The Acute Frailty Network brings together an effective blend of practical expertise and experience to support organisations to successfully implement and improve Acute Frailty Services locally.

Local teams are able to access national expertise in both older persons care and innovation and improvement approaches to support them to make tangible improvements to their services.
Background to Acute Frailty Network

- First 72 hours care crucial in improving outcomes for Frail Older People

- Focus was to support the local development of acute frailty services using a combination of best practice and improvement and innovation methodologies.

- Acute Frailty Network developed to bring together an effective blend of practical expertise and experience to achieve improvement. Local teams are able to access national expertise in both emergency care, the care of older people and innovation and improvement approaches to support them in making real, tangible improvements to services.

www.acutefrailtnetwork.org.uk/twitter
@acutefrailty
Aims of the AFN

• Develop a network based model to support the widespread adoption and improvement of acute frailty services in England and in the process co-design the emergent programme, tools and guidance with participating teams

• Connect with the wider health and social care economy, including third sector

• To further develop a measurement for improvement approach for Acute Frailty implementation

• We work in partnership with National experts to ensure a rigorous and comprehensive approach e.g. Kings Fund, Nuffield Trust
Cohort 2
Norfolk & Norwich Hospitals NHS FT
The Royal Bournemouth & Christchurch Hospitals NHS FT
Peterborough & Stamford Hospitals NHS FT
Royal Cornwall Hospitals NHS Trust
University Hospital of South Manchester NHS FT
Chelsea & Westminster Hospital NHS FT
North Devon Healthcare NHS Trust
The Royal Wolverhampton Hospitals NHS Trust
Western Sussex Hospitals NHS FT
Portsmouth Hospitals NHS Trust
Wirral University Teaching Hospital NHS FT
Medway Maritime Hospital NHS FT

Cohort 1
Poole Hospital NHS FT
Cambridge University Hospitals NHS FT
Kettering General Hospital NHS FT
Derbyshire Community Services NHS FT
Gloucestershire Hospitals NHS Trust
Imperial College Healthcare NHS Trust
The Royal Berkshire NHS FT
York Teaching Hospital NHS FT
The James Cook University Hospital
University Hospitals of North Midlands NHS Trust

Cohort 3
Blackpool Teaching Hospital NHS FT
Gateshead Health NHS FT
Northumbria Healthcare NHS FT
Lancashire Teaching Hospitals NHS FT
Calderdale & Huddersfield NHS FT
University Hospitals Bristol NHS FT
Hampshire Hospitals NHS FT
Brighton & Hove, Sussex Community NHS FT
Lewisham & Greenwich NHS Trust
East Kent Community & University Hospitals
University Hospitals Southampton NHS FT
West Suffolk NHS FT

www.acutefrailtynetwork.org.uk/twitter
@acutefrailty
WHY?
1000 days...The Compelling Story

• 10 days in hospital (acute, sub acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80
  – Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

• 48% of people over 85 die within one year of hospital admission

Imminence of death among hospital inpatients: Prevalent cohort study
David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 Palliat Med

www.acutefrailtnetwork.org.uk/twitter  @acute frailty
Older people are core users of health and social care...

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Total Leicester LA Activity</th>
<th>Activity per 1,000 over 75s England population</th>
<th>Total LA Cost</th>
<th>Cost per 1,000 over 75 (England population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective admissions</td>
<td>5,299</td>
<td>346.7</td>
<td>£5,110,148</td>
<td>£369</td>
</tr>
<tr>
<td>Non-elective admissions</td>
<td>9,318</td>
<td>388.1</td>
<td>£23,225,115</td>
<td>£1,037</td>
</tr>
<tr>
<td>First outpatient appointments</td>
<td>12,646</td>
<td>842.2</td>
<td>£2,012,718</td>
<td>£126</td>
</tr>
<tr>
<td>Follow-up outpatient appointments</td>
<td>29,837</td>
<td>2,220.0</td>
<td>£2,746,157</td>
<td>£213</td>
</tr>
<tr>
<td>Type 1 A&amp;E attendances</td>
<td>8,178</td>
<td>478.1</td>
<td>£1,115,699</td>
<td>£56</td>
</tr>
</tbody>
</table>

• Much of the current resource is tied up with urgent care – mainly in acute hospitals
But not all older people are major users of the system...

<table>
<thead>
<tr>
<th>Activity segment* - mutually exclusive, hierarchical categories</th>
<th>Percentage of England population aged 75 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>No acute activity</td>
<td>25.8%</td>
</tr>
<tr>
<td>Outpatient activity only</td>
<td>30.9%</td>
</tr>
<tr>
<td>A&amp;E activity only, no admissions</td>
<td>6.8%</td>
</tr>
<tr>
<td>Elective activity, no emergency admissions</td>
<td>13.7%</td>
</tr>
<tr>
<td>Single emergency admission</td>
<td>14.6%</td>
</tr>
<tr>
<td>Two emergency admissions</td>
<td>4.9%</td>
</tr>
<tr>
<td>3+ emergency admissions</td>
<td>3.4%</td>
</tr>
</tbody>
</table>
Who are the 10 or 25%?

- Older People with Frailty
- HES codes to identify frailty:
  - Unspecified protein-energy malnutrition
  - Dementia+
  - Incontinence+
  - Difficulty in walking
  - Somnolence
  - Very low level of personal hygiene
  - Senility
  - Falls
  - ‘Z-codes’ – functional limitations

<table>
<thead>
<tr>
<th>Activity type (frail older people)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of total admissions</td>
<td>57%</td>
</tr>
<tr>
<td>Percentage of total beddays</td>
<td>87%</td>
</tr>
<tr>
<td>Percentage of emergency readmissions within 90 days</td>
<td>84%</td>
</tr>
<tr>
<td>Percentage of deaths within 90 days of admission</td>
<td>84%</td>
</tr>
</tbody>
</table>
Urgent care axis – points for intervention

Focus on Long Term Conditions (heart failure/frailty/dementia/ COPD)
More effective responses to urgent care needs
Advance care planning/end of Life care plans
Targeted input into Care Homes
Access to integrated services through NHS Pathways (3DN)

Clear operational performance framework integrated with GP processes
Ready access to specialist advice when needed

Improved integration with 1° & 2° responders via NHS Pathways
Front load senior decision process including primary care, ED Consultants& Geriatricians

Objective: A left shift of activity across the system as a function of time; yesterday’s urgent cases are today’s acute cases and tomorrow’s chronic cases.

Optimise emergency care:
- Evidence based management
- Multidisciplinary input from PT / OT & community matrons
- Access to intermediate and social care
- Front line geriatrician input
- Effective information sharing with primary & secondary care
- Develop minimum data set

Redesign to decrease LOS with social & multidisciplinary input using a "pull" system
Effective Date of Discharge
Ambulatory care (macro level) for falls/LTC

www.acutefrailtnetwork.org.uk/twitter
@acutefrailty
10 principles

1. Establish a mechanism for early identification of people with frailty
2. Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour
3. Set up a rapid response system for frail older people in urgent care settings
4. Adopt clinical professional standards to reduce unnecessary variation
5. Develop a measurement mind-set
6. Strengthen links with services both inside and outside hospital
7. Put in place appropriate education and training for key staff
8. Identify clinical change champions
9. Patient and public involvement
10. Identify an executive sponsor and underpin with a robust project management structure
Dr Simon Conroy
Clinical Lead

Deborah Thompson
Programme Director

Dr Simon Conroy
Clinical Lead

Lisa Smith
Project Manager

Mandy Rumley-Buss
Site Lead

Jenni Guest
Site Lead

Matt Tite
Measurement Lead

Simon Griffiths
Site Lead

Lisa Godfrey
Site Lead

www.acutefrailtnetwork.org.uk/twitter
@acutefrailty
Guide to Measurement for Improvement

Acute Care for Frail Older People Toolkit
Use the AFN measurement tool....
2nd National Acute Frailty Network Conference

29th June 2017 for further information or if you would like to submit an abstract please contact:

frailty@nhselect.org.uk
Contact details

If you have a query or want to access work shared by other organisations please use:

frailty@nhselect.org.uk

www.acutefrailtynetwork.org.uk