BGS

The Nuffield Trust, in collaboration with clinical investigators at the Universities of Leicester, Southampton and Newcastle, is part of a National Institute for Health Research (NIHR)-funded project to research acute hospital care for frail older people. The aim of the work is to inform NHS managers, clinicians, patients and the public about how best to organise hospital services for frail older people.

As part of this project, we have designed a tool for use by local providers (NHS acute trusts) and commissioners (local authorities) of care for older people (aged 75 years and older) in England.

Promoting Hospital Wide CGA

Improving acute services through mainstreaming holistic care for frail older people

CEOs will be well aware of the growing population of older people accessing urgent care settings, the bed-days associated with that group, and the pressure on Emergency Department flow and the 4-hour standard, which results from excess bed-days. They may well be familiar with the concept of frailty – essentially a state of vulnerability – people more likely to experience catastrophic decline in the face of an apparently innocuous challenge such as a minor infection. We outline here two strategic, evidence based actions that hospitals can take to help improve flow:

Identifying frailty
Ensuring the early delivery of Comprehensive Geriatric Assessment to frail older people accessing acute care, involving all staff

Identifying frailty
21% of people aged 75+ admitted to acute beds account for 85% of bed-days and deaths in the 75+ group. This group is predominantly made up of those older people with frailty. Frail individuals can be very quickly (41 seconds) and easily identified upon attendance or admission using simple frailty scales that can be administered by doctors, nurses or health care assistants. Identifying an individual with severe frailty at the point they access urgent care immediately signals that the individual is at risk of major harm – for example, an in-patient death rate of 30%. This can then prompt a discussion, including the patient and their family/carer, to achieve a balance between interventional (e.g. HDU/ITU) and aggressive care (e.g. intravenous fluids and antibiotics), addressing "the matter with" patients, and a more palliative approach that acknowledges the patient's and family's wishes for care that address "what matters to" them. This helps clinical teams move from managing conditions to managing people.

Early Comprehensive Geriatric Assessment
Holistic assessment and management (through a process known as Comprehensive Geriatric Assessment) improves outcomes for older people, including cognition, quality of life, and reduces use of resources in the hospital and wider health and social care system, through reduced length of stay and reduced long term care use and costs. It is important to emphasise that this approach is not unique to geriatricians or geriatric teams. Much of the skill set is generic; the remainder is teachable. Given that frail older people can be found throughout the hospital, all staff should be able to apply these competencies. Proximity to the end of life means that the focus of care should often be on care not cure. This is not a recipe for therapeutic nihilism, but an opportunity to switch care from resource intensive specialist care, toward more holistic care focussing on dignity and comfort, which is often what patients and their relatives in this scenario would prefer. As Professor Brian Dolan puts it: "If you had 1000 days left to live how many would you choose to spend in hospital?"

Suggested actions
We encourage you to ensure that your system and hospitals are addressing the needs of frail older people in acute care settings using the self-assessment framework outlined which may be downloaded opposite. This is not intended to be prescriptive, as improvement opportunities will vary from setting to setting. You will want to delegate much of this to directorate or service levels, but we strongly encourage you to ensure that there is a robust reporting mechanism at board level, supported by clinical champions that can review responses and progress.

See downloadable Hospital Wide CGA Self Assessment Tool (Level 3 toolkit v16 - self-assessment.pdf)

Interactive Needs Tool

An interactive needs tool was developed to help commissioners and providers describe frailty and hospital activity within their older local populations aged 75 years and older. Indicators have been developed and populated with data for each local authority (LA) and NHS Acute Trust in England to describe populations, hospital costs and hospital activity using the Hospital Episode Statistics (HES) and Office for National Statistics (ONS) datasets. These are delivered with HES-based measures of frailty and hospital utilisation, as described, to provide a range of local estimates of the number and proportion of older people who could need CGA at both LA and NHS Acute Trust level. For NHS Acute Trusts additional indicators on patients outcomes (mortality and emergency readmission) have also been included.

The tool is presented as a multi-worksheet Excel file, which has been populated for an exemplar an exemplar Trust and local authority (anonymised) and is provided as additional editorial documentation.

See downloadable Hospital Wide Needs Assessment Tool (.xls)

HoW-CGA toolkit 'activating the patient voice'

The aim of this toolkit is to empower patients and carers to ask for evidence-based care when they come into contact with acute hospital service. It is part of a broader project, which is looking at an approach to care of older people that fully takes account of all of their needs, which has been shown to improve patients' outcomes in clinical trials across the world.

Recognising that older people in acute hospital are likely to be vulnerable, may feel disempowered or nervous about speaking out, we have suggested a multi-layered approach which might allow the patient voice to be heard better.

- Part 1 – identifying champions

Patient and carer representation on the hospital board
Every acute NHS Trust board should have a patient and/or carer representative on the board as a non-executive director or 'champion'. Ideally this person or people should have direct experience of care in the hospital in question. Does the "experience of care mean as patient themselves? Or are they presenting the views of patients They should have an opportunity to bring a patient story to every board meeting (standing item). Advice for becoming an effective board level champion can be found here: http://www.ageuk.org.uk/london/news--campaigns/archive/older-peoples-champions-best-practice-guide-launched/

Older people's champions
Hospitals should set up a training programme so that all staff involved in caring for older people have undergone training. Such training should also be available to hospital volunteers. Examples include:

http://www.emeraldinsight.com/doi/pdfplus/10.1108/13663666200600029

https://www.dignityincare.org.uk/Resources/Type/Leicestershire-Older-Peo...

http://www.agewellinsandwell.org.uk/older-people-champions.htm

http://webarchive.nationalarchives.gov.uk/20120106073832/http://www.dh.g...@en/documents/digitalasset/dh_4085924.pdf

Networked surveillance
There are a number of organisations that act in advocacy roles for older people. At the local level, it is important that these networks are linked up, so allowing and overview of older people's care and emerging issues. Organisations should meet quarterly and share insights from across the local area, including, but not limited to:

Healthwatch
Carer associations
Older people's champions in some hospitals
Age UK
Alzheimer's Society
Parkinsons

- Part 2 – what matters to me?

Information and guidance on how to be heard, and how to ask the right questions. This could be in the form of a patient information leaflet or video – preferably adapted to the local area. The guidance should address:

Talking with health care professionals

- Creating the space time?
- Safe questioning and building confidence in talking with professionals

Relatives' clinics: Questions to ask

- Do I know what is wrong with me or what is being excluded?
- Do you know what matters to me (not what is the matter with me)?
- What is going to happen now, later today and tomorrow to get me sorted out?
- What do I need to achieve to get home?
- Do you know what my mobility needs to be to get me home?
- Have you checked to see how my memory is working? Have you consulted with my next of kin if I appear confused?
- Have you thought about the support I will need at home and in transit? Home, implying own home, may not be available. Care home?
- What does the OT say about my care?
- What does the physio say about my care?
- Have you asked the nurses about how I am doing?
- Do I need to see a geriatrician? If not, why not?
- Have you discussed my care in a multidisciplinary team meeting?
- Have you found out about my social networks?
- Have you assessed my medication to check I am not taking any unnecessary medication? Have you checked to see if there is any medication that might help me that I am not currently taking?
- If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?
- What can I do to help myself?
- Have you taken into account whether I need an interpreter

See: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-red-green-bed-days.pdf

Sharing key information

For people who struggle to communicate for whatever reason, there should be a process to gather key facts from families or others who know the individual well, which can help the clinical teams focus on what really matters to the patient.

For example, a front sheet that describes the person's life which gives professionals and others involved insight into the issues for that person. Attention needs to be engaged and personal stories can help to engage people and make them think. Personal stories can make people stop and think.

Is there a place for 'albums" about the patient's life to give the person context and confidence. Care homes and nursing homes should produce a 'personal profile' with a photograph of residents. This can be updated over time.

- Part 3 – dissemination

Written Information
Content: general and universal
Target audience: service users and potential service users (same information)
Professionals and managers are aware of and support content
Distribution via multiple settings: GP surgery, ED, Social Services (Integrated Teams).
Organisations (Age UK, Healthwatch, Alzheimer's Society) can assist with dissemination and put their own logo on
Format: Short leaflet (folded, A4), poster version, digital/downloadable via internet (via other organisations)

Talking Heads
Content: Range of experiences: 3-5 individuals; presenters need preparation
Style: succinct, natural (not reading script), emotional, specific, personal

Examples:
Videos of patients taking charge of their own care. People can use tablets and skype. Many older people are IT savvy. Some care homes have wifi. Applications are getting more user friendly. Voice activated devices are available.
Radio advertising and TV advertising can be very helpful e.g. go to the pharmacy if you have a cold, not the doctor. Can be entitled to free pharmacy care, and patients may not be aware. Need to get to the individual and tell them what they can do to help themselves.

Web-based material
Copies of the materials described above including hyperlinks
Could use twitter, e.g. # 'Are you an Older Person going into Hospital? – Click on this link to find out how to get all the support you need'