Identifying and Understanding Frailty

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North Derbyshire CCG Joint Quest Session
8th February 2017
• What is frailty?

• Why is identifying & understanding frailty important?

• How can we do this?

• What difference will it make?
WHAT IS FRAILTY?
Setting the scene
Ageing Population: UK 1984 - 2014

People aged ≥ 100 years: 3,250 to 14,450
People aged ≥ 90 yrs: 187,000 to 550,000
People aged ≥ 65 yrs: 8.46 to 11.63 million
Total population: 56.4 million to 64.6 million
What is frailty?

- Reduced resilience and increased vulnerability to decompensation after a stressor event
- ‘The most problematic expression of human ageing’ (Clegg 2013)
What is frailty?

Related to but distinct from ageing, comorbidity and disability.
What is frailty?

An important part of many life stories.

Related to but distinct from ageing, comorbidity and disability.
WHY IS IDENTIFYING & UNDERSTANDING FRAILTY IMPORTANT?
Helps to improve the care and support that we offer to older people.
‘Making our health and care systems fit for an ageing population’

The Kings Fund, 2014
‘Fit for Frailty’
The British Geriatric Society, 2014/2015

- Advice and guidance on the **recognition and management of frailty in community and outpatient settings**

- Advice and guidance on the **development, commissioning and management of services for people living with frailty in community settings**
‘Fit for Frailty’ – Overall Framework

Developing & Commissioning Services

Managing Services

Managing Frailty

Identifying Frailty
‘Fit for Frailty’ – Implementation

- **Clinical development** supporting the identification and management of frailty, including evaluating local development needs and providing tailored educational packages

- **System management** supporting innovative approaches to the development, commissioning and evaluation services to meet the complex needs of people with frailty
Living with frailty

Right care, right time, right place can influence frailty trajectories

People living with frailty have most to gain from integrated and person-centred care

Needs addressed in isolation → Holistic approach to care

Fragmented system of care → Integrated system of care

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Caring for our Carers: In Support of Older Peoples Day – Dawn Moody

Three in five of us will be carers at some point in our lives and for many of us these responsibilities will begin or continue into our older age. Dawn Moody, Associate National Clinical Director for Older People, marks Older Peoples Day (1 October) with a blog on the importance of caring for our carers.
HOW CAN WE IDENTIFY & UNDERSTAND FRAILTY?
What does frailty look like?

The Frailty Phenotype

Syndrome characterised by 3 or more criteria

- Unintentional weight loss (4.5kg in last year)
- Self reported exhaustion
- Weakness (grip strength)
- Slow walking speed (<0.8 metres/second)
- Low physical activity
What is frailty made of?

Cumulative Deficits

- The more things that go wrong, the greater the risk of adverse outcomes.

- At some point the number of problems becomes more important than the individual problems themselves.

- Expressed as a ‘Frailty Index’ (FI), calculated as the number of deficits present/the total number of deficits being assessed, e.g. if 9 deficits are present out of 36 assessed, FI = 0.25.

What does frailty feel like?

Multi-dimensional model of frailty

- The experience of living with frailty depends upon much more than a person's physical health.

- It is also influenced by a range of other factors, for example a person's mental health, their family and social environment and their living conditions.

- A multi-dimensional model of frailty is well aligned to the biopsychosocial framework of General Practice.
The Frailty Fulcrum

A model to understand the dynamics & complexity of frailty.

**News**

The Frailty Fulcrum – Dr Dawn Moody

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The concept of frailty as a long-term condition brings with it the opportunity to adopt a much more proactive, person-centred, community-based approach to care.

Achieving this requires a new approach to care, particularly through supporting self-care. This new approach will be enabled through a wider awareness of frailty and a greater shared understanding of the condition.
Identifying frailty – tools & context

Opportunistic assessment
Opportunistic assessment

Simple instruments
- e.g. Gait Speed Test, TUGT, Prisma 7

Clinical assessments
- e.g. Rockwood Clinical Frailty Scale, Edmonton Frail Scale
The Gait Speed Test

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 the simple test opposite which will let you know if the ‘slowing-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 a 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, it’s likely you’re affected by the slowing-down process of later life. Of course, some of us walk slowly for other reasons, such as arthritis, but the test will give you a good indication of your general fitness. If you have slowed down then this guide will help improve your health and general fitness.
Opportunistic assessment

- Simple instruments
  - e.g. Gait Speed Test, TUGT, Prisma 7

- Clinical assessments
  - e.g. Rockwood Clinical Frailty Scale, Edmonton Frail Scale
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 III – 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.


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Identifying frailty – tools & context

Opportunistic assessment

Population based approaches
Population based approaches

- Questionnaires
  - e.g. Tilburg Frailty Indicator (TFI)

- Using routinely collected data
  - e.g. Electronic Frailty Index (eFI)
Using the Tilburg Frailty Indicator

Over 75 Frailty Project

Elderly Care Facilitators

North Staffordshire CCG
Newcastle under-Lyme South Locality Group
Population based approaches

- **Questionnaires**
  - e.g. Tilburg Frailty Indicator (TFI)

- **Using routinely collected data**
  - e.g. Electronic Frailty Index (eFI)
What is the electronic Frailty Index?

- Tool for measuring frailty
- Based on cumulative deficit model of frailty
- Uses coded data in electronic primary care record
WHAT DIFFERENCE WILL THIS MAKE?
Once we have identified frailty…. 

We can better support people throughout their journeys of frailty

We can take actions that will influence frailty trajectories and maximise quality of life
Opportunities

- Enables prevention and a proactive approach to care

Potentially modifiable risk factors

**Targeted interventions:**
- Good foot care
- Home safety checks
- Vaccinations
- Keeping warm & readiness for winter

*Stuck et al. Soc Sci Med. 1999 (Systematic review of 78 studies)*
Opportunities

- Enables management of frailty as a long term condition

Managing Frailty as Long Term Condition

Healthy Ageing

Supported self-management

Care & support planning

Case management / EoL care

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Opportunities

- Identifies people whose care & support can be influenced by primary care services

- Improve quality of care across different settings and at transitions
Opportunities

- Fits with recommendations: NICE guideline on multimorbidity

Multimorbidity: clinical assessment and management

NICE guideline [NG56] Published date: September 2016
Opportunities

- Ensure access to Comprehensive Geriatric Assessment for those at greatest risk

- Inform treatment decisions based on condition not age
Opportunities

- Promotes system capability to support increasing number of older people living with frailty

- 5YFV and GPFV visions: developing more engaged relationships with patients and carers to promote well being and prevent ill health
• Placed based approach
• Vision shared with community
• Prevention
• Self care and empowerment

• Self care for people with LTCs
• Care redesign
• 10 'high impact' actions including: signposting, partnership working and supporting self care
Examples of NHSE progress to date

- Read codes for mild, moderate and severe frailty
- Healthy Ageing and Caring Guides
- Discharge to Assess Quick Guide
- Safe and well visits by Fire Service
- Frailty toolkit for primary care
- Frailty CQUIN
- Standard outcomes set for older people
- Rightcare Frailty Scenario
Examples of what we are doing now

- Age well approach
- Promotion of electronic frailty index
- Care homes commissioning guidance
- NICE multi-morbidity clinical guideline
- Supporting winter planning and keeping well
- Economic modelling of impact of frailty
How did identifying & understanding frailty help Nirmala and Baldev?
Summary

Understanding the multi-dimensional nature of frailty in primary care enables the delivery of holistic, integrated, person centred care.
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Population based approaches to the identification of frailty offer new opportunities to systematically deliver evidence-based interventions to people with frailty.
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Understanding the multi-dimensional nature of frailty in primary care enables the delivery of holistic, integrated, person centred care.

Population based approaches to the identification of frailty offer new opportunities to systematically deliver evidence based interventions to people with frailty.

By combining these approaches we can reduce inequalities and improve the quality and effectiveness of our care and support for older people and their carers.
Thank You

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References


• Clegg A, Young J, Iliffe S, Rikkert MO, Rockwood K. Frailty in elderly people.

• Lancet 2013 Mar 2;381(9868):752-762.


Over 75 Frailty Project

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The Approach

Proactive, population based identification of frailty.

Assessed all people aged over 85 years, with dementia or housebound.

People aged 75-84 years screened using Tilburg Questionnaire

- 85+ years + dementia + housebound
  - Total = 785 (2%)

- 75-84 years
  - Total = 2,624 (7%)

- < 75 years
  - Total = 33,894 (91%)
The Intervention

A multi-dimensional assessment by the Elderly Care Facilitator to create a holistic, personalised action plan.
Outcomes: Referrals

- Mobility Issues: 215
- Physiotherapy / Occupational Therapy: 162
- Falls Service: 53
- Other Therapy Services: 49
- Memory Clinic: 39
- Social Services: 14
- Medical Referrals: 2
- Police & Fire Service: 65
Outcomes: Benefit claims

- Council Tax Rebate, 26
- Pension Saving Credit, 4
- Attendance Allowance, 170
- Blue Badge, 145

100 confirmed at Year One, worth £275,000 p.a.
170 claims are worth £487,968
Outcomes:
Over 75 years emergency secondary care growth 2012-2013 to 2014-2015

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<td>8%</td>
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Patient feedback

What people found most helpful...

- Sign-posting/guide to what’s available
- Showing concern/interest in me
- Supply of equipment or other specific action
- Discussing care, gaining advice and suggestions

What people said about the service....

“helpful to know where to go for help and what is available..”

“The concern shown with health problems and welfare in general”

“I found the fact that the doctors were interested in my health and welfare uplifting”

“Difficult to improve near perfection”

Postal survey
135 questionnaires sent
66 replies