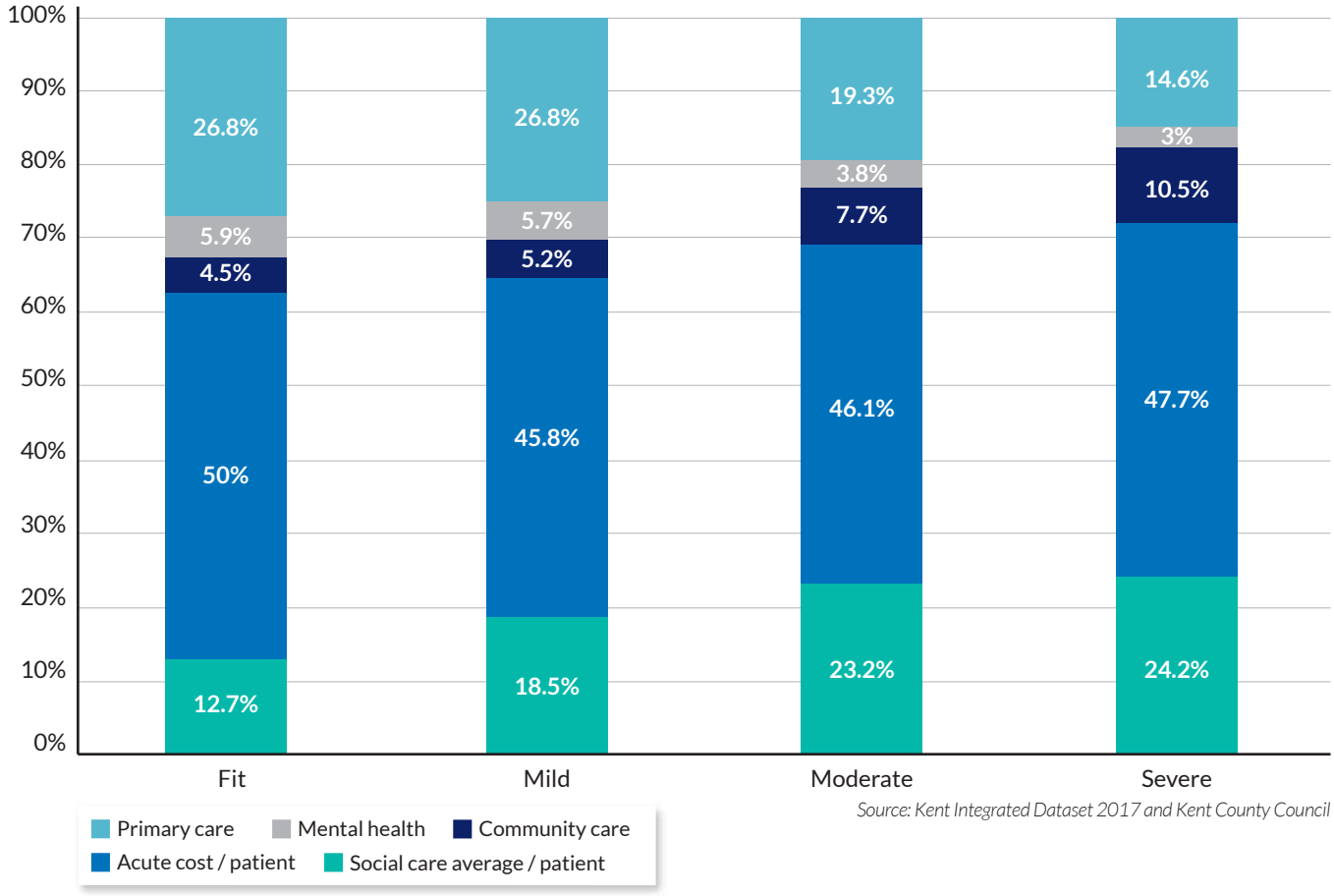
Value-based healthcare

High bed utilisation comes at a cost, both to patients and the NHS. Hospital may not be a good environment for older people with frailty. Higher length of stay is associated with a risk of increasing immobility, declining function and reduced life span[13] (see *Reducing the risk of hospital-acquired deconditioning*, page 51).

Figure 8 shows a proportional breakdown of the total cost of care for people with frailty aged over 65 in Kent, between primary, secondary, community and social care, based on data from Kent County Council and the Kent and Medway Clinical Commissioning Group (CCG). Acute care in hospitals accounts for the largest proportion of care costs and may not result in the best outcomes for people living with frailty.

A value-based system that takes account of whole-system costs and benefits should improve effectiveness with reduced need for hospitalisation and better outcomes.

Figure 8: Percentage whole system spend on care of people with frailty over 65 by severity of frailty (fit to severe)



Source: Kent Integrated Dataset 2017 and Kent County Council

It's interesting to note that the proportion of costs in acute care are similar at all stages of frailty, mild, moderate and severe. This suggests there is an opportunity to reduce acute care costs, while improving outcomes, if frailty was managed preventatively to keep people out of hospital in the earlier stages and if there were effective non-hospital models of frailty care for more severe frailty.

Reducing hospital bed occupancy may require some investment in support services outside of hospitals. However, given that a single admission of an older person living with severe frailty can cost more than £6,000[14], we believe that providing better alternatives outside hospital could result in an overall saving to the health system even allowing for the costs of change.

[13] *Walker J et al (2018) Reducing the effects of immobility during hospital admissions. Nursing Times [online]; 114: 6, 18-20. https://cdn.ps.emap.com/wp-content/uploads/sites/3/2018/05/180523-Reducing-the-effects-of-immobility-during-hospital-admissions.pdf*

[14] *Kent Integrated Dataset 2017*

A whole system approach including primary and community care

The growing challenge of frailty cannot be solved by secondary care alone. It requires comprehensive solutions that wrap around people, from the home and primary care to the care home and the hospital.

It's important that frailty is recognised as a distinct long-term condition. Local health systems need to take a whole systems population-based approach to identifying and caring for people with frailty across hospitals, community settings, care homes, social care and primary care, focused on preventing progression of frailty and avoiding the need for hospitalisation wherever possible.

Often, people with frailty could be helped where they live, without needing hospital care, if frailty were identified and recognised earlier and embedded in local care pathways as part of an integrated whole system approach. Likewise, people living with moderate frailty, identified in primary care using the eFI (see *How is frailty identified?* page 28), could be prevented from progressing to severe frailty by public health interventions focusing on nutrition, exercise and social interaction.

Changing landscape: moving towards integrated models of care

This population-based approach to care is already being driven by the system-wide changes set out in the NHS Long Term Plan:

- Integrated Care Systems (ICSs), which are in the process of replacing existing sustainability and transformation partnerships (STPs), bring local organisations together to take collective responsibility for providing care and improving the health of the population across a geographic footprint.
- Primary care networks (PCNs) join up GP practices to co-ordinate care across local areas and populations of between 30-50,000, with an enhanced role in the provision of healthcare in care homes and community settings.

The national Ageing Well programme[15] is also helping to develop frailty care in the community, based on urgent assessment and rapid response, linked to proactive care pathways that support people with frailty at home and in care homes.

Current variations in frailty systems

We found variation in how trusts work together on frailty with primary care, CCGs, care homes and other partners such as local authorities, social care and third sector organisations. On our deep-dive visits, we saw examples of good practice where trusts are working with partners to provide integrated frailty care, either as a whole system, or in bespoke initiatives (see case studies throughout this section).

However, in some locations there is little or no engagement, and in some places that have strategic partnerships there are questions about how effectively these are working and whether the workforce and the public is engaged with the process.

Some of the variation is due to structural reasons. For example, in London, a single trust might have to work with up to six CCGs and several local authorities, making it more difficult to achieve integration. A simple footprint, with one trust, one CCG and one local authority, is uncommon. However, ongoing consolidation of CCGs and the move to extend ICSs to cover all areas of England, should help to even out these variations over time.

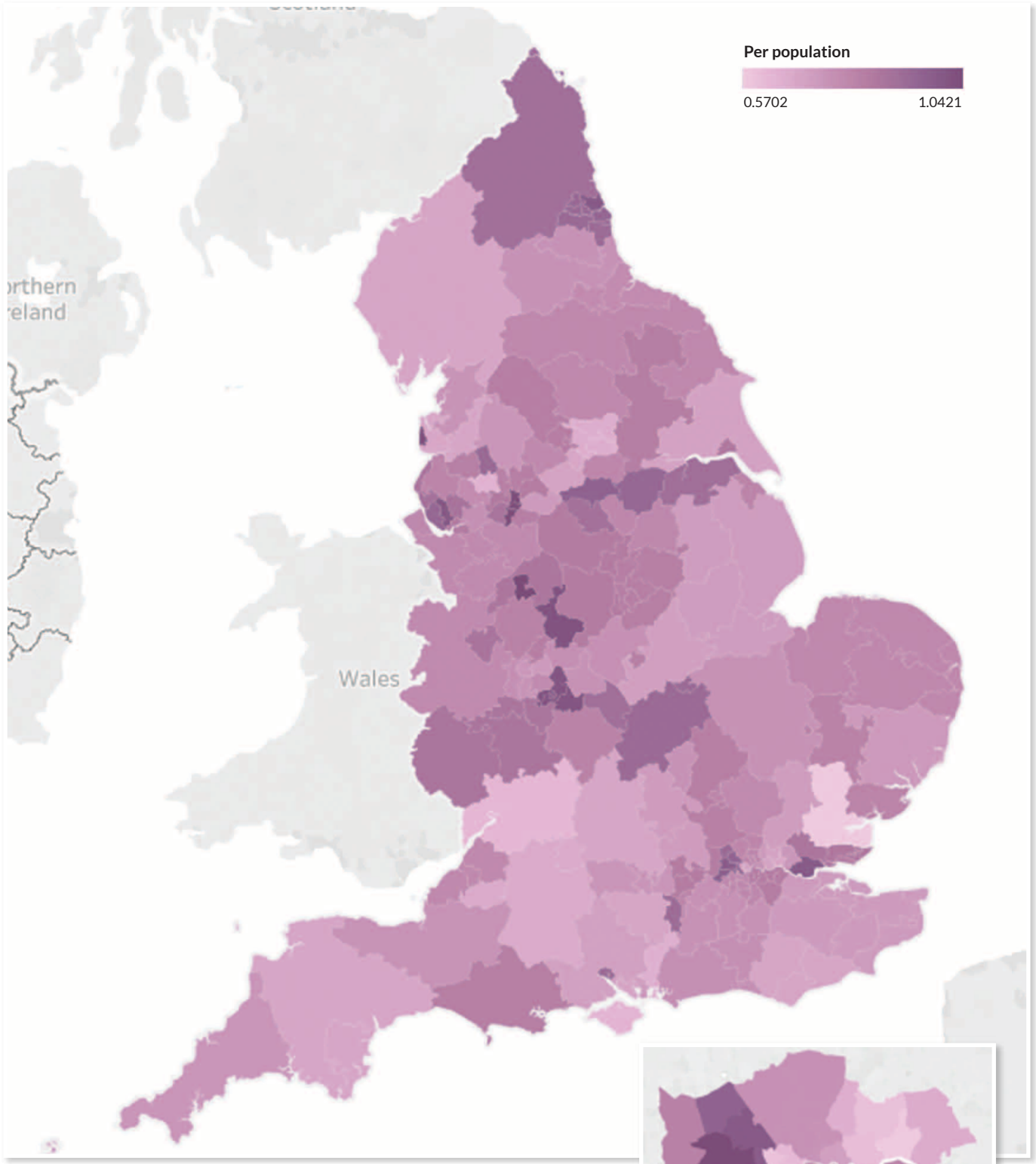
Cultural and regional differences

Where there are fewer strategic alliances, this may reflect different expectations around hospital use and frailty. In some parts of the country, we found a greater cultural acceptance of extended stays in hospital, as hospital is perceived as the right place for older people with frailty to receive care.

Attitudes may be influenced by issues such as poor housing and deprivation. Where people don't have the resources to self-fund quality care, they may see hospital as the best option. These regional variations are reflected in **Figure 9**, which shows higher levels of admissions among the over 75s in some areas.

[15] *https://www.longtermplan.nhs.uk/areas-of-work/ageing-well/*

Figure 9: Hospital admissions of patients over 75, elective and non-elective, per head of population by area



Source: Hospital Episode Statistics 2019-20

The role of community hospitals

In many parts of the country, community hospitals provide a large proportion of NHS bed-based care for older people living with frailty. This may be a product of geography. For example, in counties such as Cornwall, which has 16 community hospitals and two general hospitals, community hospitals are an essential support to acute hospitals in managing healthcare needs across large rural areas.

All bed-based care carries the risk of deconditioning and making eventual return home of patients living with frailty more difficult. From our deep-dive visits, we found that in some areas, community beds are used as an ad hoc step down measure to discharge patients with frailty safely from acute wards often in response to bed pressure, while in others they are used on a more consistent basis as part of the general bed estate and as part of a care pathway.

However, we were unable to make a meaningful analysis of the role and effectiveness of community hospitals as part of a wider frailty system, as the quality of data available to GIRFT was limited, making benchmarking comparison of bed use difficult.

One problem for our hospital benchmarking comparison is the variation in attribution of community beds to overall hospital data. Where trusts are vertically integrated between acute and community settings, they often include community beds along with acute beds in their bed use analysis, which can result in a higher overall length of stay (LoS). Where trusts are acute care only, and community beds are provided by a different provider, community beds are often counted separately. This means that LoS analysis does not include the community bed pool, and data may not be a true reflection of system-wide bed use or overall length of stay.

We need better and more consistent data in this area to enable better comparison and get a clearer picture of whole system outcomes across a local footprint. These outcomes should be measured and monitored at trust or ICS level and community and private providers should be contracted to provide data on key frailty outcome metrics.

Potential solutions: whole system models of care

There are a number of whole system models that bring trusts together with primary care, community services and care homes to deliver person-centred care and offer better alternatives to hospitalisation:

Community assessment/diagnostic hubs

People with a frailty-related conditions, such as dementia, falls or incontinence, can be referred for assessment and receive ongoing support or treatment from a community multidisciplinary team (MDT) to help them maintain function and wellbeing.

Status: This model is already in use and working well in several areas.

Crisis response hubs

Staff in an out-of-hours hub respond to sudden events, such as falls, infections and delirium, linked to community-based assessment and rehabilitation services with access to specialist support if needed. In some cases. ambulance teams may convey patients to a crisis response or community assessment hub rather than hospital with safeguards where this is clinically appropriate. In other models the initial assessment is performed in the patient's home This offers a comprehensive solution so the person does not need to go to hospital, unless they are severely ill.

Status: The NHS Long Term Plan includes a commitment to improve the responsiveness of community health crisis response services to deliver crisis response at home within two hours, alongside a commitment to provide reablement within two days of referral[16]. It is at an early stage of development but it is in use in a few areas. Although there is limited evidence as yet of its impact in reducing admissions, we note that this is difficult to assess.

Planned prevention of frailty progression

Multidisciplinary teams (MDTs) work together with GPs to prevent people with moderate frailty living at home from becoming severely frail. Based on a *Comprehensive Geriatric Assessment (CGA)* (see page 42) of the older person, they develop a joint plan to prevent deterioration. Key interventions include early diagnosis and assessment of dementia, falls prevention and improved mobility through exercise and improved nutrition.

Status: some trusts and CCGs are working towards developing the planned prevention model but they are still in the early stages of implementation.

[16] *NHS Long Term Plan, 1.8 page 14 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf*

Joint working with care homes

Care homes are working closely with the NHS, local authorities, the voluntary sector, carers and families to roll out the Enhanced Health in Care Homes (EHCH) programme, which was developed in six vanguard areas across England. This is focused on providing co-ordinated preventative care in care homes, supporting people to live independently where possible and reducing unplanned admissions to hospital. This model is discussed further in *Improving liaison with care homes*, page 80.

Status: The vanguards made a significant impact in reducing emergency admissions from care homes and, following this success, NHS England and NHS Improvement made a commitment in the Long Term Plan to roll out EHCH to all care homes in England between 2019-24.The EHCH model of care is reflected in the new Network Contract Directed Enhanced Service (DES) for GPs as well as the new NHS standard contract.

Same day emergency care

Many older people with frailty currently admitted to hospital as an emergency could be fit to return home without the need for admission if they were diagnosed and treated on the day they arrived in hospital. Same day emergency care (SDEC) aims to break down the barriers to achieve this, co-ordinating the emergency response to remove delays in the patient pathway and provide rapid access to treatment where needed.

The NHS Long Term Plan states that every major A&E department should offer SDEC 12 hours a day seven days a week. For older people with frailty, SDEC should be co-ordinated by the acute frailty team. SDEC is now being rolled out in larger hospitals, accelerated by the need to reduce hospitalisation during COVID-19. However, its success depends on having the right recuperative and reablement services available in the community to support the patient after they leave hospital – see *Removing the barriers to safe and effective discharge*, page 68.

CASE STUDY

Reducing admissions through one-stop community hubs

Buckinghamshire Healthcare NHS Trust

Hospital admissions of people with frailty have reduced in Buckinghamshire as a result of a one-stop Community Assessment and Treatment Service (CATS), jointly run between geriatricians and GPs.

CATS enables older people with frailty to get same day diagnosis and treatment closer to home and reduce the need for hospitalisation. It provides a wide range of services under one roof, including Comprehensive Geriatric Assessment, blood tests, diagnostic imaging and intravenous infusions.

The service operates in three community hospitals, Thame, Marlow and Amersham, where beds have been repurposed as community hubs. The multidisciplinary team, which includes geriatricians, GPs, nurses, therapists and healthcare assistants, has close links with local rehabilitation services, social care, district nursing and the voluntary sector.

The aim is to provide holistic support for patients and help them stay well at home. Equipment and devices, from walking frames to grab rails, can be provided to support independent living.

The service takes referrals from local GPs, inpatient wards, A&E, community providers and the ambulance service, who can use CATS as an alternative to A&E. All patients are seen within two weeks, with same day appointments if needed to avoid a hospital admission. A consultant geriatrician is available by phone seven days a week 8am-8pm to provide referrers with advice and guidance.

Where patients have to be admitted, the team provides same or next day review to support a safe and timely discharge, helping to prevent deconditioning.

Results

In a survey of patients, 50% felt their confidence and quality of life had improved as a result of CATS. Re-presentation of patients at an acute hospital within 28 days of attending CATS is 44% lower than the trust's average re-presentation rate. Waiting times at the community hospitals have also reduced.

Developing an effective frailty system

A poor frailty system is expensive, delivers poor outcomes, is stressful for patients and staff and creates high opportunity costs in management of interfaces. We need to improve how we manage this condition in a joined up way across services and geographies.

An effective frailty system should look to include primary and community care, care homes, local authorities, social care services and the voluntary sector – everyone involved in providing care and support for older people with frailty.

However, there is no prescriptive model for how the system should be structured or organised. The key thing is that all relevant partners work together in an aligned way, sharing the same information about individual patients, to manage frailty and improve outcomes for the whole population.

The focus should be on how we can improve the health and wellbeing of people with frailty by managing their health and care needs across all settings, wrapping services around them as a person, based on the principles described below.

Principles of an effective frailty system

An effective system should be planned on a population health basis, adapted to the needs and values of local communities, and provide:

- rapid, easy and equitable access to services for people with frailty across a geographic area;
- patient-centred care, responsive to the needs of people with frailty, both urgent and non-urgent;
- support and treatment for people with frailty in their own homes where appropriate;
- good pathways for hospital discharge, particularly discharge after short stays;
- avoiding extended stays in hospital or community hospital beds;
- co-ordination between services and disciplines to provide a joined up service and avoid duplication and repeated assessment and reassessment;
- ongoing improvement and iteration as patients and technology keep changing;
- better value for the health system and better outcomes for people living with frailty.

CASE STUDY

Integrating frailty services to provide joined up care

Surrey Downs Health and Care/Epsom and St Helier University Hospitals NHS Trust

A multi-agency partnership is delivering enhanced rapid care at home to help people with frailty stay well out of hospital and reduce length of stay for those admitted to hospital.

The partnership includes the Epsom and St Helier trust, the local community hospitals trust, a consortium of GPs and Surrey County Council. They came together having recognised that too many older people were being hospitalised needlessly because of a lack of joined up care.

The partners broke down barriers between their organisations to create an integrated multidisciplinary team (MDT), including frailty consultants, GPs, nurses, therapists, pharmacists, social care practitioners, reablement workers and the voluntary sector.

Together, they can mobilise the resources needed to provide rapid assessment at home within two hours of referral. Same day packages of health and care support help keep people at home who would otherwise have had to visit A&E or been admitted to hospital. The team operates 12 hours a day, seven days a week, accepting referrals from GPs, A&E, other hospital teams and the ambulance service. They work to a single shared care plan with shared electronic health records, which reduces duplication and means that patients only need to tell their story once.

They also proactively review patients in hospital and offer same-day enhanced care packages to enable the patient to go home on the day of assessment. Care and support is provided at home for up to seven days with planned handover to multidisciplinary teams in each Primary Care Network.

Results

Overnight admissions among people over 65 have fallen by 12% since the service started, while average length of stay is down by 0.8 days. On average three more patients per week stay at home and three go home sooner as a result, equivalent to a whole ward of patients being better looked after at home. This includes support at home for patients with delirium where hospitalisation may be particularly counterproductive.

Links with local networks and services

As previously mentioned, the development of ICS systems across the NHS should help to drive change and break down barriers to partnership working. Examples of potential collaborations include:

- Co-operation between primary care and community MDTs to enhance anticipatory care and develop support and services to prevent progression of frailty in the home and in care homes, aligned with the Ageing Well programme.
- Working with PCNs to co-ordinate care for people with frailty across geographic footprints, including care homes, where PCNs have to deliver the Enhanced Health in Care Homes framework– see *Improving liaison with care homes*, page 80.
- Working with ambulance services and paramedics to develop alternative pathways such as conveyance to a community assessment or out-of-hours hub as an alternative to hospital – see *Potential solutions: whole system models of care*, page 34.
- Linking with the emerging imaging networks to plan capacity for imaging services, such as MRI scanning for patients with dementia, across an area.

However, it's important that collaboration between local services is well co-ordinated, with easily accessible shared information, and does not lead to duplication. One of the main concerns reflected in complaints from older people with frailty is having multiple assessments by different services, often repeating the same questions and performing the same tests.

Prevention and public health approaches

Public health approaches to prevention should be considered. For example, proactive support such as strength and balance training and home adaptations for older people with frailty in the community, could make a big difference in reducing falls, which are the most common reason for hospital admissions. A Public Health England study[17] found that for people at high risk of falls, home assessments and home adaptations could offer a return on investment of £3.17 for every £1 spent.

Likewise, working with local authorities and other partners on safe streets initiatives and promoting exercise can aid prevention and help to improve outcomes overall. In particular, efforts should focus on increasing activity and reducing sedentary behaviour among older people. Data from the British Heart Foundation[18] showed that almost half (46%) of men and almost two thirds (65%) of women over 75 are inactive. Only 36% of men and 18% of women over 75 meet the minimum activity recommended for older adults.

While we are not able to focus on the public health aspect of frailty in this report, we recognise that prevention is a system-wide priority and should form part of integrated frailty strategies. We support the ongoing work of Public Health England in areas such as falls prevention, as detailed in its Falls and Fractures Consensus Statement[19].

Measuring and monitoring progress

There should be a commitment to apply improvement principles to change, measure and evaluate how the system is working and adapt depending on results. ICS/STPs should work with trusts to develop and monitor a dashboard of metrics for internal review as a time series to monitor and measure progress over a period of years. Metrics should include:

- A&E conversion rates.
- Four hour breach rate.
- Discharge within 48 hours.
- Reported inpatient falls (with at least annual assessment of under-reporting levels).
- Delirium identification.
- Seven-day readmission rates.
- Admission from care homes and death within 48 hours of these admissions.
- Levels of early mobilisation/sitting out.
- Inpatient hip fractures.
- Out-of-hospital metrics such as maintenance of personal independence.
- Metrics of actual place of death and achievement of death in preferred place.

Much of this data can be extracted from existing data sources such as the National Hip Fracture Database (NHFD)[20] as well as the Hospital Episode Statistics (HES).

Wider whole system measures should also be tracked at ICS/STP level, including admission from care homes, maintenance of personal independence, place of actual death and achievement of death in preferred place of care. Performance should be benchmarked to drive improvement across the local health system.

Getting local buy-in

The strategy needs to be locally-owned and driven and win the backing of local providers and the public so that it works effectively in practice and becomes embedded into local long-term plans.

It is therefore important that frailty systems take account local differences in demographics, culture and practice. For example, the needs of older people with frailty may differ widely in areas where most live in large inter-generational families compared to areas where living alone is more common. Current services and allocation of resources may poorly reflect these differences.

[17] *Public health England. A return on investment tool for the assessment of falls prevention programmes for older people living in the community. London: Public Health England; 2018*

[18] *British Heart Foundation physical activity statistics 2015 file:///C:/Users/will_/Downloads/bhf_physical-activity-statistics-2015feb%20(2).pdf*

[19] *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586382/falls_and_fractures_consensus_statement.pdf*

[20] *https://www.nhfd.co.uk/20/nhfdcharts.nsf/vwCharts/PatientSafety?open&org=*

Leading and supporting change

We know that establishing an effective frailty system is difficult. It is a major system change involving multiple agencies and is complicated by local cultural and demographic differences, as discussed above. It also represents a major shift in practice and culture, which will require engagement and alignment of the workforce across primary and secondary care.

Trusts should recognise the scale of change involved and ensure they devote the time and resources needed to achieve it. They should be supported by NHS England and NHS Improvement, for example, through leadership initiatives such as the Transformation Academy for Large Scale Change[21].

The NHS RightCare Frailty Toolkit[22], which was developed in collaboration between NHS England, GIRFT, Age UK and The National Institute for Health and Care Excellence (NICE), is a useful tool. It supports health systems to identify frailty and prioritise care, and suggests key actions to take. It also provides opportunity to assess and benchmark current systems to find opportunities for improvement. Likewise NICE guidance on improving care and support for people living with frailty has useful information and resources to help drive quality improvement[23].

CASE STUDY

Helping patients stay well at home through support and education

Blackpool Teaching Hospitals NHS Foundation Trust

More older people with long-term conditions are living well out of hospital thanks to Blackpool's Extensive Care service, which provides tailored support and education for each patient.

The multidisciplinary service is led by a consultant geriatrician, with nursing, occupational therapy, pharmacy and administration support. It is available to anyone with frailty, dementia or multi-morbidity. Patients can be referred from within the trust, or from primary care, community services, social care or mental health services.

After a Comprehensive Geriatric Assessment (CGA), the team creates a personalised plan with the patient, which may include a medicines review and goal setting, with support for self-management. Each patient is given a 'patient activation measure', an assessment of their knowledge, skills and confidence to manage their own health and wellbeing, which is reviewed and updated.

Home visits are arranged where needed with the most appropriate member of the team – for example a pharmacist may provide support and education on medicines use including dosage and administration methods. If a patient feels unwell, they can call the service's triage helpline for advice.

Results

Since the service was introduced, many patients have increased their activation measure, which would be expected to lead to fewer non-elective admissions and A&E attendances over time. Consistent with evaluations of similar changes, early results for this model have showed an increase in hospital use. This is comparable to similar experiences elsewhere showing that the benefits from transformations like this may take five to six years to realise.
For more information see: *https://www.health.org.uk/sites/default/files/upload/publications/2020/FyldeIAU.pdf*

[21] *https://www.england.nhs.uk/sustainableimprovement/leading-large-scale-change/*
[22] *https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf*
[23] *https://stpsupport.nice.org.uk/frailty/index.html*

Recommendation: A population-based approach to frailty

Recommendation	Actions	Owners	Timescale
1. Each ICS/STP area should have an integrated system for preventing and managing frailty that includes secondary care, primary care, care homes, community services, ambulance services and paramedics, local authorities, third sector, patients and carers. Priorities should include avoiding inappropriate hospitalisation and progression of frailty, and improvement should be benchmarked with similar local footprints.	**a** GIRFT to support ICS/STPs to embed partnerships in local long term plans.	GIRFT, ICS/STPs	For progress within a year of publication
	b GIRFT will work with local systems and trusts to help them collect and monitor a dashboard of key frailty-related data, including admissions, early discharges, A&E conversion rates and seven-day readmission rates, as well as community measures of how patients are doing at home, and track them continuously over a sustained period to measure progress.	GIRFT, ICS/STPs	For progress within a year of publication
	c GIRFT to support other national bodies to update and extend the eFI to support frailty management outside of hospital and enable population-based and public health approaches to frailty care.	GIRFT, NHSE/I	For progress a year after publication

Identifying frailty early through systematic assessment

When older people with frailty come to hospital, they are at greater risk of hospital acquired harms such as falls, delirium, hospital-acquired deconditioning and anxiety. Admissions often lead to extended stays, which are associated with hospital-acquired deconditioning and functional decline.

Frailty is not always immediately apparent when the person arrives at hospital. They may present with non-specific symptoms that are not easily diagnosed. It's therefore essential to have systems in place that can:

- identify frailty on arrival and monitor it through the patient's hospital journey;
- prioritise those at greatest risk of hospital-acquired harms and plan preventative care;
- triage those with immediate frailty-related issues;
- identify those who do not need to be in hospital and re-direct them to another service where that's appropriate.

This initial assessment should happen within 30 minutes where the person arrives in A&E[24]. Where someone is identified as having frailty on admission, they should be referred for a more detailed Comprehensive Geriatric Assessment (CGA) – see page 42.

How people with frailty should be monitored and supported post-admission to prevent deconditioning and hospital-acquired harms is discussed in more detail in *Reducing the risk of hospital-acquired deconditioning*, page 51.

Variations in frailty assessment

The standard tool recommended by the Acute Frailty Network and NHS Same Day Emergency Care (SDEC) for initial assessment for frailty is the Clinical Frailty Scale (CFS). This assesses the patient's function as it was two weeks before admission to get an accurate picture of their overall level of frailty (see below). It can identify people who may need more specialised assessment and can also identify those patients at high risk of complications of frailty post-admission.

The recent NICE guideline on COVID-19[25] stated that all older adults should be assessed for frailty and that the CFS score should be recorded in patient's medical record.

We found variations in the use of the CFS during our deep -dive visits and many examples where the tool had been introduced but its use was patchy. Often it was only being used by the acute frailty team. However, it is now used in most trusts, driven by the necessity of identifying vulnerable patients during the COVID-19 crisis. It remains to be seen if this will be maintained long-term at the scale that's required as hospitals return to pre-COVID levels of service.

We found significant variation in assessment for delirium, a key consequence of acute illness in frailty, with many trusts not assessing for delirium at all. This is discussed in *Improving the dementia and delirium pathways*, page 63.

Frailty assessment tools and support

The recommended measure of frailty is the Rockwood Clinical Frailty Scale (CFS), which grades people based on their physical and mental function, as shown in **Figure 10** below: 1 is very fit, 5 mildly frail, 8 severely frail and 9 is end of life. A CFS app is now available, free to download, which guides clinicians through performing the assessment[26]. Along with the 4AT test for delirium (see *4AT delirium assessment*, page 65) and the National Early Warning Score (NEWS 2), the CFS forms part of the 'triple test' which is the basis of a good initial frailty assessment.

Acute Frailty Network

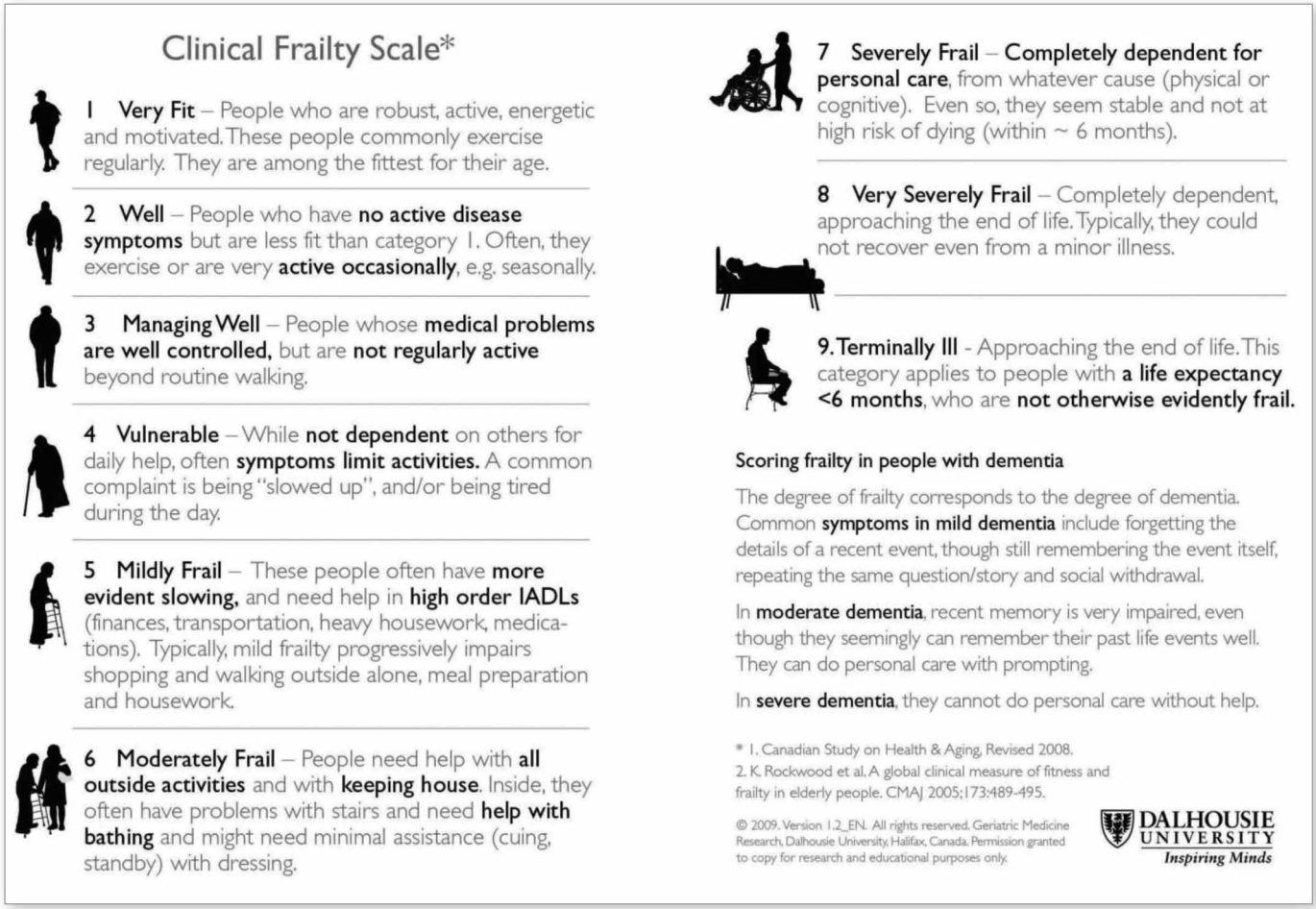
Many hospitals have found that joining the Acute Frailty Network (AFN) has proved invaluable in supporting and sustaining good assessment practice. The AFN provides resources and guidance for healthcare practitioners and works with trusts to embed frailty identification through CFS and achieve timely delivery of CGA for frail older people in urgent care settings.

[24] *NHS Long Term Plan, page 14 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf*

[25] *COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic service https://www.nice.org.uk/guidance/ng179*

[26] *https://www.acutefrailtynetwork.org.uk/Clinical-Frailty-Scale/Clinical-Frailty-Scale-App*

Figure 10: The Rockwood Clinical Frailty Scale



The Rockwood Clinical Frailty Scale.[2] Reprinted with the permission of The Geriatric Medicine Research, Dalhousie University, Halifax, Nova Scotia

Comprehensive Geriatric Assessment

CGA is an interdisciplinary process to determine the medical, psychological and functional capability of someone who is old and has frailty. The aim is to develop a co-ordinated, integrated plan for treatment and long-term support[27]. A CGA can be carried out in multiple settings such as by the patient's GP or community practitioner in conjunction with family and/or carers, but can equally be used by hospital teams as part of discharge to assess, or to get a clearer picture of an older person's health, for example as part of liaison support for other specialties and pre-operative assessment.

CGA is a powerful tool for assessment, which greatly improves outcomes and underpins high quality frailty assessment. It is important that previous assessments should be available to all staff who are in contact with the patient.

[27] *NICE Quality Standard 136 Transition between inpatient hospital settings and community or care home settings for adults with social care needs. www.nice.org.uk/guidance/qs136*

Assessment systems, practice and implementation

The key to successful management of frailty in hospital is having consistent methods of identification, assessment and monitoring.

On our deep-dive visits, we found variation in how assessments are being carried out, and in the systems and structures that support monitoring. Follow up post-admission is patchy – although we found good examples of tracking patients with frailty and use of liaison teams in the medical emergency pathways, including older persons assessment and liaison (OPAL) teams.

Most hospitals have an acute frailty team, which assesses patients and streams them to the appropriate department or service as part of emergency assessment and treatment. We found that these teams vary in size and working methods. In some places they are standalone, in others they are part of the A&E department. Often they work 9am to 5pm, so assessments are not always carried out outside these hours – when many people with frailty are referred by GPs from their afternoon surgeries or visits. Many teams are Monday to Friday only.

Lack of out-of-hours and weekend coverage can lead to unnecessary admissions and extended length of stay as other staff may feel they are not competent to carry out assessments, or to discharge patients safely, in the absence of the frailty team.

CASE STUDY

Identifying frailty early in A&E to improve care across the system

Sherwood Forest Hospitals NHS Foundation Trust

Rapid assessment of older patients presenting at the trust's A&E is helping identify frailty early, linked to targeted interventions and support to help get people home as soon as possible.

A consultant geriatrician is present in the emergency department at all times to carry out frailty assessments based on the Clinical Frailty Scale (CFS). If frailty is identified, the patient is referred to the multidisciplinary Frailty Intervention Team (FIT) for a Comprehensive Geriatric Assessment (CGA).

This can lead to either early discharge with appropriate support or targeted interventions to support the person through their hospital stay. The FIT team includes doctors, nurses, occupational therapists and physiotherapists, with access to social services and psychiatry liaison support.

The team also work with emergency staff to develop awareness of frailty, embedding the CFS as part of everyday practice and rolling out education and training to make frailty everyone's business.

Patients who are discharged following assessment can be referred for a further holistic assessment at home. The FIT team share their information with community assessors to enable joined up care across the system and engage appropriate support from partners such as community falls teams, continence nursing and social care.

Results

Early identification of frailty in A&E has increased, enabling patients to receive the detailed assessment and treatment they need more easily. Around 35% of people seen by the FIT team are discharged safely straight from A&E without the need for an admission.

Delays in assessing patients in A&E

The majority of emergency admissions for frailty come through A&E, although in some hospitals people with frailty may be triaged directly to a specialist acute frailty assessment area. Many initial frailty assessments therefore take place in A&E, where space and facilities are limited.

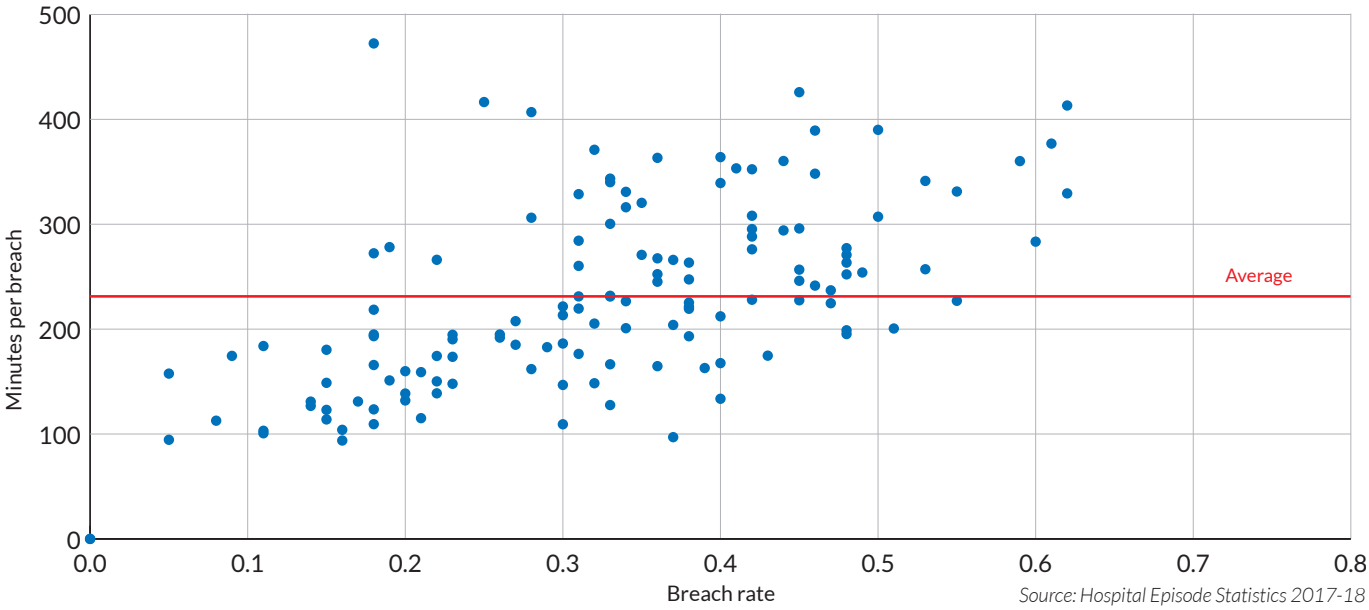
This may be another barrier to effective assessment. We found that some patients have been admitted from A&E to acute wards or short stay assessment areas while waiting for a frailty assessment, in order to avoid breaching the four-hour target. They may then remain in hospital longer because they are waiting in a queue for treatment.

Where the four-hour standard is breached within A&E, the data shows that adults aged over 75 remain there another four hours on average as shown in **Figure 11**. In some hospitals, the average additional wait is seven hours, making a total of more than 11 hours from arrival to admission[28].

These hospitals also tend to have the highest breach rates for people over 75, up to two thirds (63%) of A&E attendances in the worst performing trusts. Around one third of trusts are in the upper right quartile of the chart showing higher than average breach rates along with longer than average waiting times per breach.

These delays are particularly damaging for older people with frailty. Having waited for 11 hours, the process of deconditioning may already have begun before they have been assessed, reducing the effectiveness of any subsequent therapy or treatment. This underlines the importance of effective early assessment in A&E linked to optimised flow into treatment for people with frailty. However, we recognise that timely assessment and subsequent flow in A&E is dependent on appropriate capacity in both diagnostic and therapy services and the availability of an adequate number of acute hospital beds.

Figure 11: Four-hour breach rates vs waiting time for a bed above four hours in A+E for people over 75 years



Source: Hospital Episode Statistics 2017-18

[28] *Hospital Episode Statistics 2017-18*

CASE STUDY

Ambulatory assessment unit helps reduce A&E waits and admissions

Mid and South Essex NHS Foundation Trust

Older people with frailty presenting in A&E are seen faster, with fewer admissions and shorter length of stay, since Basildon and Thurrock Hospital began assessing patients in a dedicated frailty unit.

Previously all frailty assessment was done in A&E. Limited facilities for assessment and minimal multidisciplinary staffing meant four-hour breach rates and avoidable admissions were relatively high.

With support from the NHS Acute Frailty Network, the hospital set up a dedicated unit for assessment and ambulatory care of people with frailty, adapting an existing ward. A multidisciplinary acute frailty team, including doctors, nurses, therapists and pharmacists, offers rapid access to a range of services to help people get home as quickly as possible.

Older patients presenting as emergencies can be sent straight to the unit either for ambulatory assessment and care prior to discharge, or more detailed multidisciplinary assessment and treatment. If patients need to be admitted overnight, they remain in the assessment unit, where length of stay is lower than in existing wards.

After initial success in 2018, the unit was expanded to include 20 assessment beds and a six-chair ambulatory area. The team have also introduced a 'frailty hot clinic' allowing GPs and community care to refer patients who are having a crisis, need post-discharge follow up or at risk of deconditioning.

Results

The hospital saw a two-thirds (66%) reduction in avoidable admissions of people with frailty between October 2018 and April 2019. Average length of stay for those admitted to the frailty unit was 5.8 days compared to 12.5 days in the existing care of older people ward. More than 95% of patients are seen within four hours in A&E.

Reducing admissions through early identification

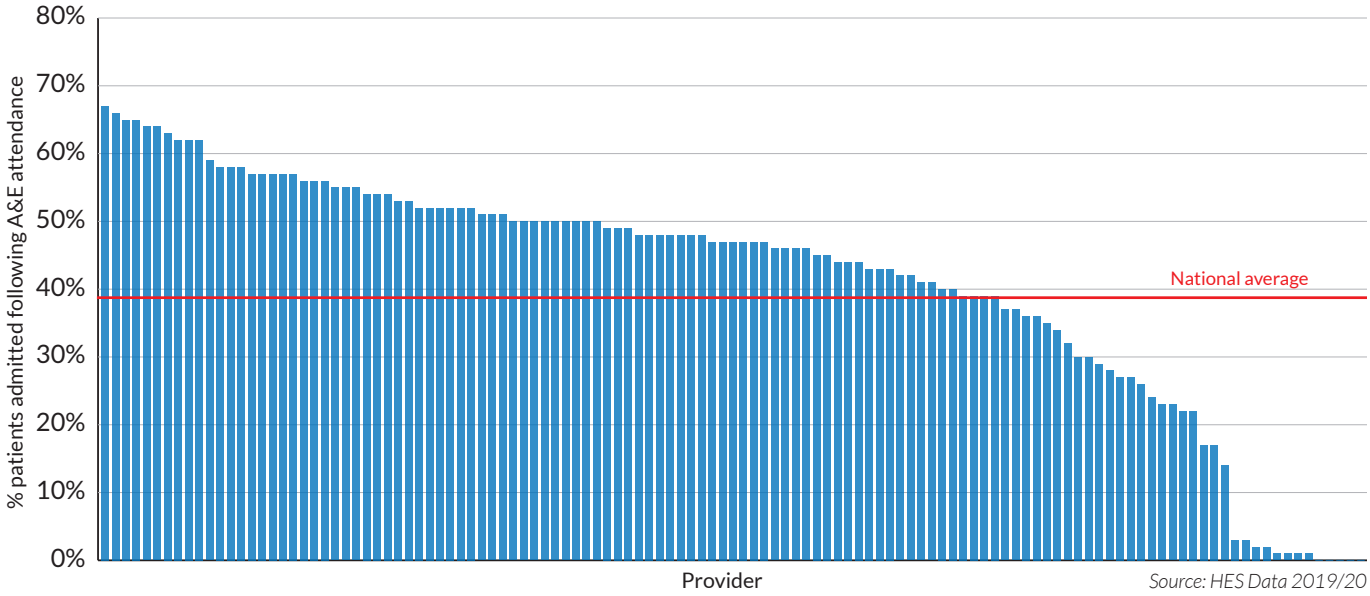
Many people with frailty currently admitted to hospital through A&E don't need inpatient care – estimates range up to 30%. They may be having a short-term crisis, such as a fall, infection or a worsening of dementia, that can be better cared for at home or in the community with support.

These people should be identified through the assessment process and re-directed where it is safe to do so. We found this is happening in some trusts but not others – as reflected in **Figure 12a**, which shows wide variation in the number of people over 75s admitted to hospital after arriving in A&E.

Some trusts are admitting more than 60% of all arrivals in this age group, while others admit very low numbers. Where admissions are high, it may be partly due to the difficulty of identifying other local services which can accept patients at short notice. Where conversion rates appear to be at zero, this is likely to be due to coding errors.

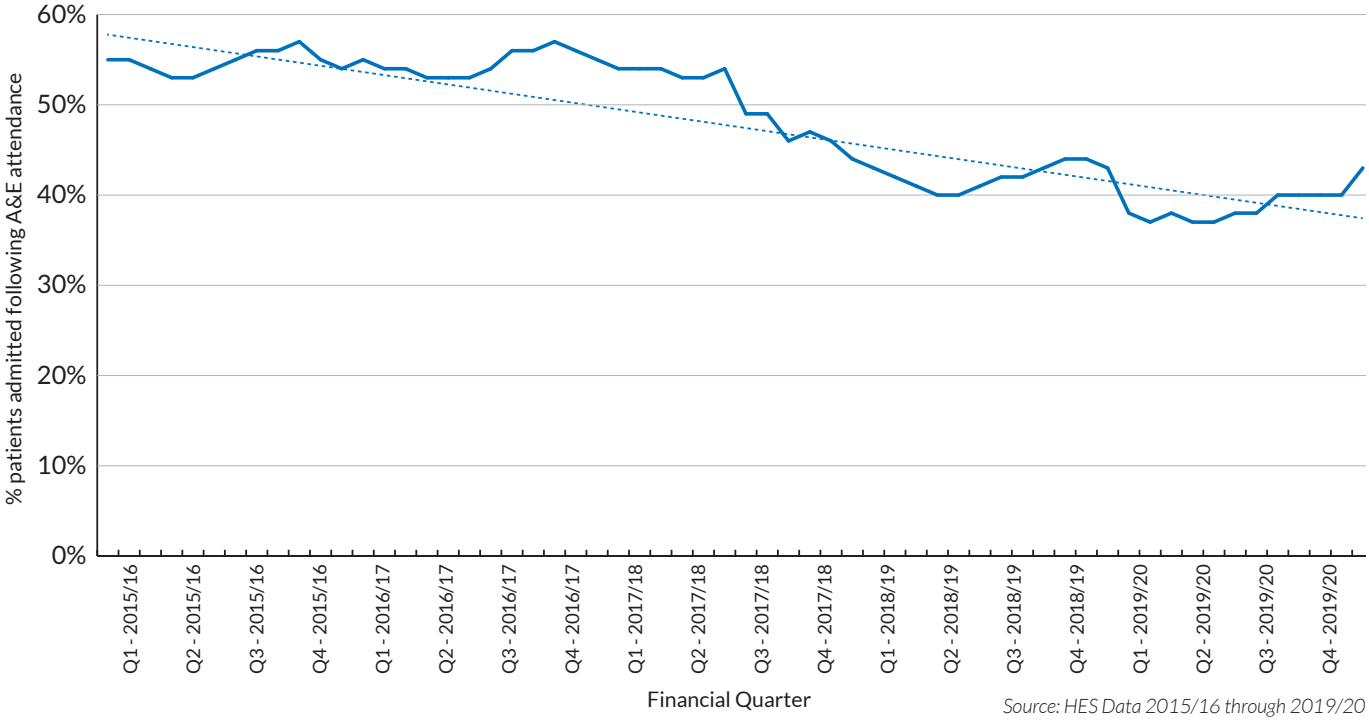
However, it's encouraging to note that the overall trend in A&E conversion rates for over 75s across all trusts is downwards from 2015 to 2019, as shown in **Figure 12b**. This reflects a sustained effort to improve in most trusts, resulting in good progress over the last few years.

Figure 12a: Proportion of patients over 75 admitted to hospital after presenting in A&E by provider



Source: HES Data 2019/20

Figure 12b: Proportion of patients aged over 75 admitted to hospital after presenting in A&E, all providers 2016-2020



Source: HES Data 2015/16 through 2019/20

Assessment linked to same day emergency care

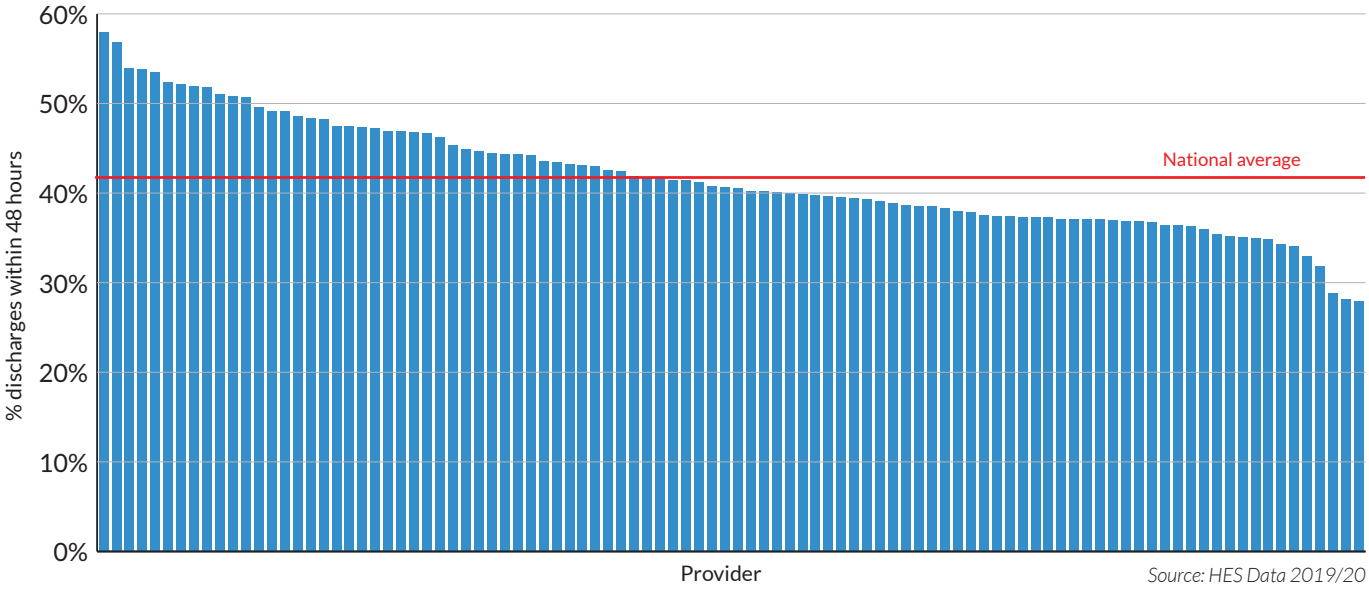
As discussed in *A population-based approach to frailty*, page 27, in some trusts acute frailty teams provide same day emergency care (SDEC)[29] for people presenting in A&E as an alternative to hospital admission. This includes clinical frailty assessment and rapid access to a CGA, linked to treatment and reablement services. SDEC has proved effective in some areas, reducing admissions and overall length of stay and should be extended and adopted wherever possible in line with the ambitions set out in the NHS Long Term Plan. The same day emergency care for frailty team has published a guide to acute frailty assessment[30], which may be useful in developing good practice.

Impact of assessment on early discharge

If frailty is not assessed and identified early, it may have the effect of adding to the time older people with frailty spend in hospital. This, in turn, contributes to the low rates of early discharge. **Figure 13a** shows that, pre-COVID, trusts were discharging an average of 40% of people over 75 within two days of an emergency admission in the medical emergency pathway (including combined specialty admissions in emergency, general and geriatric medicine). There was wide variation, from less than 30% in some trusts to almost 60% at the top end.

Figure 13b shows that although there were slight seasonal variations in discharge rates, dipping in winter and peaking in summer, overall they had remained unchanged over several years pre-COVID, despite widespread efforts to improve over this period. This may be partly because demand had increased overall in recent years, so that, despite improvements in the A&E conversion rate, trusts had been running to stand still.

Figure 13a: Proportion of patients over 75 admitted as medical emergencies who are discharged within 48 hours by provider

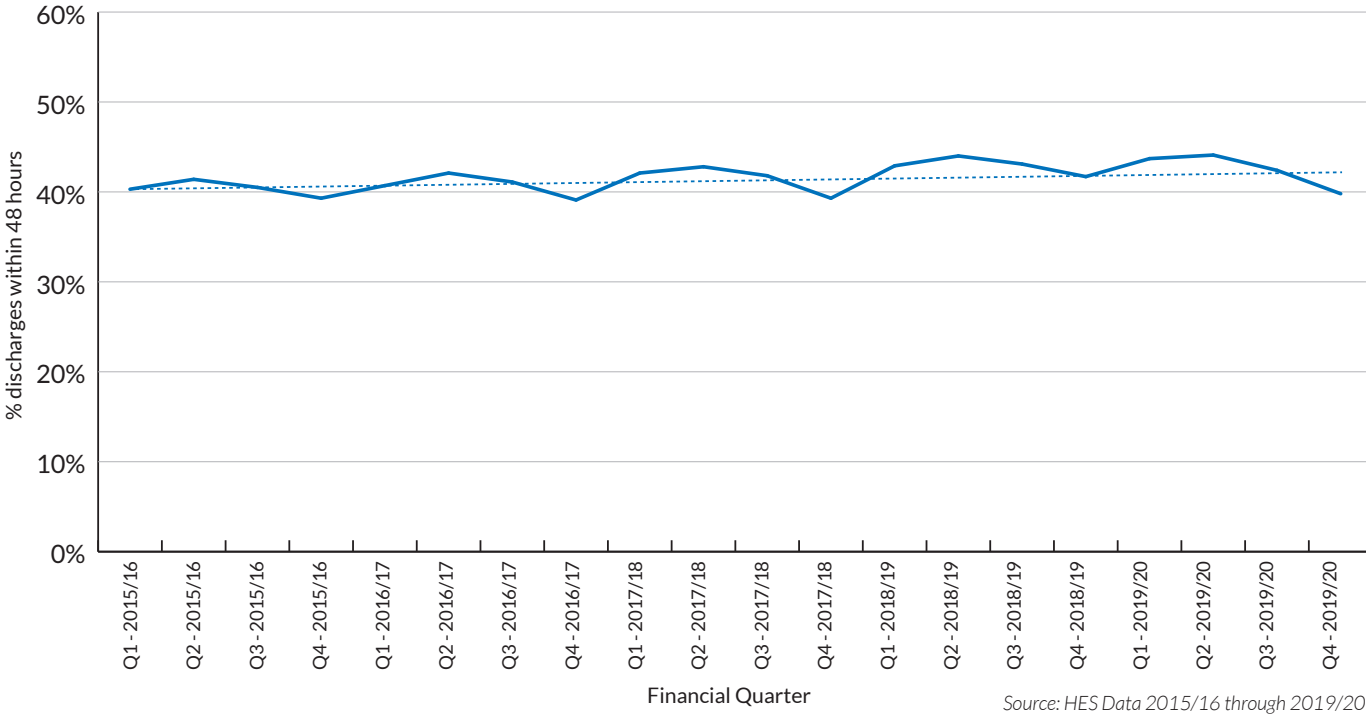


Source: HES Data 2019/20

[29] *https://improvement.nhs.uk/resources/same-day-emergency-care/*

[30] *SDEC frailty guidelines*

Figure 13b: Proportion of patients over 75 admitted as medical emergencies who are discharged within 48 hours, all providers 2015-2020



Source: HES Data 2015/16 through 2019/20

Assessment in the community

In developing local frailty strategies, as discussed in *A population-based approach to frailty*, page 27, trusts should look at ways to promote early assessment in community settings, so people can be supported at an earlier stage to reduce avoidable hospital admissions.

For example, where out-of-hours crisis response services (see *Potential solutions: whole system models of care*, page 34) are commissioned in conjunction with community recovery as an alternative to hospital admission, it's important that CGA is embedded in the pathway.

As envisaged in the NHS Long Term Plan[31], the response service should be provided within two hours of referral (2hours2day). A rapid assessment and effective response could help prevent functional deterioration following acute illness, or reduce the severity of symptoms.

The assessment should be shared in a joined up care plan with the acute and community services including the urgent care service. This, in turn, could avoid the need for admission or reduce the length of stay following admission. These services are in the early stages of development NHS England and NHS Improvement intends to roll them out across the country in the near future.

Early assessment out of hospital can also help identify those who do not have frailty or are mildly frail now, but may be at risk of becoming more frail, and enable support to be provided to prevent them developing frailty in the future.

[31] *NHS Long Term Plan, page 14 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf*

The role of the ambulance service

Ambulance crews are key responders to falls, which is the most common call out for older people. On our deep-dive visits, we saw some examples where CFS is used widely by ambulance crews, and where the person's previous CFS frailty assessment is available to paramedics.

In some cases, ambulance staff use assessments to notify A&E departments about the person's degree of frailty before they arrive – or divert them to another service, such as directly to an acute frailty team, where it is safe to do so. They may also play a role in developing safe alternatives to hospital, for example taking people to a community assessment hub where appropriate – see *Potential solutions: whole system models of care*, page 34.

However, these conveyancing models should be developed carefully. They should follow the triple assessment, including CFS, the 4AT assessment for delirium and the NEWS 2 assessment to identify possible serious illness. Effective governance and support structures are needed to ensure patient safety as serious illness can present non-specifically in older people with frailty.

Wherever possible, care plans including advance care plans, should also be visible to paramedics on board ambulances. The conveyancing practice of ambulances should be reviewed to enable this.

Effective implementation and measurement

It's important that identification and assessment systems are embedded into practice – and at the scale required to support the whole hospital. In many cases, trusts have established a system for acute frailty assessment but do not monitor its use, measure its effectiveness or review whether it is operating at sufficient scale to improve flow in the emergency pathway. Some well-resourced acute frailty teams see relatively small numbers of patients.

This needs to be addressed. All trusts need to embed identification of frailty for all older people attending as an emergency. Whatever system is used needs to be refined, tested and evaluated to make sure it is working at an appropriate scale to meet demand, as well as being clinically effective.

Each trust should monitor and measure a dashboard of metrics over a period of years to evaluate whether early identification and post-admission tracking of frailty is working to improve outcomes. This can be done as part of the metrics monitored within an integrated frailty system – see *Measuring and monitoring progress*, page 38.

The potential for coding frailty to support identification

As discussed in *About our analysis*, page 24, although some frailty syndromes have International Classification of Diseases (ICD) codes, there is no way to record frailty comprehensively as a condition using the ICD system. However, use of frailty identification tools using hospital coded data (Global Frailty Scale, Hospital Frailty Risk Score) can allow creation of a register of patients with frailty as an adjunct to clinical assessment of frailty or the primary care-based eFI. This would make it easier for clinicians to identify groups of patients likely to have frailty and the severity of their frailty.

The register should be based on a comprehensive, data-led approach, that allows the information to be shared across the system, making it easier for everyone involved in the patient's care to track their frailty more easily post-admission and target preventative measures for those at risk of deconditioning.

Recommendation: Identifying frailty early

Recommendation	Actions	Owners	Timescale
2. All trusts must assess all older people arriving in the emergency pathway for frailty using the Clinical Frailty Scale and use this to track them through the hospital if they are admitted. Wherever possible this should be an electronic system linked to the electronic patient record and used as part of a system-wide frailty strategy.	**a** GIRFT to support ICS/STPs in implementing the use of CFS in trusts.	GIRFT, ICS/STPs, NHSE/I	A year after report publication
	b Trusts to ensure that a person's CFS score is recorded in the patient record in line with NICE guidelines, is portable and visible to everyone involved in their care, and that trust level data derived from the CFS is available across the wider frailty system.	Trusts, ICS/STPs	Within a year of publication
	c Trusts to communicate the CFS score to the patient and/or their GP following assessment and include it in discharge letters to the GP. This should be accompanied by clear follow up actions for the individual to prevent deterioration and avoid A&E attendance and admissions.	Trusts, ICS/STPs	Within a year of publication
	d Trust to develop dashboard of metrics for internal review and use them to monitor and measure progress within the hospital.	Trusts, ICS/STPs	For progress a year after publication

Reducing the risk of hospital-acquired deconditioning

Hospital-acquired deconditioning is a major risk for older people with frailty admitted to hospital. Many patients with frailty will spend most of their time in bed and only walk a few steps a day, which, when combined with acute illness, produces a rapid loss of mobility and muscle strength.

Poor management of frailty can lead to deconditioning syndromes such as reduced mobility, as well as decline in physical and cognitive function, which in turn causes extended length of stay. Around a third of older people with frailty experience functional decline during their stay[32]. It's estimated that a week's admission to hospital is worth ten years of ageing. As we've seen in *A population-based approach to frailty* (page 49), extended hospitalisation of older people with frailty also comes a high cost to the NHS in terms of bed occupancy and the overall cost of care (see **Figures 7** and **8**).

After patients are assessed using the CFS, their frailty score should follow them through their hospital journey, so staff can proactively manage their frailty to prevent it getting worse. Those identified as having frailty who are subsequently admitted should be referred for a Comprehensive Geriatric Assessment (CGA) to check for the presence of other age-related syndromes.

Both the CFS and CGA should be part of a hospital-wide system such as electronic patient record (EPR) where this is available (see Recommendation 3).

Preventing progression of frailty

Support should be provided for anyone with mild (CFS 5) or moderate frailty (CFS 6) to prevent them becoming severely frail and more dependent . This can be as simple as ensuring that all those who are capable get up, get dressed and get moving each day – following the principles of the national End PJ Paralysis campaign[33]. It requires:

- space and facilities to get people moving, including chairs and walking aids such as frames and sticks;
- a patient-centred approach and team-wide recognition that frailty is everyone's business.

It's important that this support is targeted within 48 hours of admission when prevention will be most effective. All patients over 75 should have a mobilisation plan implemented within this period.

People scoring 5 and 6 on the Clinical Frailty Scale (CFS) (see *Frailty assessment tools and support*, page 41) face the greatest immediate risk of deconditioning, and should be regularly monitored during their admission. If these patients progress to a CFS score of 7 or 8, they are becoming severely frail and may need high levels of resource and often have extended stays in hospital.

As frailty is a spectrum condition, a patient can be at risk of frailty and subsequent deconditioning in hospital without having mild or moderate frailty when assessed with CFS. The approach outlined here focuses attention where there is the greatest known clinical need, in the expectation that a responsive approach to managing moderate to severe frailty will have a broader benefit for patients using the same services who are at risk of frailty.

Variation in practice and facilities

On our deep-dive visits, we found examples of good practice where trusts are helping older adults avoid deconditioning. These include registered nurses and healthcare assistants (HCAs) using day rooms to get people moving with support from physiotherapists. Some trusts we visited carry out weekly spot audits to check how many patients are out of bed.

However, we also found many places where this is not happening. Often, this is due to a lack of simple equipment such as appropriate chairs and walking aids to enable people to get out of bed, lack of space to enable movement, or a shortage of moving and handling equipment, including hoist slings, needed to support patients with severe frailty in the early stages of rehabilitation.

The risks of inactivity are higher in hospitals where the numbers of specialist old age beds is low. This can mean patients are admitted to general or medical specialty wards, where staff may not have the same focus on frailty and may not have the time or facilities to aid mobility. In some trusts, older patients with frailty may be scattered across multiple medical specialty wards and this can increase their risk of deconditioning.

[32] *See footnote 12*

[33] *https://7endpjparalysis.org/*

While the use of the CFS can allow tracking of patients at high risk of deconditioning and liaison teams may support with advice, this may not be sufficient if the culture of a ward doesn't support mobilisation and recuperative rehabilitation of their older patients living with frailty.

We understand that limited resources and busy workloads can make it difficult to offer daily mobility support. However, we think it should be made a high patient-centred priority, given the increased costs of care if patients deteriorate and need longer stays in hospital as a result.

In particular, chairs and walking aids are relatively cheap compared to the cost of extra bed days if patients have to stay in hospital for a prolonged period. Likewise, trusts should ensure that people with frailty have clothes to change into when they get out of bed. Wearing hospital gowns reinforces being ill and sedentary and older people can feel a loss of dignity walking in them.

As discussed below, if patients are not supported and discharged as soon as they are fit, many end up remaining in hospital for more than 21 days. A small amount of extra resource for people with frailty can lead to a significant reduction in the length of stay and an overall saving to the NHS.

Reducing delays in mobility assessment and support

Prevention is often best led by physiotherapists and occupational therapists, with appropriate blending of skills and multidisciplinary working to ensure that support is not held up waiting for a particular discipline or member of staff.

Ideally patients identified with frailty should have their mobility needs assessed by a physiotherapist in the first instance. However, where physiotherapists do not have the capacity to do this quickly, and where the patient does not have serious impairment, mobility assessment, support and equipment should be provided by other appropriately trained members of the ward team.

On our deep-dive visits, we have heard of patients waiting several days for mobility assessment by a physiotherapist, or for provision of walking aids, during which time they may suffer iatrogenic damage. Often ward staff do not feel qualified or empowered to offer support.

We need a more patient-centred approach in which prevention of deconditioning is integrated into the business as usual activities of wards, so that teams can take preventative action quickly as appropriate. Having basic frailty education and training for all clinical staff would help them develop confidence in offering mobility support – as discussed in *Basic frailty training for all patient-facing staff*, page 60.

As discussed above, walking aids are relatively cheap and should be made readily available for staff, given the potential costs to the health system from deconditioning. We support the recommendation from the National Audit of Inpatient Falls (NAIF) that walking aids should be given to all new patients who need them[34].

Trusts should also use electronic health records (EHRs) to allow data on patients to be shared efficiently between different specialties and professionals. This allows patients identified as at risk of deconditioning from a CFS assessment or a frailty register, to be targeted with timely interventions.

[34] *National Audit of Inpatient Falls Audit Report 2020, recommendation 3*
https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif-2020-annual-report

Increased risk of deconditioning above 21 days

Figure 14a shows that, in around a third of trusts, more than 10% of all patients over 75 admitted to hospital are staying longer than 21 days (known as super-stranded), by which time the risks of deconditioning are significantly increased. On average, 20% of all people with frailty admitted as an emergency stay more than 21 days.

There is considerable variation between the best and worst performing trusts, with many trusts successful in reducing length of stay and the proportion of patients staying more than 21 days in this age group. Overall, the long-term trend is positive as shown in **Figure 14b**.

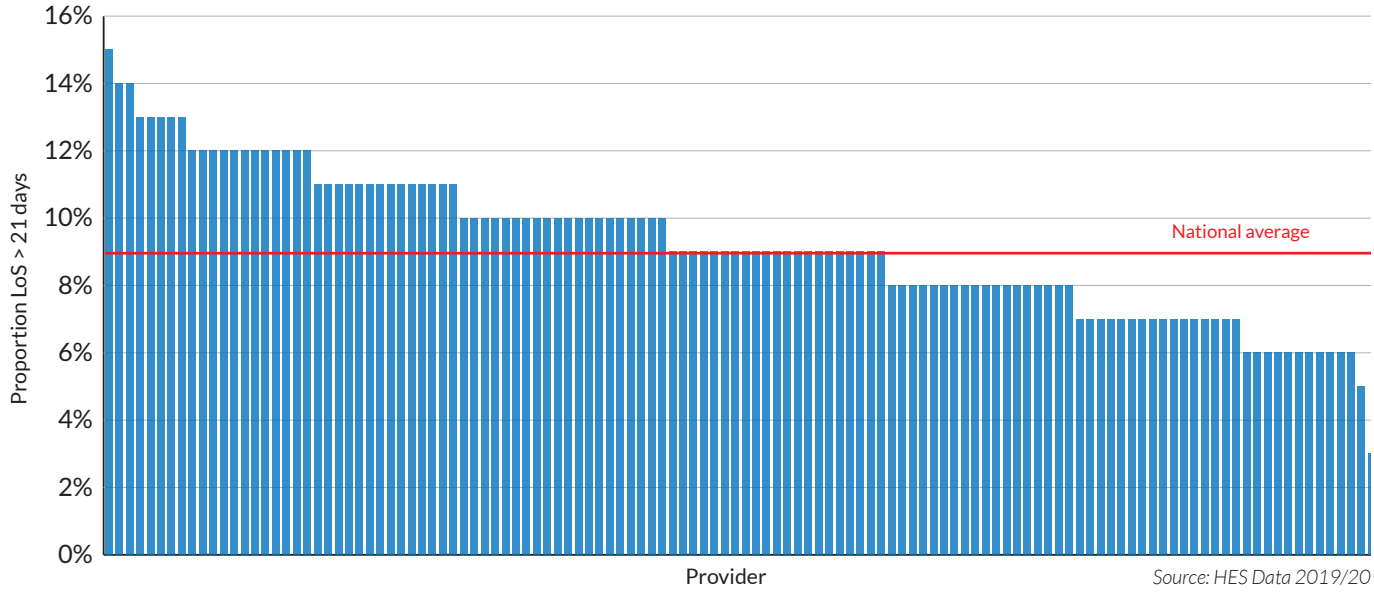
On average, people over 75 admitted through the emergency pathway who are in hospital for 21 days stay an added 19 days, bringing average total stay to 40 days. At the top end of the range, patients with frailty stay an additional 29 days.

These patients use a high proportion of total hospital bed days. Super-stranded patients over 75 account for approximately 45% of all bed days occupied by older patients in the emergency pathway, and 60% of all beds days occupied by patients with frailty over 75[35]. Preventing deconditioning therefore represents a huge opportunity to both improve outcomes for a vulnerable group of patients, while also releasing bed capacity and reducing costs. We calculate the potential saving in bed days from getting older patients moving and supporting their safe discharge could be more than £210 million – see *Notional financial opportunities*, page 113.

While some extended stays are necessary for medical reasons, in many cases, the need for continued hospitalisation could be reduced significantly with preventative treatment and support. One issue that may contribute to extended stays is the lack of weekend cover to support assessment and early mobilisation on the wards, and lack of weekend and out-of-hours cover by a specialist acute frailty team so that initial triaging such as CFS assessment is not performed.

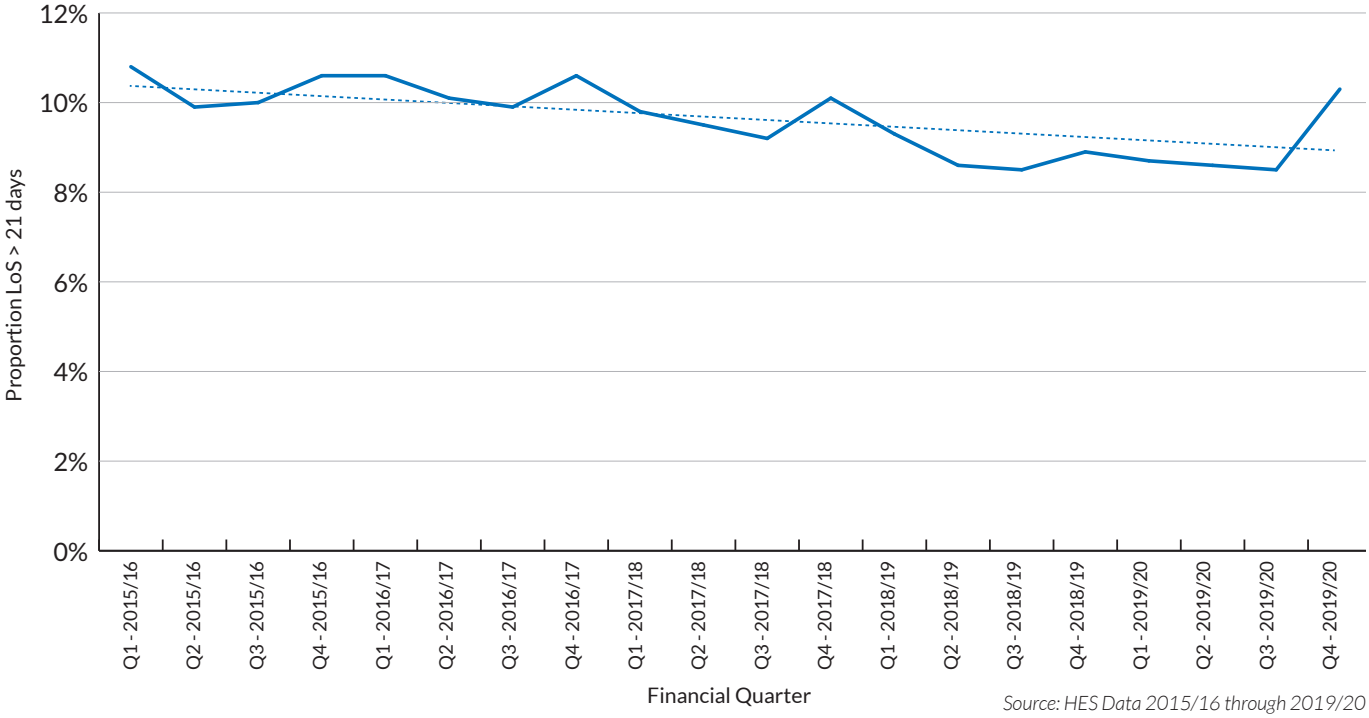
Provision of adequate physiotherapy and occupational therapy for those who need it may also be a factor, especially at weekends. There is considerable variation in the provision of seven-day services for older adult patients around the country.

Figure 14a: Proportion of people over 75 admitted to hospital, elective and non-elective, who stay longer than 21 days by provider



Source: HES Data 2019/20

Figure 14b: Proportion of people over 75 admitted to hospital, elective and non-elective, who stay longer than 21 days, all providers 2015-2020



Source: HES Data 2015/16 through 2019/20

Reducing the risk of deconditioning in other specialties

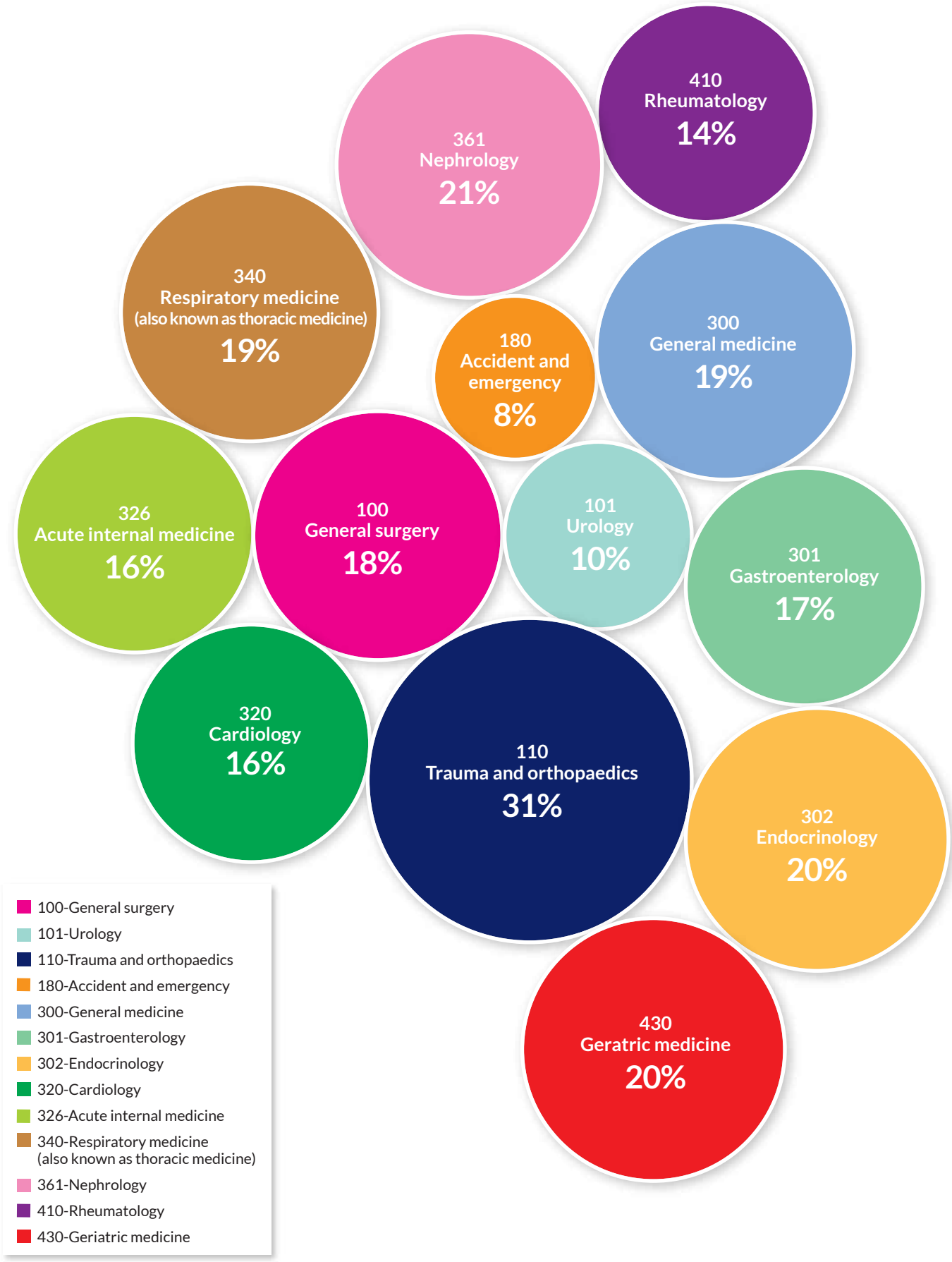
Older people with frailty are treated in many specialties other than geriatric medicine or in the medical emergency pathway. Average length of stay is high in some of these departments. For example, more than 30% of people with frailty over 75 in orthopaedics stay longer than 21 days – as shown in **Figure 15**. The recent National Audit of Inpatient Falls audit report found that only 21% of falls in hospitals happen in care of older people wards, with the rest spread among other specialties[36].

Specialist older people's liaison support into these departments using CGA can help ensure that frailty is understood and recognised, reducing the risks of deconditioning and extended length of stay. Trusts should ensure that systems to monitor patients identified as having frailty are linked to a liaison model with geriatric medicine.

However, as discussed above, everyone can contribute to deconditioning prevention. It should become part of the culture and practice of the whole hospital, not just specialist geriatricians on care of older people teams. These efforts should be accompanied by a commitment to make hospitals frailty-friendly, providing the space and facilities needed for people with frailty to get mobile and to support training for all staff in frailty management

[36] *National Audit of Inpatient Falls audit report 2020 https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif-2020-annual-report*

Figure 15: Proportion of patients with frailty over 75 staying longer than 21 days in hospital by specialty, elective and non-elective (specialties with more than 4,000 admissions and more than 2% super-stranded only included



Source: Hospital Episode Statistics 2019-20

CASE STUDY

Reducing the risks of deconditioning through awareness and resources

University Hospitals of North Midlands NHS Trust

The older adults team at UHNM developed a high impact campaign and practical resources to raise awareness of the risks of deconditioning and promote prevention among clinicians and patients.

The team had identified that prolonged bed rest and lack of activity was leading to delayed recovery of many older inpatients. They started a social media campaign, using Twitter and Vimeo, to raise awareness of the risks and developed useful information and resources for patients, clinicians and carers. These included practical guides to staying active while in hospital, bed and chair exercises, and the mobility aids and support available in the hospital.

The team invited patient groups to a deconditioning awareness and prevention event and shared the materials and resources the wider health system to promote deconditioning prevention at home and in care homes. The trust has since developed a deconditioning care bundle and incorporated it into its Comprehensive Geriatric Assessment (CGA) booklet, further increasing awareness and spread of good practice across all wards.

Results

Awareness of deconditioning risks has increased across the trust. The campaign has since been adopted by many other trusts and the materials have been requested more than 40 hospitals across England.

Keeping people with frailty safe in hospital

Because the existing benchmarking data on safety measures is poor, we did not explore patient safety in depth during our deep-dive visits. However, hospital-acquired harm is a potential cause of extended length of stay and a significant source of patient complaints and litigation.

Older people with frailty are more vulnerable to inpatient harms including those caused by falls, medicine misadventures, nutrition and swallowing issues, pressure ulcers, catheter-related urinary infections, and hospital-acquired infections such as C-Difficile or norovirus.

Often these are issues are linked – for example if patients do not receive the right medication at the right time, they may experience uncontrolled pain, which is a major cause of delirium, which in turn causes unstable frail people to fall. Likewise, low blood pressure is a major factor in immobility and may cause dizziness and nausea, which also drive falls.

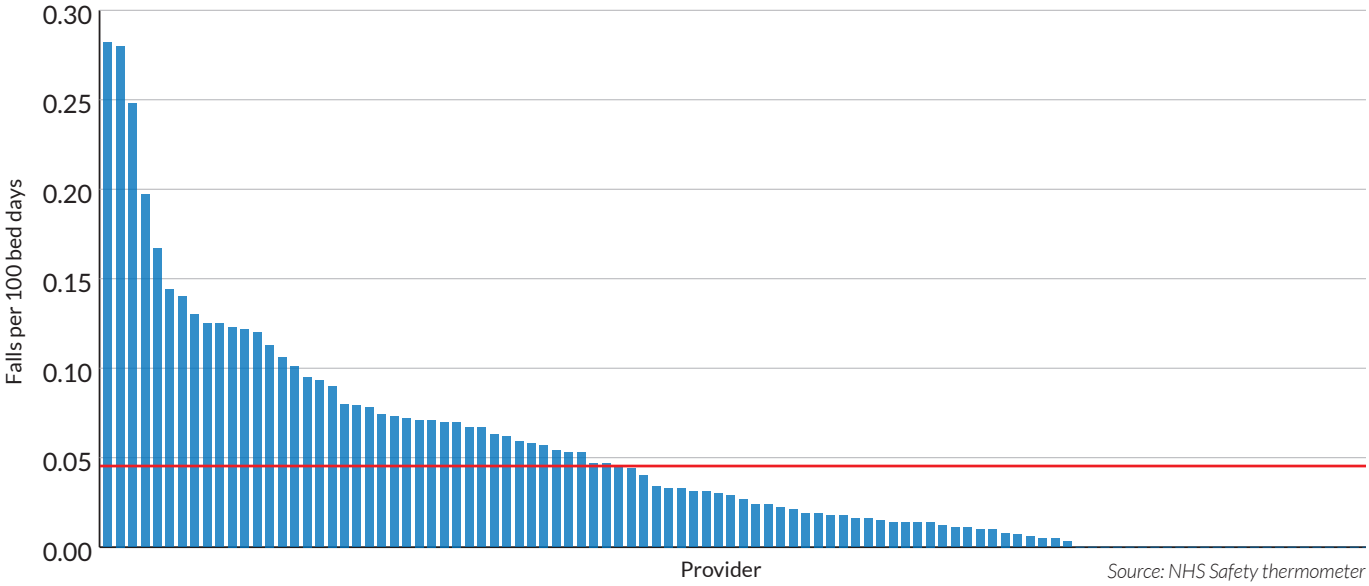
It's important that post-admission tracking of frailty checks for these risks and that trusts take proactive steps to prevent them. Trusts must ensure that staff who administer drugs to people with frailty are aware of their frailty and the potential harms that might result from any delays or errors. Trusts should measure and report on harms caused to people with frailty from drugs.

As discussed in *Improving the dementia and delirium pathways*, (page 63) all patients over 65 should be assessed for delirium and proper safeguards put in place. Trusts should also track and measure data on hospital-acquired harms such as infections – including catheter-associated urinary tract infections (CAUTI) – and pressure ulcers.

Preventing inpatient falls

Falls are more likely to cause fractures and injuries in people who have frailty and are one of the major sources of litigation related to older people with frailty (see *Reducing the impact of litigation*, page 110). **Figure 16** show the rate of falls among inpatients on geriatric medicine wards. Although there are issues with the quality of this data due to inconsistencies in the way falls are reported, the chart clearly shows that inpatient falls are common and that there is wide variation.

Figure 16: Inpatient falls per 1,000 bed days in care of older people wards, elective and non-elective, 2017-18



Source: NHS Safety thermometer

Older people who present in hospital as unsteady, or who have had previous reported falls, should be given a thorough assessment, including assessment of gait, balance and mobility, in line with the NICE guideline on preventing falls in hospital[37].

Simple tests such as the lying and standing blood pressure assessment, to detect sudden drops in blood pressure, can help to prevent episodes of low blood pressure and reduce immobility and falls. Although this measure is widely known, we have found it is not well used and measurement of this risk factor is poor, particularly the measurement at three minutes after standing as well as immediately after standing.

The test can be easily done by nurses, HCAs or any member of the ward team and should be embedded into everyday practice. In some cases, it may require two people to carry out the assessment and trusts should allocate enough resource to ensure this can be done safely. If there is significant low blood pressure, staff should take measures to alleviate it and reduce unsteadiness, thereby helping to prevent falls and potentially improve mobilisation.

[37] *Falls in older people: assessing risk and prevention Clinical Guideline CG161, recommendation 1.2 https://www.nice.org.uk/guidance/cg161/chapter/recommendations#preventing-falls-in-older-people-during-a-hospital-stay-2*

Ensuring good nutrition

Under-nutrition causing unplanned weight loss can contribute towards the progression of frailty. Likewise obesity can increase people's health risks. However, these risk factors are not always well monitored, even where the person has had a CGA. Therefore, all older people admitted to hospital should be screened on admission using the Malnutrition Universal Screening Tool (MUST) to identify those who have experience recent unplanned weight loss, are malnourished, at risk of malnourishment or obese. Most hospitals we visited use MUST screening but we did not have good data to determine the effectiveness of the pathways linked to this assessment.

Where risk of under-nutrition is identified there should be a care pathway, which may link to dietician review and follow-up after discharge. If they are unable to swallow, they may need a specialist assessment by a speech and language therapist. Good mouth care is important and should be part of routine nursing practice.

If the patient has a risk of aspiration of food or fluids going into the lungs due to an unsafe swallow, a shared decision to feed may be appropriate, known as feeding at risk. This process can be supported by decision support tools such as the FORWARD care bundle[38] to maximise the care and comfort of these patients. Prolonged periods of nil by mouth should be avoided wherever possible as this can increase the risks of deconditioning. Diet and nutrition should form part of safe discharge and be included in care and rehabilitation plans.

Potential solution

Much patient safety and quality work is focused on specifics such as falls or pressure ulcer prevention rather than taking an integrated approach focused on patients who are at high and multiple risks. We think that the quality of care for people living with frailty should become a priority at trust level, led by a senior clinician who is the accountable officer for the quality of care of people with frailty in hospital. Their role could include:

- monitoring progress and reporting to the trust board on key frailty safety metrics;
- developing prevention strategies;
- co-ordinating expert input from specialists in frailty domains such as falls, dementia, nutrition and pressure ulcers;
- making the hospital more frailty-friendly to reduce deconditioning;
- promoting a culture of frailty safety among all staff;
- liaising with patient and carer representatives;
- monitoring and promoting quality of care issues and improvements identified throughout this report.

As part of the reporting function, there should be a scorecard of safety metrics which could be linked to the Clinical Frailty Scale and/or the Hospital Frailty Risk Score (HFRS), which, in turn, can be linked to the Frailty Opportunity Identifier Tool – see *How is frailty identified?*, page 28. This would help identify which patients are at risk of frailty-related harms, where they are, and what are the safety issues that may increase their risks, with the potential to create a powerful dataset to drive improvements in patient pathways and prevention.

[38] *https://clinicalnutritionespen.com/article/S2405-4577(17)30327-3/fulltext*

Recommendations: Reducing hospital-acquired deconditioning

Recommendation	Actions	Owners	Timescale
3. Trusts should identify patients with moderate frailty in all admission wards and take action to prevent them from becoming more functionally dependent. This includes providing space and equipment such as chairs and walking aids for daily mobility support, developing a culture where all ward staff can provide that support and where frailty is everyone's responsibility, and measuring progress against key metrics over a sustained period.	**a** GIRFT will support trusts to use the Clinical Frailty Scale (CFS) to identify those at level 5/6 on the scale and intervene early, and ensure that both the person's CFS score and CGA assessment are available as part of an electronic system linked to their patient record.	GIRFT, ICS/STPs, NHSE/I	Within a year of report publication
	b Trusts to ensure that each patient over 75 identified with frailty has a mobilisation plan within 48 hours of admission.	Trusts, ICS/STPs	Within 6 months of report publication
	c GIRFT will work with Model Hospital to ensure that trusts can benchmark their performance against others.	GIRFT, Model Hospital	Within a year of publication
4. Each trust should appoint a senior member of staff who is the accountable officer leading on the quality of care for older people with frailty while in hospital, linked to ICS/STPs and local networks. They should report to the board across key frailty safety domains, and use this information to help develop and refine the system-wide frailty strategy.	**a** GIRFT will support trust management to identify accountable officers.	GIRFT, trusts, ICS/STPs	Within 6 months of report publication
	b GIRFT to support trusts to develop a dashboard of key frailty safety metrics including: • deconditioning • delirium response • dementia safety • inpatient falls • nutrition • pressure ulcers • medicines safety • safe discharge • catheter safety using existing dashboards as a base and explore how this can be linked to the Clinical Frailty Scale and/or the Hospital Frailty Risk Score/Frailty Opportunity Identifier Tool.	GIRFT, trusts, ICS/STPs	For progress within a year of publication

Basic frailty training for all patient-facing staff

Older people with frailty may come to hospital for a variety of reasons other than their frailty, often related to other long-term conditions and illnesses. With advances in medicine, age is no longer a factor in deciding on many forms of treatment. This means that older people with frailty who would previously have been considered unfit for elective treatment or surgery are now being treated.

As a result, there are people with frailty in all adult specialties, being cared for by a range of healthcare staff in surgical and medical specialties who do not have experience in geriatric medicine.

Likewise, people with frailty are being seen and treated in a variety of primary and community care settings by a range of allied health professionals and other staff.

It is therefore important that everyone involved in their care have some basic training to make sure that they understand frailty, spot the risk factors and can take action to prevent deconditioning while patients are in their care.

Specialties such as emergency medicine, acute internal medicine and acute general medicine also play a central role in assessing frailty and delivering geriatric medicine services, especially at weekends and out-of-hours. It is particularly important that staff in these specialties have a good level of frailty training and awareness.

Levels of frailty awareness

The Frailty Capabilities Framework[39] developed by Skills for Health in partnership with NHS England and NHS Improvement and Health Education England, sets out three levels of awareness that staff should have depending on where they work and their job role – level 1 being a basic understanding of frailty, and level 3 a high level of competence.

Frailty Capabilities Framework

The core capabilities described in the framework are defined for three tiers.

Tier 1 Basic frailty training for those that require a general awareness of frailty.

Tier 2 Clinicians such as emergency medicine and acute internal medicine consultants/specialist staff, as well as 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.

Tier 3 Acute internal medicine consultants/specialist staff regularly providing specialised frailty assessment services, 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.

Variation in basic frailty training

We have found variation in how this framework is used in practice. As shown in **Table 1**, there is no consistent pattern of frailty training across the country. An analysis of responses from 90 trusts to the NHS Benchmarking Network's Managing Frailty project shows that less than half (45%) of trusts have a basic frailty awareness training programme for staff. Even fewer (22%) have a programme for consultants and other senior staff. The only awareness training that is provided almost everywhere is on dementia.

On our deep-dive visits, some trusts told us they do no frailty training at all and we found that provision is patchy in many areas.

[39] *https://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework*

Table 1: Collated responses from trusts on frailty assessment training.

Question	Hospitals in survey	Responses	Response rate	# Yes	% Yes
Does the Trust/UHB/Hospital site participate in a consultant practitioner trainee programme?	90	63	70%	14	22%
Does the Trust have specific dementia training for all staff?	90	70	78%	68	97%
Does the Trust/UHB/Hospital site provide any training on frailty specifically for the surgical specialties?	90	70	78%	22	31%
Does the Trust/UHB/Hospital site provide a frailty identification / awareness training programme?	90	67	74%	30	45%
Does the Trust/UHB/Hospital site provide training on how to identify / screen for people living with frailty?	90	66	73%	34	52%
Does the Trust/UHB/Hospital site provide training on how to assess and manage people living with frailty?	90	65	72%	22	34%

Source: NHS Benchmarking collection 2019

Impact on patient care

Often staff who are not trained in frailty don't know how to recognise or manage delirium or other common symptoms linked to frailty. They may put people at risk by under-estimating, or not recognising common frailty-linked problems, or react by being over-cautious and keeping patients in bed too long, adding to their risk of deconditioning. If surgical teams are not aware of a patient's frailty it can lead to increased risk of frailty-related complications following surgery.

Potential solution

We believe a basic level of frailty training – tier 1 on the Frailty Capabilities Framework – for staff across all hospital specialties and primary and community care settings could result in big improvements in the quality of care for older people with frailty. It would enable more staff to assess and recognise frailty and delirium, help them reduce the risks of deconditioning, and contribute to safe discharge from hospital.

We have seen some interesting examples of how this can be done, from a one day intensive 'frailty boot camp' to training added to staff induction programmes when they join the service.

Wessex regional system-wide collaboration

In the Wessex region, eight trusts worked with the Wessex Academic Health Science Network (AHSN) and local partners to develop tier 1 training in frailty for the whole health and care system as part of the Wessex Healthy Ageing Programme. This followed a regional frailty audit, which identified unmet training need. The team developed a methodology to standardise training and language around frailty across all providers. The resulting e-learning package, which will be available during 2021, is supported by education resources, leaflets, posters and training materials, which can be downloaded from the website[40].

Whatever system is adopted, it's important that it is universal, well embedded across the health system – and potentially also social care – and quality assured and supported by leadership.

[40] *https://wessexahsn.org.uk/projects/315/wessex-acute-frailty-education-and-awareness*

CASE STUDY

Working with educators to develop system-wide frailty training

Kettering General Hospital NHS Foundation Trust/Northampton General Hospital NHS Trust

The trusts worked with the local university to develop frailty awareness e-learning packages for hospital staff, first responders and carers, and a training programme for senior clinicians and leaders.

Kettering and Northampton are part of a frailty collaboration with social care and the voluntary sector, which aims to reduce the need for hospital admissions and get people the care and support they need to live well out of hospital. Frailty education was identified as a key priority to support this transformation.

The system-wide team applied for funding through Health Education England, which they topped up from their local workforce development fund to develop training based on the tiers of the Frailty Capabilities Framework.

They worked with educators at the University of Northampton to develop a 90-minute basic frailty awareness module (tier 1) and a 60-minute falls prevention module, which can be completed conveniently online. They also developed a blended learning programme for senior clinicians and leaders (tier 3), including interactive seminars using virtual reality and simulation to develop professional decision making, inter-professional collaboration and leadership skills.

Results

Programme rollout was interrupted by COVID-19 but is due to complete during 2021. It is expected to improve both basic frailty awareness and leadership, helping to embed new frailty care pathways and system-wide improvement.

Recommendation: Frailty training

Recommendation	Actions	Owners	Timescale
5. All patient-facing staff within a local health system should be given basic training in frailty at Level 1 on the Frailty Capabilities Framework.	**a** GIRFT will work local systems to audit their training requirements to ensure all patient-facing staff within an ICS/STP has access to level 1 training.	GIRFT, ICS/STPs	Within a year of publication

Improving the dementia and delirium pathways

Dementia is a growing challenge for the health service. Around one third of all beds in acute hospitals are occupied by people with dementia and this figure may increase – it's estimated there will be one million people living with dementia by 2025.

We have found that the dementia pathway is reasonably established in most trusts across England. There are good examples of trusts making their facilities dementia friendly (see case study, page 67), and a growing awareness of the profile of dementia and the needs of people with dementia within hospitals. Most trusts now provide dementia awareness training. These measures have been driven in part by the CQUIN for dementia care which provides incentives for clinical improvement.

However, the progress made in hospital dementia care in recent years is not matched in diagnosis and management of delirium. Delirium is a serious condition which is under-diagnosed and often mismanaged as a result. It is a major factor in inpatient falls and is linked to longer length of stay, as well as being very distressing for patients and their carers.

We have found that many older patients are not having a simple initial assessment for delirium when they arrive in hospital, which means there is no effective management of the underlying cause or symptoms. This is concerning, given that the severity of delirium can be reduced if identified early – and can be prevented with the right support in and out of hospital.

Where patients are not assessed, it's less likely there will be an effective early response mechanism to prevent delirium or an effective management of symptoms that cause risk to patients. It is important that early screening for delirium is linked to an effective and timely pathway to support response.

Variations in delirium assessment

We found that assessment for delirium varies widely from trust to trust and delirium recognition rates are far lower than they should be. Some hospitals have no delirium pathway, while in others it is very poorly embedded.

As shown in **Figure 17**, some trusts are assessing almost all older adult patients, while others are assessing almost none. Although this data, from the National Audit of Inpatient Falls (NAIF)[41], is from 2017, the findings were repeated in a 2018 British Geriatrics Society (BGS) study carried out across 45 UK acute care hospitals[42]. This showed that an average of only 34% of older patients who had delirium were diagnosed on emergency admission across all admitting specialties, with a similar broad variation range to the NAIF. Delirium was less likely to be diagnosed in patients with a higher degree of frailty. Where the 4AT screening tool was used (see *4AT delirium assessment*, page 65), this increased delirium recognition on arrival.

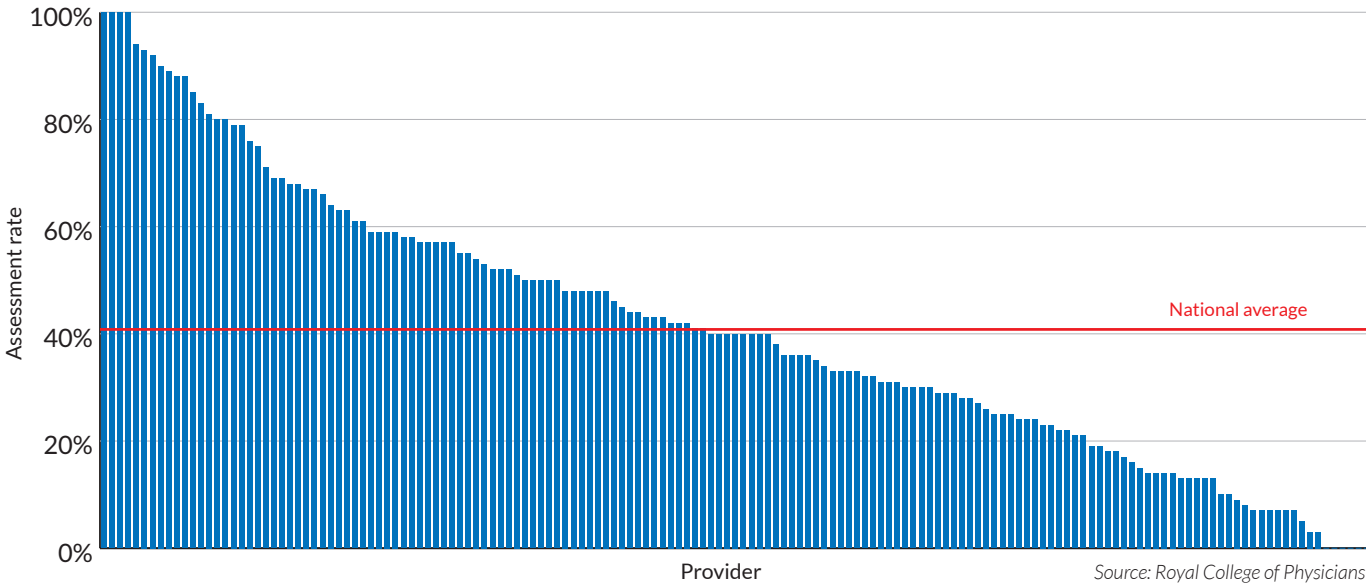
Overall, we found that the national rate of delirium recognition on emergency admission to hospital is poor, averaging 40%[43]. This pattern of variation was borne out on our deep-dive visits. We saw examples where the delirium assessment was introduced but its use was not sustained after initial successful implementation. We also found examples where two hospitals within the same trust had very different rates of delirium assessment.

[41] *National Audit of Inpatient Falls 2017. See https://www.fffap.org.uk/falls/naifweb.nsf/Falls_Rep_2017.pdf*

[42] *Welch, C., McCluskey, L., Wilson, D. et al. Delirium is prevalent in older hospital inpatients and associated with adverse outcomes: results of a prospective multi-centre study on World Delirium Awareness Day. BMC Med 17, 229 (2019). https://doi.org/10.1186/s12916-019-1458-7*

[43] *Hospital Episode Statistics*

Figure 17: Variation in delirium assessment rates by provider, emergency pathway



Source: Royal College of Physicians
National Audit of Inpatient Falls, November 2017

Why is assessment not happening?

One issue may be the availability of the acute frailty team to perform the assessment. In some hospitals, delirium assessment is done exclusively by this team, usually working 9am to 5pm.. If patients arrive out of hours, they may not be assessed, as other staff may be too busy, or reluctant to perform the test. It may be due to lack of time or awareness, or because staff feel that assessing frailty and delirium is not within their competence.

Some cases of complex delirium require specialist assessment, which should be supported by an old age psychiatry team. Trusts should ensure that the delirium pathway enables access to this service in a timely manner when needed.

Embedding assessment across all specialties

Many people with frailty will be assessed by specialties other than geriatric medicine. For example if they arrive in A&E or are admitted out of hours or at the weekend, they will be seen by emergency or acute medicine teams or by surgical teams. It is vital that delirium assessment is embedded in the practice of these teams, linked to rapid and effective response.

Many patients are also admitted from A&E to different medical or surgical specialties depending on their illness. The 2018 BGS study mentioned on page 63 has also shown that assessment on emergency admission varies depending on the specialty of admission. For example, in surgical specialties, older people are less likely to be screened for delirium. This is also true for some medical specialties.

Older people are also having more elective surgery today than ever before and they form a large proportion of patients in areas such as orthopaedics and cardiology. It's important that delirium assessment is embedded in these pathways, especially in hospitals where the service model means large numbers of people with frailty are admitted to medical specialty wards.

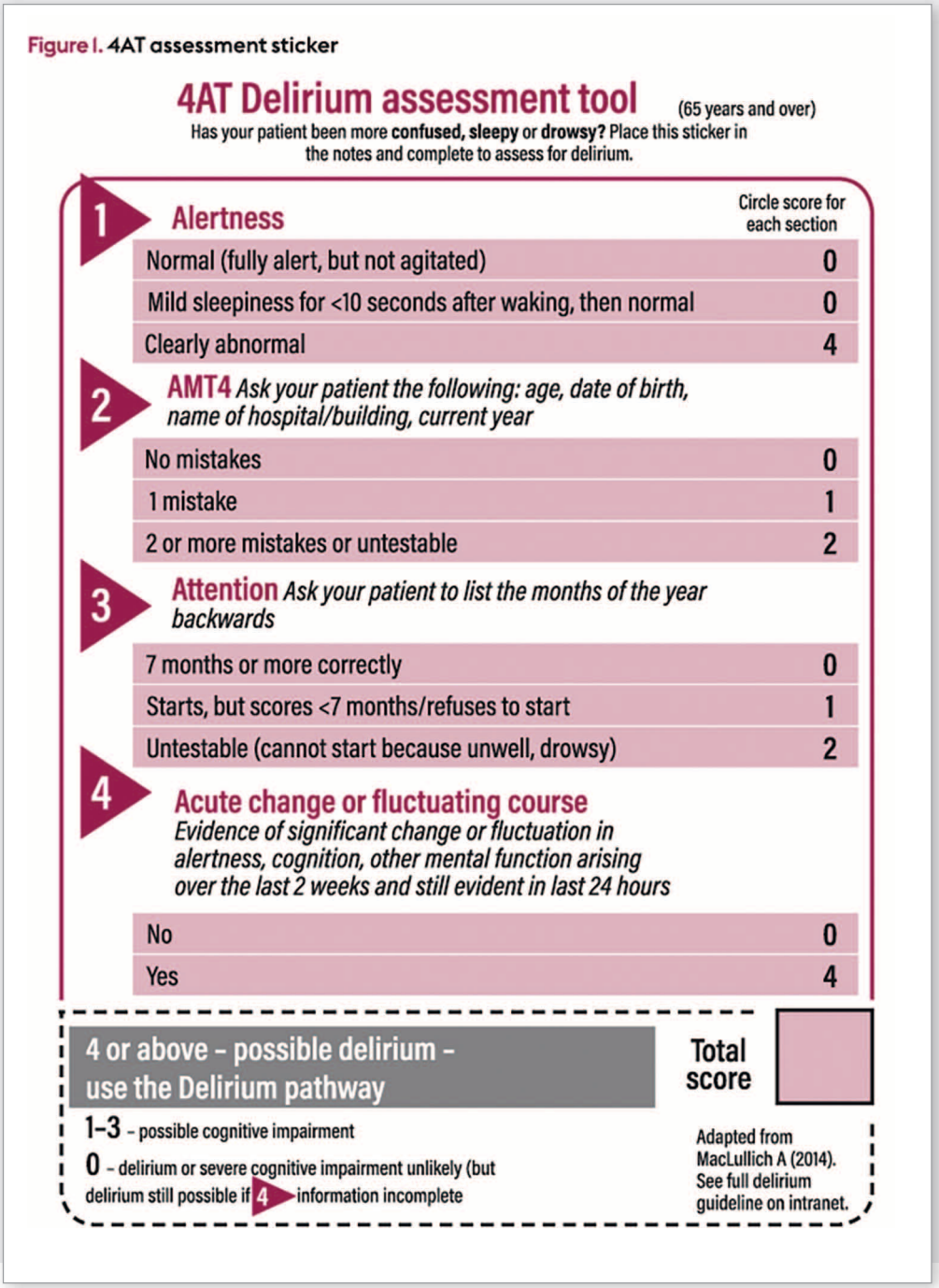
4AT delrium assessment

Older adults should be assessed using 4AT on arrival in hospital to identify delirium and/or cognitive impairment. A high score should trigger early intervention and proactive management throughout the inpatient journey. 4AT is the recognised assessment for initial rapid assessment of delirium and cognitive impairment. It is based on four assessments:

1. Alertness, normal to abnormal.
2. Awareness of age, date of birth, place and current year.
3. Attention measured by ability to list the months of the year backwards.
4. Acute change or fluctuation in alertness and mental function.

Patients are scored according to the scales shown below with scores of 4 and above indicating possible delirium.

Figure I. 4AT assessment sticker



Potential solutions

Trusts need to establish a clear pathway for both recognition and response to delirium, which includes 4AT assessment for all older people coming to hospital as an emergency admission or for surgery. It should be proactively managed through the hospital journey with early intervention to prevent delirium and deconditioning.

Pathways should include the role of carers in supporting patients – for example, carers could stay longer with them longer in hospital to avoid disorientation and delirium. Carers should also be supported with information to recognise signs of delirium at home and take preventative action before it becomes severe, to avoid a hospital stay.

The hospital environment is a bad for people with delirium. It tends to increase confusion and add to the risk of deconditioning. We believe that out of hospital 'home treatment' care models such as those used at trusts such as Watford, the Royal Free and the Epsom and St Helier, should be considered as part of a population-based approach to frailty.

CASE STUDY

Teaching tomorrow's doctors how to recognise delirium

East Lancashire Hospitals NHS Trust

East Lancashire is making recognition of delirium and dementia a priority among the next generation of doctors, including it in practical case-based learning for medical students during their training.

The trust is the teaching hospital for the University of Central Lancashire (UCLan) medical school. All year four medical students have a placement in its geriatric medicine department, during which they experience admitting older patients and spend time on geriatric wards, outpatient clinics and community hospitals.

As part of this, they learn to perform the 4AT test for delirium and the 6CIT assessment of cognitive impairment. They also take a case-based learning session on delirium and dementia, designed by the academic team at UCLan and reviewed by the geriatric medicine education lead to ensure that the scenarios are realistic, maximising the value of the training.

Results

The feedback from students has been very positive and is reflected in good learning outcomes. The training has enhanced the students' understanding of how delirium and cognitive impairment can affect older patients' experience of hospital.

CASE STUDY

Providing personalised care in dementia-friendly wards

St Helens and Knowsley Teaching Hospitals NHS Trust

The trust has improved the hospital experience for people with dementia by making wards dementia friendly and providing training in dementia care for all staff.

It redesigned the care of older people's ward to include spacious bays, handrails and seating areas, to make it easier for patients with dementia to walk safely and with dignity. It also added a reminiscence room with familiar household objects to make people feel more at home, as well as activity boxes, pictures, comfort blankets and sensory aids such as twiddle mitts and dolls.

A user-friendly screen provides orientation information at the patient's bedside, while dementia-friendly pictorial menus and tools help patients choose at meal times. Where possible, meals are served at a communal table to encourage social interaction.

The trust also provides basic dementia and delirium awareness training for all hospital staff and a two-day interactive course on dementia care aimed at staff involved in care of older people.

Dementia-friendly adaptations are now being extended to other areas of the hospital, including signage, paintwork, lighting, flooring and orientation clocks.

Results

The Trust achieved top marks in the country for its facilities for patients living with dementia in the Patient-Led Assessments of the Care Environment 2017, 2018 and 2019. The training has received excellent feedback from staff and been positively audited using the Dementia Training Design and Delivery Audit Tool.

Recommendation: Improving the delirium pathway

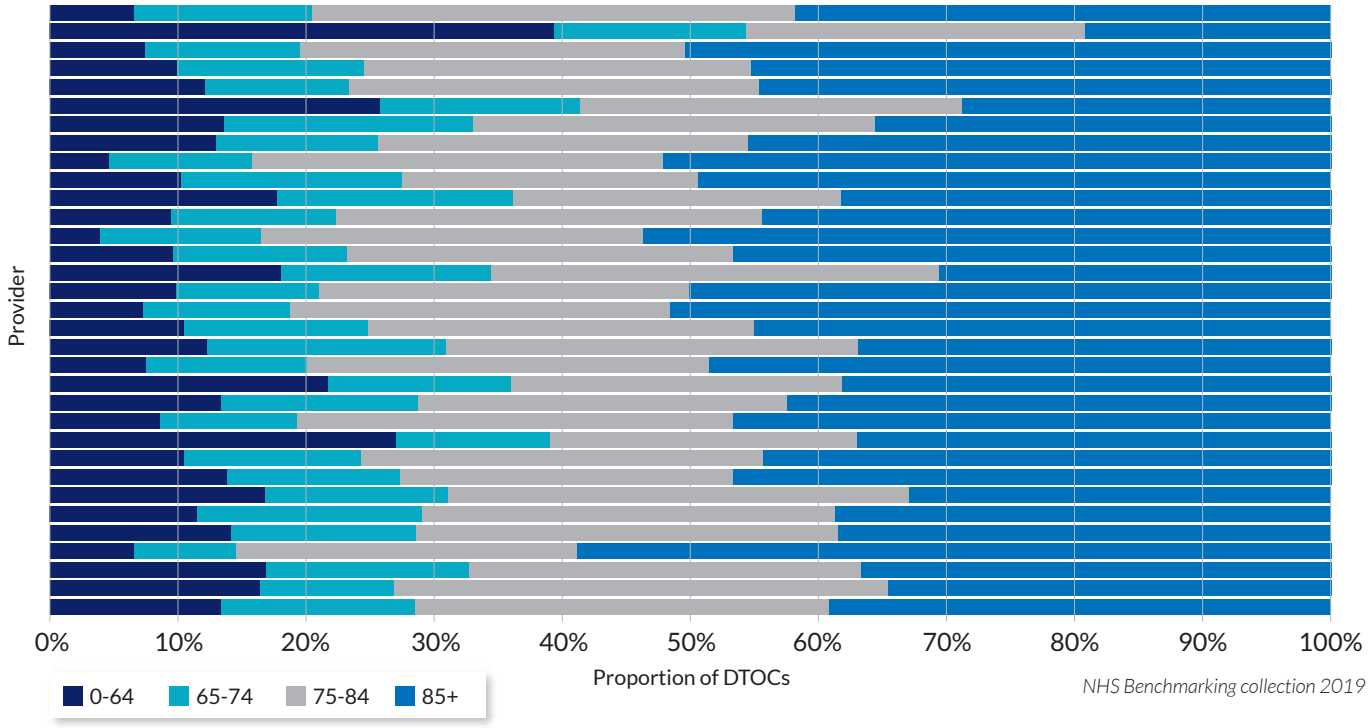
Recommendation	Actions	Owners	Timescale
6. All trusts should have a clear pathway for delirium that includes assessing all older people admitted as an emergency using 4AT, a system for identifying delirium in elective admissions, and rapid and effective delirium response. Delirium awareness should be embedded in basic frailty training for all patient-facing staff.	**a** GIRFT to support local systems to roll out and sustain the use of 4AT for delirium assessment.	GIRFT, ICS/STPs	For progress within a year of publication
	b GIRFT to work with the NHS England and NHS Improvement pricing and incentives team to explore the viability of a CQUIN for delirium to drive improvement.	GIRFT, NHSE/I	Within two years of report publication

Removing the barriers to safe and effective discharge

During our deep-dive visits, we found that many older adults who were medically fit to return to their usual place of residence after treatment were not being discharged in a timely way. This is bad for their health and wellbeing and adds to pressures on the NHS.

Figure 18, based on the NHS Benchmarking Network's Managing Frailty project (pre-COVID-19), shows that delayed transfers of care (DTOC) affect people over 75, and especially those over 85, disproportionately, with these age groups accounting for more than 70% of all DTOC days in most trusts surveyed. There is wide variation in the total number of DTOC days, from 632 in a year to more than 41,000 in the worst-affected trust. Delays in transfer of care also add to the number of bed days occupied and the overall cost of care.

Figure 18: Proportion of total transfer of care delay days by age band (pre-COVID-19)



NHS Benchmarking collection 2019

Most discharges of older adults are relatively simple. If the patient requires support, it is usually low level personal care. Patients with severe frailty or multi-morbidity may have complex needs and need more support to help them adjust as they leave hospital. These discharges fall into two categories:

1. Complex discharges to the patient's current residence with a new dependency requiring new support services and/or rehabilitation in place.
2. Discharge to a new residence, typically a care home, where the patient is transferred awaiting assessment to avoid long waits in hospital.

It's important that older people, particularly those with frailty, are discharged safely with a personalised care plan in place that identifies who is responsible for their ongoing care – if they are discharged early but without the right preparation and support, they are more likely to be re-admitted within a few days or weeks of leaving hospital (see *Reducing readmissions of older people with frailty*, page 76).

Safe and effective discharge requires planning and co-ordination, both within the hospital to prepare patients for discharge, and externally with care homes, local authorities and carers (paid and unpaid) to ensure that they are ready to receive them. It often depends on availability of care home places, support services and the involvement of local agencies.

For example, people with frailty may also need access to recuperative rehabilitation at home or in a care home or in intermediate care, along with ongoing assessment and monitoring (see *Support for recuperative rehabilitation*, below). This, in turn, depends upon the availability of the local carer workforce.

On our deep-dive visits, we found variation in the level of co-operation and co-ordination between partners. While most trusts had some level of ongoing engagement with care homes and local authorities to support safe and effective discharge, the working relationships were often not formalised or embedded in care pathways.

Changes in discharge practice accelerated by COVID-19

However, we note that discharge practice has changed since we began work on this report. A new hospital discharge service was created following the first wave of COVID-19, driven in part by the need to prioritise beds for people with acute medical needs during the pandemic. This has mobilised partners to work together to enable prompt, safe and effective discharge of those who no longer need to be in hospital – see *Solutions: the new hospital discharge service*, page 73.

While the new service is in its early stages, we expect that, as it is rolled out, it will reduce many of the variations and barriers identified in this section of the report. Daily discharge data is currently being collected to show the impact of new discharge service on discharge rates and length of stay and this will be available during 2021.

What we found: barriers to safe discharge of older patients

Space, facilities and resource for mobility support

As discussed in *Reducing the risk of hospital-acquired deconditioning*, page 51, we found that there is often a lack of facilities, such as appropriate chairs to get people out of bed and space to get patients moving.

Some patients are held up waiting for physiotherapy or occupational therapy to perform assessments or provide mobility support. However, if all they need is basic help with movement, other members of the team could help with this to avoid unnecessary delays in transfer of care. Joint blended working between occupational therapy and physiotherapy can also help by removing duplication and delays in pre-discharge treatment. We have seen some examples where this is working well.

Support for recuperative rehabilitation

Older people with frailty may need extended support to enable them to settle at home or in their care home and prevent falls and episodes of delirium. This may include community-based rehabilitation, and a crisis response service so they know who to call if they need advice or have a minor incident. People with delirium find it particularly difficult to re-adapt and may need more assistance, including specialist psychiatric support, to help them live well outside hospital.

On our deep-dive visits, we found that these services were not always available leading to delays for people who cannot be safely discharged without them. There is a general lack of robust data on community rehabilitation access, delivery and outcomes and better data collection is needed to support effective community rehabilitation services.

However, we also found good examples of support packages, such as:

- post-discharge next day visits by nurse specialists to older people with frailty in their homes or care homes;
- co-ordinated case management by the hospital frailty team for the first 72 hours;
- telephone follow up sometimes linked to a virtual multidisciplinary team;
- hospital at home remote monitoring using devices that track symptoms for people with long-term conditions such as heart disease.

Similar packages are now being rolled put as part of the new hospital discharge service model to support safe discharge of people with continuing care needs.

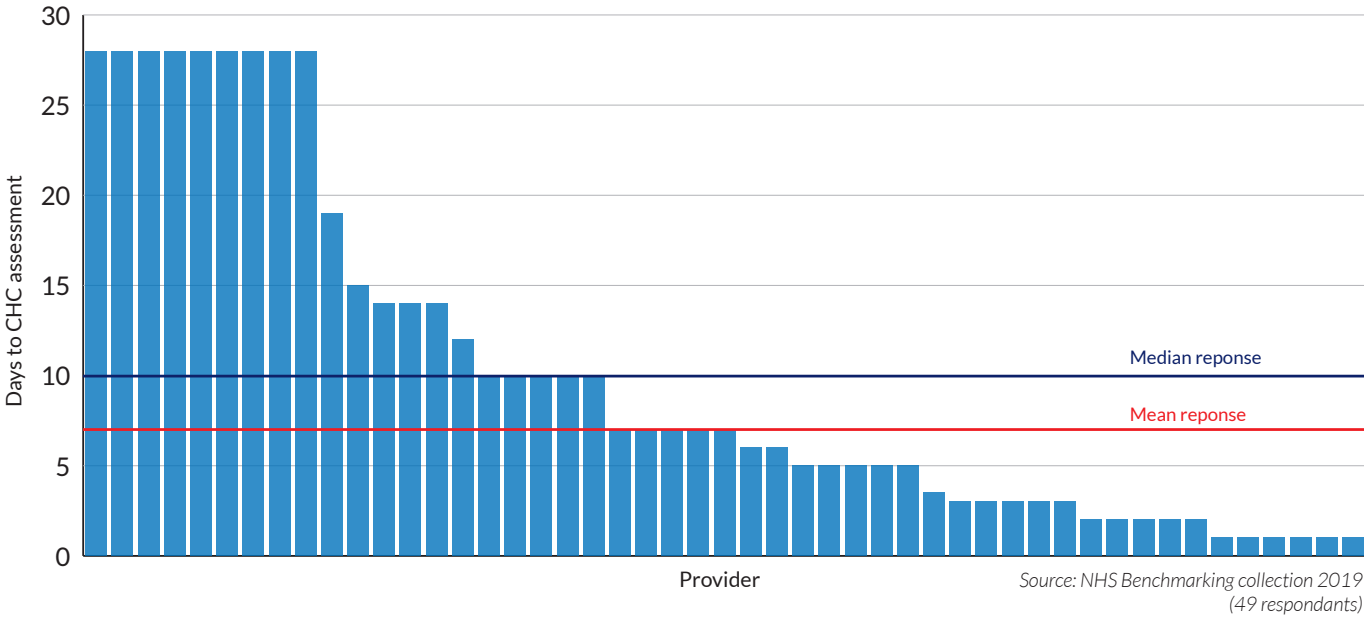
Continuing healthcare assessments

In many areas, we found that patients were waiting long periods in hospital to have a continuing healthcare (CHC) assessment to determine their ongoing social care needs before discharge. This is reflected in **Figure 19**, which shows that people were waiting up to 28 days in some areas for a response to requests for CHC assessments with large variation in waiting times.

In our discussions with trusts, we found that the CHC process was often wasteful or adds little to the understanding of the patient's care needs. Where the process is not managed well, it can lead to patients being unduly delayed, increasing length of stay and risk of illness and deconditioning.

We note that continuing healthcare assessments were paused during the first wave of COVID-19 and re-started on a new basis in September 2020. The new process should help to reduce delays and make the CHC process more responsive to requests. Increasingly CHC assessment no longer takes place with the patient waiting in a hospital but in step down assessment beds in community settings.

Figure 19: Average response time to requests for continuing healthcare assessments by provider (pre-COVID-19)

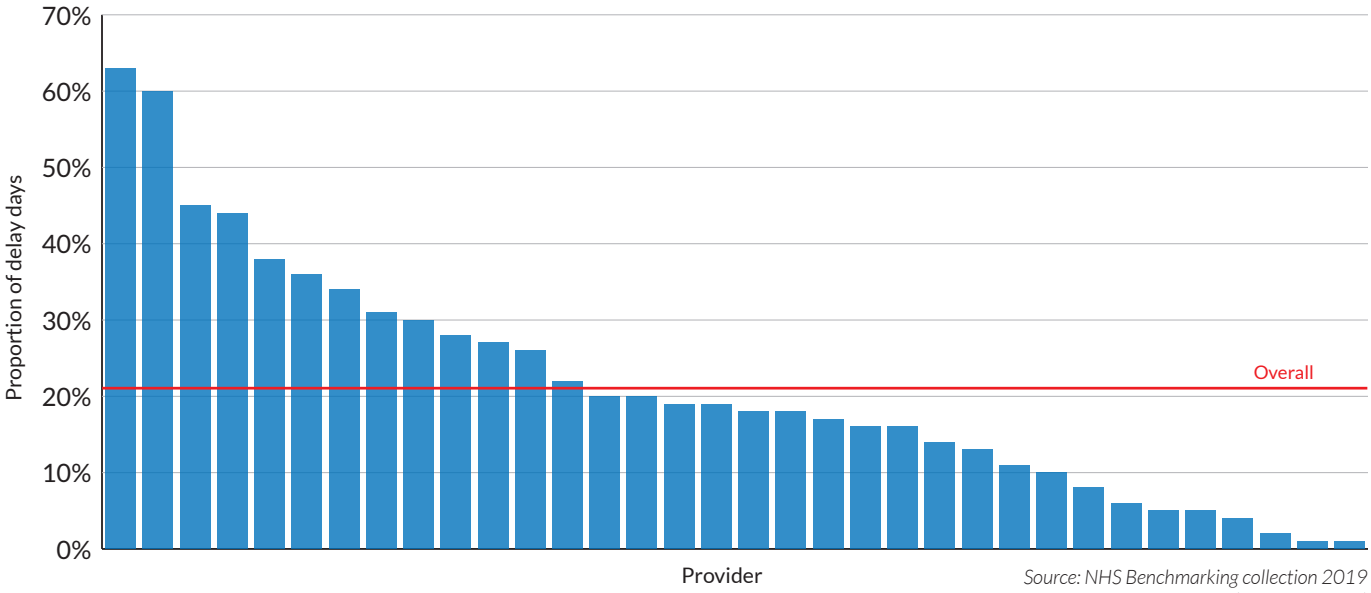


Source: NHS Benchmarking collection 2019 (49 respondants)

Delays waiting for a care home place

Figure 20 shows a wide variation in the proportion of delayed older adults who were waiting for a care home place, up to 60% in some areas, although this is based on a relatively small response to the NHS Benchmarking Network's Managing Frailty project. These delays were exacerbated by the workforce challenges facing care homes, discussed in *Supporting care workers*, page 96.

Figure 20: Proportion of delayed transfer of care delay days for patients over 75 because they were waiting for a care home place (pre-COVID-19)



Source: NHS Benchmarking collection 2019 (34 respondants)

Discharging at weekends

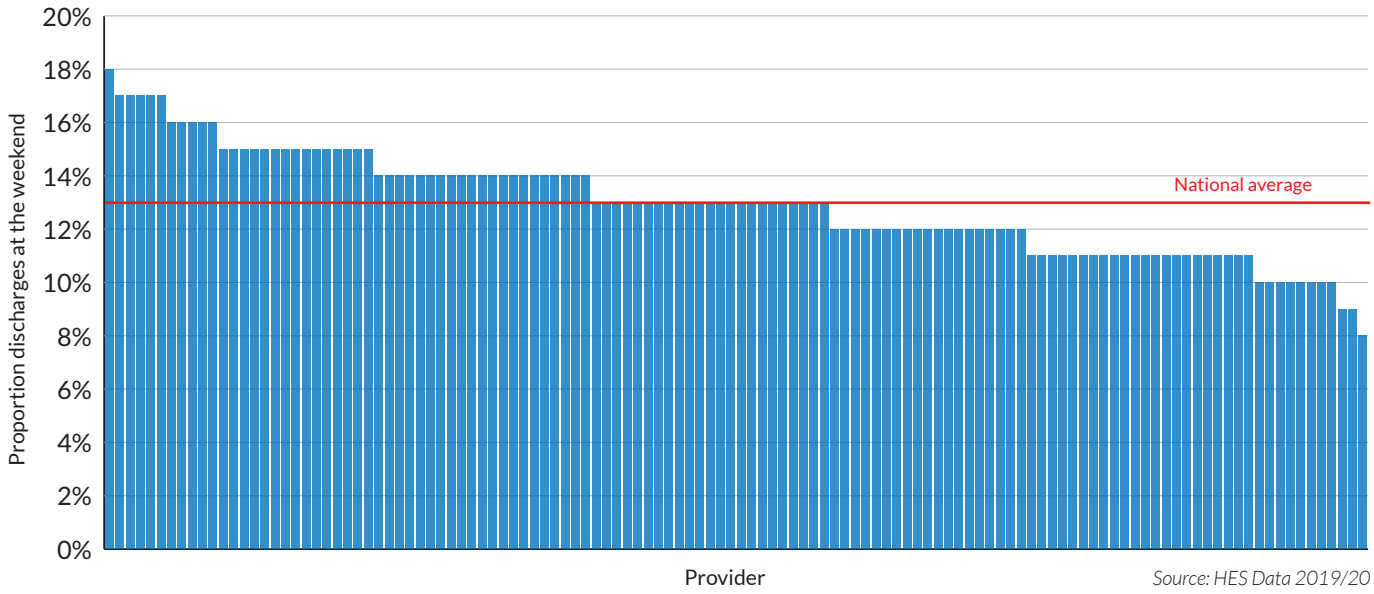
It has been more difficult for trusts to discharge older adult patients at the weekend. This is due to a combination of availability of authorised staff to perform assessments in hospital, limits on provision of community care, or problems returning patients to care homes because of reduced staffing, which means that they can't accept patients over the weekend.

This has been a growing problem, often extending beyond Saturday and Sunday. On our deep dives, we heard from some hospitals that if a patient was ready for discharge on a Thursday but needed support, they might wait until Tuesday for that support to be arranged.

Weekend delays not only increase length of stay for patients, but also create bottlenecks in the system as discharge teams try to catch up with the backlog on Mondays. This leads to flow pressure early in the week which increases stress for staff, patients and carers.

Figure 21 shows that on average, only 13% of all discharges of patients over 75 occurred on Saturday and Sunday, around half the rate per day as on weekdays. Discharge at weekends must improve if the ambitions of the new hospital discharge service are to be achieved. As well as support for recuperative rehabilitation discussed above, it requires doctors and nurses available to support patients to make decisions about their care, access to services such as blood tests and imaging if needed and co-ordination with carers and families.

Figure 21: Proportion of patients over 75 discharged on Saturday and Sunday by provider (pre-COVID-19)



Source: HES Data 2019/20

Discharging patients after 21 days

Discharge is particularly challenging for long stay older adults who have been in hospital for 21 days or more, also known as 'super-stranded'. As discussed in *Reducing the risk of hospital-acquired deconditioning*, page 51, once they pass 21 days, these patients will stay on average another 19 days in hospital.

As mentioned in *Increased risk of deconditioning above 21 days*, page 53, super-stranded patients over 75 account for 45% of all bed days occupied by older patients in the emergency pathway[44]. The consequence of long hospital admissions includes deconditioning and functional decline. Long stay patients need more therapy and support to prepare them for discharge. This is a serious issue for the health system and needs a concentrated multi-agency effort to find solutions, including a review of:

- the role of community hospital beds as a step down measure;
- intermediate care facilities that provide short-term nursing care and support under medical guidance (see https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/understanding-intermediate-care);
- temporary placements in care homes.

These issues are addressed in the new hospital discharge service guidance – the ambition is that if all trusts follow the guidance, that there will be no reason for any older people to become unnecessarily super-stranded in hospital.

[44] *Hospital Episode Statistics 2017-18*

Discharge flow using SAFER

Tools such as the SAFER discharge flow bundle provide a model for managing discharge of older adults, including long stay patients.

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic multidisciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.

Delays transferring to the patient's home

We found some good examples of intensive support packages provided by trusts in collaboration with local authorities to support safe discharge for people returning to their own home. But many people were still being delayed because an appropriate care package could not be arranged, often because of gaps in social care and community-based rehabilitation services.

Care provided within families is also an issue, as carers may work full time jobs and have childcare responsibilities and may be unable to accept the person when they are ready for discharge.

Discharging patients admitted from non-local CCGs

Some trusts work with multiple Clinical Commissioning Groups (CCGs) and receive a significant proportion of their admissions from CCGs that are outside their immediate footprint. We found that co-ordination with these non-local CCGs was often poor, resulting in delayed discharge for older patients.

On our deep-dive visits, some trusts told us that difficulties discharging patients admitted from non-local CCGs could add up to a week on to length of stay. While these CCG cohorts represent a minority of the wider patient group, they are a regular and predictable source of admissions and a significant part of a trust's workload. Trusts should monitor length of stay by CCG and take steps to improve, for example by negotiating a reciprocal agreement with social services in that area.

Solutions: the new hospital discharge service

As discussed above, the need to prioritise beds for people with acute medical needs during the first wave of COVID-19 pandemic accelerated the development of safe and effective discharge processes, as well as access to temporary care placements and rehabilitation support for those who need them, which had been difficult to co-ordinate before. The NHS supported these improvements with additional short-term funding of £588 million to April 2021. As a result, discharges with funded and well co-ordinated recuperative support became much easier to achieve.

The workstream has led to the creation of a new NHS discharge service, with new service guidelines[45] based on discharge to assess model (see below) and detailed service requirements for hospital staff at all levels[46]. Key features of the guidance include:

- A default assumption of discharge home today.
- Daily reviews of all patients on wards to identify those ready for discharge.
- Three pathways for those who need post-discharge support, ranging from basic personal care (pathway 1) to ongoing residential nursing care (pathway 3). These pathways are outlined in *Discharge to assess*, below.
- Funded recuperative care and support for up to six weeks at home for those who need it.

[45] *https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model*

[46] *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911214/Hospital_discharge_service_requirements_action_cards.pdf*

- Case managers provide a single point of contact for coordinating safe discharge including care, support, transport and temporary placements where needed.
- A single Comprehensive Geriatric Assessment (CGA) shared by all in the multidisciplinary and multi-agency teams

NHS England and NHS Improvement has since indicated that this will become the permanent model for hospital discharge in future and it is expected that the short-term funding will be renewed to enable this to continue over the coming years. The long term aim is that a majority of older people should leave hospital on the same day they arrived, be able to return home rather than to a care home placement, and live independently with support if needed[47].

Discharge to assess

Older adults who present at hospital with a new acute crisis are discharged safely to their home wherever possible, with support in place, and then given a CGA to plan their care needs. Some patients remain dependent in the short term after discharge and may need care while their long-term needs are being assessed. There are four pathways based on levels of care need and complexity:

- **Pathway 0:** able to return home without support
- **Pathway 1:** able to return home with support from health and/or social care.
- **Pathway 2:** patients needing rehabilitation or short-term care in a 24-hour bed-based setting.
- **Pathway 3:** ongoing 24-hour nursing care, often in a bedded setting, for people with complex 24-hour care needs.

Implementation challenges

Before COVID-19 and the development of the hospital discharge service, the discharge to assess pathways had been used in many areas, with varying degrees of success. We heard of from trusts that it has proved difficult so far to scale up to a population level since it requires a significant level of resource to deliver assessments and support in people's homes.

However, we expect that the additional long-term funding now allocated to the roll-out, combined with clearer guidance on implementation, will help to overcome these issues.

Continued effort is needed to break down barriers between services and improve working relationships between key stakeholders in the health service, local authorities and social care. As implementation progresses, we think that trusts should be focused on the risks of deconditioning at home for those who are discharged early, and make sure that community multidisciplinary teams (MDTs) are involved in planning post-discharge care and support.

Discharge using trusted assessors

In some areas, hospitals use suitably qualified NHS-approved trusted assessors[48] to act for them. Trusted assessors may carry out assessments for care homes and other settings, where trusts are unable to do so, negotiate return of patients to care homes, and manage complex discharges and interface with social services.

We have seen examples where this model is working effectively to enable safe discharge but also instances where trusted assessors have not been able to establish the close multi-agency relationships needed to make this work. Wherever the trusted assessor model is used, it must be continuously monitored to assess effectiveness.

Data and coding issues

There is a lack of reliable data on the role of frailty in delayed discharge. As discussed in *The potential for coding frailty to support identification*, page 49, if we had data linking patient scores on the Clinical Frailty Scale (CFS), or deterioration in CFS during admission, with length of stay and time of discharge, it could help to inform better strategies for prevention of deconditioning and safe discharge. This kind of overview analysis can be done using frailty tools linked to administrative datasets (such as the Global Frailty Score, Hospital Frailty Risk Score).

[47] *https://www.england.nhs.uk/blog/ambitions-for-hospital-discharge/*

[48] *https://improvement.nhs.uk/documents/2651/Trusted_assessment__FAQs_v5_44JW_4_FINAL.pdf*

Recommendations: Safe discharge

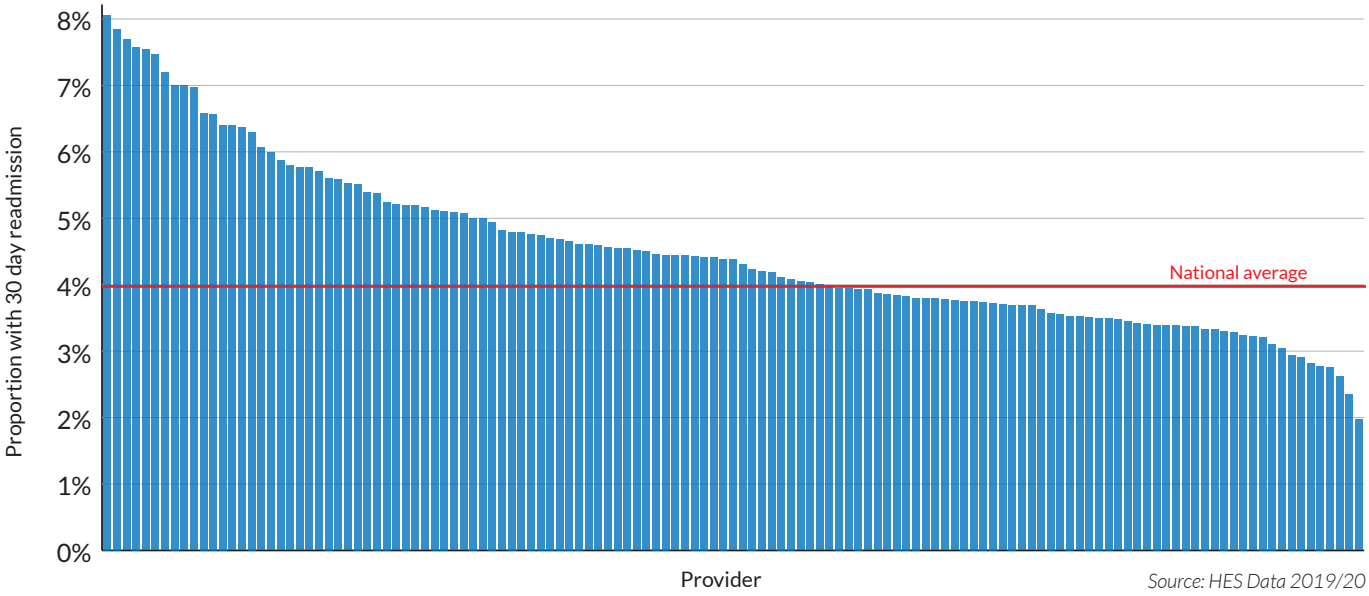
Recommendation	Actions	Owners	Timescale
7. ICS/STPs should work on a multi-agency basis to implement the new hospital discharge service guidance to improve outcomes for older adults and optimise flow and discharge rates.	**a** GIRFT to support local systems to implement the new hospital discharge service model, including: • ensuring support packages to help older people remain at home are sustainable and effective • improving data collection on delivery of community rehabilitation services and patient outcomes • developing a multi-agency pathway • benchmarking performance with peers • a review of provision in community hospitals	GIRFT, ICS/STPs	Ongoing
8. ICS/STPs should develop targeted strategies to address specific barriers to safe discharge at the weekend and for patients staying more than 21 days (super-stranded).	**a** GIRFT to support trusts and ICS/STPs to audit discharge barriers for super stranded patients within their footprint.	GIRFT, Trusts, ICS/STPs	For progress within a year of publication

Reducing readmission rates post-discharge

Early discharge of older adults is not an end in itself. It is only a success if the patient adapts and recovers well in their home environment. From our deep-dive visits, we found that some hospitals with high rates of early discharge of patients over 75 also had high rates of readmission, often within days of leaving hospital.

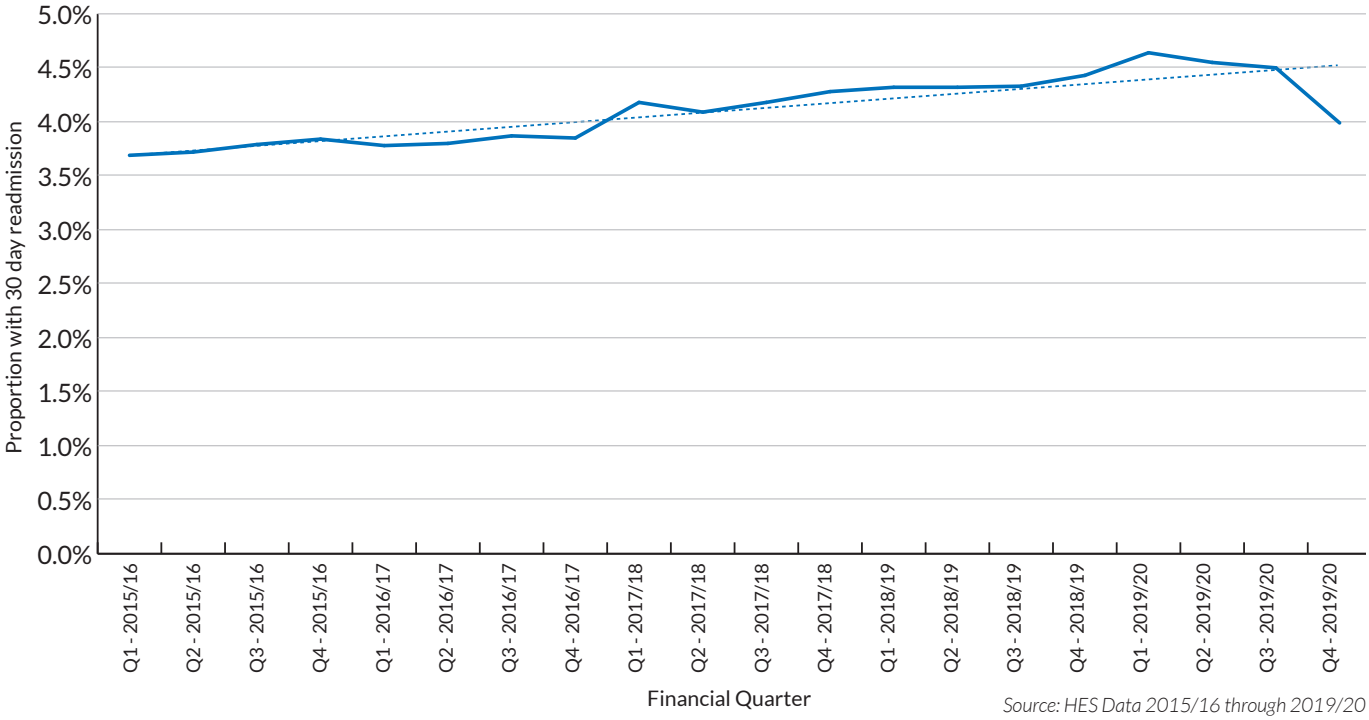
This is reflected in **Figure 22a**, which shows a wide variation in the number of short stay patients over 75 who were readmitted as an emergency within seven days of discharge, with up to 4% returning in this period in some trusts. **Figure 22b** shows that this proportion has been growing over recent years.

Figure 22a: Proportion of short stay patients aged greater than 75 years (less than 48 hours, emergency admissions) re-admitted as an emergency within seven days (pre-COVID)



Source: HES Data 2019/20

Figure 22b: Proportion of short stay patients aged greater than 75 years (less than 48 hours, emergency admissions) re-admitted as an emergency within seven days 2015-20 (pre-COVID)



Source: HES Data 2015/16 through 2019/20

A systematic review (26 studies) of older adults discharged from emergency departments reported readmission rates as high as 40% within six months of being discharged[49]. These repeat admissions are associated with higher length of stay, which defeats the purpose of early discharge and results in higher overall cost of care.

Multiple admissions

Some readmissions of older people may be unavoidable, for example where patients have recurrent illness get sick again soon after leaving hospital. Some vulnerable patients, such as those with delirium, may be discharged in the knowledge that there is a risk of repeat admission because the risks of keeping them in hospital may be greater and the only way to re-establish the patient at home is to accept the risk of transition.

However, we found that many people were being re-admitted for entirely avoidable reasons, often the same occurrence as their previous admission, often multiple times. They may be relatively healthy and readmission could be prevented, either by stronger safeguards in the discharge process to ensure it is effective, or better support post-discharge.

Readmissions of people with frailty

We found that older people with frailty, in particular, had very high readmission rates in the NHS. On average 20% of this group who were admitted as an emergency were readmitted within 30 days of discharge. More than 60% of frailty bed days were people who had repeat (three or more) admissions within a year of discharge. A large proportion of readmissions were related to falls – with delirium the second highest reason given. However, it is known that delirium often leads to falls so these two causes are intertwined.

[49] *BMJ 2019;364:l13 https://www.bmj.com/content/364/bmj.l13*

The need for post-discharge support

As discussed in *Removing the barriers to safe discharge*, page 68, older adults, especially those with frailty, may need extended support, such as community-based rehabilitation, falls prevention such as strength and balance training and a crisis response service to help them re-adapt to their home or care home. Those with delirium may need extended psychological support.

We found that most trusts offered some discharge support but the design and quality of the packages varied widely and some were not effective in reducing readmissions. There was also a widespread lack of basic education, information and advice to help people at lower risk of harm to enable them to return home with confidence.

The new hospital discharge service model provides funded support for short-term care and support for up to six weeks – see *Solutions: the new hospital discharge service*, page 73. This should help more people recover and remain at home, reducing the need for readmissions over time.

Virtual support models

During COVID-19 we have seen some examples of support provided through virtual clinics, in which clinicians carry out post-discharge reviews and give expert advice on how to manage recovery and avoid readmission. These models of outreach care, linked to community rehabilitation, are also supported by the new hospital discharge service guidance.

In implementing this model, trusts should explore whether virtual support and monitoring could help older adults adapt and avoid harms such as delirium and falls, which are the main drivers of readmission. Whatever support services or interventions are offered, trusts should ensure that they are well planned and resourced. They should carry out ongoing sampling measurement and continually refine them to make sure they are working well.

Improving the home environment

Support can also include looking at the person's home environment to help prevent falls, which are the biggest cause of readmissions. Home-based assessments can identify rehabilitation needs and home adaptations can make it safer for people to stay at home longer.

Similar interventions could be effective in reducing falls and deconditioning in care homes. Trusts should consider rehabilitation liaison teams to support older people in care homes, similar to the existing dementia care home liaison teams, which are involved in reviewing care home practice, training and advising staff.

Potential solutions

Trusts should collect data including outputs from case review on the causes of readmissions and whether they could have been avoided and to find improvements. They should monitor readmission rates and look at how these are linked to early discharge to see if any improvements can be made to support safer discharge while reducing the risk of readmission. This should include repeated systematic case reviews of a sample of readmissions at both seven days and 30 days both to support individual patients but more importantly to identify weaknesses in the current system.

7 days: a patient-focused review of the reasons for early readmissions, which asks:

- Has the patient been discharged safely?
- Is the right support in place to help them remain well outside of hospital?
- Is there a care plan in place?
- Did the community and urgent care services follow the care plan? If not, why not?
- Have they been visited or called since leaving hospital?
- Was readmission driven by the relapse of a pre-existing illness, such as COPD or heart failure?

30 days: a case review linked to potential improvement/system change, which asks:

- What are the causes of readmission?
- Do the patients have significant multi-morbidity?
- What other support might be needed to minimise the future risk of readmission?
- Was post discharge rehabilitation or falls prevention effective?

Local review of readmissions could also help to identify and develop alternatives to A&E attendance where the patient has a short-term crisis which does not need hospitalisation.

Linking with the hospital discharge service

We think that discharge letters and summaries should include the person's Clinical Frailty Scale (CFS) score, as well as details such as their weight and nutrition risk screening results, along with actions for them and their GP to help avoid deconditioning. These details could form part of a minimum dataset provided by the hospital discharge service to ensure safe and effective transfers of care across local frailty systems. As the discharge service model is rolled out, we think there is scope for a wider review of the quality of information provided on discharge to support patients and help them live well outside of hospital.

The discharge service should also link with social care to ensure that nutrition support is available with access to adequate food on discharge, especially if the patient has been identified as at risk of malnutrition during their acute stay. Although many areas do provide food packs, these often follow 'standard' government guidance relating to healthy eating and do not take account of the nutritional needs of those at risk of malnutrition.

Recommendation: Reducing readmissions

Recommendation	Actions	Owners	Timescale
9. Review readmission rates on a multi-agency basis to understand the causes and develop interventions to reduce them, including enhanced support for older people with frailty to prevent falls, delirium and multiple admissions, and targeted support for those readmitted within 7 days and 30 days of initial admission.	**a** GIRFT and Model Hospital will support local systems to benchmark discharge performance against other similar systems. This should include a case review by systems to understand local drivers of readmissions.	GIRFT, Model Hospital, ICS/STPs	For progress within a year of publication
	b GIRFT will work with trusts and local health systems to make sure that implementation of the new hospital discharge service model helps to reduce the need for readmissions.	GIRFT, trusts, ICS/STPs	Ongoing
	c GIRFT to support linking of local reviews of readmission rates data with routine recording of frailty	GIRFT, ICS/STPs, trusts	For progress within a year of publication

Improving liaison with care homes

More than 400,000 people live in approximately 11,000 care homes in England[50]. A large proportion of them have frailty, or are in the last year of their lives. Many are at risk of delirium and 69% have dementia[51].

Evidence suggests that many of these people are not currently having their needs properly assessed and met[52]. As a result, they experience unplanned and avoidable admissions to hospital – often at the end of life when hospital care may be inappropriate and increase their suffering.

This can have serious knock-on effects on the NHS. If care homes don't have the right medical support to help them manage the health needs of their residents, more older people with frailty will end up in hospital. As we've seen during COVID-19, a small proportion of care home residents needing hospitalisation at one time can potentially overwhelm the system.

Likewise, if care homes are not able to safely accept people ready to leave hospital who require a short-term care placement, it increases length of stay as well as the overall cost of care – as discussed in *Reducing the barriers to safe and effective discharge*, page 68.

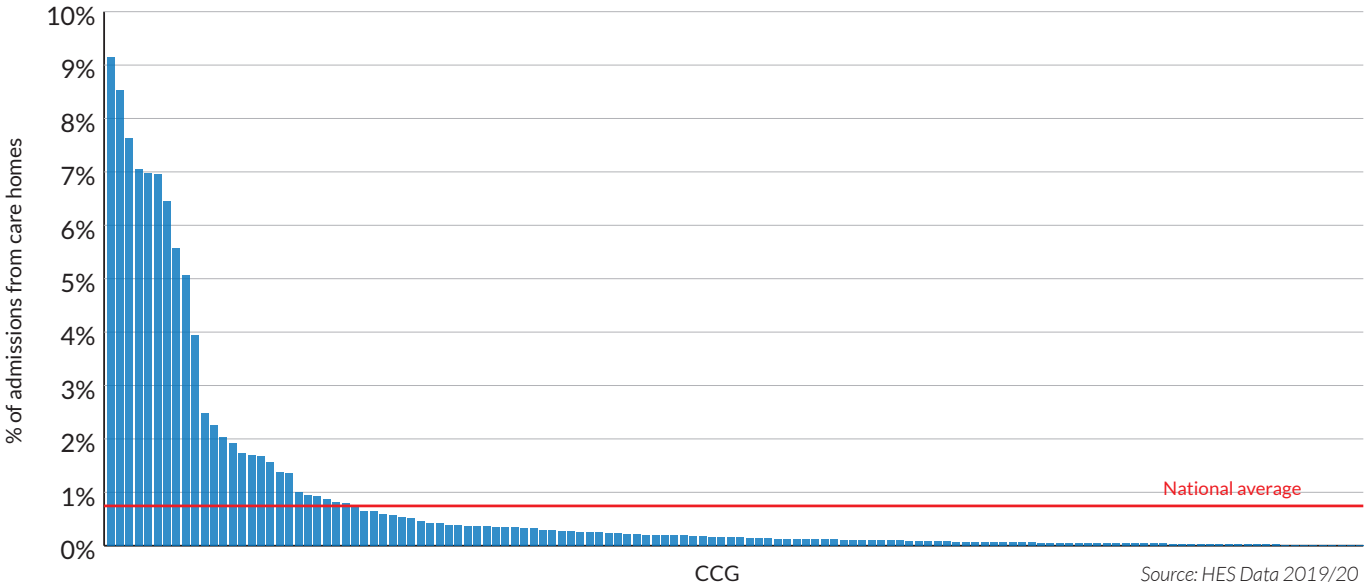
The Enhanced Health in Care Homes programme calls for all systems to work closer together to support better health and care for people living in care homes and to improve outcomes. The COVID-19 pandemic has accelerated a move towards an integrated model in which complex needs are managed on a whole population basis. The EHCH programme, discussed on page 84, aims to break down barriers between the NHS, care homes and social care to improve outcomes and reduce the number of unnecessary admissions and deaths. We welcome and support this work, which is reflected in our recommendation.

Variation in admissions from care homes

Figure 23a shows wide variation in the proportion of admissions of people over 75 coming from care homes. In some CCG areas, this accounts for up to 9% of cases, while other areas see very low numbers. Some of the variation is linked to a higher concentration of care homes in some areas of the country compared to others – for example, there are relatively few care homes in inner cities as opposed to suburbs and towns. As discussed in *Gaps in our analysis*, page 24, the low numbers may also reflect poor data quality.

Even with this under-reporting, admissions from care homes are generally accounting for an average of 6.7% of all hospital emergency admissions among people over 75, and up to 11% in some hospitals[53]. Nationally, numbers have been rising in recent years, as shown in **Figure 23b**

Figure 23a: Admissions of patients over 75 from care homes, elective and non-elective, by CCG area



Source: HES Data 2019/20

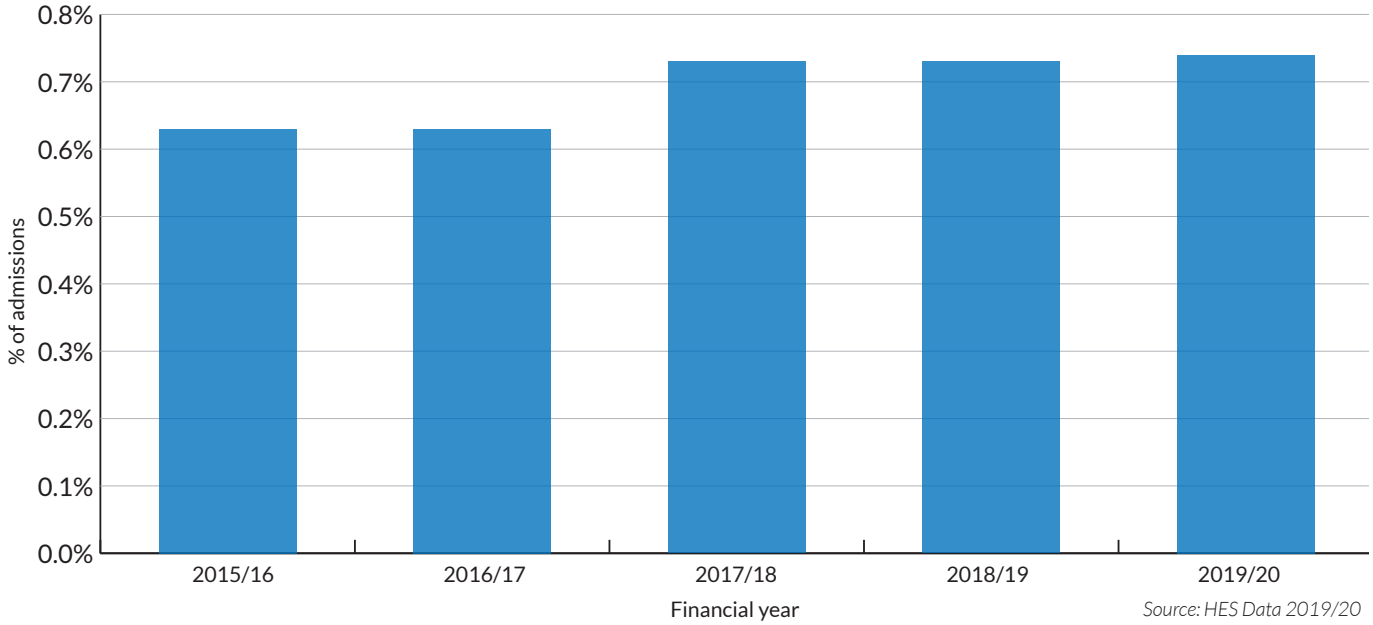
[50] *Laingbuisson Care Homes for Older People UK Market Report 2019*

[51] *Alzheimer's Research UK Dementia Research Hub, available via:https://www.dementiastatistics.org/statistics/care-services/*

[52] *NHS Long Term Plan (2019), page 15*

[53] *Hospital Episode Statistics*

Figure 23b: Admissions of patients over 75 from care homes by CCG area, elective and non-elective, 2015-20.



Source: HES Data 2019/20

Variation in deaths on admission

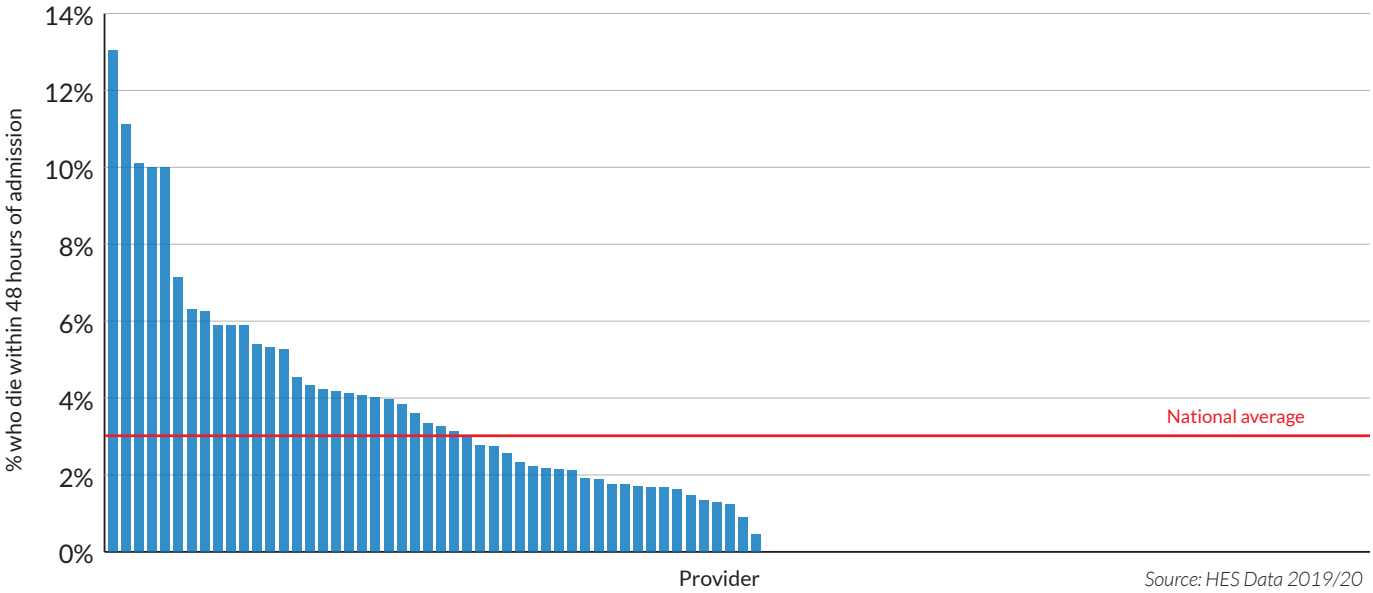
Figure 24a shows the variation in the proportion of people aged over 75 admitted from care homes, on both emergency and elective pathways, who die within 48 hours of admission (pre-COVID-19). There is very wide variation between hospital trusts, with up to 13% early mortality in some areas and less than 1% in others.

In some cases, this means that patients are being admitted who are dying. When we analysed deaths in patients over 65 following emergency admission from care homes, we found that an average 12.5% died during their admission, with variation from 7% to 20% between trusts. Of these, an average of 15% died within 48 hours, in a range from 12-25%.

Where deaths within 48 hours are high, it suggests that people have been admitted where there may be little benefit to hospitalisation. Indeed, sometimes this is a distressing and inappropriate process for managing expected end of life. The time series chart, **Figure 24b**, shows a gradual improvement in average early death rate in patients admitted from care homes in England since 2015.

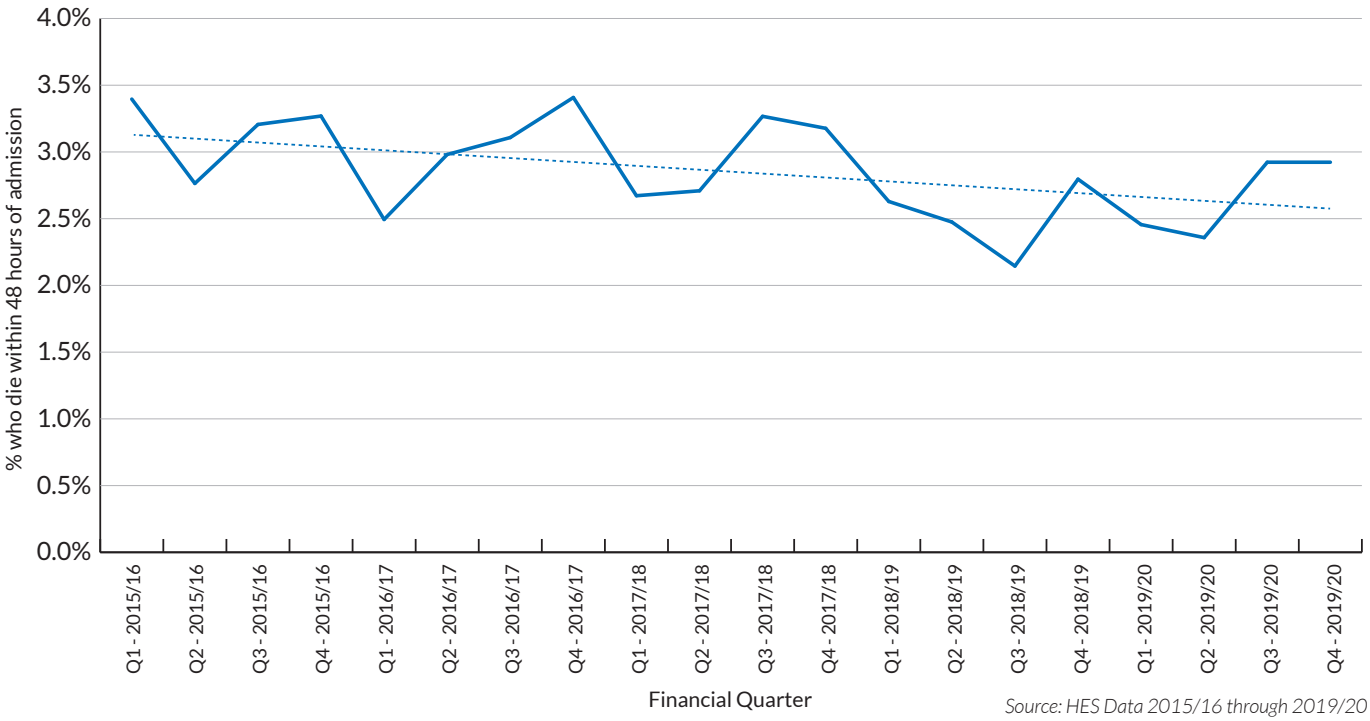
We think these admissions could be reduced significantly if there was closer working between trusts and care homes to improve practice around end of life care. This should be based on better palliative care, shared decision making linked to advance care planning with the resident and their carers, and more information sharing and communication to increase the chances that they can be looked after and die in their preferred place of care wherever possible.

Figure 24a: Proportion of patients over 75 admitted from care home, elective and non-elective, who die within 48 hours by provider



Source: HES Data 2019/20

Figure 24b: Proportion of patients over 75 admitted from care home who die within 48 hours by provider, elective and non-elective, 2015-20



Source: HES Data 2015/16 through 2019/20

Advance care planning

Advance care plans (ACPs) that record the wishes of the older person, agreed with their carers, can be particularly effective in avoiding unnecessary admissions from care homes in the last year of life and ensure that people can die in their preferred place of care. This discussed further in *Providing better end of life care*, page 82.

Effective liaison and support

We have seen some good examples of liaison models which are helping to reduce unnecessary admissions. For example, in Enfield and Croydon, hospital-based specialist multidisciplinary teams (MDTs) work in an integrated way with care homes, leading on case review and advance care planning – both services are based in geographies where there is a high number of care homes and have shown to be effective. Advance care plans are documented and accessible to the paramedics in ambulance vehicles and to the 111 call centre and the emergency departments.

We have also noted innovative liaison models developed during COVID-19 to reduce the need for hospitalisation:

- **Leicester:** consultants provide pre-transfer clinical decision (PTCD) advice and support to ambulance staff while they were attending care homes. This enables decisions to be made in the care home on whether the person needs transfer to hospital or could remain home with targeted follow up by a GP with an interest in geriatrics.
- **Guy's and St Thomas':** developed a support network for care homes on WhatsApp with rapid access to a consultant geriatrician.
- **Tameside and Glossop:** expanded its digital hub to provide proactive support for care homes linked to videoconferencing and remote assessment.
- **Waltham Forest:** local geriatricians visited all care homes to create advance care plans with all their care home residents.

Similarly, the telemedicine service for care homes developed by Hampshire Hospitals in conjunction with Wessex Academic Health Science Network, provides care home staff with urgent advice and support from hospital specialists if a resident's condition deteriorates suddenly. The service, which was accelerated as a result of COVID-19, helps to reduce the need for ambulance call outs, A&E attendance and hospital admission[54].

These models are also supported by the move towards virtual outpatient clinics and case reviews as a result of COVID-19 – discussed further in *Improving outpatient care*, page 98.

However, as well as the good practice examples described above, we also found many areas where the level of interface and co-ordination with care homes from the NHS was poor. In some cases, this relates to geography. Implementing an integrated model may be more difficult in locations with a large older population and large numbers of care homes within a single trust footprint.

CASE STUDY

Teletriage supports care home staff to manage non-urgent cases

Wirral University Teaching Hospital NHS Foundation Trust

Wirral's teletriage service provides support and advice for care home staff, helping them manage non-urgent cases and reduce the need for care home residents to go to hospital.

Based in Wirral's community trust, senior specialist nurses take between 300-400 calls a month from up to 79 care homes. The service runs from 8am-8pm, with overnight support from out-of-hours GPs offering 24/7 access. The team assess patients by video consultation, while care home staff are provided with clinical equipment and training, so they make observations and report results quickly.

The nurses have enhanced/advanced skills and experience in the complexities of caring for the multi-morbid frail older patients in community settings and how to respect their wishes, particularly those nearing the end of life. Nurses also take the opportunity to undertake a fuller holistic assessment through conversations with patients, families or carers to confirm preferences, care plans and next steps. Additionally they continue to case manage the individual through close working relationships with care home managers and multi-agency partners, such as the North West Ambulance Service, to ensure the person and their family's needs continue to be met.

Teletriage proved particularly helpful during the first wave of COVID-19, helping care homes identify patients who needed treatments such as intravenous antibiotics, oxygen or subcutaneous fluids and arranging provision through the Hospital at Home service. In this way, they helped some very sick residents survive the illness.

Results

The service has resulted in a 15% decline in care home residents conveyed to hospital and reduced unnecessary admissions, while calls from care homes to the NHS 111 service have fallen by 78%.

[54] *https://wessexahsn.org.uk/projects/371/telemedicine-in-care-homes*

Targeting support for care homes in difficulty

We found that in some areas there is a large variation in care home practice with some care homes having particularly high levels of admission and/or mortality. It is important that local health systems track that data. Trusts may need to target specific measures to target support for specific care homes that may be in difficulty. However, we recognise that data from private care home operators is often not available or may be of poor quality, which may limit the efficacy of some forms of joint working and care planning.

Solutions: Enhanced Health in Care Homes

As discussed at the top of this section, the EHCH programme[55] has developed a whole-system approach to the issues highlighted in this section, focused on breaking down barriers between health, care homes and social care.

The aims are to provide continuity of care for residents, timely medicines reviews, access to hydration and nutrition support, and streamlined referral to out-of-hours services and urgent care. Specific measures include:

- a consistent named GP for each patient;
- a weekly 'home round' by a multidisciplinary team (MDT) in each care home;
- comprehensive Geriatric Assessment (CGA) for every patient on transfer to a care home;
- prompt and efficient transfer of clinical care from hospital to care home;
- regular reviews of medicine needs and safety by a pharmacist, particularly around anti-psychotic drugs and opiates;
- regular reviews of nutrition, hydration and oral health;
- access to out-of-hours and urgent care through a single point of contact when needed.

The programme was piloted in six areas across England, and led to significant improvements including reduced admissions from care homes of between 30-40%[56], including those at the end of life. The NHS Long Term Plan (2019) committed to roll out EHCH across England as part of the Ageing Well Programme by 2024. This process was accelerated as a result of COVID-19 with the first iteration of the implementation framework introduced in March 2020 and a second in October 2020.

Working with primary care

The new Network Contract Directed Enhanced Service (DES) for GPs establishes a role for primary care networks (PCNs) to manage the healthcare needs of care homes through community MDTs, based on the EHCH model. From July 2020 all care homes were expected to align to a single PCN.

Where this is in place, it needs to be integrated with specialist geriatric medicine departments to ensure a seamless, patient-centred approach to planning and assessment of needs for people living with frailty and multi-morbidity.

[55] *https://www.england.nhs.uk/new-care-models/about/care-homes-sites/*

[56] *https://www.health.org.uk/press-release/new-analysis-finds-encouraging-results-in-reducing-emergency-admissions-from-care*

CASE STUDY

Better health in care homes through community MDTs

County Durham and Darlington NHS Foundation Trust

Joined up care co-ordinated by community-based multidisciplinary teams (MDTs) is helping to improve health in care homes, prevent deconditioning and keep people in their preferred place of care.

Known as teams around patients (TAPS), the community-based staff work proactively to identify older people with frailty at high risk of admission, both at home and in care homes, and provide early intervention to prevent deterioration. The care homes service includes:

- a clinical practitioner assigned to each care home to promote proactive holistic patient care;
- weekly meetings with GPs practice to review care plans;
- collaborative working with district nurses to build care home safety and resilience;
- telehealth and virtual elderly care clinics with secondary care;
- a 24/7 clinical advice line for care home staff;
- anticipatory care planning.

Collaborative working between TAPS, the acute frailty service and discharge management teams ensure continuity of care if a person with frailty presents in hospital. The patient will be assessed early by the front of house acute frailty team, quickly signposted to the most appropriate pathway for their needs, and discharged back to the community team in a co-ordinated handover.

Results

The trust has seen fewer unplanned admissions from care homes since the service began. Feedback from multi-agency partners, patients and staff on new collaborative ways of working has been very positive.

Recommendation: Improving liaison with care homes

Recommendation	Actions	Owners	Timescale
10. All local health systems should implement the Enhanced Health in Care Homes framework as part of the Primary Care Network (PCN) contractual obligations.	**a** GIRFT to support the continuing roll out and delivery of the Enhanced Health in Care Homes Framework.	GIRFT, NHSE/I	Ongoing
	b Trusts to measure data on admissions from care homes, including admissions in the last year of life and deaths within 48 hours of admission, to enable targeted interventions for the worst performing care homes.	Trusts, ICS/STPs, NHSE/I	For progress within a year of publication

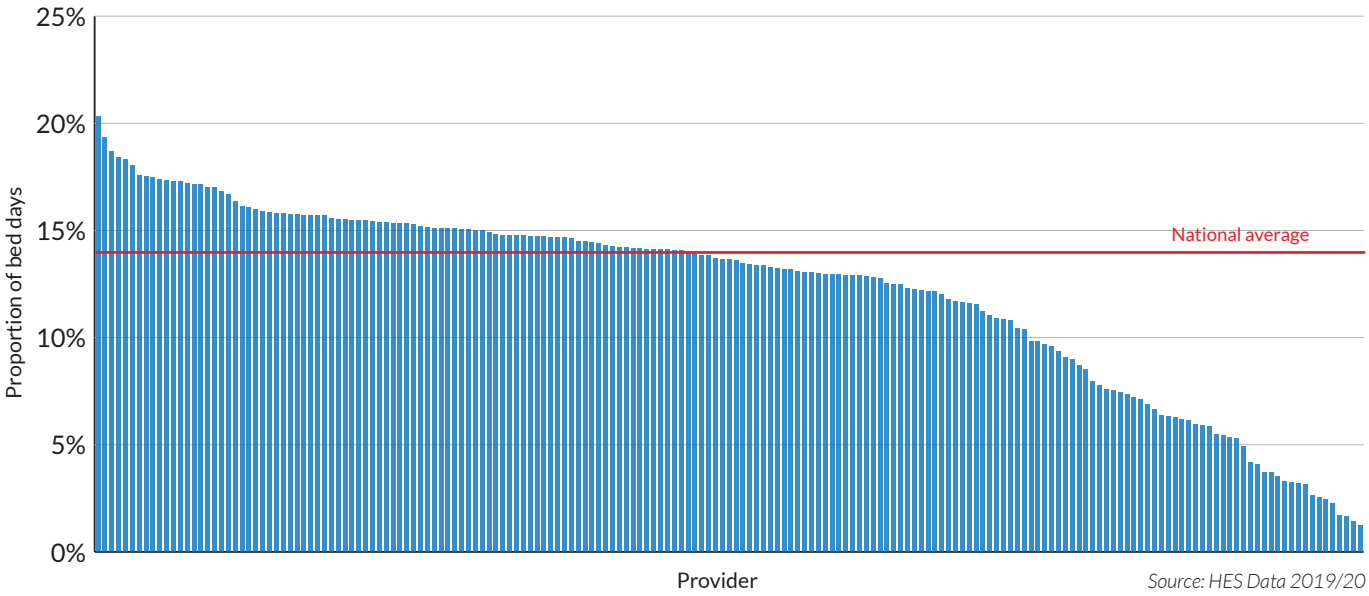
Providing better end of life care

Older people who are approaching the end of their lives should be recognised by the health system so that appropriate care decisions can be taken, in line with NICE guidance[57] and quality standards on end of life care[58].

As much as possible, patients should be able to die in their preferred place of care and have more choice in how this happens. They should be included, along with their families and carers, in shared decision making about end of life care, including preferred thresholds for interventions and treatments. Prompted by the pandemic, there is increased momentum to ensure these standards are realised.

Building on this momentum is essential, to ensure the greatest improvement possible compared to the situation prior to the pandemic. 2019-20 data showed that almost a third (30%) of older people who die in hospital experience three or more hospital admissions in the last 90 days of life[59], often causing unnecessary stress and suffering. End of life admissions of people aged over 75 made up an average of almost 15% of total bed days in NHS hospitals, as shown in **Figure 25a**. There was wide variation between trusts from around 2% of bed days to 20% at the top end of the range. Overall the proportion had remained fairly static across England over recent years as shown in **Figure 25b**.

Figure 25a: Proportion of inpatient bed days occupied by people over 75 in the last 90 days of life by provider (in-hospital deaths only)



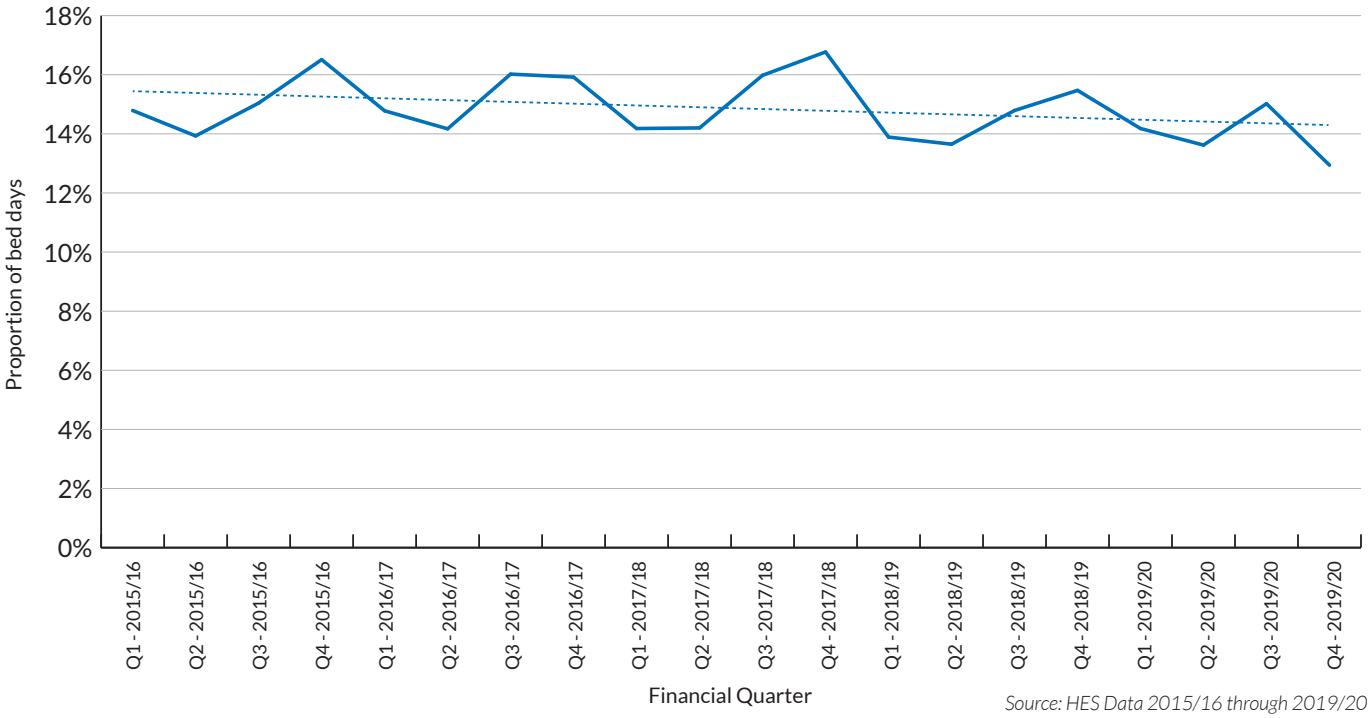
Source: HES Data 2019/20

[57] *Care of dying adults in the last days of life, NICE Guideline NG31, recommendation 1.1 https://www.nice.org.uk/guidance/ng31/chapter/Recommendations#recognising-when-a-person-may-be-in-the-last-days-of-life*

[58] *End of life care for adults, NICE Quality standard QS13, quality statement 1 https://www.nice.org.uk/guidance/qs13/chapter/Quality-statement-1-Identification*

[59] *Hospital Episode Statistics 2017-18*

Figure 25b: Proportion in inpatient bed days occupied by people over 75 in the last 90 days of life by provider (in-hospital deaths only), all providers 2015-2020



Source: HES Data 2015/16 through 2019/20

One issue is the availability of hospice care. On average, only 30% of this care is NHS funded, the rest depends on the voluntary sector, so it is less sustainable and only able to meet demand from limited categories or people such as those with certain terminal diseases. The COVID-19 pandemic has further highlighted the fragility of the sector, as hospices needed a government bailout to meet demand during the peak of the pandemic, prompting the momentum to improve the situation.

Another issue is cultural attitudes to death and dying. Good end of life care depends on patients, healthcare providers, care homes and others such as hospices working together and opening up difficult discussions around the subject, as advocated by campaigns such as Dying Matters[60].

Adopting national models and frameworks

There are several tools and models that trusts can use to support better planning and decision making around end of life care:

The Gold Standards Framework[61] provides a model for how to recognise end of life patients and plan their advance care needs, including appropriate directions around use of critical care and do not attempt to resuscitate (DNAR) orders.

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)[62] provides another useful framework for making these decisions.

The AMBER care bundle[63] is designed for use when a person has been admitted to hospital and when clinicians are uncertain whether they will recover in part due to underlying chronic conditions or frailty. If focuses on:

- Talking to the person and their carers to let them know that the healthcare team has concerns about their condition, and to establish their preferences and wishes.
- Deciding together how the person will be cared for should their condition get worse.
- Documenting these decisions in a personalised plan.
- Agreeing these plans with all of the clinical team looking after the person.

[60] *https://www.dyingmatters.org/*

[61] *https://www.goldstandardsframework.org.uk/*

[62] *https://www.resus.org.uk/respect*

[63] *https://www.guysandstthomas.nhs.uk/our-services/palliative-care/amber-care-bundle.aspx*

PEACE (Proactive Elderly Advance Care)[64] is a structured care planning tool used by hospitals when discharging patients to care homes, based on a shared personalised document that follows the patient. The document records the wishes of the patient and their carers and advance care planning (see below) decisions in the event of clinical incident or change in condition, taking account of the patient's mental capacity.

Advance care planning

Advance care plans (ACPs) can be a powerful tool in respecting the wishes of people in the final stages of life and ensuring their needs are met in the most appropriate setting. Evidence shows they can reduce admissions to hospital (see case study on p89).

What is an advance care plan?

This is a before-need plan which is discussed and agreed jointly between the older person, their carers and/or care home, and doctors – usually their GP – covering key decisions about their care. It covers issues such as:

- The person's preferred treatment thresholds in the event of clinical deterioration.
- Their wishes about hospitalisation in the final stages of life, in what circumstances.
- If they are hospitalised, whether they consent to critical care treatment.
- If the person is a care home resident, whether their treatment should be limited to palliative (comfort) treatment in the care home.

ACPs should be integrated into personalised care plans wherever possible in line with NICE quality standards[65]. Wherever possible this should be a single digital plan that is available to everyone involved in the person's care and linked to the urgent care services.

Having difficult conversations

As mentioned above, most advance care plans will be initiated and discussed between the older person and their GP. However, hospital staff may need to start conversations with patients about their ACP, for example, to update it as a result of changing circumstances.

The COVID-19 pandemic has accelerated these conversations in many trusts. We have heard feedback from trusts and third sector organisations that staff find it difficult to engage in this process and that many patients still feel like passive participants in their ACP.

Trusts need to improve levels of awareness and communication around ACPs and be clear what role they should play in patient care. We recognise that these can be difficult conversations and that staff should be adequately trained and supported to deal with them.

[64] *Advance Care Planning (PEACE) for care home residents in an acute hospital setting : impact on advance care planning and readmissions BMJ Supportive and Palliative Care 2011;1:99:*

[65] *End of life care for adults, NICE Quality standard QS13, quality statement 3 https://www.nice.org.uk/guidance/qs13/chapter/Quality-statement-3-Assessment-care-planning-and-review*

CASE STUDY

Co-ordinate My Care

Co-ordinate My Care (CMC) is an innovative NHS clinical service commissioned across the 32 London CCGs. It enables personalised care plans through a shared decision-making process with carers, doctors and care home staff. The patient is at the centre with all services joined up around them.

CMC provides a single, multidisciplinary digital urgent care plan that is co-created with the patient and their clinician and shared across acute and community health and social services. It has a patient portal and a real time reporting facility to monitor outcomes.

The patient can initiate their own care plan through the patient portal myCMC, or start their plan with their doctor, nurse or other carer. Once a CMC plan is created it can be accessed by 111, 999, out-of-hours GPs and hospital emergency departments. CMC has already brought significant increase in the number of people who die in their preferred place of care.

Results

Data from CMC shows that for over 50,000 deaths in London where patients have an Advance Care Plan accessible to the urgent care services, only 20% will die in hospital. This compares to 50% of the general population.

Variations in critical care for older adults

We found variation in the use of critical care beds for older adults, with some trusts sending very few patients with frailty over 75 to the intensive care unit (ICU), while others use it more widely. Data for people with frailty over 75 admitted to hospital as emergencies shows that an average of 1.4% are treated in critical care (levels 2 and 3), in a range from 0% in some trusts to 3.3% at the top end[66].

This variation may be due to a variety of causes, including inaccurate data, different approaches to clinical decision making in patients with risk factors for poor outcome, or the local capacity of the critical care service. Many trusts will make decisions on an individual basis, based on the person's general health and chances of recovery, but others may take a more blanket approach.

While this was not raised as a major concern during our deep-dive visits, we think that trusts should monitor patterns of ICU bed use for patients with frailty and consider reviewing their processes to ensure that decisions about access to critical care can be made in the best interest of each patient.

This theme will also be discussed in the GIRFT Critical Care national report, due to be published during 2021, which focuses on improving equity of access for patients in admission to critical care.

Embedding end of life models into practice

Trusts need to adopt end of life care models and embed them into systems and practice – for example by ensuring that advance care plans for each patient are shared in a system that everyone involved in their care can access.

In developing these procedures, trusts must take account of local cultures and attitudes and bring local communities with them – for example in certain communities, dying in hospital is preferred. Any changes need to be supported locally.

[66] *Hospital Episode Statistics 2017-18*

Recommendation: End of life care

Recommendation	Actions	Owners	Timescale
11. All local health systems should have identified older people in the last phase of life and offer them advance care planning, so they can be looked after and die in their preferred place of care wherever possible.	**a** GIRFT and NHS England and NHS Improvement will support local health systems to implement a system to recognise people at the end of life and offer them advance care planning.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress within a year of publication
	b GIRFT to support the use of agreed planning tools such as the PEACE document, Gold Standards Framework, treatment escalation plans, AMBER and Respect.	GIRFT, NHSE/I, Trusts, ICS/STPs Gold Standards Framework, Co-ordinate My Care	For progress within a year of publication
	c GIRFT to work with trusts and other providers to ensure that advance care plans are shared with NHS 111 and 999 emergency services.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress within a year of publication
	d NHS England and NHS Improvement to ensure that palliative care services are available in community settings.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress a year after publication
	e Trusts to monitor data and outcomes on good end of life care.	GIRFT, NHSE/I, Trusts, ICS/STPs, Gold Standards Framework, Co-ordinate My Care	For progress a year after publication

A workforce to meet the needs of the ageing population

As the population ages, the need for specialist geriatric services has risen dramatically. People are living longer with frailty and multi-morbidity and requiring more care in hospital, while older adults are having more surgical treatments than ever before.

Geriatricians are increasingly called on to manage people with frailty across the hospital, to work in multidisciplinary teams, and for liaison work with surgical and medical departments. Externally, there are also increasing demands for hospital-based staff to work with community rehabilitation teams and in care homes.

While the scope of practice is increasing, capacity is not matching it. We have found shortages of key staff in many areas and not enough trainees in the pipeline to meet likely future demand. It's clear that these challenges cannot be met by the existing siloed workforce and that new ways of working, with blending of skills and making use of the wider skills mix, need to be part of the solution. We think that the new integrated care systems (ICSs) should make geriatric medicine workforce development a high priority over the coming years.

Shortages of key staff

Consultants: many trusts we visited say they are having problems recruiting consultant geriatricians at a time when they want to expand, either for front door frailty work, within hospital liaison, or for surgery, oncology and community work. This may be for a variety of reasons: for example, some specialists want to work part-time or flexibly for a better work-life balance, or they may wish to focus on community geriatrics. Some hospitals have found that developing consultants through the CESR (Certificate of Eligibility for Specialist Registration) route is successful and we recommend this is explored in any hospital where there are recruitment difficulties.

Medically qualified specialist trainees in geriatric medicine: the allocation of trainee posts is uneven across regions. It largely depends on ability to provide the breadth of training required in the curriculum rather than clinical need. This means that larger teaching hospitals in cities have most trainees and smaller general hospitals relatively few. Fair allocation of trainee slots between larger and smaller hospitals matters because their future choice of hospital is often the result of a positive experience as a trainee.

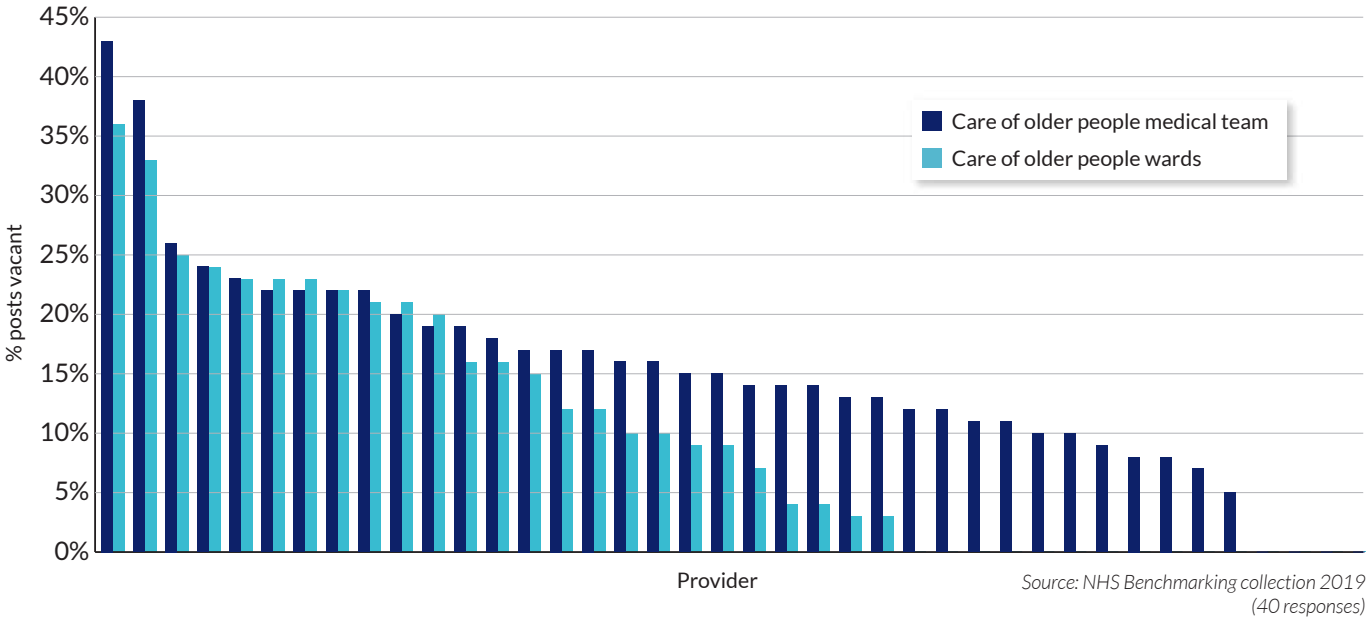
We also found a regional variation in vacancies. On our deep-dive visits, we were told that only 50% of training posts are filled in some areas, while in other areas vacancy rates are low.

Nurses/advanced practitioners: use of advanced practitioners, including nurses and therapists, for specialist work is growing but we have heard of problems in recruiting them. On our deep-dive visits, trusts told us they were seeing shortages of a range of specialist nurses including bone health and dementia and delirium nurses, with high vacancy rates in some areas.

We also heard from trusts that staff had been trained and developed locally but then found there was a lack of suitable positions for their expertise. In many hospitals advanced practitioners are the backbone of the acute frailty teams and support for career progression is essential.

Figure 26 gives a snapshot of vacancy rates for both medical and nursing staff on geriatric wards from the NHS Benchmarking Network's Managing Frailty project, based on all responses received, including some which were partially incomplete and therefore excluded from the official NHSBN data. There was wide variation, with some trusts showing vacancy rates of over 40% for nursing and allied health staff and more than 35% for specialists, while others had few or no vacancies.

Figure 26: Vacancy rates for medical and nursing teams on geriatric wards



Source: NHS Benchmarking collection 2019 (40 responses)

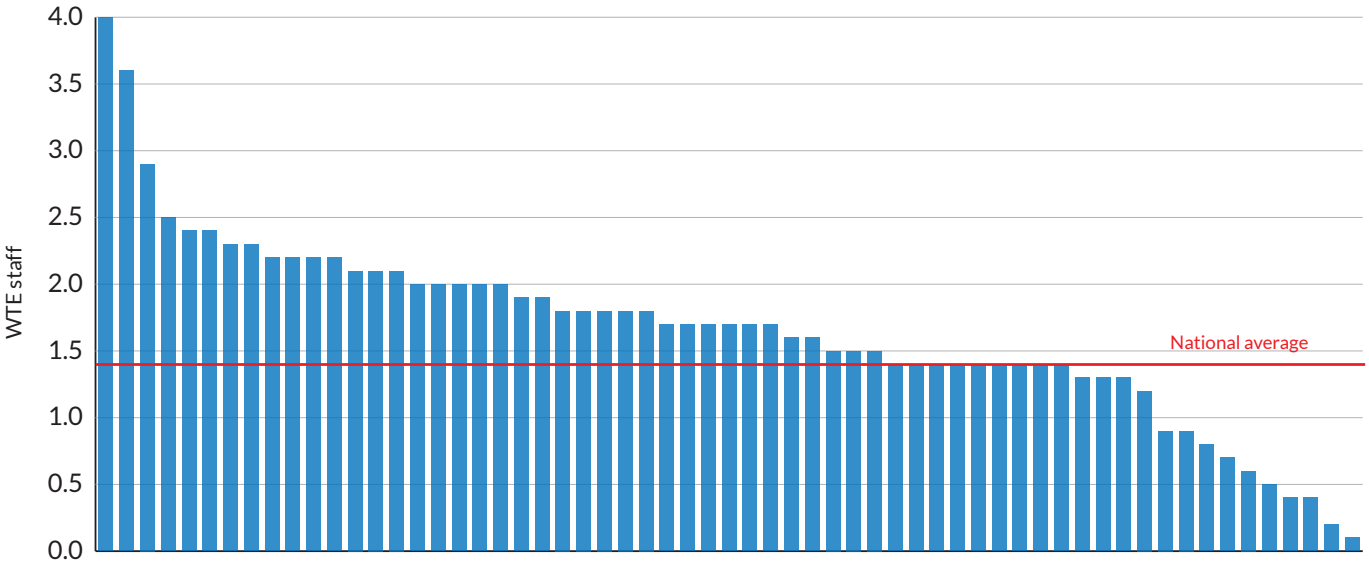
In some trusts, geriatric units are kept going by locums, raising questions about the long-term sustainability of the service. Shortages of key skills can also constrain the capacity for care home liaison and community work, holding back the progress towards integration of health and social care.

Making full use of the skills mix

Figure 27a from the NHS Benchmarking Network's Managing Frailty project shows variation in the number of whole time equivalent (WTE) staff per bed in care of older people wards, including nurses, HCAs and allied health professionals, including pharmacists, physiotherapists and dieticians.

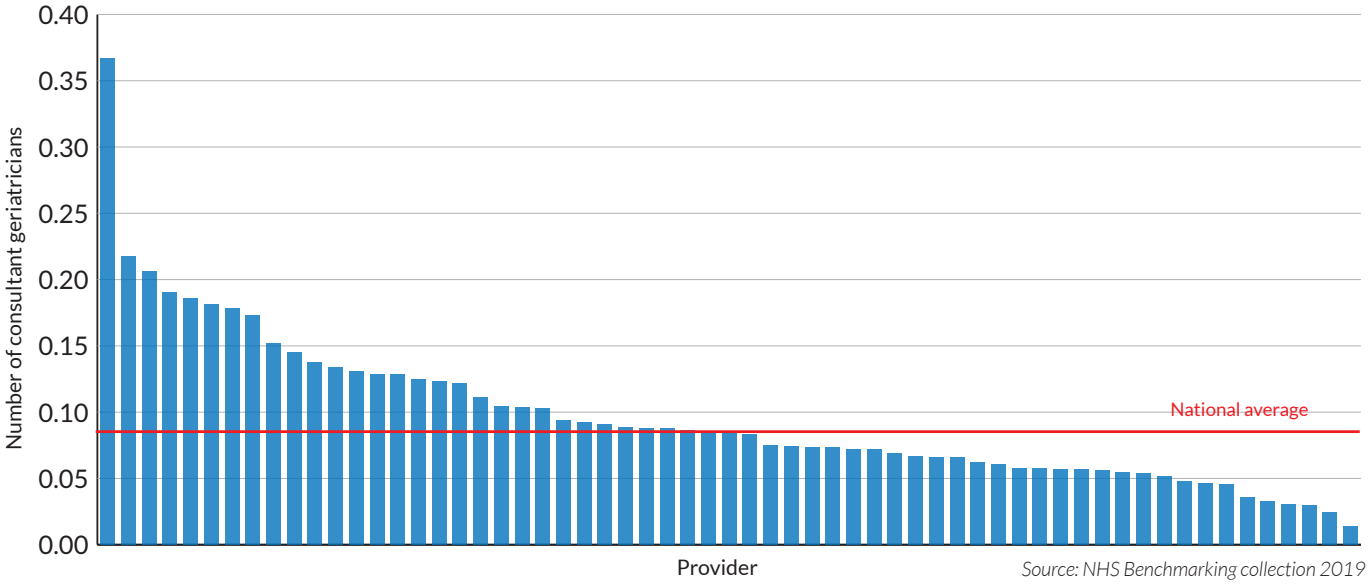
Although some trusts have less than one whole time equivalent (WTE) staff member per bed, many have two or more, suggesting there is scope in many units for greater use of the wider skills mix. **Figures 27b** and **27c** reflect the relative shortage of specialist geriatricians. One trust reported having only one WTE geriatrician for every 70 beds in care of older people wards.

Figure 27a: Whole time equivalent staff per bed on care of older people wards including doctors, nurses, HCAs, allied health and social care



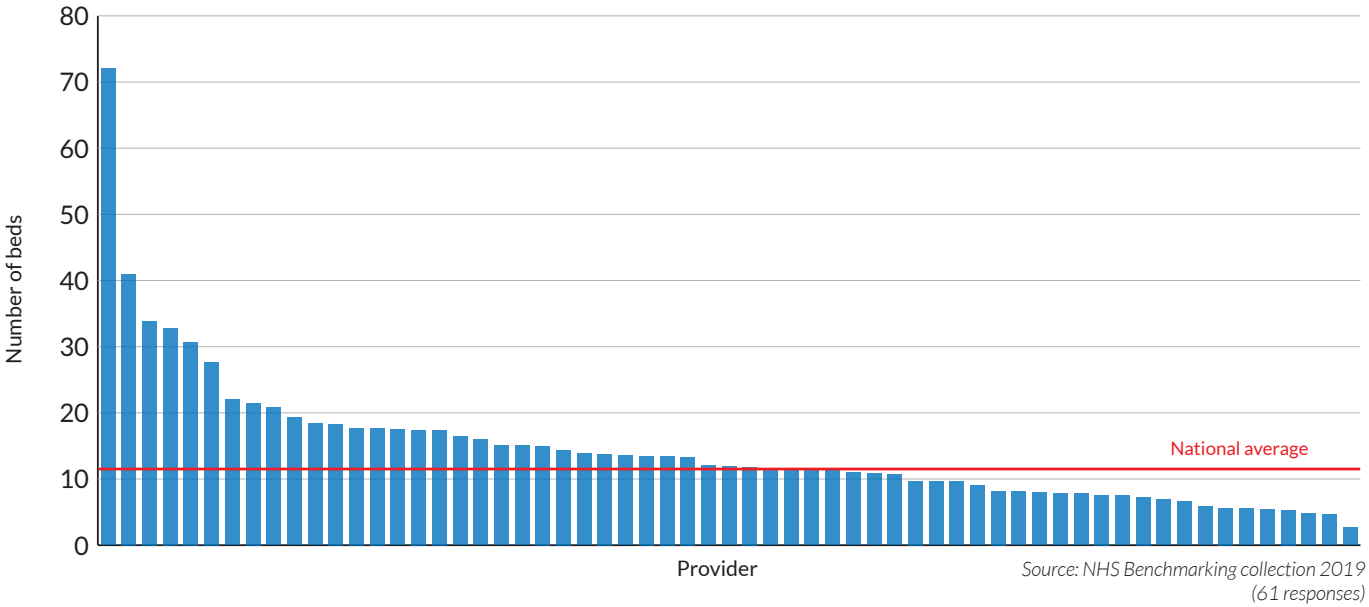
Source: NHS Benchmarking collection 2019 (61 responses)

Figure 27b: Whole time equivalent consultant geriatricians per bed on care of older people wards



Source: NHS Benchmarking collection 2019 (61 responses)

Figure 27c: Beds per whole time equivalent consultant geriatricians on care of older people wards



Source: NHS Benchmarking collection 2019 (61 responses)

To sustain viable units, we need to be more imaginative about how we provide geriatric specialist services and focus on how to meet patient needs using the skills available. Creating effective CGA based multi-professional teams will require effective support from senior medical staff in the short term.

Rather than look at how many consultants are required, trusts should review the key tasks involved in providing a service and who is best placed to do them. Units should support consultant geriatricians and other specialist clinicians to operate at the top of their licence and enable physician associates, therapist and advanced nursing practitioners (ANPs) and other clinicians in the MDT to do more of the work currently done by medical specialists. However, we recognise that taking on an enhanced role may be challenging, particularly in the care of people with severe frailty, and that staff may need support and training to enable this. New ways of working include blending of skills between staff and developing out of hospital assessment, sometimes performed virtually rather than face to face.

Advanced or enhanced practice within nursing

Some services traditionally provided by doctors can be led by ANPs. We have seen examples where this is already happening with continence clinics and fracture liaison services.

We think there is scope for this to be extended to some consultant-led activities, such as front door frailty assessment and liaison with care homes. This depends on recruitment and training and development of nurses. However, we think the added scope for development and progression could make these roles more attractive and this development should be a strategic priority for the ICSs.

We have seen examples where nursing colleagues have been supported to achieve advanced practice as well as enhanced practice roles for the benefit of patient outcomes. Examples include utilising these specialist roles within continence clinics and fracture liaison services, among many others. Additionally nurse consultant roles, where registered nurses undertake further academic study and research to complement their extensive clinical experience, are extremely valuable within geriatric medicine. Nurses within these roles have the capability to undertake a range of activities, such as complex frailty front-door assessments, care planning and co-ordination across the MDT and with wider community stakeholders, in addition to the roles they currently undertake. This does, however, depend on a range of resources being available to support the recruitment, education, training and longer-term support for these career pathways. We think the added scope for development and progression could make these roles more attractive and this development should be a strategic priority for the ICSs. Frailty training at level 3 in the Frailty Capabilities Framework (page 60) is an essential part of this.

Pharmacists and other health and care professionals

Geriatric medicine units also depend on a range of other health and social care professionals, including advanced practitioners, physiotherapists, occupational therapists, pharmacists, and social workers.

Units should think about how these staff might perform an enhanced role as part of the multidisciplinary team. For example, there may be more that pharmacists can do in managing the symptoms of frailty and multi-morbidity. Likewise, dieticians could take a greater role managing patients with dysphagia and other nutrition-related disorders.

These staff should be supported to extend their roles and perform at the top of their licence. For example, physiotherapists should be able to delegate basic mobility support to therapy support staff or ward staff, which could free up their time for complex assessments and prevention of deconditioning.

However, any change to current roles needs to be done in an efficient way that avoids duplication. Older people with frailty, who may have dementia or delirium, do not need a wider cast of professionals checking on them. Wherever possible, assessments should be shared, for example between occupational therapy and physiotherapy, with appropriate blending of skills to eliminate duplication and ensure patients are not kept waiting for a particular practitioner.

The role of old age psychiatry

Old age psychiatrists are an essential part of the geriatric medicine multidisciplinary team (MDT), for example to help with assessment of complex delirium and management of serious mental illness under the Mental Capacity Act. We found that most hospitals provide some access, while some provide 24-hour cover. However, there are a few trusts where this service is not available. We think it is important that all patients who need specialist support have appropriate access to psychiatric support regardless of where they live.

Wider role for emergency, acute and general medicine

Staff from emergency departments, acute internal medicine and general medicine are closely involved in the care of older people in hospitals and often deliver services normally provided by geriatricians and acute frailty teams, out-of-hours and at weekends.

We think there is scope to expand these co-working arrangements in many trusts, depending on capacity and local workforce availability, based on providing a continuous 24/7 for these patients. For example, acute and general medicine specialists could take a greater role in acute frailty assessments and ambulatory assessment.

However, we have heard in several deep-dive visits that acute frailty assessment is best performed by the acute frailty team rather than emergency or acute medicine services. We therefore think there is a need for further training and development to support assessment skills within these specialties. It is vital that we develop a one team 24/7 approach to frailty that embraces all specialists involved with the emergency pathway.

Integrated workforce planning

We need to develop new workforce models, including portfolio job planning to increase opportunities for development, backed with appropriate training and support. As we move towards integrated care systems (ICSs), this should be planned at ICS level to ensure that workforce solutions can meet future needs at scale across the footprint.

Using digital technologies

Digitalising processes to support staff and free up their time can also help relieve workforce pressures. This could also benefit patients by enabling the creation of a single multidisciplinary digital care plan, which can be updated online and accessed 24/7 by a range of health and care professionals, removing the need for multiple assessments and conversations. However, it means a culture change and needs to be supported by training and also effective digital infrastructure, which is often an obstacle to whole-system working.

Supporting care workers

Workers in care homes and social care provide essential support for older people with frailty, helping them live independently and reducing the need for hospitalisation. This, in turn, is a vital support to the NHS in reducing demand on services – as has been illustrated during the COVID-19 pandemic, when care workers were celebrated as key workers protecting the wider health system from being overwhelmed.

As discussed in *Improving liaison with care homes*, page 80, what happens in care homes affects the NHS and can have a major impact on admission and length of stay. If there are not enough staff in care homes to accept patients at weekends, that can mean people with frailty must stay in hospital longer, increasing their risk of deconditioning – and increasing the overall cost of care for NHS trusts. Similarly, many patients with frailty can only be discharged from hospital if a social care package is available, which is often very limited at weekends. Care workers are also crucial to the effective operation of new pathways such as discharge to assess.

Improving conditions for these workers should therefore be a priority for the wider health and care system as we move towards a whole system integrated model of care.

Workforce challenges

On our deep-dive visits, trusts told us of significant workforce challenges in their local care sector. In more affluent areas, which tend to have the largest populations of older people living with frailty, it's difficult to recruit care workers as they can't afford to live there. In more deprived areas, there is competition for staff with businesses such as Amazon or shopping centres, which pay more or have preferable conditions of employment.

Of the 800,000 WTE workforce in England, split between care homes and home care, around a quarter (25%) are employed on zero hours contracts[67]. Most are on minimum wage, with limited career or pay progression, which leads to a high turnover of staff. Many home care workers are also paid by the minute for the time they are with clients, which means that travel time between visits are unpaid.

We think that care home workers should be recognised as essential to a sustainable and effective health system and that their pay and conditions of employment should reflect the important role they play.

The role of unpaid carers

Many older people are supported by unpaid carers, usually family members or spouses, as well as or instead of more formal care arrangements. Carers UK estimate that there are up to 8.8 million unpaid carers in the UK as of 2019[68]. Modelling from New Economics Foundation (NEF) consulting on behalf of NHS England and NHS Improvement puts the cost saving of unpaid care to the economy of between £24bn and £37bn a year[69].

The number of unpaid carers will need to increase to meet the rise in demand of our ageing population. The London School of Economics estimates that the number of older people in England receiving unpaid care will increase from 2.1 million in 2015 to 2.65 in 2025 and 3.4 million in 2035 (a rise of 63%).

These projections highlight the hugely important role that unpaid carers play in the overall management of older adults and people with frailty. Often, these people are unsupported and many admissions come when they can no longer cope, leading to a crisis and presentation at A&E.

The NHS should do more to support carers and work more closely with third sector partners such as Age UK and Carers Trust to explore ways of doing this, based on the common interest of keeping people well at home and avoiding hospital admissions wherever possible.

[67] *https://www.nuffieldtrust.org.uk/news-item/what-does-the-social-care-workforce-look-like-across-the-four-countries*

[68] *Carers UK, State of are 2019*

[69] *NEF Consulting, Technical note accompanying the model: 'Socioeconomic Costs and Benefits of Unpaid Carers', 2019*

Recommendation: Workforce

Recommendation	Actions	Owners	Timescale
12. ICS/STPs should develop new ways of working to meet local service needs including: extended roles for nurses, allied health professionals, pharmacists and advanced practitioners; a greater role for consultants in acute, general and emergency medicine where capacity allows; more opportunities for portfolio career progression to attract and retain consultants and trainees.	**a** GIRFT to support Health Education England, NHS England and NHS Improvement and professional societies on guidance for extended roles for the geriatric medicine multidisciplinary team.	GIRFT, HEE, NHSE/I, BGS, RCN	For progress within a year of publication
	b Trusts to use the Frailty Capabilities Framework training at levels 2 and 3 to improve skills and help staff to work at top of licence.	Trusts, ICS/STPs	Six months after publication

Improving outpatient care

Older people, many with frailty, make up a significant proportion of the number of outpatient appointments in the NHS. According to Age UK patients over the age of 60 account for approximately 30% of all outpatient attendances[70].

On our deep-dive visits, carried out before the COVID-19 crisis, we found wide variation in outpatient clinics in geriatric medicine – some of the trusts we visited had very few clinics, while others had many, in multiple sub-specialties, seeing tens of thousands of patients each year.

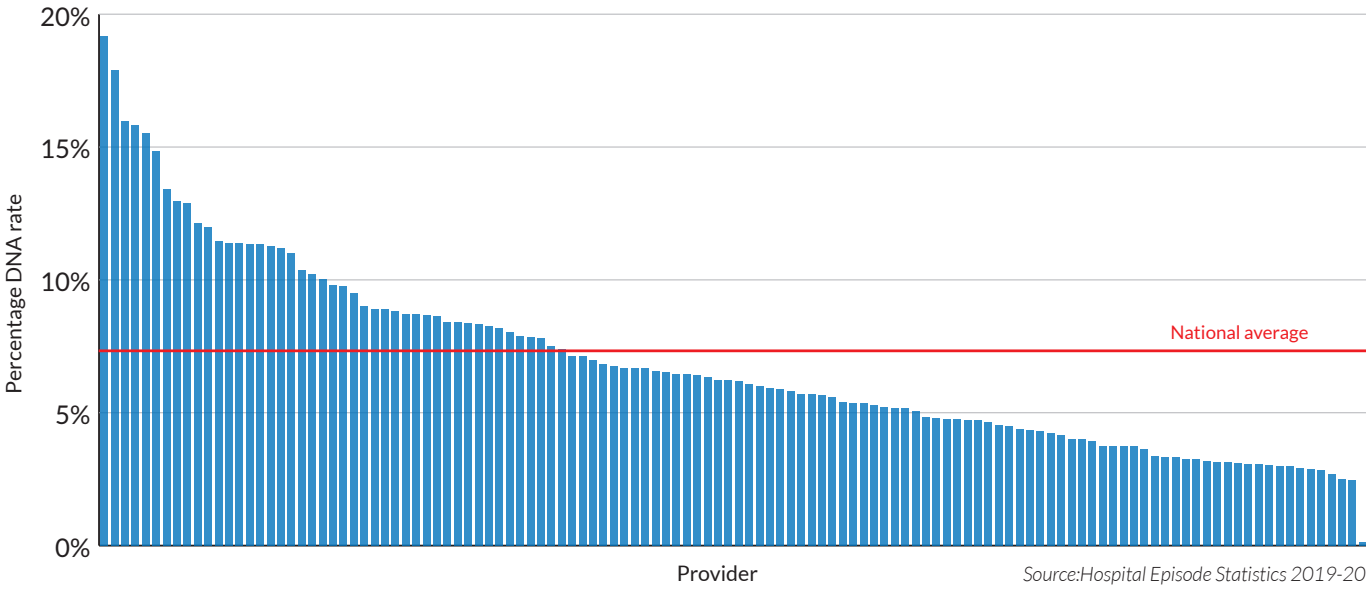
Many people with frailty were having multiple outpatient appointments in multiple specialties, attending as many as eight separate specialty clinics, in addition to an assessment in geriatric medicine. Some of this may have been dictated by medical need and urgent referrals, but often the appointments were very brief routine assessments that don't require face to face contact.

These appointments should be co-ordinated between clinics to reduce the number of hospital visits for vulnerable patients. However, we found poor co-ordination between clinics and administrative staff. Often, there was no mechanism for co-ordinating an effective patient-centred outpatient model.

For common conditions like falls, many patients only need a quick and simple assessment followed by straightforward interventions such as exercise. However, we found that many of these patients were waiting for long periods for initial assessment at a specialist clinic. Given that 40% of over 75s experience falls at some time, we think this should be a clear, separate pathway. There should be fast access to assessment linked to falls prevention advice and services, organised on a population basis at integrated care system (ICS)/sustainability and transformation partnership (STP) level.

As a result of the issues described above, it's unsurprising that outpatient 'did not attend' (DNA) rates are high, averaging around 7%, as shown in **Figure 28a**, although there has been some improvement during 2019-20 as illustrated in **Figure 28b**. However, we also found examples of trusts reducing DNA rates by contacting the patients in advance by telephone. Administrative staff also look at the scheduling of appointments and are best placed to actively manage duplicate appointments.

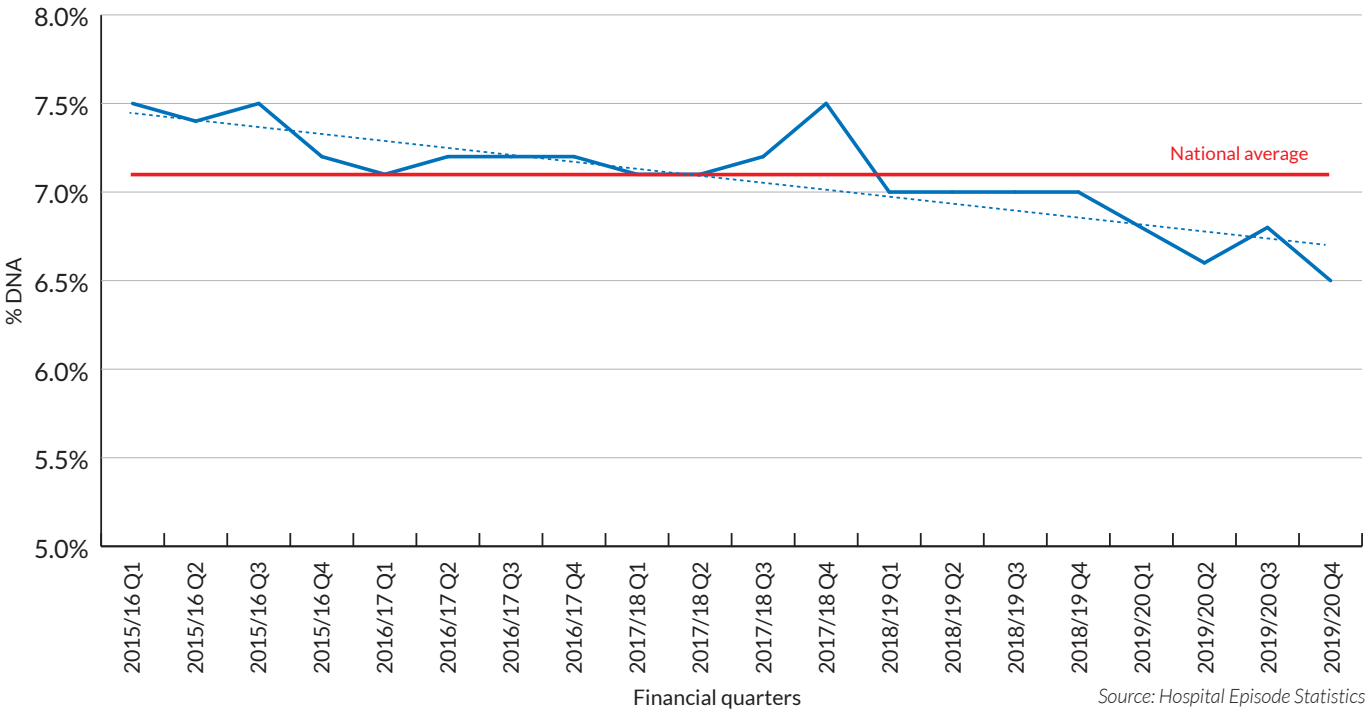
Figure 28a: Proportion of outpatients over 75 who failed to attend geriatric medicine clinics by provider



Source:Hospital Episode Statistics 2019-20

[70] *Age UK, health and care of older people briefing 2019 https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/age_uk_briefing_state_of_health_and_care_of_older_people_july2019.pdf*

Figure 28b: Proportion of outpatients over 75 who failed to attend geriatric medicine clinics, all providers 2015-20



Source: Hospital Episode Statistics

Alternative models of ambulatory assessment

Some of the trusts we visited have reduced the need for outpatient appointments through innovative methods of assessment, for example Comprehensive Geriatric Assessment (CGA) in a community assessment hub for older people with frailty as part of an integrated care system.

The focus is on preventing progression of frailty through good case management, including advance care planning, so that most issues can be dealt with in the community, eliminating the need for multiple outpatient appointments.

Same day emergency care, which provides rapid assessment, diagnosis, treatment and reablement for people with frailty presenting in A&E, also helps to reduce admissions and avoid the need for further outpatient appointments – see *Potential solutions: whole-system models of care*, page 34.

Outpatient transformation and changes during COVID-19

The NHS England and NHS Improvement Outpatient Transformation Programme is designed to give more choice to patients in how outpatient appointments are delivered, through online appointments and virtual outpatient clinics.

The need for social distancing, and for older adults to shield themselves from the COVID-19 virus, has accelerated these developments in many hospitals. We think these should become a permanent feature, reducing the volume of hospital appointments.

There are risks attached to this model as older people, and particularly those with frailty, may find consultations by phone or video difficult. The best models work by telephoning the patient in advance to see whether a virtual consultation is appropriate, or whether they need or prefer a face to face appointment. We think that, with proper safeguards, remote clinics can work as well as physical clinics for many older adults.

The move should be supported by changes to contracts with commissioners to remove anomalies in the tariff system which often incentivise physical appointments over telephone/video clinics.

In some trusts, moving to virtual clinics may entail an increase in imaging referrals. This impact needs to be monitored to ensure this does not cause undue delays or pressure on imaging services.

One stop shop appointments

Where physical appointments are needed, trusts should aim for a co-ordinated 'one-stop shop' approach, so patients can get everything they need on the same day wherever possible. This can improve life for patients with frailty, who endure considerable hardship getting to and from multiple hospital appointments.

Under the current tariff system, there may also be a disincentive to provide multiple appointments in one-stop. Local commissioners often regard more than one appointment in a single day as an error and may withhold payment. We would like to see a change in national commissioning guidance to remove the disincentive and encourage all local commissioners and providers to develop this model.

Patient-initiated follow up

Follow-up appointments which are booked by the patient rather than the hospital are seen as a way to reduce unnecessary outpatient attendances. They can also make services more responsive to patients by seeing them when they need care rather than on a three- or six-monthly schedule.

We think this can be useful for older patients with stable conditions and some patients with mild or moderate frailty who are engaged in their own care, but not those with more severe frailty or illness, such as dementia. This is a crucial co-morbidity that needs to be considered in developing an effective ambulatory strategy.

Implementing change

The move towards new models of ambulatory assessment and outpatient delivery should be led at ICS/STP level to ensure that local health systems take a co-ordinated approach and can share best practice and innovation. However, we recognise that integrated care systems and structures are not yet established in many areas. While they are being developed, trusts should continue with work already underway to provide appropriate alternatives to outpatient attendance.

Recommendation: Outpatients

Recommendation	Actions	Owners	Timescale
13. ICS/STPs should develop and embed models such as virtual clinics, community assessment hubs, out of hours crisis response, same day emergency care and patient-initiated follow up to improve the effectiveness of ambulatory assessment for older adults as envisaged in the NHS Long Term Plan.	**a** Trusts to manage duplication of outpatient appointments moving towards a one-stop shop model of ambulatory care.	GIRFT, NHSE/I, Trusts, ICS/STPs	Ongoing
	b Trusts to review the provision of specialist clinics such as falls, memory and continence, to ensure they are at the appropriate scale and linked to a wider pathway.	Trusts, ICS/STPs	Within a year of publication

Data and coding

Main specialty code 430 and treatment function code 430 can be used to identify geriatric medicine activity. In our analysis, we have found wide variations in how geriatric medicine activity is attributed, with some trusts using the main specialty code for geriatric medicine (430) for most of their non-elective frailty work and others not using this code at all.

Many hospitals allocate the majority of non-elective activity to general medicine (300). We have found examples where the treatment of older people with frailty is mostly allocated to acute internal medicine and several examples where acute frailty activity is allocated to medical specialties such as respiratory medicine or gastroenterology.

To get a clearer picture of overall levels of activity in the emergency medical pathway for older adults in this report, we have combined data for over 75s from the specialties of emergency medicine, general medicine and geriatric medicine.

Why is work being attributed to other specialties?

The reasons for variations in attribution may depend on where the work is done or established local practice:

- Some work, such as liaison, is part of a pathway led by another surgical or medical specialty, where the whole procedure is coded to that specialty.
- Short stay patients are often admitted to an assessment ward/space run by general medicine or emergency medicine, and may never leave that space until discharge.
- Activity is attributed to the specialty of the consultant in charge when the patient is admitted and not changed appropriately.
- Where the number of specialist older persons beds is small, frail patients are treated in medical specialty wards.
- Some hospitals prefer to code all geriatric activity under general medicine for administrative purposes.

There is also some variation over what falls under geriatric medicine, with some units focusing on rehabilitation and others taking all older people with frailty who come through the emergency department.

Impact of inconsistent attribution

Differing attribution of activity obscures our view of the geriatric medicine specialty and means that benchmarking just by the specialty of geriatric medicine does not work. It has a significant impact on our ability to review and improve services, making it difficult to compare performance and outcomes between trusts.

It may also impact directly on patient care. We often can't tell whether people with frailty who are being treated by surgical and medical specialties are receiving the liaison support they need, because this activity may not be captured by the specialty code, nor can it be identified using clinical codes (ICD10 and OPCS4). This is a concern given the added risks faced by some of these patients as a result of their frailty. While the Best Practice Tariff for Hip Fracture[71] has provided an incentive for trusts to code patients with frailty more comprehensively, more needs to be done. Specifically, it is important that geriatric medicine input is identifiable via the specialty code, and that frailty can be better identified using diagnostic codes.

Improving capture of diagnostic codes

Identification of frailty from International Classification of Diseases (ICD) diagnostic codes is potentially important as we move towards a more proactive, data-led system. For example, having accurate ICD code information could help us develop a register of patients with frailty and identify opportunities to improve frailty pathways. In the longer term, artificial intelligence predictive algorithms could be used to support case finding and management.

However, we have found wide variation in the rate of identification of key frailty diagnostic codes. For example, the proportion of admitted patients over 75 years with ICD10 diagnoses that map to the dementia/delirium domain ranges from 15% in some trusts to 40% in others, while the rate for falls and fractures ranges between 10-25%[72]. This is more than can be explained by variation in case mix.

[71] *https://www.nhfd.co.uk/20/hipfractureR.nsf/0/9b0c5ea2e986ff56802577af0046b1df/$FILE/Best%20Practice%20Tariff%20User%20Guide.pdf*

[72] *Hospital Episode Statistics 2018-19*

As well as this variation between hospitals it is likely that most hospitals are currently under-coding delirium and dementia in patients over 75 years old where prevalence is high. In patients admitted as a medical emergency over 70 years old 42% have dementia[73]. Additionally, 15% of all emergency admissions over 60 years old have delirium[74].There will be additional cases as delirium is commonly hospital acquired and both delirium and dementia prevalence increase with age.

The variation in recording of diagnostic codes means that trusts are unable to identify frailty with sufficient accuracy from the ICD10 diagnostic clinical codes used to describe episodes of care to support a data lead management of frailty. To help resolve this, trusts should ensure clinical records contain information which reflect the diagnoses identified via frailty assessments accurately.

What are the reasons for variations in ICD10 coding?

This is largely related to how the clinical codes are read and applied across the system. Issues include:

- Inconsistent recording of information – for example, a comorbidity recorded in one admission may not be coded on subsequent admissions unless it is re-recorded in the clinical record for the subsequent admissions (due to a specific national clinical coding rule). The consistency of how information is recorded is affected by: the quality of source documentation being used for code assignment; the completeness of the recording of comorbidities in the clinical record, and the legibility of hand written and scanned documents.
- Reading from paper documents – inconsistencies can also arise when diagnostic descriptions are copied across from scanned or paper documents, leading to inaccurate or incomplete recording.
- The ability of the coder to accurately translate the clinical information.
- Clinical coders' understanding of what is relevant in the care of the frail older patient.

Ideally frailty data should follow the patient from primary care using the e-frailty index. However, GIRFT was unable to use this data as part of our analysis and we have heard from trusts that many have difficulty accessing it.

Potential solutions: diagnostic coding

We think that there is a need for more detailed guidance for clinical coders on how to apply the existing codes and for better joint working between coders and clinicians to accurately interpret clinical records and ensure the coded data are validated.

On our deep-dive visits, we found that the depth of clinical coding is generally better when information is taken from an electronic health record (EHR). Up to date, clinically validated lists of patient comorbidities should be maintained as a standard part of the EHR wherever possible.

[73] *Sampson: Dementia in the acute hospital BJPsych 2009 195 61-66*

[74] *Welch, C., McCluskey, L., Wilson, D. et al. Delirium is prevalent in older hospital inpatients and associated with adverse outcomes: results of a prospective multi-centre study on World Delirium Awareness Day. BMC Med 17, 229 (2019). https://doi.org/10.1186/s12916-019-1458-7*

Recommendation: Coding

Recommendation	Actions	Owners	Timescale
14. Attribution of specialty should be reviewed to ensure that geriatric medicine activity and the specialty of the person doing it can be identified.	**a** Trusts to attribute all geriatric medicine activity using Main Specialty code 430 or Treatment Function code 430.	GIRFT, Trusts, ICS/STPs	For progress within a year
15. Clinicians and coders should work together to improve capture of frailty-related diagnostic codes to give trusts a clearer hospital-wide data view of frailty. Trusts should be able to see which patients are living with frailty and how severe it is.	**a** GIRFT coding team to work with professional societies to support trusts to improve the quality of clinical coding.	GIRFT, RCP, BGS	For progress within a year
16. Consider how liaison and other shared care services could be recorded and reported more effectively.	**a** GIRFT to work with NHS Digital and NHSE/I to look at how liaison services and other shared care services can be recorded and reported effectively.	GIRFT, NHS Digital	For progress within a year

Medicines optimisation

Many patients treated within geriatric medicine are on multiple medications (polypharmacy), often due to common multi-morbidities such as diabetes, dementia, osteoporosis, heart failure and COPD. Clinical commissioning group (CCG) data shows that on average, 17% of patients over 75 in England are on ten or more prescribed medicines and up to 30% in some CCG areas[75].

Older people with frailty may suffer from altered drug pharmacokinetics and loss of homeostatic reserve, which increases the risk of side effects such as falls and delirium. Certain medicines, such as anticoagulants, analgesics and drugs for diabetes, are particularly prone to cause serious side effects,

Rates of medication error are higher in older adults, in care home settings, primary and secondary care and during transfer of care. This appears to be compounded when there is evidence of co-morbidity, such as dysphagia, kidney disease or dementia[76]. These side-effects and errors contribute to high rates of hospital admission among people over 75, especially those with frailty[77].

Medicines safety in care of older people

For all of these reasons, it is vital that the use of medicines in care of older people is closely monitored and reviewed to improve outcomes for patients, avoid unnecessary admissions and reduce the overall cost of care.

Older patients should have an initial review of medicines management when they are admitted to hospital. The admission may be triggered by adverse drug reactions and the risks and benefits of drugs needs to be reviewed. This can be done using a structured approach such as the STOPP-START tool, or the anticholinergic burden score to assess the risk of drugs that contribute to falls and delirium.

Deprescribing for older patients with polypharmacy

We have found a shift to proactive deprescribing in older patients and those with frailty. In some areas, clinical pharmacists are trained to deprescribe as part of multi-agency structured medication reviews (SMRs) working as part of integrated and multidisciplinary services.

We support this work. However, the aim of deprescribing should not simply be to reduce the amount of medicines prescribed. It should be based on patient-orientated outcomes, appreciating the complexity of care in older people, and approached stepwise and with regular follow up. Clinicians should use patient-centred consultation skills, therapeutic skills, research and evidence, as well as deprescribing decision tools and benchmarking dashboards[78].

Tools should also be used to optimise the use of medicines and to prevent avoidable adverse drug reactions. For example, to decide when gastroprotection should be provided for elderly patients who are prescribed antiplatelets used to prevent blood clots. Clinical pharmacists can help with practical suggestions to simplify regimens for those administering medicines.

NHS England and NHS Improvement has a suite of frailty medicines optimisation resources[79] available to reduce problematic polypharmacy in the frail and elderly. The Specialist Pharmacy Service commissioned by NHS England and NHS Improvement also has resources to support clinicians in deprescribing. There are professional practice groups, such as The English Deprescribing Network (EDeN) to shares ideas, best practice and learning.

The Chief Pharmaceutical Officer, Dr Keith Ridge, is leading a National Overprescribing Review commissioned by the Secretary of State in 2018. The review will consider problematic polypharmacy, handover between primary and secondary care, management of repeat prescriptions, digital technologies and social prescribing. The review is expected later in 2020.

[75] *NHS RightCare*

[76] *http://www.eepru.org.uk/wp-content/uploads/2020/03/medication-error-report-edited-27032020.pdf*

[77] *https://www.sps.nhs.uk/repositories/safer-prescribing-for-frailty-jane-hough/*

[78] *https://www.sps.nhs.uk/wp-content/uploads/2018/08/Lelly-Oboh-10-strategies-for-managing-Polyphamacy-LO-271118-comp.pdf*

[79] *https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources/#meo*

Discharging patients with polypharmacy safely

Due to the complexity of problematic polypharmacy it is important that patient hospital discharge summaries are accurate and include information on what medicines were stopped, trialled and started during the person's hospital stay. Summaries should also give indications to assist with medicines reconciliation in care home and general practice settings.

It is vital that when older patients and those with frailty leave hospital, they receive support with their medicines during and after the transfer of care to ensure continuity and avoid errors and adverse reactions. The Transfer of Care Around Medicines (TCAM) programme provides a good model for how this can be done, including assistance for primary care and community pharmacists helping them to prioritise older patients and those with frailty.

Co-ordinating with care homes

More than 40% of all medication errors in England occur in care homes and pharmacy input is a core part of the Enhanced Health in Care Homes programme – see *Solutions: Enhanced Health in Care Homes*, page 84. Local health systems need to work harder to support medicines safety for care home residents, including those with frailty.

Progress has been made during the COVID-19 pandemic, as a new system-wide pharmacy service for care homes was developed and delivered at pace. Remote clinical pharmacy consultations were provided for patients in their own home, including care homes. Integrated care systems (ICS)/sustainability and transformation partnerships (STPs) should seek to build on this and integrate remote pharmacy consultations into system-wide frailty services.

The role of primary care networks (PCNs)

Hospital trusts should link with primary care networks, which have a new contractual responsibility for the care of patients with chronic diseases in care homes, to ensure good management and review of older people with complex polypharmacy.

In particular, it is important that pharmacists in primary care networks (PCNs) and community pharmacy have access to information from Comprehensive Geriatric Assessments, as this can affect measures needed to support medicines adherence and avoid adverse reactions.

A greater role for pharmacy

Pharmacists play an increasing role in medicines management and optimisation for older people in hospital, including medicines reconciliation on admission, medicines optimisation and deprescribing, assessment of patients who need support with medicines administration or timely management of medicines on discharge from hospital.

In some trusts, there are consultant pharmacists who lead pharmacy services for care of older people and work in multidisciplinary teams to manage problematic polypharmacy. In the community pharmacists are a vital resource to support community multidisciplinary teams and care homes. We believe that pharmacists should be supported to develop and extend these roles with appropriate training. This can help to free up geriatrician time and also support the safe practice of those who administer medicines.

CASE STUDY

Prioritising medicines safety to reduce errors and harms

Ashford and St Peter's Hospitals NHS Foundation Trust

A medication safety programme at Ashford and St Peter's has reduced incidents that cause harm to patients, including older people, and increased awareness and reporting of incidents.

The trust set medicines safety as its quality improvement priority for 2018/19. It held a series of cross-specialty workshops to review all incident reporting data and brainstorm ideas for change.

Weekly monitoring of incidents and severity was introduced to support long term improvement. A priority was getting doctors to report medicines safety incidents even when they resulted in no harm to patients, so that everyone can learn from near misses. Actions from the programme included:

- Weekly multidisciplinary medication safety huddles to discuss and learn from errors that cause harm or are part of a trend in incidents.
- Additional teaching for junior doctors on high risk medications.
- A trust-wide medicines safety week to raise awareness.
- Infographics, emails and social media to communicate key safety messages.
- Pre-printed labels for safe prescribing of some medicines.
- A pharmacy presence in the emergency department.
- New protocols for insulin and intravenous drugs.
- Extended roles for pharmacy to support medication rounds.
- A drug chart check has also improved handover between ward nurses, reducing drug omissions.

Results

In the first year, the trust achieved its ambition of reducing safety incidents that result in moderate or severe harm by 30% and increasing reporting of no-harm safety incidents by 30%. It has now set a new target of reducing harm caused by medication by 50% over five years.

Recommendation: Medicines optimisation

Recommendation	Actions	Owners	Timescale
17. Local health systems should address the prescribing and pharmaceutical care needs of older people to improve safety and optimise adherence.	**a** GIRFT to support NHSE/I and local health systems to implement safe prescribing practices for older people that cover polypharmacy, discharges and deprescribing where appropriate.	GIRFT, NHS England and NHS Improvement, ICS/STP	For progress within a year of report publication

Learnings from COVID-19

As part of the GIRFT process, we focused on how trusts adapted their services to cope with the first wave of pandemic while continuing to meet the needs of older patients, and any lessons that can be learned for the restoration of geriatric medicine services.

Delirium care

Delirium was a common symptom in frail patients infected with COVID-19 and caused an increased risk of nosocomial infection from patients who were agitated and walking with purpose (wandering) on wards. To reduce this risk, some trusts offered distraction activities and therapies to reduce wandering.

In Lancashire Teaching Hospitals NHS Foundation Trust, behaviour charts were kept for COVID patients who became agitated, which helped the multidisciplinary team (MDT) to recognise triggers and promote de-escalation techniques to reduce agitation and the need to wander. This approach can also help reduce inpatient falls, which are a major risk from delirium.

Care home support

Care homes were an important source of infection and hospital admission particularly early in the first wave of the pandemic. Some hospitals developed outreach support for care homes during the outbreak and linked this to a large scale advance care planning. This helped to avoid admissions for some patients with multi-morbidity or severe frailty approaching end of life, with proactive support for patients and carers. In Leicester consultants provide pre-transfer clinical decision (PTCD) advice and support to ambulance staff, enabling decisions to be made in the care home on whether the person should be taken to hospital or could remain home with targeted follow up.

Home support and virtual outreach

Some trusts offered specialist advice for patients at home through virtual outreach, linked to community networks. In Lancashire Teaching Hospitals Foundation Trust, a nurse-led virtual community MDT offered support for patients post discharge. Every frail patient who was discharged from hospital following COVID infection was screened for appropriateness of referral to the 'virtual frailty ward' with tailored telephone follow-up post-discharge to review progress, answer queries, maintain patient safety and prevent readmission, co-ordinated with community services.

Advance care planning and end of life care

We found that initial assessment of the severity of frailty using the Clinical Frailty Scale (Rockwood) linked to patient-centred advance care planning discussions and agreement on ceilings of care helps in the management of end of life care and gives patients and families more control. This is particularly important in the decision whether to use critical care for those patients with poor prognosis either due to frailty or multi-morbidity.

Some hospitals developed wards specific for management of dying patients. In Leicester, the palliative care team worked closely with the discharge hub, particularly recognising patients stating that they did not want to come back to hospital and how to co-ordinate their wishes. The ReSPECT tool (see *Adopting national models and frameworks*, page 87) was found to be helpful, particularly in guiding higher quality conversations regarding treatment escalation plans and end of life discussions.

Procurement

In 2016 NHS Improvement mandated all trusts to submit their monthly purchase order data to a central database: the NHS Spend Comparison Service (SCS). This was the first time a single national dataset of procurement information had been established for the NHS.

Since that time, the GIRFT programme has been analysing this data to better understand the variation in products and brands used, and prices paid across NHS trusts. This analysis has been a feature of previous GIRFT reports with examples of variation in the number of brands used by clinicians.

Variation can lead to compromises in patient safety and can add significant costs to the NHS Supply Chain. Addressing variation therefore would have the potential to improve safety and efficacy and provide a potential opportunity to secure better deals and improved value for money for trusts.

Reducing unwarranted variation and improving value for money

To help, GIRFT has established a programme to root out unwarranted variation, improve the evidence-base to enable better decision-making, accelerate adoption of new proven technologies, and improve overall value for money by reducing supply chain costs.

The GIRFT Clinical Technology Optimisation programme has been working with GIRFT clinical leads to examine the data and evidence that support products. In some specialties, national Clinical Technology Advisory Panels (CTAPs) have been established with leading clinicians from the specialty to address safety, efficacy, innovation and value – with the objective of providing better information to clinicians and procurement professionals across the NHS.

GIRFT has also been working with the new NHS operating model for NHS procurement, including the new Category Towers, to develop plans for helping trusts and clinicians to address variation and improve value for money.

A further issue is knowing whether different brands have clinical impacts, and to assess that NHS England and NHS Improvement has launched 'Scan4Safety[80]' (2020) in which individual products can be traced to individual clinicians. We are looking at the feasibility of creating links between NCIP and Scan4Safety to assist in identifying the efficacy of different brands and, perhaps most importantly, to allow tracking of new implants or procedures across the NHS.

Unwarranted variation between prices paid in geriatric medicine

In terms of procurement, geriatric medicine is a low spend high volume specialty. We attempted to look at Spend Comparison Service (SCS) data for items such as walking frames, orthopaedic shoes and chairs that are commonly used by geriatric medicine departments. However this proved difficult as many items used in geriatric medicine are not specific to the specialty and are therefore not procured by it or coded to it. Furthermore, there was not much variation in the prices that trusts pay for this sort of equipment due to the low costs involved.

However, as discussed in *Reducing the risk of hospital-acquired deconditioning*, page 51, we know that relatively inexpensive items such as walking frames and appropriate chairs for recovering patients can be vital aids in preventing deconditioning, enabling older people with frailty to return home safely. **Table 2** shows indicative costs for some of the most commonly used items.

Table 2: Indicative costs of typical devices and consumables used in care of older people

Item	Average cost
Pads for incontinence	£5
High backed chair	£200
Walking frame	£200
Hoists	£1,000
Alternating cycle mattress (pressure ulcer prevention)	£1,000
Profiling hospital bed	£2,000

[80] *https://www.scan4safety.nhs.uk/*

These items not only improve outcomes but can save the NHS the cost of prolonged hospital stays. Given that the costs are relatively low compared to the benefits they bring, we should remove barriers to procuring them where they are needed for care of older people, while ensuring best value for the system overall.

We recommend that providers adopt the GIRFT three-point strategy to improve procurement of devices and consumables.

Recommendation: Procurement

Recommendation	Actions	Owners	Timescale
18. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.	**a** Use sources of procurement data, such as SCS and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.	GIRFT	Ongoing
	b Identify opportunities for improved value for money, including the development of benchmarks and specifications. Locate sources of best practice and procurement excellence, identifying factors that lead to the most favourable procurement outcomes.	GIRFT	Ongoing
	c Use Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.	Trusts, ICS/STPs, GIRFT	Ongoing

Reducing the impact of litigation

Each of the GIRFT programme teams has been asked to examine the impact and causes of litigation in their field – with a view to reducing the frequency of litigation and, more importantly, reducing the incidents that lead to it. It is important for clinical staff to have the opportunity to learn from claims and complaints, including serious incidents (SIs), patient safety incidents (PSIs) and inquests. This can lead to improved patient care and reduced costs both in terms of litigation itself and the management of the resulting complications of potential incidents.

It was clear during our GIRFT visits that many providers had little knowledge of the claims against them. This includes some with high litigation costs per admission, as well as those at the low end. As a consequence, there is an opportunity to learn from the claims to inform future practice. Further work is needed at both a local and national level to analyse claims to maximise this opportunity to improve patient care.

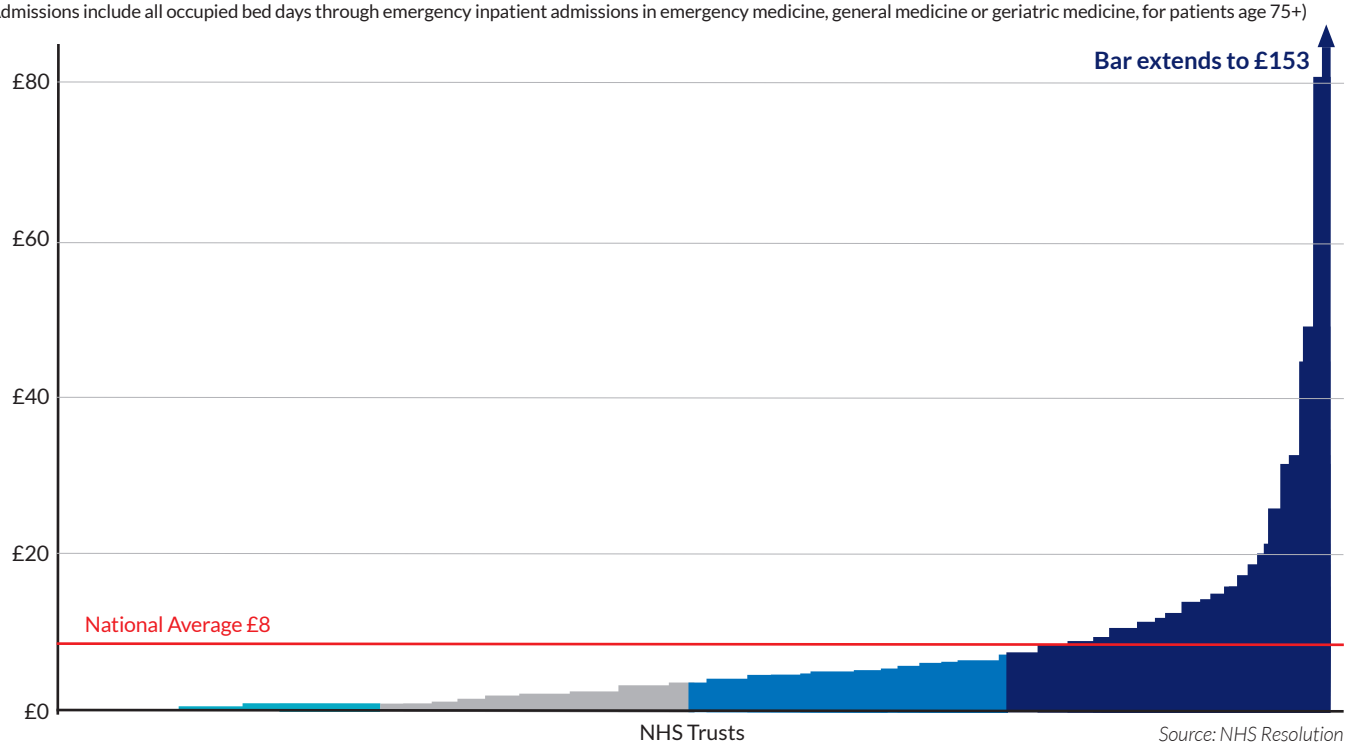
Variation in average litigation costs

Data obtained from NHS Resolution shows that potential estimated clinical negligence claim costs in geriatric medicine rose from £7.6 million to £20.4 million per year over the five years from 2013-18, as shown in **Table 3**.

We found the national average estimated cost of litigation per admission in geriatric medicine was £8, when admissions were defined as all occupied bed days through emergency inpatient admissions in A&E, general medicine or geriatric medicine, for patients age 75+. There are noticeable differences between providers, as shown in **Figure 29**: the best performing provider is estimated to cost £0, while at the other end of the scale, one provider is expected to generate a potential average of £153 of litigation costs per admission.

Figure 29: Variation in England between trusts in estimated litigation costs for geriatric medicine per admission notified to NHS Resolution 2013/14 to 2017/18

(Admissions include all occupied bed days through emergency inpatient admissions in emergency medicine, general medicine or geriatric medicine, for patients age 75+)



Source: NHS Resolution

Table 3: Volume and potential estimated cost of medical negligence claims against geriatric medicine notified to NHS Resolution 2013/14 to 2017/18

Year of notification	No. of claims	% change in no. of claims	Total claim cost (£million)	% change in total claim cost
2013/14	171	-	7.6 million	-
2014/15	195	14%	9.9 million	28%
2015/16	200	3%	15.1 million	53%
2016/17	196	-2%	12.1 million	-20%
2017/18	184	-6%	20.4 million	70%
Grand Total	**946**	**-**	**65.1 million**	**-**

Claims trends and causes

Geriatric medicine is the 14th highest clinical specialty for number of claims and the 28th highest for total claims costs during the financial years 2013/14 – 2017/18. Although there hasn't been a significant increase in the number of claims over the five year period, there has been an increase in the associated costs. This reflects the fact that clinical negligence claims are becoming more expensive, especially when there is an outcome involving neurological deficit.

Table 4: Top five most frequent causes for litigation in geriatric medicine 2013/14 to 2017/18

Causes	No. of claims
Nursing	495
Treatment	236
Patient supervision	165
Diagnosis	82
Medication errors	37

Causes

We identified common causes for litigation in geriatric medicine using NHS Resolution data. It is important to note that more than one cause can be assigned to each claim.

The two most important clinical themes are injurious falls and hospital-acquired pressure ulcers, which links to our proposal on improving patient safety for frailty. Inpatient falls are often linked to agitation from delirium so improving delirium care as discussed in *Improving the dementia and delirium pathways* on page 63 can also help to reduce potential claims.

Nursing care is the most common cause and patient supervision the 3rd most common. There were a total of 342 claims related to falls and a total estimated potential claim cost of £23.2 million across geriatric medicine. These claims are often attributed to nursing care or failure in patient supervision and represent a significant litigation burden in geriatric medicine[81]. This area has been a focus of improvement efforts by NHS Improvement[82] and the Royal College of Nursing[83] and have been supported by NICE guidance published in 2017 on preventing falls in the community and in hospital[84].

[81] *Oliver D, Killick S, Even T, Willmott M. Do falls and falls-injuries in hospital indicate negligent care -- and how big is the risk? A retrospective analysis of the NHS Litigation Authority Database of clinical negligence claims, resulting from falls in hospitals in England 1995 to 2006. Qual Saf Health Care. 2008 Dec;17(6):431-6*

[82] *https://improvement.nhs.uk/resources/patient-falls-improvement-collaborative/ accessed 27/2/2020*

[83] *https://www.rcn.org.uk/clinical-topics/older-people/falls accessed 27/2/2020*

[84] *Falls in older people: assessing risk and prevention Clinical Guideline CG161 https://www.nice.org.uk/guidance/cg161*

There were 154 claims relating to pressure sores with a total estimated potential claim cost of £8.2 million in geriatric medicine. Pressure sore prevention is a growing issue for geriatric departments as they are managing increasing numbers of people with frailty and co-morbid patients. Pressure sore prevention has been the subject of NHS campaigns and several guidelines exist for management in all hospital wards[85]. Early identification of severe frailty on emergency presentation (within 30 minutes) and a reduction in time waiting for a bed, as discussed in *Identifying frailty early through systematic assessmen*t, page 41, are important system factors to reduce pressure ulcers

Common causation themes for litigation in all specialties include treatment, diagnosis and medication errors. All these cause groups feature in the top five causes for litigation for geriatric medicine.

Recommendation: Litigation

Recommendation	Actions	Owners	Timescale
19. Reduce litigation costs by application of the GIRFT Programme's five-point plan.	**a** Clinicians and trust management to assess their benchmarked position compared to the national average when reviewing the estimated litigation cost per activity. Trusts would have received this information in the GIRFT 'Litigation data pack' .	Clinicians and trust management	For immediate action
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution included in the data set to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk	Clinicians and trust management	Upon completion of 19a.
	c Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support.	Clinicians and trust management	Upon completion of 19b.
	d Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI)/patient safety incidents (PSI) and where a claim has not already been reviewed as SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all front-line clinical staff in a structured format at departmental/directorate meetings (including Multidisciplinary Team meetings, Morbidity and Mortality meetings where appropriate).	All trusts	Upon completion of 19c.
	e Where trusts are outside the top quartile of trusts for litigation costs per activity GIRFT we will be asking national clinical leads and regional hubs to follow up and support trusts in the steps taken to learn from claims. They will also be able to share with trusts examples of good practice where it would be of benefit.	GIRFT	For continual action throughout GIRFT programme.

[85] *NHS Improvement: Stop the pressure - Helping to prevent pressure ulcers. Available from https://nhs.stopthepressure.co.uk (accessed 5/3/2020)*

Notional financial opportunities

Calculating gross notional financial opportunities and cost implications in GIRFT reports

GIRFT reports provide financial opportunity figures to illustrate how improving clinical care will also improve productivity, using a methodology endorsed by the Healthcare Financial Management Association (HFMA). These figures are calculated after the report's draft recommendations are finalised, and after establishing what changes to clinical metrics they would be expected to deliver. The financial opportunity figures are not used to inform the report's findings or the development of the recommendations.

The financial opportunities provided are gross and notional. They are not inherently cash-releasing and apply a notional financial value to activity, ordinarily using figures from national prices or reference costs. They are not a net figure, because implementation costs could not usually be calculated in this way: costs may be locally contingent or otherwise not calculable using reference costs or national prices. Instead, implementation costs are identified separately, in consultation with colleagues in NHS England and NHS Improvement, once draft recommendations have been finalised from a clinical perspective.

The opportunities figure includes reductions to:

- length of stay (LoS);
- planned admissions where no procedure took place;
- re-operation rates;
- readmissions;
- outpatient attendances and follow-ups; and
- unnecessary procedures and appointments.

Financial opportunities and potential cost implications from this report

As discussed earlier in this report, there is an opportunity to reduce acute care costs, while improving outcomes, if frailty was managed preventatively to keep people out of hospital in the earlier stages and if there were effective non-hospital models of frailty care for more severe frailty particularly when linked to acute deterioration.

This financial opportunity is significant. Reducing elderly frail bed days by 30% (clinical lead achievable target) could result in estimated gross savings nationally in the region of £680m.

To realise this opportunity however will require significant investment in alternative services, which are discussed in detail within this report.

The table below includes examples of areas identified within the national report where there is potential to make significant changes that would contribute to this overall reduction in acute bed days that are currently being used to treat elderly patients.

The report highlights that demand is going up so the potential financial opportunities identified are relative rather than absolute. The examples are not mutually exclusive, there is overlap between them and they may also duplicate elements identified as opportunities within other GIRFT national reports (such as hip replacement length of stay).

Table 5: Notional financial opportunities for geriatric medicine based on standard and target predictive modelling

Improvement	Standard			Target		
	Target (patients aged over 75)	Activity opportunity*	Gross notional financial opportunity**	Target (patients aged over 75)	Activity opportunity*	Gross notional financial opportunity**
Reduce admissions via A&E of elderly patients *(Recommendation 2)* Opportunity = Reduce number of all patients 75+ admitted via A&E *Base data: April 19 - Mar 20.* *Cost estimated based on average Geriatric medicine short stay non elective unit cost (18/19 ref costs uplifted to 20/21 prices)*	*National average* 45.6% admissions from A&E	110,500 emergency admissions	£56.58m	*Upper quartile* 40.3% admissions from A&E	198,900 emergency admissions	£101.84m
Increase proportion of emergency elderly admissions discharged within 2 days *(Recommendations 2 and 7)* Opportunity = Reduce proportion of elderly emergency admissions with a LOS over 2 days (assume average LOS reduction of 2 days per patient) *Base data: April 19 - Mar 20.* *Cost estimated based on average Geriatric medicine non elective excess bedday cost (17/18 ref costs uplifted to 20/21 prices)*	*National average* 57.5 % emergency admissions with LOS over 2 days	91,600 bed days	£28.07m	*Upper quartile* 53.4 % emergency admissions with LOS over 2 days	190,400 bed days	£58.34m
Mobilise patients within 48hours of admission and develop safe discharge models (to reduce risk of 'stranded' patients) *(Recommendations 3b and 7a)* Opportunity = Reduce length of stay of patients over 21 days (super stranded) (assume average LOS reduction of 19 days per patient) *Base data: April 19 - Mar 20.* *Cost estimated based on average Geriatric medicine elective and non elective excess bedday cost (17/18 ref costs uplifted to 20/21 prices)*	*National average* 9% admissions with LOS over 21 days	343,900 bed days	£105.38m	*Upper quartile* 7.6 % admissions with LOS over 21 days	693,500 bed days	£212.5m

Table 5: Notional financial opportunities for geriatric medicine based on standard and target predictive modelling

Improvement	Standard			Target		
	Target (patients aged over 75)	Activity opportunity*	Gross notional financial opportunity**	Target (patients aged over 75)	Activity opportunity*	Gross notional financial opportunity**
Review and reduce frail elderly readmissions *(Recommendation 9)* Opportunity = Reduce frail elderly emergency readmission rates *Base data: April 19 - Mar 20.* *Cost estimated based on Geriatric medicine average non elective unit cost (18/19 ref costs uplifted to 20/21 prices)*	*National average* 4.43% emergency readmissions (within 7 days of a short stay admission)	12,200 emergency admissions	£30.2m	*Upper quartile* 3.73% emergency readmissions (within 7 days of a short stay admission	21,700 emergency admissions	£53.71m
Improve end of life care avoiding multiple hospital admissions *(Recommendation 11c)* Opportunity = Reduce bed days occupied by people over 75 in the last 90 days of life*** *Base data: April 19 - Mar 20.* *Cost estimated based on average Geriatric medicine non elective unit cost (18/19 ref costs uplifted to 20/21 prices)*	*National average* 14.6% age 75+ bed days (patient in last 90 days of life)	108,300 admissions	£33.2m	*Upper quartile* 13.3% age 75+ bed days (patient in last 90 days of life)	245,700 admissions	£75.32m
Trusts to manage duplication of outpatient appointments *(Recommendation 13)* Opportunity = Reduce outpatient attendances *Base data: April 19 - Mar 20.* *Cost estimated based on General & Geriatric med average OP attendance cost (18/19 ref costs uplifted to 20/21 prices)*	*Clinical view*			*Clinical view*		
New outpatient attendances	1% reduction in new OP attendances	New outpatient attendances	£8.36m	2% reduction in new OP attendances	Outpatient attendances	£16.71m
Follow up outpatient attendances	5% reduction in FU OP attendances	FU outpatient attendances	£84.56m	10% reduction in FU OP attendances	Outpatient attendances	£169.11m
Total			**£346.35m**			**£687.53m**

Note: The examples of potential financial opportunities shown in the table above are not mutually exclusive (ie it is recognised there is overlap between them) and may duplicate elements identified as opportunities within other GIRFT national reports.

The table does not include any impacts related to workforce and training. Please refer to recommendations set out in *A workforce to meet the needs of the ageing population*, page 91

* Activity opportunities are annual figures, based on one year of activity data. Unless specified (eg shift from non-elective to day case), activity would be avoided.

** Costing financial opportunity: unless otherwise stated, cost estimates are based on national average of 17/18 reference costs, uplifted to 20/21 pay and prices using tariff inflation.

*** Analysis looks at patients admitted to acute provider trusts only. Specialist, community and mental health end of life admissions have not been included within this financial impact analysis

About the GIRFT programme

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS.

Funded by the Department of Health and Social Care and jointly overseen by NHS England and NHS Improvement and the Royal National Orthopaedic Hospital NHS Trust, it combines wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal they can, when multiplied across an entire trust – and even more so across the NHS as a whole – deliver substantial cumulative benefits.

The programme was first conceived and developed by Professor Tim Briggs to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics. In the 12 months after the pilot programme, it delivered an estimated £30m-£50m savings in orthopaedic care – predominantly through changes that reduced average length of stay and improved procurement.

The same model is now being applied in more than 40 different areas of clinical practice. It consists of four key strands:

- a broad data gathering and analysis exercise, performed by health data analysts, which generates a detailed picture of current national practice, outcomes and other related factors;
- a series of discussions between clinical specialists and individual hospital trusts, which are based on the data – providing an unprecedented opportunity to examine individual trust behaviour and performance in the relevant area of practice, in the context of the national picture. This then enables the trust to understand where it is performing well and what it could do better – drawing on the input of senior clinicians;
- a national report, that draws on both the data analysis and the discussions with the hospital trusts to identify opportunities for NHS-wide improvement;
- an implementation phase where the GIRFT team supports providers to deliver the improvements recommended.

Implementation

GIRFT works in partnership with NHSE/I regional teams to help trusts and their local partners to implement improvements and address the issues raised in both the trust data packs and the national specialty reports. The GIRFT team provides support at a local level, advising on how to reflect the national recommendations into local practice and supporting efforts to deliver any trust specific recommendations emerging from the GIRFT visits. GIRFT also helps to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice. Through all its efforts, local or national, the GIRFT programme strives to embody the 'shoulder to shoulder' ethos that has become GIRFT's hallmark, supporting clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

Glossary

Academic Health Science Networks
NHS-led organisations that bring together health service, academic and industry members to improve patient outcomes and generate economic benefits by promoting innovation in healthcare.

Advanced practitioner
Healthcare professionals such as nurses, pharmacists and therapists who build on the knowledge, skills and experience provided by their profession and integrate the four pillars of advanced practice into their work: leadership and management, education, research and clinical work.

Ageing Well
An NHS programme that aims to support older people with frailty in their communities. It promotes healthier ageing and begins to address inequalities through population health management.

Acute medical unit
A dedicated facility within a hospital that acts as the focus for acute medical care for patients that have presented as medical emergencies.

Advance care planning
A process in which a person makes decisions about their future care in conversations with their family and health and social care professionals, which can be followed if they aren't able to make decisions in the future.

Ambulatory care
Ambulatory care is any hospital care provided without the need for an admission. It includes outpatient appointments and also services such as same day emergency care, which aim to provide rapid assessment and treatment as an alternative to hospitalisation.

Anticholinergic burden
The cumulative effect of taking one or more medications with anticholinergic activity. It is a strong predictor or cognitive and physical impairment, especially in the older population.

Casemix
The type or mix of patients, categorised by a variety of measures, including: demographics, disease type and severity, and the diagnostic or therapeutic procedures performed.

Catheter-associated urinary tract infections (CAUTI)
Urinary tract infections associated with having a catheter inserted in the urethra.

CESR (Certificate of Eligibility for Specialist Registration)
The route to specialist registration for doctors who have not completed a GMC-approved programme but are able to demonstrate that their specialist training, qualifications and experience are equivalent.

Clinical Frailty Scale
An assessment tool developed by Rockwood to enable rapid assessment of frailty on a spectrum from 1 (fit) to 8 (severely frail).

Clinical Commissioning Groups (CCGs)
Clinically-led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area.

Comorbidity
Presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder.

Continuing healthcare assessment
An assessment to determine whether a person has long-term complex health needs that may qualify them for free social care arranged and funded solely by the NHS.

CQUIN
Commissioning for Quality and Innovation (CQUIN) is a commissioning framework that supports improvements in the quality of services and care by setting agreed goals and incentivising best practice.

Deconditioning
Decline of body systems and functional ability caused by physical inactivity or disuse.

Delayed transfers of care (DTOC)
A delayed transfer of care from NHS-funded acute or non-acute care occurs when an adult patient is ready to go home and is still occupying a bed.

Delirium
Delirium is an abrupt change in the brain that causes mental confusion and emotional disruption.

Directed Enhanced Service (DES)
Nationally negotiated services for primary care, over and above those provided under usual contracts.

Electronic Frailty Index
A system used in primary care to analyse coded data on 36 domains of frailty. It can help segment local populations based on levels of frailty to assess health risks.

Elective (surgery or care)
Surgery or care that is planned rather than carried out as an emergency (non-elective).

Global Frailty Score (GFS)
A risk prediction model developed by Dr Foster from data analysis based on seven frailty syndrome groups and their relationship to outcome metrics.

Electronic health record (EHR)
An electronic version of a patient's medical history which is shareable between providers.

Electronic patient record (EPR)
A digital version of a patient's chart during their hospital stay.

FORWARD care bundle
Feeding via the Oral Route With Acknowledged Risk of Deterioration (FORWARD) is a care bundle to support patients who have an unsafe swallow, which is unlikely to improve, to feed at risk.

Frailty Capabilities Framework
A framework to identify and describe the skills, knowledge and behaviours required to deliver high quality care and support for people with frailty.

Homeostatic reserve
Maintenance of the state of steady internal, physical, and chemical conditions by living systems.

Hospital episode statistics
Data on all admissions, out-patient appointments and A&E attendances at NHS hospitals in England. The aim is to collect a detailed record for each 'episode' of admitted patient care commissioned by the NHS and delivered in England, by either an NHS hospital or the independent sector. HES data is used in calculating what hospitals are paid for the care they deliver.

Hospital Frailty Risk Score (HFRS)
A tool used by hospital clinicians, which analyses diagnostic codes in hospital admissions data for recognised markers of frailty.

Integrated care systems (ICS)
Advanced local partnerships involving primary and secondary care, local councils and others, taking shared responsibility to improve the health and care system for their local population.

ICD codes
International Classification of Diseases are globally-recognised diagnostic codes for a wide rage of indications such as diseases, signs and symptoms, abnormal findings and complaints. They form the basis of diagnostic recording in the NHS.

Length of stay
The length of an inpatient episode of care, calculated from the day of admission to day of discharge, and based on the number of nights spent in hospital.

Main specialty code
A unique code identifying each main specialty designated by Royal Colleges. It identifies the specialty of the health professional delivering the service.

Model Hospital
A free digital tool provided by NHS Improvement to enable trusts to compare their productivity and identify opportunities to improve. The tool is designed to support NHS provider trusts to deliver the best patient care in the most efficient way.

Multidisciplinary team (MDT)
A team of healthcare professionals from different disciplines.

Multi-morbidity
The presence of two or more long-term health conditions.

National Audit of Inpatient Falls (NAIF)
The National Audit of Inpatient Falls (NAIF) audits the delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards in England and Wales.

National Hip Fracture Database (NHFD)
A national clinical audit undertaken by the Royal College of Physicians on behalf of the NHS collecting data on all aspects of the care given to hip fracture patients in England, Wales and Northern Ireland aged 60 and over.

National Institute for Health and Care Excellence (NICE)
Provides evidence-based guidance, advice, quality standards, performance metrics and information services for health, public health and social care.

NEWS 2
An assessment based on an aggregate score of a range of physiological measurements when patients present to, or are being monitored in hospital.

NHS Benchmarking Network
A benchmarking service of the NHS which enables performance comparison between more than 300 health and social care organisations in the UK.

NHS Resolution (formerly the NHS Litigation Authority)
An arm's length body of the Department of Health that provides expertise to the NHS to resolve negligence concerns, share learning for improvement and preserve resources for patient care.

NHS RightCare
An NHS England programme that works locally with systems (bodies involved in delivering services) to diagnose issues, develop solutions and deliver improvements.

NHS Safety Thermometer
A point of care survey tool that provides a 'temperature check' on potential harm to patients.

Pathway
An agreed set of evidence-based practices and interventions for a specific patient group.

Pharmacokinetics
The movement of drug into, through, and out of the body, including its absorption, bioavailability, distribution, metabolism, and excretion.

Polypharmacy
Concurrent use of multiple medications.

Primary Care Network (PCN)
A network of GP practices covering a population that develops services across a geographic area of between 30-50,000 people.

RX-Info Define
A software package that helps healthcare organisations analyse their medicines spend.

Spend Comparison Service (SCS)
Provides benchmarking and spend analytics on purchase order data from across all of NHS England's providers including acute hospital, ambulance and mental health trusts.

Specialist Pharmacy Service
An expert service providing impartial advice for pharmacists, GPs and clinicians.

STOPP-START
A tool containing a series of rules and suggestions to help in decision making around deprescribing in patients with polypharmacy.

Structured medication reviews
A review of all of a patient's medications to identify medicines that could be stopped or need a dosage change, or new medicines that are needed.

Sub-specialty
A single specialty with its own specialist list that is also grouped with other specialties within an area of medicine or dentistry.

Sustainability and transformation partnerships (STPs)
Partnerships between NHS providers, CCGs, local authorities and other health and care services to develop proposals for how local areas will work together to improve health and care for their local population.

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