



Acute Care of the Elderly Service: Croydon Health Services NHS Trust

The Acute Care of the Elderly Service (ACE) provides a comprehensive assessment of treatment needs for older people arriving at A&E. It aims to avoid admission or to help the patient move rapidly through the hospital and back into the community. A key feature is the comprehensive geriatric assessment (CGA) completed by a consultant-led multidisciplinary team when the patient presents at A&E, facilitated by access to rapid same-day diagnostics.

Croydon Health Services NHS Trust provides acute and community healthcare across the borough of Croydon for a population of over 380,000. The trust includes Croydon University Hospital, a district general hospital with more than 500 beds.

Aims

ACE supports older people with deteriorating and complex health needs to avoid further deterioration or crisis.

Hospital specialists in elderly care work alongside primary and community services to manage the patient journey and make sure frail older patients get specialist treatment in the right place at the right time.

The service aims to:

- rapidly and comprehensively assess older patients who have come into A&E
- facilitate packages of care to support patient recovery at home where possible

Characteristics

- multidisciplinary team
- consultant-led
- comprehensive geriatric assessment as close to patient presentation at hospital as possible
- integrated with acute teams, rapid response team, ambulatory care, primary and social care
- GPs and community teams can speak to an ACE consultant for advice and referral from Monday to Friday between 9am and 5pm.

- improve hospital efficiency to shift the care of older patients closer to home, safely and seamlessly.

Origins

Croydon University Hospital Trust set up ACE in November 2012 to meet the needs of frail older people. The service is funded internally as part of the trust's whole-system transformation, improving the management of older patients.

Underlying ACE is the recognition that frail older people can reach crisis rapidly and unpredictably. Accurately diagnosing, managing and treating them can be challenging, so they need easy and rapid access to specialist geriatric assessment and treatment.

Structure

Acute-based The ACE team is based at two main locations within the acute hospital: the observation ward, next to A&E, and an outpatient rapid assessment setting.

7-day service The service operates seven days a week, 9am to 7pm.

Senior multidisciplinary team

The team includes five consultants in elderly care, a specialist nurse, physiotherapist, occupational therapist, social worker and voluntary sector representatives.

Enabler: rapid access to diagnostics

- Early consultant-led CGAs for frail older adults improve care quality, patient satisfaction and patient flow, and reduce length of stay.
- Rapid access to same-day diagnostics makes the CGAs possible.
- The ACE team managed this change of focus by working closely with diagnostic departments from the outset to secure senior commitment.
- Diagnostic departments have been highly responsive to this way of working. They particularly appreciate the consultant-to-consultant discussions about patient care.

How patients benefit

There are two components to this service: 'in-reach into the emergency department' and the 'fast-track rapid assessment clinic'.

Older patients are assessed as soon as they arrive at the hospital.

The 'in-reach' element looks after complex frail patients who have presented at the front door of the hospital as an emergency or patients who are entering crisis. The consultant-led, multidisciplinary team provides early **comprehensive geriatric assessments** of frail older patients, with a view to managing and treating them so they can return safely to the community and to their own homes.

The service initially delivered care in the A&E observation ward, where most of these elderly patients were being admitted. It has now extended further into A&E, liaising with a number of hospital teams to identify suitable patients.

The service is primarily for patients over 80 years old, but the ACE team will see younger patients if their needs are suitable for the service.

The consultant-led MDT administers a CGA and treatment plan.

The CGA assesses the patient's medical, nursing, mobility, functional and social needs.

Physiotherapists assess mobility and risk of falls, and recommend community mobility programmes and other rehabilitation pathways as required. Occupational

therapists assess patients' ability to manage daily tasks at home, and refer to social services teams or rehab teams as required. Social workers arrange or optimise home care for patients, assist with respite care or arrange for a patient to have an interim care home placement, as well as addressing any safeguarding issues.

Enabler: communication with primary care

Apart from being able to follow up patients rapidly if necessary, the fast-track assessment clinic mainly aims to provide primary and community teams with an opportunity to refer patients for same-day care as an alternative to emergency admissions.

GPs can directly speak to the ACE consultant on call for advice and/or referral to the clinic, Monday to Friday 9am to 5pm, on the ACE consultant mobile number.

ACE aims not to admit patients if there is no medical reason to do so. Rather, the ACE team completes a comprehensive assessment of the patient and sets up ongoing care packages to support them in the community. The trust reports that without the ACE service these patients would have been admitted and therefore exposed to the risks associated with an acute inpatient stay.

The CGA supports timely patient flow through the hospital if a patient does need to be admitted to acute medical units or hospital wards. Early consultant geriatric review and multidisciplinary review can lead to better outcomes for patients, as well as assisting with patient flow.

Out-of-hours patients are seen the next morning by the ACE team. Outside operating hours, patients who previously would have been referred to the on-call team and admitted to a ward or acute medical unit, are admitted to the observation ward and seen by the ACE team the following morning.

Fast-track rapid assessment clinic The second element of the ACE service is the fast-track rapid assessment clinic. Patients may need to return to this clinic for follow-up following discharge from the in-reach element of the ACE service. It is run by a consultant in elderly care and staffed primarily by the ACE team, although routine clinic staff also provide support.

Enabler: dedicated area

- fast-track assessment clinic based in a quiet area of the hospital, dedicated to assessing and treating patients aged 75 and over and staffed by staff with specialist skills
- looks and feels like an outpatient centre, with four clinic rooms and three beds
- offers a better experience for patients who do need to be admitted
- designed to be dementia friendly

This clinic is both a hotline and a treatment centre. GPs, community teams, rapid response and intermediate care teams can call this clinic if the condition of patients in the community is deteriorating, as an alternative to referring them to the emergency department. The ACE consultant takes all the calls so specialist advice can be given as well as referrals to the service accepted. The consultants carry a designated ACE mobile phone and pager. Patients can be seen within 24 to 48 hours of referral. If they are well enough to go home the same day, they are discharged from the unit straight home.

Onward care Once patients are discharged from the ACE service, ACE nurses can provide follow-up calls, and the service directs patients towards other community pathways as appropriate, such as reablement services, day centres, rapid response, or the intermediate care team.

The ACE team works particularly closely with the trust's rapid response service, a 24/7 scheme that provides intensive nursing and therapy interventions in the home to prevent and manage crisis among high intensity hospital users and avoid unnecessary admissions. The ACE and rapid response services support each other to provide care for older adults with patients being referred between the two teams.

Impact

The ACE service can improve quality of care for older patients. The immediate provision of CGAs by a skilled multidisciplinary team as soon as frail older adults arrive at the hospital is widely regarded as best practice. It increases the likelihood that conditions such as dementia, falls and stroke are recognised and appropriate treatment plans are put in place. This can improve patient health and reduce the time the patient has to spend in hospital.

This scheme may be important in alleviating operational pressure at the trust caused by increasing demand. The trust reports that ACE has contributed to reductions in length of stay at the trust. Since November 2013 the average length of stay across elderly care wards has reduced by five days and 84 inpatient beds have been closed. Since ACE began, there have also been fewer admissions into hospital from the A&E observation ward at Croydon University Hospital for patients over 80 years of age. This is despite increasing attendance at A&E and admission to the observation ward among this age group.

Reductions in length of stay and fewer admissions suggest potential for the service to deliver cost savings, if fixed costs can be taken out.

Challenges

ACE needs capacity to cope with increasing numbers of referrals, particularly in the fast-track clinic.

There are demands on the workforce due to increasing demands on the service. The trust has responded by:

- investing in greater consultant input
- providing nursing staff with ongoing training to develop their specialist elderly care skills
- recruiting a full-time social worker to be part of the team.

More information

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This is one of a suite of case studies designed to increase awareness of schemes to move healthcare closer to home. For more materials see [Moving healthcare closer to home](#)