GIRFT report aims to bring together all sectors to collaborate on preventing frailty and avoiding hospital admissions

Getting It Right First Time's (GIRFT) national report on geriatric medicine 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.

Measures recommended in the report have the potential to both improve outcomes for older patients across England and reduce acute care costs for the NHS by up to £687m*, primarily through a reduction in bed days.

Author Dr Adrian Hopper – a geriatrician at Guy's and St Thomas' NHS Foundation Trust in London – advocates a population-based approach to frailty, where trusts work closely with partners across the system to provide joined-up care and alternatives to hospitalisation, especially important in light of the COVID-19 pandemic.

Among the recommendations are a call for all integrated care system (ICSs) and sustainability and transformation partnership (STPs) to develop an integrated frailty system, working across all sectors, offering rapid access to services, support and treatment for people in their own homes where appropriate, and good pathways for hospital discharge.

By joining up the interfaces between secondary care and primary care, community settings and care homes, there is an opportunity to improve health and care for older people. In many cases, hospitalisation could be avoided in the first place through a more patient-centred approach to managing frailty.

It is recognised that reducing hospital bed occupancy will require investment in support services outside of hospitals. However, with a single admission of an older person living with severe frailty costing more than £6,000, providing better alternatives outside hospital could result in a big saving to the health system, even allowing for the costs of change.

The GIRFT report focuses mainly on the management of frailty in older people – the area of geriatric medicine where there is the greatest risk of avoidable harm and therefore the most scope for improvement.

Demand for frailty services is growing as people live longer. More than half of people aged 65 to 74 live with at least one long-term health condition, and the number of over-85s in England with dementia or other long-term health conditions is predicted to almost double from 233,000 in 2015 to 446,000 in 2035.

Data collected pre-COVID shows that between 5% and 10% of people attending A&E departments and 30% of patients in acute medical units were older and living with frailty. There were more than 4,000 admissions daily of people with frailty, for reasons such as falls, minor

infections and reactions to medications, while over-75s with frailty occupied about 20% of all bed days across England.

Older people, many with frailty, make up around 30% of outpatient appointments in the NHS.

As well as advocating a joined-up approach, Dr Hopper makes a series of specific recommendations for better hospital-based care, including:

Stronger leadership and training: frailty care is important throughout hospitals, across all medical and surgical specialties. The report says some falls, medicine errors, pressure ulcers and infections could be avoided if all trusts appoint a senior member of staff to lead on frailty care, overseeing safety issues, quality of care, staff training and awareness. The report also recommends that all staff caring for people with frailty in and out of hospital should have basic training to enable them to spot risk factors.

Better management of outpatient appointments: the report encourages the further development of online appointments and virtual outpatient clinics, with appropriate support. Where physical appointments are needed, trusts should aim for a co-ordinated 'one-stop shop' approach, so patients have all appointments they need on the same day wherever possible.

Avoiding hospital-acquired deconditioning: around a third of older people with frailty lose some of their ability to function during their stay, and remain longer in hospital or require permanent nursing care as a result. The report calls for trusts to better identify patients with mild or moderate frailty to prevent them becoming severely frail, providing the support, equipment and facilities needed to get them out of bed, dressed and moving each day.

Improving delirium pathways: delirium (the confusion that commonly follows acute illness) can cause inpatient falls and longer stays in hospital, but some older patients who arrive at hospital are not assessed, especially if they arrive out-of-hours or at weekends. The report recommends trusts have a clear pathway for delirium, which includes assessment, to help improve patient safety.

Measures such as these can reduce costs by preventing hospital admissions, reducing the length of time patients stay in hospital and resulting in fewer outpatient attendances and follow-ups. For example, the report shows that if trusts can avoid duplication of new and follow-up outpatient appointments using a 'one-stop shop' approach, up to £186m could be saved for the NHS.

The report also contains measures for improving end of life care – so that more older people can be looked after and die in their preferred place of care wherever possible – as well as measures which can improve care for the 400,000 people living in care homes across England, reducing unplanned and avoidable admissions to hospital towards the end of a patient's life.

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.