NE Hants – Frailty Update

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Overview

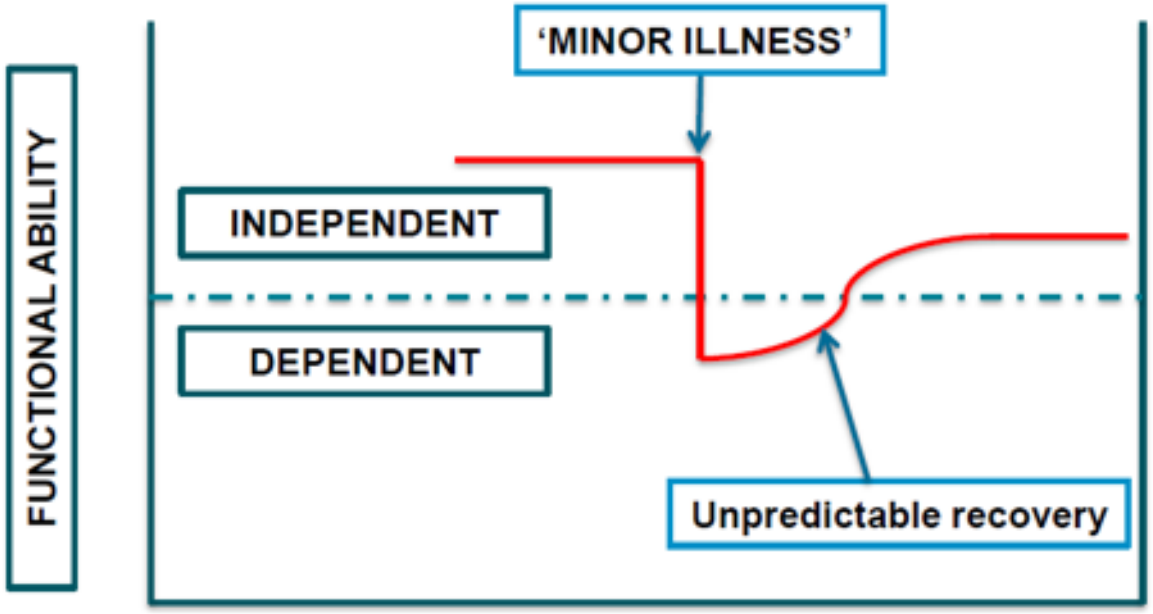
- Frailty background
- Identifying and measuring frailty
- Frailty management
- Comprehensive geriatric assessment
- The Frimley Integrated Frailty Liaison Team
  - Working with you to support patients.
- The future

What is frailty?

Who?

Frailty

- ***A long-term condition characterised by lost biological reserves across multiple systems and vulnerability to decompensation after a stressor event***

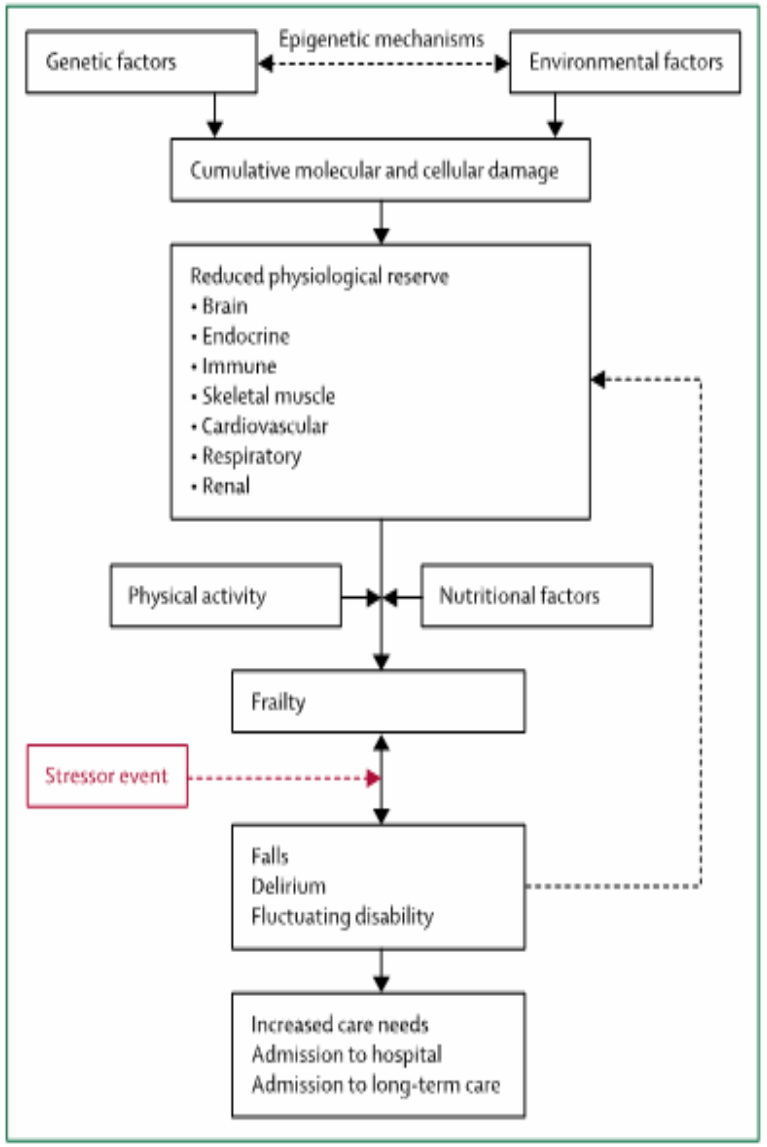


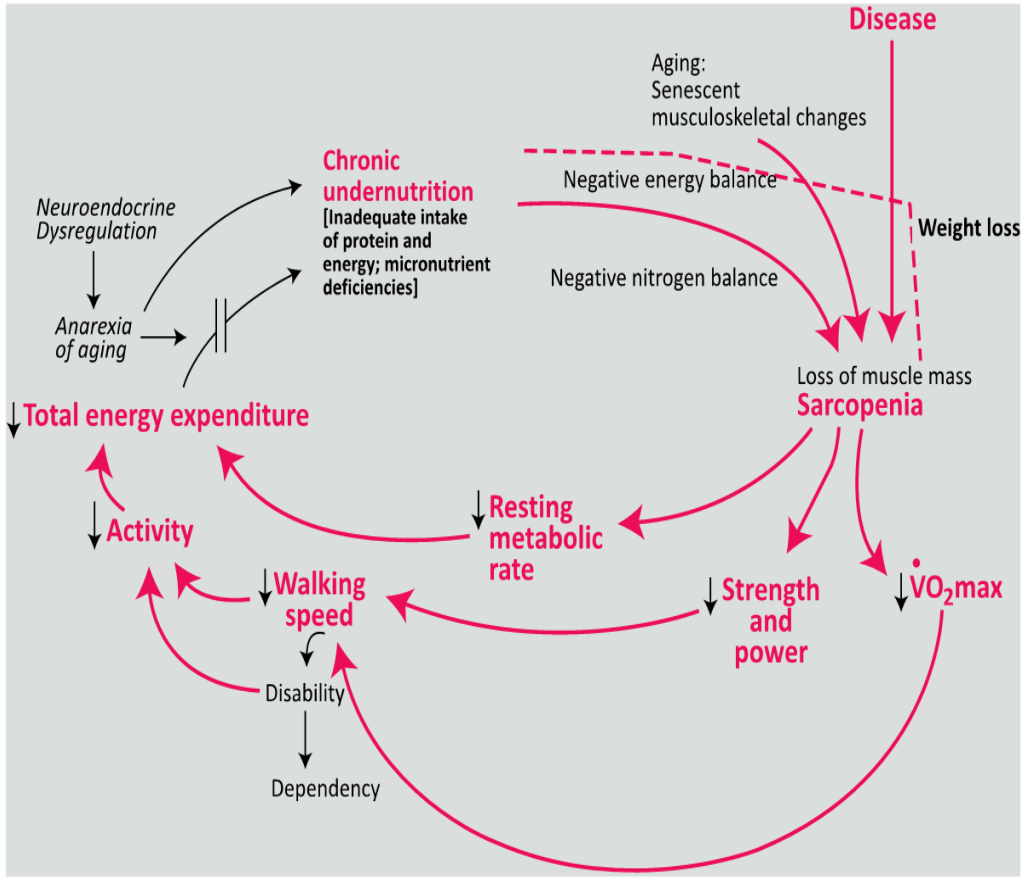
Frailty Syndromes

- As a result of a stressor event, people with frailty present in non-specific ways with frailty syndromes:

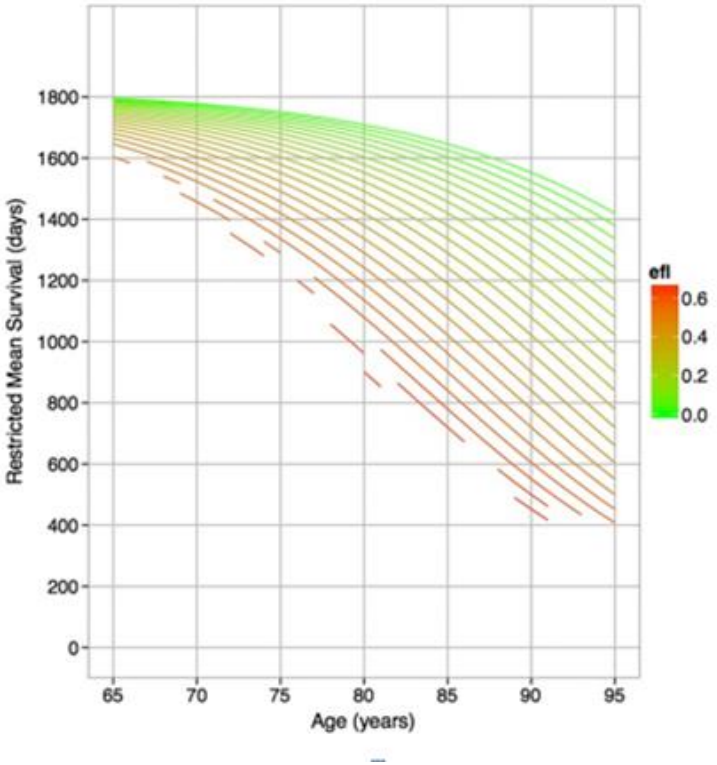
- Falls
- Reduced mobility/functional decline
- Altered cognition/delirium/dementia
- Incontinence/constipation
- Lots of medications (>5)

Why does frailty develop?





Relationship between age and frailty

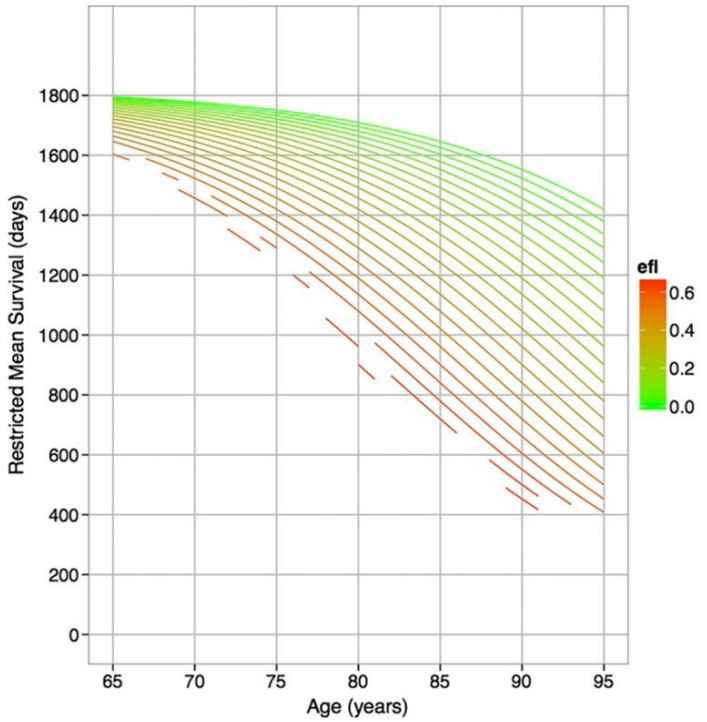


How is frailty measured? - eFI

- Electronic frailty index is calculated from primary care data. This is not something we can measure in the acute hospital. The eFI predicts your risk of death, hospitalisation and nursing home admission.
- IPA – yes/no

Frailty Status	Score
Fit	0-0.12
Mild frailty	0.12-0.24
Moderate frailty	0.25-0.36
Severe frailty	>0.36

One year outcome (hazard ratio)	Mild frailty	Moderate frailty	Severe frailty
Mortality	1.92	3.1	4.52
Hospitalisation	1.93	3.04	4.73
Nursing home admission	1.89	3.19	4.76



This graph demonstrates that the eFI is a much better predictor of survival than age alone.

Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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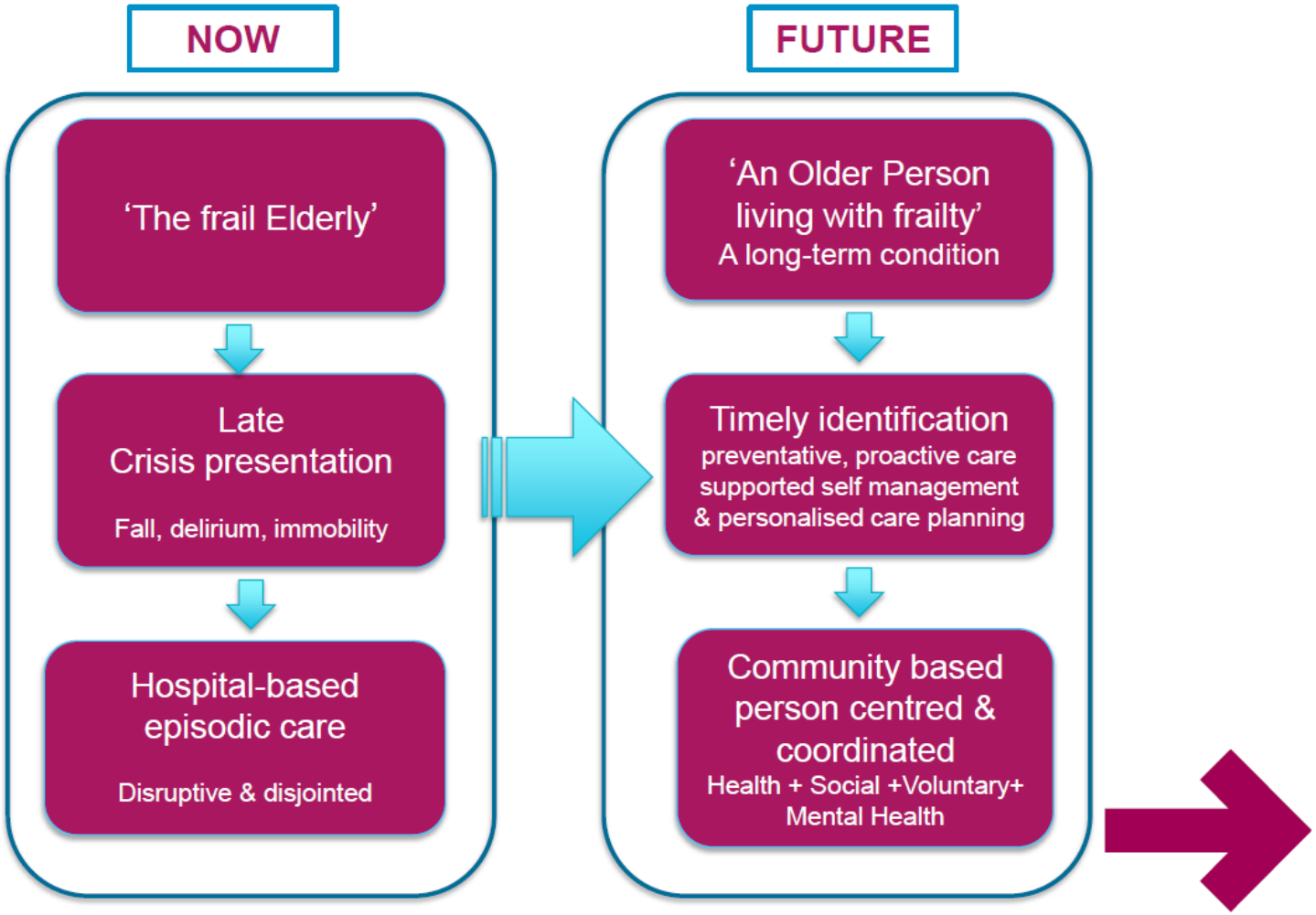
What is the scale of the problem?

- 50% of over 85s estimated to have frailty
- 75% of over 75s attending ED estimated to have frailty
- 48% of those over the age of 85 will die within 1 year of hospital admission
- We need to re-design systems of care for older people with frailty

Find → Recognise → Assess → Intervene → Long-term

Frailty as a Long Term Condition

NHS England

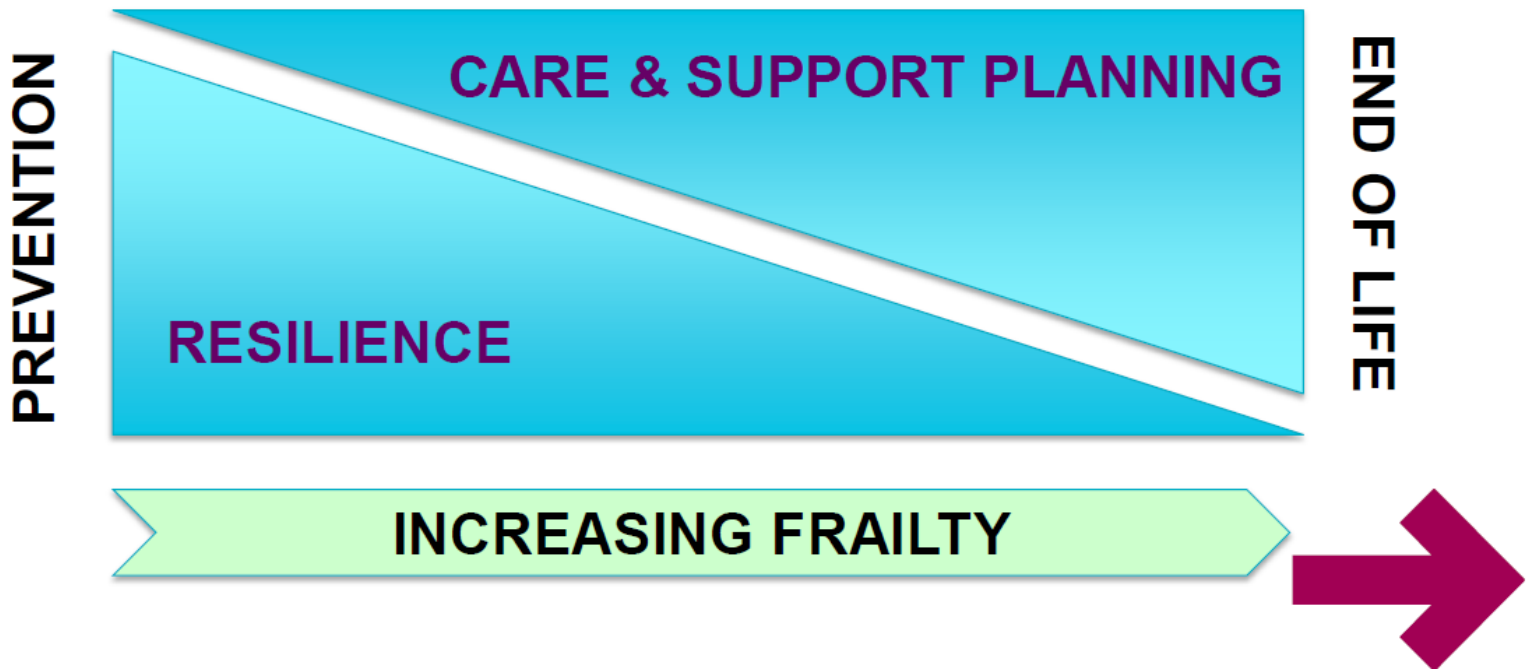


NHS England

Frailty as a Long Term Condition

- A long term condition can be **diagnosed**, is **not curable** but **can be managed** and **persists**

- As resilience is lost, care and support planning assumes greater importance through to the end of life



Why is it important to identify frailty?

- Increased risk of:
  - Disability
  - Hospitalisation
  - Nursing home admission
  - Mortality

One year outcome (hazard ratio)	Mild frailty	Moderate frailty	Severe frailty
Mortality	1.92	3.1	4.52
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What can we do to prevent or stop frailty progression?

- Nutrition
- Exercise
- Protective factors – environment, finances, social engagement
- Comprehensive geriatric assessment
- Adequate care and support

Management of Frailty In Practice

Supported Self-Management

Care & Support Planning

Comprehensive Geriatric Assessment

Advanced Care Planning & End of Life Care

CGA is..... *British Geriatric Society 2014 (BGS)*

- Gold standard process of care for managing Frailty
- Involves an holistic, multi-dimensional, multi-disciplinary assessment of an individual
- Results in the formulation of a list of needs and issues to tackle, together with an individualised care and support plan, tailored to an individual's needs, wants and priorities'

What happens during CGA?

- Medical (Dr, pharmacists, nurses, SALT, dietitian)
  - Diseases, polypharmacy, nutrition
- Functional (Physio, OT)
  - ADLs, gait and balance, activity/exercise status
- Psychological (psych team)
  - Cognition, mood
- Social (social care, voluntary sector)
  - Informal support, social activities and network, eligibility for care resources
- Environment (OT, social care)
  - Home facilities, personal safety, transport, use of telehealth, accessibility of local resources

CGA – The Evidence

Acute Based CGAs
Associated with improvement in all outcomes at discharge; including better functional status, decreased nursing home admissions and reduced mortality ***(Bachmann et al. 2010)***
Those who underwent CGA on a ward had a 30% higher chance (OR 1.31 CI 1.15 – 1.49) of being alive and being in their own home at 6 months. This equates to a Number needed to treat of 13 ***Ellis et al. 2017)***

Integrated Frailty Liaison Team

- Funded for 6 months by NHSE
  - Started in April 2018
- Consultant Geriatricians
- Consultant nurse
- In-reach GPs M/W/F
- Frailty SHO
- 2 frailty practitioners – nurse and OT
  - Looking to recruit 2 further frailty practitioners

Front door frailty team

- Work alongside existing MDT in EDOU
- Seeing people in frailty crisis directly in ED
  - Falls, reduced mobility, Altered cognition, incontinence, lots of medications
- Home first principle
  - Avoid inappropriate admission
  - Link with community support
  - Manage risk
  - Provide community follow up
- If admission appropriate, will be clerked and post-taked by frailty team
- Patients with expected LOS <72 hours should be admitted to OPSS Unit

Inpatient frailty team

- Support for inpatients (surgical/orthopaedic/medical)
- Provide:
  - General advice
  - Discharge planning
  - Capacity assessments
  - Suitability for rehabilitation
  - Falls assessment
  - Fracture liaison
  - Delirium prevention, assessment, management
  - Continence advice
  - Cognitive assessment

Older Persons Short Stay Unit

- Launched October 2017
- For Older people with frailty who require acute medical treatment
- Full MDT with representation from ERS team and social care
- Acute medical treatment and rehabilitation run concurrently
- Provide CGA
- Aim to minimise length of stay
- Enable discharge to assess
- Open visiting
- Maintaining routine, self medication
- Twice daily board rounds
- Get up, get dressed, get moving!
  - #EndPJParalysis campaign


new older persons short stay unit

Meet some of the team from Frimley Park Hospital's older persons short stay unit (OPSSU) – a new ward transforming the way we care for patients with frailty.

They are focused on helping people who are admitted with a frailty syndrome to maintain their mobility and independence and avoid a lengthy stay in hospital.

The unit opened in September with the aim of assessing, treating and safely discharging appropriate older patients within 72 hours, and is currently seeing about five new admissions each day.

Surrey Heath Frailty MDT (and now Farnham!)

- Weekly MDT
- Discuss patients referred to SPA who have severe eFI score
  - Frailty confirmed with PRISMA 7 and self reported health tools
- Rapid response, mental health, social care, community nursing, medicines management, geriatrician, GP
- Go through virtual CGA
- Make recommendations eg bone health, strength and balance training, advance care planning, polypharmacy review, continence
  - May refer for full face to face CGA
- Frailty navigator ensures actions completed

Area of risk	Intervention	Action	Who
Individual in crisis	Referral to ICT		
Several areas of risk	Comprehensive Geriatric Assessment	Farnham DATC	ICT
Link to LTC risk area?	Review by GP or referral to Specialist Team	GP to action	GP
Falls/immobility	Falls assessment	Falls Team referral (Rapid Response/ DATC)	ICT
	Mobility assessment	CRT/Rapid Response referral	ICT
	Physio assessment and ongoing therapy as required	CRT referral	ICT
	Strength and balance training to reduce sarcopenia	CRT referral	ICT
	Functional/ADL assessment	CNT/Rapid Response	CNT ICT
	OT input/aids and adaptations as required	ASCT/Rapid Response – depending on if a long term social need or health need	ASCT ICT
Prevention of fractures	Bone health assessment	FRAX tool ± DEXA Bone protection medications started if appropriate	GP
Memory loss/cognition - unknown	Cognitive assessment, dementia bloods & CT brain	Referral onto Memory Service if appropriate.	GP MHP DLP
Memory loss/cognition - known	Post-diagnostic support and signposting (eg Dementia Navigator)	Referral to Memory Service if appropriate. Cognitive enhancers commenced if appropriate. Advice on advance care planning.	MHP
Psychological wellbeing - unknown	Psychological wellbeing assessment		MHP
Psychological wellbeing - known	Review by patient's primary mental health clinician (this may be primary or secondary care)	Medications started if required. Psychological option explored and signposted to, including IAPT, Safe Haven, Recovery College, Catalyst, etc. CMHT referral if required.	GP MHP
On >5-10 medications	Polypharmacy review	Medication review – include STOPP START and ACB	GP Pharmacist
Chronic / long term conditions	Optimisation of chronic conditions, including appropriate community support	GP/Practice Nurse LTC review (or Community Matron/Specialist Nurse if appropriate). Refer to Diabetes, MS, PD, HF or LD Nurse Specialist, Community Respiratory Team, etc.	GP CNT
Vaccination status	Influenza, pneumococcal & shingles vaccinations	Arrange for the patient to have their vaccinations with their GP (or for influenza vaccination, the pharmacist can administer them)	GP CNT
Incontinence	Continence assessment	Appropriate investigations done to reach a diagnosis. Exclusion of UTI. Interventions started where appropriate.	GP CNT

Sensory impairments	Assess for treatable or reversible cause	Eg refer for hearing aids, cataract surgery, low vision aids, etc	GP
Social situation	Social care assessment	Information, advice and signposting (eg CAB). Carer's/young carer's assessment. Review financial situation and ensure claiming relevant benefits.	ASCT FMC
	Carer's wellbeing	Referral to NW voluntary services	
Alcohol/smoking	Review alcohol, smoking & drug history	Offer support/cessation therapy as appropriate. Encourage self-referral to Catalyst, i-Access, etc	GP ICT
Nutrition, weight loss and hydration	Nutritional & hydration assessment - Basic MUST carried out by CNT.	If weight loss identified – discussion and information given on fortifying diet (protein and energy optimisation supplements only if necessary). If weight loss dramatic – refer to GP for further interventions and dietician. Hydration advice. Refer to SALT for (identified) swallowing problems.	CNT GP ICT
Crisis planning	Anticipatory, advance and urgent care planning	Escalation (anticipatory care) plans for patient/carer - what to look out for and contact details for who to call for help. Urgent care plans (to guide OOH GP & Ambulance Services, etc) – IBIS & Adastra plans. DNACPR decision & Living Will.	GP ICT
End of life	Palliative care planning	Referral to GP, CNT and Hospice	GP CNT ICT

Outcomes so far – first 7 months

- 106 patients
- 575 interventions
- 25% reduction A and E attendances
- 23.5% reduction in admissions

Outcomes

- Medications review – cost saving £47 per patient
- Estimated annual saving £372K based on reduced hospital attendances
- 75% people felt better post intervention

Interaction with the Frimley Frailty team

- Available for advice
  - Especially if patient recently discharged
- Support the Farnham proactive case reviews
- If patient attends ED
  - Can see patient in ED Mon-Friday
  - Can follow up patients on the ward
- Please contact us to hand over any vital information or if you want information back
- Rapid access slots in clinic every day (except Tues)

What information is useful

- “What matters to you?”, not “what’s the matter with you?”
- Expectations
- Family involvement and expectations
- What the person’s support network is like and their routine
- Baseline cognition, physical function
- Discussions around anticipatory care planning, DNACPR
- Rockwood score

How to refer

- Monday to Friday 8.30-5pm
- Urgent – Frailty coordinator
  - From outside: **01252 649596**
- At any time:
  - Fhft.frailtyteamfph@nhs.net
- Please phone us – we would love to hear from you!

- More than welcome to shadow us
- Working towards 7 day working

Future plans

- NEH Frailty MDT
  - Monthly locality MDT: Yateley, Farnborough, Aldershot, Fleet
  - eFI and Rockwood score
- Community beds at Fleet
  - Fixed beds for community only
- Professional Advice & Guidance service for care home residents
  - Aim to assist in setting up parameters and to avoid hospital admissions
  - Yellow stickers
- ICT email cards to junior doctors
  - Improve communication between acute hospital & ICT
- TORCH tool in care homes
  - Trend in observations of residents in care homes

Key points

- Frailty is a long term condition that needs to be identified and managed in a coordinated, multidisciplinary, patient centred way
- Frimley Park now has integrated frailty liaison team and older person's Short Stay Unit to respond to the needs of people with frailty when they present to ED
- Evidence from Surrey Heath that using CGA in a proactive way is reducing hospital utilisation, improved patient satisfaction
- More work to be done across the ICS to proactively manage frailty
  - Really keen to work together to provide a joined up pathway

Questions