

**Ageing Well**  
Quality Healthcare in Later Life

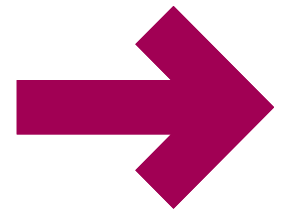
***National Frailty Approach***

***Martin Vernon***  
*National Clinical Director Older People*



# Ambition for frailty..

***Everybody should know what to do next  
when presented with a person living with  
frailty and/or cognitive disorder'***



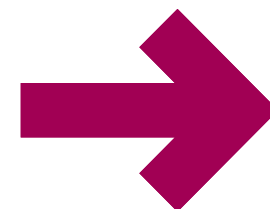
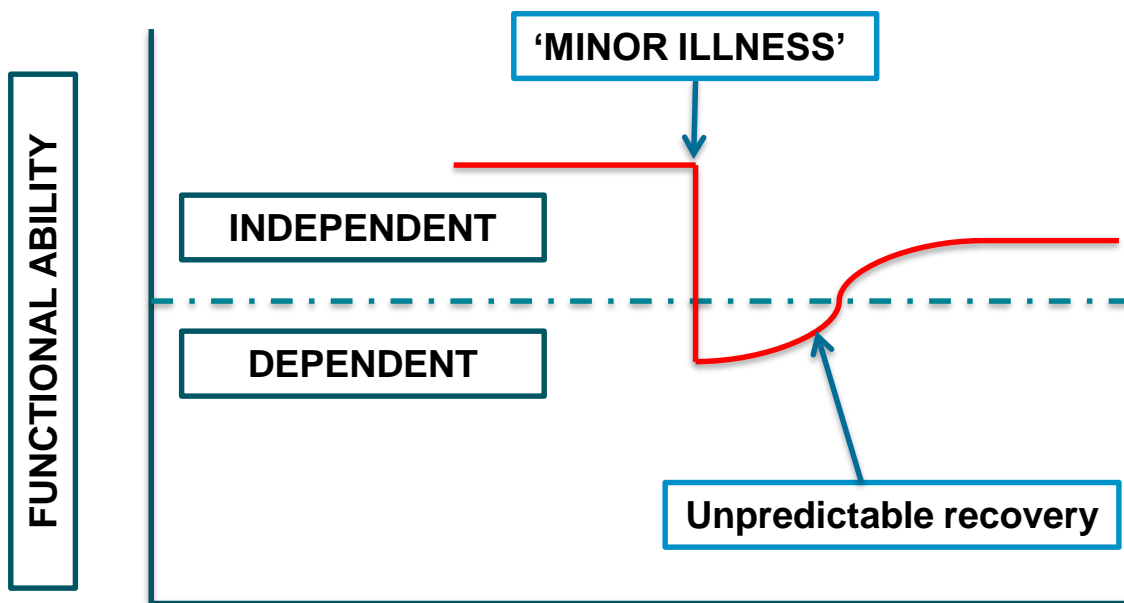
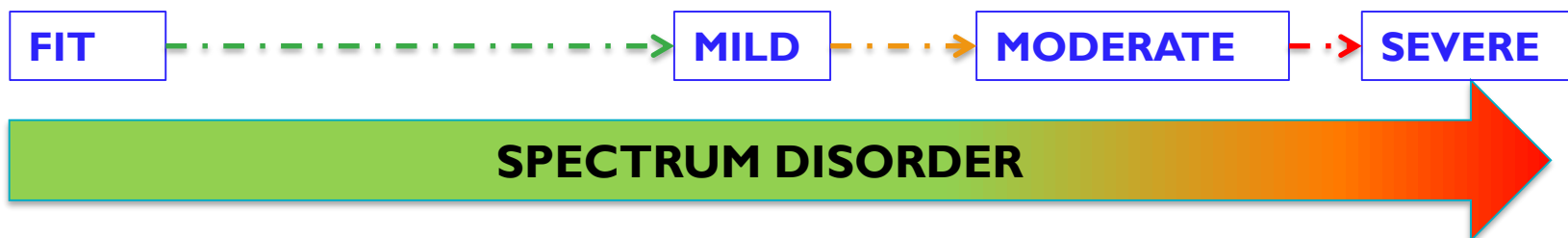
**In other words...**

***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”*

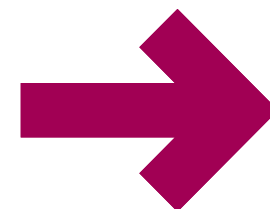


# Why is frailty so important right now?

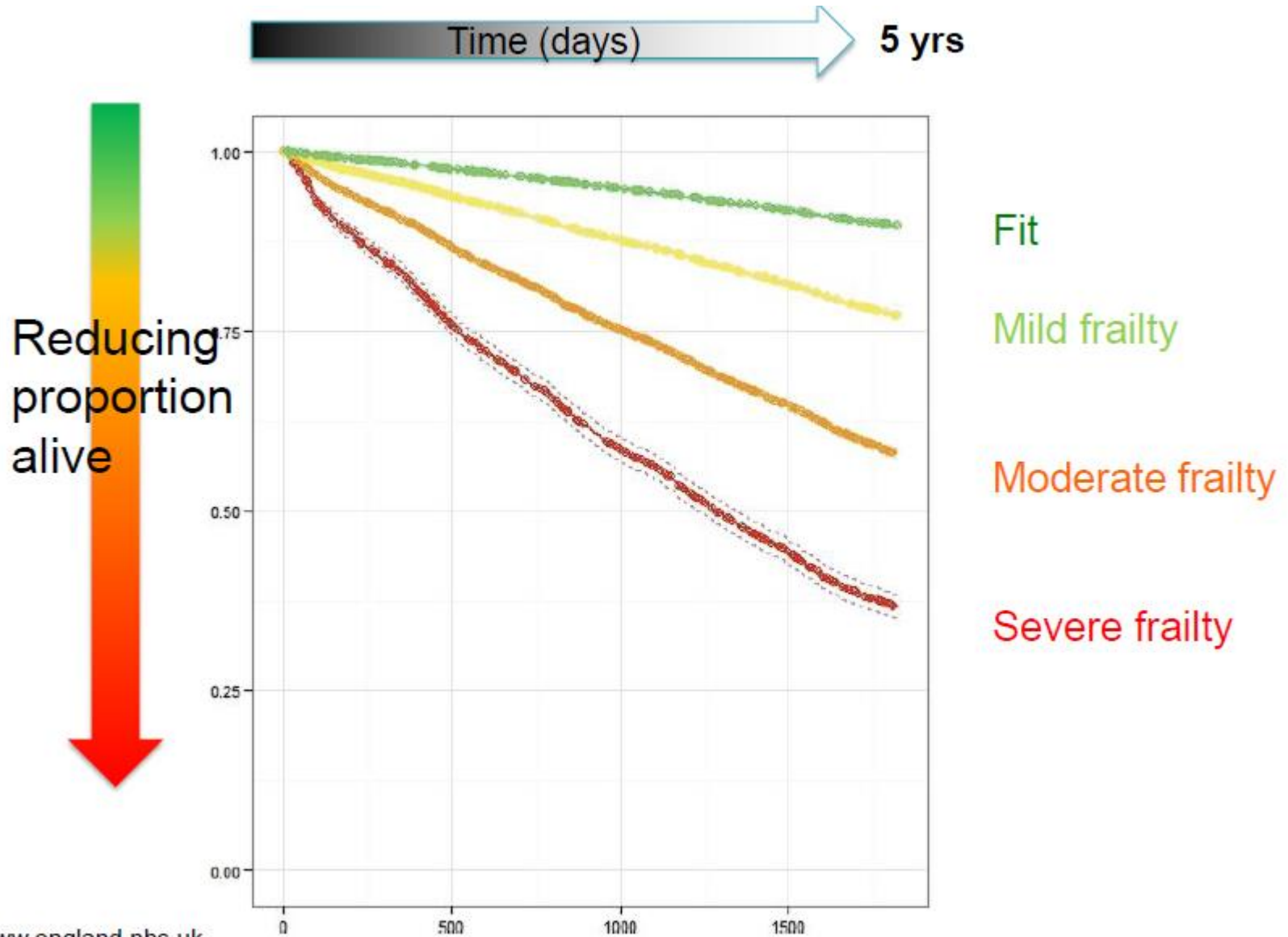
- **Timely identification of people at risk** with **complex care needs**
- It permits **sub-stratification by needs**, not age
- It crosses health & social care, **so can drive integration**
- It's **predictive**: finding those who benefit from **active and healthy ageing**
- It will **guide & track 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

Hazard Function for patterns 1 - 4

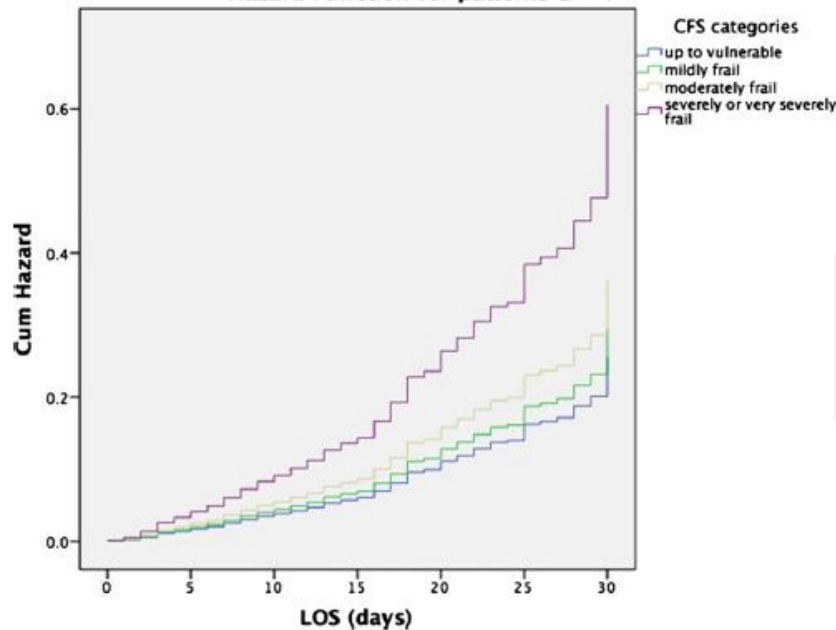


TABLE 4. Results of Multivariate Regression Models

Dependent variable: LOS  $\geq 10$  d (n = 5546); chi-square = 708.1;  $P < 0.001$ ; AUC = 0.71

	Unstandardized coefficients		OR	95% CI for OR		P
	B	Std. error		Lower bound	Upper bound	
Age	0.01	0.01	1.01	1.00	1.03	0.009
Gender	0.07	0.06	1.08	0.95	1.22	0.234
ED-MEWS	0.11	0.02	1.12	1.08	1.16	<0.001
CCI	0.09	0.01	1.09	1.07	1.11	<0.001
CFS $\geq 6$	0.44	0.07	1.55	1.36	1.77	<0.001
HoD	0.77	0.10	2.16	1.79	2.61	<0.001
ACS	1.20	0.12	3.31	2.64	4.15	<0.001
Dc gen med	-0.87	0.09	0.42	0.35	0.51	<0.001
Dc geri med	0.00	0.10	1.00	0.83	1.21	0.995
Dc surgery	0.08	0.10	1.09	0.89	1.32	0.411

NOTE: The reference category for gender is male (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; Geri Med, Geriatric Medicine; HoD, history of dementia; LOS, length of stay; n, number; OR, odds ratio.

Clinical frailty adds to acute illness severity in predicting mortality hospitalized older adults: An observational study<sup>☆</sup>

Roman Romero-Ortuno<sup>a,b,\*</sup>, Stephen Wallis<sup>a</sup>, Richard Biram<sup>a</sup>, Victoria Keevil<sup>a,b</sup>

<sup>a</sup> Department of Medicine for the Elderly, Addenbrooke's Hospital, Cambridge, United Kingdom

<sup>b</sup> Clinical Gerontology Unit, Department of Public Health and Primary Care, University of Cambridge, United Kingdom

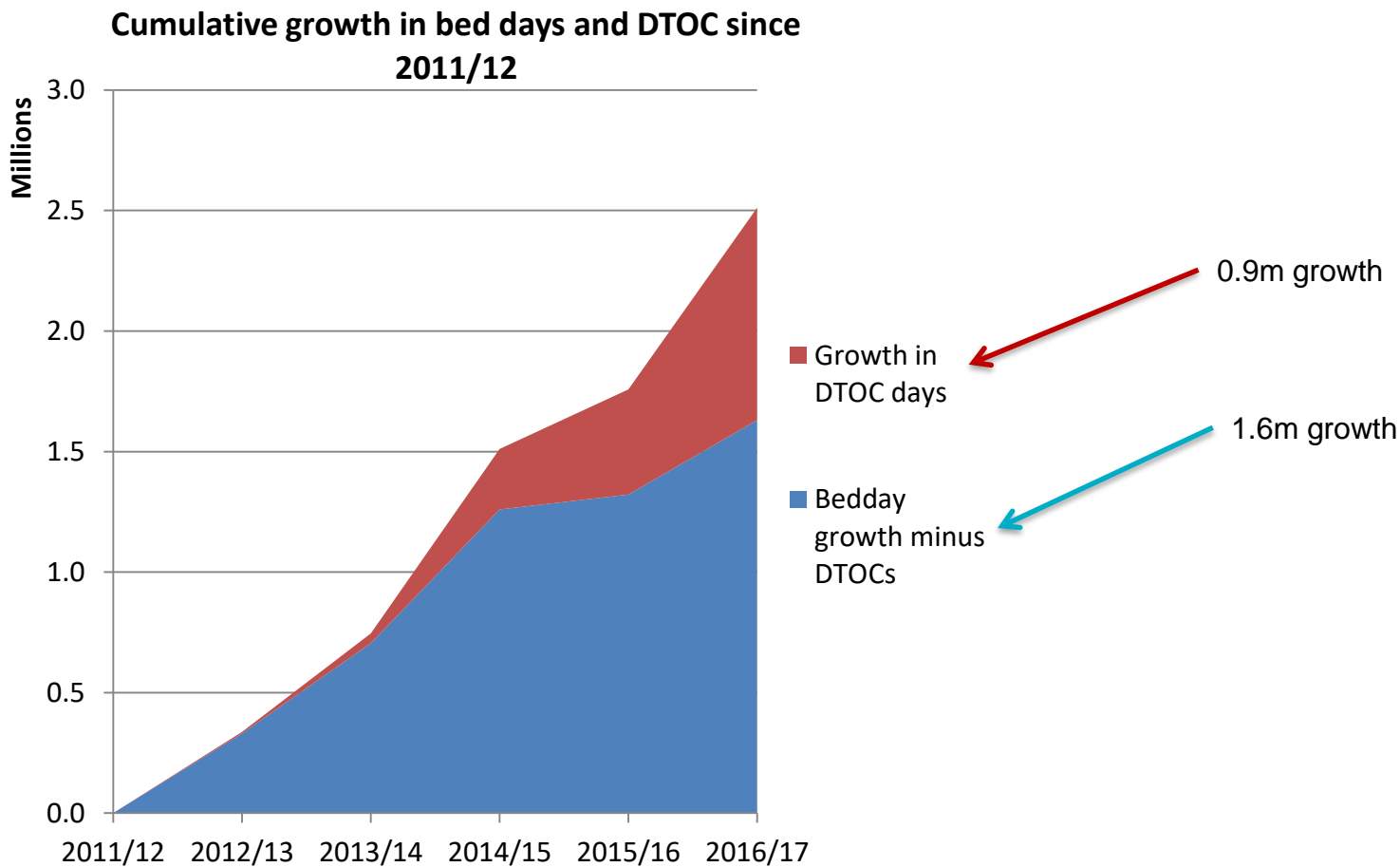
## The Association of Geriatric Syndromes with Hospital Outcomes

Roman Romero-Ortuno, PhD<sup>1,3\*</sup>, Duncan R. Forsyth, MA<sup>1</sup>, Kathryn Jane Wilson, MBBS<sup>1</sup>, Ewen Cameron, MD<sup>2</sup>, Stephen Wallis, MB BChir<sup>1</sup>, Richard Biram, MBBS<sup>1</sup>, Victoria Keevil, PhD<sup>1,3</sup>



# Growth in DTOC & 7/7 stranded patients

## Requires us to Optimise acute care and grow community capacity & capability

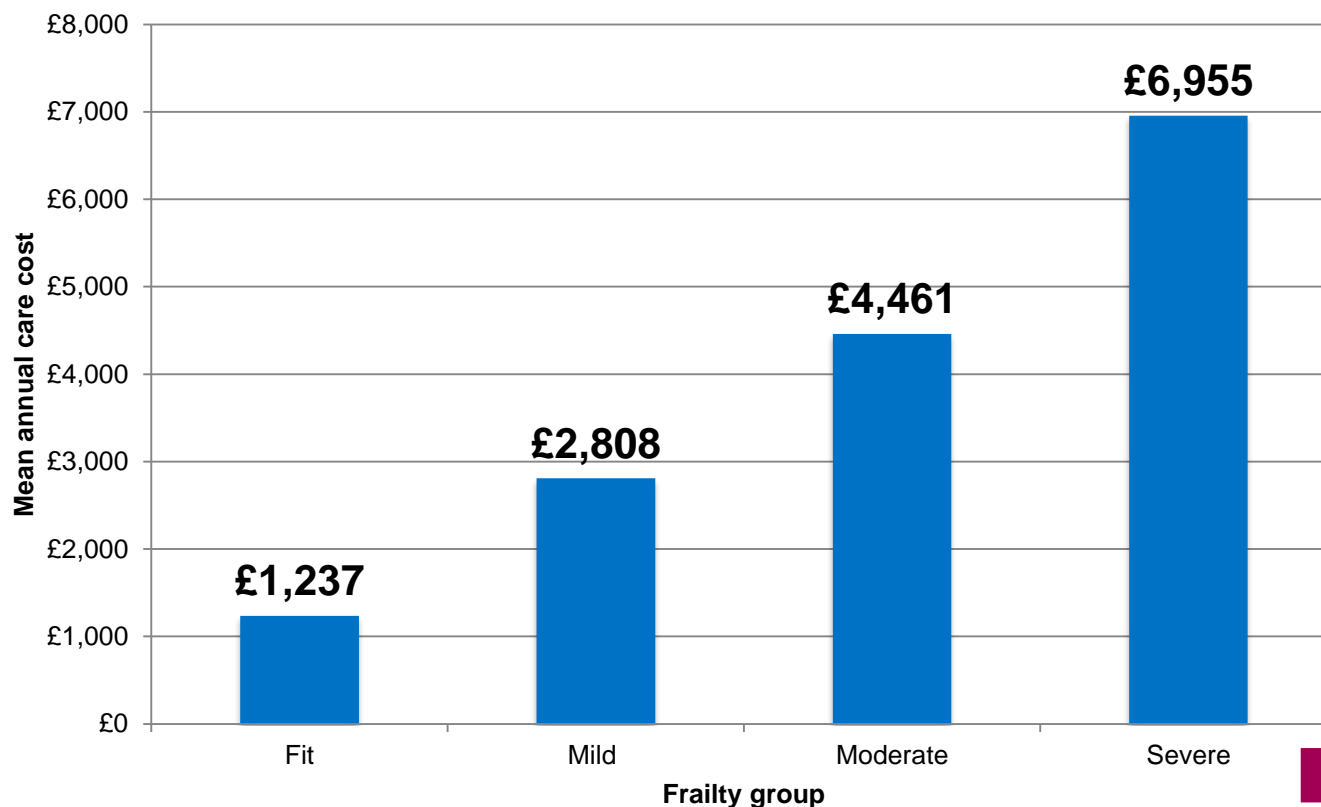


\* This assumes that only a negligible proportion of DTOCs are for non-emergency care

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

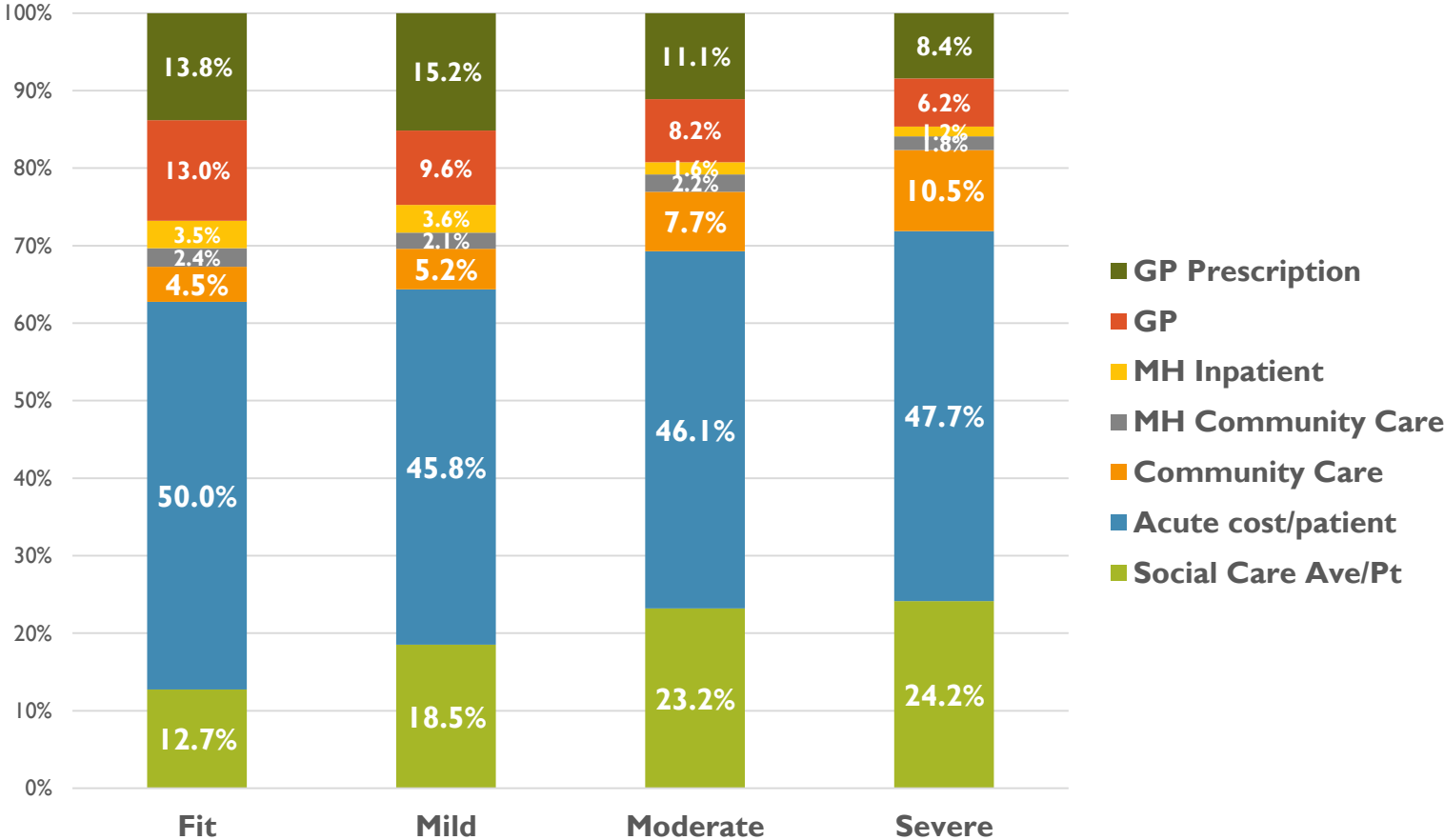
# Frailty is expensive when severe

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



# Costs distribute differently as frailty progresses

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



# NHS England Next Steps-Priorities

*'Health and high quality care –now and for future generations'*

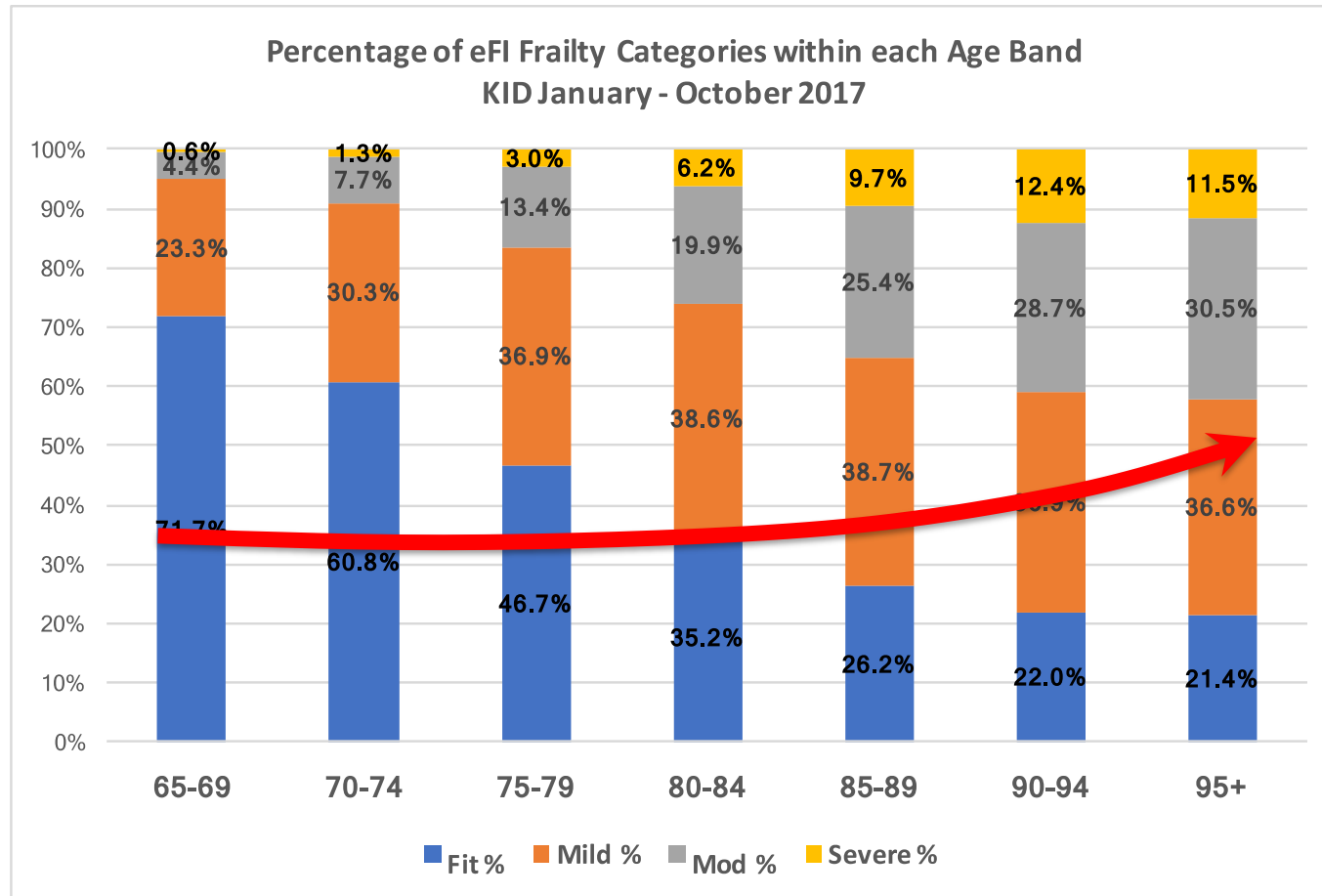
- ❑ **Urgent and emergency care 24/7:** **Admitting** sicker patients & **discharging** home promptly
- ❑ Next 2 years hospitals to free up 2-3K beds through **close community services working**
- ❑ **Cancer:** will affect 1 in 3 in lifetime: survival at record high (LTC)
- ❑ **Mental health:** loneliness, 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:**

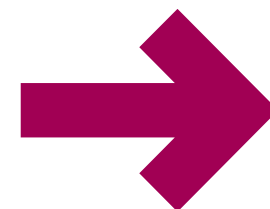
**Lowest economic quartile** frailty commences **earlier** in the life course and **progresses more rapidly**, contributing to **reduced life expectancy**

# 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*

Gross cost savings if 10% of cohort were less frail by one EFI stage		
	Per patient	For 10% of Kent cohort
Mild	£1,117	£8,878,776
Moderate	£1,228	£3,682,197
Severe	£1,982	£1,644,832

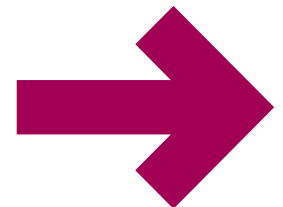


# Starting with..

## Routine timely frailty identification

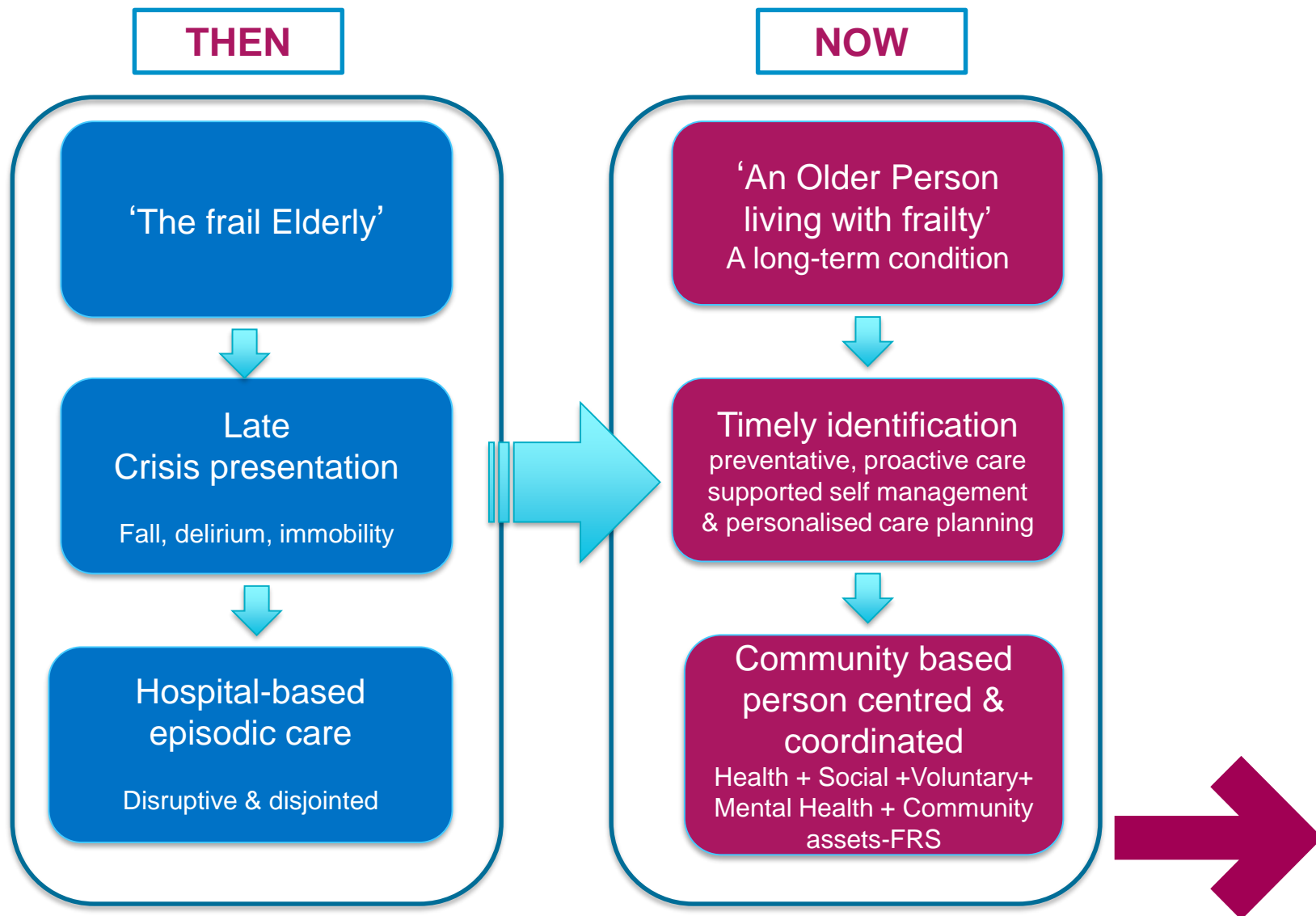
□ Routine frailty identification in primary care has 2 potential merits:

1. Population risk stratification
2. Targeted individualised interventions for optimal outcomes

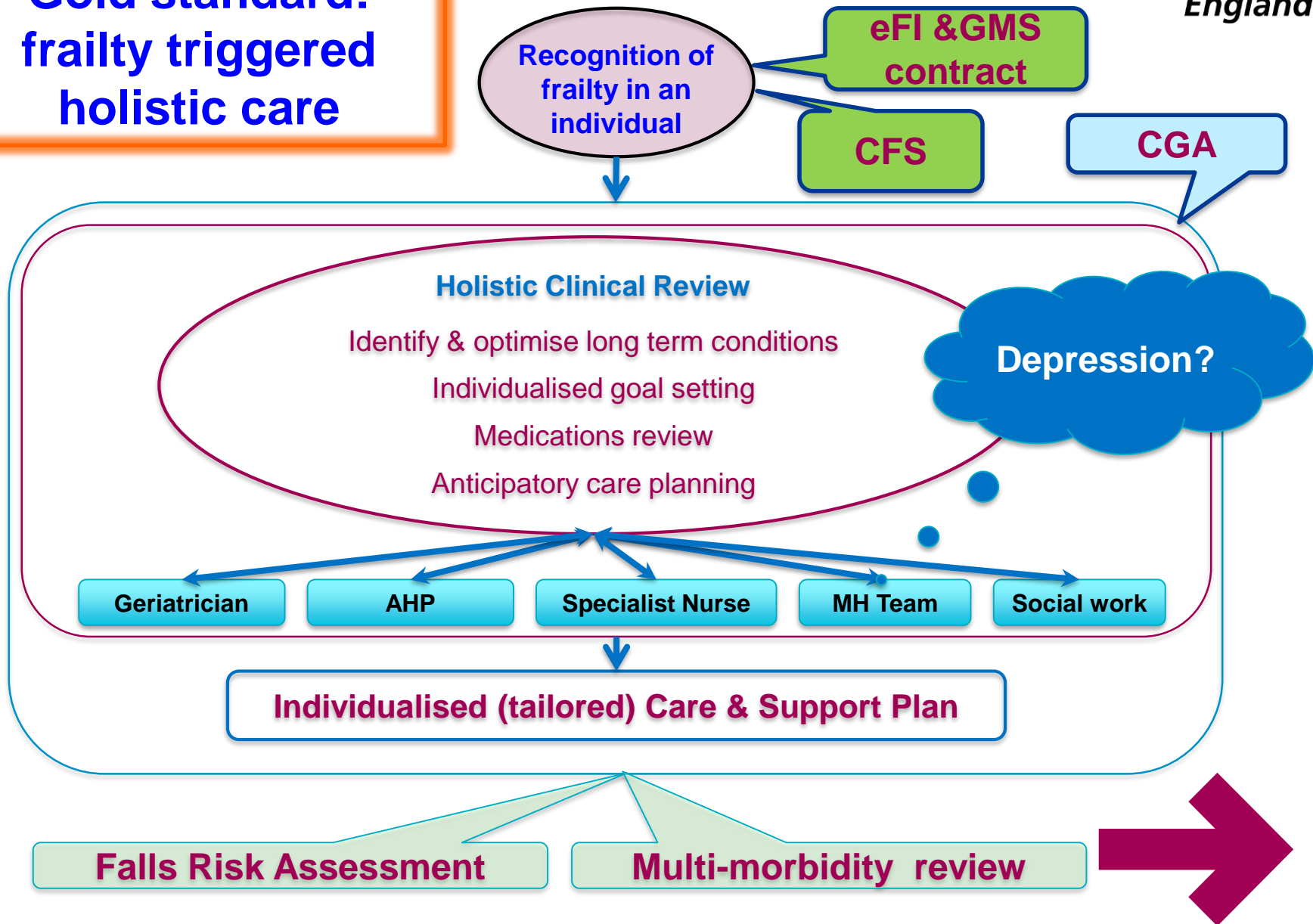




# Creating a Paradigm shift



**Gold standard:  
frailty triggered  
holistic care**

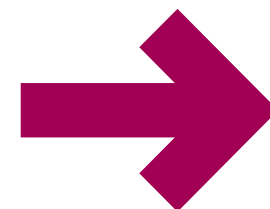


# Key enablers

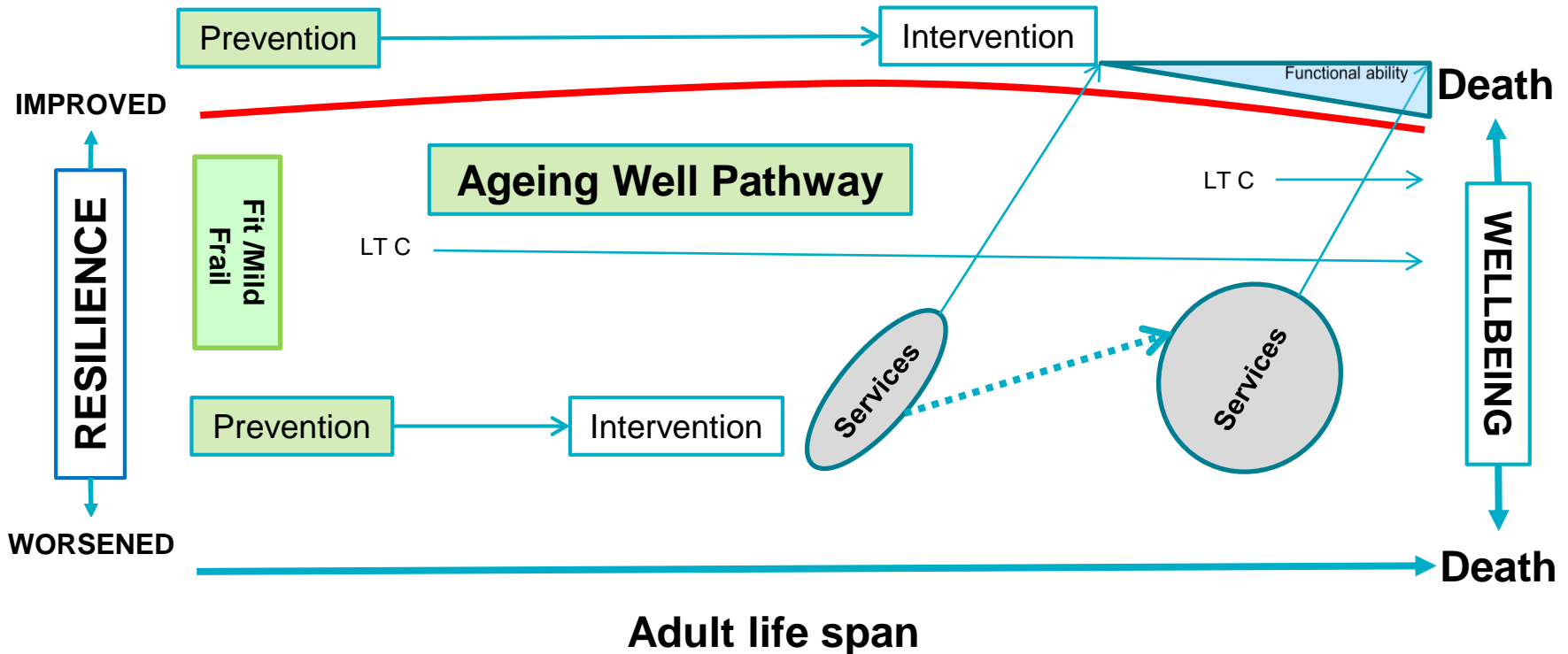
- **Population sub-segmentation** by need to guide planning
- Industrialising best practice through **national frailty standards**
- **Workforce development** (core skills, capability, competencies)
- **Data**: integrated, linked health and social care data
- **Existing best practice** models and frameworks
- **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]

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



# Population sub-stratification: Prevention



- **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**

# A testable eFI based currency (example)

## Preventing (where possible) while managing frailty progression

### Moderate frailty cohort

Cohort size (Q3 2017/18) :569,828 (5.8% 65+ England)

Mean/STP ~12950 patients per STP

Mean/CCG ~2700 patients per CCG

FMO-01 Moderate – recoverable (CFS=6 at time zero and <6 at time T)

FMO-02 Moderate – Stable (CFS=6 at time zero and time T)

FMO-03 Moderate – Progressive (CFS=6 at time zero and >6 at time T)

#### Suggested metrics

- Number recoverable= $n_{1t} - n_1$
- Number stable= $n_{2t} - n_2$
- Number progressive= $n_{3t} - n_3$
- Number community contacts
- Number outpatient attends
- Days spent in hospital in time t
- Days spent in own home in time t
- Patient wellbeing index change

### Recoverable



**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.

### Stable



**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.

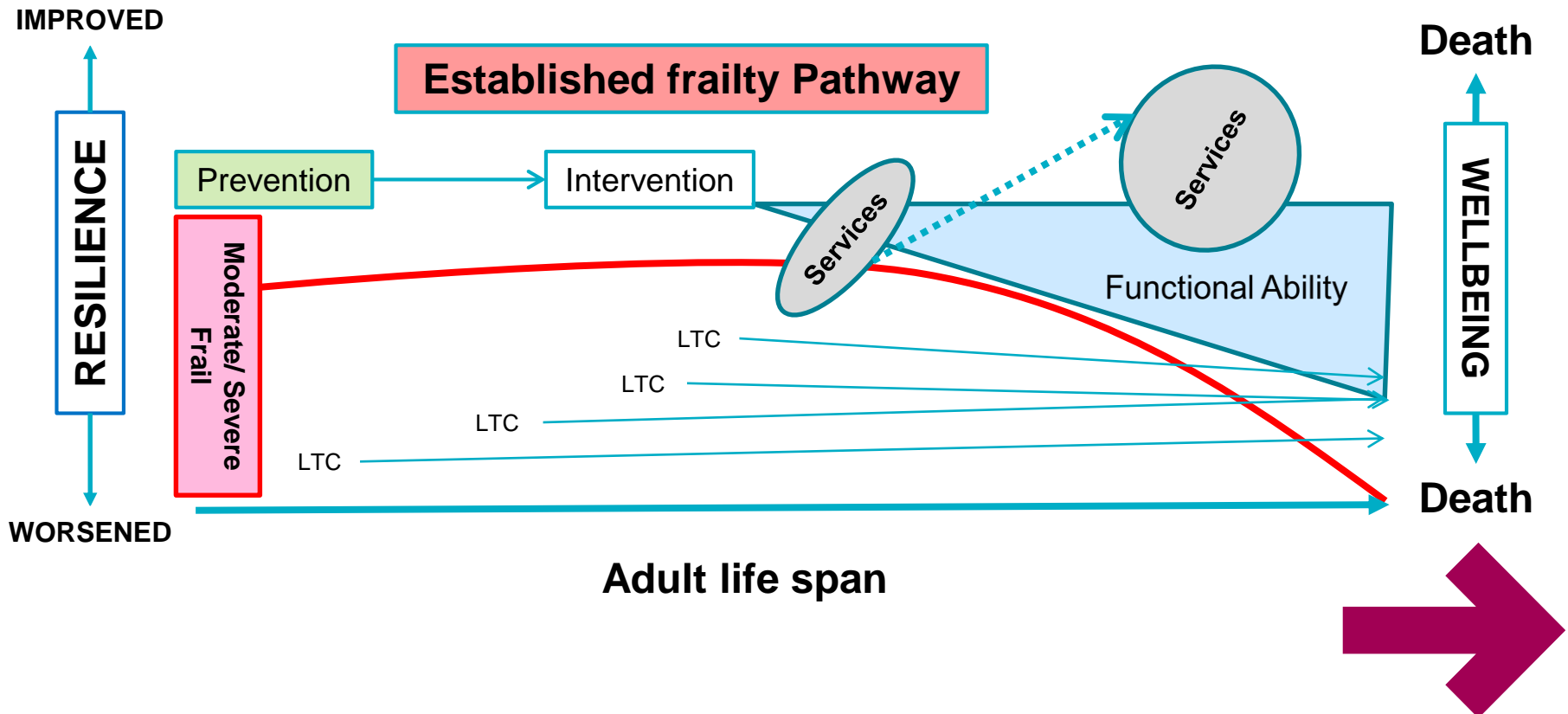


**9. Terminally Ill** - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

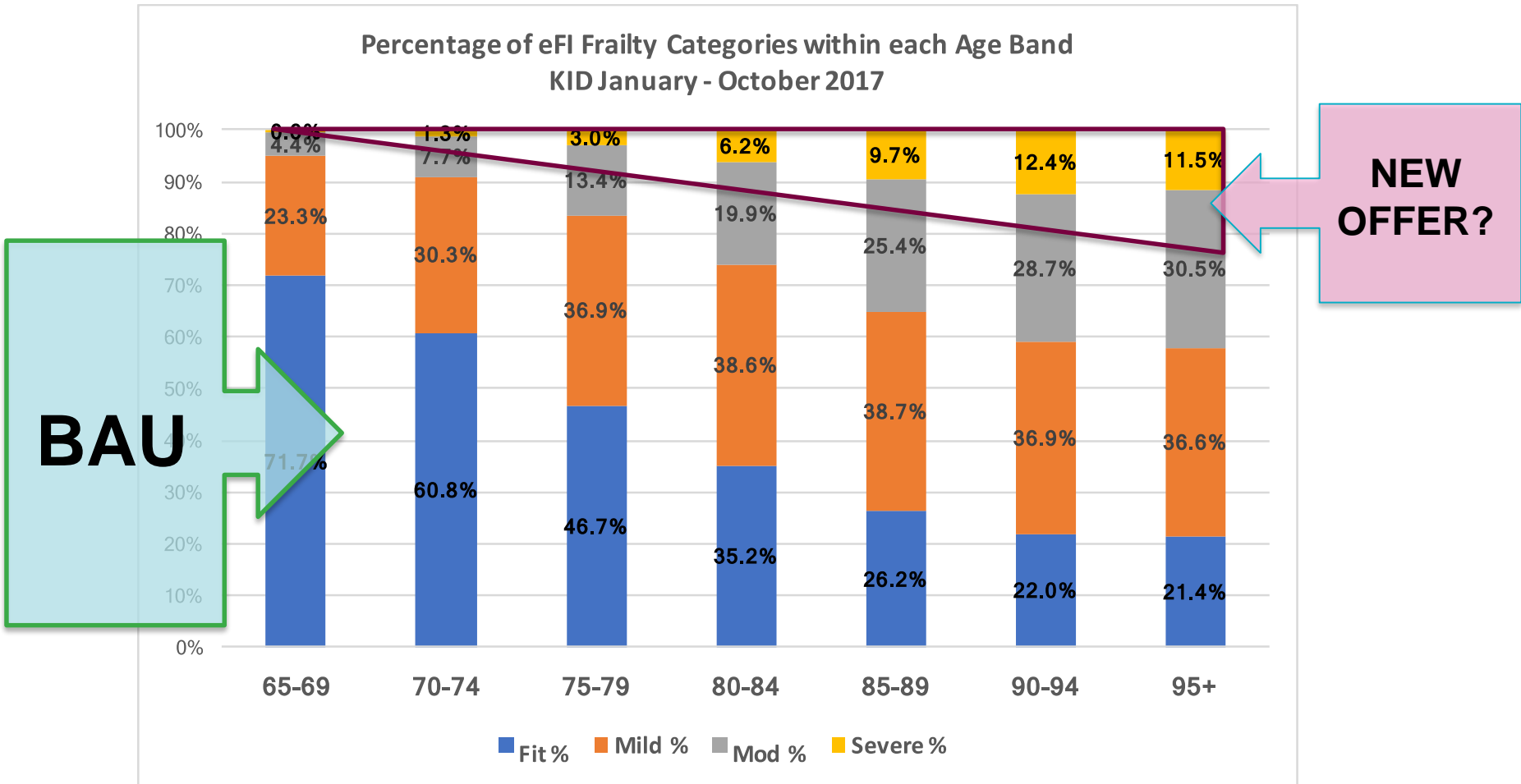


# Population sub-stratification: Intervention

- **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

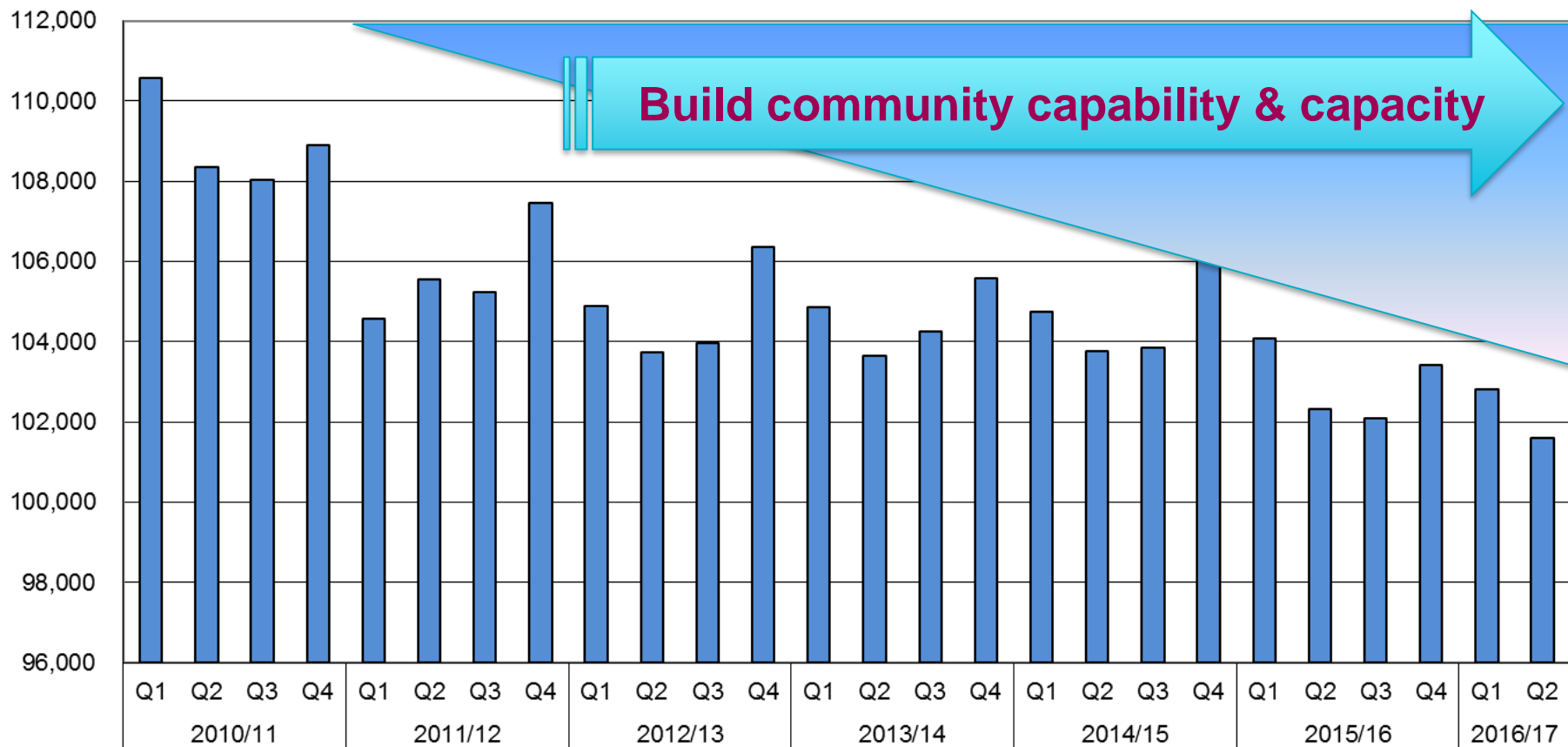




# Proactive & Reactive Community MDT care

## Integrated care system offer provides the alternative to hospital care

General and acute beds open overnight - 2010/11 onwards



8% reduction in general and acute beds since 2010: NHSB 2017

# Want to know and share more? [england.clinicalpolicy@nhs.net](mailto:england.clinicalpolicy@nhs.net)

## Supporting Older People living with Frailty

- Frailty Webinars 2017
- Resources (shared)
- Case studies
- Guidance documents
- futureNHS collaboration platform - key documents
- Frailty Fulcrum Animation
- Falls webinar and Resource Pack - Routine frailty identification in the GP contract
- Archive
- BLOG: Be careful using the F-word with frail patients: Professor Martin J Vernon
- Calendar
- Discussion Forum
- Organisation Contacts

Workspace home

### Workspace Home

#### 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

#### 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 and how does this compare with the new GP contract. Participants will receive 20 minutes

<https://future.nhs.uk/connect/ti/frailtyinprimarycare/groupHome>

[www.england.nhs.uk/ourwork/ltc-op-eolc](http://www.england.nhs.uk/ourwork/ltc-op-eolc)

