What’s new in front door frailty?

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Acute Frailty Network

www.acutefrailtynetwork.org.uk
The why

- Demography remains an important driver

**Table 1: Age distribution of the UK population, 1975 to 2045 (projected)**

<table>
<thead>
<tr>
<th>Year</th>
<th>UK Population</th>
<th>0 to 15 years (%)</th>
<th>16 to 64 years (%)</th>
<th>65 years and over (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>56,226,000</td>
<td>24.9</td>
<td>61.0</td>
<td>14.1</td>
</tr>
<tr>
<td>1985</td>
<td>56,554,000</td>
<td>20.7</td>
<td>64.1</td>
<td>15.2</td>
</tr>
<tr>
<td>1995</td>
<td>58,025,000</td>
<td>20.7</td>
<td>63.4</td>
<td>15.8</td>
</tr>
<tr>
<td>2005</td>
<td>60,413,000</td>
<td>19.3</td>
<td>64.7</td>
<td>15.9</td>
</tr>
<tr>
<td>2015</td>
<td>65,110,000</td>
<td>18.8</td>
<td>63.3</td>
<td>17.8</td>
</tr>
<tr>
<td>2025</td>
<td>69,444,000</td>
<td>18.9</td>
<td>60.9</td>
<td>20.2</td>
</tr>
<tr>
<td>2035</td>
<td>73,044,000</td>
<td>18.1</td>
<td>58.3</td>
<td>23.6</td>
</tr>
<tr>
<td>2045</td>
<td>76,055,000</td>
<td>17.7</td>
<td>57.8</td>
<td>24.6</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics
• Not yet found a cure for frailty or dementia
The why

• No new magic bullet
The why

• Clinical challenge
  – Demography remains an important driver
  – Not yet found a cure for frailty or dementia
  – No new magic bullet

• Resource challenge
  – STPs
  – Workforce
So what can we do?

• Control what is within our control

• Focus on those most at risk

• Competent, holistic assessment (Comprehensive Geriatric Assessment)

• Focus on ‘what matters to me’ vs. what is the matter with me

• Shared decision making

➢ Better care, better patient outcomes, greater staff satisfaction, reduce resource use
Focus on the most at risk

- Not all about older people
  - But they are the major at risk group

- Not all older people the same – 80/20

- Delirium & dementia play a big part
Frailty assessment

- Electronic frailty index
  - Proactive care; medication reviews; advance care planning

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mild frailty (HR, 95% CI)</th>
<th>Moderate frailty (HR, 95% CI)</th>
<th>Severe frailty (HR, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr care home admission</td>
<td>2.00 (1.68 to 2.39)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>5.94 (4.61 to 7.64)</td>
</tr>
<tr>
<td>3 yr care home admission</td>
<td>1.52 (1.37 to 1.69)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>3.42 (2.84 to 4.12)</td>
</tr>
<tr>
<td>5 yr care home admission</td>
<td>1.56 (1.43 to 1.70)</td>
<td>2.34 (2.10 to 2.61)</td>
<td>3.00 (2.42 to 3.70)</td>
</tr>
<tr>
<td>1 yr hospitalisation</td>
<td>1.85 (1.81 to 1.88)</td>
<td>2.96 (2.90 to 3.02)</td>
<td>4.62 (4.50 to 4.74)</td>
</tr>
<tr>
<td>3 yr hospitalisation</td>
<td>1.71 (1.69 to 1.73)</td>
<td>2.54 (2.51 to 2.58)</td>
<td>3.64 (3.57 to 3.70)</td>
</tr>
<tr>
<td>5 yr hospitalisation</td>
<td>1.63 (1.61 to 1.64)</td>
<td>2.43 (2.40 to 2.46)</td>
<td>3.59 (3.54 to 3.65)</td>
</tr>
<tr>
<td>1 yr mortality</td>
<td>1.91 (1.78 to 2.04)</td>
<td>3.39 (3.15 to 3.65)</td>
<td>5.23 (4.73 to 5.79)</td>
</tr>
<tr>
<td>3 yr mortality</td>
<td>1.74 (1.68 to 1.81)</td>
<td>3.02 (2.90 to 3.14)</td>
<td>4.56 (4.29 to 4.84)</td>
</tr>
<tr>
<td>5 yr mortality</td>
<td>1.66 (1.62 to 1.71)</td>
<td>2.73 (2.64 to 2.81)</td>
<td>3.88 (3.68 to 4.09)</td>
</tr>
</tbody>
</table>
Frailty assessment

- Urgent care
  - Lots of scores
  - Clinical Frailty Score quick and simple
  - Frailty marker coming into hospital records
  - Cross-validation with eFI planned

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 "slowly up," and/or being tired during the day.

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

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

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

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

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

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

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

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

* 1. Canadian Study on Health & Aging, Revised 2008

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Percentage of patients admitted in year with frailty marker: 20.2%
Overall percentage of patients with frailty marker: 18.7%

### High level activity breakdown for patients admitted with at least one frailty marker during year (all figures refer to 2018/19)

<table>
<thead>
<tr>
<th>Activity type</th>
<th>LA</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of total admissions</td>
<td>52.0%</td>
<td>56.8%</td>
</tr>
<tr>
<td>Percentage of total bed days</td>
<td>81.2%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Percentage of emergency readmissions within 30 days</td>
<td>14.6%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Percentage of deaths within 30 days of admission</td>
<td>94.3%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

#### Breakdown of individual frailty markers for residents aged 75 and over in Sheffield:

- **Dependence or disability**
- **Nutrition and nutritional deficiencies**
- **Urinary incontinence**
- **Vascular disease**
- **Joint disease**
- **Cataracts**
- **Senility**
- **Falls**
- **Depression**
- **Dementia**

### Potential frailty marker

<table>
<thead>
<tr>
<th>Frailty marker</th>
<th>LA</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary incontinence</td>
<td>2.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Depression</td>
<td>2.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Dementia</td>
<td>2.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Falls</td>
<td>0.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Cataracts</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Senility</td>
<td>0.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Vision problems</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Nutrition and nutritional deficiencies</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Skin ulcer</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other functional incontinence</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other functional incontinence</td>
<td>0.0%</td>
<td>0.1%</td>
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</tr>
</tbody>
</table>
Competent, holistic assessment (CGA) – 24/7

The unlikely geriatricians
Nicholas Coni FRCP

THE OLD IN ACCIDENT DEPARTMENTS
The rapid ageing of populations in Europe and other developed countries affects almost all aspects of the health and social services, including the hospital accident and emergency department (AED). The old and the young attend AEDs proportionately more than do the middle-aged, and among elderly attenders the very old (85 and over) are over-represented. Other patients are much more likely to arrive by ambulance than the generality of AED patients. They take up more medical and nursing time, require more investigations and are more likely to be admitted to the hospital. They are highly likely to suffer a functional decline following attendance, and, if they become unable to cope, community support will often be inadequate and the remain some activities which can be intuitively accepted as a good thing. An example is being kind to patients; and improved education of doctors is similar in that it is reasonably inexpensive but extraordinarily difficult to validate statistically. Disappointingly, a recent AED-based geriatric assessment and management programme in the USA, which disclosed an average of more than three previously unknown important problems per patient, failed to demonstrate improved outcomes, possibly because of poor compliance with the doctors’ recommendations.

EMERGENCY PHYSICIANS & GERIATRIC SKILLS

‘Geriatrics is too important to be left to geriatricians. We are all geriatricians now, and geriatric medicine should be like a caretaker government-self-appointed to instruct others how to do it, and then to preside over its own demise.’
• Geriatric services/frailty units a BIG part
  – But geriatricians 4% UK workforce

• Size of the prize
  – Geriatric Emergency Medicine
  – Orthogeriatrics
  – Oncogeriatrics
  – Cardiogeriatrics
  – Perioperative geriatrics
  – Community geriatrics
Role for geriatric services

• ‘In from the cold’
  – Clinical knowledge transfer vehicles
  – Evidence, engage & educate
  – Outward facing
  – Evaluate – is liaison effective...?
  – Academic base needs to be stronger
Embed competence whilst embracing complexity
Role for geriatric services

• Develop capacity
  – Advance nurse practitioners
  – Consultant therapists/nurses
  – Geriatric fellowships

• Needs to be across the board
BOX 1: MULTI-LEVEL APPROACH TO CHANGE

1. **Strategic (regional) level**: Relevant strategic players, namely System Resilience Groups (SRGs) with Chief Executives and Commissioners as their attendees, will be alerted about the problem in care such as higher than expected volumes of attendance and high admission rates, length of stay, readmission rates and institutionalisation. They will be offered a solution in the form of improving care for the frail older patients detailed in this toolkit, and prompted to take action, e.g. to include service development in strategic planning, and delegate implementation to operational arms.

2. **Operational (trust) level**: Managers will be presented with convincing evidence of the problem, for example national reports from Royal Colleges, data from the NHS benchmarking audit on acute care for older people and patient stories. Their action will ideally be supported by strategic level decisions. Divisional and service managers will delegate service development across the hospital to non-geriatric services and provide support to improvement teams. Support may include: oversight by experienced senior clinical and managerial teams from different directorates and specialities, dedicated measurement team, devolved budgetary autonomy, project management support, and service level review.

3. **Service level** will see improvement teams being set up who will lead on embedding CGA in services. This is the area covered by this toolkit.

4. **Patient and carer level** will be empowered to take a more active role in their care, if they wish to do so. Patients and carers may influence the ways acute services are provided locally, and will be targeted by a specific intervention (an information leaflet or a video) to increase awareness about high-quality care for frail older people. In turn, patient and carers will be able to demand the care from their services.
ABOUT THE TOOLKIT

You are an anaesthetist, a surgeon, an oncology specialist, or other acute care physician. In your service, yours and other team members’ training may not have focused on the needs of older people. There may be a lack of confidence and expertise in managing older people and conditions associated with ageing. Yet you are interested in improving care for these patients who come to your service.

You may have seen research evidence and you may have talked to your colleagues and reflected on personal experience. You may have collected own data showing the care for frail older people in your service could be improved. Or you may have been asked to improve your service performance in respect to this patient group.

There are different starting points on your journey to improve care for frail older people in your service, and this toolkit will try to assist you on that journey.
Role for geriatric services

• Develop the context
  – Advocacy as well as care
Help your older patients **USE IT not LOSE IT**

How you care for older, frailer patients can reduce deconditioning and hospital complications such as falls, delirium and infections. You can increase their chances of going back to their own homes sooner.

- Older people may be vulnerable
- When an older person comes to hospital...
- ...we often put them in a hospital bed. This can impact their mobility, resulting in:
  - Functional incontinence (not being able to reach toilet in time)
  - Increased confusion
  - Deconditioning and muscle wastage, with increased risk of falls and pressure ulcers

- Reduced appetite and increased risk of aspiration
- Multiple medications may make this worse
- Not planning for discharge early leads to unnecessary delays

# hello
my name is...

- Does my patient know who I am and where they are?
- Do I know how my patient manages at home; have I involved their next of kin?
- Does my patient need to be in bed? Can they sit out in a chair or mobilise?

- Can we remove the catheter? Are they constipated? Could I help them to the toilet rather than commode?
- Do they need glasses, or hearing aids; something to tell them where they are & what's happening?
- Can they reach their walking aid? Is a falls alarm required? Is the chair the right height?

- Do they need help to eat and drink? Am I using a red tray? Can I help them sit out for meals?
- Can the team review the medication? Has my patient received their meds on time?
- Does my patient have a clinically fit date? Is there anything I can do to help them get home sooner?
Multimorbidity: clinical assessment and management

NICE guideline [NG56]  Published date: September 2016

Guidance

Overview

Recommendations

Putting this guideline into practice

Context

Recommendations for research

Update information

Guidance

Recommendations

1.1 General principles
1.2 Taking account of multimorbidity in tailoring the approach to care
1.3 How to identify people who may benefit from an approach to care that takes account of multimorbidity
1.4 How to assess frailty
1.5 Principles of an approach to care that takes account of multimorbidity
1.6 Delivering an approach to care that takes account of multimorbidity
1.7 Comprehensive assessment in hospital

Terms used in this guideline
Core Clinical Operating Model

1. Ambulance Handover
2. GP Streaming
3. Emergency Department (including ressus, majors, minors and front-door triage)
4. Mental health
5. Ambulatory Emergency Care
6. Clinical Decision Units
7. Acute Medical Unit
8. Frailty
9. Admission, Transfer, Discharge
10. Specialties (medicine, surgery, paeds)

Draft for consultation
What matters to me

- Patient experience - Experience Based Design
What matters to me

- Experience Based Design
What matters to me

• Patient outcomes (PROMs)
  – Standardised, validated questionnaires completed by patients to measure their perceptions of their own functional status and wellbeing
  – Can drive improvements in diagnosis, communication, needs prioritisation and care
  – Can be used for research, benchmarking, service improvement and commissioning
What matters to me

• Shared decision making
  – Health care partnership
  – Patient owned vs. paternalistic
  – Concordance vs. compliance
## NICE Database of Treatment Effects

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Outcome</th>
<th>Trial duration</th>
<th>Number needed to treat (NNT)</th>
<th>Annualised NNT (ANNT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihypertensives</td>
<td>MI</td>
<td>10 years</td>
<td>84</td>
<td>840</td>
</tr>
<tr>
<td>Statins (secondary prevention)</td>
<td>Mortality</td>
<td>3.8 years</td>
<td>67</td>
<td>255</td>
</tr>
<tr>
<td>Aspirin (angina)</td>
<td>Mortality</td>
<td>4.2 years</td>
<td>46</td>
<td>192</td>
</tr>
<tr>
<td>Anticoagulants (AF)</td>
<td>Stroke</td>
<td>1 year</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

www.acutefrailtynetwork.org.uk/(@acutefrailty)
• Population planning (eFl)
• Decision to admit (ACP)
• Population segmentation (CFS)
• Broaden assessment (CGA)
• Ascertaining priorities (PROM)
• Shared decision making
• Case manage admission (R2G)
• Plan ahead – transfer of care
• Evaluate (PROM)

• Start influencing
  – Structure
  – Strategy
  – Policy
  – Workforce
  – Processes
  – Outcomes
  – Commissioning
    ➢ Better care
    ➢ Get connected; get coordinated
The world is in your hands
Acute Frailty Network

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