Acute care for older people with frailty

Professor Simon Conroy
Clinical lead, Acute Frailty Network, England
Geriatrician, University Hospitals of Leicester
Worldview that will colour this talk

• Demography
• Specialist care driving longevity and comorbidities
• Specialist vs. whole person tension
• Eternal search for the fountain of youth
• Life, death and taxes
Demography

Women’s LE, DFLE and DLE at age 85

Expansion of disability

LE
DFLE
DLE

Remaining years of life

↑2010-2030
1.8 years
0.7 years
1.1 years

2006 2010 2014 2018 2022 2026 2030
The last year of life

End of life care + disability + resource use = geriatric medicine
How to ‘protect’ acute hospitals?

• Proactive care

• Admissions avoidance

• Advance care planning
Proactive care

• Dutch Proactive Care evaluations
  • ~8 RCTs, well conducted (not all reported yet) – no impact, not cost-effective

• Falls prevention (screen and intervene on higher risk - FRAT 2+)
  • IRR 0.73 for falls (not statistically significant)
  • ICER £3200 per fall averted

• UK Evercare evaluation
  • Population based risk stratification approach, focussing on preventing hospital admissions; nurse led case management – community based
  • Controlled before/after evaluation: no difference in emergency admissions, bed-days & trend to increased mortality (34.4%, 95% CI −1.7% to 70.3%)

• MRC trial of multidimensional assessment (1995-1998)
  • No difference in: mortality, hospital admissions
  • Trend towards reduced institutionalisation
  • Increase in QoL
‘Prediction is very difficult - especially if it's about the future.’

Niels Bohr,
19th century Danish physicist
Identifying frailty using routine data: the eFI

Development cohort 250,000

Internal validation cohort 250,000

External validation cohort 500,000

Clegg Age Ageing 2016 (open access)
## Frailty outcomes

<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 informs evidence-based prescribing

### NICE Database of Treatment Effects

<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>
Frailty predicts response to therapeutic interventions

<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</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>

Beswick Lancet 2008
Admissions avoidance

• Effective
• But for a small proportion of people

COCHRANE REVIEW

10 RCTs (n=1333)

Reduction in mortality at six months follow-up (adjusted HR 0.62, 95% CI 0.45 to 0.87; p=0.005).
Patients reported increased satisfaction with admission avoidance hospital at home.
When the costs of informal care were excluded admission avoidance hospital at home was less expensive than admission to an acute hospital ward.
Hospital at home

• Cost-effective?
  • UK RCT underway

• Acute hospital ward ~10,000 bed days

• Average LoS 11 days = 75 patient per month

HaH unit cost calculation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual budget</strong></td>
<td>£1,582,452</td>
</tr>
<tr>
<td><strong>Population coverage</strong></td>
<td>530,000</td>
</tr>
<tr>
<td><strong>Referred to HaH per month</strong></td>
<td>235</td>
</tr>
<tr>
<td><strong>Referred to HaH per year</strong></td>
<td>2,820</td>
</tr>
<tr>
<td><strong>% admitted to hospital after been referred to HaH</strong></td>
<td>25</td>
</tr>
<tr>
<td><strong>admitted to HAH per year</strong></td>
<td>2,115</td>
</tr>
<tr>
<td><strong>Average LoS (days)</strong></td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Annual HAH bed days</strong></td>
<td>11,633</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>cost per HAH admission</strong></td>
<td>£748</td>
</tr>
<tr>
<td><strong>cost per HAH bed day</strong></td>
<td>£136</td>
</tr>
</tbody>
</table>
Advance care planning

• Let me decide
  • Mortality – no significant differences
  • Hospitalisation (mean per patient): 0.27 vs 0.48, p = 0.001
  • Hospital days: 2.61 vs 5.86, p = .01
  • Total costs: $3490 vs $5239, p = 0.01

• Caplan, Australia
  • Hospital admission RR 0.89; 95% CI 0.85–0.93
However...

Shifting the balance of care: great expectations. Nuffield Trust, 2017
Opportunities within the hospital

<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
21% of admitted patients are 75+ & frail, but:

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%
Is a different model required?

• Acute medical model does what it says on the tin very well
• But is it all just about medicine?
• Frail older people, 90 days post AMU discharge:
  • 76% had one or more adverse outcomes
    • 6% died
    • 20% increased dependency
    • 46% reduced mental well-being
    • 49% reduced quality of life
    • 42% had two or more individual adverse outcomes
Lots of variation in process measures
Clinician variability

Study ID | ES (95% CI) | % Weight
---|---|---
1 | 0.15 (0.13, 0.17) | 4.56
2 | 0.24 (0.20, 0.28) | 3.31
3 | 0.13 (0.10, 0.16) | 3.88
5 | 0.14 (0.11, 0.18) | 3.74
7 | 0.16 (0.12, 0.20) | 3.52
8 | 0.19 (0.17, 0.22) | 4.29
9 | 0.15 (0.13, 0.17) | 4.63
10 | 0.20 (0.17, 0.23) | 4.14
11 | 0.17 (0.14, 0.20) | 4.13
12 | 0.19 (0.17, 0.22) | 4.12
13 | 0.17 (0.13, 0.20) | 3.65
14 | 0.17 (0.15, 0.19) | 4.51
15 | 0.20 (0.15, 0.25) | 2.99
16 | 0.12 (0.10, 0.14) | 4.71
17 | 0.22 (0.20, 0.25) | 4.66
18 | 0.18 (0.14, 0.22) | 3.51
19 | 0.17 (0.14, 0.18) | 4.12
21 | 0.15 (0.12, 0.19) | 3.62
22 | 0.17 (0.14, 0.19) | 4.23
23 | 0.20 (0.17, 0.22) | 4.37
24 | 0.19 (0.15, 0.23) | 3.11
25 | 0.18 (0.15, 0.21) | 4.29
26 | 0.18 (0.14, 0.23) | 3.11
27 | 0.15 (0.12, 0.18) | 4.16
28 | 0.19 (0.17, 0.21) | 4.64
Overall (I-squared = 75.4%, p = 0.000) | 0.17 (0.16, 0.19) | 100.00

NOTE: Weights are from random effects analysis.
Clinical outcome variability
Why?

• Hospitals designed to do this:
When they need to be doing this:
Every system is exactly designed to deliver the result it gets......

- Paul Batalden, Founding Chair, Institute for Healthcare Improvement, Cambridge, MA, USA
Improving acute care
Improving acute care - locally
ESCAPE 85+ - whole systems issues

- Whole system perspective: integration
  - acute and community care
  - health and social care
  - information systems
- Skill mix along patient pathway (community); 24/7, responsive services
- Avoid transient pilots - ‘pilotitis’
- Risk sharing across acute & community
  - Clinical
  - Financial
  - Societal
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
Improving acute care – at scale

Silver Book
Acute Frailty Network

‘getting older people home sooner and healthier’

frailty@nhselect.org.uk
@acutefrailty
www.acutefrailtynetwork.org.uk
Acute Frailty Network

• Breakthrough series collaborative
• Focus on:
  • Frail older people
  • CGA
  • First 72 hours
  • Quality improvement
AFN 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
Acute Frailty Network metrics

**Macro-level**
External comparisons – AFN sites vs. rest of NHS to determine benefits over & above usual care; using Nuffield & HES based algorithms to standardise assessment of frailty across the NHS

**Meso-level**
Internal service metrics based on HES data (age, conversion rates, bed-days; internal progress, local commissioners & benchmarking)

**Micro-level**
Internal service development metrics aligned to specific aims
AFN internal evaluation

- **Reaction**
  - The structured site interviews indicate high levels of satisfaction with the network, especially site visits, site support, national events to network, measurement support and meetings, validity given by being part of AFN, Executive level support.
  
  - Some themes about AFN needing to develop a more MDT and less geriatrician led approach, need for a ‘clinician day’ rather than a ‘nursing/ therapies’ day, focusing less on first 72 hours and more on whole pathway, usefulness of sustainability tool, and not knowing about venues until too late.
AFN internal evaluation

• Learning
  • 7 more sites reported implementing frailty related training for staff, to varying degrees.
  • 9 out of 12 sites improved their sustainability scores during the programme,
  • Trusts reported critical success factors as being bravery, frailty identification, measurement, winning over hearts and minds, MDT approach, someone with a vision, time for key team members to commit, working together.
AFN internal evaluation

• Behaviours
  • 8 more sites now identify frailty than at the beginning of the programme
  • 6 more sites now have a rapid response system for frail older people in urgent care settings, including increasing the MDT available at the front door, better in reach in ED / MAU, relocation of services with fewer beds and more clinics. Future plans include 7 day services, developing more integrated working with partners
  • 6 more sites now adopt clinical standards to reduce unnecessary variation
  • 6 more sites believe they now have a measurement mind set
  • 3 more sites identify clinical change champions. Portsmouth has focused on ward accreditation
  • 8 more sites report having identified an executive sponsor for frailty services. For most, this has made a huge difference in raising profile and tackling ‘blocks’
Results

The Acute Frailty Pathway at Medway NHS Foundation Trust

Outcome

Stranded Frailty Patients Over 75 by Day

In March 2016 the new medical model was introduced to the trust, which provided greater continuity in care. Two AAW’s (Acute Assessment Wards) were opened, one male ward, one female ward. From this point consultant geriatricians directly manage and assess frail patients admitted to the hospital. By the Consultant Geriatricians taking full management of frail patients the stranded patient rate spiked as the new process was embedded and the patients still admitted under the previous medical model were assessed and discharged; this then dropped hitting more often than not below the lower limit average this then began to rise slightly then from August 2016 the stranded patient rate massively dropped and has stayed significantly below the lower limit consistently, resulting in less patients staying in hospital for over 7 days.

Proving that managing frail patients by consultant geriatricians from Day 1 of admission impacts hospital length of stay.
Results

Increase in early discharges has been essential to improve flow

Bournemouth ROI Calculations

<table>
<thead>
<tr>
<th></th>
<th>Weekly</th>
<th>LOS reduction</th>
<th>Discharges</th>
<th>Days saved (a week)</th>
<th>Based on Audit commission data (£59)</th>
<th><em>Based on Bed day rate (</em>£171)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using Averages</td>
<td>4.05</td>
<td>88.50</td>
<td>358 bed days</td>
<td>£21,122</td>
<td>£61,290</td>
<td></td>
</tr>
<tr>
<td>Using 80% Variation</td>
<td>3.87</td>
<td>108.08</td>
<td>418 bed days</td>
<td>£24,662</td>
<td>Not Available</td>
<td></td>
</tr>
<tr>
<td>Using UCL</td>
<td>3.68</td>
<td>127.66</td>
<td>470 bed days</td>
<td>£27,730</td>
<td>Not Available</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Based on Audit commission data (£59)</th>
<th>*Based on Bed day rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using Averages</td>
<td>£1,098344</td>
<td>£3,187115</td>
<td></td>
</tr>
<tr>
<td>Using 80% Variation</td>
<td>£1,282424</td>
<td>Not Available</td>
<td></td>
</tr>
<tr>
<td>Using UCL</td>
<td>£1,441960</td>
<td>Not Available</td>
<td></td>
</tr>
</tbody>
</table>

*Bed day rate: Provided by Bournemouth, but only as an average figure
More geriatricians?

- Orthogeriatrics
- Community geriatrics
- Oncogeriatrics
- Cardiogeriatrics
- Geriatric Emergency Medicine
- Perioperative geriatrics etc

- But UK 4% workforce geriatricians
Not just geriatricians!

• Geriatric competence
  • Delirium vs dementia
  • Asymptomatic bacturia
  • Falls assessment
  • Medication reviews
  • Rehabilitation
  • Managing long term conditions
  • Palliation

• Generic competencies
  • Senior decision making
  • Situational awareness
  • Rapid assessment
  • Risk assessment
  • Communication skills
  • Team working
  • Leadership
Hospital Wide CGA (HoW-CGA)
Group with frailty characteristics?

<table>
<thead>
<tr>
<th></th>
<th>Cluster 1 (n = 3,419)</th>
<th>Cluster 2 (n = 6,568)</th>
<th>Cluster 3 (n = 1,708)</th>
<th>Cluster 4 (n = 3,558)</th>
<th>Cluster 5 (n = 4,907)</th>
<th>Cluster 6 (n = 1,979)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at start (years)</td>
<td>80.9</td>
<td>82.1</td>
<td>81.7</td>
<td>82.4</td>
<td>84.5</td>
<td>82.8</td>
</tr>
<tr>
<td>Died over 2 years</td>
<td>8.0%</td>
<td>16.0%</td>
<td>17.0%</td>
<td>46.0%</td>
<td>48.0%</td>
<td>38.0%</td>
</tr>
<tr>
<td>Elective admissions</td>
<td>1.31</td>
<td>0.84</td>
<td>0.92</td>
<td>1.14</td>
<td>0.55</td>
<td>0.82</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>0.31</td>
<td>0.96</td>
<td>1.09</td>
<td>1.78</td>
<td>2.90</td>
<td>2.51</td>
</tr>
<tr>
<td>Pre-defined frailty code</td>
<td>11.6%</td>
<td>38.2%</td>
<td>25.9%</td>
<td>47.7%</td>
<td>86.8%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Days in hospital*</td>
<td>1.66</td>
<td>6.97</td>
<td>6.68</td>
<td>17.74</td>
<td>34.39</td>
<td>24.21</td>
</tr>
<tr>
<td>Cost per patient*</td>
<td>£ 2,267</td>
<td>£ 3,952</td>
<td>£ 4,274</td>
<td>£ 7,054</td>
<td>£ 9,963</td>
<td>£ 9,229</td>
</tr>
</tbody>
</table>

* Clustering variables included bed days, costs and diagnoses
Group with frailty characteristics?

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>Diagnosis name</th>
<th>% with diagnosis in cluster 5</th>
<th>% with diagnosis in whole cohort</th>
<th>ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>F00</td>
<td>Dementia in Alzheimer's disease</td>
<td>11.5%</td>
<td>3.0%</td>
<td>3.8</td>
</tr>
<tr>
<td>F05</td>
<td>Delirium, not induced by alcohol and other psychoactive substances</td>
<td>18.8%</td>
<td>6.0%</td>
<td>3.1</td>
</tr>
<tr>
<td>G30</td>
<td>Alzheimer's disease</td>
<td>15.3%</td>
<td>5.0%</td>
<td>3.1</td>
</tr>
<tr>
<td>I69</td>
<td>Sequelae of cerebrovascular disease</td>
<td>7.0%</td>
<td>2.3%</td>
<td>3.1</td>
</tr>
<tr>
<td>Z75</td>
<td>Problems related to medical facilities and other health care</td>
<td>8.9%</td>
<td>2.9%</td>
<td>3.0</td>
</tr>
<tr>
<td>B96</td>
<td>Other bacterial agents as the cause of diseases classified to other chapters</td>
<td>18.7%</td>
<td>6.3%</td>
<td>3.0</td>
</tr>
<tr>
<td>S00</td>
<td>Superficial injury of head</td>
<td>11.6%</td>
<td>4.0%</td>
<td>2.9</td>
</tr>
</tbody>
</table>
Predicts outcomes in acute hospital

- Frailty score calculated from 2-year history for a cohort of all >75 with emergency admission in 2015 (Apr-Dec)

* Length of stay > 10 days
BOX 1: MULTI-LEVEL APPROACH TO CHANGE

1. **Strategic (regional) level**: Relevant strategic players, namely System Resilience Groups (SRGs) with Chief Executives and Commissioners as their attendees, will be alerted about the problem in care such as higher than expected volumes of attendance and high admission rates, length of stay, readmission rates and institutionalisation. They will be offered a solution in the form of improving care for the frail older patients detailed in this toolkit, and prompted to take action, e.g. to include service development in strategic planning, and delegate implementation to operational arms.

2. **Operational (trust) level**: Managers will be presented with convincing evidence of the problem, for example national reports from Royal Colleges, data from the NHS benchmarking audit on acute care for older people and patient stories. Their action will ideally be supported by strategic level decisions. Divisional and service managers will delegate service development across the hospital to non-geriatric services and provide support to improvement teams. Support may include: oversight by experienced senior clinical and managerial teams from different directorates and specialities, dedicated measurement team, devolved budgetary autonomy, project management support, and service level review.

3. **Service level** will see improvement teams being set up who will lead on embedding CGA in services. This is the area covered by this toolkit.

4. **Patient and carer level** will be empowered to take a more active role in their care, if they wish to do so. Patients and carers may influence the ways acute services are provided locally, and will be targeted by a specific intervention (an information leaflet or a video) to increase awareness about high-quality care for frail older people. In turn, patient and carers will be able to demand the care from their services.
ABOUT THE TOOLKIT

You are an anaesthetist, a surgeon, an oncology specialist, or other acute care physician. In your service, yours and other team members’ training may not have focused on the needs of older people. There may be a lack of confidence and expertise in managing older people and conditions associated with ageing. Yet you are interested in improving care for these patients who come to your service.

You may have seen research evidence and you may have talked to your colleagues and reflected on personal experience. You may have collected own data showing the care for frail older people in your service could be improved. Or you may have been asked to improve your service performance in respect to this patient group.

There are different starting points on your journey to improve care for frail older people in your service, and this toolkit will try to assist you on that journey.
The Older Person Standard Set of outcomes

This 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)²:

For example:
- UK: age 84 → ≥74
- Japan: age 86 → ≥76
- South Africa: age 76 → ≥66
- Australia: age 85 → ≥75
- Canada: age 85 → ≥75

Scope

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Frail 
friendly 
design

University of 
Leicester

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 “frailty-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 >65 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 frailty 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.
- Three 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, door, 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 carers 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


#EM3

www.em3.org.uk

PEMLA
Final thoughts

• Frailty in urgent care is THE issue
• Lots of opportunities to improve
• Whole system, patient centered, holistic approach
• Education and training for all
• Needs to infiltrate from policy down to clinical care level