Ageing Well

Quality Healthcare in Later Life

National Frailty Approach

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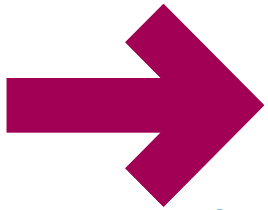
Ambition for frailty..

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



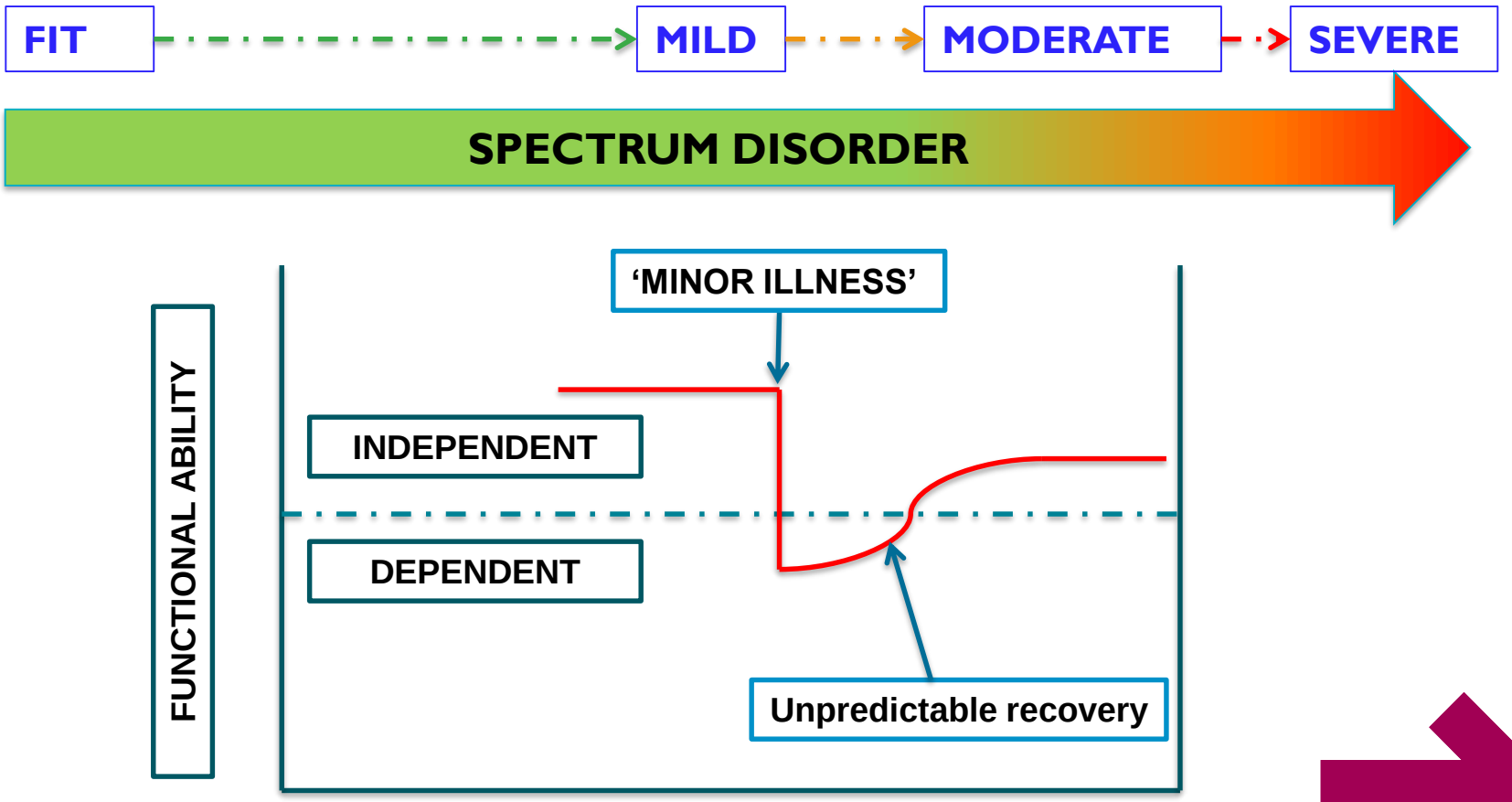
In other words…

It's something we can all get around locally

What do we mean by frailty?

NHS England

"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?

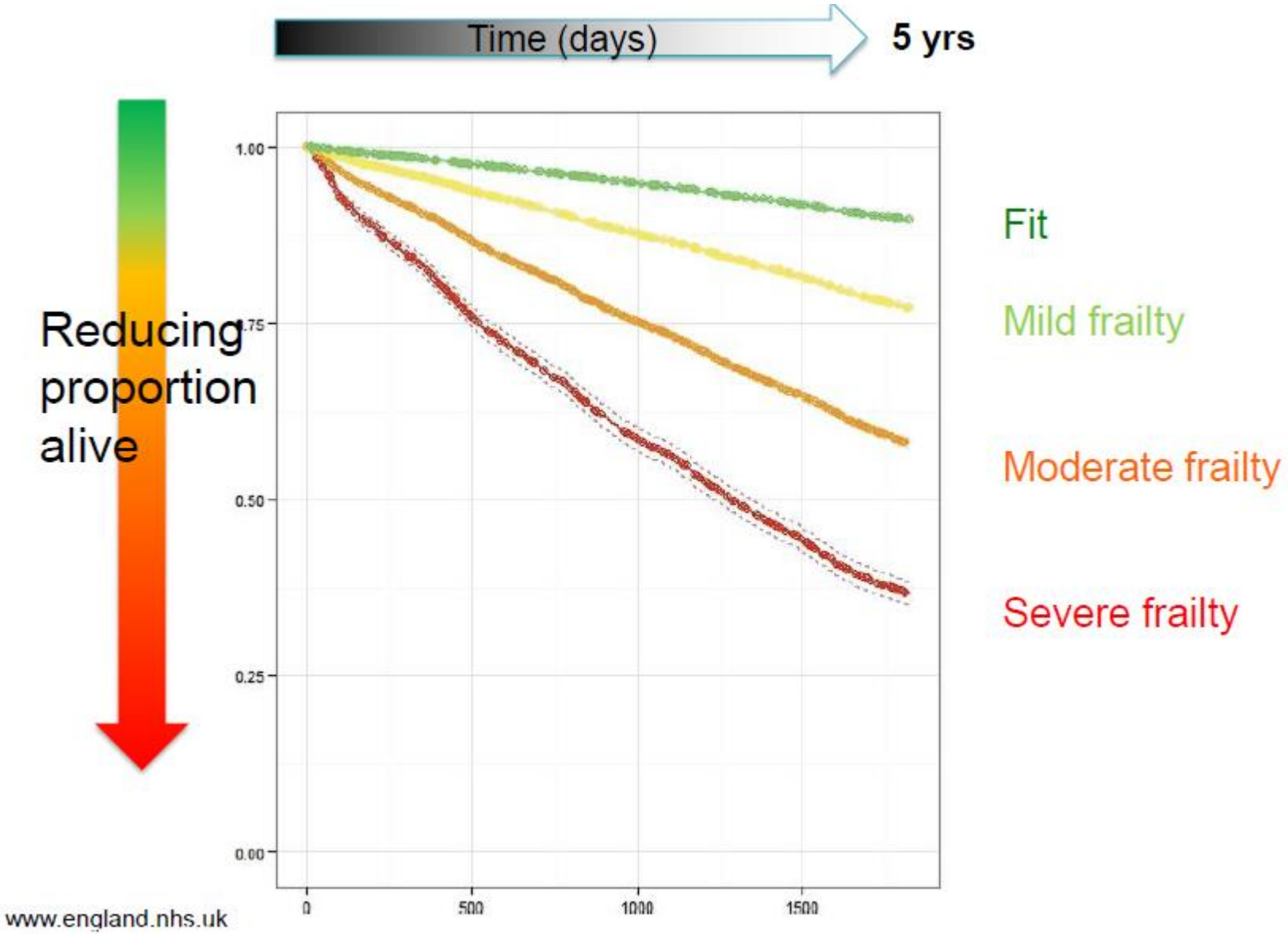
- **Timely identification of people at risk** with **complex care needs**
- It permits **sub-stratification by needs**, not age
- It crosses health & social care, **so can drive integration**
- It's **predictive:** finding those who benefit from **active and healthy ageing**
- It will **guide & track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

Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study: *Guzman-Castillo et al, Lancet Public Health 2017*

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**

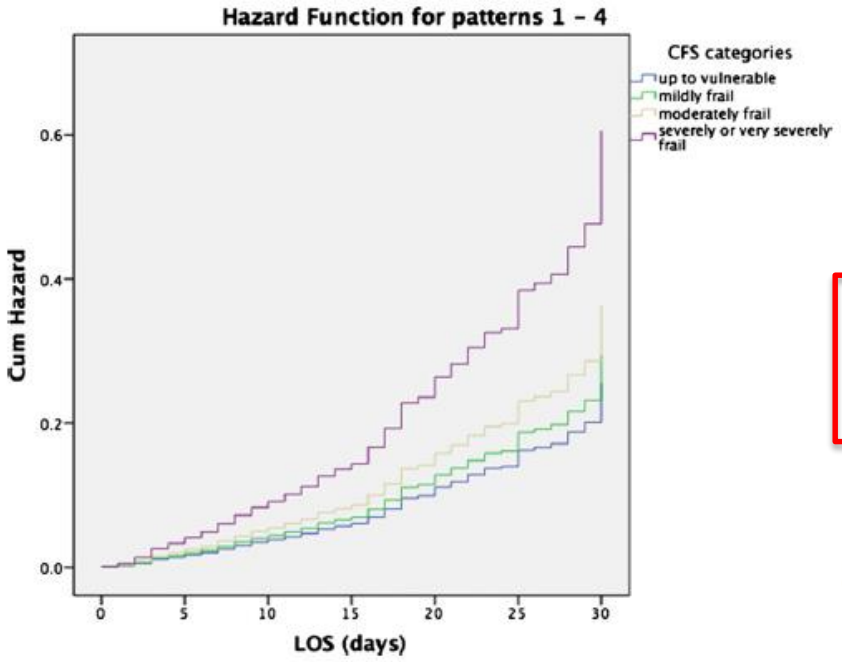


TABLE 4. Results of Multivariate Regression Models

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

	Unstandardized coefficients			95% CI for OR		
	B	Std. error	OR	Lower bound	Upper bound	*P*
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 ≥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☆

Roman Romero-Ortuno [a,b,*], Stephen Wallis [a], Richard Biram [a], Victoria Keevil [a,b]

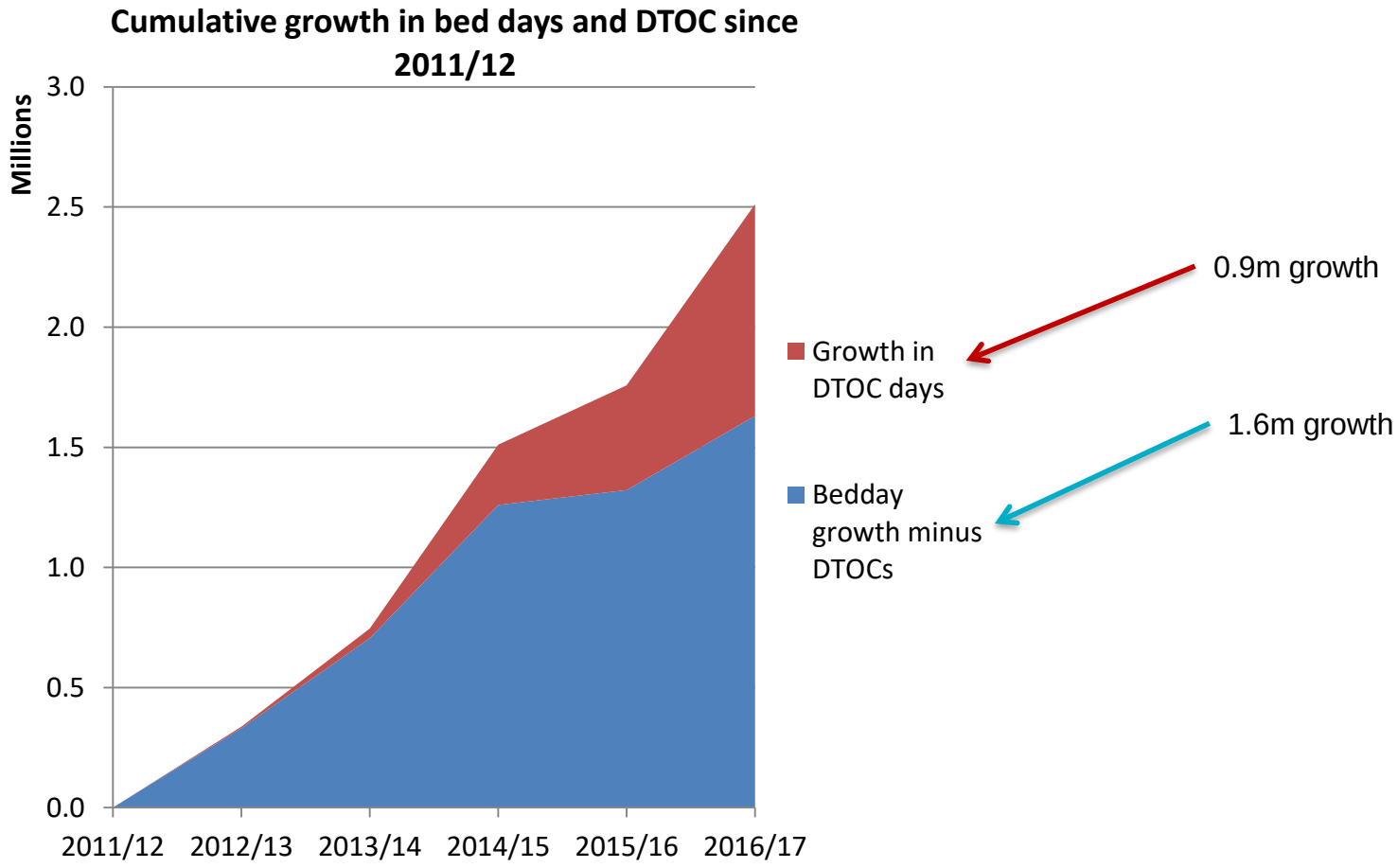
[a] Department of Medicine for the Elderly, Addenbrooke's Hospital, Cambridge, United Kingdom
[b] Clinical Gerontology Unit, Department of Public Health and Primary Care, University of Cambridge, United Kingdom

The Association of Geriatric Syndromes with Hospital Outcomes

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

Growth in DTOC & 7/7 stranded patients

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

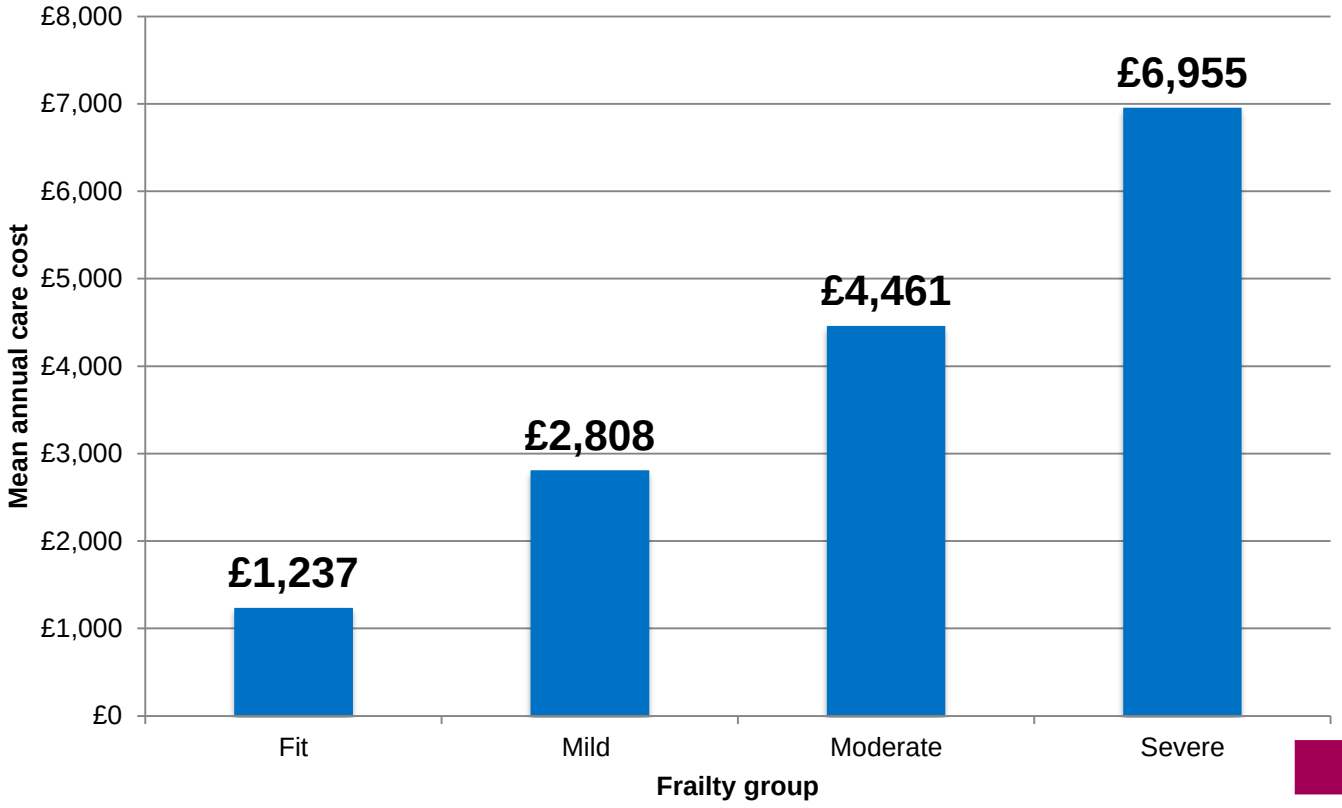


* This assumes that only a negligible proportion of DTOCs are for non-emergency care

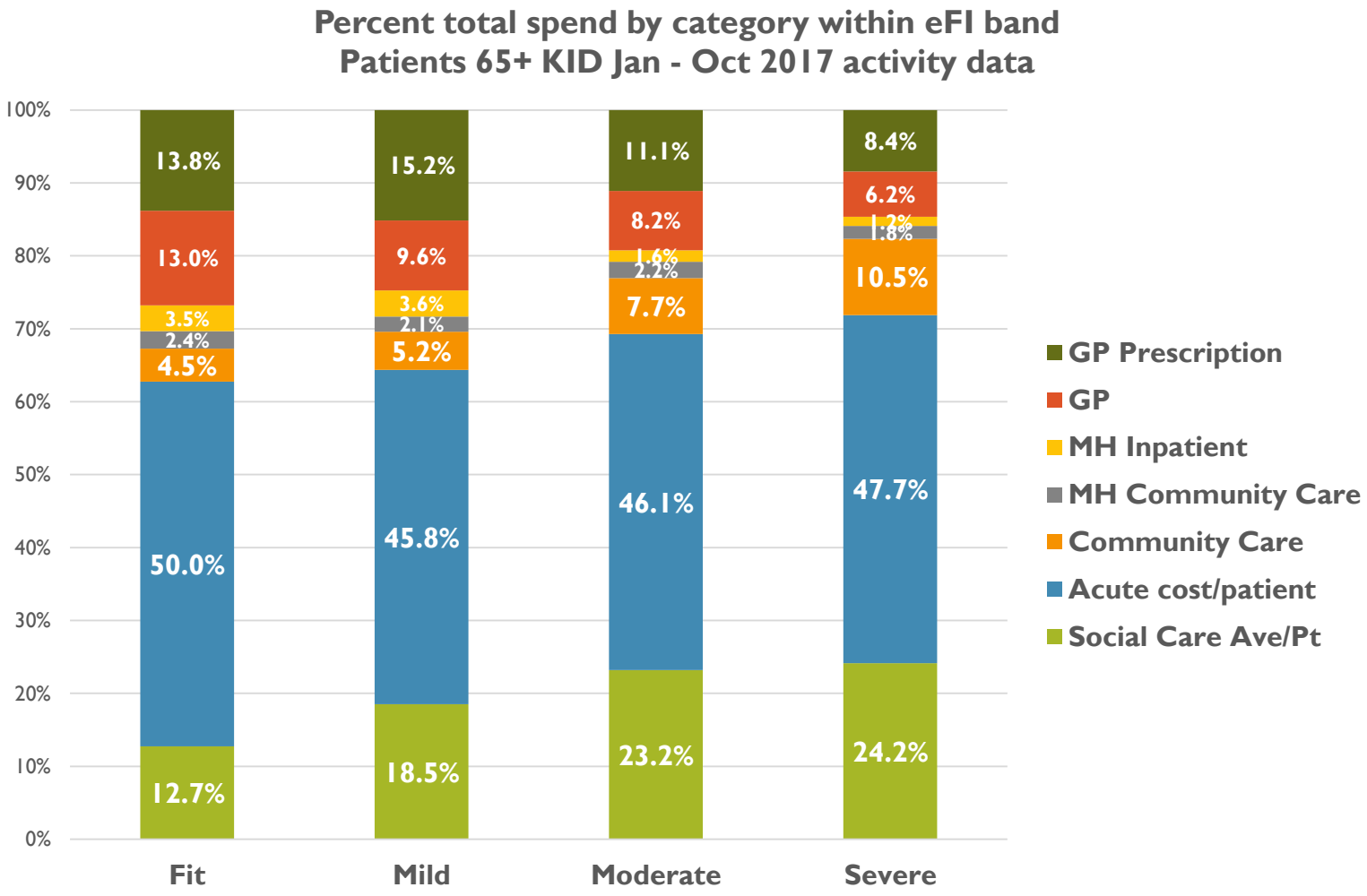
Sources: NHS England published DTOC Data - April 2011 - March 2017
SUS bed days data for financial years 2010/11 to 2016/17

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



NHS England Next Steps-Priorities

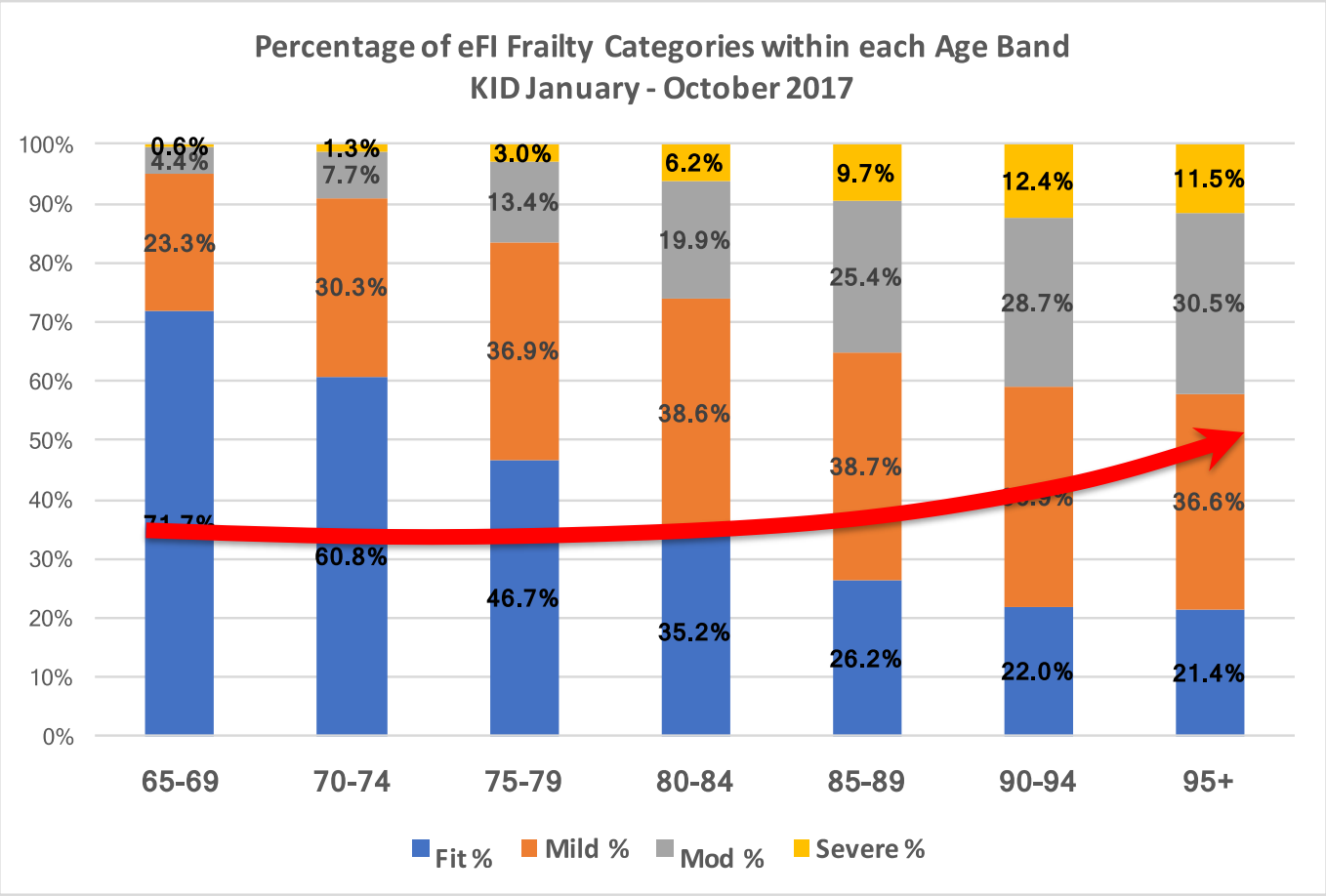
'Health and high quality care –now and for future generations'

- **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..

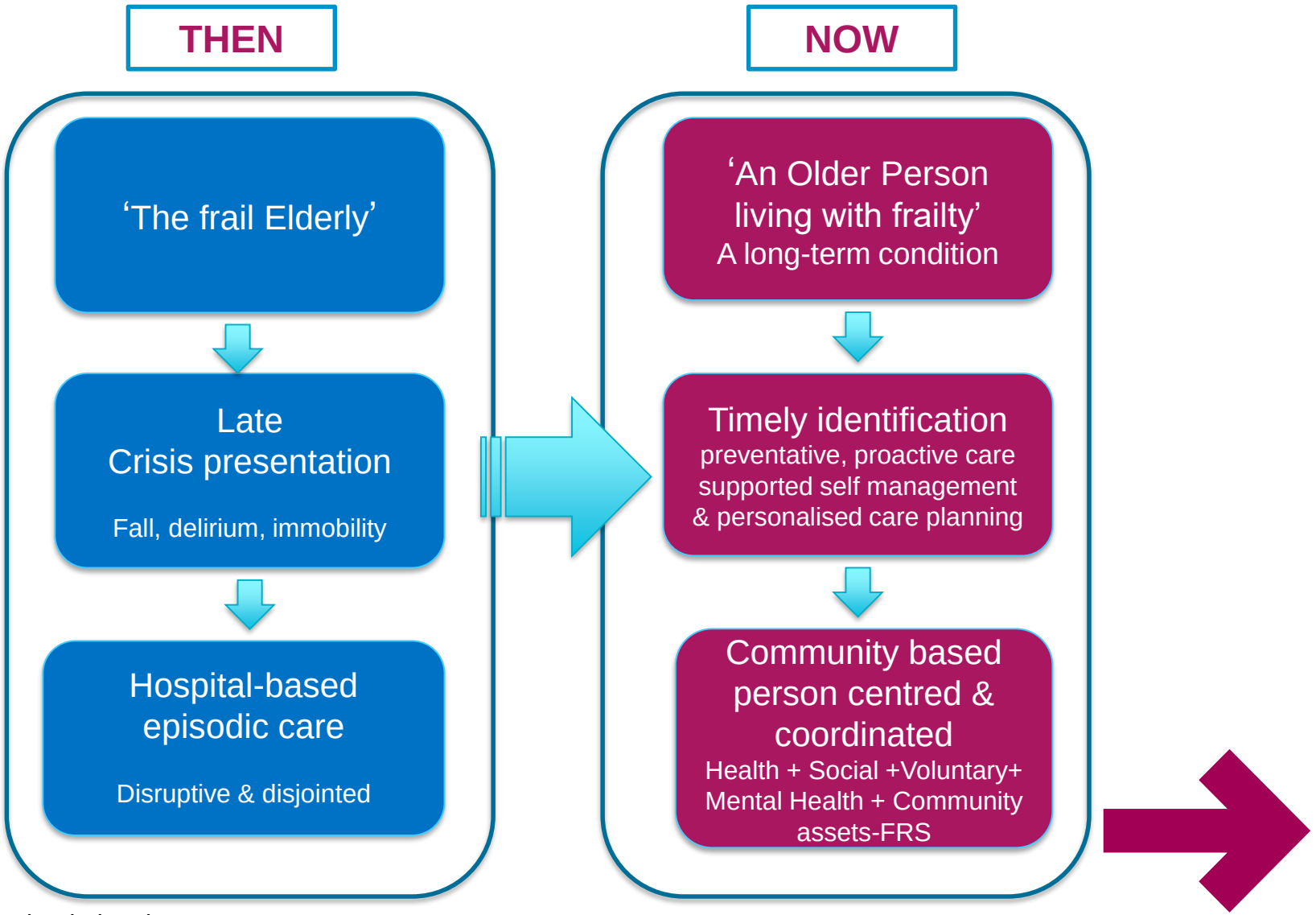
Routine timely frailty identification

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

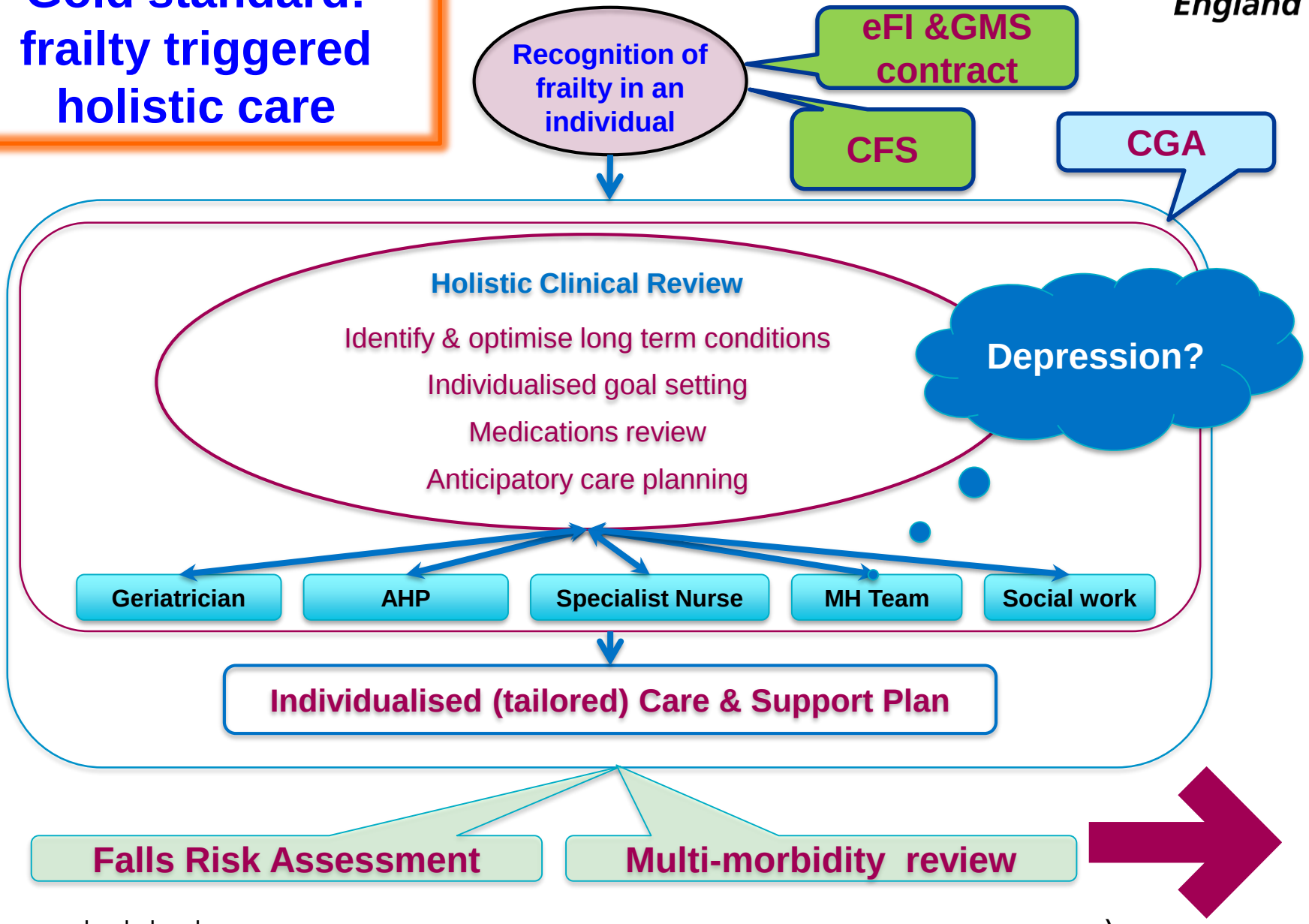
1. **Population risk stratification**

2. **Targeted individualised interventions for optimal outcomes**

Creating a Paradigm shift



Gold standard: frailty triggered holistic care



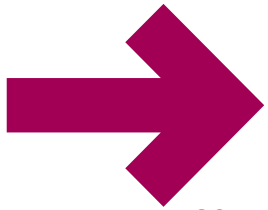
Adapted from BGS: Fit for Frailty (2014)

Key enablers

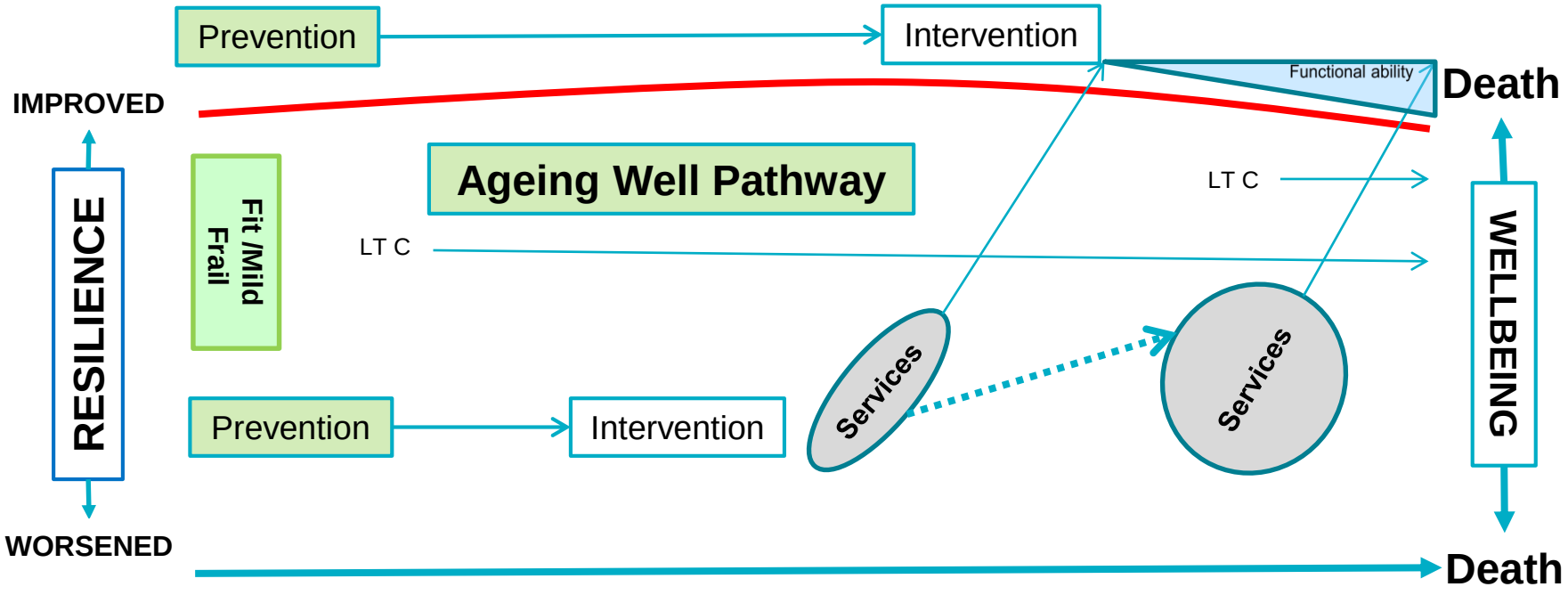
- **Population sub-segmentation** by need to guide planning
- Industrialising best practice through **national frailty standards**
- **Workforce development** (core skills, capability, competencies)
- **Data**: integrated, linked health and social care data
- **Existing best practice** models and frameworks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

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+
Total moderately frail	569,828	5.8% 65+
Total severely frail	295,180	3% 65+
Total moderate and severely frail	**865,008**	**8.82% 65+**
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

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**

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)

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.

Progressive

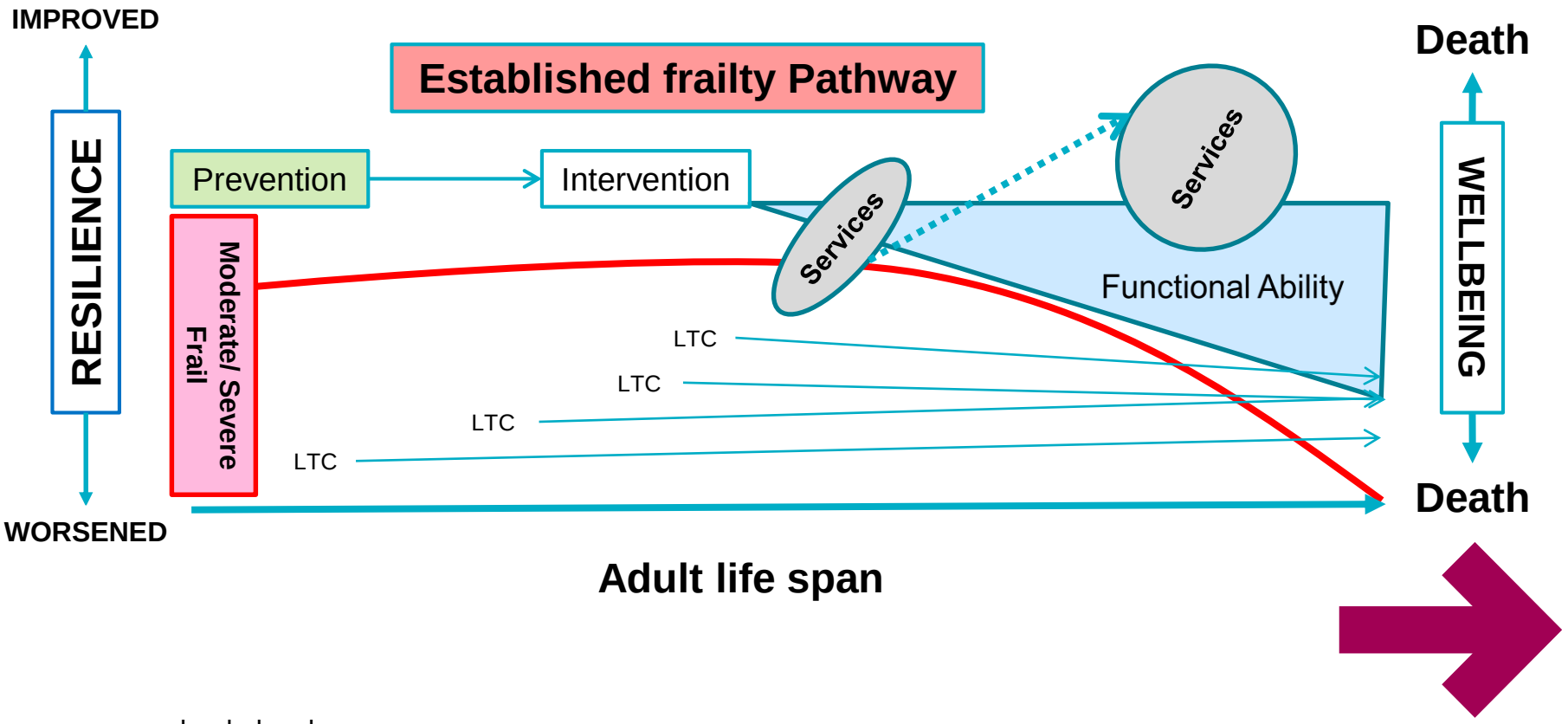
7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

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

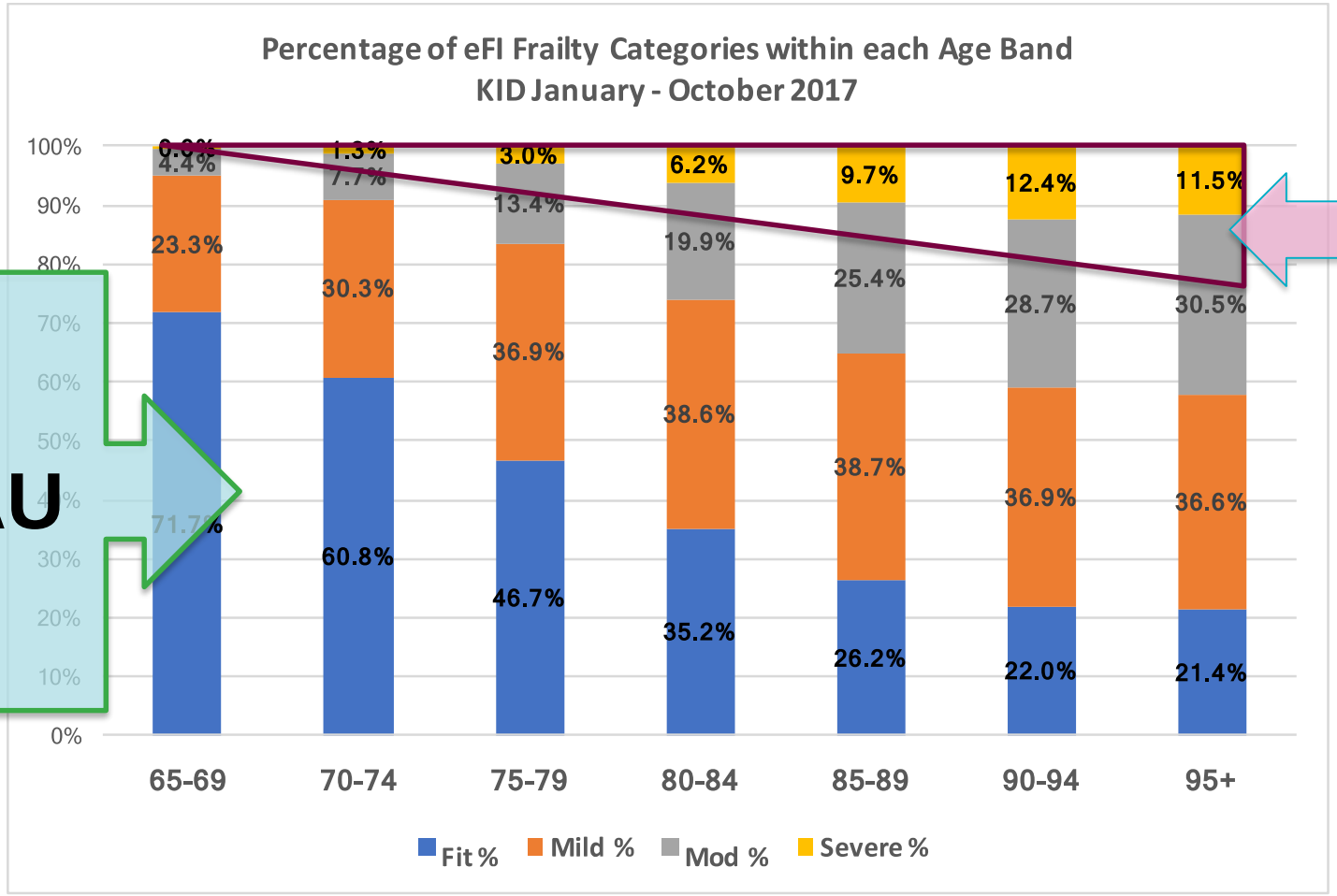
9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

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

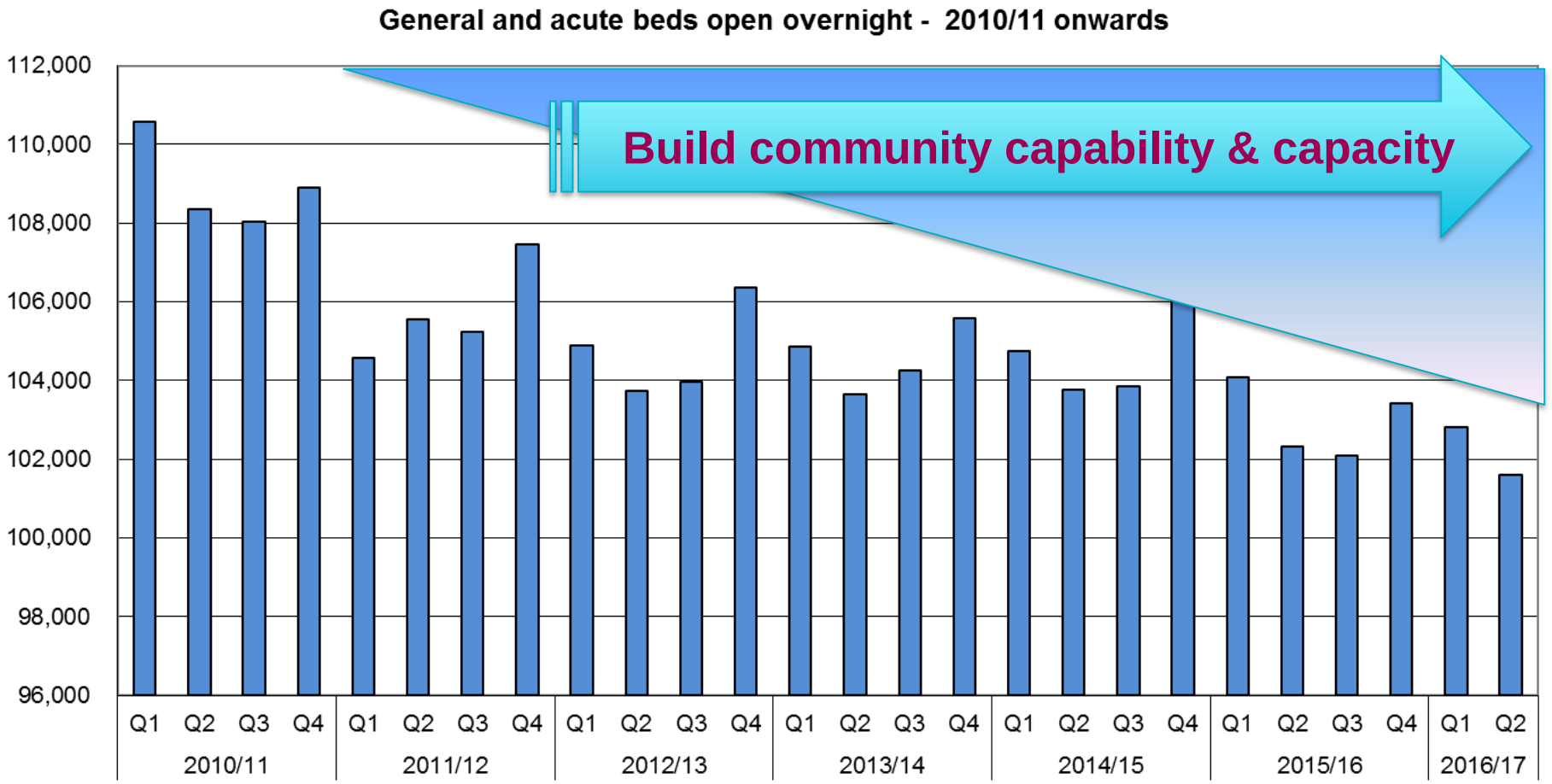


BAU

NEW OFFER?

Proactive & Reactive Community MDT care

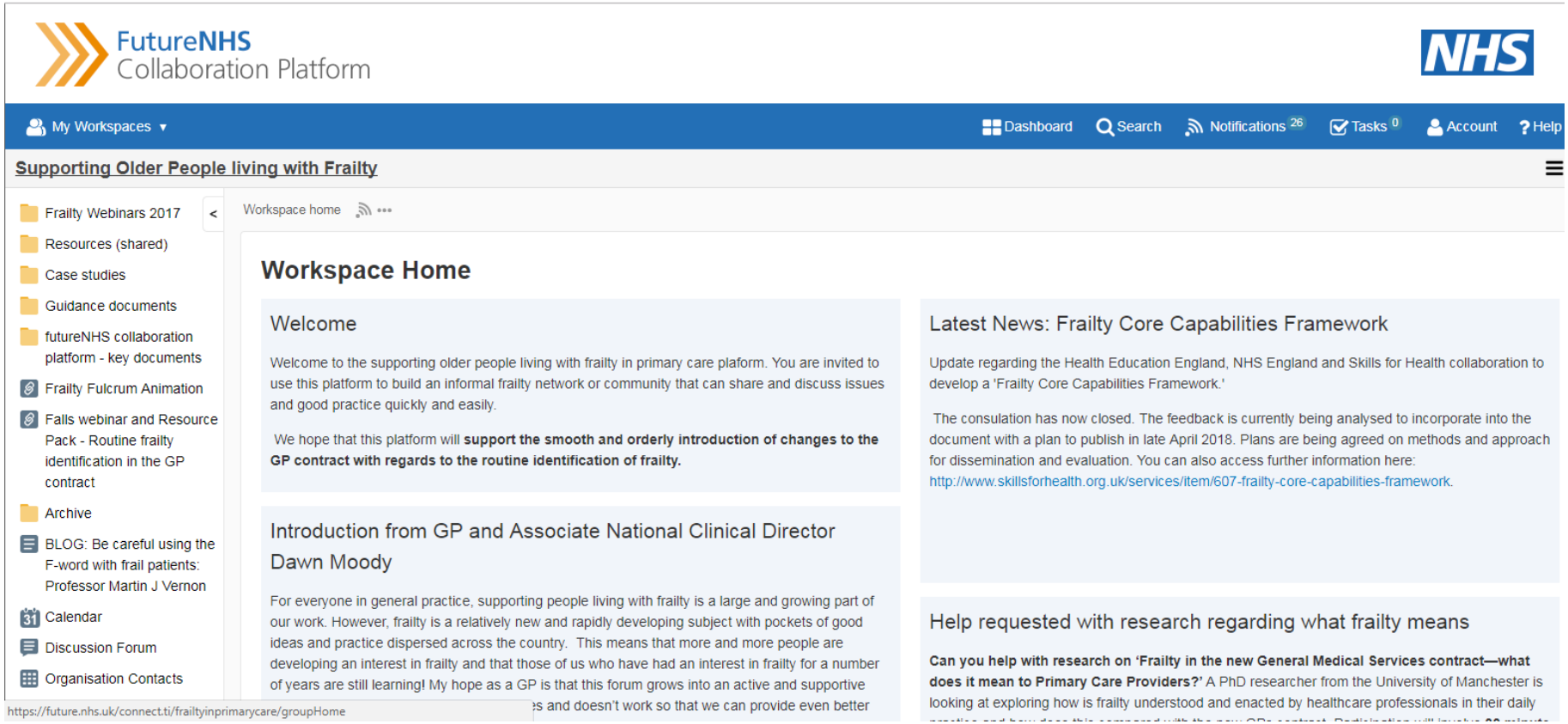
Integrated care system offer provides the alternative to hospital care



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

Want to know and share more?

england.clinicalpolicy@nhs.net



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