Empowering Older People’s Care Summit: Raising Awareness of Frailty

Wednesday 25 February 2015

#frailtysummit
What do we mean by “frailty”? 

John Young
NCD for the Frail elderly & Integration

(10.30 am)
Frailty: what is it?

A summary label?

OR

An abnormal health state?

• Disability
• Long-term care
• Falls
• Mortality
25-55 year olds are physiologically similar
65 – 95 year olds are physiologically different
“Be ever booted and spurred and ready to depart”

Life expectancy woman aged 65yrs = 21yrs (HLE = 11yrs)
Life expectancy man aged 65yrs = 18yrs (HLE = 10yrs)
Prevalence rate estimates for frailty
(Systematic review of 21 cohort studies)

Community dwelling adults

>65 = 10.7%
65-69 = 4%
70-74 = 7%
75-79 = 9%
80-84 = 16%
Over 85 = 26%

Collard et al. JAGS 2012: 60; 1487-92
Frailty as a crisis presentation (the hyperacute frailty syndromes)

Frailty presenting in crisis as sudden loss of mobility/independence

Frailty presenting in crisis as a fall

Frailty presenting in crisis as delirium

Clegg, Young, Rockwood Lancet 2013
Mrs Greenaway was found on the floor (“FLOF”) with new confusion by the home care staff and taken to hospital where it was found to be poorly mobile.

- Fall
- Delirium
- Immobility

“She was a fall waiting to happen.”

Home care staff
Frailty as a progressively abnormal health state (ie a LTC)

Clegg, Young, Iliffe, Olde-Rikkert, Rockwood. Frailty in elderly people. Lancet 2013; 381: 752-762
Frailty as a LTC

Clegg, Young, Iliffe, Olde-Rikkert, Rockwood. Frailty in elderly people. Lancet 2013; 381: 752-762

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Frailty as a long-term condition?

A LTC is:
“A condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies” (DH 2012)

Frailty is:
- Common (25-50% of people over 80 years)
- Progressive (5 to 15 years)
- Episodic deteriorations (delirium; falls; immobility)
- Preventable components
- Potential to impact on quality of life
- Expensive

(Harrison, Young, Clegg, Conroy Age & Ageing 2015)
Frailty as a LTC

—I’m not as steady on my feet as I was

Ten years ago
Two years ago
One month ago

“Mum is slowing down”

‘She’s a fall waiting to happen

“Mum is slowing down”

“I’m not as steady on my feet as I was”

Ten years ago
Two years ago
One month ago

“Minor illness”

Independent
Dependent

FUNCTIONAL ABILITIES

www.england.nhs.uk
Frailty: key issues

• Related to the ageing process
• Around 10% of over 65s have frailty
• Increases to 25-50% of over 85s
• Independently associated with adverse outcomes, which are expensive
• Best understood as a long-term condition
Frailty as a crisis presentation (the hyperacute frailty syndromes)

Clegg, Young, Rockwood Lancet 2013
What does it mean to identify as frail?

Concepts of frailty
‘Lay’ v ‘specialist’ perceptions…..

• Public and non-specialist HCP’s understandings of ‘frailty’ are a long way away from the clinical definition

For the public and HCPs frailty is synonymous with people who are:

• Usually, but not always, in late old age
• At the end of their lives (link for HCPs especially strong with end-of-life cancer patients)
• Malnourished (both audiences find it extremely difficult to conceive of an overweight person as ‘frail’)
• Dependent on care
• More usually associated with women than men

• Both audiences understand the word ‘frail’ as an irreversible state
• There is no sense, even among healthcare professionals, that there are spectrums or scales of ‘frailty’
Is ‘frail’ a helpful term?

• From the perspective of the older people, carers and non-specialist HCPs the answer would seem to be **NO**
  • Frail isn’t part of older people’s vocabulary when describing themselves and their lives
  • Term provokes a very emotional reaction – usually incredulity and offense – amongst older people
  • For carers the term is less emotionally charged but still suggest a situation that is serious and irreversibly
  • For HCPs the term is not front of mind or used clinically - instead used as shorthand to describe a person perceived to be very dependent

“No, I’m definitely not frail. Frail means you’re dodderly and shaky. You can’t do anything at all.”
Female, 71, South (6 on Rockwood scale)

“Only specialist doctors use ‘frail’. For example our hospital has a frailty elderly project. The only other time I hear or see it used is on resuscitation forms as a reason for not.”
Ward Manager, South

“It’s used in end of life care for patients with cancer or very old age.”
Older GP, North
Words matter.....

Ultimately for the public, the word ‘frailty’ is understood to mean an irreversible state that some older people enter into in the very final stages of their lives that means almost total loss of independence.

Non-specialist HCPs tend to conceive of frailty as a descriptive term for a state and many had a real aversion to ‘descriptive’ language to classify patients that they wouldn’t feel comfortable using to a patient’s face.
So what do older people say?

- Older people describe frailty and wellbeing in terms of **everyday tasks** and **how it feels** if these tasks start to become difficult.

  "It’s very annoying. I can’t do things I used to do - I used to do all of my windows and my nets."

  Female, 71, South (7 on Rockwood Scale)

  "It’s disheartening really, because your brain tells you can walk but then your body can’t do it."

  Male, 83, South (6 on Rockwood Scale)

  "My house always used to be so spotless. I do feel useless sometimes that I can’t keep it like I used to."

  Female, 85, North (7 on Rockwood Scale)

  "My friend and I go out to the shops for a look around and a cup of tea and a piece of cake. It’s the highlight of my week."

  Female, 83, North (7 on Rockwood Scale)
And older people tend to conceive their ability to live independently as a ‘spectrum’……

Losing independence *entirely* and becoming totally reliant on support
- Synonymous with entering into a care home or hospital for many older people

Becoming almost or totally *unable* to manage personal hygiene *without (significant) support*
- Viewed as a distinct ‘step up’ in terms of invasiveness of support

Becoming almost or totally *unable* to do the everyday tasks important to maintaining the status quo *without (significant) support*
- When coping mechanisms and adaptations are no longer sufficient to ‘get by’

Being able to do everyday tasks to maintain the status quo *with some minor adaptations or ‘light touch’ support*
- Often through coping mechanisms older people develop themselves
- And in some circumstances, through informal help from others (e.g. relatives)

Being able to do everyday tasks that are critical to maintaining the status quo *without any support from others*
- For older women, this is particularly about keeping up the routine at home
- For men, this is often tied up with outdoor and social activities
And emotional language matches up.....

Less independent

- "Getting frail"
- "Losing control"
- "Struggling"
- "Getting slower"

More independent

- "Giving up"
- "Not coping"
- "Feeling frustrated"
- "Feeling tired"

- "Feeling weak"
- "Feeling vulnerable"
- "Feeling low"
- "Finding things tough"

The status quo......
And non-specialist HCPs:

- Non-speciality HCPs are very in tune with older people...
  - Describe an older patient’s general wellbeing in terms of the everyday tasks that they can and can’t complete independently
  - Place importance on their patients’ attitude to life and their mood/mental wellbeing
  - Focus on older people maintaining their independence as the ultimate priority
  - Feel strongly their role is to support older people in this goal as far as possible
  - Tend to mirror the practical language and ‘common sense’ approaches adopted by older people

“Professionally, older people are 80+ but it doesn’t always feel like that. It’s really dependent on their condition and their state of mind. They just want to go back home and be as independent as they can be. And if they can’t then they normally sort of start to give up.”

Ward manager, South

“The language we use for older patients is mostly in terms of function. It’s not especially personal or emotional a lot of the time - it’s to the point. We’d say ‘to retain their independence, someone at this functionality needs this type of support.’”

Ward manager, South

“Their attitude is so important to maintaining their health. Whether they’ve still got that glint in their eye.”

Practice nurse, North
Engaging with support

• When older people begin to move up the ‘spectrum’ of frailty, their first instinct is to find their own solutions
• Past a certain ‘trigger point’ people often recognise they are ‘struggling’ – some become more open to external support
  • People without previous experience tend to have low awareness of the types of support available and be much more resistant
• Medical professionals are not naturally seen as the first port of call
• HCPs highly aware of this barrier, but find it difficult to overcome in practice

“I wouldn’t tell this gentleman [in the case study] to go to his GP, no... He can still get about so he doesn’t need a carer or to go into a home. He’s better off managing on his own for as long as he can.”
Male, 79, North

“Why on earth would I tell my GP it’s taking me longer to do the ironing and I can’t get out into the garden any more?! He’s a serious doctor who I go to when I’ve got an ailment, he doesn’t need to be bothered with that rubbish.”
Female, 73, South

“We’ll have people who are admitted purely to buy some time while their care package gets set up. It’s like they’ve been hiding all this time and then they suddenly get ‘found out’ and their lives get turned upside down.”
Ward manager, Southampton
In summary.....

• Frailty is synonymous with very old age, malnutrition and end of life – *an end state with no return*

• Not very surprising then that older people don’t self-identify as frail – and in practice HCPs/ carers tend not to use this language either....

• Frailty framed through very practical everyday tasks and life style issues – and, critically, *how people feel* when and if they become more difficult

• HCPs tend to be very in tune with older people and carers – clear focus on practical tasks and mirror older people’s emotional language and common sense approaches

• Desire to be independent is both a barrier and an opportunity – great motivator *however*.... low awareness of support and ideas that the only solution is to cope for as long as possible..... can mean help isn’t sought or actively resisted.....
Older People’s Experience of Care

Catherine Thompson
Head of Patient Experience

25/02/2015
Older people generally report more favourably

Net satisfaction with the running of the NHS

1. Overall satisfaction has increased since early 1990s (though now falling?)
2. But pre-war generation have always been much happier with NHS
3. Younger generations are close to each other in attitude – i.e. less satisfied

Data: BSA 1983-2010. Each data point represents >100 respondents
Older patients typically give more positive responses when asked about their experiences of NHS services

- Older patients are more likely to report that they were treated with respect and dignity and had confidence and trust in the people treating them.

- Some of the variation in experience may be due to differences in expectations rather than differences in care.

- Older patients do not consistently report more positive experiences.

- Those over 75 are less likely to report that they understand the explanations given to them about their treatment and medicines.
# CQC Inpatient Survey Scores

## Overall Inpatient Survey Score

<table>
<thead>
<tr>
<th>Score Range</th>
<th>16 - 64</th>
<th>65 - 69</th>
<th>70 - 74</th>
<th>75 - 79</th>
<th>80 - 84</th>
<th>85+</th>
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<tbody>
<tr>
<td>75.8</td>
<td>78.9</td>
<td>78.6</td>
<td>78.1</td>
<td>76.1</td>
<td>73.2</td>
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</table>

## Safe, high quality, coordinated care

<table>
<thead>
<tr>
<th>Score Range</th>
<th>16 - 64</th>
<th>65 - 69</th>
<th>70 - 74</th>
<th>75 - 79</th>
<th>80 - 84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>65.4</td>
<td>68.8</td>
<td>68.0</td>
<td>67.7</td>
<td>64.9</td>
<td>62.1</td>
<td></td>
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</tbody>
</table>

## Better Information, more choice

<table>
<thead>
<tr>
<th>Score Range</th>
<th>16 - 64</th>
<th>65 - 69</th>
<th>70 - 74</th>
<th>75 - 79</th>
<th>80 - 84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.3</td>
<td>72.7</td>
<td>71.0</td>
<td>69.4</td>
<td>64.2</td>
<td>57.9</td>
<td></td>
</tr>
</tbody>
</table>
## Older People’s Dashboard

### Data Table

<table>
<thead>
<tr>
<th>Region</th>
<th>Area Team Code</th>
<th>Area Team Name</th>
<th>Overall Inpatient Survey Score</th>
<th>Access and Waiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midlands and East of England</td>
<td>Q54</td>
<td>Birmingham And The Black Country</td>
<td>76.8</td>
<td>83.8</td>
</tr>
<tr>
<td>Midlands and East of England</td>
<td>Q55</td>
<td>Derbyshire And Nottinghamshire</td>
<td>76.8</td>
<td>83.8</td>
</tr>
<tr>
<td>Midlands and East of England</td>
<td>Q56</td>
<td>East Anglia</td>
<td>78.3</td>
<td>83.8</td>
</tr>
<tr>
<td>Midlands and East of England</td>
<td>Q57</td>
<td>Essex</td>
<td>74.2</td>
<td>83.8</td>
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<tr>
<td>Midlands and East of England</td>
<td>Q58</td>
<td>Herefordshire And The South Midlands</td>
<td>73.7</td>
<td>83.8</td>
</tr>
<tr>
<td>Midlands and East of England</td>
<td>Q59</td>
<td>Leicester And Lincolnshire</td>
<td>72.4</td>
<td>83.8</td>
</tr>
<tr>
<td>Midlands and East of England</td>
<td>Q60</td>
<td>Shropshire And Staffordshire</td>
<td>78.3</td>
<td>83.8</td>
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<tr>
<td>London</td>
<td></td>
<td>London AT</td>
<td>74.1</td>
<td>83.8</td>
</tr>
<tr>
<td>South of England</td>
<td></td>
<td>Bath, Gloucestershire, Swindon And Wilts</td>
<td>76.2</td>
<td>83.8</td>
</tr>
<tr>
<td>South of England</td>
<td>Q64</td>
<td>Cotswold, North Somerset, Somerset And South Gloucestershire</td>
<td>76.2</td>
<td>83.8</td>
</tr>
<tr>
<td>South of England</td>
<td>Q65</td>
<td>Devon, Cornwall And Isles Of Scilly</td>
<td>76.2</td>
<td>83.8</td>
</tr>
<tr>
<td>South of England</td>
<td>Q66</td>
<td>Kent And Medway</td>
<td>72.9</td>
<td>83.8</td>
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</tbody>
</table>

The table provides data on overall inpatient survey scores and access and waiting times for different regions and area teams in England. The data is presented in a Microsoft Excel format, with regions and area teams listed in the first column, followed by specific metrics for each category.
High quality care for all, now and for future generations

Patient-led assessments of the care environment (PLACE)

Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments will provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

April 2013 saw the introduction of PLACE, which is the new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments will apply to hospitals, hospices and day treatment centres providing NHS funded care.

The assessments will see local people go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.

The assessments will take place every year, and results will be reported publicly to help drive improvements in the care environment. The results will show how hospitals are performing nationally and locally.

PLACE assessment forms and supporting
Patient Centred Visiting

Imperial College Healthcare NHS

Carers are welcome here

We welcome the Carers of our patients in the ward. We would like to work in partnership with you.
If you are a Carer, please ask for a Carer’s Passport and let the staff know who you are.

I am a carer
I am the main carer for this patient and this card allows me to visit them outside of visiting hours

Name:_____________________
Ward:_____________________
Ward No:__________________
Additional agreements:_______
_________________________________

Imperial supports John’s Campaign
www.johnscampaign.org

www.england.nhs.uk
Nutrition and Hydration

- Quality of hospital food
- Recognition of malnutrition and dehydration
- NHS England commissioning support tools
- Training for health and care professionals
- Tackling the problem of food packaging
Continence and Toileting

- Understand current provision of continence services in England
- NHS England commissioning resource
- Appropriate assessment and treatment
- Provision of appropriate continence products
- Levers and incentives
## Contents

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7. Section title 25
8. Section title 27
9. Section title 31
10. Section title 36
11. Section title 38
12. Section title 41
You can use a maximum of two different types of icon per slide

You can use the same type of icon more than once on a page

- You can use icons as bullet points
- This can help when you are making lists
- If you resize an icon, keep the proportions the same
Our icons - blue
Our icons - pink
Our icons - dark blue
Our icons – light blue
Our icons – white
How do we identify people living with “frailty”?

John Young
NCD for the Frail elderly & Integration

#frailtysummit

(11.15 am)

www.england.nhs.uk
Hands up who’s frail?
Diagnostic Test Accuracy (DTA) for simple frailty instruments (Systematic Review)

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity</th>
<th>Specificity</th>
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<tbody>
<tr>
<td>Gait Speed &lt;0.8m/s</td>
<td>99%</td>
<td>64%</td>
</tr>
<tr>
<td>Gait Speed &lt;0.7m/s</td>
<td>93%</td>
<td>78%</td>
</tr>
<tr>
<td>TUGT &gt;10s</td>
<td>93%</td>
<td>62%</td>
</tr>
<tr>
<td>PRISMA 7</td>
<td>83%</td>
<td>83% (wide CIs)</td>
</tr>
<tr>
<td>Self-reported Health</td>
<td>83%</td>
<td>72% (wide CIs)</td>
</tr>
<tr>
<td>Groningen Frailty Indicator</td>
<td>58%</td>
<td>72%</td>
</tr>
<tr>
<td>Polypharmacy (&gt;5 meds)</td>
<td>67%</td>
<td>72%</td>
</tr>
<tr>
<td>GP clinical assessment</td>
<td>58%</td>
<td>72%</td>
</tr>
</tbody>
</table>

(Frailty instruments assessed against a reference standard)

(Clegg, Rodgers, Young Age & Ageing 2014)
Identification of frailty in practice

1. Comprehensive geriatric assessment (CGA) (Structured, multi-disciplinary assessment)
2. Simple assessment
   - Gait speed/timed-up-and-go test
   - Questionnaires (e.g. PRISMA 7)
   - Brief clinical tools (e.g. Edmonton frail scale)
3. Routine data
The 4m walking speed test detects frailty

Taking more than 5 seconds to walk 4m predicts future:

- Disability
- Long-term care
- Falls
- Mortality

Van Kan et al JNHA 2009; 13:881
Systematic Review of 21
Prisma 7 Questions

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?

**score of 3 or more indicates frailty**


www.england.nhs.uk
Identification of frailty using existing primary care data

- **Question:**
  - Is it possible to construct a frailty index using existing data contained in the electronic GP record?

- **Answer:**
  - Yes
  - We have developed & validated an electronic frailty index (eFI) using de-identified data from around 500,000 UK GP patients records, using the ResearchOne database.
Cumulative Deficit Model of Frailty: Frailty Index (Rockwood et al)

“The more things that are wrong with you, the more likely you are to be frail”

- Frailty Index counts “deficits”
- A deficit is a think that is wrong with you (symptom, sign, disease or disability)

Frailty Index = the proportion of deficits accumulated over time

**Simple calculation:**
- Zero deficits from list of 50: FI = 0/50 = 0
- Ten deficits from list of 50: FI = 10/50 = 0.20
- Frailty Index(s) based on deficit accumulation closely related to risk of death (Mexico, China, Canada, Europe etc. …)
<table>
<thead>
<tr>
<th>Activity limitation</th>
<th>Ischaemic heart disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaemia &amp; haematinic deficiency</td>
<td>Memory &amp; cognitive problems</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Mobility and transfer problems</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>Parkinsonism &amp; tremor</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>Peptic ulcer</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Polypharmacy</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>Requirement for care</td>
</tr>
<tr>
<td>Falls</td>
<td>Respiratory disease</td>
</tr>
<tr>
<td>Foot problems</td>
<td>Skin ulcer</td>
</tr>
<tr>
<td>Fragility fracture</td>
<td>Sleep disturbance</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>Social vulnerability</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Heart valve disease</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>Housebound</td>
<td>Urinary system disease</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Visual impairment</td>
</tr>
<tr>
<td>Hypotension/syncope</td>
<td>Weight loss &amp; anorexia</td>
</tr>
</tbody>
</table>
Primary care electronic Frailty Index (eFI): survival plots \((n=227,648; \, >65y)\)

Proportion alive

"Yes, you can"

Love from, HSCIC

www.england.nhs.uk
Read Codes for Frailty (Oct 2014)

CTV3
X76Ao | Frailty
  XabdY | Mild frailty
  Xabdb | Moderate frailty
  Xabdd | Severe frailty

Read V2
2Jd.. | Frailty
  2Jd0. | Mild frailty
  2Jd1. | Moderate frailty
  2Jd2. | Severe frailty
Primary care electronic Frailty Index (eFI): survival plots (n=227,648; >65y)
Summary…

• Gait speed (4m/5sec)

• PRISMA 7 questionnaire

• eFI

• (CGA)

http://www.bgs.org.uk/index.php/fit-for-frailty
Helen Lyndon

Case Finding and Risk Stratification

#frailtysummit
Care and Support for Older People Living with Frailty in Action

• Introduction to NHS England service component handbooks:
  ✓ Risk stratification and case finding
  ✓ Personalised care and support planning
  ✓ Multidisciplinary team working

• Service components – examples from practice
NHS England Service Component Handbooks

Using case finding and risk stratification:
A key service component for personalised care and support planning

Personalised care and support planning handbook:
The journey to person-centred care
Executive Summary

MDT Development
- Working toward an effective multidisciplinary/multiagency team
Case Finding and Risk Stratification: Clinical Uses

To identify:

- people with highly complex, multiple morbidity and/or frailty who might benefit from multi-disciplinary team support as part of case management and care planning;
- specific service needs of patient groups to improve their quality of care, experience of care and clinical outcomes;
- suitable patients for the caseload of specialist nursing or medical services
- people who need end of life advance care planning.
Planning work for commissioning services and contracts such as:

- for setting up capitated budgets.
- to inform Better Care Fund distribution for people with multiple LTCs.
- Planning pathway re-design.
Case finding in frailty: a warning

Risk stratification is not always effective because:

- one third of older people with frailty have only one LTC, or none at all*, these people can remain invisible within the operating parameters of risk stratification tools based on LTCs.
- older people with this condition typically use health resources most intensively during the last year of life. This implies a late diagnosis in the trajectory of frailty when preventative interventions may be ineffective.

Personalised care and support planning for people living with frailty

<table>
<thead>
<tr>
<th>When care plan….</th>
<th>True/false</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I make an assessment of the patient</td>
<td></td>
</tr>
<tr>
<td>2. I pass on lots of information to the patient</td>
<td></td>
</tr>
<tr>
<td>3. I do most of the talking</td>
<td></td>
</tr>
<tr>
<td>4. I follow a template closely</td>
<td></td>
</tr>
</tbody>
</table>

Making a care plan v care planning
CARE & SUPPORT PLANNING

What is care and support planning?
Care and support planning encourages clinicians and people with long-term conditions to work together to clarify and understand what is important to that individual. They agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a planned and continuous process, not a one-off event.

http://coalitionforcollaborativecare.org.uk/

• An equal partnership based on a trusting relationship
• A conversation, building the narrative
Care and Support Planning in Action

- **Person’s Story**
  - Information gathering
  - Information Sharing
  - Goal Setting and Action Planning
  - Agreed & shared ‘care plan’

- **Professional Story**
Comprehensive Geriatric Assessment

- The gold standard for the management of frailty
- It involves an holistic, multidimensional, interdisciplinary assessment of an individual
- Demonstrated to be associated with improved outcomes in a variety of settings
- CGA typically 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.
Domains of the CGA

- Physical Symptoms – include pain, underlying LTCs
- Mental Health Symptoms – include memory, mood
- Level of function in daily activity – include personal care and life functions
- Social Support Networks – include informal and formal. Consider family/carer needs
- Living Environment – state of housing, facilities and comfort.
- Level of Participation and individual concerns
- Compensatory mechanisms and resourcefulness which the individual uses to respond to having frailty.

**Initial Comprehensive Geriatric Assessment Form**

**Kernow Clinical Commissioning Group**

---

### Personal Details

- **Name:**
- **Role:**
- **Date of Birth:**
- **Gender:**
- **Address:**
- **Telephone:**
- **GP:**
- **QOF:**
- **Disability:**

---

### Cognitive Function

- **Within Normal Limits:**
- **Mild Cognitive Impairment:**
- **Dementia:**
- **Mental Capacity/Consent Required:**

---

### Emotional Function

- **Within Normal Limits:**
- **Mood:**
- **Depression:**
- **Anxiety:**
- **Suicide Risk:**
- **Mood Regulation:**

---

### Medication

- **Prescribed:**
- **Over the Counter:**
- **Illegal:**
- **Other:**
- **Prescription Status:**

---

### Health Attitude

- **Excellent:**
- **Good:**
- **Fair:**
- **Poor:**
- **Unstable:**

---

### Communication

- **Within Normal Limits:**
- **Impaired:**
- **Language:**
- **Within Normal Limits:**
- **Impaired:**

---

### Mobility

- **Within Normal Limits:**
- **Impaired:**
- **Falls:**
- **Falls Frequency:**

---

### Activity

- **Within Normal Limits:**
- **Impaired:**
- **Social:**
- **Engaged:**

---

### Clinical Data

- **Confused:**
- **Cataracts:**
- **Strokes:**
- **Diabetes:**
- **Hypertension:**

---

### Social Support

- **Marital Status:**
- **Social Support:**
- **Caregiver Relationship:**
- **Caregiver Stress:**

---

### Long-Term Conditions

- **Type:**
- **Severity:**
- **Onset:**

---

### Other Information

- **For MDT Discussions, consider long COG:**
- **Long COG:**
- **COG and:**
- **Date of Clinical Frailty seen by GP:**

---

**Assessor**

(Name, Grade & Signature)  
Date:  

---

**PLEASE TURN OVER**
Multidisciplinary Team Working

‘A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations’

Five Year Forward View New Models of Care:
• Multispeciality Community Providers (MCPs)
• Primary and Acute Care Services (PACS).
MDT Working in Action: Cornwall
‘Living Well’.

• An opportunity for a structured conversation about a person who has complex issues, involving a range of practitioners, patients and carers.

• Each practitioner/person brings their knowledge about the person and / or their area of specialist knowledge, to inform and jointly create an anticipatory care and action plan, which will be coordinated by the most appropriate key worker (as determined at the MDT).

• The information gathered will be shared and used to complete assessments requirements, to prevent duplication of work and ensure accuracy of information, e.g. Comprehensive Geriatric Assessment, Anticipatory Care Plans.
MDT Working in Action: Cornwall ‘Living Well’.

- Improved communication and coordination, reducing duplication and preventing people falling between services
- Better experience for people as it prevents ‘ping pong’ around the system
- Provides more robust understanding about a person and their situation and therefore their support needs, matching the right practitioner to the person.
- Improved integration and trust
- Identification of and use of a wider range of resources
- Proactive approach to managing support
Coordinated community care models

Shaping care around communities in line with needs and assets

1. Peer groups
2. Community groups and pharmacies
3. Integrated locality team health, social care and VCS
4. Domiciliary care providers
5. Getting specialist help

Guided Conversation PCSP

Living Well
Pioneer for Cornwall and the Isles of Scilly

Frailty Screening

Acute hospitals

Living well
Managing a crisis effectively
House of Care

Catherine Thompson
Head of Patient Experience
The House of Care

Organisational and clinical supporting processes

Engaged, informed individuals and carers

Person-centred coordinated care

Health and care professionals committed to partnership working

Commissioning
Click on the links for more information about each component and use this to build your own house

www.england.nhs.uk
Lunch 12:30 – 13:30 pm

• Empowering Older People’s Care Summit: Raising Awareness of Frailty

• Tweet #frailtysummit
Building resilience amongst older people

Deeper, wider, richer networks for support
Building resilience for individuals and families

- Resilience = having the capacity to manage everyday life and the ability to deal with problems and ‘shocks’
What does good resilience look like?

<table>
<thead>
<tr>
<th>Mental and physical</th>
<th>Social</th>
<th>Financial</th>
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</thead>
<tbody>
<tr>
<td>• Able to maintain wellbeing and independence</td>
<td>• Strong individual and family networks</td>
<td>• Having a decent income</td>
</tr>
<tr>
<td>• Supported to manage health and care needs</td>
<td>• Inclusive safe places to live</td>
<td>• Sufficient resources to cope with financial shocks</td>
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<tr>
<td>• Able to achieve health and wellbeing goals</td>
<td>• Access to good social infrastructure</td>
<td>• Able to manage increased cost associated with disability and ageing</td>
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<tr>
<td>• Access to health and care services</td>
<td>• Having a role and feeling valued in society</td>
<td></td>
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</tbody>
</table>
Personalised services and support working together around individual needs

- Healthcare
- Housing
- Community
- Social care
- Social networks
- Financial security

Individual older person
Interventions along the pathway: what works?

John Young
NCD for the Frail elderly & Integration

(10.30 am)
Summary of the evidence base

Recognising and managing frailty in primary care

- Frailty is a distinct health state where a minor event can trigger major changes in health from which the patient may fail to return to their previous level of health.
- Simple tests with high sensitivity for frailty are gait speed, the timed up-and-go test and the PRISMA 7 questionnaire.
- Comprehensive geriatric assessment is essential in the management of moderate to severe frailty.
- Exercise programmes, particularly high intensity interventions, may improve gait, balance and strength and have positive effects on fitness.
- Supported self-management can improve health outcomes. However, the value of case management has still to be proven.

This issue of Effectiveness Matters has been produced by CRD in collaboration with the Yorkshire and Humber AHSN Improvement Academy. The views expressed in this bulletin are those of the authors and not necessarily those of the AHSN or the University of York.

The University of York
Centre for Reviews and Dissemination

http://www.york.ac.uk/inst/crd/effectiveness_matters.htm
# Evidence summary: interventions for older people

<table>
<thead>
<tr>
<th></th>
<th>Living at home</th>
<th>Death(s)</th>
<th>Nursing home</th>
<th>Acute admission</th>
<th>Emerg admissions</th>
<th>Re-admis</th>
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<td>Hosp based CGA</td>
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<td>Com based CGA</td>
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<td>Case mgt</td>
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<td>Nurse-led home visits</td>
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**N=22 RCTs**

$\text{n}=10,315$

**N=89**

$n=97,984$

**N=26**

(RCTs=17)

**N=11 RCTs**

$n=1736$

**N=18**

$n=13,447$

**222 SRs**

**N=19**

RCTs

$n=10865$

- **Reduced mortality & increased function but in context of multiple (>9) visits; geriatric training; CGA; collaborative working**
- **Case mgt varies in content. Overall, no impact on acute admission rates**
- **Increases knowledge about condition; how to self-care; improves confidence and coping; improves appropriate use of health care**
- **Improvements in indicators of physical, psychological health, ability to self-manage condition and self-care**
A life course approach to frailty/multiple-comorbidity

LTC System of Care
- Embedded E-audit system
- General & specialist care

Care & Support Planning

Single LTC

Standardised care

Multiple LTCs/Frailty

Individualised care

www.england.nhs.uk
A life course approach to frailty/multiple-comorbidity

LTC System of Care
- Embedded E-audit system
- General & specialist care

Prevention

Care & Support Planning

Single LTC

Multiple LTCs/Frailty

Standardised care

Individualised care

www.england.nhs.uk
Candidate Preventable Components for “Frailty”

- Alcohol excess
- Cognitive impairment
- Falls
- Functional impairment
- Hearing problems
- Mood problems
- Nutritional compromise
- Physical inactivity
- Polypharmacy
- Smoking
- Social isolation and loneliness
- Vision problems

(Systematic review of 78 studies)

Additional topics:
- Look after you feet
- Make your home safe
- Vaccinations
- Keep warm
- Get ready for winter
- Continence
- ..........others........??

A Practical Guide to Healthy Ageing

www.england.nhs.uk
A practical guide to healthy ageing
Try this at home

Have you noticed it's taking longer to get to the bus stop than it used to? Or that your weekly supermarket shop takes longer than before?

These can be signs that you've started slowing down.

If you've noticed you're a little slower than you used to be, or even if you haven't, you may want to try this simple test which will let you know if the 'slow-down' process of later life is affecting you. It is called the Walking Speed Test. You can do it easily at home. All you need is a tape measure and a watch with a second hand or mobile phone with a stopwatch function.

Using a tape measure, mark out on the ground two lines 4 metres (13 feet) apart.

Stand next to the first line.

Walk at your usual speed (using a walking aid if you usually use one) until a few steps past the 4-metre mark (don't slow down as you approach the mark).

Your friend/helper should say "Go" and start timing you.

As you pass the 4-metre mark, your friend/helper should stop timing you.

Repeat three times, allowing sufficient time to recover between tests.

If you take more than 5 seconds to walk, at normal speed, a measured distance of 4 metres (13 feet), then it is likely you are affected by the slowing down process of later life. Of course, some people walk slowly for other reasons – perhaps knee or hip arthritis, for example. But the test will give you a good indication of your general fitness. If you have slowed down you may want to try some simple exercises. If you have any concerns, you may wish to see your GP or nurse to discuss things further.

www.england.nhs.uk
Look after your eyes

Your eyes should give you a lifetime’s service, but sometimes they can be affected by conditions that develop as you grow older.

You can help keep your eyes healthy by:
- not smoking – smoking damages the eye making it more likely to develop age related macular degeneration and cataracts
- eating lots of fruit and vegetables
- protecting them from the sun by wearing sunglasses.

It’s easy to neglect your eyes because they rarely hurt when there’s a problem. Having an eye test will not only tell you if you need new glasses, it also checks the health of the eye and can pick up eye conditions before you may be aware of them so they can be treated early. If you have a low income, you may be eligible for help with the cost should you need glasses or contact lenses.

An eye test can pick up eye conditions, such as glaucoma and cataracts, as well as general health problems, such as diabetes and high blood pressure.

The good news is that if you’re 60 or over, you can have a free NHS eye test every two years. You can have a free test every year if you’re 70 or over.

Make your home safe

Have a look round your home and check for some simple things you can do to make your home as safe as possible:

- Remove any clutter on the stairs that might trip you up.
- Use plug-in night lights that turn on automatically at night. They provide a low light so you can see your way to the bathroom or stairs.
- Loose rugs and mats can be a trip hazard and should be avoided if possible.
- Replace frayed carpets or repair with double-sided carpet tape.
- Coil up any long or trailing electric leads, particularly around doorways or stairs, or tape them close to the wall.
- Don’t walk on slippery floors in socks or tights. Wear well-fitting slippers.
- Don’t wear loose-fitting, trailing clothes that might trip you up, such as a long dressing gown.
- Make sure you have good lighting, especially on the stairs.
- It’s easy to slips in the bathroom. Consider getting a non-slip bath mat and a handrail to help you feel more stable.
- Consider getting and wearing a personal alarm, particularly if you live on your own. This will let you contact a 24-hour response centre at the touch of a button should you fall or become unwell. Don’t be afraid or embarrassed to push the button if you need to. The response centre will be glad to reassure you or call for help.
- Check fire & carbon monoxide alarms are installed and working correctly. The fire brigade may be able to fit and check free fire alarms.
- If you have an electric blanket, get it tested at least every three years and replace it every ten years. Check for danger signs such as frayed fabric and scorch marks. You can ask the shop where you bought it about testing and servicing, or contact the trading standards department at your local council – they often have free testing days.
A life course approach to frailty/multiple-comorbidity

LTC System of Care
- Embedded E-audit system
- General & specialist care

Prevention

Proactive care

Care & Support Planning

Single LTC

Multiple LTCs/Frailty

Standardised care

Individualised care
Mrs Greenaway was found on the floor (“FLOF”) with new confusion by the home care staff and taken to hospital where is was found to be poorly mobile.

- Fall
- Delirium
- Immobility

“She was a fall waiting to happen.”

Home care staff
Another view of Mrs Greenaway

85 years
Lives alone
Recently in hospital following a fall
Broken hip 2011
Chronic heart failure
Diabetes
Chronic Kidney Disease
Taking 10 medications

System designed to fragment care into packages

...... and the frailty???
The burden of multimorbidity

Applying NICE guidelines to a 78 yr old woman with previous myocardial infarction; type-2 diabetes; osteoarthritis; COPD; and depression……………………………

- 11 drugs (and possibly another 10)
- 9 lifestyle modifications
- 8-10 routine primary care appointments
- 8-30 psychosocial interventions
- Smoking cessation appointments
- Pulmonary rehabilitation

*(Hughes et al Age & Ageing 2013)*

“I’d like my life back please!”

www.england.nhs.uk
Yet another view of Mrs Greenaway

What are the most important things you’d like to discuss today?

1. The pain in my feet
2. Difficulty sleeping
3. Getting out for a chat
4. I don’t like all these tablets; do I really need them all?
A life course approach to frailty/multiple-comorbidity

Proactive care

Proactive Care Model
- Identification
- “Conversations”
- Care Planning/CGA
- Info sharing (e-system)
- Reviews and updating

EoLC ACP (EPaCCS)

Guideline medicine

Planning

Single LTC

Multiple LTCs/Frailty

Standardised care

Individualised care
Frailty & palliative care

Gill NEJM 2010
A life course approach to frailty/multiple-comorbidity

LTC System of Care
- Embedded E-audit system
- General & specialist care

Proactive Care Model
- Identification
- “Conversations”
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EoLC ACP (EPaCCS)

Prevention
Proactive care
Planning

Single LTC
Multiple LTCs/Frailty

Standardised care
Individualised care

www.england.nhs.uk
Evidenced-based approach for older people with frailty (& multimorbidity) in primary care

- Assess for frailty during all healthcare encounters
- Record frailty, and frailty severity, using Read codes
- In people with moderate or severe frailty, carry out a comprehensive geriatric assessment to:
  - diagnose medical illnesses and optimise treatment
  - conduct a medication review
  - generate a personalised care and support plan
- Refer for specialist assistance in complex or uncertain diagnoses
- Share health record information between primary care, emergency services, secondary care and social services.
- In people with very severe frailty, offer Advance Care Planning

Effectiveness Matters: Recognising and managing frailty in primary care
Care and Support for Older People Living with Frailty in Action

- Implementing a frailty pathway
- Using a frailty toolkit in primary care
- The role of community and general practice nurses – NHS England Central Nursing Directorate Strategy
If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm.

This document summarises the evidence of the effects of an integrated pathway of care for older people and suggests how a pathway can be commissioned effectively using levers and incentives across providers.

http://www.england.nhs.uk/ourwork/pe/safe-care/
Progress Since April 2014

- Publicising and supporting implementation of Frailty Pathway Guidance
- Visits to 15 CCGs/stakeholders/partners
- 6 masterclasses for Primary Care
- 3 webinars hosted by NHS England national team
- Links made through Commissioning Nurse Network, Commissioning Assembly and many others
- Regional events to launch frailty products and service components
- Development of the concept of frailty as a LTC in primary care supported by a toolkit
A model of care for those who are frail or who have complex care needs in Cornwall and Isles of Scilly

Elements and standards of a ‘Home-to-Home’ Frailty Care Pathway

Cross-organisational standards
Frailty Toolkit for Primary Care

Includes:

• Case finding tools and advice
• How to populate frailty registers and read coding
• Comprehensive geriatric assessment
• Care coordination
• Care planning
• Medication review in frail older people
Transforming Nursing for Community & Primary Care

February 2015
Core Narrative

New Models Of Care
Contribute to implementation

Good Practice
Development and support in line with the 5YFV

The Shape Of Caring
Contribute to the workforce strategy

6 Cs
Embedding the values of Compassion in Practice

www.england.nhs.uk
Where are we now?

- Meeting the health and care needs of people in their local communities
- New Models of Care - right skills, values and behaviours to deliver them
- Aging population
- Engage and mobilise Community and Primary Care Nursing
- Inspiring nursing in partnership
Where do we need to be?

- Changing Communities – secondary prevention
- Patient Engagement
- Upskilled Workforce – across all healthcare
- Coordinated Approach
What Next

• Communication & engagement

• Mobilise – in partnership with regions

• Build a strong community workforce – Ten point plan

• Continue to listen – National forum

• Embed & action the 5YFV
What have we done so far?

**Commissioning Development**
- Sharing good practice
- Pricing & Incentives
- Frail Older People
- Supporting Community & PC Nursing

**Integration**
- Joint medical & nursing collaboration
- Service component handbooks

**Prevention**
- Securing clinical leadership
- Commissioning tools & levers
- Working in partnership
- Action planning
- Supporting carers

**Workforce**
- Education & career pathways
- Workforce planning
BREAK

#frailtysummit
INTERACTIVE SESSION

#frailtysummit
INTEGRATING SERVICES:
ASK THE EXPERTS
Round Up - CLOSE

#frailtysummit