How to get the best of benchmarking guides

Managing Frailty – avoiding inappropriate admissions

How to get the best of benchmarking guides show how data from NHS Benchmarking Network projects can help identify service improvement opportunities and track transformation.

Each guide highlights how Network members are tackling key Long Term Plan transformation priorities and using evidence from NHSBN projects to demonstrate the positive impact of these initiatives on service delivery.

Avoiding inappropriate admissions of people living with frailty

In the NHS Long Term Plan, reducing pressure on acute hospital services was outlined as one of the key goals for the NHS in the next 10 years. This had three elements: improving pre-hospital urgent care, reforming emergency care by implementing same day emergency care (SDEC), and cutting delays to people going home. For people living with frailty, who are often admitted to hospital with complex needs but experience longer lengths of stay due to deconditioning, the policy clearly outlined a shift towards keeping people out of hospital and cared for at home or in the community.

Whilst SDEC services should increase the number of acute admissions discharged on the day of attendance, the Long Term Plan also explicitly outlines the need to ensure that avoidable admissions are reduced. For frailty services, this requires the input from multi-disciplinary teams (MDTs) in the Emergency Department (ED) and assessment units, working to assess frailty needs and quickly establish care plans that can be implemented outside of hospital.

To achieve this goal, the NHS Long Term Plan sets out two targets for acute providers:

- **Provide an acute frailty service for at least 70 hours a week**
- **Work towards achieving clinical frailty assessment within 30 minutes of arrival**

With these services in place, the NHS intends to avoid unnecessary admissions of people living with frailty into hospital.

In 2016, the British Geriatrics Society in collaboration with the Royal College of General Practitioners highlighted the effect that an efficient frailty service in ED can have on avoiding unnecessary admissions. They reported that St James's Hospital, Leeds, saw conversion rate to admission fall from 74% to 39%, after the introduction of a geriatrician service within the department.

One key aspect of this improvement involves ensuring that there is an integrated, whole system approach across secondary, primary and community care. With patients discharged from hospital as soon as possible, communication across the system has to be strong to ensure developing care needs are met.

These case studies show how members of the NHS Benchmarking Network have developed their services and made significant improvements in this area, achieving the Long Term Plan targets and reducing avoidable admissions.

Did you know
The Network will be holding two webinar events: a Share Learning event and a Frailty 2021 Findings event

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Case study 1 – Use of new technology, training and an integrated whole system approach to avoid inappropriate admissions at Frimley Health

Frimley Health services approximately 30,000 people living with moderate/ severe frailty across two acute sites: Frimley Park Hospital and Wexham Park Hospital. As a result, management of frailty has been a key priority for the ICS, with a recent focus on reducing the time taken to undertake clinical frailty assessment and avoiding inappropriate admissions through the development of an effective front door acute frailty service.

In April 2019, a new building at Wexham Park Hospital gave the frailty team the opportunity to tap into new technology, with the installation of an electronic system, 'Symphony'. The system prompts the completion of a Clinical Frailty Scale (CFS) assessment for anyone over 65 years of age, arriving in ED. The system means that a CFS assessment is now mandatory at triage in ED.

It was recognised that the technology was not enough, without the team being fully equipped to assess and identify frailty as early as possible in the patient journey. In response to this, training on frailty assessment was incorporated into handover times in the ED hub, with an identified frailty champion.

Did you know

The Managing Frailty project covers the whole secondary care pathway, from assessment through to discharge.

of patients would recommend the service at Wexham Park Hospital

With the Acute Frailty Service (AFS) identifying and discharging patients with frailty in ED, the next step was to ensure that services were integrated with primary and community care, to support these patients in their homes and avoid readmission. At Frimley Health a number of steps have been taken to improve this integration including, holding regular meetings with community groups, creating a system-wide frailty advisory board, seconding frailty practitioners from the community, and implementing a 3rd and 7th day follow-up phone call service.

What were the challenges?

- There was a reluctance from staff to complete the mandatory CFS assessment. The Frimley Heath team overcame this by changing the ethos, making frailty assessment the norm. This included adding frailty training into the induction for new staff and issuing mouse-mats. 1:1 conversations with staff members gave them more support when completing the assessment.
- The team faced a challenge in ensuring that CGA[(1)] was initiated as early as possible for people that needed it. Rapid CFS screening allows the team to initiate CGA as early as possible in the patient's journey.
- An internal audit showed that many readmissions were medication related. The addition of pharmacists on MDTs helped tackle this.

How have Frimley Health used Benchmarking to improve frailty services?

Frimley have participated in the Managing Frailty project for the last three years. They use the annual project to ensure that their services are meeting targets. The project provides a framework to develop the service.

For example, if a project asks 'Does your service have an x?' and the response is no, this then prompts discussion and development.

Frimley now have established frailty teams that are working well together, that were built from the ground up.

[(1)] Comprehensive Geriatric Assessment - *an interdisciplinary diagnostic process to determine the medical, psychological and functional capability of someone who is frail and old.* https://www.nice.org.uk/guidance/qs136/chapter/Quality-statement-2-Comprehensive-geriatric-assessment (accessed 11/08/2021)

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Case study 1 – An integrated whole system approach, training and use of new technology to avoid inappropriate admissions at Frimley Health

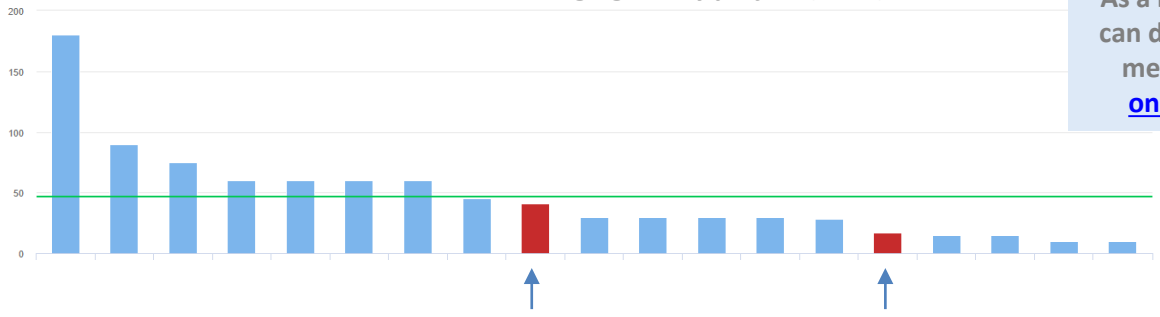
Impacts on the service

- At Wexham Park Hospital, the AFS[2] have been minimising inappropriate admissions, reducing conversion rate to admission from **33.3% (2019)** to **27.6% (2020)**
- With new initiatives like the automatic prompt to complete a CFS, frailty assessment wait times at Wexham Park Hospital have decreased from **30 minutes (2019) to 17 minutes (2020)**
- MDT completion of CGAs is likely to have saved on care home admissions
- Pharmacist input into CGAs has tackled medication related readmissions.

Conversion rate to admission – Wexham park Hospital

Year	Conversion rate to admission
2018	32.1%
2019	33.3%
2020	27.6%

Frailty assessment wait time – minutes (Frimley Health position 2020)
Source: NHSBN Managing Frailty project (2020)



As a member, you can discover more metrics on our online toolkit

What next?

The ethos at Frimley Health is to ensure that the right care is delivered at the right time for each individual, recognising that hospital may not always be the best place for people living with frailty.

The team at Frimley Park are working on a new pilot scheme called 'Hospital at Home'. This scheme involves frailty teams visiting people in their own homes to provide assessment and appropriate care. Feedback has been positive toward the new service.

People with frailty are at risk of in-hospital deconditioning whilst receiving acute care, resulting in prolonged hospital stays with complex discharge planning and a period of rehabilitation. Now, 3-5 days of care can be delivered at home, alongside other community services, with patients less likely to experience deconditioning, enabling rapid discharge from the service without an increase in readmission rates.

The Frimley Park team hopes that, with the introduction of the new electronic patient record, the Clinical Frailty Score from ED will be available to clinicians across the whole patient journey in hospital.

Did you know
You can use the online Forum to ask questions to other members.

[2] Acute Frailty Service - *refers to those services that identify and respond to the needs of frail, usually older people presenting to urgent and emergency care (UEC) services*. https://www.england.nhs.uk/wp-content/uploads/2021/02/SDEC_guide_frailty_May_2019_update.pdf (accessed 11/08/2021)

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Managing Frailty – avoiding inappropriate admissions

Case study 2 – Avoiding admissions at Ashford and St Peter's Hospitals NHS Foundation Trust with comprehensive geriatric consultant cover and frailty hubs

The team at Ashford and St Peter's Hospitals NHS Foundation Trust identified a gap whereby they needed staff to cover all seven clinical areas within the Trust with comprehensive geriatric care, seven days a week. This became more apparent with the impact of COVID-19 reducing staff on the ground and Geriatricians splitting their time with responsibilities in General Internal Medicine (GIM).

To combat this, greater levels of senior doctors were employed. Current practice sees nine geriatricians now incorporated into a 1-in-6 geriatric specialty weekend doctor rota to ensure that geriatricians are available seven days a week. A locum geriatrician has also been secured, in order to streamline the Acute Frailty Service (AFS) and turn around patients as quickly and efficiently as possible.

Whilst avoiding admissions into hospital, the team have ensured that connections to community partners are strong, to provide excellent geriatric care across the whole system. Two geriatricians work in the community, using the community bed base to help keep patients out of hospital, and community partners currently work in ED providing in-reach and fast turnaround. Frailty hubs in the community have been working particularly well, with a dedicated location for follow-up checks and tests providing reassurance to both care providers and patients. With these in place, hospital staff are able to discharge patients much sooner. The integrated system enables care providers across the system to work collaboratively, prioritising the 'home-first' ethos. Admission is no longer the default position.

Acute Frailty Service availability (hours) – Trust position 2019 vs 2020

Year	Weekday	Weekend
2019	8 hours	0 hours
2020	10 hours	8 hours

The process

A frailty tracking system monitors assessment from Clinical Frailty Scale (CFS) score to Comprehensive Geriatric Assessment (CGA). A CFS assessment can be completed at different points in the pathway by different members of staff, e.g. paramedics, in triage at ED etc.

A therapy assessment form is used, which is based on the CGA domains. All staff use this form, including the frailty team and the rapid response team; it outlines action plans assigned for each domain. A pharmacy technician was introduced to the team on trial and this is now intended to continue, with benefits around ordering and prescribing medicines.

What were the challenges?

- Expanding into two new wards on another hospital site added pressure on the number of geriatricians on the ground. Locum staffing and on call rotas helped manage this challenge.
- There were some challenges in establishing the role of the frailty hubs alongside GPs and existing community services. Work is being done to clearly assign responsibilities.
- With frailty assessment implemented across the pathway, the team have recognised that there needs to be more training for staff.

Did you know
More examples of innovation can be found in the Managing Frailty Good Practice Compendium.

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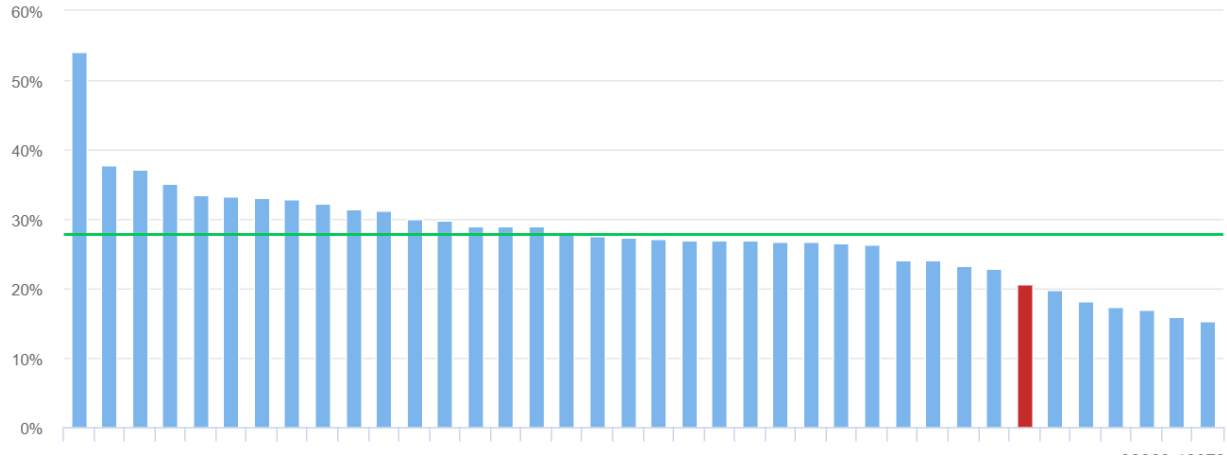
Case study 2 – Avoiding admissions at Ashford and St Peter's Hospitals NHS Foundation Trust with comprehensive geriatric consultant cover and frailty hubs

Conversion rate to admission – all ages (%) – Trust position 2020
Source: NHSBN Managing Frailty project (2020)



Impacts on the service

- Conversion rate to admission fell from **24.7% (2019) to 20.7% (2020)** suggesting that the Trust is successfully avoiding unnecessary admissions.
- The frailty service is now available 10 hours per day on weekdays and 8 hours per day on weekends.
- Through analysing their data, the Trust has shown that geriatricians working in frailty hubs have reduced patient referrals.
- The Trust has saved funds by implementing the 1-in-6 weekend rota, ensuring that a specialty doctor is covering the older person's short stay unit on the weekends.

Did you know
The 2021 Managing Frailty project includes a new dashboard with a monthly timeseries

What next?

The Trust is investing in a new Pan Assessment Unit (PAU) which will cover all assessment areas and attach to the ED base, implementing same day emergency care. The team aim to have an MDT frailty team working within an older person's assessment unit. The PAU expects to implement system-wide solutions, with advanced care practitioners, therapists and integration with the local community provider. Community partners will be involved in rapid discharge from the PAU as well as being involved in the frailty unit. The local Clinical Commissioning Group is helping to create an integrated model by developing the governance structure.

A new integrated computer system is being developed so that a CFS can be flagged and the appropriate pathway initiated. This, combined with a new streaming process within the PAU, will help with the transition towards CFS assessment becoming mandatory before a patient is admitted. The team is also currently developing ways to ensure that a CGA initiated at hospital follows patients into the community. Some hospital staff now have access to the GP EMIS system and the community rapid response team have access to the hospital system. This improves handover and ensures that care is connected across the pathway.

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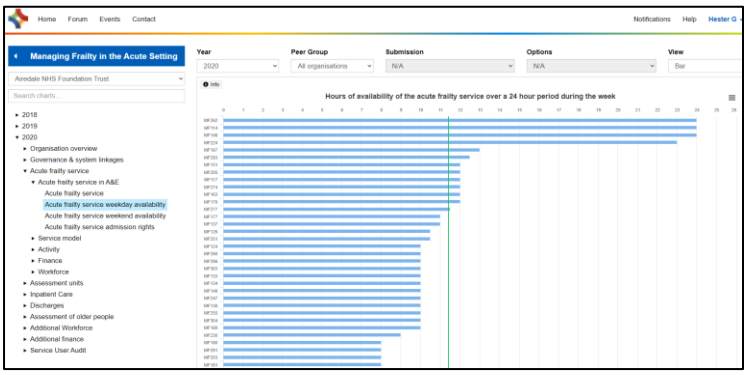
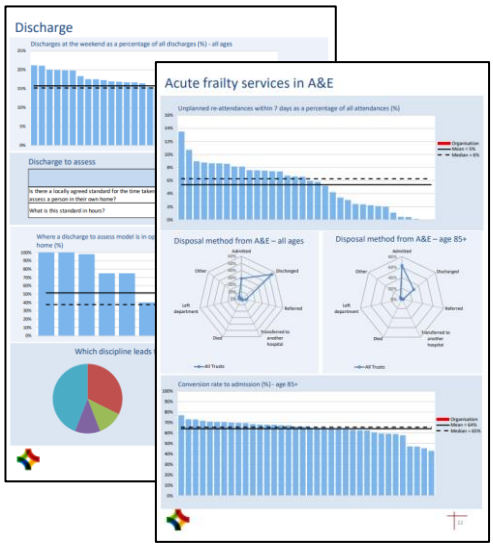
Further resources

The Managing Frailty project outputs are available on the members' area, including bespoke reports, online toolkits, and good practice compendiums. Contact the Support Team for login access to the site.





In addition to metrics featured in this guide, there is a range of information to track service development within frailty services teams, including: