People living with frailty: View from NHS England

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April 2013

NHS England Older People & Frailty

TODAY

'The Frail Elderly'
(i.e. a label)

Presentation late & in crisis
(e.g. delirium, falls, immobility)

Hospital-based: episodic, disruptive & disjointed

TOMORROW

"An older person living with frailty"
(i.e. a long-term condition)

Timely identification for preventative, proactive care by supported self-management & personalised care planning

Community-based: person-centred & co-ordinated
(Health + Social + Voluntary + Mental Health)

NHS England: older people with frailty: nationally led but locally implemented

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The I statements

Community interactions

- I can maintain social contact as much as I want

Independence

- I am recognised for what I can do rather than assumptions being made about what I cannot
- I am supported to be independent
- I can do activities that are important to me
- Where appropriate, my family are recognised as being key to my independence and quality of life

I'm still me

... a narrative for coordinated support for older people

Care and support

- I can build relationships with people who support me
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me
- Taken together, my care and support help me live the life I want to the best of my ability

Decision making

- I can make my own decisions, with advice and support from family, friends or professionals if I want it

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)

SO, HERE'S A NOVEL IDEA:
"FOCUS ON THE PERSON,
NOT THE DISEASE!"

The "new" narrative:
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)

Developing the frailty narrative

Fit for Frailt

Consensus best practice guidanc
of older people living with frailty i
and outpatient setting

A report by t
British Geriatric
in association with the R
General Practitioners

EffectivenessMatters

January 2015

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 pr level of health
- Simple tests with high sensitivity for frailty are speed, the timed up-an go test and the PRISMA questionnaire
- Comprehensive geriatri assessment is essential management of moder severe frailty
- Exercise programmes, particularly high intens interventions, may imp gait, balance and streng have positive effects on
- Supported self-manage can improve health out However, the value of s management has still to 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.

Centre for Reviews and Dissemination

Improvem
Academy

LIVING WITH FRAILTY:
A GUIDE FOR PRIMARY CARE

This supplement was developed and produced in partnership with NHS England

A practical guide to
healthy ageing

NHS England: older people with frailty: nationally led but locally implemented

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Making frailty visible: identification of frailty in practice

1 Comprehensive geriatric assessment (CGA)

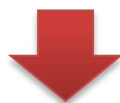
(Structured, multi-disciplinary assessment)

2. Simple assessments
   - Gait speed/timed-up-and-go test
   - Questionnaires (e.g. PRISMA 7)
   - Brief clinical tools (e.g. Edmonton frail scale; Rockwood 7)

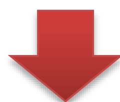
3. Routine data (is this possible?)

Development of a primary care electronic Frailty Index (eFI)

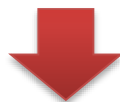
Existing primary care EHR ("SystmOne")



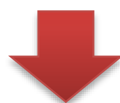
Read Codes (>80,000 ➡ 8,000 ➡ 2,200)



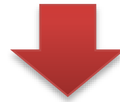
Read codes map onto 36 'DEFICITS'



Tested in "ResearchOne" (n=454,711 ≥65y)



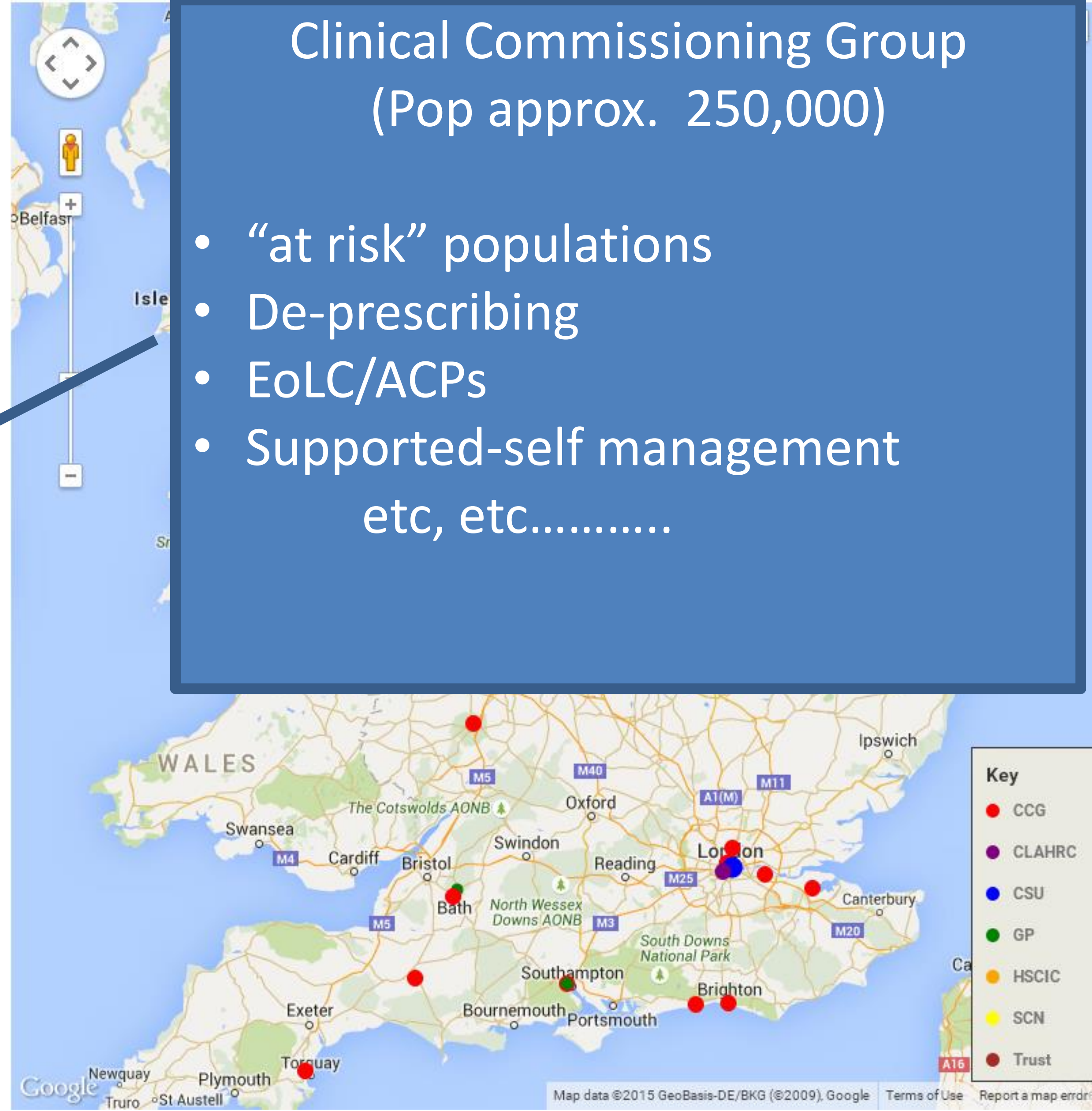
Internal Validation Process (n=227,063 ≥ 65y)



External Validation Process (n=500,000 ≥ 65 y)

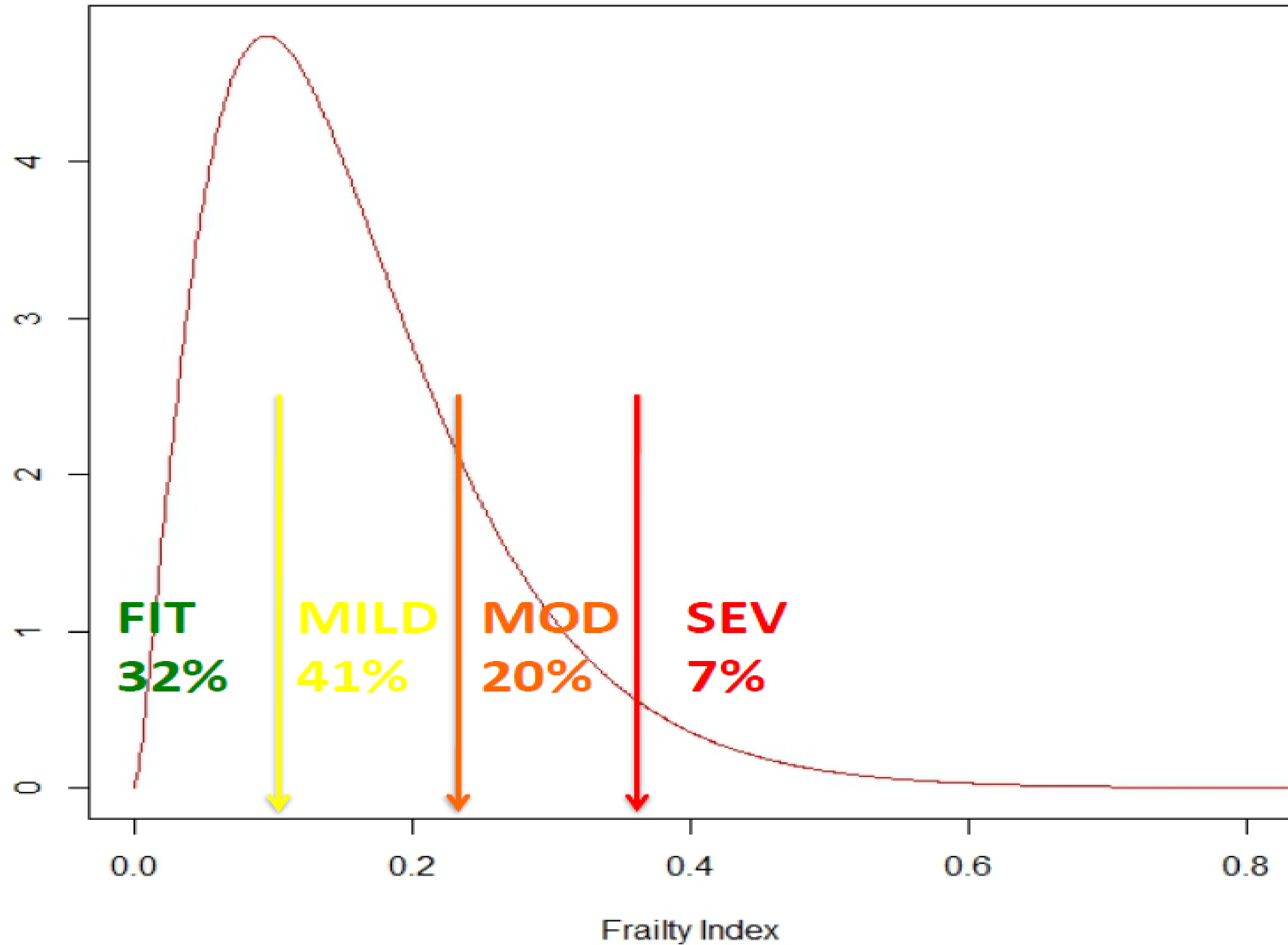
eFI National Spread (Year 1)

Partners	Engagement Count
GP Practices	22
CCGs (n=211)	**35**
CSU	1
SCN	1
CLAHRC	1
Public Health (regional)	3
Industry Partners	2 (ACG Systems)
VCS	1 (Age UK Y&H)



http://www.improvementacademy.org/improving-services/efi-engagement.html

Distribution eFI: Frailty Severity Grade



Candidate Preventable Components for "Frailty"

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

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

Additional topics:

- Look after you feet
- Make your home safe
- Vaccinations
- Keep warm
- Get ready for winter
- Continence
- Preserving memory

A Practical Guide to Healthy Ageing

Supported self-management for people with mild "frailty"

1st Oct 2015: Partnership with Fire & Rescue Services to incorporate into 670,000 Safety and Wellness home visits targeting homebound people

A practical guide to
healthy ageing

NHS England: ol
nationally led bu

- Primary care audit of frailty codes
- “Enhanced” Summary Care Record

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NHS England: old… nationally led bu…

PRIMARY CARE

- Offer MDT assessment
- Offer C&S Planning
- Offer ACP

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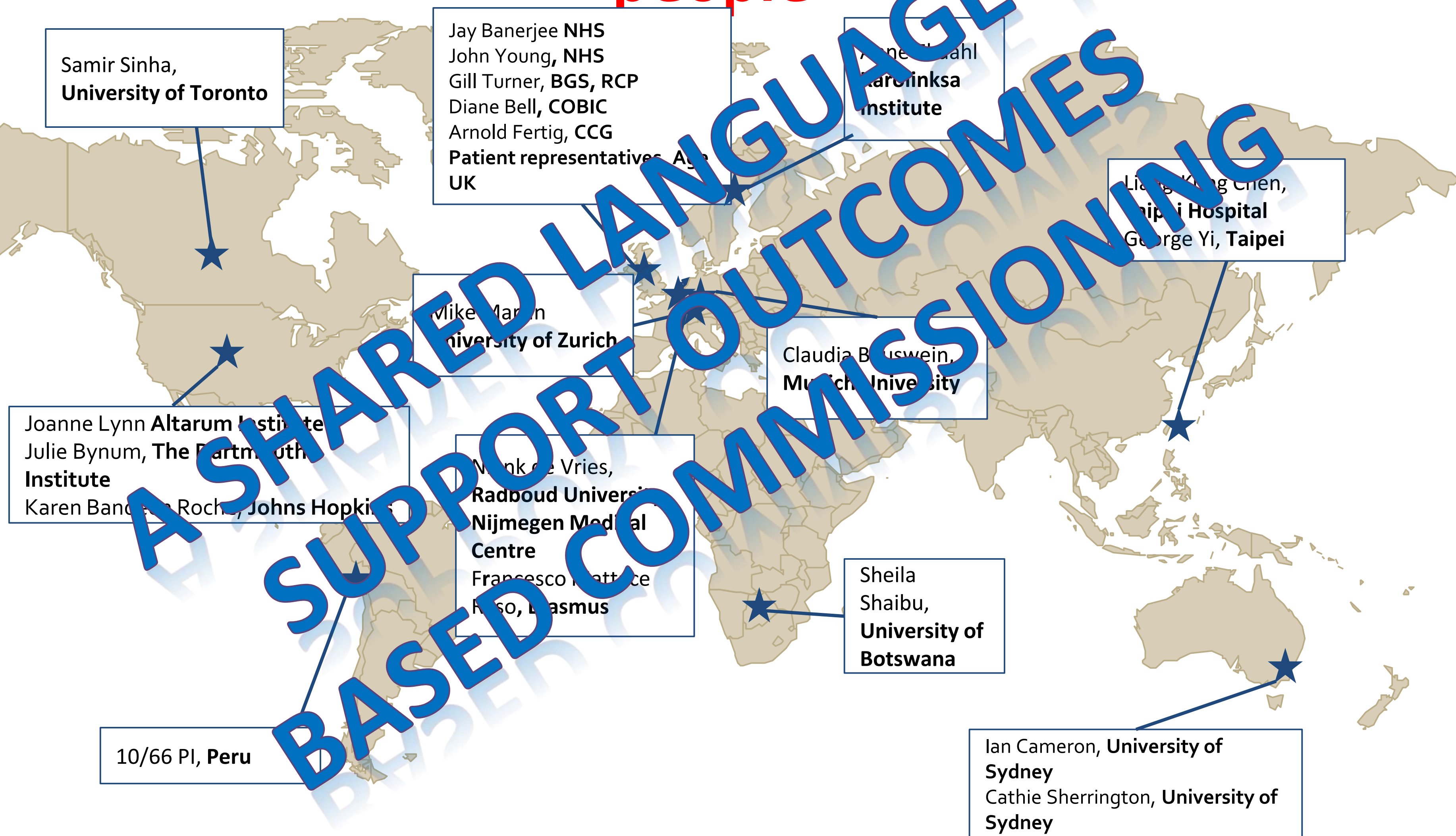
WHOLE SYSTEMS THINKING

International Convention on Health Outcomes Measurement (ICHOM): outcomes suite older people



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