GIG CYMRU NHS WALES | Y Weithrediaeth Executive

Right care, right place, first time

Six Goals for Urgent and Emergency Care

National Front Door Acute Frailty Service (AFS) for Acute Hospitals Framework for Wales

May 2025

Contents

1. Executive summary

The scope of this framework is for older adults living with frailty who present to acute hospital sites in urgent and emergency care settings in Wales, although it is recognised that high quality, holistic, compassionate care as outlined in this document will benefit people of all ages, particularly those with medical complexity and/or disability.

The framework outlines the strategic priority of implementing an Acute Frailty Service (AFS) at all acute hospitals integrated with community frailty services, with the aim of diverting older people with frailty to appropriate services quickly and discharging them home on the same day where possible.

The document outlines how to enhance the skills of health and care workers in managing frailty by using the tools required to identify frailty and using measures to evaluate the implementation of frailty pathways based on individual experience, harm reduction, quality of life, and system support.

Acute frailty teams will provide same day urgent and emergency care for people presenting in emergency departments (EDs) and Same Day Emergency Care (SDEC) as an alternative to hospital admission. This includes clinical frailty assessment and rapid access to a Comprehensive Geriatric Assessment (CGA) (if required), linked to treatment, Community Resource Teams including Rebatement, Community Nursing, Community Therapies and/or Enhanced Community Care (ECC) service provision. (Appendix 1)

1.1 Key recommendations

An Acute Frailty Service (AFS) is set up at the front door in all health boards to support urgent care services within or linked to SDEC and ED with an attached Acute Frailty Unit (AFU) or an Acute Clinical Unit (ACU) with an AFS provision providing up to 72hrs Length of Stay (LoS) for people requiring more than same day care.

All AFS need access to a local community infrastructure and processes that will receive direct referrals enabling a transfer of care back to the person's home (or a community bedded facility close to the person's home) ensuring a whole system response.

An AFS will provide seven day a week, 12 hours a day (84 hours a week) cover at the 'front door'

All health boards 'front door' staff and relevant trusts are trained on how to use the Clinical Frailty Score (CFS) for 65+ years, 4AT- Delirium scoring tool and NEWS2 with scores completed in all people 65+ years within 60 minutes of arrival to the unit and have full understanding of the implications of these scores for their ongoing care.

Health boards should implement pathways to ensure Comprehensive Geriatric Assessment (CGA) is initiated on the day of arrival into urgent care for older people with frailty. This will require systems that support rapid access to frailty teams from the time of arrival for anyone with a CFS >6.

People with moderate (CFS 6) to severe frailty (CFS 7) who are felt to need a >72hr inpatient stay should be rapidly streamed to either an acute older persons' inpatient ward for ongoing medical intervention alongside CGA, or have access to specialist frailty teams that can deliver CGA in other acute ward settings (such as surgical liaison services).

People who are assessed as having premorbid CFS 8 CGA should ascertain whether Future and Advance Care Planning has been undertaken by GP and that associated documentation e.g. DNACPR/TEP are accessible and available to support clinical decision making and care planning that meet their expressed needs.

All acute areas (ED, SDEC and Acute Clinical Units) and any inpatient care units that receive older people living with frailty should ensure staff are proactive in preventing deconditioning, with a particular focus on supporting them to be able to undertake activities of daily living according to the individual's usual physical and cognitive functional ability.

Health boards should ensure staff who care for people living with frailty admitted to general medical and specialist inpatient wards are trained and competent in managing people with frailty syndromes and are well versed in processes around avoiding deconditioning and discharge planning.

Staff working in acute areas that receive older people living with frailty should feel confident in having conversations with individuals and carers about how frailty the clinical condition predisposes them to increased risk in the hospital environment and our Home First offer. Discharge planning conversations commences from the day of arrival, including, but not limited to, accurate allocation of D2RA pathways.

All HBs to provide local training to staff on discharge planning processes. Health board multi professional staff working in hospital departments and ward environments that provide care for older people living with frailty should be well versed on how they access care, treatment and support D2RA pathways that enable efficient transfer of the person to the next stage of their care journey.

1.2 Key drivers for success

2. Introduction

The NHS Wales Planning Framework 2025/26 sets out as a strategic priority and delivery expectation for Implementing a Front Door Acute Frailty Service at all acute hospitals – integrated with community frailty services - that ensure that older people with frailty are diverted to the most appropriate services within the hospital as quickly as possible and, where possible, discharged home on the same day.

While this framework focuses on older people's frailty at the 'front door' in acute hospitals across Wales and the key priorities in establishing or improving their provision, other service provisions also support the avoidance of unnecessary attendance at ED and/or admission including for older people; for example, Urgent Care Centres (UCC), Community Resource Teams including Reablement, Community Nursing, Community Therapists and Enhanced Community Care. (Appendix 1)

The scope of this framework is for older adults living with frailty who present to Acute Hospital sites in urgent and emergency care settings in Wales, although it is recognised that high quality, holistic, compassionate care as outlined in this document will benefit people of all ages, particularly those with medical complexity and/or disability.

Frailty is a long-term condition related to the ageing process in which multiple body systems gradually lose their in-built reserves. It is now widely recognised as a state of reduced resilience and increased vulnerability, which results in some older people becoming more vulnerable to relatively minor changes in their circumstances which can lead to a deterioration in their health and/or ability to live independently.[1] It is estimated that 25-50% of people over the age of 85 are living with some degree of frailty and these people have significantly increased risk of falls, disability, long-term care and death.[2,3]

People living with frailty are less able to adapt to stress factors such as acute illness, injury or changes in their environment, personal or social circumstances, and such changes are more likely to result in adverse health outcomes and loss of independence.

There is evidence to suggest that the term frailty might not resonate with older people or their family members or care givers. However, frailty is a useful concept because it can help us to recognise and provide for the needs of people living with this long-term condition. We, therefore, use the term 'frailty' in this strategy, although recognise that many people living

with frailty might not recognise themselves as such, but may more often describe themselves using terms such as 'I'm slowing down'. One of the aims of this framework is to empower people living with frailty, as well as their family, friends and carers, to understand the condition, make the most of available support and to plan effectively for their own current and future care needs.

Frailty also remains a new area for much of the workforce and work is now needed to position frailty as a long-term condition and underpin it with the upskilling of the workforce. Recent research has highlighted the current variation and inconsistency in education and training and the siloed working that still exists between different sectors and professions which can be particularly problematic in care of older people.[4]

The Framework will be a working document as the Six Goals for Urgent and Emergency Care support health boards and trusts to deliver the ministerial priority for 2025/2026. Please contact ABB.SixGoalsUEC@wales.nhs.uk with any comments or suggestions.

3. Background

The Six Goals for Urgent and Emergency Care (UEC) National Programme[5], co-designed by clinical and professional leads, spans the urgent and emergency care pathway and reflects the priorities in the Welsh Government Programme for Government 2021– 2026. Our strategic aim is to prevent unnecessary escalation of care where possible, by providing proactive support and to enable access to the right care, first time for people who have a need for urgent or emergency care.

This approach aligns with the commitments of A Healthier Wales (2018)[6], the Workforce Strategy for Health and Social Care (2020)[7], the Programme for Government (2021)[8] and the National Clinical Framework (2021)[9], to deliver:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible.
- Services designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.
- A system where people only present at, or are admitted to, a general hospital when it is essential, with hospital services designed to minimise the time spent in hospital.

- A shift in resources to the community that enables hospital-based care (when needed) to be accessed more quickly.
- The use of digital change and technology to support high quality services.
- A motivated and engaged workforce with the right capacity, capability and confidence.

Our vision for urgent and emergency care is also founded on the Wellbeing of Future Generations Act (2015)[10], 'Five Ways of Working', setting out:

- A longer-term vision for designing a seamless urgent and emergency care model along with short to medium term action requiring collaborative planning across health, social care and the third sector to optimise outcomes.
- Public involvement which has been key to shaping the Six Goals and will remain fundamental to tackling health inequalities, the delivery of personalised care and the co-design of new models of care, with a strong focus on preventive activity aimed at keeping people well and maintaining independence.
- This approach includes schemes that support people to remain safely at home, for example through healthier homes and focus on supporting individuals to manage their health conditions to avoid exacerbations that result in admission to hospital.
- Collaboration and partnership working across key partners in the health and social care system, health boards and trusts, social care, regional partnership boards, the third sector and beyond, to deliver on the system changes required.

4. Frailty in our acute hospitals

Our population is ageing, and this brings with it the challenge of caring for increasing numbers of people living with frailty and multimorbidity. This population have ever more complex healthcare needs and, accordingly, the demand on our healthcare services is rising. Frailty affects up to half of people aged 85 and over,[11] half of all hospital inpatients and care home residents and costs UK healthcare systems £5.8billion per year.[12]

Currently more than 60% of hospital beds at any one time are occupied by people aged over 65 years and these admissions are associated with an increased rate of mortality, length of stay, high rates of readmission and institutionalisation. Hospital admission within the previous 12 months is the

single most predictive risk factor for new functional decline amongst community dwelling older adults.[13]

The unsustainable nature of the traditional models of inpatient focussed care for those with multimorbidity and complexity has been recognised at multiple levels, as evidenced by its prominence in recent healthcare policy documents from the British Geriatrics Society (BGS) and the Royal College of Emergency Medicine (RCEM) as well as at government level.[14]

Proactive and urgent care management of people living with frailty in the community and as inpatients in the hospital environment is becoming a priority for the NHS in partnership with their social care and third sector colleagues. Evidence based approaches should be implemented across our systems to ensure the provision of timely and effective care for this population group.

There is much that hospital staff can do to improve the quality and safety of care and contribute to holistic and anticipatory care for older people with frailty: proactive identification of frailty and delirium, early comprehensive geriatric assessment (CGA) alongside interventions to reduce harm and improve outcomes, and better coordinated transfers of care to the community. Despite evidence that CGA can improve care outcomes and experience, implementation in hospitals remains patchy. This contributes to considerable variation between hospitals for many quality metrics.

Other contributing factors to this unwarranted variation are systematic differences in recognition and management of frailty and delirium, preventing deconditioning, and in discharge planning. Solutions require pathways attuned to the needs of older people with frailty across the whole hospital.

It is important to reflect that frailty is everyone’s business, and to ensure a person receives the right care, in the right place, first time.

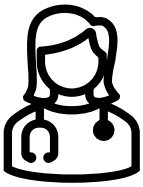
5. Acute Frailty Service (AFS)

What is an Acute Frailty Service?

The definition:

An Acute Frailty Service (AFS) routinely and systematically identifies frailty in people who present acutely to community or hospital based urgent and emergency care services.

These services then consider the personalised needs of individuals living with frailty, considering the impact of their frailty and degree of illness, supported by clear reliable pathways into and out of hospitals aligned to the severity of frailty identified, linked to evidence based Comprehensive Geriatric Assessment (CGA).



An Acute Frailty Service in an acute hospital is an integrated approach involving most staff working in an ED, SDEC and urgent care services. It is not simply a unit, and it is not just a team. Depending on the local context and resource, how the AFS is run will vary but its essential purpose and principles are constant.

Front door services on acute sites incorporating AFS can often manage older people living with frailty in a way that is planned, personal and much less distressing for the person concerned.

It is important to recognise that many people will need both community and hospital care, and systems should allow for seamless transfer depending on greatest need. Whilst avoidance of admission should be sought wherever possible, many people living with frailty will present will illness severity that must be managed in an inpatient setting. Systems that support direct links for community providers (GPs and paramedics, for

example) to access the Acute Frailty Service and Same Day Emergency Care (SDEC), are essential.

There is an attributing need to accelerate based on negative outcomes being increasingly evident for this population group across our acute hospital environments in terms of deconditioning / Pathways of Care Delays (PoCD). The demographic and epidemiological profile for this population group is dictating the need for us to also accelerate our efforts to facilitate direct access for General Practitioners (GPs) and paramedics to hospital-based teams including SDEC, and AFSs.

A large proportion of people attending the Emergency Department (ED) are over 65 years of age and have a higher likelihood of presenting with frailty; this requires early recognition for the person to be directed to the right place for treatment, at the right time. Poor or late recognition of frailty and/or its associated syndromes increases the likelihood that the person will be admitted to hospital, have a longer length of stay (LoS) in hospital and experience poor long-term health outcomes.

5.1 Acute Frailty Service provision in hospital

Acute frailty teams will provide same day urgent and emergency care for people presenting in ED and SDEC as an alternative to hospital admission. This includes clinical frailty assessment and rapid access to a Comprehensive Geriatric Assessment (CGA) (if required), linked to treatment, Community Resource Teams including reablement, Community Nursing, Community Therapies and/or Enhanced Community Care service provision. (Appendix 1)

It is recommended that:

An Acute Frailty Service (AFS) is set up at the front door in all health boards to support urgent care services within or linked to SDEC and ED with an attached Acute Frailty Unit (AFU) or an Acute Clinical Unit (ACU) with an AFS provision providing up to 72hrs LOS for people requiring more than same day care.

All AFS need access to a local community infrastructure and processes that will receive direct referrals enabling a transfer of care back to the person's home (or a community bedded facility close to the person's home) ensuring a whole system response.

An AFS will provide 7 day a week, 12 hours a day (84hrs a week) cover at the 'front door'

All health boards 'front door' staff and relevant trusts are trained on how to use the Clinical Frailty Score (CFS) for 65+ years, 4AT- Delirium scoring tool and NEWS2 with scores completed in all people 65+ years within 60 minutes of arrival to the unit and have full understanding of the implications of these scores for their ongoing care.

Health boards should implement pathways to ensure Comprehensive Geriatric Assessment (CGA) is initiated on the day of arrival into urgent care for older people with frailty. This will require systems that support rapid access to frailty teams from the time of arrival for anyone with a CFS >6.

People with moderate (CFS 6) to severe frailty (CFS 7) who are felt to need a >72hr inpatient stay should be rapidly streamed to either an acute older persons' inpatient ward for ongoing medical intervention alongside comprehensive geriatric assessment or have access to specialist frailty teams that can deliver CGA in other acute ward settings (such as surgical liaison services).

People who are assessed as having premorbid CFS 8 CGA should ascertain whether Future and Advance Care Planning has been undertaken by GP and that associated documentation eg DNACPR / TEP are accessible and available to support clinical decision making and care planning that meet their expressed needs

All acute areas (ED, SDEC and Acute Clinical Units) and any inpatient care units that receive older people living with frailty should ensure staff are proactive in preventing deconditioning, with a particular focus on supporting them to be able to undertake activities of daily living according to the individual's usual physical and cognitive functional ability.

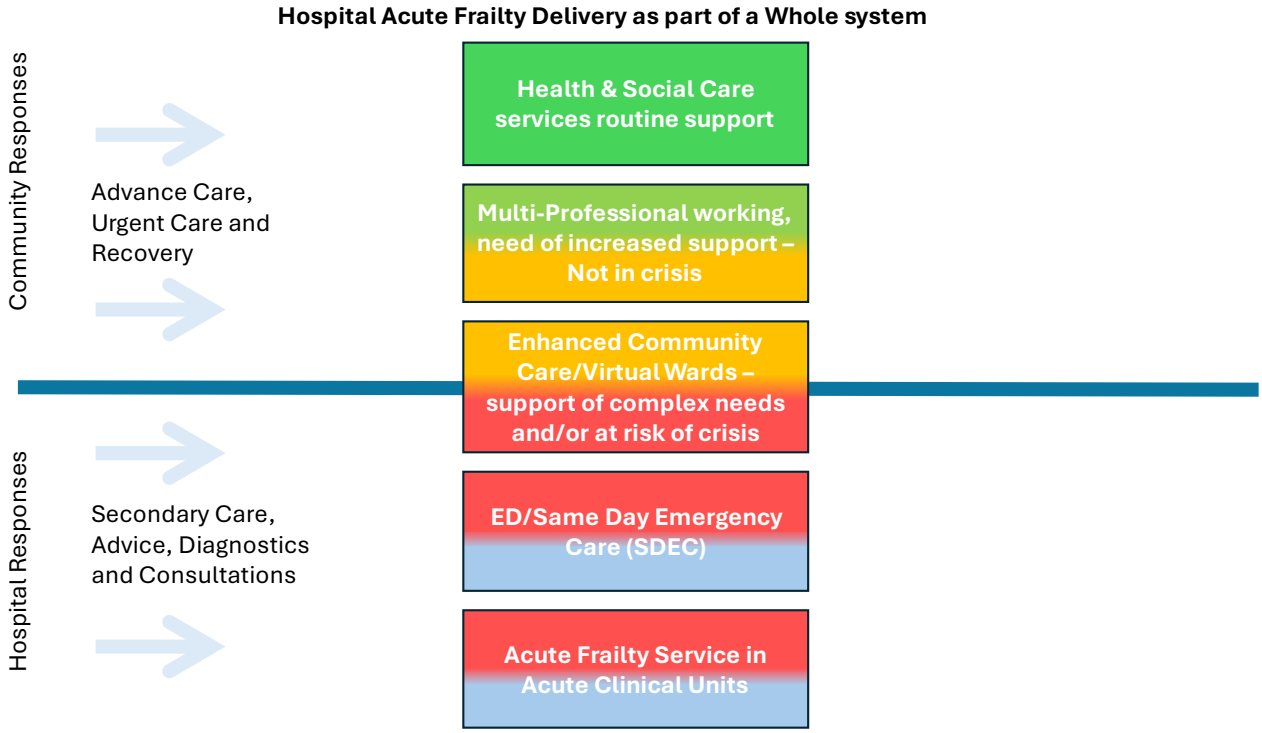
Health boards should ensure staff who care for people living with frailty admitted to general medical and specialist inpatient wards are trained and competent in managing people with frailty syndromes and are well versed in processes around avoiding deconditioning and discharge planning.

Staff working in acute areas that receive older people living with frailty should feel confident in having conversations with individuals and carers about how frailty the clinical condition predisposes them to increased risk in the hospital environment and our Home First offer. Discharge planning conversations commences from the day of arrival, including, but not limited to, accurate allocation of D2RA pathways.

All HBs to provide local training to staff on discharge planning processes. Health Board multi professional staff working in hospital departments and ward environments that provide care for older people living with frailty should be well versed on how they access care, treatment and support D2RA pathways that enable efficient transfer of the person to the next stage of their care journey.

5.2 Key drivers for success

It is important that the system infrastructure supports older people living with frailty to access the right care, first time. Acute Frailty Services will need to support a cross sector of the urgent and emergency care system: primary care, community services, ambulance services, social services, third sector and acute hospitals. Collaboration will be a key to success.



Adapted from: Unplanned Hospital Care Acute Frailty Service Specification_FINAL_20210901.pdf and *Appendix 1*

A key piece of guidance Six Steps to Better Care for Older People in Acute Hospitals and the GIRFT Hospital Acute Care Frailty Pathway aiming to support hospital teams in their work to improve care of older people living with frailty was published in 2023, in a collaboration between Getting It Right First Time (GIRFT) and the British Geriatrics Society (BGS). The guidance offers detailed measures teams should take to improve care and reduce hospital-acquired dependency for those living with frailty, as well as stressing that interventions should be monitored and linked more widely to community-based services.

6. Comprehensive Geriatric Assessment (CGA)

The cornerstone of high-quality care for older people in hospital settings is Comprehensive Geriatric Assessment (CGA). This is an evidence based

multi-professional process that improves outcomes for older people in both community and hospital settings. People who receive CGA in an inpatient unit (such as an acute geriatrics ward or frailty unit) have a 25% higher chance of being alive and living in their own homes six months after their admission than those who do not have CGA based care.[15]

What is CGA?

A comprehensive geriatric assessment is a multicomponent assessment and planning process that explores multiple domains, including functional and psychological areas, alongside medical review. This allows teams to address more than just the medical reason for admission and focusses not only on aspects necessary to support discharge but on implementing plans for longer term management of comorbidities, polypharmacy and care needs.

Who should have access to CGA?

CGA should be available to people screened for frailty and assessed with a CFS >4 in an acute setting. These people often present to urgent and emergency care as:

- Sudden physical/cognitive decline often presenting as acute frailty syndromes such as falls (sudden coming to the ground), reduced mobility and continence (sudden change in gross motor function) delirium.
- Adults with an assessed need for formal long-term care at home or residing in a care home (CHC/social care).

These people's medical history may include:

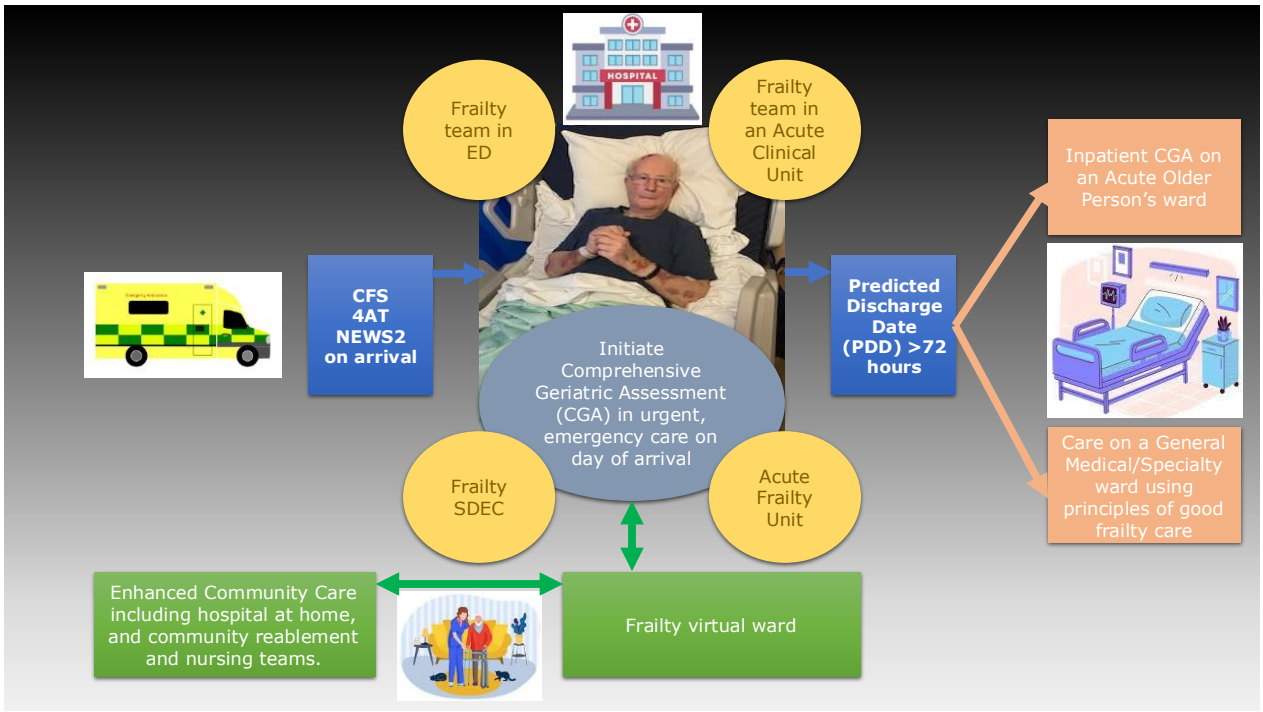
- Parkinson's disease or other progressive neurological condition
- Multi morbidity
- Dementia
- Older people who present with a medical complaint but have underlying frailty indicated by CFS >6.

How should CGA be delivered in urgent care?

The way that CGA is delivered in urgent care will vary according to local workforce and facilities. It is recommended using frailty screening at the front door to flag on the digital system and that this then prompts a review from a roving frailty team. The roving frailty teams will review people within an urgent care setting or via inpatient beds in a specific acute unit.

Contact with community services should always be considered as part of a hospital CGA as a CGA may already be in place and/or community services are likely to be able to provide significant insights into a person's health and wellbeing and living conditions at home. This is essential in preventing over excessive risk mitigation strategies for people living with frailty at home.

For older people living with frailty, the CGA should be a core component of Future Care Planning as part of proactive management of this population by primary care and community services.



The roving frailty team

The team will consist of a range of multi-professional members who seek out older people with frailty within an acute care footprint such as ED or the acute medical unit.

Acute Frailty Unit

Many centres across the UK have consolidated Acute Frailty Services into units that operate as an Acute Medical Unit (AMU) for older people. This allows ward-based CGA to occur from a full multi-professional and in a suitable and supportive environment with a length of stay up to 72 hours.

Non-medical specialties

Older people living with frailty attend urgent care with a range of presentations and will require care within a range of specialties. It is important that frailty is not a barrier to receiving high quality specialist care and that staff within specialties outside of Internal Medicine are equipped and skilled to manage such individuals. Alongside ensuring all staff are trained in frailty attuned care there may be a role for additional frailty teams who can support more complex cases in these areas.

High quality transfer of information between teams is vital to ensure assessments are not duplicated and can be acted on by onward services.

The Six Goals for Urgent and Emergency Care National Team will start developing an all-Wales electronic CGA with involvement from key stakeholders in 2025 that is accessible across the persons' pathway. This will ensure a standardised approach and support the embedding of the CGA in health boards across acute and community services.

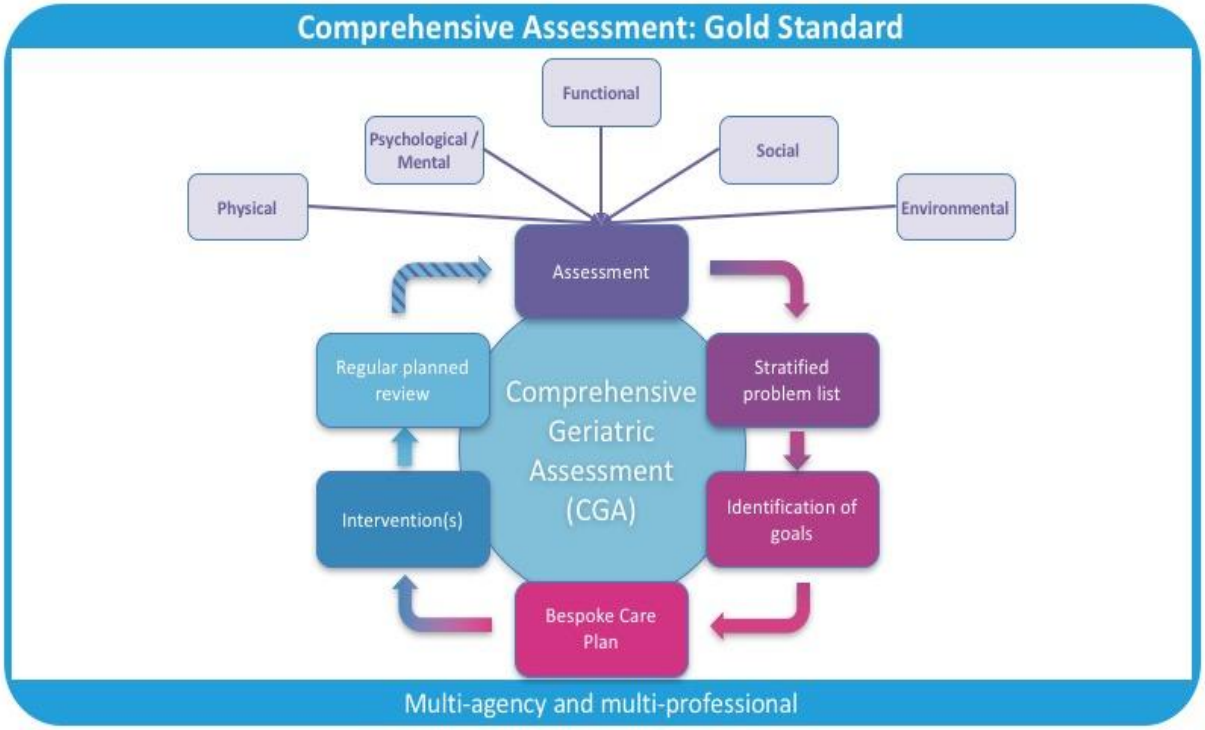


Illustration of the multi-agency and multi-professional approach that is key to a CGA

7. Identifying frailty

Looking for frailty must become an embedded part of the acute assessment of people aged over 65, to enable earlier targeted assessment and intervention using comprehensive geriatric assessment (CGA). As frail people can be found across a hospital, this is an issue for all clinical teams.

Clinical Frailty Scale (CFS)

The Clinical Frailty Scale (CFS) is a quick and simple tool that identifies the degree of frailty based on symptoms and functional status.

The Clinical Frailty Scale (CFS) was introduced in the second clinical examination of the Canadian Study of Health and Aging (CSHA) to summarise the overall level of fitness or frailty of an older adult after they had been evaluated by an experienced clinician.[16]

Although introduced as a means of summarising a multidimensional assessment in an epidemiological setting, the CFS quickly evolved for clinical use, and has been widely taken up as a judgment-based tool to screen for frailty and to broadly stratify degrees of fitness and frailty. It is not a questionnaire, but a way to summarise information from a clinical encounter with an older person, in a context in which it is useful to screen for and roughly quantify an individual's overall health status.

Completion of the CFS by front door teams should only take 2-3 minutes[17] and has been shown when used in acute hospital settings to be an independent predictor or inpatient mortality, transfer to a geriatric medicine ward and prolonged length of stay.[18] The use of CFS is also a common way of assessing frailty in community nursing services and has been implemented in most district nursing teams across Wales.

Please refer to the CFS guidance in Appendix 2.

Delirium – 4AT

Delirium characterised by the recent onset of fluctuating inattention and confusion is common in older people with frailty in hospital. It contributes to substantial morbidity and mortality and causes considerable distress to individuals and families. Approximately one in three unwell older adults who attend the emergency department have signs of delirium, whilst half have delirium during their hospital stay.[19]

Delirium can have catastrophic outcomes for hospitalised older adults and is associated with increased mortality (both at discharge and at 12

months), increased length of hospital stays and new care home admission; early detection is vital as up to 40% of cases are likely preventable.[20]

The most important part of delirium being diagnosed is someone noticing that the person is not themselves, or that they're acting strangely. Other features include recent reduced mobility, reduced oral intake or new drowsiness. This could be anyone who knows them well, such as a spouse or family member if they're living at home, a carer or nurse if they're living in a care home, or a healthcare professional or visitor if they're in hospital. A clinician should then assess the person's mental state as soon as possible.

It is very common for delirium to be missed or thought to be something else. Using a screening tool, such as a 4AT (the 4 As test), can help to identify delirium more accurately. The 4AT can be completed in 2 minutes and should be undertake on arrival into urgent and emergency care settings for all older adults (>65).[19]

Please refer to 4AT Guidance in Appendix 3.

National Early Warning Score (NEWS) to National Early Warning Score2 (NEWS2)

NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

In December 2017, an updated version of NEWS, NEWS2 was published.

The National Early Warning Score 2 (NEWS2) is the established track and trigger system to assess illness severity and risk of deterioration for people in acute episodes of care in the UK.

How NEWS2 works

The NEWS2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice presentation or when a person is being monitored in hospital.

Six simple physiological parameters form the basis of the scoring system:

1. respiration rate

2. oxygen saturation

3. systolic blood pressure

4. pulse rate

5. level of consciousness or new confusion*

6. temperature.

*The individual has new-onset confusion, disorientation and/or agitation, where previously their mental state was normal – this may be subtle. The individual may respond to questions coherently, but there is some confusion, disorientation and/or agitation. This would score 3 or 4 on the GCS (rather than the normal 5 for verbal response), and scores 3 on the NEWS2 system. (Appendix 4)

8. Developing the workforce

Enhancing the skills of health and care workers who care for people with frailty, from prevention through to end-of-life care, is essential. Access to education and training at both pre and postgraduate levels is necessary to achieve this.

Investment to right-size current and future workforce capacity needs to be matched by support to build effective interdisciplinary teams, ensuring the best use of limited resources. High-performing teams are characterised by mutual respect and trust, allowing each member professional agency to operate at the upper end of their skills and licenses, rather than being restricted by hierarchical structures that can limit their contributions.

Opportunities for skill development and expanded scope of practice can strengthen professionals' contributions to the multi-professional team improve their experience and enhance care outcomes. Teamwork and individual judgment are particularly crucial in caring for older people with multiple health and social care needs, where the benefits and potential harms of interventions must be carefully balanced.

There are not enough healthcare professionals currently working in older people’s care and in the long term, more people will need to be recruited to all roles across the multi-professional team. In the interim however, there are steps that can be taken to increase capacity in older people’s healthcare.

Promoting newer roles such as physician associates can help to alleviate pressure in older people’s healthcare. Specialty and Associate Specialist

(SAS) grade doctors should also be encouraged to specialise in older people's medicine. The SAS workforce which includes specialty doctors, associate specialists, and specialist grade doctors currently makes up 30% of all licensed doctors, and by 2030 the General Medical Council (GMC) predicts that SAS doctors will become the largest group on the medical register.[21] This role will continue to be essential in the ongoing healthcare of older people.

An opportunity to review the Multi-Professional Framework for Integrated Working - Primary Care One to support the delivery of joined up, outcome focused services in the community that will support the front door pressure.

Additionally, a growing number of GPs are taking on extended roles in frailty across various settings. This enables them to champion care for the older population in proactive and urgent care settings, working across different organisations. These new positions provide sustainability and resilience across the workforce groups.

Staffing allocation for Acute Frailty Services

Appropriate staffing should be provided to operate an Acute Frailty Service on a sustainable basis for at least 12 hours a day, seven days a week.

Managing the needs of older people living with frailty should be a core responsibility for everyone, with training and development provided to the workforce to support this. There are however specific roles that are considered integral to implementing an effective, person-centred approach to managing the complex needs of this population group.

Suggested roles needed to deliver an efficient frailty at the front door model:

1. Consultant Physician with frailty expertise/Consultant Geriatrician
2. Specialist Palliative Care Clinicians (Consultant/Clinical Nurse Specialist (CNS)/Clinical AHP specialist)
3. Nurse/ AHP consultants
4. Advanced Clinical Practitioners with frailty expertise
5. Medical staff (which can include GPs with extended roles (GPwER) and physician associates)
6. Nursing staff (both registered and unregistered) to assess, deliver direct care, provide treatment and discharge people
7. AHPs, e.g. (but not limited to) physiotherapists, occupational therapists, dieticians, speech and language therapists
8. Pharmacists and pharmacy technicians

9. Administrative and clerical staff
10. IT business analyst
11. Service managers and operational staff
12. Social care staff (liaison or embedded in front door team)

Access to other staff such as porters and radiographers will also be important, and links should be established with social care and community staff to facilitate extra support for people discharged home as required.

9. Optimal Hospital Flow Framework (OHFF)

As part of the work of Goal 5, the Optimal Hospital Flow Framework (OHFF) was developed in December 2022 to enhance the management of hospital patient flow, facilitate effective discharge processes and improve overall quality and safety. The framework aims to achieve these objectives by promoting a proactive approach for hospital flow and discharge, integrating the OHFF principles as 'business as usual' throughout hospital processes.

Seen/Aim/Flow/Early Discharge/Recovery (SAFER)

- Ensure that all individuals are seen before midday.
- Ensure that discharge plans reflect the 'What matters to me' questions:
    - What do you think is wrong with me?
    - What is going to happen to me today?
    - What is needed to get me home and is there anything I can do to help?
    - When can I go home?
- Ensure individuals get the right care, in the right place, first time.
- Admission avoidance where safe to do so.
- Ensure individuals are in the right ward. Discharge planning from the point of admission and daily review of discharges.
- Prioritisation of individuals being discharged today to ensure they are home for lunch.
- Open discussion with the individual on their recovery goals and what matter to me questions.

Discharge to Recover then Assess (D2RA)

- Discharge planning commenced within 24hours of decision to admit and daily review of D2RA pathways.

- Working smartly for the benefit of people in our care by being clear on the roles and responsibilities of staff and professional groups relating to flow and discharge.
- All individuals should have an estimated date of discharge (EDD) that has been discussed and agreed with the individual and their family/carers where applicable.
- Drive the **D2RA** approach to ensure more individuals can be assessed in their own environments.

Red to Green Days (R2G)

- Reinforce that R2G directly relates to the 'Last 1000 Days' concept – individuals time is the most important currency in healthcare.
- Every day a person is in a hospital bed should add value to their care
- Promote a culture of zero tolerance for avoidable individual treatment delays. Every day in the hospital is a day away from home. Ensure each day should include treatment/s that contribute to a 'green' hospital day (day of value) actively progressing the individual towards discharge.

Preventing deconditioning

- Mitigate against the fact that the longer older, frail people spend in hospital the greater risk of clinical deconditioning through effective timely provision of rehabilitation and activity during admission by:
    - Maximising mobility and encourage self-care, including earing away from the bedside and toileting independently
    - Explaining the specific risks to the individual, for example the potential impact on future independence and returning home
    - Involve the individual and family and carers where possible prevent and identify deconditioning, promote functional activity, support continence management and promoting activities that provide cognitive stimulation.

In integrating these principles this, hospital organisations could create a culture of continued OHFF momentum and best practices to realise the benefits that full adopting of the OHFF principles will provide, such as:

- Optimise individuals' experience and outcomes by ensuring every admitted person achieves timely hospital care and efficient discharge as soon as it is safe to do so
- Reduce individuals' overall length of stay, release hospital beds and increase hospital patient flow
- Prevent individuals deconditioning

- Enhance digital local and national reporting.

10. Palliative and End-of-Life Care (PEoLC) within Acute Frailty Services (AFS)

Palliative and End-of-Life Care (PEoLC) is an essential component of high-quality care for people living with frailty, particularly those with advanced frailty (CFS) 7–9) and individuals approaching the last months of life. There is substantial overlap between frailty and palliative care needs, with shared priorities of symptom management, reducing unnecessary interventions, and ensuring person-centred care.

The *Front Door Acute Frailty Service* must work in close collaboration with specialist palliative care teams to ensure that individuals receive the right care, in the right place, at the right time. This includes timely recognition of palliative needs, proactive management of common symptoms (including pain and delirium), and clear referral pathways to community-based palliative care services.

Identifying patients who may benefit from PEoLC

Recognition of palliative care needs should be embedded into frailty screening and assessment, ensuring early identification and planning. Key indicators include:

- Frailty screening and Comprehensive Geriatric Assessment (CGA): Individuals with a CFS of 7 or higher should be assessed for palliative care needs, particularly in relation to symptom burden, function, and goals of care.
- Clinical indicators for referral:
    - Advanced frailty with multimorbidity
    - Frequent hospital admissions with deteriorating function
    - Acute deterioration without a reversible cause
    - Persistent symptoms despite optimal frailty management.
- Advance Care Planning (ACP): ACP should be routinely reviewed and documented at the point of acute care. This includes ReSPECT forms, Treatment Escalation Plans (TEPs), and DNACPR decisions.

Delirium and end-of-life care

Delirium is common in patients approaching the end of life and is often hypoactive, making it difficult to recognise. Early detection and management are critical to maintaining patient comfort and avoiding unnecessary distress. Acute frailty teams should:

- Use the 4AT tool routinely in urgent care settings
- Ensure proactive symptom control (e.g. non-pharmacological interventions, appropriate use of medication for distressing agitation)
- Engage families/carers early to discuss expected changes and avoid inappropriate escalation.

Referral pathways and integration with PEoLC services

- Screen for palliative needs within the Comprehensive Geriatric Assessment (CGA), ensuring that individuals with a CFS of 7 or higher are assessed for Advance Care Planning (ACP), DNACPR, and Treatment Escalation Plans (TEPs).
- Use the All-Wales Palliative Care Referral Form to facilitate timely access to specialist palliative care teams, ensuring appropriate escalation for symptom management, psychosocial support, and end-of-life planning.
- Ensure that palliative care planning is incorporated into hospital discharge pathways, particularly for individuals transitioning to home-based or hospice care.
- Establish clear discharge pathways back to GP and inclusion on to the GP palliative register.
- Establish clear referral pathways, in line with the All-Wales Referral Guidance, for patients requiring hospice, community-based PEoLC, or symptom control support.

To ensure a seamless approach to palliative care within Acute Frailty Services:

- Establish clear referral pathways for early involvement of specialist palliative care teams.
- Strengthen links with hospices, community nursing teams, and general practice to facilitate home-based palliative care.

- Ensure acute frailty teams can access palliative care expertise for complex symptom management and end-of-life decision-making.

Symptom management and holistic care in acute settings

- Management of pain, breathlessness, and distress: Acute frailty teams should be trained in anticipatory symptom management to prevent crisis situations.
- Avoiding unnecessary interventions: Care should prioritise comfort, avoiding unnecessary investigations or hospital transfers where goals of care indicate a palliative approach.
- Psychosocial and spiritual support: a holistic approach should include emotional, psychological, and spiritual care, involve chaplaincy, social work, and third-sector organisations where needed.

Workforce development: Embedding PEoLC in frailty training

All staff within Acute Frailty Services should receive training in:

- Recognising and responding to palliative needs
- Having sensitive conversations with patients and families
- Providing effective symptom control
- Understanding the role of PEoLC referral pathways and community services.

Monitoring and evaluation: Measuring outcomes for frailty and PEoLC

There is an opportunity to harmonise frailty and PEoLC outcome measures through Wales's *Core Outcome Set (COS) for PEoLC* and the development of digital data capture systems.

Recommended measures include:

a) Percentage of frail patients (CFS 7–9) with a documented ACP within 48 hours of admission.

b) Number of patients referred to specialist palliative care teams.

c) Percentage of patients who die in their preferred place of care.

d) Use of anticipatory medication plans for symptom control.

e) Patient and carer-reported experience measures (PREMs) for frailty and palliative care services.

f) Percentage of PEoLC patients on the GP palliative register

Embedding PEoLC within Acute Frailty Services ensures that older people with frailty receive care that is compassionate, person-centred, and aligned with their wishes. Strengthening referral pathways, workforce capabilities, and symptom management approaches will enhance quality of life and dignity for individuals at the end of life. A collaborative approach between frailty and PEoLC teams, supported by robust digital infrastructure and outcome measurement, will ensure better integration and continuity of care across acute and community settings.

11. Digital and data

In 2023, Welsh Government refreshed the Digital and Data Strategy for Health and Social Care. The updated strategy provides a national direction for digital and data to improve the experience of health and social care staff and users, tackle key strategic challenges facing the sectors and help people to lead happier, healthier and longer lives. It places a focus on inclusive and user-centred digital and data services and how the use of innovative new technologies can empower people to manage their own health and prevent illness.

Welsh Emergency Care Data Set (WECDS)

The Welsh Emergency Care Data Set (WECDS) is a new data set to be used across Wales for capturing data relating to urgent and emergency care. WECDS is adapted from version 4 of the Emergency Care Data Set (ECDS) which was first implemented across trusts in England in 2017. WECDS is a key enabler for delivering the Six Goals for Urgent and Emergency Care strategy and is supported by the Welsh Government and other professional bodies such as the Royal College of Emergency Medicine (RCEM). WECDS was mandated via a DSCN in May 2024 and is set to replace the current Emergency Department Data Set (EDDS). The first phase of WECDS implementation will focus on Emergency Departments, Minor Injury Units and Same Day Emergency Care in line with Goal 4 of the Six Goals for Urgent and Emergency Care policy. Further phases are planned to develop and implement WECDS further to capture data from NHS 111 Wales, the ambulance service, urgent care.

Admitted Patient Care (APC)

The Admitted Patient Care (APC) data set captures data for all consultant-led or non-consultant/nurse led (including midwives) admitted patient activity, regardless of the patient's area of residence. Once admitted a patient may have several episodes within a hospital spell. All episodes, including unfinished episodes should be captured within the APC data set.

Any activity which is not undertaken by a consultant or non-consultant/nurse led (or a member of their firm) should be excluded.

All NHS activity regardless of the care provider is included. Private patients seen at an NHS organisation are also included.

From April 2009 assessment unit activity has been required to be reported in the APC data set.

NHS Digital provide data on Welsh resident or registered patients treated in English NHS organisations.

Microsoft Word - DSCN 2009 05 W Assessment Unit v1.0 Final RW 18-05-2009.doc

Currently in the APC dataset subspecialty code '666' is used to identify assessment unit activity. This code alone will not differentiate between the different units e.g. Acute Medical Unit, Acute Surgical Unit or Acute Frailty Unit etc.

There is a requirement to work with Digital Health and Care Wales to update the definition of Assessment Unit to Acute Clinical Unit in the DSCN and split '666' Assessment Unit to capture for example:

- 661 Acute Clinical Unit
- 662 Acute Frailty Unit etc.
- Or an agreed sub speciality code.

12. Standards, measurement and metrics to support implementation

NHS England's: *Safe, compassionate care for frail older people using an integrated care pathway*[22] recommended that measures to evaluate the implementation of any older people with frailty's pathways are based on the following categories:

1. **Individual experience**: where individuals themselves have provided feedback on the quality or effectiveness of the service they have received.
2. **Harm reduction:** where outcome measures indicate whether harm to older people with frailty has occurred.
3. **Quality of life:** whether older people with frailty can maintain reasonable quality of life after contact with health services.
4. **Systems supporting older people:** where measures relate to the systems that treat older people with frailty, and whether these support improvements in care.
5. **Financial:** where indicators show any savings released because of changes to the pathway.

Category	Measure
Individual Experience	Support to self-manage long term conditions
	Care received in ED/inpatient wards
Harm Reduction	Pressure sore incidence
	Harm from medication errors
Quality of Life	Discharge rate to usual place of residence
	Proportion of individuals with fragility fractures recovering to their previous levels of mobility at 120 days
	Reduction in LoS for people living with frailty compared to previous 12 months
Systems supporting older people	Emergency readmissions: 30 and 90 days
	Comprehensive Geriatric Assessment (CGA) is initiated on the day of arrival into urgent care for older people with frailty
	Limiting bed moves to one transfer to right bed first time. Zero bed moves between 23:30 and 06:00
	LoS
Financial	Cost of emergency admissions in over 65s
	Cost of excess bed days

The table above gives some suggested measures which are already recorded within the health system. There is a need to develop a balanced scorecard of outcome measures relating to older people with frailty and their care.

Metrics (for people with moderate to severe frailty, CFS 7–9)

The following metrics could be introduced to measure effective Acute Frailty Service provision[23]:

Metric 1: Identification

Frailty in older people (65+) who arrive at acute services (ED, AMU, SDEC) by ambulance should undergo clinical frailty scale and 4AT assessment within 60 minutes of arrival.

Metric 2: Response to identification

Older people with frailty (65+) presenting to acute services with a frailty syndrome or those who have a CFS of 6 or above should have CGA initiated by the frailty service on the day of arrival; or confirmation that a CGA has been shared by community services; documented consideration of end-of-life care should also be routine if appropriate.

Metric 3a: Action response during core hours

A multi-professional team capable of assessing and managing geriatric syndromes should be available12 hours a day, seven days a week. This availability will promote same-day emergency care and reduce time spent in hospital.

Metric 3b: Action response outside core hours

Older people with frailty presenting and admitted outside Acute Frailty Service hours should have CGA initiated by the frailty team by noon the following day or confirmation that a CGA has been shared by community services.

Metric 4: Decision-making

The multi-professional input should be recorded in the clinical management plan, incorporating all five domains of the CGA (medical, cognitive/psychological, functional, social and environmental problems).

Getting It Right First Time (GIRFT) national report on geriatric medicine[24] recommends a collaborative approach across whole systems – including primary and secondary care, care homes, community services, ambulance services, local authorities and the voluntary sector – to help prevent frailty and avoid the need for older people to be admitted to hospital where more effective care can be offered elsewhere.

Contact with community services should always be considered as part of an individual's admission to hospital as community services are likely to be able to provide significant insights into a person's health and wellbeing and living conditions at home. This is essential in preventing over excessive risk

mitigation strategies for people living with frailty at home and preventing excessive length of stays.

In NHS England, the measures recommended in the report have the potential to both improve outcomes for older people across England and reduce acute care costs for the NHS by up to £687m, primarily through a reduction in bed days (Appendix 4).

Future work on developing a specific set of quality measures in Wales is planned for later in 2025.

13. Principles for the care of older people with frailty in urgent and emergency care

Alongside delivering CGA there are general principles that health boards should adopt to promote independence and avoid deconditioning in urgent care settings. These should be initiated from the time of arrival, including older people with frailty conveyed in by ambulance and awaiting handover as this will ensure individuals are able to return home as soon as they are clinically ready.

Mobility

- Individuals supported to mobilise within the department and supported to walk to toilet facilities if they would usually be able to do so.
- People encouraged to bring in their own walking aids, and staff feel confident in providing walking aids when these are not available.

Maintaining continence

- The use of pads, bedpans, bottles, and catheters should be used only if the medical condition is severe enough that the use of toilet facilities would not be suitable.
- Individuals not to be placed in hospital gowns unless necessary for medical purposes. People encouraged to bring in their own clothing and nightwear and to change into these at the appropriate times.

Pain

- Older people will often not ask for pain relief, deny they are in pain as they are not currently moving, or may have cognitive impairment

and struggle to express their discomfort. However, pain can have a significant impact on mobility in the urgent care setting.
- Pain is common in older people even in the absence of an acute fracture or injury, and chronic pain can be worsened through inactivity. Care should be taken to ensure pain is managed such that older people are able to maintain their usual mobility. Urgent medical review should be sought if pain is poorly controlled.

Nutrition, hydration, and swallowing

- Older people with frailty can very quickly become dehydrated in urgent care as they may struggle to access food and fluid. Food and drinks should be available 24 hours a day and if placed by a bed or chair it should be within the individual's line of sight and within easy reach.
- Sufficient staff in the unit assist people who require support with feeding and hydration.
- Care be taken to ensure people with delirium are supported to maintain sufficient hydration as some will not maintain sufficient intake without intensive assistance and encouragement.
- Care to be taken to obtain histories regarding an individual's usual diet, e.g. use of thickened fluids or modified diet, to ensure they can maintain adequate intake during their stay.

Orientation

- Individuals supported to be orientated – use of clocks and good lighting/signage is essential.
- Glasses and hearing aids are to be always used if required and care must be taken to ensure these items are not lost during the stay.
- Hearing assist devices readily available in all acute areas to ensure good communication with those who are hearing impaired.

Comfort and sleep

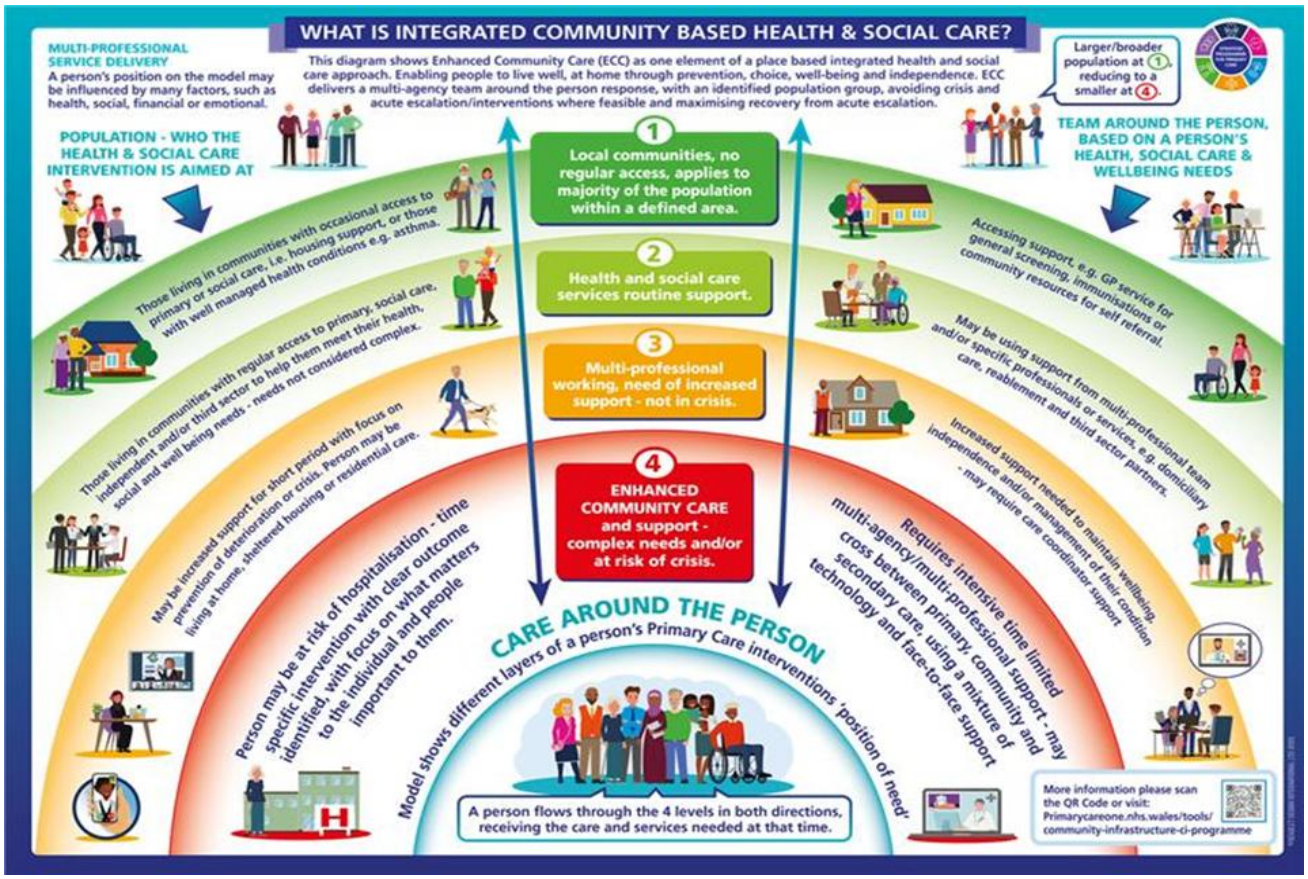
- Noise and light to be kept to a minimum at night to support quality sleep and reduce the risk of delirium.
- Individuals always have access to suitable seating and long waits in trolleys should be avoided.

Ward moves

- Ward moves can worsen delirium and increase length of stay and should only occur if they provide benefit for the person. Older people with frailty do not move wards overnight.
- Health boards monitor ward moves to ensure these are kept to a minimum.

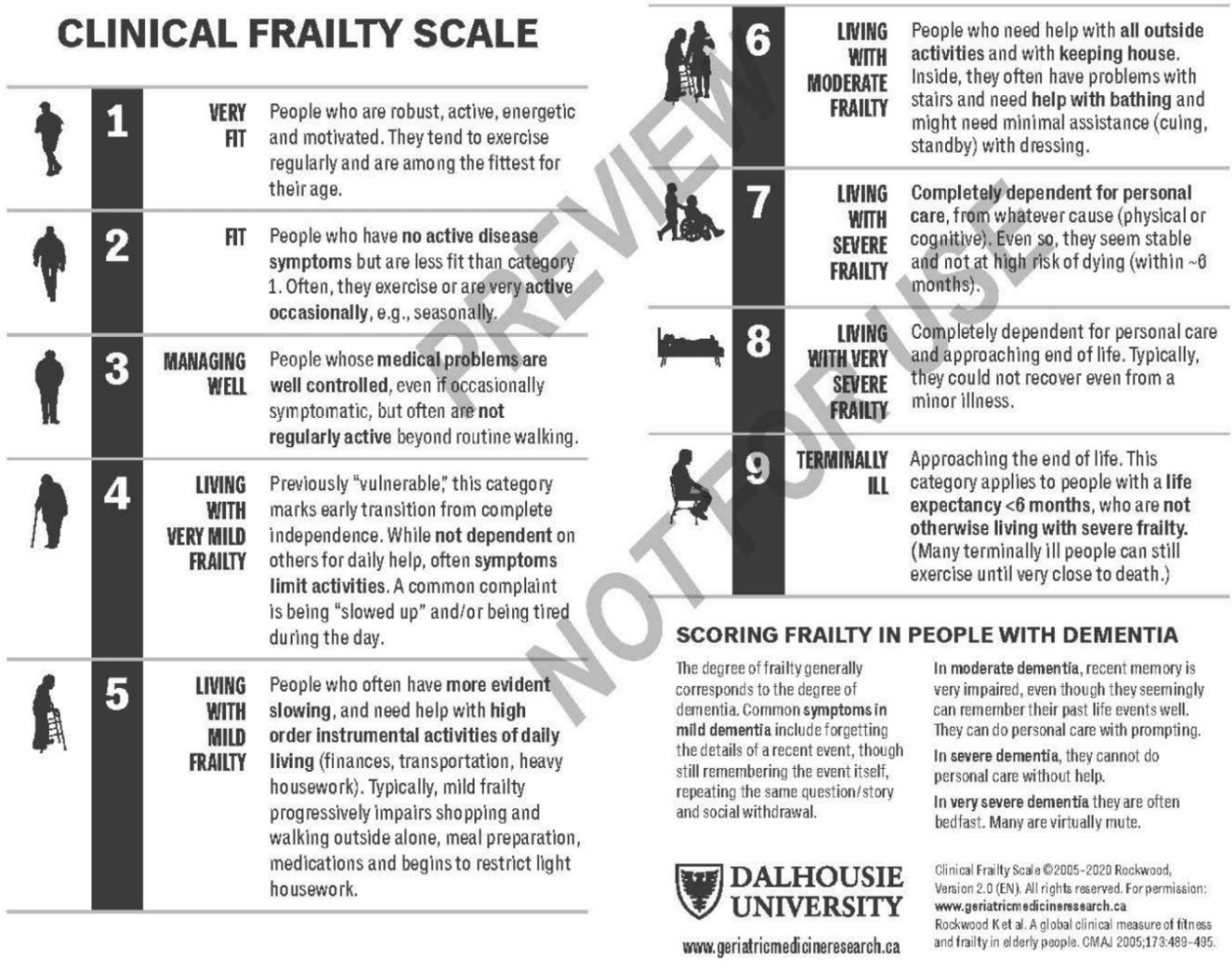
14. Appendices

Appendix 1: Enhanced Community Care (ECC)



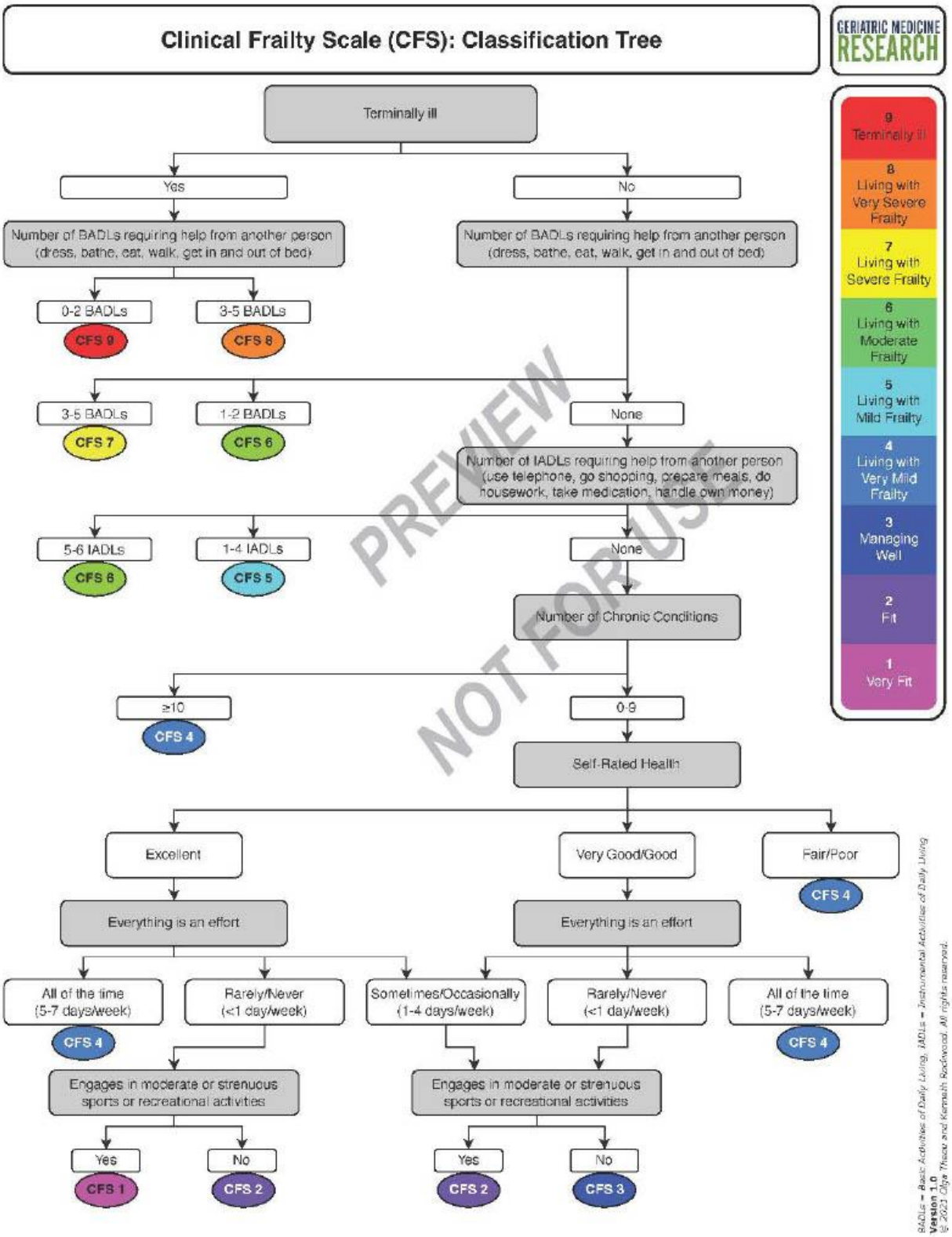
Appendix 2: Clinical Frailty Scale (CFS) tools

The CFS is a quick and simple tool that identifies degree of frailty based on symptoms and functional status.



CFS classification tree

The classification tree was developed to simplify use of the CFS for new staff and as an educational and training tool. This classification tree is not intended to replace the CFS or clinical judgement. It may not be useful to experienced staff that use CFS regularly as part of their assessments, but it can aid in routine CFS scoring for inexperienced staff.


Clinical Frailty Scale (CFS): Classification Tree
GERIATRIC MEDICINE RESEARCH
Terminally ill
Yes
No
Number of BADLs requiring help from another person (dress, bathe, eat, walk, get in and out of bed)
0-2 BADLs
CFS 9
3-5 BADLs
CFS 8
3-5 BADLs
CFS 7
1-2 BADLs
CFS 6
None
Number of IADLs requiring help from another person (use telephone, go shopping, prepare meals, do housework, take medication, handle own money)
5-6 IADLs
CFS 6
1-4 IADLs
CFS 5
None
Number of Chronic Conditions
≥10
CFS 4
0-9
Self-Rated Health
Excellent
Very Good/Good
Fair/Poor
CFS 4
Everything is an effort
Everything is an effort
All of the time (5-7 days/week)
CFS 4
Rarely/Never (<1 day/week)
Sometimes/Occasionally (1-4 days/week)
Rarely/Never (<1 day/week)
All of the time (5-7 days/week)
CFS 4
Engages in moderate or strenuous sports or recreational activities
Engages in moderate or strenuous sports or recreational activities
Yes
CFS 1
No
CFS 2
Yes
CFS 2
No
CFS 3
9 Terminally Ill
8 Living with Very Severe Frailty
7 Living with Severe Frailty
6 Living with Moderate Frailty
5 Living with Mild Frailty
4 Living with Very Mild Frailty
3 Managing Well
2 Fit
1 Very Fit
PREVIEW
NOT FOR USE
BADLs = Basic Activities of Daily Living, IADLs = Instrumental Activities of Daily Living
Version 1.0
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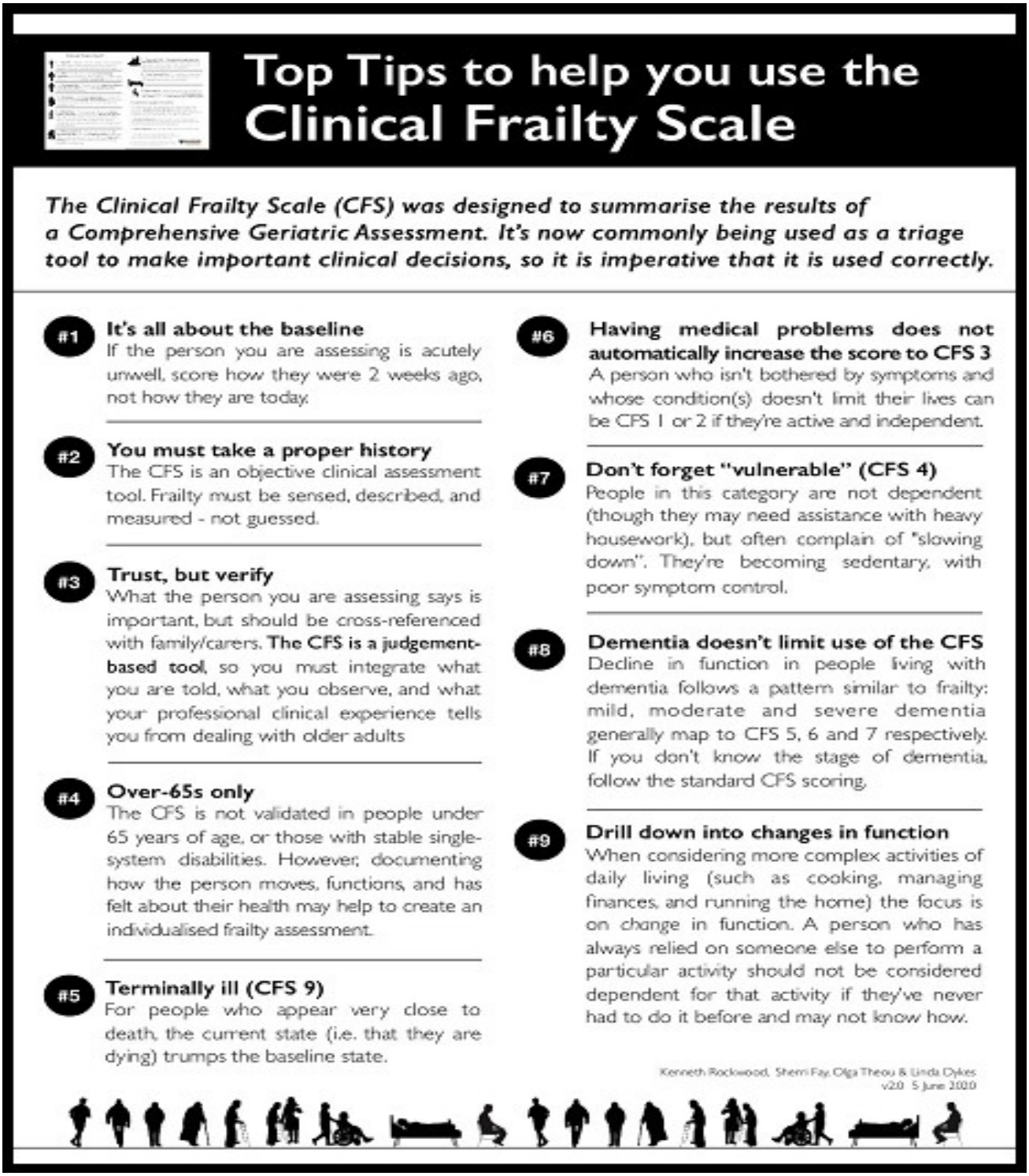
CFS tips for assessment

To help use the tool correctly some top tips to support the education and training of staff members.



Top Tips to help you use the Clinical Frailty Scale

The Clinical Frailty Scale (CFS) was designed to summarise the results of a Comprehensive Geriatric Assessment. It's now commonly being used as a triage tool to make important clinical decisions, so it is imperative that it is used correctly.

#1 It's all about the baseline
If the person you are assessing is acutely unwell, score how they were 2 weeks ago, not how they are today.

#2 You must take a proper history
The CFS is an objective clinical assessment tool. Frailty must be sensed, described, and measured - not guessed.

#3 Trust, but verify
What the person you are assessing says is important, but should be cross-referenced with family/carers. **The CFS is a judgement-based tool**, so you must integrate what you are told, what you observe, and what your professional clinical experience tells you from dealing with older adults

#4 Over-65s only
The CFS is not validated in people under 65 years of age, or those with stable single-system disabilities. However, documenting how the person moves, functions, and has felt about their health may help to create an individualised frailty assessment.

#5 Terminally ill (CFS 9)
For people who appear very close to death, the current state (i.e. that they are dying) trumps the baseline state.

#6 Having medical problems does not automatically increase the score to CFS 3
A person who isn't bothered by symptoms and whose condition(s) doesn't limit their lives can be CFS 1 or 2 if they're active and independent.

#7 Don't forget "vulnerable" (CFS 4)
People in this category are not dependent (though they may need assistance with heavy housework), but often complain of "slowing down". They're becoming sedentary, with poor symptom control.

#8 Dementia doesn't limit use of the CFS
Decline in function in people living with dementia follows a pattern similar to frailty: mild, moderate and severe dementia generally map to CFS 5, 6 and 7 respectively. If you don't know the stage of dementia, follow the standard CFS scoring.

#9 Drill down into changes in function
When considering more complex activities of daily living (such as cooking, managing finances, and running the home) the focus is on change in function. A person who has always relied on someone else to perform a particular activity should not be considered dependent for that activity if they've never had to do it before and may not know how.

Kenneth Rockwood, Sherri Fay, Olga Theou & Linda Dykes
v2.0 5 June 2020

Appendix 3: 4AT scoring for delirium

The 4AT is a short set of simple questions that measure:

Scoring: summary

The 4AT is scored from 0-12.

A score of 4 or more suggests delirium. As with all delirium tools, a delirium positive result is not diagnostic. In every case the diagnosis is reached by clinical judgement.

A score of 1-3 suggests cognitive impairment but not delirium.

A score of 0 suggests no delirium and no moderate-severe cognitive impairment. This score does not definitively exclude delirium or cognitive impairment: more detailed testing may be needed depending on the clinical context.

The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Note: 4AT scoring of patients unable to engage in conversation
No patients with delirium are 'Unable to Assess' (UTA) with the 4AT. You can always generate a score.

Many patients with delirium are unable to produce meaningful speech because of drowsiness or severe inattention. A key feature of the 4AT is that it allows these patients to have a score on the test.

How does this work?
If the patient cannot engage with the tester and attempt the AMT4 or the Attention test, the 4AT allows each item to be scored 'untestable', and a score is given (2 for each item). Untestable status on both items yields a score of 4, which suggests possible delirium.
So, if a patient is unable to speak because of drowsiness, the tester is still able to give a score on these items on the 4AT.

This will allow a 4AT score to be given, rather than the delirium assessment not being completed and potentially no diagnosis being made.

Alertness – whether the person is drowsy or agitated

This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or a gentle touch on the shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

Guide to scoring: altered level of alertness is >95% likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item.

Awareness – for example, their age or date of birth, or where they are.

Ask the patient to state their age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes / untestable	**2**

Guide to scoring: the Abbreviated Mental Test 4 or AMT4 is a brief test of orientation in which the patient is asked: age, date of birth, place (name of the hospital or building), and the current year. 1 mistake scores 1 point on the item, and 2 or more mistakes scores 2 points.

If the patient cannot provide meaningful answers because of altered arousal, inability to produce speech, etc., then the patient is given **a score of 2** (given for patients who are 'untestable' on simple cognitive tests).

Attention – the ability to stay focused on a mental task

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Achieves 7 months or more correctly	**0**
Starts but scores <7 months / refuses to start	**1**
Untestable (cannot start because unwell, drowsy, inattentive)	**2**

Guide to scoring: Months of the Year Backwards is a simple, widely used test of attention which is sensitive to both delirium and general cognitive impairment. The patient is asked to recite the months of the year in backwards order from December.

If the patient verbally declines to start the test or cannot correctly recite to June, score 1. If the patient cannot start the test for example through being drowsy or too inattentive, they are in the 'untestable' category for this item and receive **a score of 2**.

Acute change – if symptoms seem to come and go.

Evidence of significant change or fluctuation in alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evidence in last 24 hours.

No	**0**
Yes	**4**

Guide to scoring: rapid (hours, days) deterioration in mental functioning is highly specific to delirium. If there is evidence of change or fluctuation, then this item scores 4. This gives an overall 4AT score of at least 4, indicating likely delirium.

Item 4 requires information from one or more source(s), e.g. your own knowledge of the patient, other staff who know the patient (e.g. ward nurses), GP letter, case notes, or carers.

As part of the process of determining change from baseline in non-cognitive areas it can be helpful to elicit any hallucinations and/or paranoid thoughts by asking the questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium.

It takes around two minutes to do a 4AT. The more mistakes a person makes with these simple tests, the more likely it is that they have delirium.

Appendix 4: NEWS 2

Royal College of Physicians – National Early Warning Score (NEWS) 2
[National Early Warning Score (NEWS) 2 | RCP London]

Each setting will have methods to record this data; this guide is for your information only.

Chart 1: The NEWS scoring system

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

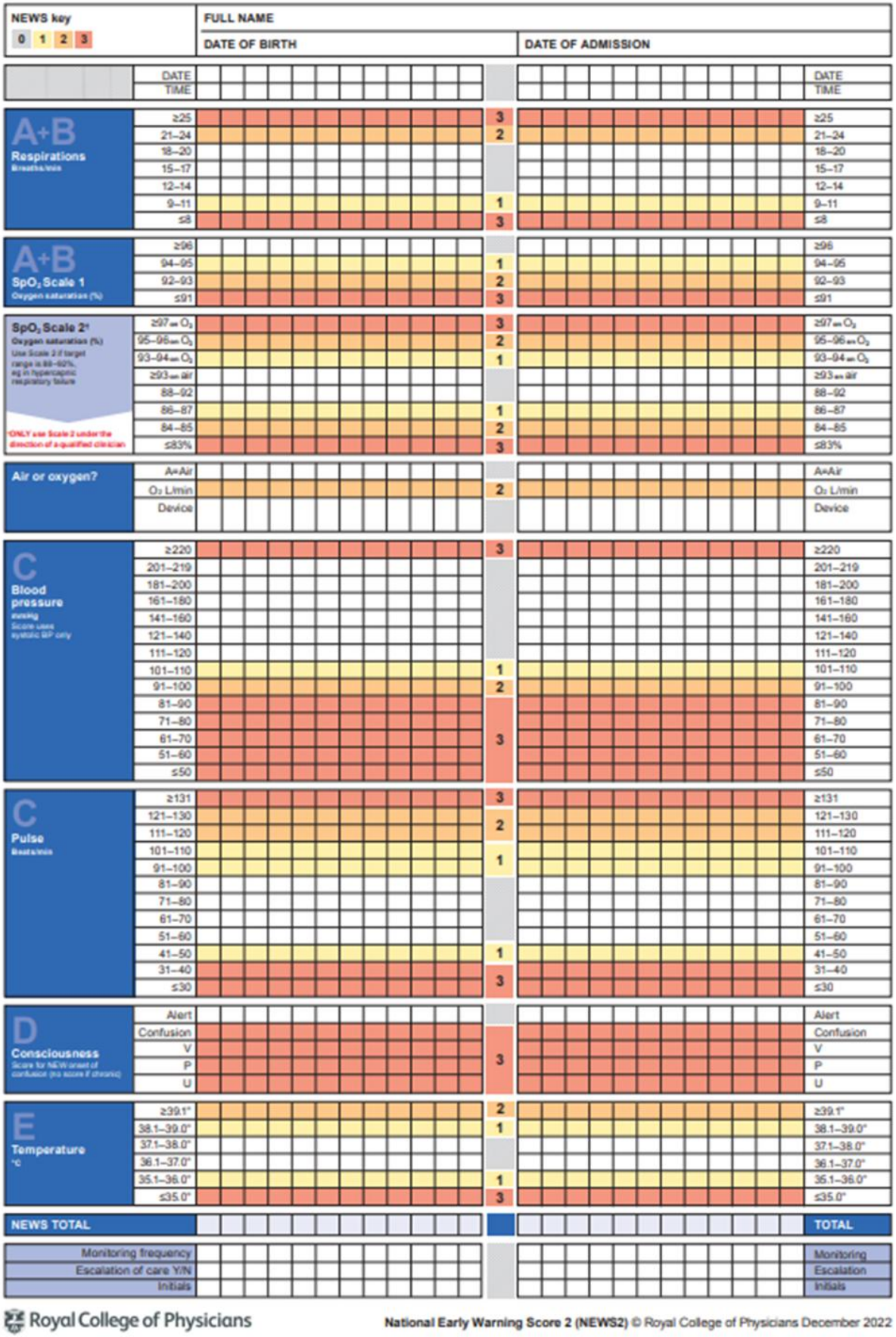
Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

Chart 3 – NEWS Observation Chart



NEWS key 0 1 2 3	FULL NAME		DATE OF ADMISSION	
	DATE OF BIRTH			
	DATE / TIME			DATE / TIME
A+B Respirations breaths/min	≥25	3		≥25
	21–24	2		21–24
	18–20			18–20
	15–17			15–17
	12–14			12–14
	9–11	1		9–11
	≤8	3		≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96			≥96
	94–95	1		94–95
	92–93	2		92–93
	≤91	3		≤91
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure *ONLY use Scale 2 under the direction of a qualified clinician	≥97% on O_2	3		≥97% on O_2
	95–96% on O_2	2		95–96% on O_2
	93–94% on O_2	1		93–94% on O_2
	≥93% on air			≥93% on air
	88–92			88–92
	86–87	1		86–87
	84–85	2		84–85
	≤83%	3		≤83%
Air or oxygen?	A=Air			A=Air
	O_2 L/min	2		O_2 L/min
	Device			Device
C Blood pressure mmHg Score uses systolic BP only	≥220	3		≥220
	201–219			201–219
	181–200			181–200
	161–180			161–180
	141–160			141–160
	121–140			121–140
	111–120			111–120
	101–110	1		101–110
	91–100	2		91–100
	81–90	3		81–90
	71–80			71–80
	61–70			61–70
	51–60			51–60
	≤50			≤50
C Pulse Beats/min	≥131	3		≥131
	121–130	2		121–130
	111–120			111–120
	101–110	1		101–110
	91–100			91–100
	81–90			81–90
	71–80			71–80
	61–70			61–70
	51–60			51–60
	41–50	1		41–50
	31–40	3		31–40
	≤30			≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert			Alert
	Confusion	3		Confusion
	V			V
	P			P
	U			U
E Temperature °C	≥39.1°	2		≥39.1°
	38.1–39.0°	1		38.1–39.0°
	37.1–38.0°			37.1–38.0°
	36.1–37.0°			36.1–37.0°
	35.1–36.0°	1		35.1–36.0°
	≤35.0°	3		≤35.0°
NEWS TOTAL				TOTAL
Monitoring frequency				Monitoring
Escalation of care Y/N				Escalation
Initials				Initials

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National Early Warning Score 2 (NEWS2) © Royal College of Physicians December 2022

Chart 4: Clinical response to the NEWS trigger thresholds

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

Appendix 5: GIRFT report recommendations

1. Each ICS/STP area should have an integrated system for preventing and managing frailty that includes secondary care, primary care, care homes, community services, ambulance services and paramedics, local authorities, third sector, patients and carers. Priorities should include avoiding inappropriate hospitalisation and progression of frailty, and improvement should be benchmarked with similar local footprints.

2. All trusts must assess all older people arriving in the emergency pathway for frailty using the Clinical Frailty Scale and use this to track them through the hospital if they are admitted. Wherever possible this should be an electronic system linked to the electronic patient record and used as part of a system-wide frailty strategy.

3. Trusts should identify patients with moderate frailty in all admission wards and take action to prevent them from becoming more functionally dependent. This includes providing space and equipment such as chairs and walking aids for daily mobility support, developing a culture where all ward staff can provide that support and where frailty is everyone's responsibility, and measuring progress against key metrics over a sustained period.

4. Each trust should appoint a senior member of staff who is the accountable officer leading on the quality of care for older people with frailty while in hospital, linked to ICS/STPs and local networks. They should report to the board across key frailty safety domains and use this information to help develop and refine the system-wide frailty strategy.

5. All patient-facing staff within a local health system should be given training in frailty at Level 1 on the Frailty Capabilities Framework.

6. All trusts should have a clear pathway for delirium that includes assessing all older people admitted as an emergency using the 4AT, a system for identifying delirium in elective admissions, and rapid and effective delirium response. Delirium awareness should be embedded in basic frailty training for all patient-facing staff.

7. ICS/STPs should work on a multi-agency basis to implement the new hospital discharge service guidance to improve outcomes for older adults and optimise flow and discharge rates.

8. ICS/STPs should develop targeted strategies to address specific barriers to safe discharge at the weekend and for patients staying more than 21-days (super-stranded).

9. Review readmission rates on a multi-agency basis to understand the causes and develop interventions to reduce them, including enhanced support for older adults with frailty to prevent falls, delirium and multiple admissions, and targeted support to those readmitted within 7 days and 30 days of initial admission.

10. All local health systems should implement the enhanced health in care homes framework as part of the Primary Care Network (PCN) contractual obligations.

11. All local health systems should have identified older people in the last phase of life and offer them advance care planning, so they can be looked after and die in their preferred place of care wherever possible.

12. ICS/STPs should develop new ways of working to meet local service needs including extended roles for nurses, allied health professionals, pharmacists and advanced practitioners; a greater role for consultants in acute, general and emergency medicine where capacity allows; more opportunities for portfolio career progression to attract and retain consultants and trainees in geriatric medicine.

13. ICS/STPs should develop and embed models such as virtual clinics, community assessment hubs, out-of-hours crisis response, same day emergency care and patient initiated follow up to improve the effectiveness of ambulatory assessment for older adults as envisaged in the NHS Long Term Plan.

14. Attribution of specialty should be reviewed to ensure that geriatric medicine activity and the specialty of the person doing it can be identified.

15. Clinicians and coders should work together to improve capture of frailty-related diagnostic codes to give trusts a clearer hospital-wide data view of frailty. Trusts should be able to see which patients are living with frailty and how severe it is.

16. Consider how liaison and other shared care services could be recorded and reported more effectively.

17. Local health systems should address the prescribing and pharmaceutical care needs of older people to improve safety and optimise adherence.

18. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.

19. Reduce litigation costs by application of the GIRFT programme's five-point plan.

Appendix 6: self-assessment tools

a) Self-assessment tool: current delivery

This tool helps you assess if your Acute Frailty Service (AFS) model meets the recommended minimum requirements.

ACUTE FRAILTY SERVICE MINIMUM REQUIREMENT	ARE THEY MET? YES/NO
1. A Roving Frailty Team set up at the front door to support ED, SDEC and Acute Clinical Units (ACU)	
2. An attached Acute Frailty Unit or an Acute Clinical Unit with an AFS provision providing up to 72hrs LoS for individuals requiring more than same day care	
3. Access to a local community infrastructure and processes with a system map to identify pathways/direct referrals to support discharge to the persons' home (or a community bedded facility close to the person's home)	
4. 7 days a week, 12 hours a day service provision (84hrs a week)	
5. All Staff trained on how to use Clinical Frailty Score (CFS)	
6. All Staff trained on how to use 4AT – Delirium scoring tool	
7. All Staff trained on how to use NEWS 2	
8. All Staff trained and competent in managing people with frailty syndromes and are well versed in processes around preventing deconditioning and discharge planning.	
9. Implementation of pathways to ensure Comprehensive Geriatric Assessment (CGA) is initiated on the day of arrival into urgent care for older people with frailty	
10. Rapid access to frailty teams from the time of arrival for anyone with a CFS>6	
11. People with moderate (CFS 6) to severe frailty (CFS 7) who are assessed as needing a >72hr inpatient stay can be rapidly streamed to an acute older persons' inpatient ward for ongoing medical intervention alongside a Comprehensive Geriatric Assessment (CGA).	
12. In the absence of an acute older person's inpatient bed there is access to specialist frailty teams that can deliver CGA in other acute ward settings (such as surgical liaison services)	

13. Referrers can discuss referrals with an Acute Frailty senior clinical decision maker to ensure they are appropriate for the service.	
14. Standardised referral process is agreed and shared with healthcare partners.	
15. People can be streamed direct from ED to Acute Frailty Unit or Specialist Older persons' inpatient bed.	
16. Acute Frailty individuals are captured in WECDS for ED, SDEC and MIU	
17. Acute Frailty individuals are captured in Admission Patient Care (APC) dataset for Acute Frailty Unit and Acute Clinical Unit admissions	
18. Acute Frailty Service collects feedback from individuals and identifies actions to improve individual experience	
19. Regular meetings with Clinical, Operational and Informatics leads in place for service delivery	
20. Each Acute Frailty clinical lead has professional activity sessions in their job plan to support the development of the Acute Frailty Service (for example, development of polices and guidance, review of clinical practice, audits).	

b) Self-assessment tool: striving to achieve

The tool helps you assess the potential to transform further and identify what you should be striving to achieve to improve your Acute Frailty Service model.

ACUTE FRAILTY SERVICE STRIVING TO ACHIEVE	ARE THEY MET? YES/NO
1. Workforce training and development plan is in place for all roles in the Acute Frailty Service.	
2. Advanced level practice roles are embedded in the service model (for example, advanced clinical practitioners, nurse practitioners, clinical nurse specialists, clinical pharmacists).	
3. A full multi-professional presence is embedded in the Acute Frailty Service workforce model.	
4. WAST, NHS 111 services can refer individuals directly to the Acute Frailty Service	

5. Community services (including Urgent Care Centres), virtual wards and Single Point of Access services can refer individuals directly to Acute Frailty Service.	
6. Referral criteria for the Acute Frailty Service are standardised across a HB/ trust footprint.	
7. Digital tools are considered as part of future planning to ensure ease of referral and sharing of individuals' information.	
8. Booking tools are considered as part of future planning to ensure ease of referral and sharing of individual information.	
9. Workforce boundaries are reduced by working across all areas of the HB/Trust, maximising the opportunity to work across primary, community, mental health and secondary care.	
10. Acute Frailty Services have PROMS and PREMS in place to seek feedback from individuals and from this identify any necessary changes to service provision.	
11. Acute Frailty activity is recorded via WECDS for attendances and APC for ACU and Inpatient admissions	
12. Acute Frailty has a subspecialty code to collate accurate data in the APC dataset	
13. Capital investment for Acute Frailty Unit estate is adequate to improve both physical and virtual capacity.	
14. Demand and capacity modelling is undertaken to ensure that the Acute Frailty footprint is fit for purpose.	
15. Robust communication loops in place at all levels to ensure constant staff feedback to improve the service	
16. Staff working in the Acute Frailty Service are involved in developing the service.	
17. HB/Trust leadership supports the provision of Acute Frailty Services across primary, community, mental health and secondary care boundaries.	
18. Acute Frailty services have the same access to diagnostics and reporting that ED has locally.	
19. Acute Frailty Services have access to community diagnostic centres to reduce pressure on acute diagnostic services.	
20. Acute Frailty Services work across the community to support delivery of hospital@home.	

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