Supplementary material 1: summary of case study sites

Case study site 2.1

Area and population

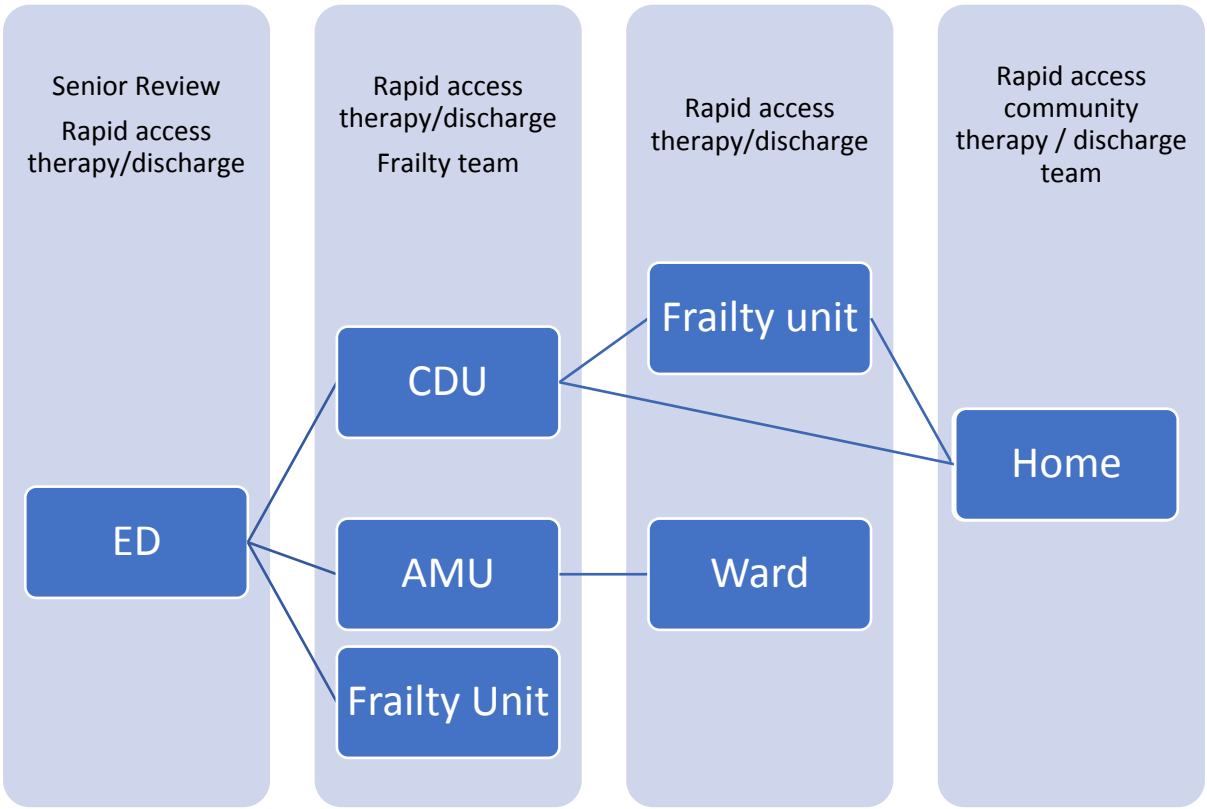
- Rural area, towns and villages
- Large older / Frail population, lots of chronic illness
- High Social deprivation, ex-mining area
- Mainly white

Hospital and ED

- Small hospital
- Small ED

Services and pathway of care for frail older people in ED

The culture of the hospital was said to be 'a little behind' with frailty not being a priority. Most of the frailty services which were being developed with the support of the AFN have been a casualty of COVID.



NB: This is a representation of pre-COVID services

Rapid access therapy/discharge team

The hospital has a rapid access therapy / discharge service which was set up in 2014 with a priority to assess patients in ED/CDU/Frailty Unit and put urgent discharge support packages in place to prevent admission and facilitate speedy discharge. The team aim to discharge within 72 hours and operate 365 days a year from 8am to 6pm with six staff on shift each day (3 physio, 3 OT). More recently (since COVID) band 6 nurses have been operating as case managers. Physio and OT carry out joint assessments and have some joint competencies when this is not possible. Assessments are started as soon as possible in ED. Patients must be medical stable and require no further investigations. Staff carry out holistic assessment and have access to same day equipment, care packages and rehab beds in the community. They can also refer to the discharge to assess team who will carry out assessments in patients' homes within 24 hours.

The services was highly valued and praised by ED staff and frailty staff alike, and was said to be liked by patients. Outcomes were described as a high rate of discharge home within 72 hours, preventing admission to long stay wards and thus preventing deconditioning.

Frailty team/unit

A small frailty team started in 2017 with some dedicated geriatricians who are still trying to keep the service going (not all geriatricians involved). Started work on base wards doing CGA with a view to getting people home faster.

A small frailty unit was started by the frailty team in 2018 with the aim of getting frail older people out of ED and reduce the number of bed moves. This consisted of an ambulatory area with chairs (6-8) on a ward with 15 other beds (not frailty). The unit was nurse-led with geriatrician input 9-5. If patients could not be discharged from the ambulatory area they could be given a bed overnight and length of stay was restricted to 72 hours. Ambulatory area in frailty unit was open 8am to 6pm / 7am to 7pm Monday to Friday and Saturday mornings and accepted patients 8am to 3pm Monday to Friday.

Patients had to have one or more frailty syndrome, be ambulatory and able to sit in a chair, and be clinically stable to access the frailty unit / team. Frailty scoring was not carried out. ED consultants could refer direct to the frailty team and patients would be accepted if there was capacity. The frailty team also carried out in-reach into ED / CDU / AMU. MDT CGA was carried out with the help of the rapid access therapy team.

Outcomes were said to be a high rate of discharge home with support with 60% being discharged same day. Patients and relatives were said to value the service.

Staffing was said to be inadequate and inconsistent in terms of medical cover, therapy and nursing. This meant that capacity varied and there were not always enough staff to take patients from ED. Not all geriatricians were involved in frailty, just a small number of dedicated individuals. There were no dedicated therapy staff appointed to the frailty unit, and the urgent therapy team were too small to cover all the areas they were assigned to. If patients couldn't be discharged from the ambulatory area by 6pm, the staff to patient ratio was not high enough for them to stay overnight, though this did happen. The capacity of the ambulatory frailty area was low (6-8 chairs) so it filled up quickly and frail patients were sent to CDU or AMU. Also this chaired area did not remain ring-fenced during times of bed pressures and was frequently converted to a non-frailty bedded area.

Post COVID, a new area on another ward was allocated for frailty unit but no therapy staff were allocated. The feeling is that this is not a frailty unit, but a care of older people ward and patients deteriorate due to lack of therapy and access to rapid discharge.

Relationships between ED and geriatrics

It was felt that relationships between ED staff, the urgent therapy team and the frailty team were good. This was largely because the therapists and frailty team had a presence in the ED prior to COVID, visiting daily to assess and take patients. In terms of shared aims/vision between ED and FT both had a desire to send patients straight to the frailty unit from the front door of ED rather than have multiple bed moves via CDU or AMU. The motivations behind this shared aim were different however with the frailty team wanting as few bed moves as possible and rapid CGA, and ED wanting frail older people with no medical needs to be taken out of the department.

Issues

Issues were said to be lack of staff / capacity, lack of commitment from management for frailty services and poor treatment of staff leading to low staff morale.

> *It's not overly dramatic to say that the COVID pandemic completely destroyed all of what I've just said – all of those pathways have gone, all of the – essentially the frailty team were absorbed into the general medical staffing and were managing COVID wards or non-COVID wards. So I'm unsure what their specialist nurses were doing but certainly from my perspective, as far as I was aware, there was no longer a frailty service to refer to from the department… Our CDU was*

the only place that we could ventilate COVID suspected patients, so we lost our CDU. [S2.1 01]

And the consultants knew nothing of it, the nursing team knew nothing of it, they literally came in on Monday to find that the ward had been closed and the nurses were then disbanded to various other locations across the hospital. And the rest of the junior doctor population were distributed across the other care of the elderly wards and it was the same for the consultants and we had no ambulatory area, no frailty ward and no team essentially. [S2.1 03]

Case study site 2.2

Area and population

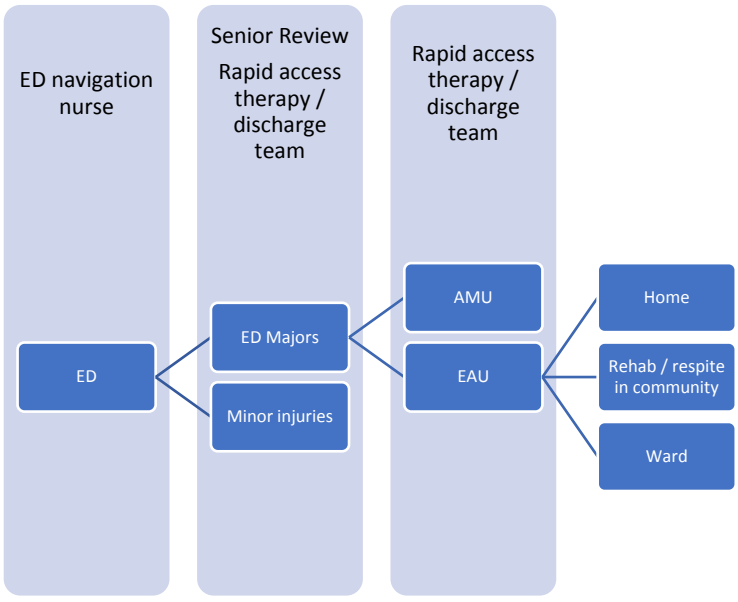
- Coastal/Rural area
- Large older population
- High social deprivation
- Mainly white
- Lots of care homes
- Less developed community services

Hospital and ED

- Small hospital
- Merged with larger hospital trust several years back as it was 'failing'
- Small ED

The culture of the hospital was said to be 'admit'. There was a lack of awareness of frailty and CGA among ED staff. ECIS involvement helped with setting up SDEC.

Services and pathway of care for frail older people in ED



Ambulatory chaired area in Emergency Assessment Unit

The EAU was started in 2016 by a doctor interested in getting frail older patients home rather than admitting them. Has had many iterations, areas, admission criteria over the years. Started as a small, chaired area in ED, then to a larger area near ED, then to a ward near ED that 'became available' during COVID. EAU has 20 seats that can be converted to 10 beds overnight if needed. Patients can stay up to 24 hours whilst support at home is being arranged. Unit is not dedicated to frailty, but also takes younger patients who require same day emergency care, ambulatory care or medical ambulatory care. Estimated that 50% frail patients / 50% SDEC. The unit is open 24/7 and deals with about 40 patients a day

EAU is run by medical and ED staff, nurses and therapists. There is no geriatrician involvement. The team is made up of individuals with the same mind set to get people home as quickly as possible. Staff have been chosen according to their interest and expertise. Therapy team are key in setting up discharge packages and the unit has a small number of dedicated staff, but the Rapid Access Therapy team also work on the unit.

The EAU is for ambulant patients, who are encouraged to be self-caring and mobile. The simple criteria is that patients should be 80% likely to be dischargeable on the same day, but requiring a bit more time and discharge planning than can be organised in ED within 4 hours. Patients can be referred direct from ED and the MDT from EAU do 2 hourly board round in ED to look for appropriate patients, and select patients remotely via the electronic system. MDT holistic assessment are carried out as soon as possible.

As noted the EAU was located on an old nightingale ward at the time of interviews and set up as an ambulatory area with chairs where patients were encouraged to be independent. Though described as 'shabby' in appearance, it was felt to have a nice, calm, quiet environment with space for mobility assessment and facilities to make tea. Overnight stays were facilitated by beds /trolleys for patients to sleep on until discharge could be arranged.

The unit was said to be popular with staff and with patients, and had raised the profile of therapists. It was stated that there was a 80-90% same day discharge rate, and that the ambulatory environment and admission prevention reduced the likelihood of hospital deconditioning.

Rapid access therapy / discharge team

The Rapid access therapy team were set up in 2016 to place therapists at the front door of the hospital. The success of the team led to further investment and expansion of the team over time. The teamwork in ED and EAU 7 days a week 8am – 8pm, and in AMU 7 days a week from 8am to 4pm. The team consisted of OT's and Physio's who have dual competencies to a certain extent and are trained as trusted assessors for social care. There are also therapy assistants in the team. Therapists are specialists in frailty, and some are advanced clinical specialists.

The team are proactive in finding patients in ED, and members attend 2 hourly ward rounds in ED and will move patients from ED to the EAU. The sorts of patients the teamwork with are those who have a high chance of being discharged within 24 hours with support if needed. They carry out holistic assessment (mainly on EAU).

It was stated that the team were highly valued by staff and had helped changed attitudes about who could be discharged from ED. They have a high rate of same day discharge – upwards of 80%, and thus have reduced admissions and hospital deconditioning.

Criticism of the team was that they were not dealing with all the patients' issues

> *I know somebody – a few of our team members kind of describe our service as putting a plaster on it and I sort of said 'well I don't want them to feel that because we may be putting a plaster on it a little bit but I want us to be planning for the future as well'. [S2.2 06]*

Relationship between ED and geriatrics

Though it was felt that some geriatric staff were interested, it was stated that there was a reluctance from geriatricians to change their ways of working. Geriatricians did not have a presence in ED though it was noted that some visited prior to COVID.

Issues

Issues included lack of capacity and problems with access to social care. The hospital was felt to be short on staff in many departments. It was felt that the location and perception of the hospital made it difficult to recruit new staff to the hospital.

Case study site 2.3

Area and population

- Urban area
- Not a high older population

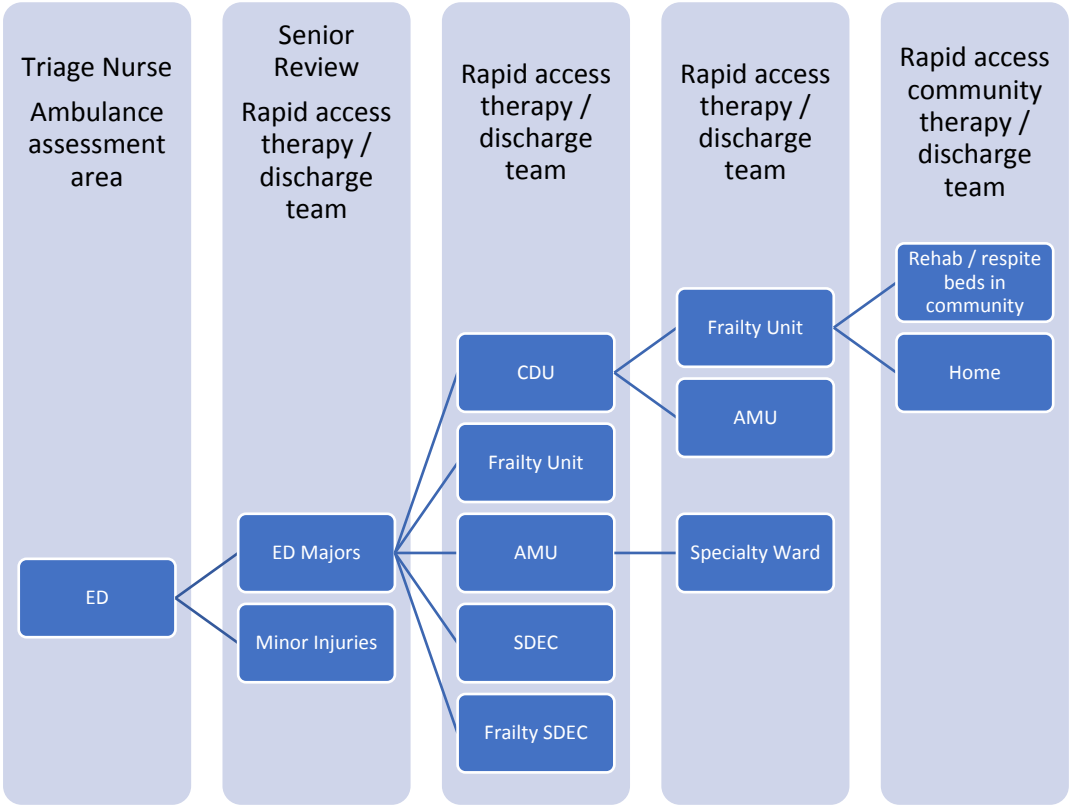
- Mixed economic area
- Multicultural population

Hospital and ED

- Large hospital
- Large ED/very busy/trauma centre

The ED consists of an ambulance assessment area, 2 rooms for nurse triage from the waiting rooms; Two large majors areas; a resus area; minor injuries unit; CDU. There were very long waits for ambulances and in ED. During the observation period the number of breaches per day was around 200 and there was a 4-5 hour wait to see a doctor. The CDU seemed to be used as a holding area for patients awaiting review, beds, test results etc. Meetings with multiple stakeholders are carried out regularly to discuss and implement improvements perceived as needed by staff using PDSA cycles.

Services and pathway of care for frail older people in ED



Rapid access therapy/discharge team

The rapid access therapy team had been operating in one guise or another since 2008 and had evolved over time. The aim of the team was to facilitate speedy safe discharge and coordination of ongoing care. The team's main priority was ED areas and the frailty unit, but

they did visit the base wards if patients had been in for less than 48 hrs. They operate 7 days a week from 8am-8pm

The team consists of Occupational therapists, physiotherapists and specialist nurses. There are 22 members of staff, 7-8 on shift each day. They are classed as community staff but work in the hospital liaising closely with community services and rotating with the urgent care community therapy team. The team have access to hospital and community systems making history checking easier.

It was stated that the majority of patients were frail older people, lots of falls and some social problems. Holistic assessments were carried out including a CFS score. Assessments were carried out in ED, on CDU and on the frailty unit. Same day discharge packages and equipment could be arranged with support from the urgent care community service.

The team were highly valued by staff and patients. It was stated that they had reduced admissions and facilitated a large number of same day discharges (85%).

The only complaint was that the team did not operate 24 hours.

Frailty unit

The first frailty unit was set up in 2012 on the MAU, but a purpose built 28 bed frailty unit opened in 2017. The unit is open 24/7 and length of stay is limited to 48hrs, though there is flexibility on this. The unit was described as comfortable and safe and set up to ensure patients remain as self-caring as possible. There is an ambulatory area of 11 chairs

The unit was specifically frailty focussed not age focussed and would admit any frail older patients not requiring other specialist care. Patients can be referred from the ED or via GP's and an outpatient clinic service operates from the unit. Frailty unit staff have been known to visit ED to identify appropriate patients.

The team include geriatricians, ACP's, ANP's, therapy staff and nurses. MDT CGA is carried out as quickly as possible.

It was stated that 25%-30% of patients were discharged same day.

ED staff felt that the admission criteria were unclear and possibly to restrictive. There was felt to be a lack of flow with the unit being full a lot of the time and unable to receive referrals.

Relationship between ED and geriatrics

No geriatrician presence in ED and frustration from ED staff that is was very difficult to access beds on the frailty unit.

Issues

Lack of staff, lack of capacity

Case study site 2.4

Area and population

- Semi-rural
- Very large older population, lots of frailty
- Wealthy area
- Mainly white
- Large number of care homes

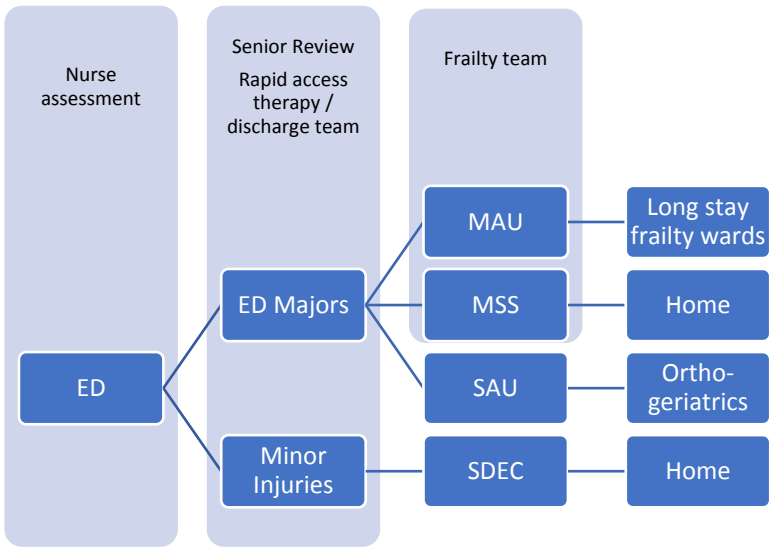
Hospital and ED

- Small hospital with no specialty services
- Integrated acute and community care for many years
- Small ED

The hospital and community trusts being integrated was helpful in terms of facilitating discharge. As there were no specialty services at the hospital the attendances at ED were mostly general medical.

Services and pathway of care for frail older people in ED

The profile of frailty in the hospital was said to be improving and there was AFN involvement, though no specific frailty services existed.



Rapid access therapy/discharge team

The rapid access therapy / discharge service was set up in 2018 to take people home from hospital with some bridging support while packages of care were set up, and up to 2 weeks rehab support. They offer a wide range of support from supplying equipment and checking suitability at home to 4 times a day visits for 2 weeks. It is a community service although is based in the hospital. In-reaches into the hospital to support the discharge of admitted patients but more recently a renewed focus on ED and preventing admissions. The team are able to follow up people in the community after discharge for up to 2 weeks. Currently operates 7 days 8-6.

The team is mainly therapists and therapy assistants but there are some nurses and a small amount of geriatrician time. It is not frailty specific but sees mainly frail older people. The team use the CFS and CGA is carried out routinely. Assessment takes place in ED with home follow up.

The service is highly valued by ED staff and has a high rate of same day discharges.

There is no out of hours service.

Short stay frailty wards and orthogeriatrics

There are 3 consultant geriatricians doctors who work specifically within short stay frailty as opposed to the longer stay frailty wards. They are based on Medical Admissions Unit (MAU) and the Medical Short Stay (MSS) ward and see patients who would be expected to be discharged in 2-3 days.

There is an ortho-geriatrics team working on a post-surgery ward who operate an award winning 5-star service for older people with hip fracture. This is a highly rated service with a multidisciplinary team who are very committed and work very closely together.

Relationship between ED and geriatrics

There was no geriatrician presence in ED. ED staff were very keen that a frailty service be developed. However geriatricians working in MAU felt that they were doing the work of a frailty unit there and a separate unit with take away scare resources.

Issues

Staffing issues, lack of staff in ED and care for older people.