Welcome and Housekeeping
Herts Valleys CCG continues to deliver ‘Your Care, Your Future’ plans to move care closer to home and develop new and innovative pathways that benefit patient care.

**During 2018/19** HVCCG has commissioned the following services:

- Integrated MSK, rheumatology, pain and postural stability (Jan 18)
- Integrated diabetes (April 18)
- Enhanced community gynaecology (April 18)
- Community vasectomy (June 18)
- Continuing Health Care fast track pilot with hospices (Sept 18)
- Respiratory referral management (Oct 18)
- Community nutrition and dietetics (Nov 18)
Herts Valleys Transformation Plan

During 2019 Herts Valleys CCG will launch the following new services:

• Community ENT and Ophthalmology (Jan 19)
• Adult community health services (Oct 19)

We are currently procuring the following services
• Direct access ultrasound scanning services
• Primary care enhanced community dermatology pilot
Introduction to Frailty

Clair Moring
Frailty for TARGET Events 2018

Dr Ros Kings, Geriatrician WGH
Frailty

• Context
• What is frailty?
• Why is it important?
• How do we recognise it?
• What do we need to do about it?
The Ageing Population

• NHS founded in 1948
• 48% died before the age of 65
  • Now 14% (ONS)
• By 2030, one in 5 people in England will be over 65 (House of Lords)
Ageing with more complexity

• Success story for society and modern medicine
• BUT as you get older more likely to live with complex co-morbidities, disability and frailty
• Increasing cost to the NHS
Problem...

• NHS hasn’t kept up with the demographic shift
• In general, services are designed around single organ diseases
Solution...?

- A focus on frailty
- Not organ/disease specific
- Looks at a person as a whole
WHAT IS FRAILTY?
Three terms are commonly used interchangeably to identify vulnerable older adults...

- **Disability**: Difficulty or dependency in carrying out activities essential to independent living.
- **Frailty**: Loss of resilience: High vulnerability for adverse health outcomes.
- **Multimorbidity**: The concurrent presence of two or more medically diagnosed diseases.

Fried et al, 2004

But what about physiological ageing...?
What is frailty?

• “A clinically recognised state of increased vulnerability that results from aging, associated with a decline in the body’s physical and psychological reserves.” BGS definition

• But what does this actually mean?
“Frailty” means different things to different people.

Older People

Non-Specialist Health Care Professionals
What is frailty?

- State of vulnerability
- Living close to a line of decompensation
- Minor trauma has a major impact
- Tip over the edge with minor illness
- Independent ➔ Dependent

Clegg et al (2013)
Frailty as a long-term condition

• Frailty is best understood as a long-term condition
  • eg diabetes, dementia, heart failure

• Varies in severity across a spectrum

• Some more severely affected than others

British Geriatrics Society (2014)
WHY IS FRAILTY IMPORTANT?
Frailty

- Associated with increased risk of:
  - Falls
  - Disability
  - Hospitalisation
  - Death

Clegg et al, 2013
Frail patients in hospital

• Increased risk of:
  • Delirium
  • Length of stay
  • Discharge to a care home
  • Death

Illness Trajectories

Source: Murray, S.A. et al

- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)
HOW DO WE RECOGNISE FRAILTY?
Two international models of frailty

- Frailty phenotype (Fried et al, 2001)
  - 3 or more of
    - unintentional weight loss (10 lbs in past year)
    - self-reported exhaustion
    - weakness (grip strength)
    - slow walking speed
    - low physical activity

- Cumulative deficit model (Rockwood et al, 2005)
  - eFl
  - maps well onto Clinical Frailty Score
Recognition of frailty (primary care)

• eFI
  • Based on a cumulative deficit model
  • 36 deficits
  • Population risk stratification tool
  • GP contract 2017/18

• Mild/Moderate/Severe

• Clinical review/medication review/history of falls

• Activate enriched summary care record
Identification of frailty (secondary care)

- Screening at the front door >65
- Clinical Frailty Score (Rockwood)
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.

Importance of Rockwood

- Gives objectivity
- Reproducible
- Predicts outcome
- Addresses complexity
  - without “single organ” preoccupation
- Helps identify patients that need discussion
  - eg expectations of treatment
- 2 weeks before admission
Other ways of recognising frailty

- Timed up and go (TUG) test
- PRISMA 7 questionnaire
- Gait (walking) speed test
- Presenting with the frailty syndromes
TUG test

Step 1: Stand up

Step 2: Walk 3 metres

Step 3: Turn around

Step 4: Walk 3 metres

Step 5: Sit down

>14 seconds = high risk of falls, and frailty
PRISMA 7 Questionnaire

<table>
<thead>
<tr>
<th>Patient Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you older than 85 years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are you male?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. In general, do you have any health problems that require you to limit your activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you need someone to help you on a regular basis?</td>
<td></td>
<td></td>
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<tr>
<td>5. In general, do you have any health problems that require you to stay at home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. If you need help, can you count on someone close to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you regularly use a stick, walker or wheelchair to move about?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total checked: _____  ____

If the respondent had 3 or more “yes” answers, this indicates an increased risk of frailty and the need for further clinical review.
Frailty Syndromes = The Geriatric Giants

“It was a fall waiting to happen…”

“She’s just gradually got more confused…”

Can we recognise these before people hit crisis point?

“Geriatric Giants”

- Confusion
- Falls
- Incontinence
- Immobility
- Polypharmacy
- (Pressure sores)
WHAT DO WE NEED TO DO ABOUT FRAILTY?
What do we need to do about frailty?

• Recognise it
  • Before crisis point
• Recognise the risks associated with it
• Remember it’s not static
Fit for Frailty

- Managing Frailty
  - Managing services for people with frailty
  - Developing and commissioning services for people with frailty

www.england.nhs.uk
Comprehensive Geriatric Assessment (CGA)

- Evidence-based approach to the care of older people
- Helps clinicians form a holistic, patient-centred management plan
- Addresses what matters to the patient more than what is the matter with the patient
Different Domains of CGA

- Medical
- Psychological
- Functional
- Social circumstances
- Environment
Cochrane Review 2017

- CGA works!
- Review of 29 studies
- More likely to be living at home and less likely to be in a care home up to 1 year after hospital admission (compared to standard medical care)
Fit for Frailty

Identifying Frailty

Managing Frailty

Managing services for people with frailty

Developing and commissioning services for people with frailty
Managing services for people with frailty
‘Education & Evaluation’

Develop training and education packages for local needs, to enable multi-professional and cross-organisational delivery of care for frailty

Evaluation must be an integral part of service design and delivery

Education

- Providers
- Commissioners
- System wide
- Professional groups
- Academic
Developing and commissioning services for people with frailty

Develop ‘whole system’ frameworks using new structures and flexible workforce development to overcome traditional boundaries in care

Establish integrated contractual frameworks and collaborative commissioning to support and/or reinforce provider innovation
Summary

• Frailty is important
• Not disease-specific
• Early recognition helps to shape plan
• Think of frailty when a patient presents with a frailty syndrome
• Proactively look for frailty
• CGA works
• Everyone should be involved
Frailty in Practice
MDT working

Dr Elizabeth Kendrick
GPwSI Geriatrics
The Triple Aim - What

Better care for Individuals

Better health for Populations

Lower Cost
Frailty as a Long Term Condition

**NOW**

- ‘The frail elderly’
  - Late crisis presentation
    - Fall, delirium, immobility
  - Hospital-based episodic care
    - Disruptive & disjointed

**FUTURE**

- ‘An Older Person living with frailty’
  - A long-term condition
  - Timely identification preventive, proactive care
  - Supported self management & personalised care planning
  - Community based person centred & coordinated
    - Health + Social + Voluntary + Mental Health
STP Frailty Pathways

- Frailty Pathways – mild/moderate/severe
- Falls pathways
- End of Life
- Lower limb
Reducing the need and spend curve: Preventing avoidable spend in public service

- Reduce or delay need here
- Intervene here before need escalates
- Highest cost. Reduce and delay need here

Volume of spend vs Severity of need

Existing curve
The Aim from reducing the spend curve

Volume of spend and cost

Existing curve

The Achievable curve?

Healthy

Place based, social prescribing, social marketing

Diagnosed Condition Pathway Treatment

Complex

Wrap round care coordinated approach

Severity
How do we diagnose?

- EFI
- Rockwood
- Clinical judgement
- Prisma 7
Prisma 7

• 1. Are you more than 85 years?
• 2. Male?
• 3. In general do you have any health problems that require you to limit your activities?
• 4. Do you need someone to help you on a regular basis?
• 5. In general do you have any health problems that require you to stay at home?
• 6. In case of need can you count on someone close to you?
• 7. Do you regularly use a stick, walker or wheelchair to get about
MILD Frailty

- Volunteering
- Exercise
- Reducing social isolation
- Self Management
- Guide to healthy aging
Moderate Frailty

• Comprehensive Geriatric Assessment
• Prevention of admission
• Discharge home to assess
• Single Care plan
• Guide to healthy aging
Severe Frailty

- End of Life
- GSF meetings
- Single care plan
- Rehabilitation potential
Case 1

- Mrs D. W.
- 76 year old lady admitted to discharge home to assess following a fall.
- Lives alone
- Admitted from A and E
Size of the Problem

- 30% of over 65s will fall per year
- 40-60% of falls lead to injury
- 14,000 deaths per year due to falls
- 50% will lose ability to live independently
- 60% of people in care homes fall each year
Case Study continues

• Tripped when bringing bin in from outside. 2 other falls both inside.
• Takes atenolol 100mg, aspirin 75mg, and temazepam 10mg at night
• BP 146/76 dropping to 120/60 on standing
• Lives alone. No carers
• Socially isolated
Multi-disciplinary team

- OT
- Physio
- Social worker
- Nurse
- CPN
- Medical input
- Voluntary sector
Access to:

- Optician
- Dietician
- Chiropody
- Specialist services
GP MDTs

• Relationship building
• Continuity of care
• Educational opportunities
• Advice re different services
GP MDTs Markers of success

• Dedicated time to complete
• Updated in real time in records
• Right Membership
• What can we learn from GSF?
GP MDTs Practical Advice

• Who to discuss?
• Who to include?
• Timings
• Preparation
• Template
Community CGA

Assessment

- Functional
- Mobility/Balance
- Psychological/Mental
- Medication Review
- Physical
- Socioeconomic/Environmental

- Regular planned review
- Creation of problem list
- Personalised care plan
- Intervention
Making CGA work

• Single patient held documentation
• Information sharing systems
• Regular MDT review meetings to share knowledge and develop team working
Locality Networks and Introducing Group Discussions

Dr Daniel Carlton-Conway
Collaborative working
Current system

• Huge demand on health services
• Workforce issues
• Financial issues
• Often fragmented service
• Multiple providers
• Barriers between organisations
• Leads to busy patients
The paradigm shift

• Move towards commissioning services based on populations
• Working collaboratively rather than separately
• Solving shared problems
• Reducing barriers
• Shift from reactive to proactive care
• General practice needs to be at the heart
• Delivering better outcomes for patients
• Resources and funds will follow
How?

- Primary Care Networks
- Provider Delivery Board
- Re-imaging how teams function
- Re-imaging the potential of primary and community care
Primary Care Networks

- Groups of practices working more collaboratively around populations of 30,000 to 50,000
- Other members of the network could include community services, physiotherapists, OTs, pharmacy, mental health workers, voluntary sector, care navigators, etc.
- Networks will attract new resources
- Practices working more closely together, but does not require practices to merge
Advantages of networks

• Increased skill mix
• Most appropriate worker first time
• Managing demand
• Centralised management of back office functions
• Enhanced specialty care
• Shift of workers to networks
• Expanding diagnostic facilities
• Support recruitment, retention and career development
• Develops the potential of primary care
Locality Provider Delivery Board

- GP Federation
- Mental Health
- Community teams
- Social care
- District Council
- Patient Representatives
Locality provider delivery board plan 2018/2019

- Developing effective Multi Disciplinary Teams (MDTs)
- Urinary Tract Infections
  - reducing admissions from UTIs in care homes
- Frailty
  - supporting frailty work
- Falls
  - Reducing incidence and impact of falls
Forming Networks

- Geographic splits would be natural – where patients are rather than practice location
- Ideally align with practices with shared vision
- Need to balance against physical locations of patients as community teams need to be able to function
Group Discussion

1. What can we do differently for our frail patients, working more collaboratively?

2. How would your ideal multidisciplinary team function in the future? What would be different?

3. How could a primary care network better care for patients in a more proactive and preventative way?
Plenary