Ambition for frailty..

‘Everybody should know what to do next when presented with a person living with frailty and/or cognitive disorder’
In other words...

It’s something we can all get around locally
What do we mean by frailty?

“A long-term condition characterised by lost biological reserves across multiple systems & vulnerability to decompensation after a stressor event”
Why is frailty so important right now?

- Timely identification of people at risk with complex care needs
- It permits sub-stratification by needs, not age
- It crosses health & social care, so can drive integration
- It’s predictive: finding those who benefit from active and healthy ageing
- It will guide & track commissioning, design & service delivery
- It directs towards key outcomes: maintained functional ability & wellbeing
- It provides opportunity to standardise care for people with similar needs
Population ageing

- **Number of people aged 65 & over** will increase by **19.4%**: from 10.4M to 12.4M

- **Number with disability** will increase by **25.0%**: from 2.25M to 2.81M

- **Life expectancy with disability** will increase **more in relative terms**

Frailty is not good for you
Impact of frailty on hospital mortality and LOS

- Severe frailty adversely impacts mortality in acute care
- Severe frailty, acute illness, delirium and dementia all lead to longer LOS

**TABLE 4. Results of Multivariate Regression Models**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Unstandardized Coefficients</th>
<th>OR</th>
<th>95% CI for OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.01 (0.09)</td>
<td>1.01</td>
<td>0.98 - 1.05</td>
</tr>
<tr>
<td>Gender</td>
<td>0.04 (0.01)</td>
<td>1.04</td>
<td>1.01 - 1.08</td>
</tr>
<tr>
<td>ED-MEWS</td>
<td>0.11 (0.02)</td>
<td>1.12</td>
<td>1.06 - 1.16</td>
</tr>
<tr>
<td>CCI</td>
<td>0.09 (0.01)</td>
<td>1.09</td>
<td>1.07 - 1.11</td>
</tr>
<tr>
<td>GFS</td>
<td>0.44 (0.07)</td>
<td>1.55</td>
<td>1.36 - 1.77</td>
</tr>
<tr>
<td>hip</td>
<td>0.77 (0.10)</td>
<td>2.16</td>
<td>1.79 - 2.51</td>
</tr>
<tr>
<td>ACs</td>
<td>1.20 (0.12)</td>
<td>3.31</td>
<td>2.64 - 4.15</td>
</tr>
</tbody>
</table>

**Note:** The reference category for gender is male (0 = female = 1). Abbreviations: ACs, acute confusional state; AUC, area under the curve; CFS, Clinical Frailty Scale; CCI, Charlson Comorbidity Index; CI, confidence interval; Dc, discharge; ED-MEWS, Emergency Department Modified Early Warning Score; Gen Med, General Medicine; Gen Med, Geriatric Medicine; HoD, history of dementia; LOS, length of stay; n, number; OR, odds ratio.
Growth in DTOC & 7/7 stranded patients
Requires us to Optimise acute care and grow community capacity & capability

* This assumes that only a negligible proportion of DTOCs are for non-emergency care

Sources: NHS England published DTOC Data - April 2011 - March 2017
SUS bed days data for financial years 2010/11 to 2016/17
Frailty is expensive when severe

Mean annual cost of care by frailty category, KID population aged 65+, Jan – Dec 2017 (excluding deceased patients)

Frailty group

- Fit: £1,237
- Mild: £2,808
- Moderate: £4,461
- Severe: £6,955
Costs distribute differently as frailty progresses

Percent total spend by category within eFI band
Patients 65+ KID Jan - Oct 2017 activity data

- **Fit**: 13.8% GP Prescription, 15.2% GP, 11.1% MH Inpatient, 8.4% MH Community Care, 50.0% Acute cost/patient, 12.7% Social Care Ave/Pt
- **Mild**: 13.0% GP Prescription, 9.6% GP, 8.2% MH Inpatient, 7.7% MH Community Care, 46.1% Acute cost/patient, 18.5% Social Care Ave/Pt
- **Moderate**: 3.5% GP Prescription, 3.6% GP, 2.4% MH Inpatient, 7.7% MH Community Care, 46.1% Acute cost/patient, 23.2% Social Care Ave/Pt
- **Severe**: 2.1% GP Prescription, 5.2% GP, 2.2% MH Inpatient, 10.5% MH Community Care, 47.7% Acute cost/patient, 24.2% Social Care Ave/Pt
NHS England Next Steps-Priorities

‘Health and high quality care – now and for future generations’

- Urgent and emergency care 24/7: Admitting sicker patients & discharging home promptly
- Next 2 years hospitals to free up 2-3K beds through close community services working
- Cancer: will affect 1 in 3 in lifetime: survival at record high (LTC)
- Mental health: loneliness, depression and anxiety in older people
- Older people: Help older people and those with frailty stay healthy & independent.
- Integration: GP, community health, MH & hospitals: Integrated Care Systems
- Workforce development & continue drive to improve safety
- Technology & innovation: enable patients to take greater role in self care
Three priorities for frailty

1. Change in approach to health & social care for older people

2. Preventing poor outcomes through active ageing

3. Quality improvement in acute & community services
Bending the fitness curve

Also, consider inequalities carefully:
Lowest economic quartile frailty commences earlier in the life course and progresses more rapidly, contributing to reduced life expectancy
Preventing frailty progression: Potential Cost Impact

Adjusting for age, gender and deprivation:

- If 10% of the severely frail had remained moderately frail the gross savings in Kent would be £1.6m over 10 months.

- If 10% of the mildly frail had remained fit, gross savings would be nearly £9m (owing to higher patient numbers).

- NB: Gross estimates- these figures do not account for the costs of interventions to prevent frailty progression.

<table>
<thead>
<tr>
<th>EFI stage</th>
<th>Per patient</th>
<th>For 10% of Kent cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>£1,117</td>
<td>£8,878,776</td>
</tr>
<tr>
<td>Moderate</td>
<td>£1,228</td>
<td>£3,682,197</td>
</tr>
<tr>
<td>Severe</td>
<td>£1,982</td>
<td>£1,644,832</td>
</tr>
</tbody>
</table>
Starting with..

**Routine timely frailty identification**

- Routine frailty identification in primary care has 2 potential merits:
  1. Population risk stratification
  2. Targeted individualised interventions for optimal outcomes
Creating a Paradigm shift

THEN

‘The frail Elderly’

Late Crisis presentation
Fall, delirium, immobility

Hospital-based episodic care
Disruptive & disjointed

NOW

‘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 + Community assets-FRS
Gold standard: frailty triggered holistic care

Recognition of frailty in an individual

Holistic Clinical Review
- Identify & optimise long term conditions
- Individualised goal setting
- Medications review
- Anticipatory care planning

Depression?

Individualised (tailored) Care & Support Plan

Falls Risk Assessment

Multi-morbidity review

Adapted from BGS: Fit for Frailty (2014)
Key enablers

- Population sub-segmentation by need to guide planning
- Industrialising best practice through national frailty standards
- Workforce development (core skills, capability, competencies)
- Data: integrated, linked health and social care data
- Existing best practice models and frameworks
- Community currencies
- Right care: ensure best local system offer for prevention and management
- GIRFT: improve selected, linked pathways: up/downstream
- Devolution, localised strategic planning and delivery
### GP Contract 2017/18 Data [Q3]

<table>
<thead>
<tr>
<th>Definition</th>
<th>Cumulative Q3 total</th>
<th>Cumulative Q3 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count 65+ with frailty assessment</td>
<td>2,302,355</td>
<td>23.48% 65+</td>
</tr>
<tr>
<td>65+ without frailty assessment</td>
<td>7,501,842</td>
<td>76.52% 65+</td>
</tr>
<tr>
<td>Total moderately frail</td>
<td>569,828</td>
<td>5.8% 65+</td>
</tr>
<tr>
<td>Total severely frail</td>
<td>295,180</td>
<td>3% 65+</td>
</tr>
<tr>
<td><strong>Total moderate and severely frail</strong></td>
<td><strong>865,008</strong></td>
<td><strong>8.82% 65+</strong></td>
</tr>
<tr>
<td>Severe frailty w/medication review</td>
<td>151,130</td>
<td>51.2% (severe frailty)</td>
</tr>
<tr>
<td>Moderate or severe frailty w/fall</td>
<td>71,142</td>
<td>8.22% (moderate/severe frailty)</td>
</tr>
<tr>
<td>Moderate or severe frailty w/falls clinic</td>
<td>18,024</td>
<td>2.1% (moderate/severe frailty)</td>
</tr>
<tr>
<td>Moderate or severe frailty w/consent to SCR</td>
<td>91,813</td>
<td>10.61% (moderate/severe frailty)</td>
</tr>
</tbody>
</table>
Adult life span

- Maintained functional ability & wellbeing throughout life
- Emphasis on activation and self help
- Timely, well planned & proportionate service support for needs
- Lower level support towards end of life
- Key Outcome: Increased care free life years

Population sub-stratification: Prevention

Fit/Mild Frail

Prevention

Intervention

Ageing Well Pathway

Services

Prevention

Intervention

Services

Death

LT C

Functional ability
Population sub-stratification: Intervention

- Earlier declining function & need for service support
- Timely identification of risk and managed escalating need
- Early opportunity to trigger planning & decisions
- Timely support towards end of life
- With declining function, maintained wellbeing key is a key outcome
Frailty data to commission a new integrated care offer for those NOT ageing well

Percentage of eFl Frailty Categories within each Age Band
KID January - October 2017

BAU

NEW OFFER?
Proactive & Reactive Community MDT care
Integrated care system offer provides the alternative to hospital care

Build community capability & capacity

General and acute beds open overnight - 2010/11 onwards

8% reduction in general and acute beds since 2010: NHSB 2017
Supporting Older People living with Fraility

**Welcome**

Welcome to the supporting older people living with frailty in primary care platform. You are invited to use this platform to build an informal frailty network or community that can share and discuss issues and good practice quickly and easily.

We hope that this platform will support the smooth and orderly introduction of changes to the GP contract with regards to the routine identification of frailty.

**Introduction from GP and Associate National Clinical Director Dawn Moody**

For everyone in general practice, supporting people living with frailty is a large and growing part of our work. However, frailty is a relatively new and rapidly developing subject with pockets of good ideas and practice dispersed across the country. This means that more and more people are developing an interest in frailty and that those of us who have had an interest in frailty for a number of years are still learning! My hope as a GP is that this forum grows into an active and supportive and doesn’t work so that we can provide even better

**Latest News: Frailty Core Capabilities Framework**

Update regarding the Health Education England, NHS England and Skills for Health collaboration to develop a ‘Frailty Core Capabilities Framework.’

The consultation has now closed. The feedback is currently being analysed to incorporate into the document with a plan to publish in late April 2018. Plans are being agreed on methods and approach for dissemination and evaluation. You can also access further information here: http://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework.

**Help requested with research regarding what frailty means**

Can you help with research on ‘Frailty in the new General Medical Services contract—what does it mean to Primary Care Providers?’ A PhD researcher from the University of Manchester is looking at exploring how is frailty understood and enacted by healthcare professionals in their daily practice. Contact: Sunny.Pathak@manchester.ac.uk

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www.england.nhs.uk/ourwork/ltc-op-eolc