Frailty as a long-term condition: its management in primary care

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Frailty as a Long Term Condition?

A Long Term Condition 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
Implementation of a pathway of care for older people living with frailty – NHS England Guidance

If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm.

This document summarises the evidence of the effects of an integrated pathway of care for older people and suggests how a pathway can be commissioned effectively using levers and

http://www.england.nhs.uk/ourwork/pe/safe-care/
NHS England Service Component Handbooks

Using case finding and risk stratification:
A key service component for personalised care and support planning

Personalised care and support planning handbook:
The journey to person-centred care
Executive Summary

MDT Development
- Working toward an effective multidisciplinary/multiagency team

http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care
www.england.nhs.uk
Frailty Toolkit for Primary Care

Includes:
- Case finding tools and advice
- How to populate frailty registers and read coding
- Comprehensive geriatric assessment
- Care coordination
- Care planning
- Medication review in frail older people

Five Year Forward View
New Care Models Vanguards

Integrated primary and acute care systems – joining up GP, hospital, community and mental health services
Multispecialty community providers – moving specialist care out of hospitals into the community
Enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services
Urgent and emergency care – new approaches to improve the coordination of services and reduce pressure on A&E departments

A further wave of vanguards is now in the application process – known as acute care collaborations, these will aim to link local hospitals together to improve their clinical and financial viability.
Identifying Older People Living with Frailty.
Our session today:

- Recognising Frailty
- Interventions in primary care
- Prevention of admissions for frailty
Where is frailty?

“I know it when I see it but what I see may not be the same as what everyone else sees”

Community dwelling adults aged 65+ = 7% - 12%
Community dwelling adults aged 85+ = 25% - 50%

The Frailty Paradox
Not recognised
Not diagnosed
Not recorded

Frailty – a complex syndrome of increased vulnerability

Prevent/delay frailty
Primary prevention
Health promotion

Delay onset

Life course determinants:
- Biological
- Genetic
- Psychological
- Social
- Environmental

Decline in physiologic reserves +
- Multiple long term conditions

Candidate markers:
- Nutrition
- Mobility
- Activity
- Strength
- Endurance
- Cognition
- Mood

Adverse Outcomes:
- Disability
- Morbidity
- Hospitalisation
- Institutionalisation
- Death

Delay/prevent adverse outcomes

Reversibility

Frailty is a loss of physiological reserve

Frailty presenting in crisis as sudden loss of mobility/independence

Frailty presenting in crisis as a fall

Frailty presenting in crisis as delirium

FUNCTIONAL ABILITIES

Brain function

Alert/orientated

Acute confusion/delirium

Clegg, Young, Rockwood Lancet 2013
Primary care electronic Frailty Index (eFI): survival plots (n=227,648; >65y)

Proportion alive

Time 5 yrs
Frailty & palliative care

Gill NEJM 2010
Concepts of frailty

What does it mean to identify as frail?

Britain Thinks (2015) Frailty: Language and Perceptions. tinyurl.com/pz7qq92
(Last accessed: August 21 2015.)
Is ‘frail’ a helpful term?

From the perspective of the older people, carers and non-specialist HCPs the answer would seem to be NO

• Frail isn’t part of older people’s vocabulary when describing themselves and their lives
• Term provokes a very emotional reaction – usually incredulity and offense – amongst older people
• For carers the term is less emotionally charged but still suggest a situation that is serious and irreversibly
• For clinicians the term is not front of mind or used clinically - instead used as shorthand to describe a person perceived to be very dependent

“No, I’m definitely not frail. Frail means you’re dodgy and shaky. You can’t do anything at all.”
Female, 71, South (6 on Rockwood scale)

“Only specialist doctors use ‘frail’. For example our hospital has a frailty elderly project. The only other time I hear or see it used is on resuscitation forms as a reason for not.”
Ward Manager, South

“It’s used in end of life care for patients with cancer or very old age.”
Older GP, North
Words matter…..

Ultimately **for the public**, the word ‘frailty’ is understood to mean an **irreversible state** that **some** older people enter into in the **very final stages of their lives** that means almost **total loss of independence**

**Non-specialist HCPs** tend to conceive of frailty as a **descriptive term for a state** and many had a real aversion to ‘descriptive’ language to classify patients that they **wouldn’t feel comfortable using to a patient’s face**
So what do older people say?

Older people describe frailty and wellbeing in terms of **everyday tasks** and **how it feels** if these tasks start to become difficult....

**Domestic activities**
- Cleaning, washing and ironing
- Shopping and preparing meals

**Outdoor activities**
- Gardening
- Walking / walking the dog

**Social activities**
- Going out with friends / family to restaurants, cafes, pubs, organised events, shops

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“*My house always used to be so spotless. I do feel useless sometimes that I can’t keep it like I used to.*”
Female, 85, North (7 on Rockwood Scale)

“*It’s very annoying. I can’t do things I used to do - I used to do all of my windows and my nets.*”
Female, 71, South (7 on Rockwood Scale)

“*It’s disheartening really, because your brain tells you can walk but then your body can’t do it.*”
Male, 83, South (6 on Rockwood Scale)

“*My friend and I go out to the shops for a look around and a cup of tea and a piece of cake. It’s the highlight of my week.*”
Female, 83, North (7 on Rockwood Scale)
And older people tend to conceive their ability to live independently as a ‘spectrum’……

- **Less independent**
  - Losing independence *entirely* and becoming totally reliant on support
    - Synonymous with entering into a care home or hospital for many older people
  - Becoming almost or totally *unable* to manage personal hygiene *without (significant) support*
    - Viewed as a distinct ‘step up’ in terms of invasiveness of support
  - Becoming almost or totally *unable* to do the everyday tasks important to maintaining the status quo *without (significant) support*
    - When coping mechanisms and adaptions are no longer sufficient to ‘get by’
  - Being able to do everyday tasks to maintain the status quo *with some minor adaptations or ‘light touch’ support*
    - Often through coping mechanisms older people develop themselves
    - And in some circumstances, through informal help from others (e.g. relatives)
  - Being able to do everyday tasks that are critical to maintaining the status quo *without any support from others*
    - For older women, this is particularly about keeping up the routine at home
    - For men, this is often tied up with outdoor and social activities

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And emotional language matches up…..

Less independent

“Getting frail”  “Giving up”

“Losing control”  “Not coping”  “Feeling vulnerable”  “Feeling weak”

“Struggling”  “Feeling frustrated”  “Feeling low”  “Finding things tough”

“Getting slower”  “Feeling tired”  “Lacking in strength”

The status quo......
Frailty Diagnosis

Is there a diagnostic test?
Frailty syndromes

- Falls
- Immobility
- Delirium/acute confusion
- Incontinence
- Susceptibility to side effects of medication
Assessing frailty

3 out of the following 5 indicates frailty:

- Unintentional weight loss (10 pounds or more in a year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow walking speed
- Low levels of physical activity.
Gait Speed Test

The 4m walking speed test detects frailty

>5 seconds for 4m predicts:

✓ Disability
✓ Long-term care
✓ Falls
✓ Mortality

Van Kan et al JNHA 2009; 13:881
Systematic Review of 21 cohorts

Studenski et al, 2011

http://www.nihtoolbox.org/WhatAndWhy/Motor/Locomotion/Pages/NIH-Toolbox-4--Meter-Walk-Gait-Speed-Test.aspx
Rockwood Clinical Frailty Scale

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 “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.

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.

Where dementia is present, the degree of frailty usually corresponds to the degree of dementia:

- Mild dementia – includes forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

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

- Severe dementia – they cannot do personal care without help.


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Geriatric Medicine Research, Dalhousie University, Halifax, Canada
Prisma 7 Questions

1] Are you more than 85 years?
2] Male?
3] In general do you have any health problems that require you to limit your activities?
4] Do you need someone to help you on a regular basis?
5] In general do you have any health problems that require you to stay at home?
6] In case of need can you count on someone close to you?
7] Do you regularly use a stick, walker or wheelchair to get about?

> 3 indicates frailty

Identification of frailty using existing primary care data

**Question:**
- Is it possible to construct a frailty index using existing data contained in the electronic GP record?

**Answer:**
- Yes
- We have developed & validated an electronic frailty index (eFI) using de-identified data from around 500,000 UK GP patients records, using the ResearchOne database
Cumulative Deficit Model of Frailty: Frailty Index *(Rockwood et al)*

“The more things that are wrong with you, the more likely you are to be frail”

- Frailty Index counts “deficits”
- A deficit is a thing that is wrong with you (symptom, sign, disease or disability)

Frailty Index = the proportion of deficits accumulated over time

**Simple calculation:**

- Zero deficits from list of 50: \( FI = \frac{0}{50} = 0 \)
- Ten deficits from list of 50: \( FI = \frac{10}{50} = 0.20 \)
- Frailty Index(s) based on deficit accumulation closely related to risk of death (Mexico, China, Canada, Europe etc. …)
New Read Codes for Frailty

CTV3
X76Ao | Frailty
   XabdY | Mild frailty
   Xabdb | Moderate frailty
   Xabdd | Severe frailty

Read V2
2Jd.. | Frailty
   2Jd0. | Mild frailty
   2Jd1. | Moderate frailty
   2Jd2. | Severe frailty
Comprehensive Geriatric Assessment

- The gold standard for the management of frailty
- It involves an holistic, multidimensional, interdisciplinary assessment of an individual
- CGA typically results in the formulation of a list of needs and issues to tackle, together with an individualised care and support plan, tailored to an individual’s needs, wants and priorities.
Domains of the CGA

• Physical Symptoms – include pain, underlying LTCs
• Mental Health Symptoms – include memory, mood
• Level of function in daily activity – include personal care and life functions
• Social Support Networks – include informal and formal. Consider family/carer needs
• Living Environment – state of housing, facilities and comfort.
• Level of Participation and individual concerns
• Compensatory mechanisms and resourcefulness which the individual uses to respond to having frailty.

Primary Care Based Comprehensive Geriatric Assessment

Systematic Review & Meta-analysis

• Reduced risk of not living at home
• Reduced care home admissions
• Reduced hospital admissions
• Reduced falls
• Improved physical function
• No effect on mortality

• Need to focus on the frail
Recognition of Frailty in Primary Care

Recommendations

Older people should be assessed for the possible presence of frailty during all encounters with health and social care professionals.

Provide training in frailty recognition to all health and social care staff who are likely to encounter older people.

Do not offer routine population screening for frailty.
Interventions along the pathway: What works?

http://www.york.ac.uk/inst/crd/effectiveness_matters.htm
Mrs Greenaway was found on the floor with new confusion by the home care staff and taken to hospital where it was found to be poorly mobile.

“She was a fall waiting to happen.”

Home care staff

- Fall
- Delirium
- Immobility
Another view of Mrs Greenaway .......

85 years
Lives alone
Recently in hospital following a fall
Broken hip 2011
Chronic heart failure
Diabetes
Chronic Kidney Disease
Taking 10 medications

Review 1
Review 2
Review 3
Review 4

System designed to fragment care into packages

....... and the frailty???
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)

“I’d like my life back please!”
Yet another view of Mrs Greenaway

What are the most important things you’d like to discuss today?

1. The pain in my feet
2. Difficulty sleeping
3. Getting out for a chat
4. I don’t like all these tablets; do I really need them all?

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Evidenced-based approach for older people with frailty (& multimorbidity) in primary care

- Assess for frailty during all healthcare encounters
- Record frailty, and frailty severity, using Read codes
- Support self management in mild frailty - reversibility
- In people with moderate or severe frailty, carry out a comprehensive geriatric assessment to:
  - diagnose medical illnesses and optimise treatment
  - conduct a medication review
  - generate a personalised care and support plan
- Refer for specialist assistance in complex or uncertain diagnoses
- Share health record information between primary care, emergency services, secondary care and social services.
- In people with very severe frailty, offer Advance Care Planning

Effectiveness Matters: Recognising and managing frailty in primary care
www.england.nhs.uk
Discussion:
Can we prevent admissions for frailty and why would we want to?
Why worry?

Look at the patient lying alone in bed,
What a pathetic picture he makes.
The blood clotting in his veins.
The lime draining from his bones.
The scybala stacking up in his colon.
The flesh rotting from his seat.
The urine leaking from his distended bladder and the spirit evaporating from his soul.
Teach us to live that we may dread unnecessary time in bed.
Get people up and we may save patients from an early grave.

Dr. Richard Asher, 1942

With thanks to Dr Ian Sturgess
Associate MD
Operational Improvement Monitor

www.england.nhs.uk
The compelling story

- 48% of people over 85 die within one year of hospital admission
  
  *Imminence of death among hospital inpatients: Prevalent cohort study*
  
  David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*

- If you had 1000 days left to live how many would you choose to spend in hospital?

- 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80

  Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

HSJ Commission: Mrs Andrews Story: her failed care pathway

https://www.youtube.com/watch?v=Fj_9HG_TWEM
Mrs Andrews: What could have been different....

Before ED

On discharge
A New Care Paradigm for Older People Living with 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 personalised care and support planning

Community-based, person centred, co-ordinated care & support

With thanks to John Young
Thank you for listening

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