Why you should read this article:

- To recognise that identifying frailty is important to support older people living with complex needs
- To be aware that a frailty screening and assessment tool should be used that is most appropriate for the clinician's service
- To understand that collaborative working can improve care and reduce hospital admissions for older people living with frailty

How can identifying and grading frailty support older people in acute and community settings?

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Abstract

Identifying frailty is essential to support older people living with complex health and social care needs. This article discusses how a Florence Nightingale Foundation travel scholar used her scholarship to explore best practice in identifying frailty in acute and community settings in Scotland with the aim of developing services for people living with frailty locally and regionally in England.

As the move to integrated care services develops in England, valuable insights from Scotland will assist in the proactive design of bespoke services around the needs of individuals in the community and, when acutely unwell, in the hospital setting.

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Introduction

This article discusses how a Florence Nightingale Foundation travel scholarship was used with the aim of comparing and contrasting health services for older people and those living with frailty in Scotland, Nova Scotia and Toronto, with ongoing work streams in the Wessex region of England (Lewis et al 2020).

The article first defines frailty and why it is important to identify it using a validated screening and assessment tool. It discusses national work in Scotland to improve acute care for older people, including the development of the Think Frailty screening tool (Healthcare Improvement Scotland (HIS) 2014). Finally, it focuses on the author's learning from Scotland and how this relates to her work in Wessex in terms of identifying older adults living with frailty in the community and acute hospitals, and how they can best be supported. While the Scottish health and social care system is funded differently, with integration of services more established than in many parts of England, it is still part of the NHS, so it is more realistic to apply the Scottish approach to local and regional work in Wessex. In addition, the Scottish examples identify the connection between community and acute services, providing a truly person-centred approach.

Why identifying frailty is important

Frailty is a syndrome that has been defined as a loss of physical and psychological reserves leading to increased vulnerability to minor stressor events (British Geriatrics Society (BGS) 2014). There has been resistance to using the word frailty. Research conducted by Age UK and the BGS (2015) found that some older people associated the word with the loss of independence.

As healthcare professionals, our challenge is to be proactive in influencing colleagues and the public, so they do not shy away from using the word frailty. Identifying that a person is living with frailty is important because it can predict several adverse

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outcomes, including frequent hospitalisation, functional dependence, falls and ultimately death (Fried et al 2001, Lee et al 2015). The literature continues to support the clinical application of frailty, including its identification. By using a validated tool to identify that a person is living with frailty, we will have a greater understanding of where that person is on the frailty trajectory.

Identifying if a person is living with pre-frailty, mild, moderate or severe frailty means that we can then work with that individual and those closest to them to develop a personalised care plan based on what matters most to them and their holistic needs. This may not always be focused on a medical diagnosis and physical health needs, and may require input from a variety of community health and social services including the voluntary sector. It is often achieved through a process of comprehensive geriatric assessment (CGA). CGA and personalised care planning can improve outcomes for people living with frailty in acute hospitals and increase the likelihood of them living in their own homes at follow-up (Fox et al 2013, Ellis et al 2017).

Reid (2018) discussed the importance of identifying frailty in acute hospitals to ensure that CGA is started promptly and the benefits of developing multidisciplinary teams in the emergency department (ED) to undertake this assessment and personalised care planning. The benefits of identifying frailty in practice include (Nelson 2017):

- Early identification of an at-risk population.
- Promoting proactive rather than reactive care.
- Reducing the incidence of unplanned care.
- Supporting individuals and their families through informed decision-making while balancing the risks and benefits of interventions.

Nelson (2017) argued that nurses and allied health professionals are ideally placed to identify older adults living with frailty using validated screening and assessment tools.

Frailty screening and assessment tools

There are many frailty screening and assessment tools to choose from. NHS Improvement (NHSI) (2017) identified that different hospitals use different tools and that no one tool is better than any other. This can cause confusion among clinicians, managers and people living with frailty. NHSI urges that a consistent approach be adopted across the country, as variation can compromise patient safety; this reflects principle 5 set out by the Acute Frailty Network (Thompson 2016), 'adopt clinical professional standards to reduce unnecessary variation'. HIS ihub (2019a) has developed a useful frailty screening and assessment tools comparator that includes a decision tree and details of each specific tool (19 tools in total).

The comparator advises the level of expertise required to administer each tool, including the Clinical Frailty Scale (Rockwood et al 2005). However, I would argue that the Clinical Frailty Scale (Rockwood et al 2005) is not solely within the gift of a geriatrician, as it can be administered by an experienced frailty practitioner once a comprehensive history has been taken from the person being assessed. The comparator aims to support teams to appraise and select the tool that is the most appropriate for their service, and includes a time rating which indicates how time-consuming the different tools are to administer.

The Scottish approach to identifying and managing frailty

In 2011, the Scottish Government identified that a combination of the projected growth in the older population living with complex health needs and service models remaining unchanged would require an annual increase in health and social care investment of £1.1 billion by 2016. The desire to decrease unplanned admissions to hospital and strong evidence supporting CGA undertaken by multidisciplinary teams resulted in the Scottish Government providing funding for two years in 2012 to support HIS to improve acute care for older people.

The initiative, the older people's acute care (OPAC) improvement programme, focused on frailty and delirium. The aim of the frailty element of the programme was to screen older people for frailty on admission to hospital (at the 'front door' or ED) and, where people were identified as living with frailty, to carry out a CGA within 24 hours.

A prototype frailty screening tool for use in acute settings, Think Frailty, was developed by frailty specialists and improvement advisers from across Scotland working together (Table 1) (HIS 2014). Think Frailty was straightforward, quick and easy to use and its application at the hospital front door was important in enabling correct and rapid referral for CGA and specialist care (HIS 2014).

Acute visits

I was awarded my travel scholarship several years on from the initial work in Scotland to improve acute care for older people. I visited four acute hospital sites in Scotland: two large

teaching hospitals (Aberdeen Royal Infirmary and Queen Elizabeth University Hospital) and two district general hospitals (University Hospital Monklands and University Hospital Crosshouse). Although there was variation in approaches, they all shared the same vision of the earlier HIS work: identifying frailty at the hospital front door and starting rapid CGA.

NHS Grampian: Aberdeen Royal Infirmary

NHS Grampian has taken a city-wide approach (Hoyle 2014): 'To promote health, well-being and independence among frail older people living in Grampian through person-focused clinical practice, effective systems of care and active engagement in research and teaching.'

There are three main elements to this approach: a geriatric assessment unit, quality improvement (QI) meetings, and 'Silver city'. The geriatric assessment unit at Aberdeen Royal Infirmary provides early identification, assessment and creation of a bespoke frailty plan. Median length of stay in the unit is three days compared with 11 days in Woodend Hospital, a community hospital in NHS Grampian (Hoyle 2014).

There is great enthusiasm for QI, including QI meetings every Friday, with the topic rotating weekly through each work stream based on the Think Frailty driver diagram (HIS 2014): identification of frailty, care pathway and education, leadership and culture.

Beyond the hospital setting the 'Silver city' approach (Aberdeen is known as the Silver city because of the colour of many of its buildings made from local granite) identifies that health is more than treatment of disease. It focuses on well-being and personalised goals and seeks to work with people in their own home whenever possible.

QI has been core to our values in developing local and regional services following the Wessex acute and community frailty audits (Lewis et al 2020). Observing a department that emphasises the value of QI has convinced me that this is possible, and we have already begun to evidence this approach in the organisation I work with and region-wide. The proactive, cross-system Silver city approach identifies the importance of working collaboratively across the system as we plan to set up our 'ageing well' pathway as part of the new integrated care systems (NHS England (NHSE) 2019) in the Wessex region.

NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital

A comprehensive frailty service was implemented at the Queen Elizabeth University Hospital in 2017. Data on the first six weeks after implementation showed a significant reduction in the length of stay in the department of medicine for the elderly, a positive effect on the hospital's overall length of stay and no negative effect on length of stay in medical specialties (HIS ihub 2019b). The hospital also has a short-stay frailty unit of 12 beds that has reduced length of stay to less than 72 hours.

The frailty team was also established in March 2017 and includes elderly care assessment nurses, community teams, social workers, allied health professionals and medical staff. The frailty team assesses any patient over the age of 75 (or over the age

Table 1. Think Frailty screening tool

Step 1: Would this person benefit from comprehensive geriatric assessment (CGA)?

	Aged 75 and over/aged 65+ from nursing or residential care or admitted from community hospital	Yes	No
F	Functional impairment in context of significant multiple conditions (new or pre-existing)		
R	Resident in a care home		
A	Acute confusion (Think Delirium), for example the 4AT screening tool – is there a diagnosis of dementia or a history of chronic confusion?		
I	Immobility or falls in last 3 months		
L	List of six or more medicines (polypharmacy)		

If the response is 'yes' to any of the above, move to Step 2: for those potentially being referred for CGA, would this person be better managed by another specialty team at present? If yes, this is deemed an indicator for care by another acute specialty regardless of age. If not, priority for transfer of care to specialist geriatric assessment service is advised

(Healthcare Improvement Scotland 2014)

Key points

- Identifying frailty is essential to support older people living with complex health and social care needs
- It is important to find a frailty screening and assessment tool that best fits the needs of the people using your service
- Developing services to keep older people at home even when they are acutely unwell should be a priority for all health and social care systems
- Working collaboratively across acute and community organisations improves care and reduces hospital admissions for older people living with frailty
- When it is appropriate for an older person living with frailty to be admitted to hospital, a specialist frailty multidisciplinary team should be available to assess their individual needs and provide a personalised care plan

FURTHER RESOURCES

RCNi Frailty resource collection
rcni.com/features/frailty-resource-collection-84906

Canadian Frailty Network – AVOID Frailty
cfn-nce.ca/frailty-matters/avoid-frailty

Scottish Care of Older People (SCoOP) Project
abdn.ac.uk/iahs/research/acer/scoop.php

of 65 from a care home) for frailty using the Think Frailty tool (HIS 2014). The identification of frailty enables the frailty team to commence CGA for that patient. The proactive therapy team continually seeks improvement initiatives, including the use of Glasgow landmarks for mobility, going to the dayroom and associate practitioner exercise classes.

NHS Lanarkshire: Hospital at Home and University Hospital Monklands

In Lanarkshire, there is a streamlined, whole-system approach to managing acutely unwell older adults. This involves the frailty unit at University Hospital Monklands and the Hospital at Home team, which accepts people who are discharged from hospital and referrals from GPs. Rapid assessment of older adults in their own home is undertaken within one hour of referral from a GP, with a multidisciplinary team undertaking investigations, diagnosing illness and providing care and treatment.

The team consists of consultant geriatricians, advanced assessment nurses, occupational therapists, physiotherapists and rehabilitation support workers. All team members have basic rehabilitation competencies, and the culture of a flat hierarchy increases patient safety from a human factors perspective, that is, human-system interactions and the effect this has on risk and safety (Care Quality Commission 2018). The team has caseload capacity for up to 30 people, and a 1.5 hours ward round takes place each day. The average length of stay is five days.

A proactive approach is taken to prevent hospital admission, but when a person deteriorates medically and requires hospital admission, acute care for the elderly (ACE) nurses screen for frailty in the ED at University Hospital Monklands and cover medical receiving. The Think Frailty tool (HIS 2014) is used in combination with the Clinical Frailty Scale (Rockwood et al 2005).

The average length of stay on the frailty unit is 48 hours; between 4 March and 29 April 2019 the frailty unit showed nine weeks of sustained shorter stays for patients (HIS ihub 2019b). As a multidisciplinary team it prioritises 'safe for home' and early intervention for people staying in hospital. Communication is important, with frailty huddles held following the multidisciplinary team meeting. The team is standardising the CGA process by concentrating admissions through one ward, the frailty unit. Frailty consultant reviews take place every one or two days. The team is thinking about the workforce moving towards advanced clinical practitioner roles for some ACE nurses. Flow has improved through collaboration with other teams including discharge to assess, community rehabilitation team, home care support and Hospital at Home.

NHS Ayrshire and Arran: University Hospital Crosshouse

In the combined assessment unit, a consultant geriatrician and five senior allied health professional ACE practitioners provide a front-door frailty service. Using an adapted Clinical Frailty Scale (Rockwood et al 2005) score, they deliver rapid CGA for those identified as living with frailty, promoting early mobilisation and independence to prevent loss of function and early discharge planning. Those with a score of 5-7 are identified as requiring urgent CGA. There is also a clear plan for people with a score of less than four or a score of 8-9, with emphasis on advance care planning for the latter. Advance care planning is vital for people living with frailty and should be an integral aspect of CGA.

As nurses we have opportunities to start conversations about advance care planning early when people are living with pre-frailty or mild frailty, for example (Lewis 2019). The ACE practitioners also provide in-reach to other areas of the hospital except high dependency and conduct regular reviews of people on the inpatient rehabilitation list.

Primary care and community visits

In addition to the acute settings in Scotland, I visited the Midlothian improvement project and the Oban living well support services to explore primary care and community approaches to identifying people living with frailty.

Midlothian improvement project

Between March 2018 and April 2019, the Health Foundation (2020) funded an improvement project run by Midlothian Health and Social Care Partnership, which established a whole-system analytical framework to identify people living with frailty in Midlothian. The project analysed data from the electronic frailty index (eFI), which uses general practice read codes to identify older people living with mild, moderate and severe frailty in a practice population (Clegg et al 2016), with the aim of using it to improve care. A learning collaborative guided by GPs was set up focusing on polypharmacy, advance care

planning and diabetes management. For people living with mild frailty and social isolation, funding was made available for neighbourhood links through the British Red Cross.

Midlock practice in Glasgow also uses the eFI to identify people living with frailty at various points on the trajectory, meeting monthly as a community-wide multidisciplinary team.

Oban living well support services

This community-wide initiative is a collaboration between the NHS, third sector and the community. It focuses on (HIS ihub 2020):

- Prevention.
- Controlling, managing or improving chronic conditions.
- Reablement.
- Supporting people identified as living with frailty to live well at home.

The Edmonton Frail Scale, a brief, valid and reliable tool, is used to screen people (Rolfson et al 2006). The first component is prevention for people with no evidence of frailty. The prevention component is delivered by Healthy Options, a non-profit organisation that works with healthcare professionals and other community groups to support people to make long-term behavioural changes and become more active. Controlling, managing or improving chronic conditions involves the Healthy Options team, with NHS advice and influence providing exercise-based programmes for people identified as not living with frailty (0-5).

Reablement is provided by the community physiotherapy team devising an exercise programme alongside Healthy Options colleagues for people identified as apparently vulnerable (6-7) or living with mild frailty (8-9). For those with moderate frailty (10-11), the Oban frailty team at Lorn Medical Centre provides regular review and holistic management of people living at home with complexity secondary to frailty.

Referrals are generated from analysis of eFI data. Anticipatory, person-centred care planning is the approach used for working with these people. The lead community therapist and advanced nurse practitioner, also a partner in the medical centre, have been pivotal to the development, implementation and ongoing evaluation of this enviable model.

These models are evidence of a whole-system approach incorporating third-sector organisations to identify people living with frailty proactively in the community. The effect is a process that enables colleagues from a wide range of professions to collaborate and respond to the bespoke needs of individuals and improve their quality of life. Taking learning from these models will be important as we move towards setting up ageing well pathways in Wessex.

Making Wessex frailty fit

In the Wessex region, with facilitation from the Wessex Academic Health Science Network Healthy Ageing programme, we have concentrated on several region-wide QI approaches to support people living with frailty. These approaches include the development of frailty education and training and best practice guidelines for identifying frailty. Two acute and community frailty expert groups bring together the expertise, knowledge and skills of a multidisciplinary team to review practice collaboratively and improve standards of care across the region.

In 2018, the Wessex acute frailty audit used QI methodology to design and implement an audit to provide insights into the identification of frailty, comprehensive assessment and personalised care planning in the hospital setting and how these plans were shared between specialties and from hospital to community (Lewis et al 2020).

The valuable learning from this audit led to the development of a community frailty audit, focusing on the new primary care networks (PCNs) of local GP practices and community teams. PCNs are the vehicle for the delivery of the frailty elements of the NHS Long Term Plan (NHSE 2019), enabling people to remain in their own homes and stay independent for longer. Combining the findings of the acute and community audits we now have a whole-system regional overview that informs us where to focus frailty QI projects.

Conclusion

This article has identified several inspiring models of health and social care in Scotland that aim to manage people living with frailty. Using frailty screening and assessment tools has enabled health and social care professionals to ensure that the most appropriate care is delivered to individuals by the right person in the most suitable place. Keeping people at home where possible has been a priority in several of the initiatives, with collaborative working between community and acute services when necessary.

In the Wessex region we continue to work with the eFI (Clegg et al 2016) in primary care and the Clinical Frailty Scale

(Rockwood et al 2005) in some community and many acute settings, alongside identifying frailty syndromes. We are not mandating the use of a specific tool but recommend that organisations select a validated tool and evaluate its effectiveness in their service.

The travel scholarship has provided access to many resources for us to consider in Wessex, and there is learning to be taken from all organisations visited in Scotland, Nova Scotia and Toronto. We hope we can continue to develop a collaboration with HIS and look forward to sharing ideas and best practice examples to improve healthcare for our older population living with frailty across the UK and beyond.

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