Utilising the diagnosis of "Frailty" for Personalised Care in Community Hospitals

Dr Kirsten Protherough

Director and Chair of the Community Hospital Association

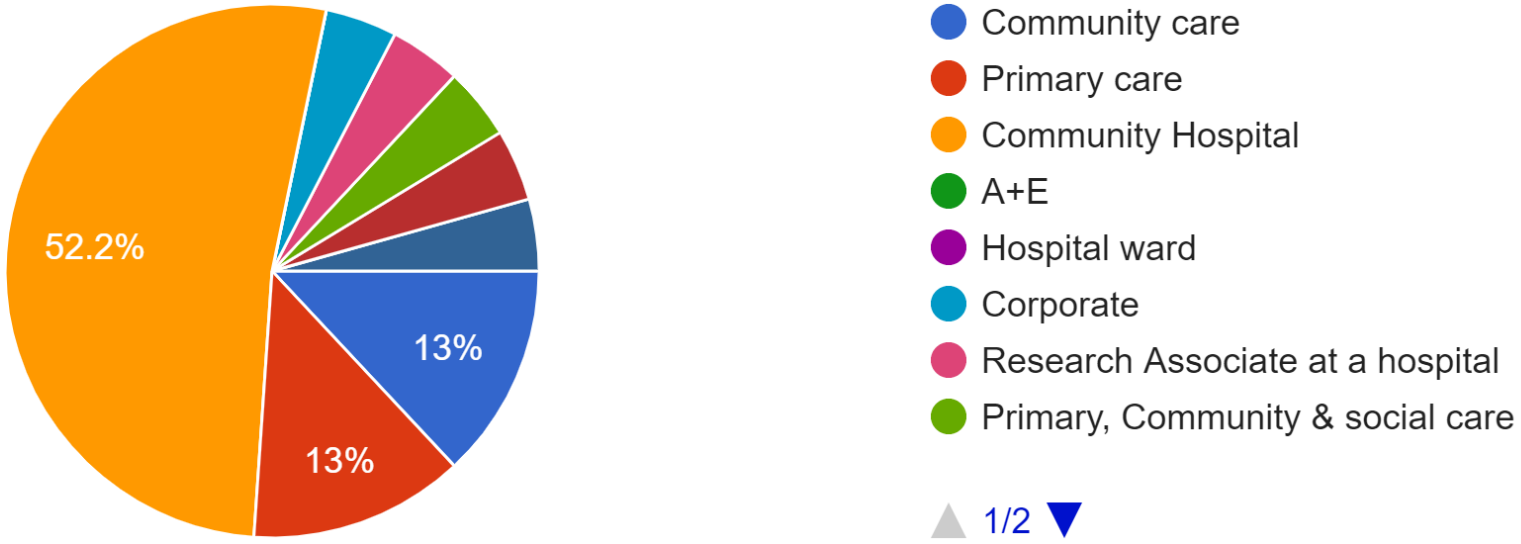
My background and journey

- Qualified in 2007 University of Birmingham
- Worked at UHB trust, Old Selly Oak within a Elderly Care Firm in F1
- F2 I worked on a placement in Elderly care rehab at West Heath Hospital which was 4 wards some orthopaedic rehab, some general elderly care rehab
- Academic GP training included an MSc in Primary Care and Community Studies which included going to heart failure clinics, INR clinics ran within primary care/ the community
- Became a GP and have covered normal GP, out of hours, fell into Community Hospital role, completed the Diploma of Geriatric Medicine in 2016 as felt slightly isolated within my role, wanted to ensure best practice
- Organised teaching sessions related to frailty and realised a lot of the NICE guidance and research we are taught in training is not applicable to the population within Community Hospitals
- Became clinical director of the Community Hospitals in Worcestershire 2018
- Here I mentored 3 ACPs completing their V300 prescribing modules and am currently a Mentor to Nurse completing her Advanced Practice Msc. who also works in community hospitals
- Support and facilitate the Frailty Module ran by the University of Worcester and am a senior lecturer at the University of Worcester for the new medical students
- Passion for elderly care and education
- Member of the British Geriatrics Society

Thankyou for attending this session this evening

Please select your current healthcare sector:

23 responses



Multidisciplinary attendance

- Locum Consultant Geriatrician
- Advanced Clinical Practitioner
- GP
- Medical Director
- Locum GP
- Advanced Community Practitioner
- Quality Lead
- Occupational Therapist
- Transformation Programme Manager
- Assistant Director Community Services
- Independent Member of Committees
- Researcher

A lot of experience between you!

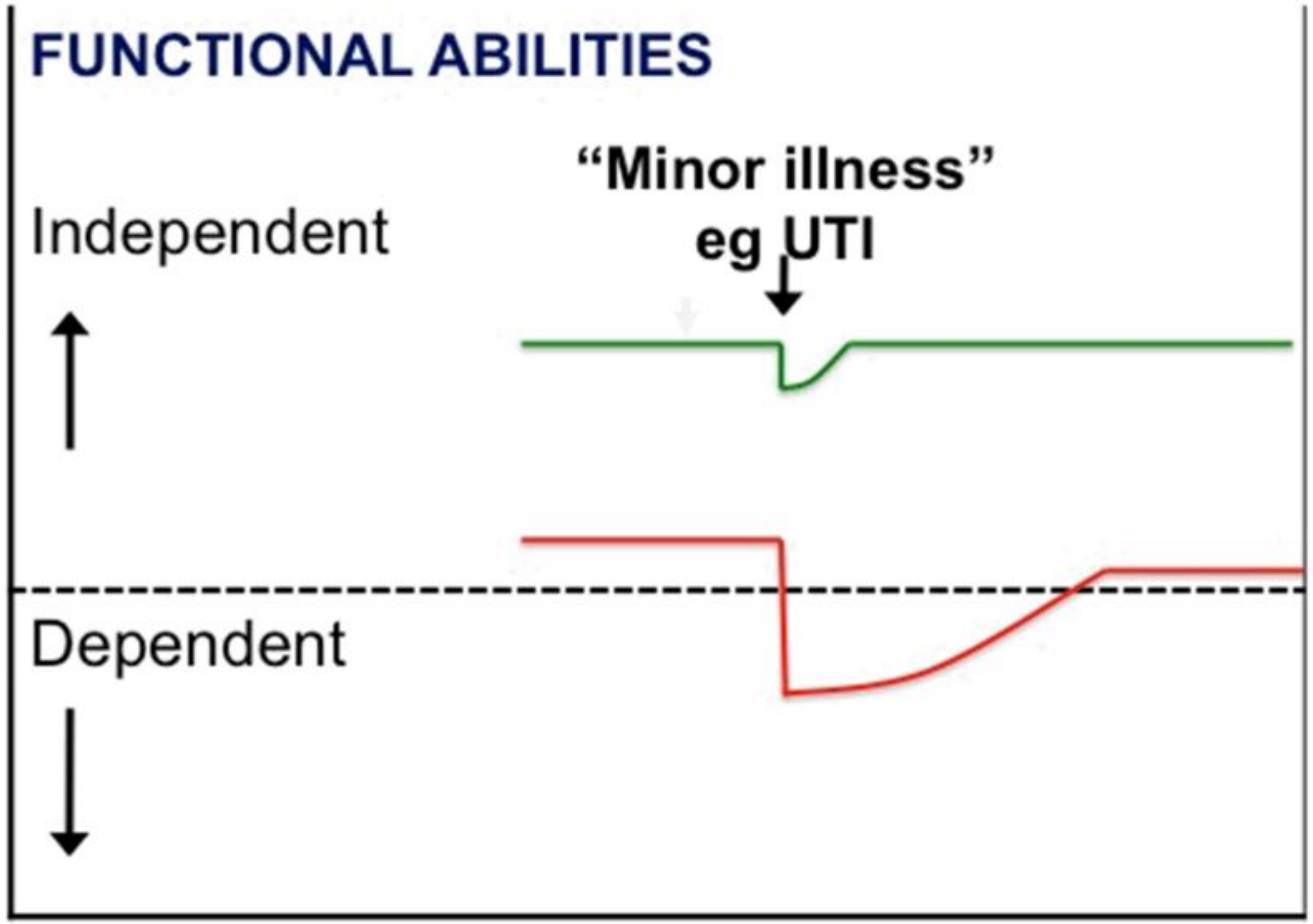
How long have you worked in your current sector?

23 responses

Frailty: a clinical syndrome not a descriptive term

WHO definition is:

"A clinically recognisable state in which the ability of older people to cope with everyday or acute stressors is compromised by an increased vulnerability brought by age-associated declines in physiological reserve and function across multiple organ systems."



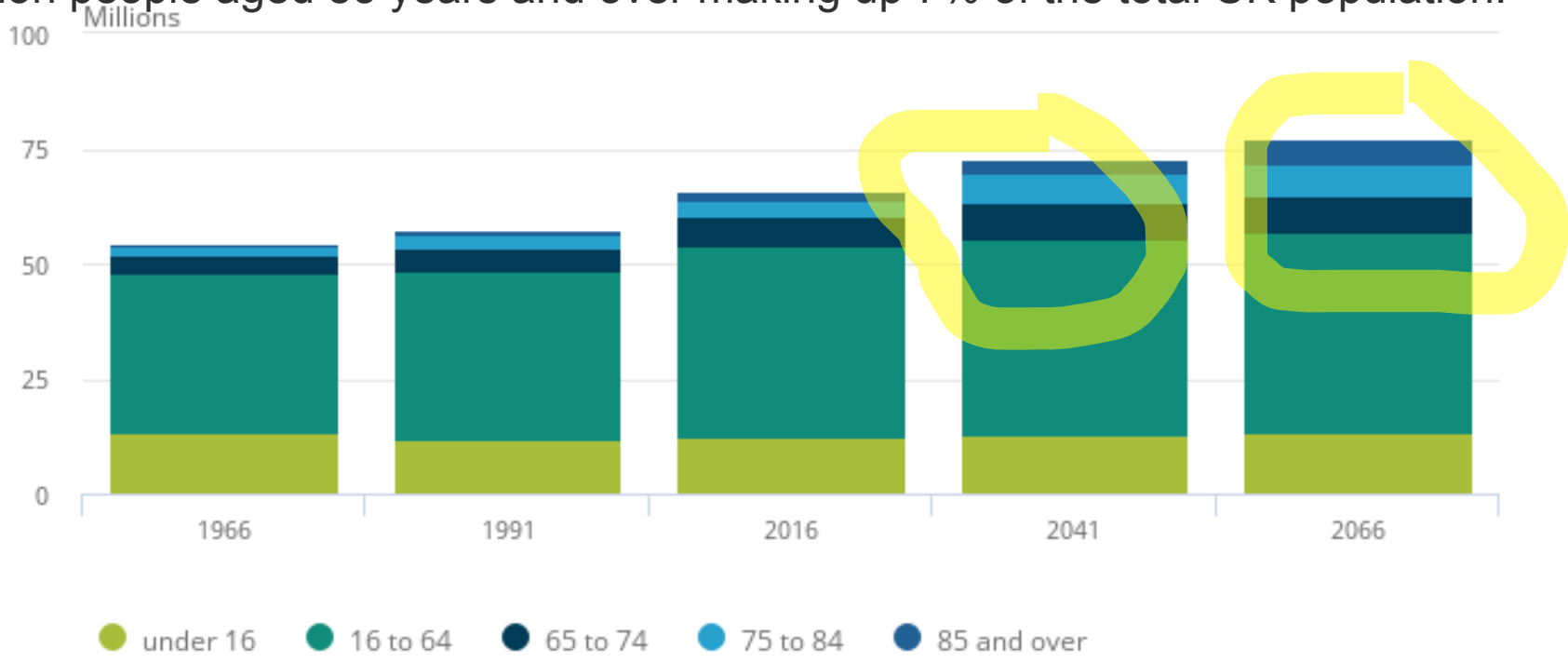
Taken from: Clegg A, Young J, Iliffe S, Rikkert MO, Rockwood K. Frailty in elderly people. Lancet (London, England). 2013 Mar;381(9868):752-762. DOI: 10.1016/s0140-6736(12)62167-9. PMID: 23395245; PMCID: PMC4098658.

Why is recognition of frailty important in our work within NHS and wider society?

- Ageing population - In 1981 the life expectancy at birth for a man was 70yrs and for a woman 76.9yrs. In 2018 it was 79.3yrs for a man and 82.9yrs for a woman (1).
- With ageing you are more likely to pick up comorbidities which contribute to increased frailty
- Implications for service delivery within the NHS and all aspects of society as recognised by the World Health Organisation who has announced a "Decade of Healthy Ageing" which includes promoting initiatives throughout society, including the built environment, to help people who are living longer live better and have a longer "Healthy lifespan"
- "If you make it accessible for adults living with frailty you make it accessible for everyone!"

Figure 2: Population by age group, selected years, UK

In mid-2016, there were 1.6 million people aged 85 years and over (2% of the total population); by mid-2041 this is projected to double to 3.2 million (4% of the population) and by 2066 to treble, by which time there will be 5.1 million people aged 85 years and over making up 7% of the total UK population.



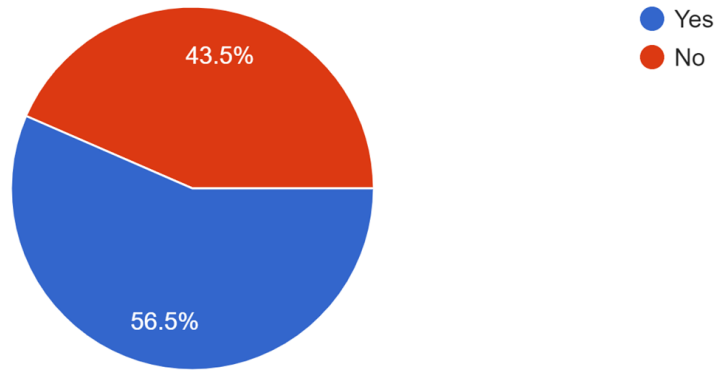
Source: Population estimates, Principal population projections, 2016-based, Office for National Statistics

Objectives of this Special Interest Group Session

- How do we harness the power of the Frailty diagnosis and Frailty scores to provide tailored care to our patients?
- Results of the survey conducted among multidisciplinary healthcare professionals working in Community Hospitals, shedding light on their current understanding and experiences of frailty, and how it influences their care delivery.
- By the end of this session, we aim to inspire and equip attendees with fresh perspectives on leveraging frailty to enhance our provision of personalised care.

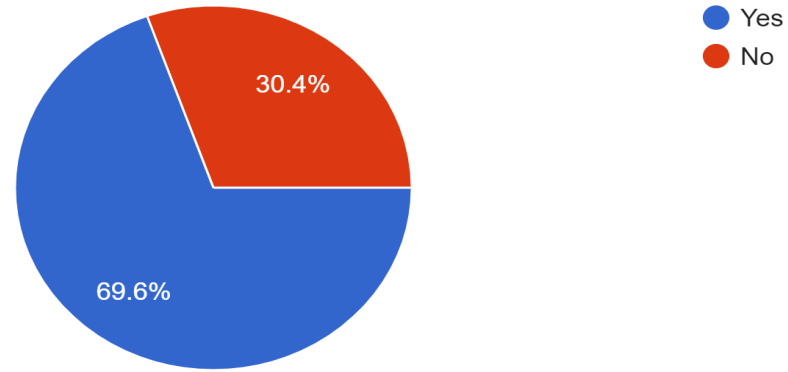
Are you familiar with the Electronic Frailty Index (eFI)?

23 responses



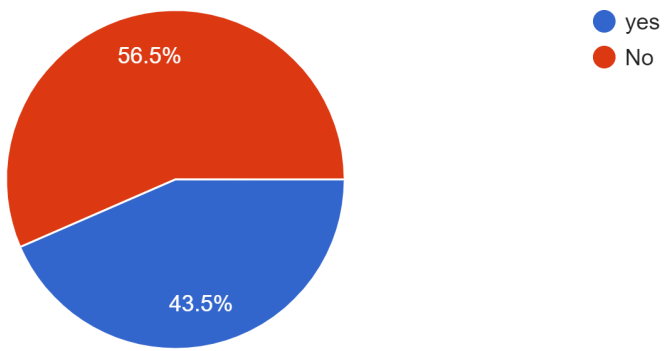
Are you familiar with the timed up and go test? (TUGT)

23 responses



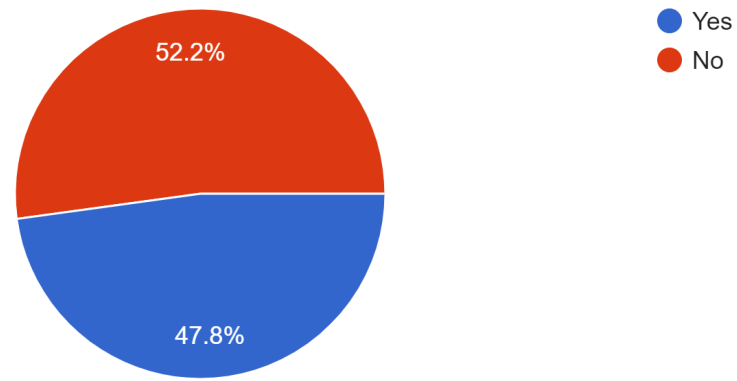
Are you familiar with the PRISMA-7 questionnaire for frailty assessment?

23 responses



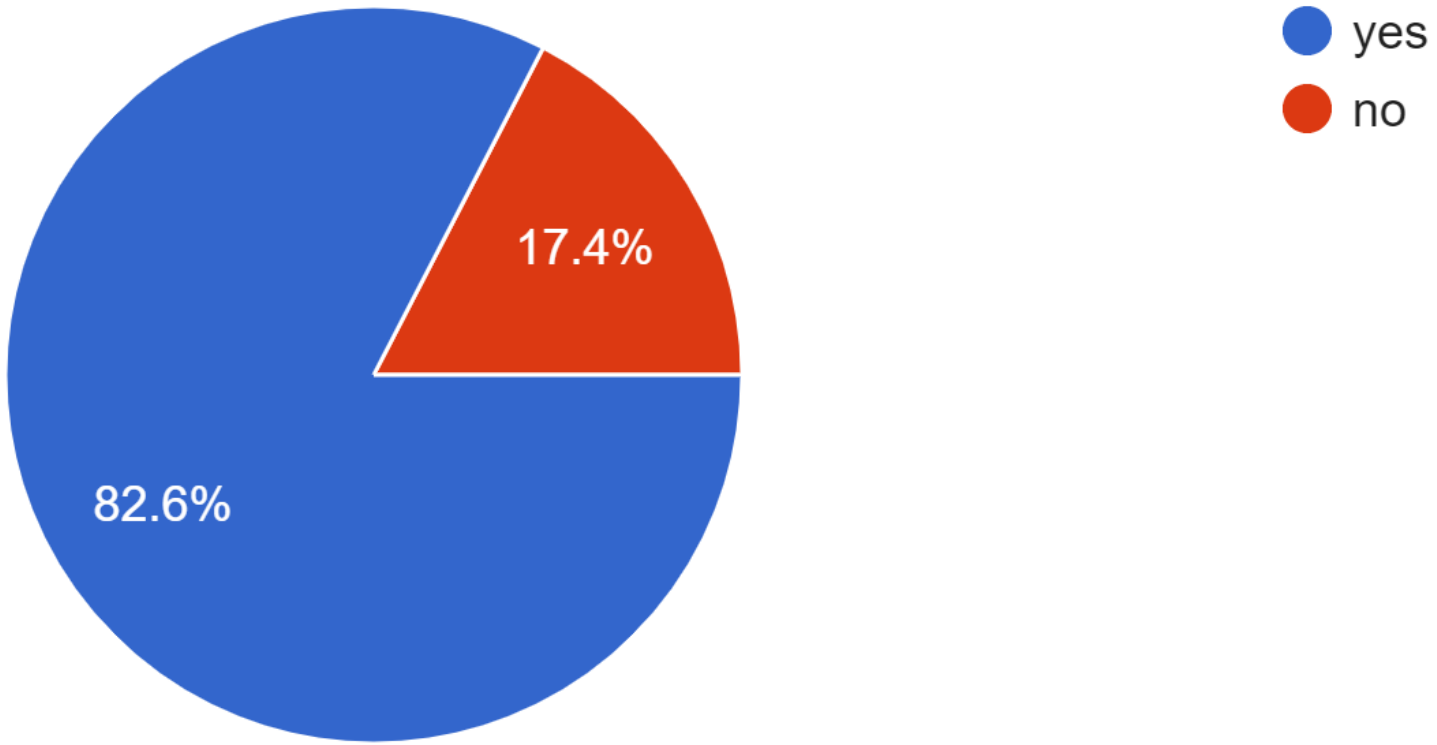
Have you heard of the Edmonton Frail Scale?

23 responses



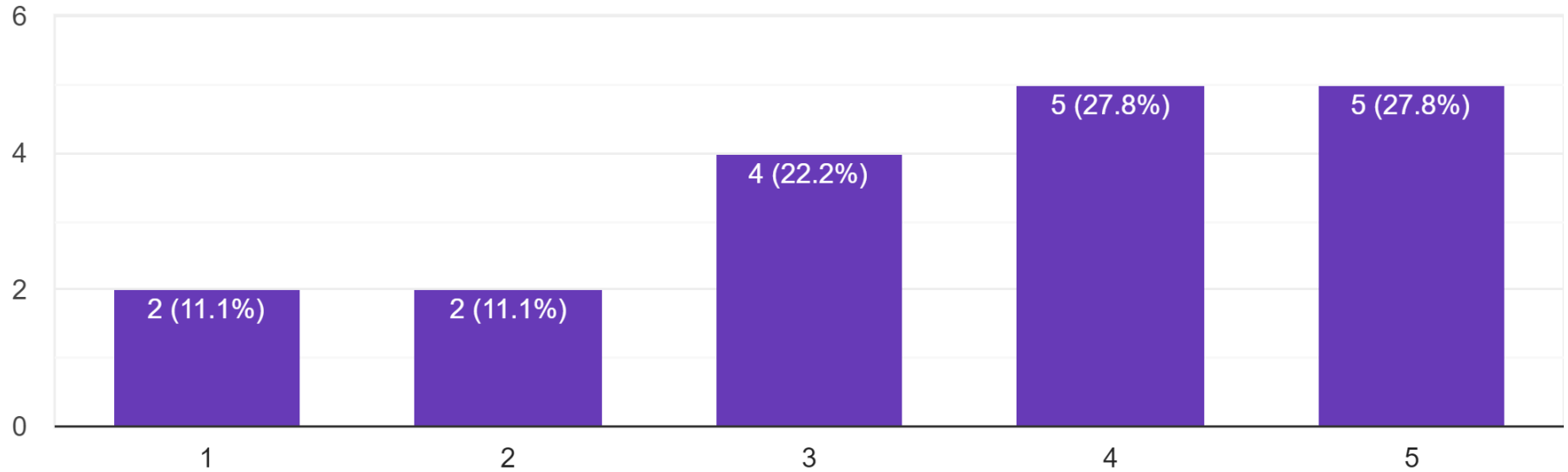
Have you heard of the Rockwood Frailty Score?

23 responses



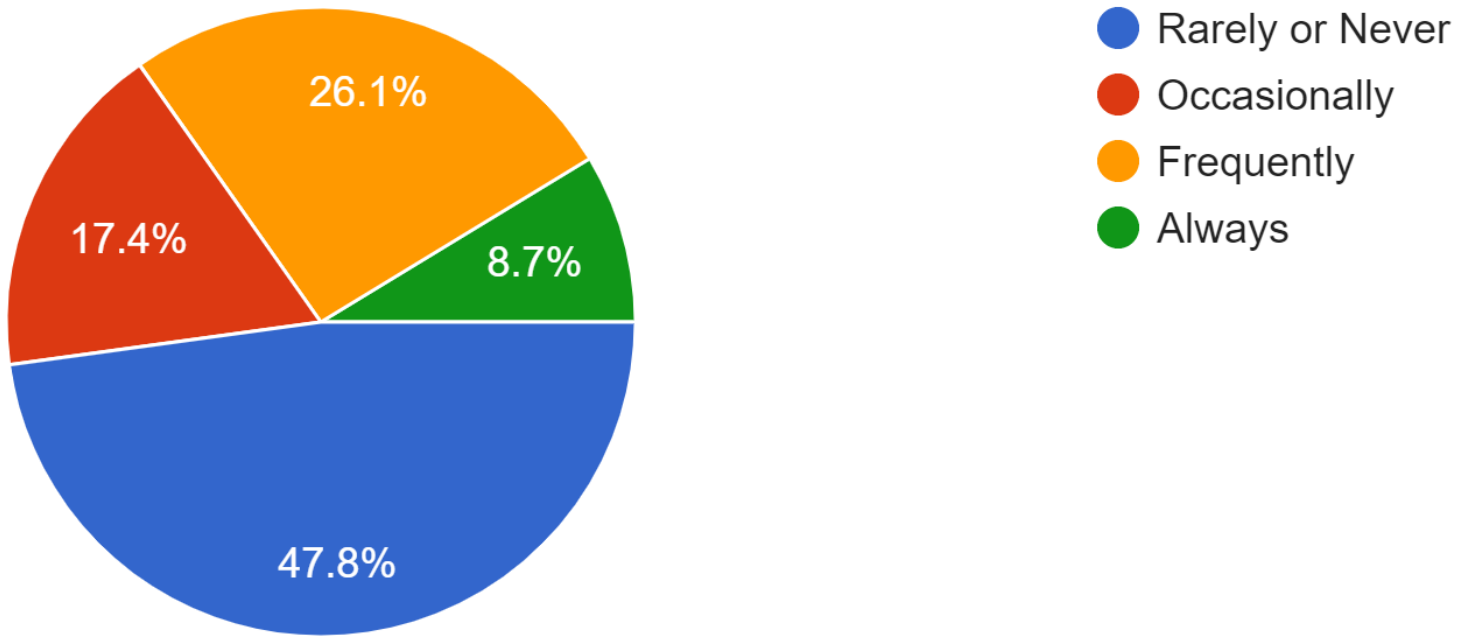
If you are familiar with the Rockwood Frailty Scale/Clinical Frailty Scale, please rate your level of confidence in using it on a scale of 1 to 5, with 1 be... very confident. If you are not familiar leave blank

18 responses



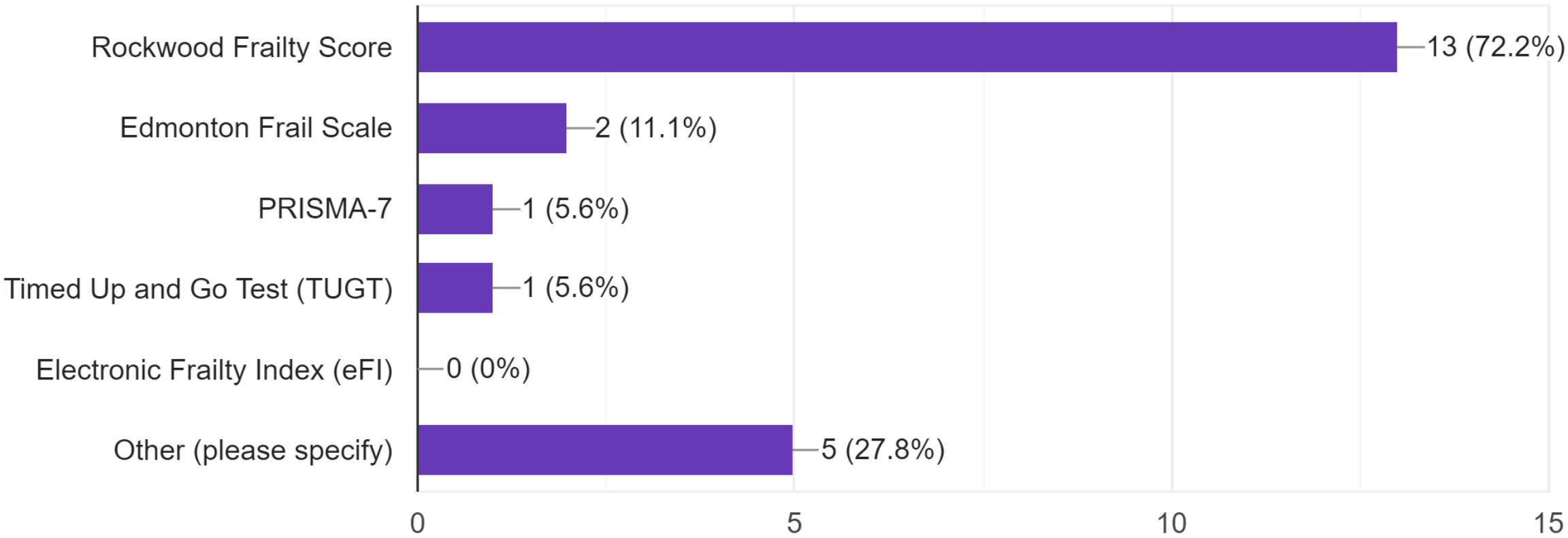
In your current role, how frequently do you use frailty assessment tools in clinical practice?

23 responses



Which frailty assessment tool(s) do you find most effective in your work ? (Select all that apply)

18 responses



Why Rockwood?

"Easy to use and well recognized, easily taught to juniors. A validated tool.“

"This is the one we've determined we should be implementing."

"Ease of use and trust-wide use."

"Easy to use. Included in Frailty training.“

"Visual chart. Quick and easy to use.“

"Familiarity and common usage.“

History of Rockwood

- Initially developed in a research/epidemiological for the Canadian Study of Health and Aging
- Adapted into clinical practice
- **Clinical Frailty Scale (CFS):**
  - A 9-point scale assessing an older adult's overall fitness or frailty.
  - Scored by clinicians, higher scores indicate greater risk.
  - Not a questionnaire, but a judgment-based tool for frailty screening and stratification.
  - Validated
- **Observable Items:**
  - Focuses on easily observable items.
  - Important to judge when at baseline
  - Particularly important in clinical settings where health appearance can change rapidly, like the Emergency Department.

CLINICAL FRAILTY SCALE

1 **VERY FIT** — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 **FIT** — 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**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 **LIVING WITH VERY MILD FRAILTY** — Previously "vulnerable," this category marks early transition from complete independence. 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 **LIVING WITH MILD FRAILTY** — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

6 **LIVING WITH MODERATE FRAILTY** — People who 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 **LIVING WITH SEVERE FRAILTY** — **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 **LIVING WITH VERY SEVERE FRAILTY** — Completely dependent for personal care and approaching 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 living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

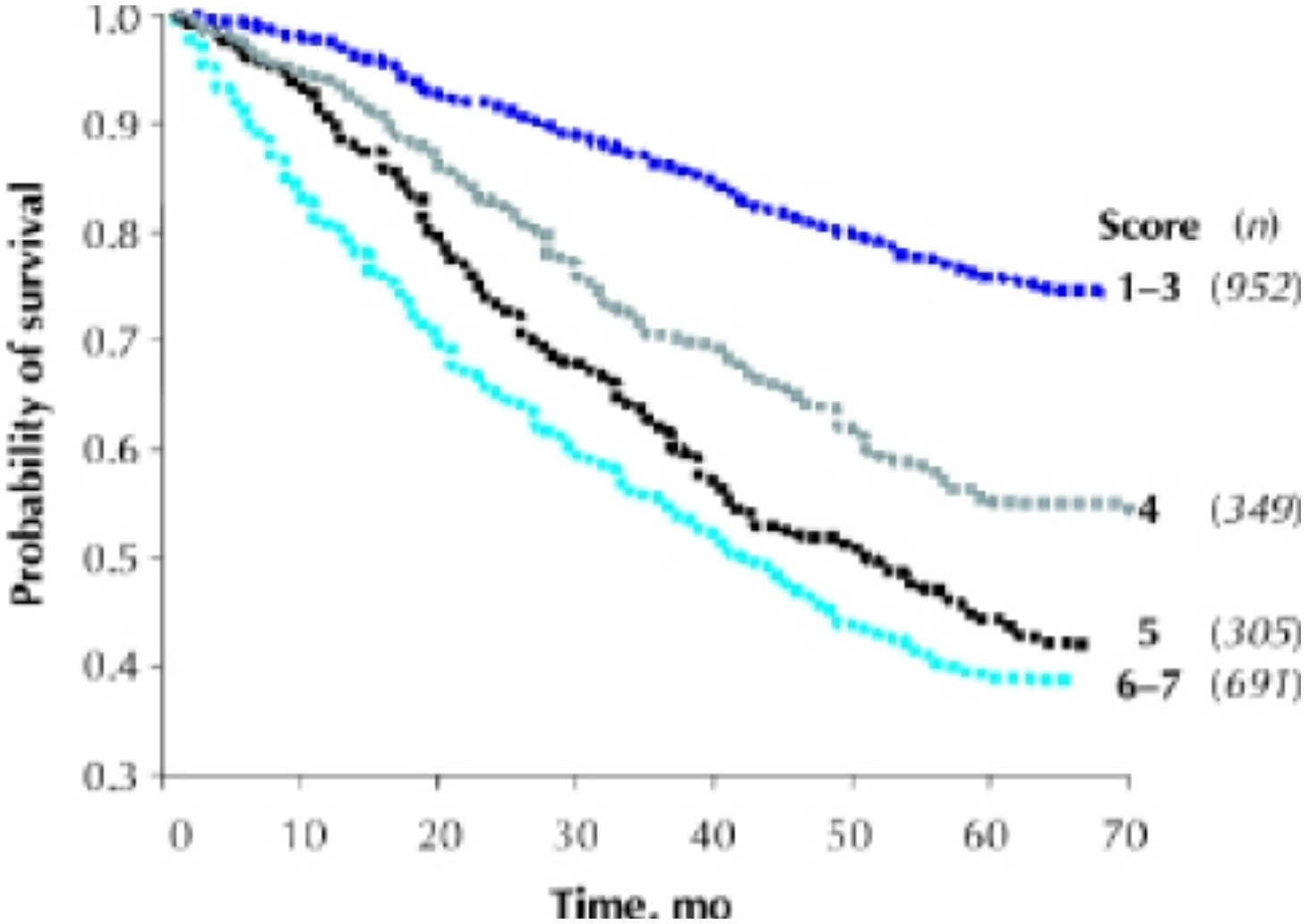
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.



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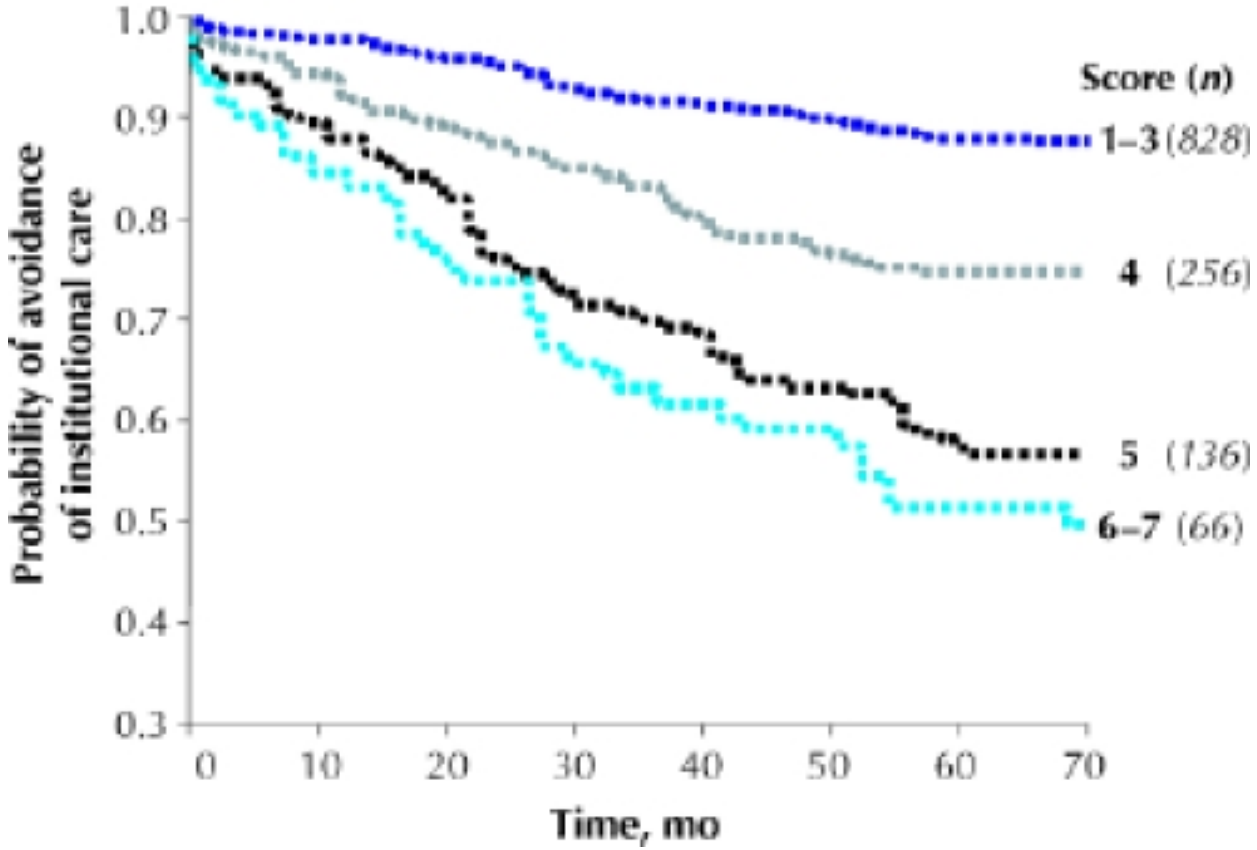


Taken from: Rockwood K, et al “A global clinical measure of fitness and frailty in elderly people.” CMAJ. 2005

CFS grade	Length of stay	Readmission rate	In-patient mortality	Care intentions	Service referrals	Post-discharge support
1	4	4%	2%	Detect and manage geriatric syndromes e.g. delirium	General internal medicine	Self-care
2	5	7%	2%			
3	7	11%	2%			Prevention (e.g. falls, memory clinic)
4	8	13%	3%			
5	10	15%	4%			
6	12	15%	6%			
7	13	14%	11%	Think about palliative vs. restorative care	Geriatric medicine	Transitional care
8	12	10%	24%			
9	10	13%	31%			

Taken from:
https://www.scfn.org.uk/clinical-frailty-scale

Frailty measured using the CFS or Frailty Index is associated with higher in-hospital (relative risk (RR) 1.7) and long-term mortality (RR 1.5)(10). Frail patients were less likely to be discharged home than fit patients (RR 0.6)(11). Additional studies undertaken since these reviews support the importance of frailty as a prognostic marker (Table 1).

Table 1 Outcomes from ICU using frailty as a predictor

Author, year	Setting	Sample size	Age	Frailty	ICU mortality	30-day mortality	Predictors of poor outcomes
Zampieri, 2018	Brazilian ICUs	24,494	Mean 75.7	MFI[1] non-frail (=0), pre-frail (MFI=1–2); frail (MFI ≥ 3)			In-hospital mortality 28.8%; in a multivariate analysis, frailty OR 2.4 for in-hospital mortality
Darvall, 2019[12]	Australian/ New Zealand ICUs	6203	>80	CFS≥5			In-hospital mortality 17.6% v 8.2%, OR 1.87
Guidet, 2020[13]	European ICUs	3920	Median 84	CFS median 4 (3-6)	72.5%	61.2%	Age Hazard Ratio 1.02/year; SOFA 1.15/point; CFS 1.1/point
Muessig, 2018	German ICUs	308	Median 84	CFS≥5	22.4%	42.4%	CFS OR 1.4 for 30-day mortality (multivariate analysis)
Langlais, 2018[14]	French ICU	189	Mean 74	CFS≥5			CFS OR for in-hospital mortality 1.3
Fronczek, 2018	Polish ICUs	170	>80	CFS≥5	47.6%	40.4%	SOFA score (OR=1.16), emergency admission (OR=5.1) and frailty (OR=2.3) increased the risk of ICU death
Zeng, 2015[15]	Chinese specialized geriatric ICU	155	Mean 82.7	Frailty Index			Each 1% increase in FI was associated with an 11% increase in the 30-day mortality risk adjusting for age, sex, and prognostic scores
Shears, 2017[16]	Canadian ICUs	150	Mean 63.8	CFS			CFS OR 1.2 for ICU, OR 1.19 for hospital mortality
Silva-Obregon, 2020[17]	Spanish ICU	53	Mean 78		37.7%	52.8%	CFS≥5 Hazard Ratio 4 for one year survival after adjustment for sociodemographics, comorbidities, severity scores, treatment intensity and complications

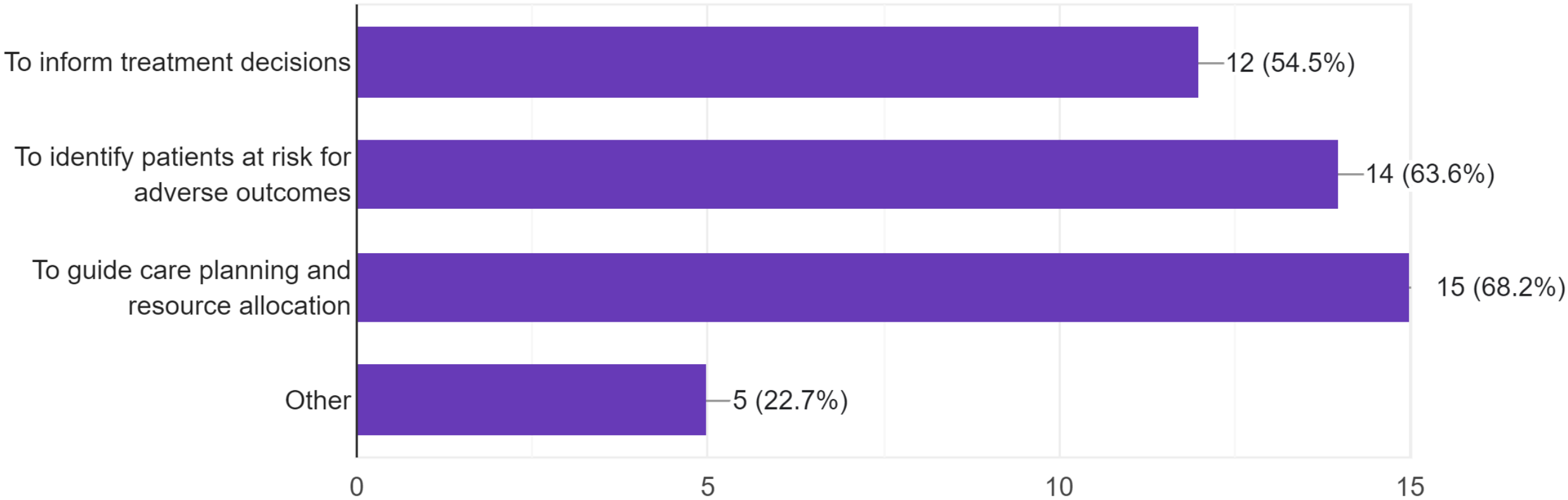
Taken from: https://www.scfn.org.uk/clinical-frailty-scale

Community Hospital Data/Research related to frailty scores

- Paucity of data on frailty scores and outcomes in Community Hospital Settings
- No specific data available related to Clinical Frailty Scale
- More research needed
- Example of some relevant ongoing research is Professor Kathryn Evans who attended CHA AGM in 2019, updated us on some important research she is leading which looks at large sets of CH data and outcomes.
- In an unstratified population 1:4 patients admitted to community hospitals had died within one year
- Community Healthcare Alliance of Research Trusts (CHART) – follow on twitter @CommunityHART.CHART

What is the primary purpose of using frailty assessment tools in your practice? You can choose more than one choice

22 responses

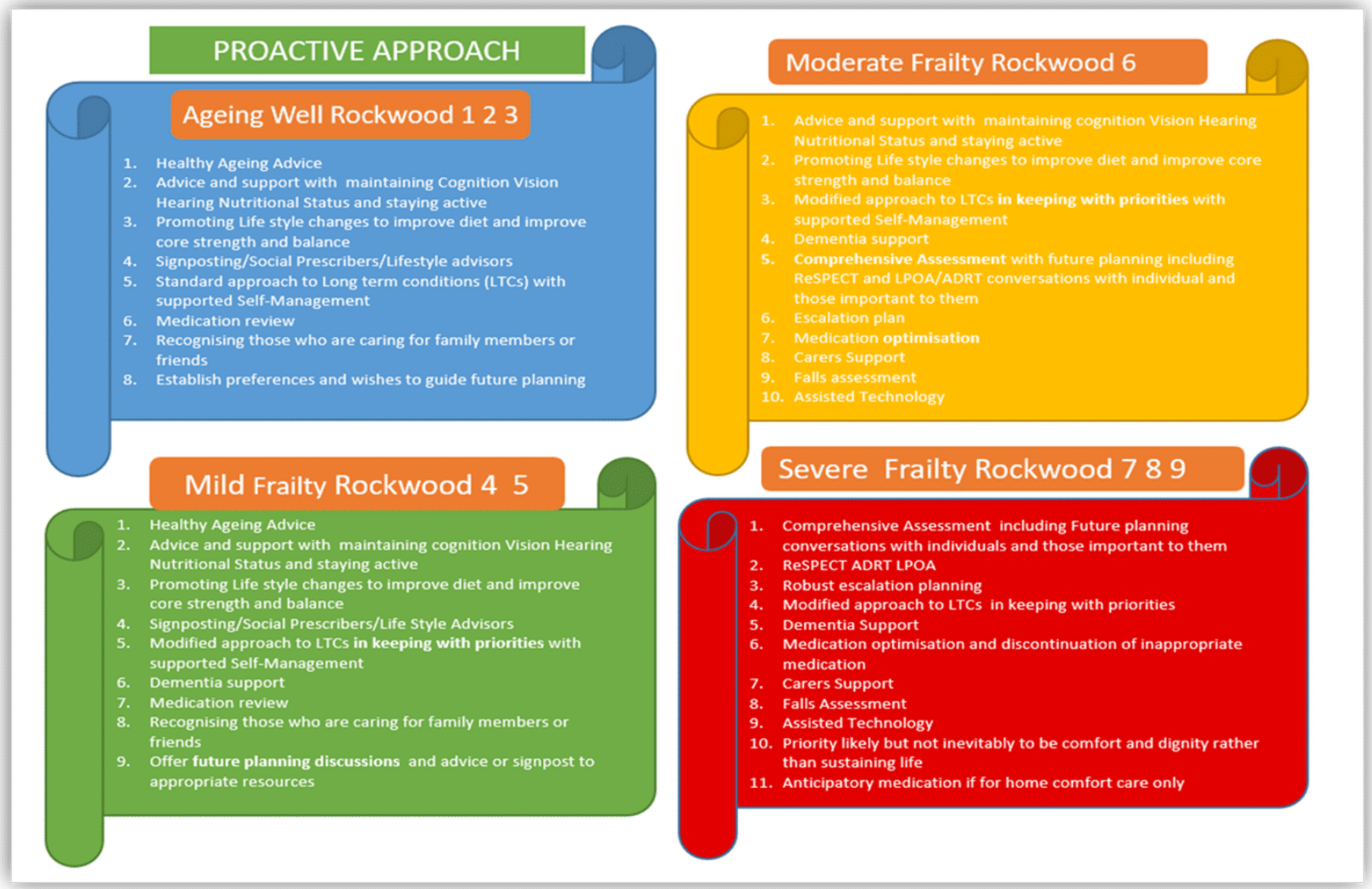


Other purposes of using Frailty Assessment Tools

“To satisfy some NHSE directive”

“To aid screening and prevention of worsening frailty”

“To help support patient expectations”



Taken from: University of Worcester Online E-learning Frailty course

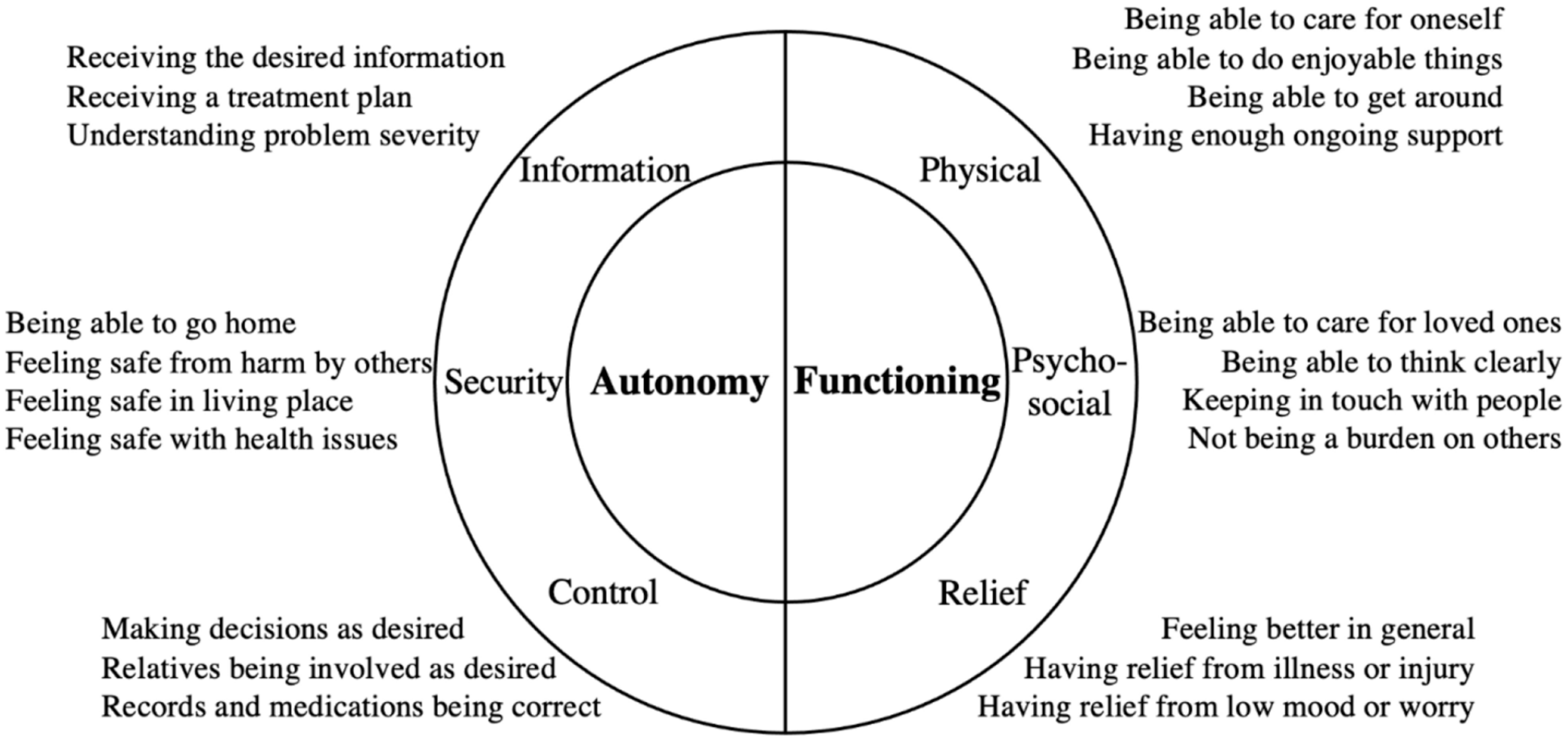
What Matters The Most?

- How many of your ask consistently to patients “What matters most to you?”
- What answers do you get?
- How do these answers align with their personalised care plan– examples?
- How does our frailty scoring help with focusing on what matters most to patients? – validated tool, helps refocus conversations and expectations
- “Frailty sensitive approach”
- WMTM as a golden thread weaving its way through care plans, helping prioritisation along with knowledge of frailty to ensure best outcomes for patient which is often related to family, comfort, symptomatic control and not aligned to extensive investigations, prolonged stays in hospital, futile treatment

Link to article

“What matters most in acute care: an interview study with older people living with frailty”

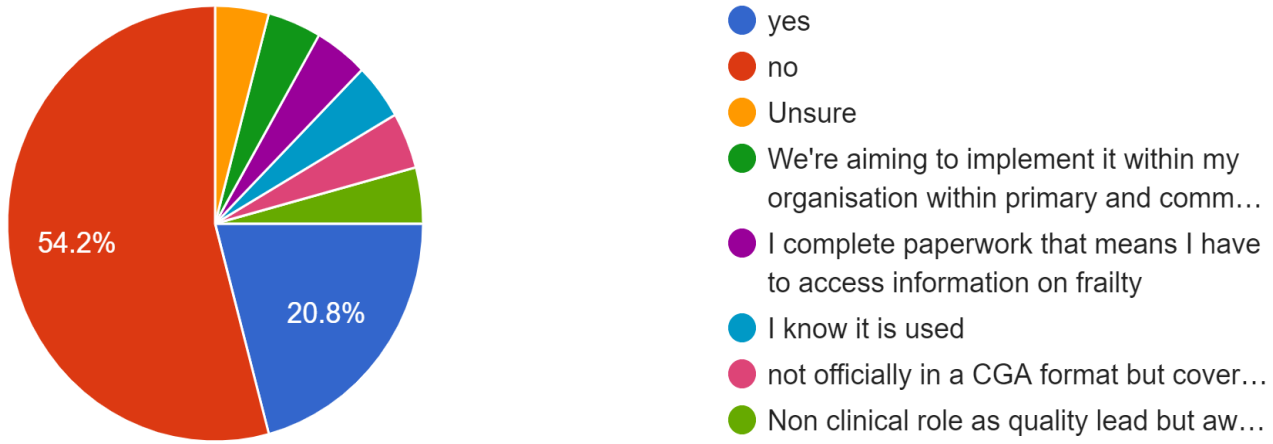
https://rdcu.be/dnlQ2



Taken from: van Oppen, J.D., Coats, T.J., Conroy, S.P. *et al.* What matters most in acute care: an interview study with older people living with frailty. *BMC Geriatr* **22**, 156 (2022). https://doi.org/10.1186/s12877-022-02798-x

Do you use a comprehensive geriatric assessment in your current role?

24 responses

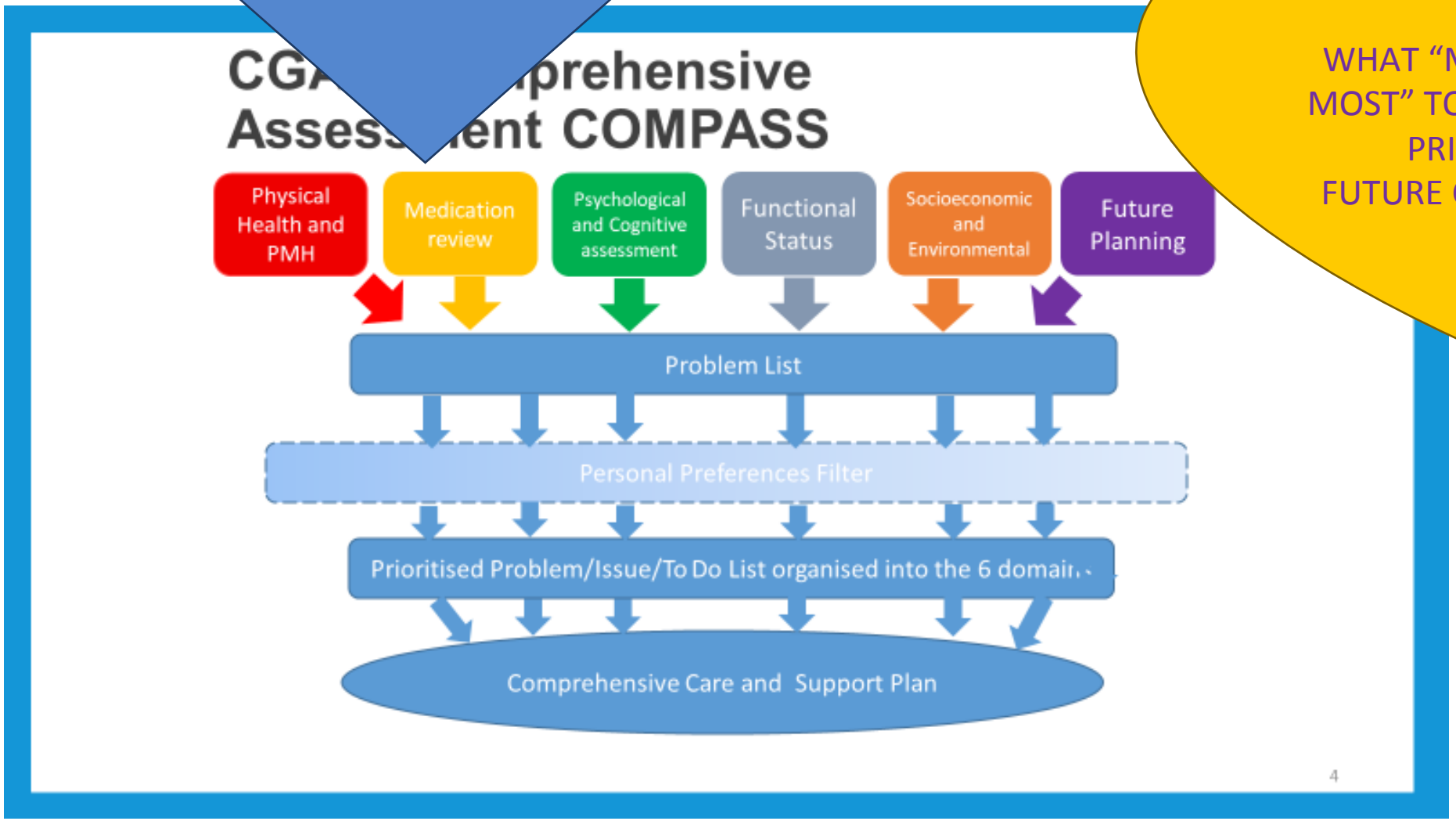


“We're aiming to implement it within my organisation within primary and community care as part of the programme I support.”

“Not officially in a CGA format but covers all aspects of the assessment.”

“Non clinical role as quality lead but aware or rockwood in use in our Trust.”

ROCKWOOD /FRAILTY SCORES



WHAT "MATTERS THE MOST" TO THE PATIENT
PRIORITIES
FUTURE CARE WISHES

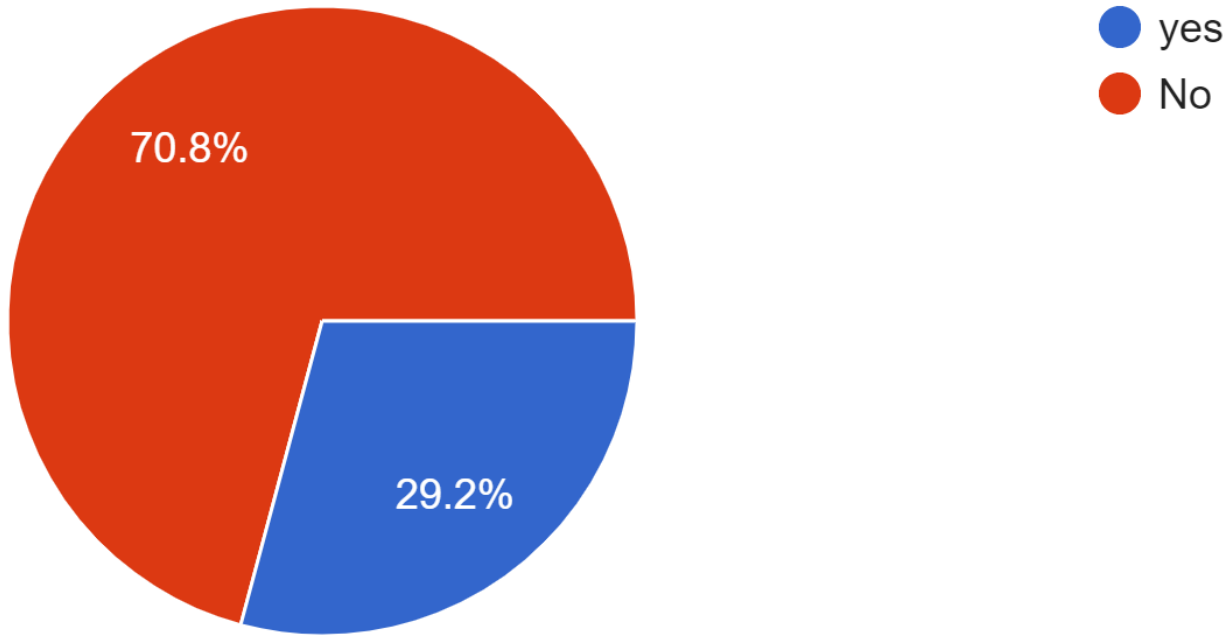
Challenges to using frailty tools

Departmental Challenges

- Primary and Community Care
- Multidisciplinary Team
- Lack of Standardization
- Community Setting
- Standardization Efforts
- Time Constraints
- Consistency

Have you received formal training in the use of frailty assessment tools?

24 responses



How are your findings and plans for patients living with frailty are communicated between care settings and sectors?

- “Not well, a work in progress.”
- “We're working through this as part of the programme.”
- “Multi disciplinary team meetings good paperwork and communication”
- “Discharge summaries, patient record also accessible via EMIS”
- “Paper based. Electronic record”
- “Narrative”
- “Poorly at present due to lack of unified system”
- “They don't exist at the moment”
- “Dependent on clinical area”
- “Not sure”
- “RIO”
- “Care plans are given directly to the patient or the family community, matron and community health services to have access to emis so they can login directly. I will community matron in the Nursing Home also has direct access to emis If there’s no access to the communication is done through the email or telephone calls”
- “Rely on manual entry by care providers”
- “No idea”
- “Through routine liaison/handover with other agencies; discharge summaries; work with families.”
- “Discharge summaries”

No standardised practice for patients Living with frailty

Navigating Solutions for Frailty and Personalised Care

Lack of formal training in frailty scoring:

Explore Frailty Training Opportunities:

- University of Worcester
- British Geriatric Society
- NHS E-learning for Health
- CHA SIG – many of our SIG sessions are relevant to frailty education

Navigating Solutions for Frailty and Personalised Care

Lack of standardised practice across sectors and settings

- Integrate IT systems
- Standardise high quality education and training in frailty
- Collaborate between sectors, joint training sessions inc social work, carers

Navigating Solutions- Frailty and Personalised Care- More Research

More research into the use of frailty scores relevant to our patient populations within the community and community hospitals needed :

Community Healthcare Alliance of Research Trusts (CHART) – follow on twitter @CommunityHART.CHART

NIHR recognising Frailty as an important area

CHA SIG has received funding from the Health Foundation for our Q study

Continued collaboration between professionals (inc Social care)

The Community Hospital Association Special Interest Group

"Enhancing Collaboration"

- Sharing Best Practices
- Networking & Open Dialogue about Opportunities and Challenges
- Supportive Environment

Stay Updated

- Receive SIG Event Notifications via Email
- Upcoming Community Hospital Conference
- Innovation & Best Practice Awards: Share Your UK Initiatives

Continued collaboration with Patients and Carers

The good thing about Frailty also being a descriptive term is it is something carers can understand (caveat: patients do not like being described as frail)

“Enhancing Collaboration and co-production”

- League of Friends
- Patient participation groups
- Communities, Community Hospitals sit within communities

Thankyou!

- Any further questions?

References

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