

Debate & Analysis

Using collaborative community care to deal with the emergency department frailty epidemic

Mr R.B. smiled at me, eyes dull in his shrunken face. *'I just want to go home'*, he said. Exasperation radiated from his daughter. *'But Dad, you'll fall again. The carers are only there twice a day. Who's going to help the rest of the time? Take the community hospital bed, Dad.'* A long pause. *'I just want to go home'*, he said.

One day after discharge, Mr R.B. had returned to A&E. Deconditioned after a long surgical admission he had waited hours for transport home, declining sandwiches — he didn't like egg or cheese. Once home, too tired to eat, he nevertheless took his insulin. Worried about his new catheter bag overflowing, he slept poorly. The following morning, tired and weak with low sugar levels, he suffered an almost inevitable fall struggling to juggle sticks, catheter bag, and hearing aids. His pendant alarm signalled his return to hospital.

Mr R.B. (although fictitious) captures perfectly the conundrum of the frail patient. Multiple comorbidities and reduced physiological reserve conspire against their independence. Until recently, hospital admission has been their default destination. However, with ever tighter budget constrictions, an ageing population, and the over-representation in resource utilisation among frail older patients, innovative relationships are needed to promote individual autonomy and minimise the toll on public services.

THE CONCEPT OF FRAILTY

The 'frailty phenotype' is a relatively recent concept. Despite the operational definition as an *'age-related state of decreased physiological reserves characterized by a weakened response to stressors and an increased risk of poor clinical outcomes'*,¹ a lack of consensus exists regarding the underlying pathophysiology and thus whether physical markers are diagnostically sufficient or whether psychological and social diminutions must also be considered. Prevalence rates range from 4% to 59.1%.² A number of frailty scores and tools exist, although, pragmatically, few outperform the 'end-of-the-bed-ogram' carried out by an experienced clinician.

The associations between frailty, hospital admission, and increased mortality are clear.³ Early detection of frail individuals

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and interventions to stabilise function and mitigate further decline is therefore crucial. Failure to do so affects both individual and health service. Falls, immobility, delirium, and other sentinel conditions act as red flags for deeper problems. Attendance itself may indicate an inability to cope given current social or psychological support.

FRAILTY-FRIENDLY EMERGENCY DEPARTMENTS

Over the last decade, the proportion of those aged >85 has increased by 31%. Older people have the highest rates of A&E attendance and greatest chance of admission when they do.⁴ While reflecting comorbidity and frailty within this age group, the pressures on primary care services and the challenge individuals experience in accessing appropriate community social support also contribute. Such figures highlight the importance of the emergency department (ED) as an opportunity to identify frail individuals and implement interventions to minimise admission, prevent readmission, and improve their quality of post-discharge life.

First established in the East Midlands, 'frailty friendly' approaches have become standard practice across many UK ED departments. Frailty screening and early comprehensive geriatric assessment (CGA) are associated with reductions in mortality and functional deterioration, length of hospital stay, readmission, long-term care rates, overall costs, and improvements in quality of life.⁵

However, the complexity of frailty is mirrored by the myriad of initiatives attempting to combat it. Does an individual require extra help with activities of daily living? Do they need assistance with medication they can no longer see or remember to take, or help getting to hospital appointments? Do they need advice and support about finances, filling in forms, or dealing with bills? Most importantly, do they need company? Loneliness and social isolation are associated with excess mortality⁶ and the development of frailty,⁷ thus assistance getting to the 'knit and natter' or walking groups — or just a friendly person popping in for a chat — may be among the most beneficial interventions.

THE ROLE OF THE EMERGENCY DEPARTMENT IN COORDINATED CARE

An ever changing wealth of initiatives attempt to meet this need. Tax-funded services and third-sector programmes exist alongside local community groups and individual volunteers. The list evolves with funding fads, the passage of charismatic leaders, and shifting policy priorities. Although a patient's GP may previously have signposted appropriate services, the volume of frail older patients, number of services with which they are involved, and current strain on primary care resources frequently make this an unrealistic aspiration. How then can an individual, or pressurised ED discharge team, make meaningful sense of this morass?

Interorganisational communication and coordination is vital. Frailty multidisciplinary

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teams (MDTs), with cross-tier representation from GPs, geriatricians, nurses, members of the ED team, social services, therapists, and locally relevant others, may offer an important contribution. Such meetings facilitate CGA for frail patients and suggest holistic, upstream interventions to optimise management. Acceptable to patients and their families,⁸ such approaches are associated with greater quality of life.⁹ Furthermore, although evidence is currently lacking to support improvements in objective health outcomes and functional ability,⁹ it is arguable that such patient-centred approaches have an inherent value independent of such quantifiable variables.

Compassionate Communities is another novel approach attempting to support frail individuals. Promoted within recent policy initiatives and funding streams,¹⁰ these schemes centre around the individual as a person, supporting their self-management and quality of life by addressing pertinent social determinants of health. Although highly variable in nature, many employ a coordinator to assess patients referred by primary or secondary care services who have presented with a predominantly social problem. The coordinators then attempt to identify, and in some cases coordinate, non-medical, non-traditional social support from local community groups, third-sector services, or even individual volunteers.

Given the Marmot Review's conclusion that over two-thirds of health outcomes in England are determined by societal factors,¹¹ these schemes may help to reduce pressure on primary care, and on emergency and specialist services, build up the local community, and produce economic benefits.¹² The potential impact of such collaborative models can be seen in examples like Health Connections Mendip, which has been associated with a decrease of 14% in unplanned emergency hospital admissions.¹³

In order to be maximally effective, both frailty MDTs and compassionate

communities require the active participation of the ED. Due to the relatively small proportion of overall activity that the oldest old currently represent — despite their high resource usage — it is unsurprising that, until recently, the majority of departments have given little specific attention to the needs of the frail within the ED, nor their community support on discharge. A seismic cultural upheaval will be required if we are to transform our services to provide the coordinated, frailty-friendly care our older patients deserve.

Mr R.B. went home. He left hospital with new mobility aids and adaptations throughout his house. A formal care package was put in place with daily visits planned for the district nurses to change his catheter. He left with his daughter's grudging blessing and the best wishes of the ED team. He will probably be back. No frailty MDT or compassionate community exists for him. Aside from his family's sporadic visits there is little to assuage his loneliness and isolation. Sad though it is that we need to recreate the supportive communities of former times, it is essential that we do so, to allow all the Mr R.B.s the best possible end in the homes where they long to be.

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