Improving older people’s care in Emergency Departments

Jay Banerjee
Leicester, UK
COI

- HK College and QE Hospital reimbursing all travel/accommodation
- I chair the RCEM (UK) SIG in GEM/Frailty
- Reimbursed for my time by the Acute Frailty Network (NHS Elect)
- I deliver commissioned work on QI coaching and training
- Teach on MSc Qual/Saf UoL
- Leicester’s hospital pays my mortgage
What is the problem?
ED

• 15-25% of attendances
• 50-65% of trolley patients
• 35-55% of admissions
• 75-85% of non-elective bed days
• An ED visit for an older person is a “sentinel” event
• Vast majority of harms (falls, pressure ulcers, HAI, wrong diagnosis, adverse drug effects, delirium in hospital....)
Older people: ED outcomes

• ACEP survey 2008
• Schnitker et al. Australasian Emergency Nursing Journal (2011) 14, 141—162
• doi:10.1016/j.aenj.2011.04.001

Higher delays in diagnosis:
AMI, sepsis, appendicitis, ischemic bowel

Unsuspected diagnoses:
Delirium, depression, drug and alcohol use, elder abuse, polypharmacy

Undertreatment:
Low rates PCI, TPA, pain management

Overtreatment:
Higher rates of foley catheters
Adverse drug events
Overuse of sedation and restraints
# Frailty: outcomes - SYSTEMS

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mild frailty (HR, 95% CI)</th>
<th>Moderate frailty (HR, 95% CI)</th>
<th>Severe frailty (HR, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr care home admission</td>
<td>2.00 (1.68 to 2.39)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>5.94 (4.61 to 7.64)</td>
</tr>
<tr>
<td>3 yr care home admission</td>
<td>1.52 (1.37 to 1.69)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>3.42 (2.84 to 4.12)</td>
</tr>
<tr>
<td>5 yr care home admission</td>
<td>1.56 (1.43 to 1.70)</td>
<td>2.34 (2.10 to 2.61)</td>
<td>3.00 (2.42 to 3.70)</td>
</tr>
<tr>
<td>1 yr hospitalisation</td>
<td>1.85 (1.81 to 1.88)</td>
<td>2.96 (2.90 to 3.02)</td>
<td>4.62 (4.50 to 4.74)</td>
</tr>
<tr>
<td>3 yr hospitalisation</td>
<td>1.71 (1.69 to 1.73)</td>
<td>2.54 (2.51 to 2.58)</td>
<td>3.64 (3.57 to 3.70)</td>
</tr>
<tr>
<td>5 yr hospitalisation</td>
<td>1.63 (1.61 to 1.64)</td>
<td>2.43 (2.40 to 2.46)</td>
<td>3.59 (3.54 to 3.65)</td>
</tr>
<tr>
<td>1 yr mortality</td>
<td>1.91 (1.78 to 2.04)</td>
<td>3.39 (3.15 to 3.65)</td>
<td>5.23 (4.73 to 5.79)</td>
</tr>
<tr>
<td>3 yr mortality</td>
<td>1.74 (1.68 to 1.81)</td>
<td>3.02 (2.90 to 3.14)</td>
<td>4.56 (4.29 to 4.84)</td>
</tr>
<tr>
<td>5 yr mortality</td>
<td>1.66 (1.62 to 1.71)</td>
<td>2.73 (2.64 to 2.81)</td>
<td>3.88 (3.68 to 4.09)</td>
</tr>
</tbody>
</table>
### Frailty and Evidence Based Prescribing, NICE

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Outcome</th>
<th>Trial duration</th>
<th>Number needed to treat (NNT)</th>
<th>Annualised NNT (ANNT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihypertensives</td>
<td>MI</td>
<td>10 years</td>
<td>84</td>
<td>840</td>
</tr>
<tr>
<td>Statins (secondary prevention)</td>
<td>Mortality</td>
<td>3.8 years</td>
<td>67</td>
<td>255</td>
</tr>
<tr>
<td>Aspirin (angina)</td>
<td>Mortality</td>
<td>4.2 years</td>
<td>46</td>
<td>192</td>
</tr>
<tr>
<td>Anticoagulants (AF)</td>
<td>Stroke</td>
<td>1 year</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Intervention (community-based)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive geriatric assessment of older people</td>
<td>14% reduction in nursing home admission</td>
</tr>
<tr>
<td>Comprehensive geriatric assessment of ‘frail’ older people</td>
<td>10% reduction in hospital admissions</td>
</tr>
<tr>
<td>Community-based post discharge care</td>
<td>13% reduction in nursing home admission 10% reduction in hospital admission</td>
</tr>
<tr>
<td>Group-based education (supported self-management)</td>
<td>40% more likely to be living at home</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>8% reduction in falls</td>
</tr>
<tr>
<td>Exercise interventions</td>
<td>Improved function</td>
</tr>
</tbody>
</table>

Shifting the balance of care: great expectations. Nuffield Trust, 2017
Lots of variation in process measures: LOS in assessment units.
Clinician variability

NOTE: Weights are from random effects analysis

Overall (I-squared = 75.4%, p = 0.000)

ES (95% CI)  Weight

<table>
<thead>
<tr>
<th>Study ID</th>
<th>ES</th>
<th>Weight</th>
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<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>0.24 (0.20, 0.28)</td>
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<tr>
<td>3</td>
<td>0.13 (0.10, 0.16)</td>
<td>3.88</td>
</tr>
<tr>
<td>4</td>
<td>0.14 (0.11, 0.18)</td>
<td>3.74</td>
</tr>
<tr>
<td>5</td>
<td>0.16 (0.12, 0.20)</td>
<td>3.52</td>
</tr>
<tr>
<td>6</td>
<td>0.19 (0.17, 0.22)</td>
<td>4.29</td>
</tr>
<tr>
<td>7</td>
<td>0.15 (0.13, 0.17)</td>
<td>4.63</td>
</tr>
<tr>
<td>8</td>
<td>0.20 (0.17, 0.23)</td>
<td>4.14</td>
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<tr>
<td>9</td>
<td>0.17 (0.14, 0.20)</td>
<td>4.13</td>
</tr>
<tr>
<td>10</td>
<td>0.19 (0.17, 0.22)</td>
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</tr>
<tr>
<td>11</td>
<td>0.17 (0.13, 0.20)</td>
<td>3.65</td>
</tr>
<tr>
<td>12</td>
<td>0.17 (0.15, 0.19)</td>
<td>4.51</td>
</tr>
<tr>
<td>13</td>
<td>0.20 (0.15, 0.25)</td>
<td>2.99</td>
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<tr>
<td>14</td>
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<td>16</td>
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<td>3.51</td>
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<tr>
<td>17</td>
<td>0.17 (0.14, 0.19)</td>
<td>4.12</td>
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<tr>
<td>18</td>
<td>0.15 (0.12, 0.19)</td>
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<tr>
<td>19</td>
<td>0.17 (0.14, 0.19)</td>
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<tr>
<td>20</td>
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<td>21</td>
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<td>23</td>
<td>0.18 (0.14, 0.23)</td>
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<tr>
<td>24</td>
<td>0.15 (0.12, 0.18)</td>
<td>4.16</td>
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<tr>
<td>25</td>
<td>0.19 (0.17, 0.21)</td>
<td>4.64</td>
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<tr>
<td>26</td>
<td>0.17 (0.16, 0.19)</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Consultant

Discharge rate

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Medication errors

Falls
Emergency admissions from A&E, weekly data

Admissions

April  May  June  July  August  September  October  November  December  January  February  March

2012/13  2013/14  2014/15
Flow and breaches

Figure 3.3: Link between occupancy and waiting time/breaches (based on average occupancy, 2010 to 2013)
Time spent by age/outcome

Qualitywatch 2014

Figure 4.1: Average time spent in A&E by age and outcome
Breach by age/outcome

Qualitywatch 2014

Figure 4.2: Likelihood of breaching four-hour target by age and outcome
HES 2013-14 ED LOS/age

Admitted patients

Non-admitted patients

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Image 1: Distribution of long-term conditions by age of A&E attendee 2012/13, Focus on A&E attendances, QualityWatch

Figure 4.3: Distribution of long-term conditions (LTCs) by age of A&E attendee, 2012/13

Source: Nuffield Trust and Health Foundation (2014)
What is the problem???
Working hard does not change results.....

Every system is exactly designed to deliver the result it gets......

- Paul Batalden, Founding Chair, Institute for Healthcare Improvement, Cambridge, MA
Thanks to Don Berwick & IHI.ORG
The “problem” (or what I think of it)

- A system wide failure in understanding and addressing the needs of complex older people
- Poor clinical decision making not tailored to person centred outcomes
- Over-dependence on “quick-wins” & “reductionism”

- Leading to wrong older person lying in the wrong place at the wrong time and for prolonged periods of time; suffering harm and poor care
- ....manifest as issues with “capacity” and “flow”
Let us “change”

“All improvement will require change, but not all change will result in improvement!”

Complex older person
Characteristics of Complex Systems

1. Across types of systems, across scales, and thus across disciplines
   - Which exhibit common behaviors:
   - Giving rise to a number of hierarchical levels
   - Dynamically interacting
   - Many components

2. Complex Systems Involve

3. A "simple" system

4. A "complex" system

5. Emergent behavior that cannot be simply inferred from the behavior of the components
   - Emergence
   - Hierarchies
   - Control Structures
   - Self-Organization
   - Decomposability into Subsystems

New England Complex Systems Institute
Optimizing Care of Older in the ED

Primary Drivers:
- Linkages to community services
- ED pathways

Secondary Drivers:
- Improved information sharing
- Clinical navigators / discharge planners
- Ambulatory pathways (single system)
- Complex pathways (frailty syndromes)
- Frailty syndromes
- Privacy, dignity & autonomy of elders
- Multidisciplinary input
- Geriatric assessment standardised
- Use of safety trigger tools
- Incentives for alternatives to admissions
- Incentives for better community care

Goal:
ED will provide optimal care for older patients in <3 years

Desired Outcomes:
- Hospitalization will decrease by 10%
- Wait time in the ED will be decreased by 25%
- Patient satisfaction metrics will increase by 50%
- 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) including health & social care

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

Improved integration with 1st & 2nd 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 care/secondary care/community
- 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

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Working up solutions

• What are we doing to address this locally?

• What are the relevant emergency care projects nationally?
Resource use in Leicester for older people with frailty

- Percentage of total beddays: 86.3%
- Percentage of emergency readmissions within 90 days: 85.4%
- Percentage of deaths within 90 days of admission: 86.5%
• A controlled evaluation of comprehensive geriatric assessment in the emergency department: the 'Emergency Frailty Unit' Article in Age and Ageing 43(1) · January 2014

• Potentially avoidable emergency department attendance: Interview study of patients' reasons for attendance Article in Emergency Medicine Journal 29(12) · December 2011  DOI: 10.1136/emermed-2011-200585 · Source: PubMed


### ED Patient Assessment

**Patient Details**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>STAT Doctor</th>
<th>Nurse - Name and ID</th>
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<tbody>
<tr>
<td></td>
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</table>

**Pain Score**

<table>
<thead>
<tr>
<th>Score</th>
<th>Time Analgesia</th>
<th>Time Pain Score</th>
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<tbody>
<tr>
<td>0</td>
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</table>

**Bloods and IV access**

<table>
<thead>
<tr>
<th>Access</th>
<th>Done by</th>
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<tbody>
<tr>
<td>RBC</td>
<td></td>
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<tr>
<td>WCC</td>
<td></td>
</tr>
<tr>
<td>Platelets</td>
<td></td>
</tr>
</tbody>
</table>

**Further Tests**

- **ECG**
- **Urine tests**
- **Imaging**

**Interventions**

- **O₂ target SpO₂**
- **Blood cultures**
- **IV fluids**

**Falls and Bone Health Management**

- **Presented with a fragility fracture**
- **Presented with a fall**
- **Fall within last year**
- **No fall within last year**

### Cognitive Function Screening

**AMT4 (4 Item Abbreviated Mental Test)**

- **What year is it?**
- **What is your date of birth?**
- **How old are you?**
- **What is the name of this place?**

### Identification of Seniors at Risk (ISAR)

- **ISAR > 1 signals increased 6-month risk of severe functional impairment, frequent hospitalisation & depression**

### Good Communication

- **Does someone know patient in ED?**
- **Dependents needing care?**
- **Has patient a social worker?**
- **Is this a vulnerable adult?**
- **Is pt's ADL restricted?**
- **Does patient need further explanation?**
- **Risk of wandering?**

### Allergies

- **Name band on patient (tick when done)**

### Indications for Emergency Frailty Unit (EFU) Physician Review in ED

- **Presented with a fragility fracture**
- **No action required**
Geriatric EM Fellowship

Purpose

• To understand the importance of the bio-psycho-social model of care for older people and be able to deliver patient-centred clinical care based on these principles

• To appreciate the influence of socio-cultural factors on presentation and shared decision making in the management of acutely unwell and injured older patient

• To be a champion of older peoples’ care in the ED and develop liaison with relevant services

• To facilitate the learning of colleagues in caring for older people

UK - Leicester: 2010
The Emergency Frailty Unit
**What else can we learn? ESCAPE 85+**

- Shared vision - quality care for older people
  - Medical, functional, managerial perspectives
- Shared understanding of roles and responsibilities
- Patient focussed re-design
- Invest effort in developing skills of key groups e.g. staff in care homes
- Inspirational leaders but build in resilience
- Politics: e.g. local authorities

*Establishing and implementing best practice to reduce unplanned admissions in those aged 85 years and over through system change [Establishing System Change for Admissions of People 85+ (ESCAPE 85+)]: a mixed-methods case study approach.*

[https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr03370/#/abstract](https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr03370/#/abstract)

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April’17
Designing the UK's first older friendly Emergency Department
Banerjee J, Department of Emergency Medicine, UHL NHS Trust

**BACKGROUND**

The ED is a crucial interface between hospital and community and health and social care where older people with medical and social crisis present. EDs need to be supported to deliver optimal care and the build, resources and processes need to be "friendly-friendly".

This is the experience of a large University teaching hospital that is in the process of building the UK's first ED that incorporates design principles to improve care of older people. Currently <20% of the attendances in this ED are in people >85 years age. The emergency department does not have the capacity for the workload and there was a health community plan to build a new department that was friendly friendly.

**METHODOLOGY**

The process for incorporating geriatric design had three objectives:
- To ensure that the geriatric and frailty specific elements of the Design Brief for the new ED were fully explored, and the requirements incorporated at the appropriate time
- These sessions were held; for topical discussion related to the development of the 1:200, departmental layouts, 1:50 room layouts and the interior finishes scheme
- A specialist review group was assembled to review the design at key stages. Partners included doctors and nurses (emergency medicine, acute medicine and geriatrics), allied health services, imaging, architects, representatives from local older people's and visual impairment charities.

**RESULTS**

Significant changes were made to the design brief based on the empirical literature, expert advice and experiential knowledge amongst the team members:
- Specialist room design affected furniture, bedding and specialist sanitary and patient entertainment equipment.
- Interior finishes including ceiling, floor, doors, fixtures, lighting, signage and wall were altered.
- The "front-door" would also include adjacencies, emergency frailty units, imaging and point-of-care testing with access to all therapy services.
- There would be open access for care and families at all times.
- Greater emphasis on multidisciplinary teams and integrated workforce also emerged from this collaboration.

**DISCUSSION**

Older people represent the most important "customers" of future emergency care and the need to improve emergency and acute care is well articulated in the empirical literature. This venture represents the hospitals' and ED's plans to "future-proof" provision in the face of growing demand for older peoples services.

Quality in healthcare, simply stated, depends on the right provision of structures and processes that address the outcomes that matter to patients. Structures include environment and physical build that not only affect staff working and processes but also directly impact on the safety and quality in care. The new build has started and is due to be completed in winter 2016.

**REFERENCES**

Oliver D, Foot C, Humphries R. Making our health and care systems fit for an ageing population. Kings
Segmentation - older people

- 90 year old, plays golf, stumbles on caddy, attends with fracture wrist
- 78 year old, Alzheimer's, nursing home, needs help with feeding/dressing/personal hygiene – fell – head injury + raised Trop I
- 80 year old, lives alone at home, carer once/day, house dependent, possible recent forgetfulness, fell in the kitchen – wrist fracture
- 69 year old, bed-dependent, Lewis body dementia, pneumonia with septic shock
- **PERSON CENTRED CARE – NOT CONDITION CENTRED CARE**
Frailty index – deficits accumulation


• Frailty Index =
Number of deficits in an individual
Total number of deficits measured

Clinical Frailty Scale*

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

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

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

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

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

6. Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

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

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

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

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal. In moderate dementia, recent memory is very impaired even though they seemingly can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help.


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Quality Improvement

Quality improvement is
• Improving patient outcomes
• By changing staff behaviour
• Using systematic change methods

• The CFS offers a means of addressing behaviour change - through process redesign
What is the matter WITH the older person?

Versus

What matters TO this older person?
The Older Person Standard Set of outcomes

This is set is recommended for an older population, however there is no globally agreed definition on what age this is.

As a guideline, the Working Group recommend measuring outcomes for a population which, on average, is in the last 10 years of life based on average life expectancy at age 60 (Global AgeWatch Index 2014):

For example:

- UK: age 84 \( \geq 74 \)
- Japan: age 86 \( \geq 76 \)
- South Africa: age 76 \( \geq 66 \)
- Australia: age 85 \( \geq 75 \)
- Canada: age 85 \( \geq 75 \)
## Comprehensive Geriatric Assessment

<table>
<thead>
<tr>
<th>Domains</th>
<th>Items to be assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td>Co-morbid conditions and disease severity</td>
</tr>
<tr>
<td></td>
<td>Medication Review</td>
</tr>
<tr>
<td></td>
<td>Nutritional status</td>
</tr>
<tr>
<td></td>
<td>Problem list</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Cognition</td>
</tr>
<tr>
<td></td>
<td>Mood and anxiety</td>
</tr>
<tr>
<td></td>
<td>Fears</td>
</tr>
<tr>
<td><strong>Functional capacity</strong></td>
<td>Basic activities of daily living</td>
</tr>
<tr>
<td></td>
<td>Gait and balance</td>
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<tr>
<td></td>
<td>Activity/exercise status</td>
</tr>
<tr>
<td></td>
<td>Instrumental activities of daily living</td>
</tr>
<tr>
<td><strong>Social circumstances</strong></td>
<td>Informal support available from family or friends</td>
</tr>
<tr>
<td></td>
<td>Social network such a visitors or daytime activities</td>
</tr>
<tr>
<td></td>
<td>Eligibility for being offered care resources</td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td>Home comfort, facilities and safety</td>
</tr>
<tr>
<td></td>
<td>Use or potential use of telehealth</td>
</tr>
<tr>
<td></td>
<td>Transport facilities</td>
</tr>
<tr>
<td></td>
<td>Accessibility to local resource</td>
</tr>
</tbody>
</table>

(Courtesy: Prof Finbarr Martin, BGS)
DESCRIBE THE CLINICAL FRAILTY SCORE

SCORE ≤ 4
USUAL CARE - CONDITION BASED

SCORE 5 & 6
COMMENCE USUAL CARE. CGA INCLUDING PCC/ THERAPISTS. INVOLVE SPECIALTIES. DEVELOP DEFINITIVE PLAN

SCORE ≥ 7
COMMENCE SUPPORTIVE CARE. IMMEDIATE ED SENIOR INVOLVEMENT (≥ ST4). CONSIDER PALLIATIVE APPROACHES & INVOLVE SPECIALTIES IF NEEDED. AMBER CARE BUNDLE IF AGREED.

ED FRAILTY: “SOP”
## Driver Diagram: improving frailty

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>PRIMARY DRIVERS</th>
<th>SECONDARY DRIVERS</th>
<th>ACTIVITIES</th>
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<tbody>
<tr>
<td>IMPROVED CARE FOR FRAIL OLDER PEOPLE ACROSS UHL AS EVIDENCED BY IMPROVED PERFORMANCE IN SERVICE AND PATIENT RELATED OUTCOME MEASURES</td>
<td>IMPROVE FRAILTY AWARENESS</td>
<td>RELIABLY IDENTIFY FRAILTY ACROSS ALL AREAS</td>
<td>UNIVERSAL USE OF CFS</td>
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<td>DEVELOP PATHWAYS FOR FRAILTY SYNDROMES</td>
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<td>1) DELIRIUM RECOGNITION AND MANAGEMENT</td>
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<td>2) FALLS RECOGNITION AND MANAGEMENT</td>
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<td>3) CONTINENCE CARE</td>
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<td>4) POLYPHARMACY MANAGEMENT</td>
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<td>5) END OF LIFE CARE</td>
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<td>SERVICE MEASURES: ADMISSION, READMISSION, OVERNIGHT BED DAYS, STRANDED PATIENT, INPATIENT MORTALITY, MORTALITY POST DISCHARGE, HOSPITAL ACQUIRED HARM (FALL, ADR, DELIRIUM, HAI, PRESSURE ULCER, VTE)</td>
<td>PERSON-CENTRED CARE FOR OLDER PEOPLE</td>
<td>CAPABILITY</td>
<td>TRAINING ON CGA - NEW AND EXISTING STAFF</td>
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<td>PATIENT REPORTED OUTCOMES: PLACE OF DEATH, RELEVANT BITS FROM FRIENDS AND FAMILY TEST</td>
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<td>LEADERSHIP DEVELOPMENT AND CHAMPIONS</td>
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<td>FRAIL AND DEMENTIA FRIENDLY DESIGN</td>
<td>REFER TO &quot;HBN DEMENTIA&quot;</td>
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<td>PPI INVOLVEMENT</td>
<td>DEVELOPING CMG LEVEL PRACTICES FOR PPI INVOLVEMENT</td>
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<td>HEALTHWATCH</td>
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<td>FRAIL FRIENDLY HOSPITAL POLICIES WITH SUPPORTING DATA</td>
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Silver Book: QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS (>197,000 in 5 years)
Acute Frailty Network

‘getting older people home sooner and healthier’

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Prof Finbarr Martin (Kings)
Dr David Hunt (Sussex)
Dr Sally Briggs (South Manchester)
Dr Matt Thomas (Poole)
Dr Jay Banerjee (Leicester)
It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.

_Hubert H. Humphrey (US VP 1965-1969)_