FRAILTY TARGET EVENT
Welcome and Housekeeping
HVCCG continues to deliver ‘Your Care, Your Future’ plans in line with the STP strategy ‘Healthier Future’ Aspirations to move care close 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)
- CHC fast track pilot with hospices (Sept 18)
- Respiratory referral management (Oct 18)
- Community nutrition and dietetics (Nov 18)
During 2019 HVCCG 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
Herts Valleys Transformation Plan
Planned Care

Significant work taking place across the planned care pathways. For 2019/20, HVCCG will be working to develop and transform these in the following areas:

- Transformation of Adult Community Services
- Cancer
- Living with and beyond Cancer
- Direct Access to Diagnostics
- Faecal Immunochemical Testing
- Frailty
- End of Life
- Urology
- Gastroenterology
- Cardiology
- Pathology
Frailty for TARGET Events 2018

Dr Ros Kings, Geriatrician WGH
Dr Clifford Lisk, Geriatrician BGH
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

But what about physiological ageing...?

Fried et al 2004
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.
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)
FUNCTIONAL ABILITIES

Independent

"Minor illness" eg UTI

Dependent
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

>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>
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<tr>
<td>4. Do you need someone to help you on a regular basis?</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>
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<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?
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
  - Identifying Frailty
  - Managing services for people with frailty
  - Developing and commissioning services for people with frailty
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)
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

Evaluation
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 preventative, 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

Volume of spend

Existing curve

Severity of need

Reduce or delay need here

Intervene here before need escalates

Highest cost. Reduce and delay Need here
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
Making CGA work

• Single patient held documentation
• Information sharing systems
• Regular MDT review meetings to share knowledge and develop team working
DACORUM LOCALITY

FRAILITY PROJECTS
Dacorum Healthcare Providers Limited

The provider arm of the

Dacorum GP Federation
For Dacorum GPs by Dacorum GPs
How the Dacorum Holistic Healthcare Team are integral to any Frailty Pathway

About collaborative model of care being jointly provided by GP Practices in Dacorum, the Holistic Team and HPFT

Other initiatives taking place within Dacorum
How the Dacorum Holistic Healthcare Team are integral to any Frailty Pathway

- The Team is key to providing care for frail and often complex
- It has an integrated and holistic approach to the care it provides and thus the Team comprises: nurses, care coordinators, a physiotherapist, an occupational therapist, a social worker and a psychiatric nurse
- It works closely with Herts Community Trust, Social Services, HPFT, community navigators, a wide range of voluntary services and, of course, Dacorum GPs
- The Team Lead and Administrator play a key role in the Multi Specialist Team which meets weekly to review patients, often frail and complex, with a myriad of social and care needs
- The Team routinely undertakes frailty assessments on behalf of Dacorum GPs
The Dacorum Integrated Mild Cognitive Impairment (MCI) Project

A collaborative model of care being jointly provided by GP Practices in Dacorum, the Holistic Team and HPFT

Patients with MCI are often frail, unsupported and have a number of medical and social needs

The aim of the project is to identify patients with MCI by undertaking a collaborative review by their GP and HPFT

HPFT will provide training for practice nurses to perform cognitive screening and assessments

Patients will be referred to the Holistic Team to assess their unrecognised care needs
Other Initiatives taking place within Dacorum

Dacorum Extended Access (DEA)
• The provision of extended access to patients from a number of hubs in Dacorum weekday evenings and at weekends
• In hours extended access at Hemel Hempstead Hospital

Clinical Pharmacists in General Practice
• DHPL have recruited 3 pharmacists as part of an NHS England Enhanced Service
• 8 practices have joined the scheme which should commence towards the end of the year

Team Working with Social Services
• It has been agreed that a “named social worker” will work with clusters of surgeries within Dacorum
• Dacorum Social services are piloting a “wellness Centre” for patients

The Dacorum Carers Project
• Aims to support people who care for someone
• Planned to hold a Carers Event in December to raise awareness of what it means to be a carer and what support is available

AND FINALLY...
Herts County Council and Quantum Care are piloting the Dacorum Wellbeing Centre at Mountbatten Lodge, Hemel Hempstead

Aim of Service

To support individuals to:
• Maximise independent daily living skills
• Improve mobility
• Educate and enable importance of healthy eating and hydration
• Improve medication management
• Access communities

To prevent/reduce:
• Reliance on care services
• Hospital admissions
• Falls risk
• Risk of self-neglect
• Loneliness and isolation
• Anxiety and build confidence
• Carer breakdown

Eligibility criteria for the service:

• People aged 65 or over living in Dacorum
• People who have no significant cognitive difficulties
• People that are continent
• People that are able to mobilise independently or with a walking aid

For further information about this service, please contact either:

Gill Malcolm, E-mail: Gillian.Malcolm@hertfordshire.gov.uk, or
Dawn Kennedy, E-mail: Dawn.Kennedy@hertfordshire.gov.uk
Tom will be very happy to answer any questions you may have?