CLEAR
Empowering staff to innovate care

CLEAR Urgent and Emergency Care 2023

East of England – UEC frailty project

Improving the care of frail older people while reducing ED attendances and hospital admissions in Norfolk and Waveney

AT A GLANCE

CLEAR CHALLENGE

Increasing number of older people living with frailty and complex needs, no same day emergency care service and a need for better communication between services

KEY CHANGES

SDEC units in each ED, a frailty helpline at JPUH, more support for care homes and better use of virtual wards

FORECAST BENEFITS

Reduced ED attendances, hospital admissions and lengths of stay, better patient care and potential productivity savings of more than £12 million

THE CHALLENGE

Norfolk and Waveney ICS has a higher than average population of older people living with frailty – many with complex needs and co-morbidities. Frailty patients accounted for a large proportion of unplanned care at Queen Elizabeth Hospital King's Lynn (QUH) and James Paget University Hospitals (JPUH) NHS Foundation Trusts with high levels of ED attendances and hospital admissions. There were unclear pathways for frailty patients and they were not always being assessed and coded with a universal tool across all services.

There was a need for better communication to improve awareness of existing pathways designed to avoid hospital admissions. Neither hospitals had a same day emergency care service (SDEC) and discharges were delayed because of the need for more community services.

WHAT THEY DID

The project team gathered the views of more than 40 staff from the two hospitals, care homes, ambulance service, community services and the integrated care board through site visits, workshops and one-to-one meetings. This was combined and analysed with data for 150,000 patients – including more than 25,600 frail patients along with reports from the acute frailty unit and ambulance service.

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CLEAR RECOMMENDATIONS

New blended SDEC and acute frailty units could be created in each emergency department (ED) open from 8am – 8pm, seven days a week to assess frail patients as soon as possible by a senior clinical decision maker and streamed to the most appropriate setting.

A consultant-led frailty helpline offering access to a senior clinical decision maker could be introduced at JPUH, modelled on the existing QEH service. Clinical support for care homes could be increased and frail patients treated at home as far as possible using urgent community response and virtual ward services.

The clinical frailty scale (CFS) – a tool to assess frail patients - could be adopted across the system and used by ambulance crews before ED handovers.

Other system-wide recommendations included multi-disciplinary teams in care homes, better patient transport services and intensive support for dementia patients.

> "This was an excellent programme that provided in-depth analysis of our service and an insightful reflection on how we can improve to better serve our patients"
>
> **Dr Kate Honney**
> **Lead Frailty Geriatrician**
> **The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust**

FORECAST IMPACT

ED attendances, hospital admissions and length of stay would all be reduced and new dedicated pathways give frailty patients a consistently high standard of timely care in the right environment.

Collaboration between services would improve, use of the CFS would ensure a universal language for handovers of patients and there would be increased access to a senior clinical decision maker, improving patient outcomes.

Cost savings of more than £12 million could be achieved if all the recommendations were implemented and successful, while the cost of taking no action would be more than £32 million.