

**FRAILTY AT THE FRONT DOOR: FLOW,
QUALITY AND CO-CREATION**

PRESENTED BY
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Frailty & acute care: the current national policy landscape

Nine national documents that now shape prevention, front-door frailty, the first 72 hours, discharge and the elimination of corridor care.

1. Strategic direction

Where the system is being asked to move

JUL 2025

10 Year Health Plan

- Three shifts: hospital → community; analogue → digital; sickness → prevention.
- Neighbourhood urgent alternatives and an explicit ambition to end corridor care.

SYSTEM STRATEGY • DHSC

2. Front door & first 72 hours

How frailty should be assessed and managed acutely

FEB 2024

FOUNDATIONAL

FRAIL Strategy

- Acute frailty/SDEC: identify frailty early, start CGA at the front door and access a skilled MDT.
- Minimum acute frailty service: 10 h/day, 7 days/week; maximise safe same-day discharge and avoid overnight admission.

ACUTE FRAILTY SDEC • NHS ENGLAND

3. Flow, safety & discharge

How to reduce harm, delay and inappropriate care spaces

MAY 2026

Best Practice Guide for NHS Frailty Pathways

- Eight actions: systematic identification, shared/actionable CGA and care plans, neighbourhood integration and workforce capability.
- Provide ≥70 h/week acute frailty/SDEC and enable same-shift neighbourhood-supported discharge.

CORE FRAILTY GUIDE • NHS ENGLAND

MAR 2026

Neighbourhood Health Framework

- Frailty is a priority cohort for integrated neighbourhood teams.
- UCR, Hospital at Home and rehabilitation should reduce avoidable admissions and bed days.

HOSPITAL → COMMUNITY • DHSC / NHS ENGLAND

FEB 2026

Model Emergency Department

- ED should be a destination, not the default: route rapidly to SDEC, frailty and community alternatives.
- Overcrowding and flow are whole-hospital/system responsibilities, not ED-only problems.

FRONT DOOR • NHS ENGLAND

MAR + JUN 2026

Corridor care: definition & principles

- National definition includes >45 min in a clinically inappropriate setting; corridor care must not be normalised.
- Not acceptable for severe frailty, dementia/confusion/delirium or end-of-life care; boards must measure and de-escalate.

SAFETY + BOARD GOVERNANCE • NHS ENGLAND

JUL 2026

Quality Strategy for NHS-funded Care

- Quality is framed around safety, effectiveness and experience; frailty/dementia variation is a national concern.
- Frailty & Dementia Modern Service Framework expected by end 2026.

QUALITY + ACCOUNTABILITY • NHS ENGLAND

FEB 2026

NEW STANDARD

Model Acute Pathway — first 72 hours

- Age >65: CFS + 4AT within 30 min. CFS 5+: senior frailty decision-maker within 1 h of referral.
- Expert review ≤6 h daytime / ≤14 h overnight; receiving-area stay usually 24–48 h and >72 h needs senior sanction.

FIRST 72 HOURS • NHS ENGLAND / RCP / SAM / BGS

JUL 2026

Model Discharge Pathway

- Discharge planning starts at admission; clinically ready should trigger movement, not more queues.
- Home First / assessment outside hospital, with 7-day enabling services and neighbourhood handover.

HOME FIRST • NHS ENGLAND

Change in terminology: Corridor Care → Temporary Spaces

Same issue. New terminology. A clearer focus on patient safety and dignity.

*No one
left behind.*

Previous terminology

Corridor care

(used in earlier guidance)



- Term used to describe patients receiving care in inappropriate non-designated spaces (e.g. corridors, in waiting areas).
- Highlighted the risks to safety, dignity and quality of care, particularly for older people and those with frailty, dementia or delirium.
- Used in earlier NHS England guidance and national reporting.

Updated
terminology
to better reflect
the issue

Current terminology (2025/26 onwards)

Temporary spaces

(used in current NHS England guidance)



- “Temporary spaces” is the new national term used by NHS England.
- Refers to care provided in non-designated clinical areas (e.g. corridors, waiting areas or other spaces not intended for ongoing patient care).
- Emphasises that this should only be used in exceptional circumstances, for the shortest possible time, and with robust safety measures.
- Recognises the same unacceptable risks and harms, particularly for people with frailty, dementia or delirium.



Temporary spaces are not normal care.

They should never be used for people with severe frailty, dementia, delirium or end-of-life care needs.



The change in terminology does not change the expectation – patients must not receive ongoing care in temporary spaces, and services must work to eliminate the need for them.

NHS England, 2025/26

Key requirements in current guidance



Only in
exceptional
circumstances



For the
shortest possible
time



Risk assessment,
monitoring and
escalation



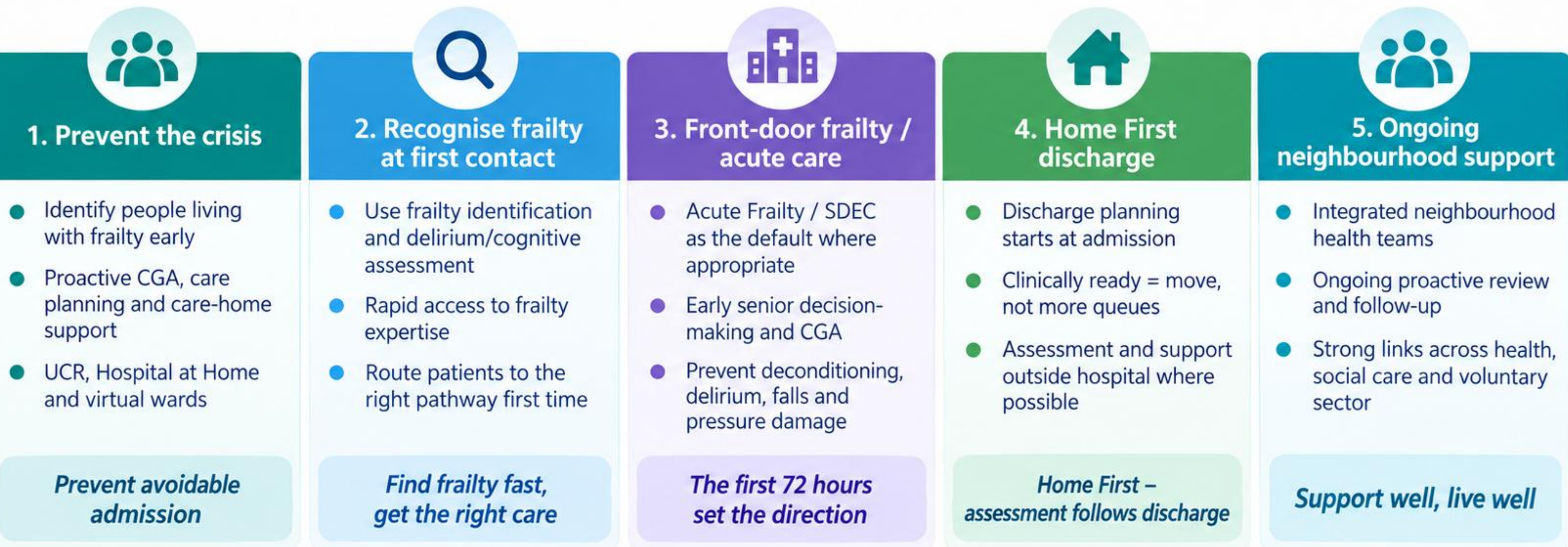
Not for people with
severe frailty, dementia,
delirium or end-of-life
care needs



Board-level oversight,
reporting and active
plans to eliminate
the need for temporary
spaces

Frailty, Acute Care

A whole-system approach for safer, kinder, better care



HOW?

ED + MSDEC

March



8th

**EMERGENCY
DEPARTMENT**
9,831 DEPARTURES
2615 26.6% 65+
1693 17.22% 75+



MSDEC
1413 PATIENTS
>65 411PTS (86.37%)
>75 210PTS (82.86%)

SAMIT75+



Trust Positions

01

RED LINES

1. NEVER OVERNIGHT PATIENTS IN AN SDEC.
2. NEVER PLACE MEDICAL PATIENTS IN SURGICAL BEDS.
3. NEVER BED DISCHARGE LOUNGE.
4. WE DO NOT BOARD PATIENTS AT WHT (NORTH BRISTOL MODEL 22)

FLOW

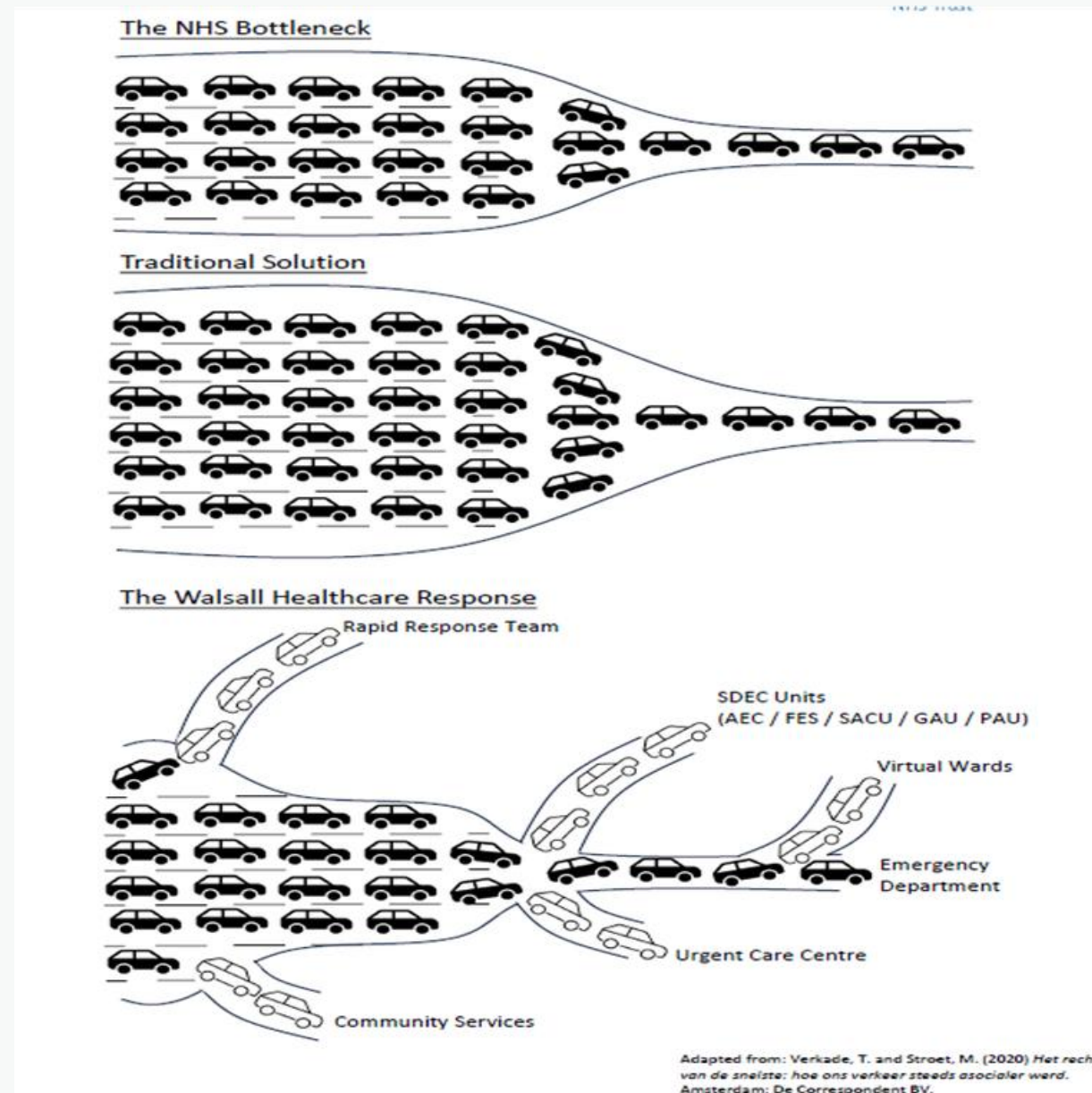
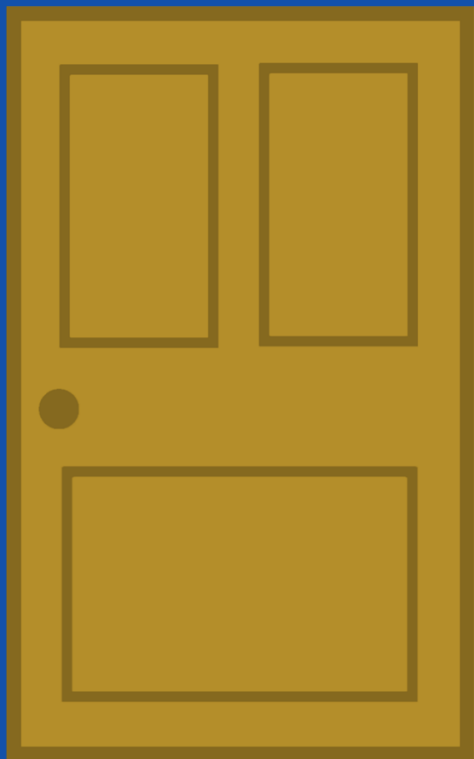


Figure 2: The imbalance between things that go right and things that go wrong

From "From Safety-I to Safety-II: A White Paper"

Front Door Offer

03



FRONT DOOR
TEAM

F2F FSDEC

ROAMING

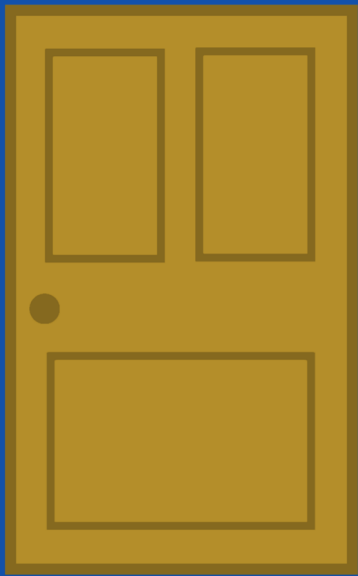
PHONE

CEM

S

Front Door Numbers...

03



89 PATIENTS
42 >75YRS OLD
ESD 23PTS - 14 >75
ONE WEEK



5-DAY SERVICE
195 PTS
AVG LOS 6.4HRS
ADMISSION RATE 21%
RETURN RATE 22%



CAPACITY AND
WEEKEND
37 PTS
49% ADMISSION RATE



5-DAY SERVICE
126 CALLS
0 ADMISSIONS



CEMS >65 NON-
CONVEYANCE 57
PATIENTS CFS >5 54

VIRTUAL WARD...

- Admissions: 54
- Discharges: 41
 - Step-up: 10
- Step-down: 44
- Readmissions:
1

The ENVIRONMENT



12



1

Staffing

04



Profile

X2 SENIOR SISTERS (7-7) - (8-8)

X2 FLOW COORDINATORS

1 STAFF NURSE

X2 CSWS



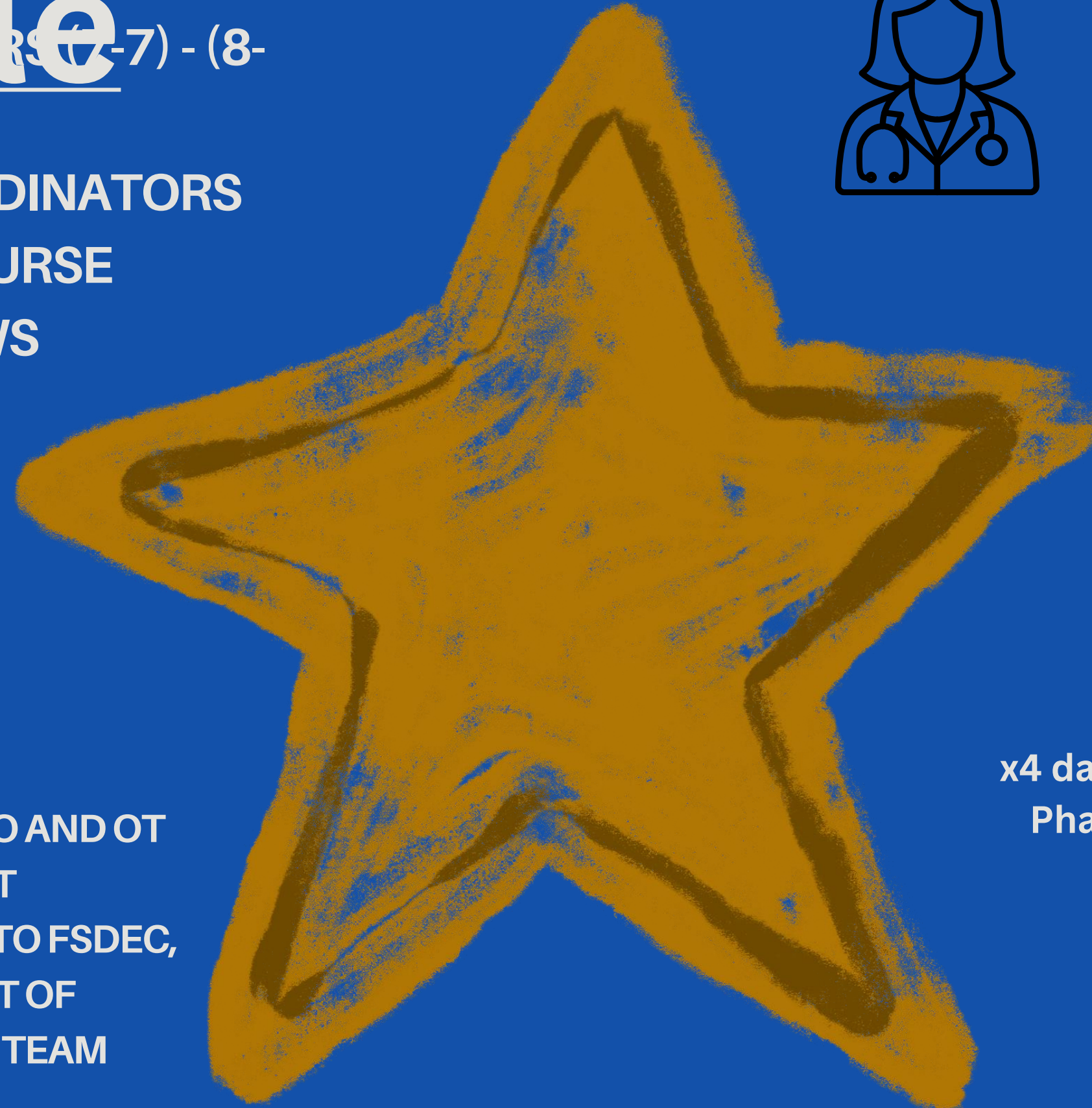
1 Cons 9-5 (VW 2-4)

1 SCF/REG (9-5)

1 JCF/RD (9-5)



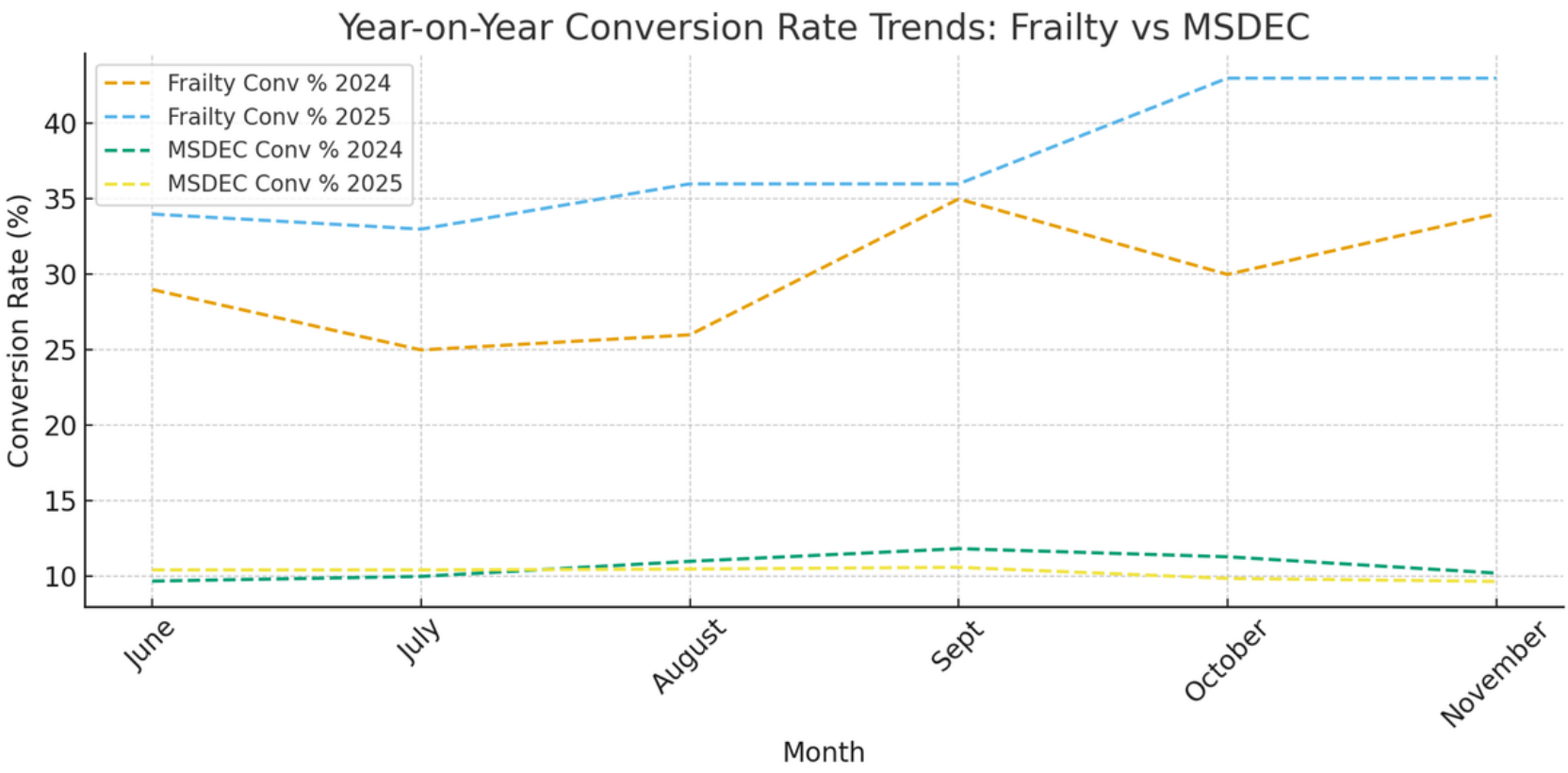
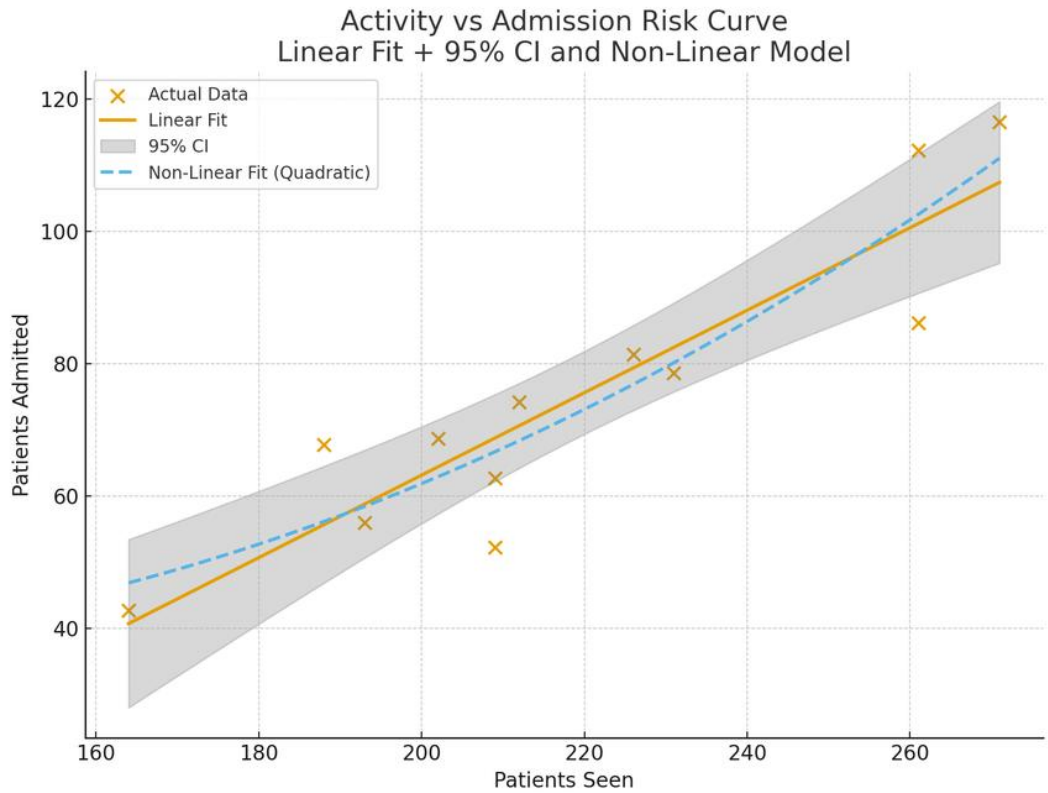
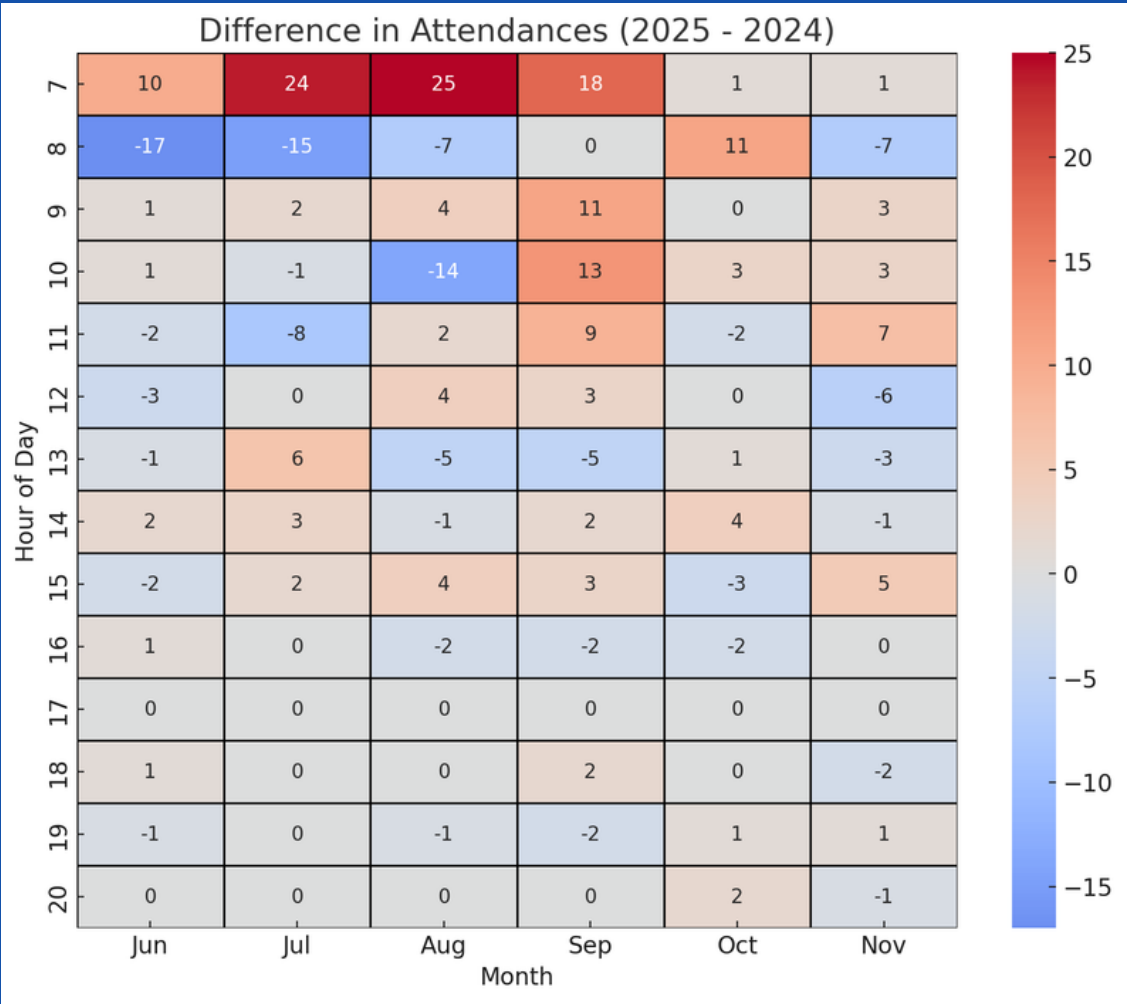
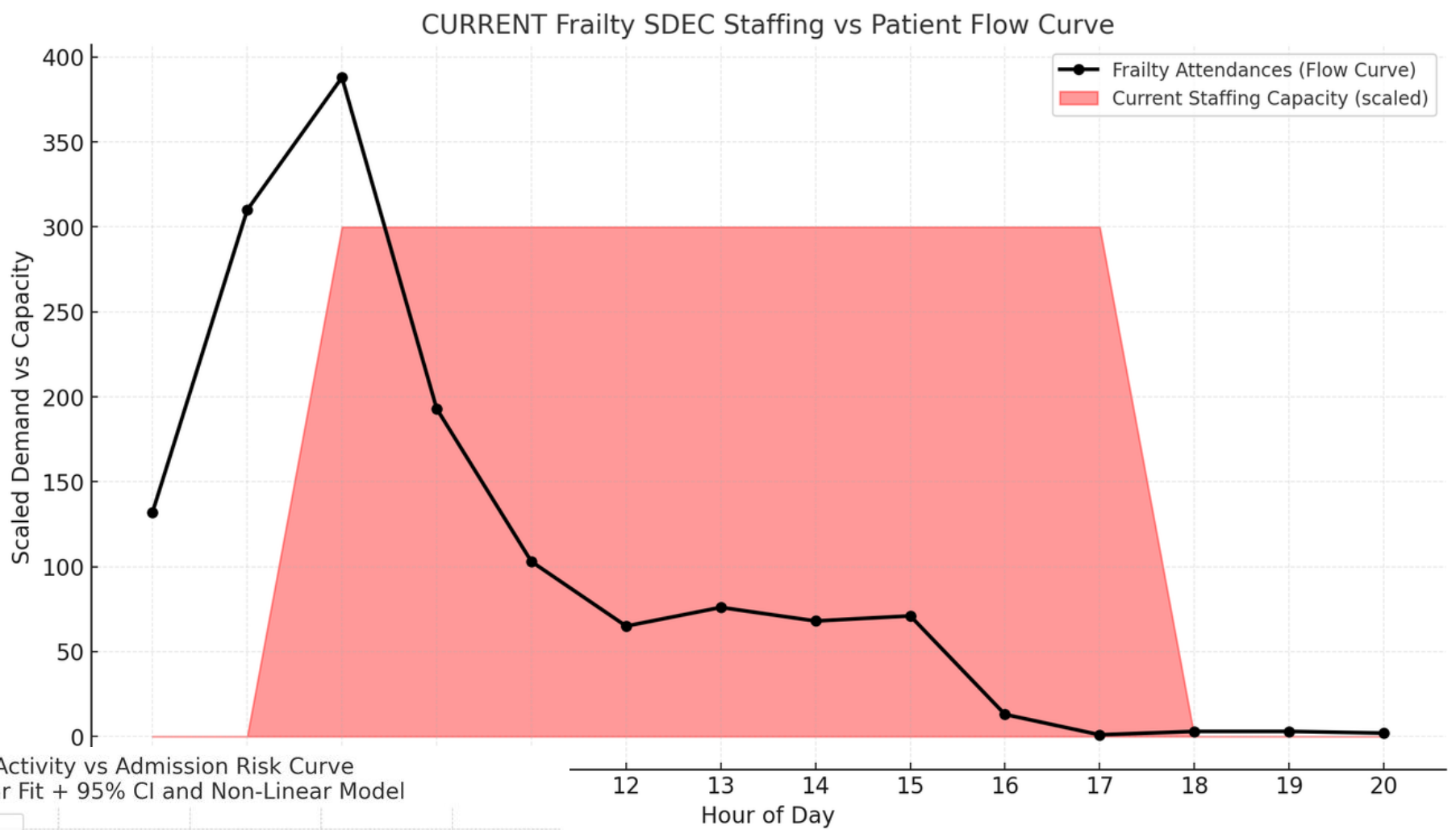
ROAMING PHYSIO AND OT
SUPPORT
NOT DEDICATED TO FSDEC,
FORMS PART OF
FRONT DOOR TEAM



ACPs (?)
x4 days a week 8-6
Pharmacists (?)



Activity



Challenges

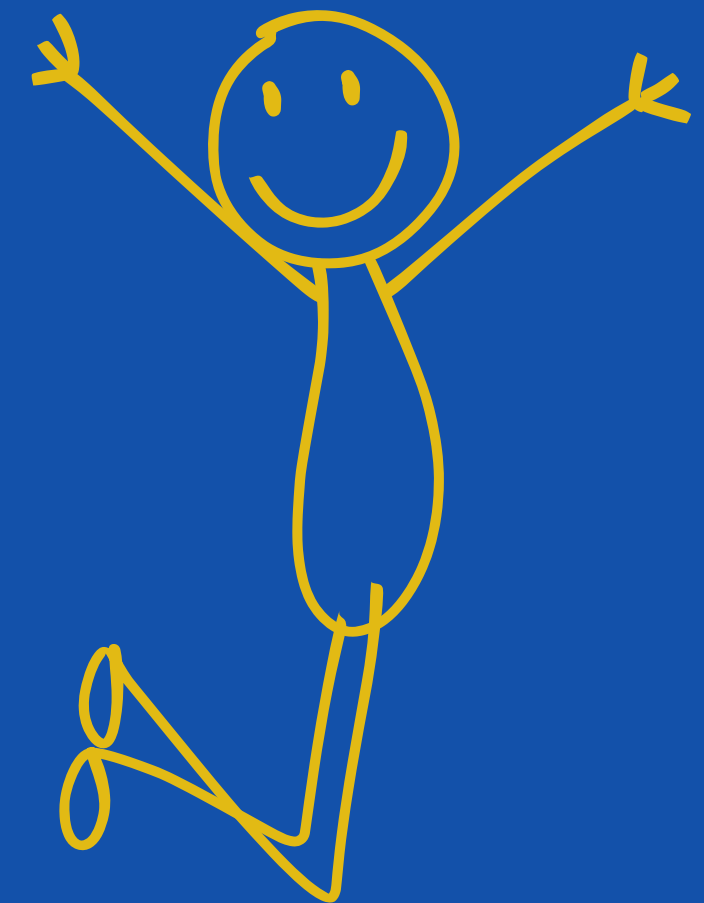
06



CFS SCORING



**OOA PATIENTS 34%
HIGHER ADMISSION
RATE
LONGER LOS**



MORE STAFF

COMPLEX, PERMEABLE, BOUNDARIES



Co-production and service development

How we are listening to service users and shaping the next phase of frailty care

Public engagement

- ✓ Meeting the public at the LEP event on two occasions next week
- ✓ Opening up discussion about what local people want from frailty services
- ✓ Using lived experience to inform improvement priorities

Extended service evaluation

- ✓ Speaking directly with patients and relatives
- ✓ Exploring what matters most to service users
- ✓ Understanding how well the current service meets their needs

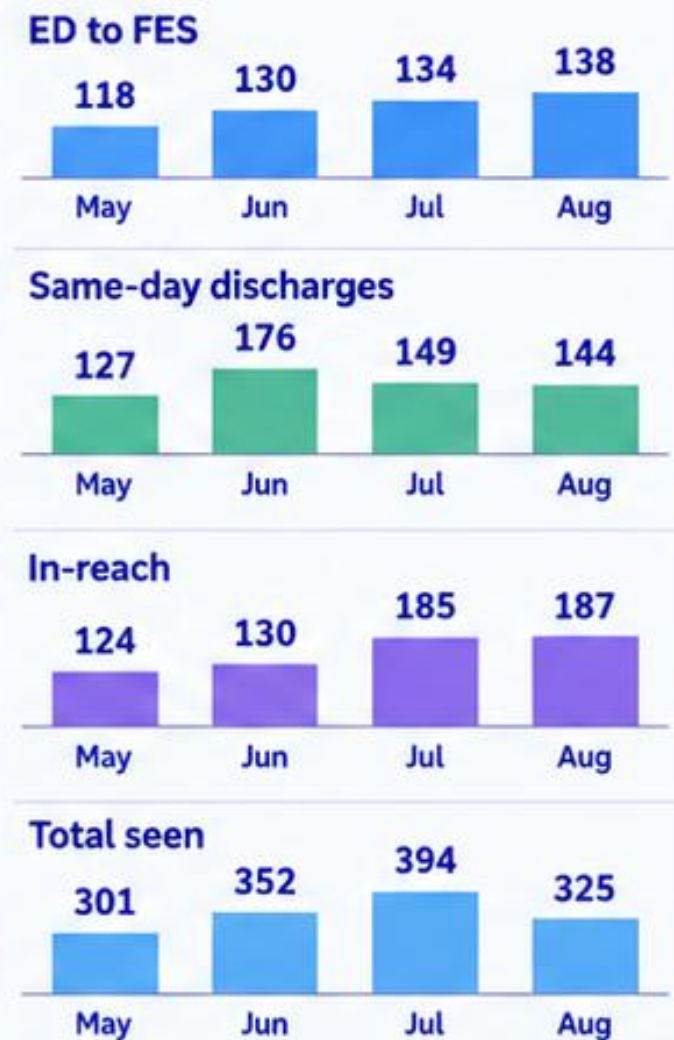
Co-creating improvement

- ✓ Using feedback to shape the future service offer
- ✓ Writing a paper on co-creation of services
- ✓ Moving from professional assumptions toward shared design

Service development priorities

- ✓ Revisiting staffing with the aim of seven-day working
- ✓ Strengthening prevention through Feel Good Fridays, case management, nursing home management and UCR teams
- ✓ Outreach frailty activity has increased substantially

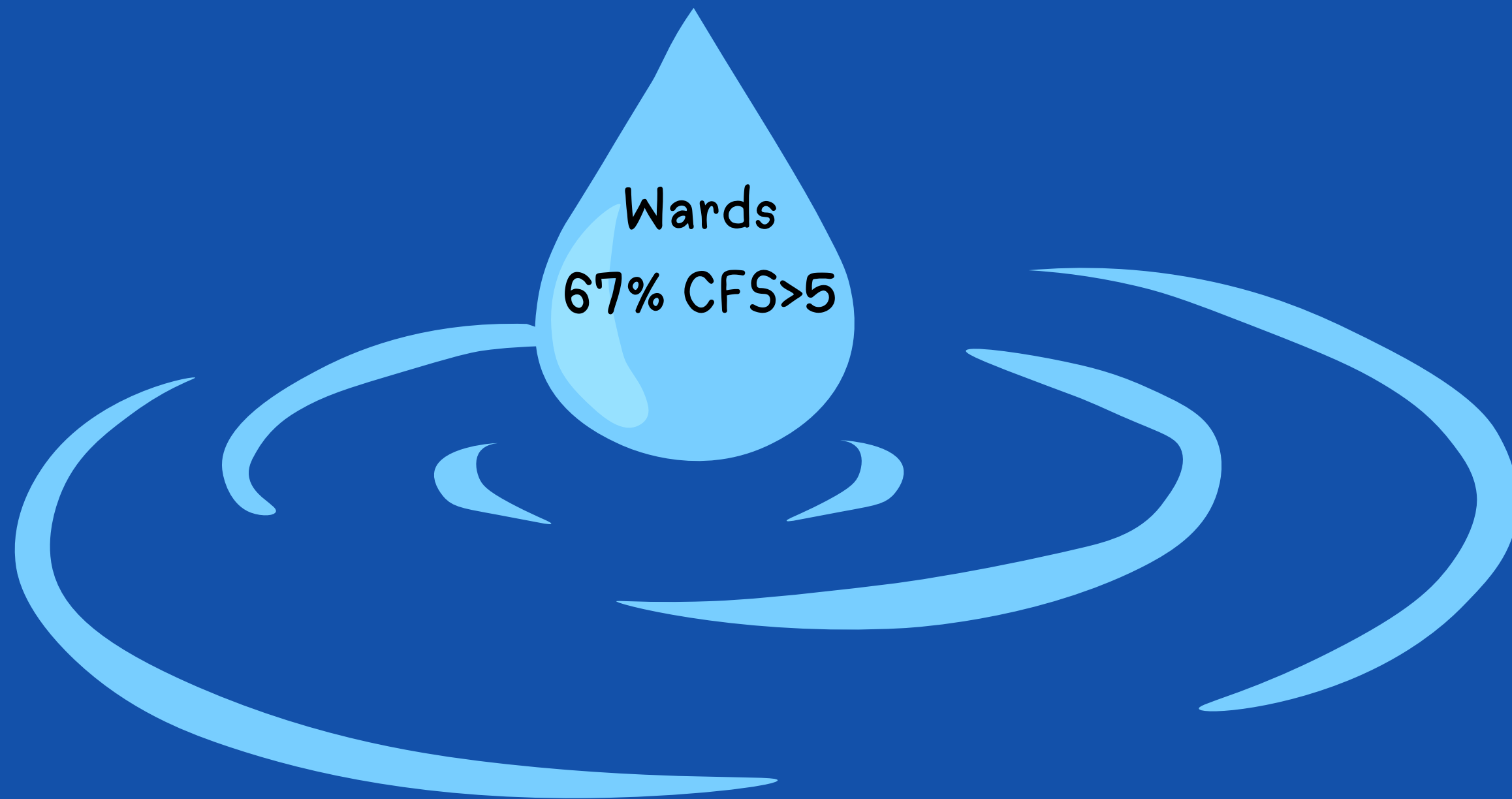
Activity trends



We have established flow. Now we need to establish quality with people.

Activity data shows what the service does; co-production tells us whether it delivers what matters.

A DROP IN THE OCEAN....



THANK YOU