South West Regional Frailty Event

Follow-up webinar

17 July 2018, 12-1pm
## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
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<tbody>
<tr>
<td>12.00pm</td>
<td><strong>Welcome and introductions</strong></td>
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<tr>
<td>12.05</td>
<td><strong>Feedback from the SW Regional Frailty Event</strong></td>
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<tr>
<td></td>
<td>Bernard Allen, South West Academic Health Science Network</td>
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<td>12.15</td>
<td><strong>Case studies</strong></td>
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<tr>
<td></td>
<td>- ‘Developing the frailty approach at Weston Area Health NHST Trust’: Dr Rachael Morris-Smith, Frailty Service Lead, Weston General Hospital</td>
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<td>- ‘Frailty integration Dorset Healthcare’: Dr Andy Dean, GP Extensivist, Dorset HealthCare Trust</td>
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<td></td>
<td>- ‘Use of the Electronic Frailty Index in the South West’: Richard Blackwell, Information Analysis Manager, SW AHSN</td>
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<tr>
<td>12.30</td>
<td><strong>The NHS England national offer</strong></td>
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<td></td>
<td>Dawn Moody, Associate National Clinical Director Older People, NHS England</td>
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<tr>
<td>12.40</td>
<td><strong>Q&amp;A session</strong></td>
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<td>Please ask questions using the chat function during the webinar</td>
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<tr>
<td>12.55</td>
<td><strong>Closing remarks and contacts for further information</strong></td>
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</table>
Why we are addressing frailty

- The number of people aged 65 to 69 has grown by 34 per cent in the last 10 years, with corresponding hospital admissions growing by 57 per cent.
- By 2040, nearly 1 in 7 people are projected to be over 75.
- People living with severe frailty have a four times greater risk of hospitalisation, care home admission or death with the next year.

NHS England have defined frailty as a progressive, long term condition characterised by a loss of physical and/or cognitive resilience that means people living with frailty do not bounce back quickly after an acute stressor event such as a physical illness, an accident or other stressful event.
Purpose of the regional frailty events

• Discuss national strategic plans for older people living with or at risk of developing frailty.
• Identify regional variation and develop good practice with regards to the frail elderly.
• Help STP areas develop strategic plans for managing the frail elderly population.
• Explore workforce issues across health and social care.
Feedback from the day

• 122 people attended, with representatives from seven STPs:
  – Bath, Swindon & Wiltshire; Bristol, North Somerset & South Gloucestershire; Cornwall & the Isles of Scilly; Devon; Dorset; Gloucestershire; Somerset

• Positive feedback overall.
• Sharing of ideas across services and regions.
• Provided the opportunity to flag challenges to NHS England.
• Full feedback from the STP discussions are in the event report.
Key messages

1) The need for a common definition of frailty and nationally-led common approaches.
2) The importance of communication and multi-disciplinary working to join up local services.
3) Many STPs suggested mapping of services and offering a directory or online portal.
4) Ensuring consistency and use of existing toolkits and other approaches across systems.
5) Taking opportunities to identify frailty at different points where the patient uses services.
6) ‘Pinching with pride’ sharing and using good practice from around the country.
Developing the frailty approach at Weston Area Health Trust

Dr Rachael Morris-Smith, Frailty Service Lead
Joe Middleton, Lead Physiotherapist
Identifying frailty at the front door

- Clinical Frailty Score (CFS) for all patients at triage in the Emergency Department.
- CFS handed over by SWAFT.
- Same scoring system allowing continuity of care and understanding of ‘same language’.
- Allows direct referral to frailty team
- Now electronic to track patients
  - Prevent multiple bed moves
  - Allowing Specialist team review
Frailty at the front door

- 15th January – 12th March
- 1 Doctor 1 Physio, 9-5, Monday & Tuesday.
- Based in ED and MAU
- Aim to initiate early CGA
- And provide specialist care to patients living with frailty.
- Important to not be seen as an ‘admission avoidance’ team, rather here to deliver the right care to the patient.
Results

• 40 patients seen

• Comprehensive Geriatric Assessment initiated

• Specialist care provided

• 18 (45%) patients discharged home from the ED after our review
  • Admission avoided as patients already on the medical in-take list
  • Were being discussed with Consultant for admission
  • Experience of similar cases

• 22 patient required hospital admission for appropriate ongoing medical care.

• 2 patients returned with 30 days. Have yet to determined if returning complaint related to initial complaint.
Mean Daily % of Patient’s Admitted to Ward from ED (Age 75+)

- National average, at this time of year, was a 4% increase in admissions.

<table>
<thead>
<tr>
<th>Days</th>
<th>15&lt;sup&gt;th&lt;/sup&gt; Jan - 12&lt;sup&gt;th&lt;/sup&gt; March 2017</th>
<th>15&lt;sup&gt;th&lt;/sup&gt; Jan - 12&lt;sup&gt;th&lt;/sup&gt; March 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon/Tues</td>
<td>57.14%</td>
<td>56.77%</td>
<td>- 0.37%</td>
</tr>
<tr>
<td>Wed/Thur/Fri</td>
<td>52.35%</td>
<td>60.17%</td>
<td>+ 7.82%</td>
</tr>
<tr>
<td>Sat/Sun</td>
<td>51.55%</td>
<td>58.11%</td>
<td>+ 6.56%</td>
</tr>
</tbody>
</table>
On-going work

- Hospital-wide education
- New doctor induction
- ED team
- Launch of ‘red bag’ project
- Frailty Folder for all patients.
- Collaborative working group with SWAFT, community and GP.
- Volunteer sector
- ‘carers cards’
- Delirium pathway and guidelines
- Falls
- Developing the frailty team
- Working towards launch of Acute Frailty Unit
- BNSSG ‘Healthy Weston’ frailty working group
If you would like to discuss further…

rachael.morris6@nhs.net

Twitter: @two_docs
Frailty Integration

Dr Andy Dean, GP Extensivist, Dorset HealthCare Trust
Where we are now

Rapid response – community rehab team
  - community matron/ Emergency Care Practitioner
  - medical opinion geriatric consultant/extensivist GP

Advanced care Planning – treatment escalation, place of care
  - appropriate investigations
  - Dorset Care Plan
Areas for improvement

- still admitting for investigations due to long waits for outpatient investigations

- still admitting due to lack of interim care to ensure safety
AIMS

Inreach  - realtime tracking of admissions of our patients
  - Pulling patients out of acute Hospital beds
  - investigations via ambulatory care whilst supporting at home with CRT and AHAH

Advanced care planning - via Dorset Care Plan –linking into acute care to inform patient pathway
CHALLENGES

- sourcing care in the home at short notice
- linking IT systems between trusts (DHC, DCH, SWAST)
- gaining the trust of the GPs
- liaising with out of hour services
- 7 day service
Measuring success

- Numbers of readmissions to acute hospital
- Patient satisfaction - preferred place of care
- Unplanned bed days for the locality of over 75s
Use of the Electronic Frailty Index in the South West

Richard Blackwell
Information Analysis Manager
richard.blackwell@swahsn.com

Working together to achieve better health and wellbeing
Electronic Frailty Index (eFI)

- NIHR CLAHRC Yorkshire and Humber, University of Leeds, Bradford and Birmingham and SystmOne and ResearchOne developed and validated an (eFI) to identify and severity grade frailty.
- Frailty is defined on the basis of the accumulation of a range of deficits, which are clinical signs (e.g. tremor), symptoms (e.g. breathlessness), diseases (e.g. hypertension) and disabilities.
- The eFI consists of 36 deficits which constructed from around 2,000 Read codes
- The score is a robust predictor of those who are at greater risk of adverse outcomes
- The eFI will help improve care for older people with frailty by:
  - Directing better primary care pathways for older people by considering frailty rather than age
  - Identifying the top 2% most vulnerable for targeted care planning to reduce unplanned admissions
  - Structuring integrated care around frailty, so those who benefit most are identified for integrated services
  - Enabling targeted medication reviews for older people with frailty using evidence-based checklists (e.g. STOPP/START criteria)
  - Identifying the presence of frailty to guide shared decision making in secondary care
  - Identifying those with advanced frailty who may be entering the terminal phase of life for advance care planning discussions
Electronic Frailty Index (eFI)
36 Deficits
Progression of Frailty Over Time

Progression of Electronic Frailty Index (eFI) In Terms of Number of Deficits Over Time

Year


Number of Deficits

0 2 4 6 8 10 12 14 16

- Fit to Mild Boundary
- Mild to Moderate Boundary
- Moderate to Severe Boundary
- Fit
- Mild
- Moderate
- Severe
- Overall
Population (3 practices c. 57k) by Frailty

% of Population by Number of Frailty Deficits

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

% of Population

Cumulative %

Number of Frailty Deficits

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21

Severe Frailty
Moderate Frailty
Mild Frailty
Fit

87.4% 96.4% 99.1%
Population (3 practices c. 57k) with Zero Long Term Conditions by Frailty

% of Population with 0 Long Term Conditions by Number of Frailty Deficits

- Severe Frailty
- Moderate Frailty
- Mild Frailty
- Fit

% of 0 LTC Population

Number of Frailty Deficits

- Zero Long Term Conditions
- Cumulative %
Population (3 practices c. 57k) with 3 or more Long Term Conditions by Frailty

![Graph showing the percentage of population with 3 or more long term conditions by number of frailty deficits.](image)
Integrated Care Exeter
Public Health Maps

INTEGRATED CARE EXETER RISK STRATIFICATION TOOL - FRAILTY SUMMARY - EXETER (BASED ON 15 PRACTICES), APR-17

Numbers by Frailty Category

<table>
<thead>
<tr>
<th>Frailty Category</th>
<th>Persons</th>
<th>%</th>
<th>Males</th>
<th>%</th>
<th>Females</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Likely Frail</td>
<td>5735</td>
<td>9.64</td>
<td>665</td>
<td>11.0</td>
<td>4919</td>
<td>8.64</td>
</tr>
<tr>
<td>Likely Frail</td>
<td>13,071</td>
<td>22.14</td>
<td>1634</td>
<td>26.8</td>
<td>11,437</td>
<td>20.14</td>
</tr>
<tr>
<td>Moderate Frail</td>
<td>25,348</td>
<td>42.94</td>
<td>3276</td>
<td>54.9</td>
<td>22,072</td>
<td>39.64</td>
</tr>
<tr>
<td>Mild Frail</td>
<td>21,945</td>
<td>37.34</td>
<td>2701</td>
<td>44.8</td>
<td>19,244</td>
<td>33.54</td>
</tr>
<tr>
<td>Well or Mostly Well</td>
<td>12,682</td>
<td>22.02</td>
<td>1715</td>
<td>28.3</td>
<td>10,967</td>
<td>19.62</td>
</tr>
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</table>

Age Profile

<table>
<thead>
<tr>
<th>Age Group</th>
<th>00 0000</th>
<th>0000 000</th>
<th>0000 0000</th>
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<tbody>
<tr>
<td>00 to 54</td>
<td>29,987</td>
<td>50.8</td>
<td>3865</td>
</tr>
<tr>
<td>55 to 64</td>
<td>15,920</td>
<td>27.3</td>
<td>1855</td>
</tr>
<tr>
<td>65 to 74</td>
<td>9,855</td>
<td>16.9</td>
<td>1145</td>
</tr>
<tr>
<td>75 to 84</td>
<td>6,437</td>
<td>11.2</td>
<td>747</td>
</tr>
<tr>
<td>85 and over</td>
<td>5,685</td>
<td>9.8</td>
<td>689</td>
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</table>

Numbers by Frailty Risk Factor

<table>
<thead>
<tr>
<th>Frailty Risk Factor</th>
<th>Total</th>
<th>All</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory disease</td>
<td>3335</td>
<td>29.8%</td>
<td>27.6%</td>
<td>30.9%</td>
</tr>
<tr>
<td>Urinary system disease</td>
<td>2402</td>
<td>20.0%</td>
<td>15.5%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>2372</td>
<td>20.5%</td>
<td>15.6%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>2077</td>
<td>17.7%</td>
<td>12.7%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>1345</td>
<td>11.5%</td>
<td>7.7%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>1192</td>
<td>10.3%</td>
<td>6.8%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1152</td>
<td>9.8%</td>
<td>6.9%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>1020</td>
<td>9.0%</td>
<td>6.1%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>1004</td>
<td>8.7%</td>
<td>5.4%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>955</td>
<td>8.2%</td>
<td>5.3%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Frailty fracture</td>
<td>912</td>
<td>7.9%</td>
<td>4.7%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Depression</td>
<td>964</td>
<td>8.4%</td>
<td>4.8%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>741</td>
<td>6.4%</td>
<td>3.9%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Hypertension / syncope</td>
<td>739</td>
<td>6.3%</td>
<td>3.9%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>624</td>
<td>5.5%</td>
<td>3.3%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>610</td>
<td>5.3%</td>
<td>3.2%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>594</td>
<td>5.2%</td>
<td>3.0%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Falls</td>
<td>564</td>
<td>4.9%</td>
<td>2.9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Social vulnerability</td>
<td>4577</td>
<td>39.8%</td>
<td>21.9%</td>
<td>37.7%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>399</td>
<td>3.4%</td>
<td>2.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Skin ulcer</td>
<td>392</td>
<td>3.3%</td>
<td>1.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>249</td>
<td>2.2%</td>
<td>1.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>230</td>
<td>2.0%</td>
<td>1.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>COPD</td>
<td>230</td>
<td>2.0%</td>
<td>1.2%</td>
<td>2.1%</td>
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</tbody>
</table>

Crude Percentage

Shows the total percentage of population in any frailty category. Highlights the overall burden of frailty influenced by age and risk.

South West Academic Health Science Network

This version produced for Integrated Care Exeter by Simon Chant, Public Health Specialist (integrated), Devon County Council, April 2017, with further data analysis by Richard Blackwell and Lesley Galle, South West Academic Health Science Network.

Sources: LSWNWeb, SystemOne, ESI-Tool, Indices of Deprivation 2015, South West Academic Health Science Network

Legend:
- Red = Increased risk
- Green = Lower risk
- Brown = Mixed risk

Map Source: Devon County Council, 2017, Devon County Council

Area Description:
Profile population profiles Typically younger than the Devon and Exeter population profile with older populations in some areas (e.g. Topsham and Alphington).
Depression profiles Overall levels above Devon. Hotspots in city centre, Waterford, Whipton, Beacon Health and Coughlan.
One Devon Dataset information pack
Rural areas around Exeter have average to higher levels of frailty due to older population profile but lower age standardised due to lower levels of deprivation. The exception is Pathfinder Village, a park home site to the West which has higher crude and standardised risk, and Starcross.
Average unit costs* by frailty

- Well: £448
- Mild Frailty: £2,138 per person
- Moderate Frailty: £3,875 per person
- Severe Frailty: £5,433 per person

* Covers primary, secondary and adult social care costs
Frailty: principle findings

- Frailty is age-related but not inevitable
- First frailty signs can appear at relatively young age
- Slow progression, large window of opportunity to do something about it
- Disability, wellbeing and social factors as important as medical conditions
- Earlier onset in more deprived areas
- Higher reported frailty in females
- Housing type a major predictor of frailty
- Moving closer to services can be an indicator
- Close association with social isolation / loneliness
Ageing Well
Quality Healthcare in Later Life

Integrated Care for Older People

Dawn Moody
Associate National Clinical Director Older People

Webinar Series
July 2018
NHS England Frailty Support Offer 2018

- Support effective population sub-segmentation by degree of need using the electronic frailty index.
- Use this information to recurrently guide planning as well as sharing learning from current and future health and social care resource use.
- Support effective information governance among health and social care professionals using linked data to promote effective population health management and care for older people living with frailty.
- Promote peer to peer networking and sharing through providing access to the Kahootz forum for frailty (joining details from england.clinicalpolicyunit@nhs.net).
- Support existing local work on agreed care standards and ambitions for frailty.
- Support effective care planning for older people living with frailty.
- Promote workforce development by developing and implementing the core capability framework for frailty.
- Support effective local commissioning including through integrated health and social care systems, STPs and primary care networks.
- Consider instruments such as CQUINs and a frailty currency.
- Develop and refine over time RightCare and Get It Right First Time (GIRFT) Frailty pathways and data packs.
Want to know and share more? england.clinicalpolicy@nhs.net

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

www.england.nhs.uk
Further information

• Fusion48 has shared an STP-level analysis of frailty-related GP Contract Data 2017-18, as referred to in Martin Vernon’s blog:  
  – [https://www.england.nhs.uk/blog/small-steps-become-giant-leaps-for-frailty-care](https://www.england.nhs.uk/blog/small-steps-become-giant-leaps-for-frailty-care)

• ‘Managing Frailty and Delayed Transfers of Care in the Acute Setting’ project run by the NHS Benchmarking Network:  
Local contacts

• West of England AHSN:
  – Nathalie Delaney, Improvement Lead (Patient Safety), nathalie.delaney@weahsn.net

• Wessex AHSN:
  – Kathy Wallis, Healthy Ageing Programme Lead, kathy.wallis@wessexahsn.net
  – Sarah Howard, Senior Programme Lead Primary and Community Care, Dorset CCG, sarah.howard@dorsetccg.nhs.uk

• South West AHSN:
  – Richard Blackwell (EFI), richard.blackwell@swahsn.com
  – Bernard Allen, bernard.allen@swahsn.com
Useful links

- Acute Frailty Network: https://www.acutefrailtynetwork.org.uk/
- AGE UK: https://www.ageuk.org.uk/
- AHSNs: http://www.ahsnnetwork.com/
- British Geriatric Society: http://www.bgs.org.uk/
- GIRFT: http://www.gettingitrightfirsttime.com/
- Local Professional Networks: https://www.england.nhs.uk/commissioning/primary-care/primary-care-comm/lpn/lpn-role/
- NHS RightCare: https://www.england.nhs.uk/rightcare/
- NICE: https://www.nice.org.uk/
South West Regional Frailty Event

Follow-up webinar

17 July 2018, 12-1pm

Thank you