Same Day Emergency Care & Acute Frailty

Regional Event, Leicester: May 21st 2019

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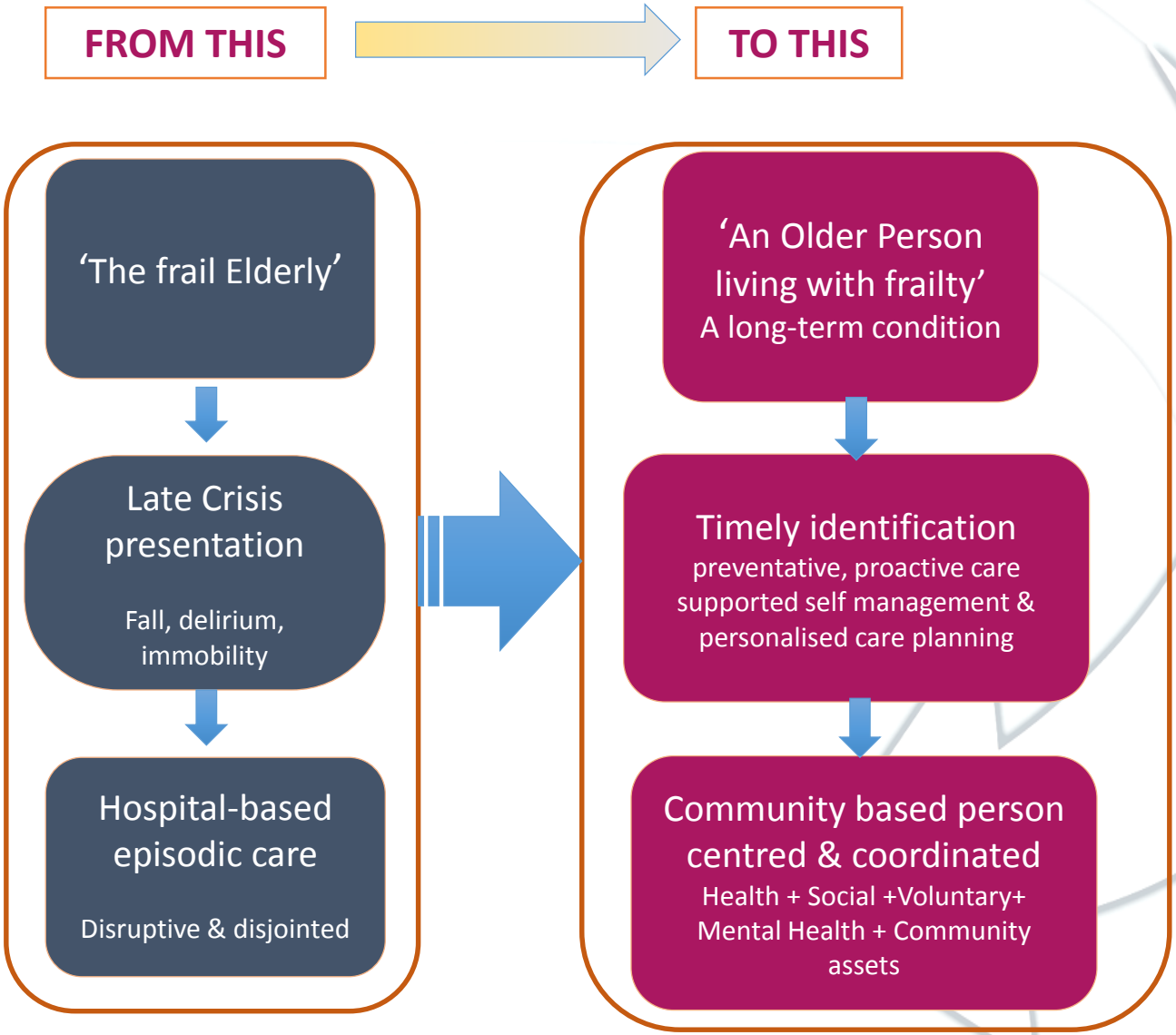
SDEC Frailty Sub-Group Lead

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

Putting SDEC in policy context

What's the national approach?



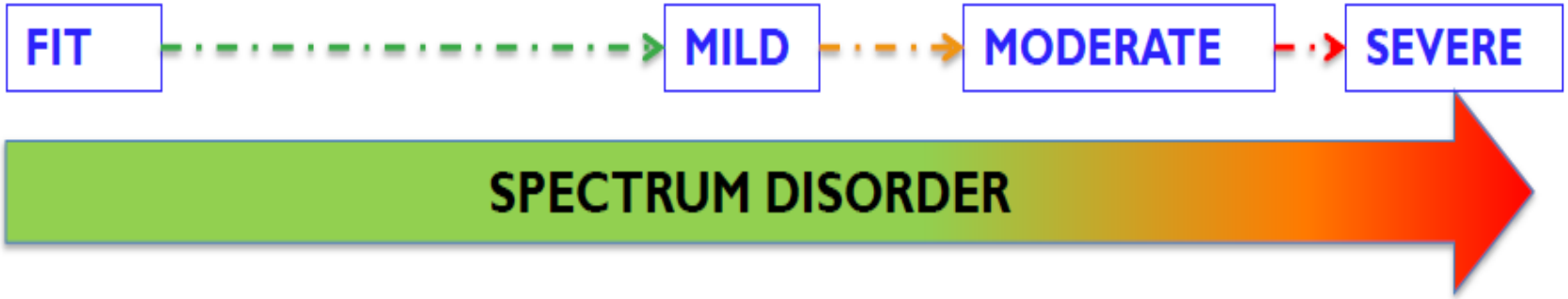
Slide courtesy of Martin Vernon and NHS England

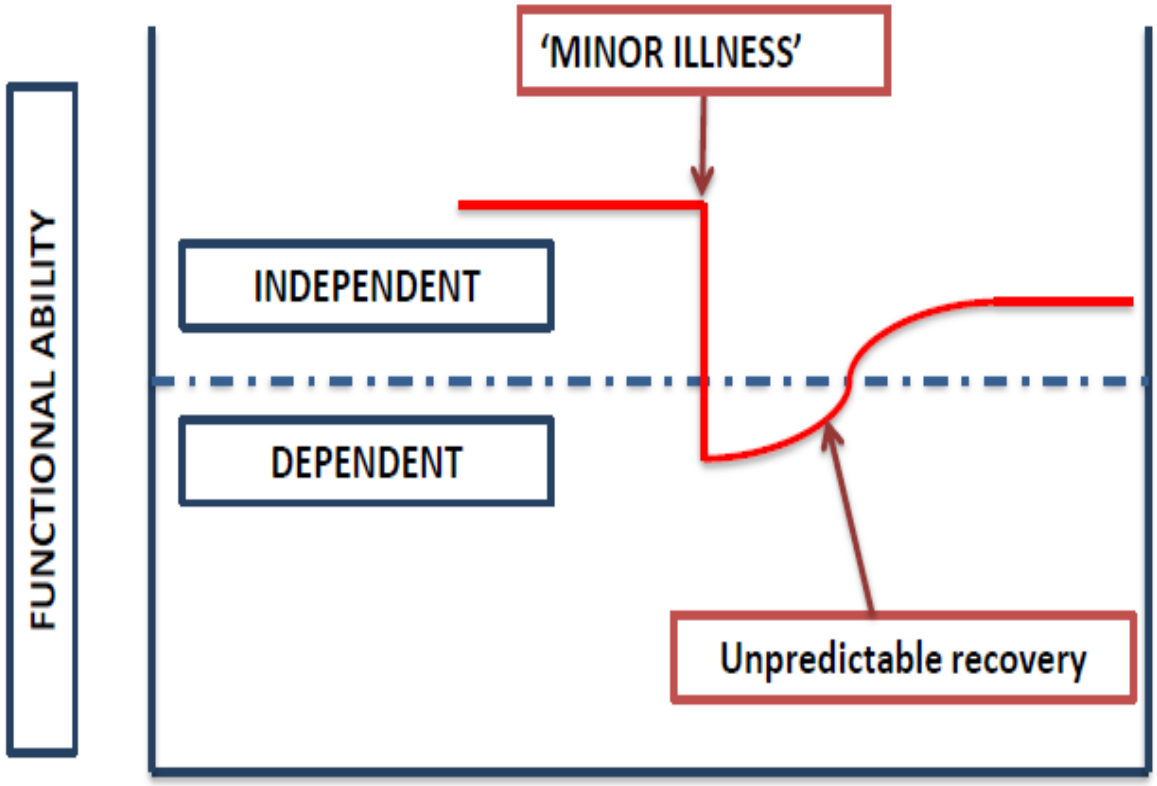
What is frailty?

- *“a condition or syndrome which results from a multi-system reduction in reserve capacity to the extent that a number of physiological systems are close to, or past the threshold of symptomatic failure. As a result the frail person is at increased risk of disability or death from minor external stresses.”*

(Campbell and Buchner, 1997)

"A long-term condition characterised by lost biological reserves across multiple systems & vulnerability to decompensation after a stressor event"





Clinical challenge

- Non-specific presentations can be underestimated
- It takes time to identify key issues

Three part system challenge

- Age attune community services to prevent deterioration
- Provide community alternative urgent responses
- Age attune the hospital to optimise the approach to the modern patient

What are we trying to achieve?

Right patient, right place and right time etc etc

- Admit the patient who can benefit and get the issues clear at the outset
- Don't admit the patient who will not benefit
- Don't admit if the benefit can be achieved as well and as efficiently somewhere else, eg at home

…….In a little more detail

What are we trying to achieve?

Frail and acutely ill	Admission is probably useful and necessary • Identify geriatric syndromes that will impact the next few days eg delirium • Build in a CGA approach to maximise function • Anticipate discharge and post acute needs
	Admission is probably NOT useful • Identify palliative needs: ? end of life care
	Admission might be useful but is not necessary • Discharge to competent service for medical and other interventions and support • Liaise with hot clinics /CGA
Frail + not acutely ill	• Discharge +/- urgent functional support • Rehabilitation to increase reserve and resilience to future events

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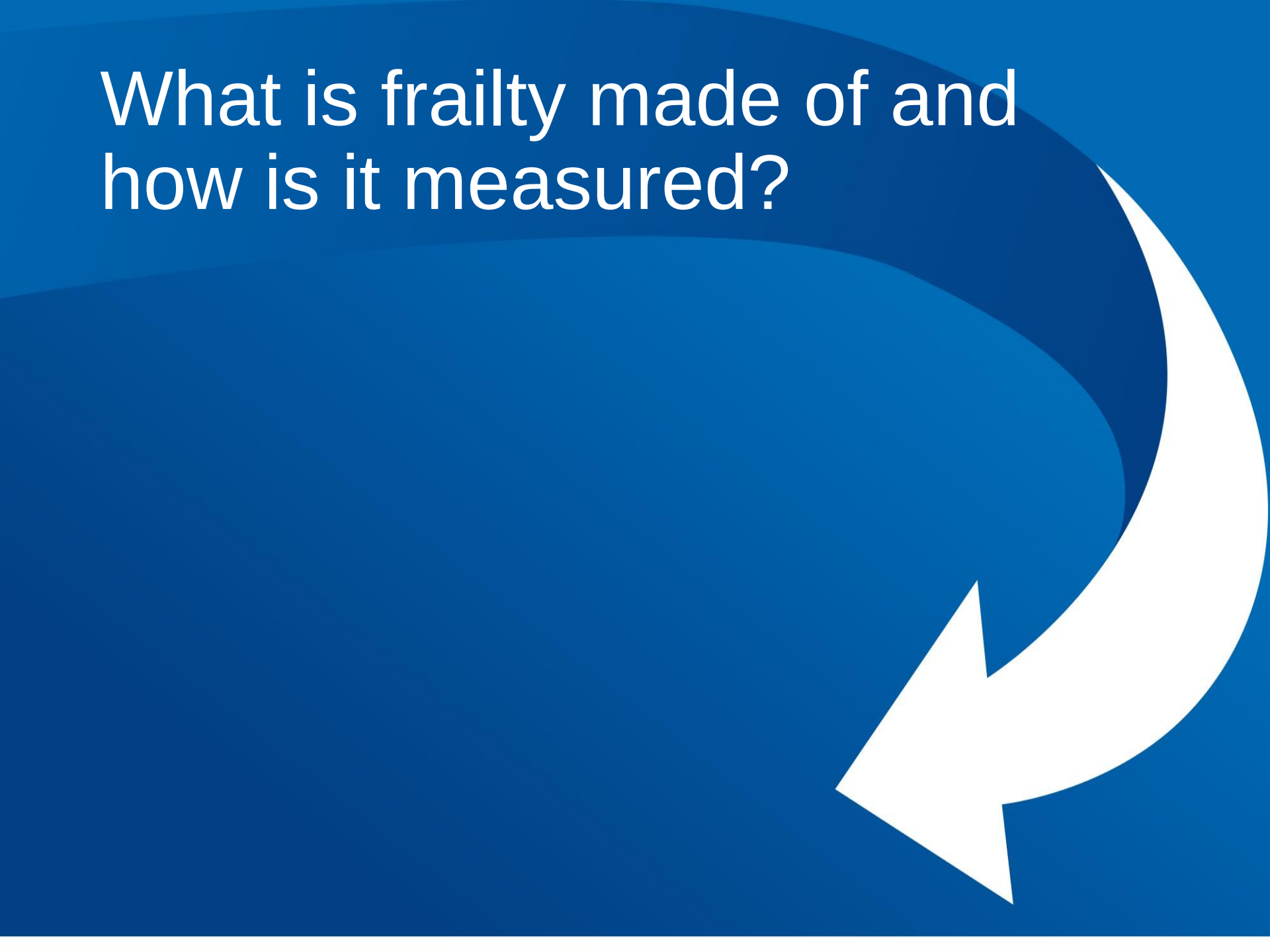
SDEC

What is frailty made of and how is it measured?



Different concepts, each with its own usefulness

Phenotype

- specific measurable impairments
- distinct from co-morbidity

Deficit accumulation model

- risk prediction using symptoms, diagnoses, disability + impairments + behaviours

Clinical impression based on an overview

- eg Clinical Frailty Scale (Rockwood)

Fried's phenotype approach

Fried LP et al J Gerontol A Biol Sci Med Sci 2001; 56: M146-56

Weight loss	Self-reported weight loss of more than 4·5 kg or recorded weight loss of "5% per year
Exhaustion	Self-reported exhaustion on US Center for Epidemiological Studies depression scale73 (3–4 days per week or most of the time)
Low energy expenditure	Energy expenditure <383 kcal/week (men) or <270 kcal/week (women)
Slow gait speed	Standardised cut-off times to walk 4·57 m, stratified by sex and height
Weak grip strength	Grip strength, stratified by sex and body-mass index

Categories

Number of factors	
0	Not frail
1-2	Pre-frail
3-5	Frail

How does this help?

- Establishes frailty as a potential target for intervention as well as an indicator of vulnerability
- Community based treatment programmes can focus on strength, balance, nutrition, physical activity etc

in addition to

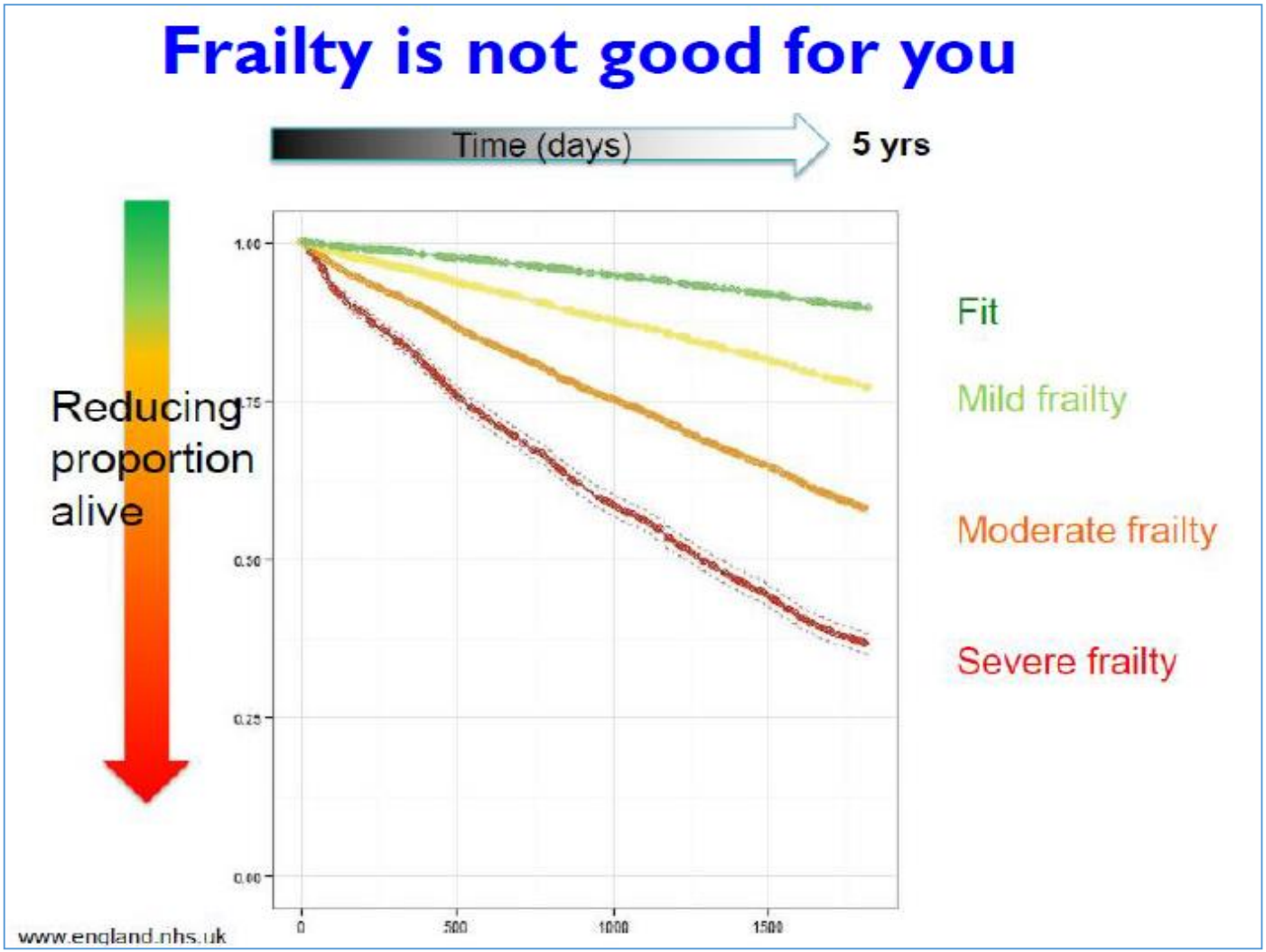
- the current emphasis on function

Deficit accumulation approach

- Each “deficit” has equal weighting
- Each dichotomised (0/1) or trichotomised (0, 0.33, 0.66, 1.0)
- Add all individual item scores
- Divide by number of items
- Thus the Frailty Index score is between 0 and 1
- Predictive ability improves with more parameters , >30 is enough!
- Good evidence for all outcome prediction

Rockwood et al JAGS 2006; 54:975-979

eFI: the deficit approach from routine primary care data



How does this help?

- Enables targeting in primary and community care for issues such as
  - ➢Medication reviews and de-prescribing
  - ➢Advance care planning

  (What matters to you)

Case finding – a simple tool

- CFS based on how the patient was **TWO** weeks ago
- Ask them, families or carers. Can the ambulance service help?

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.**

Scoring frailty in people with dementia

The degree of frailty 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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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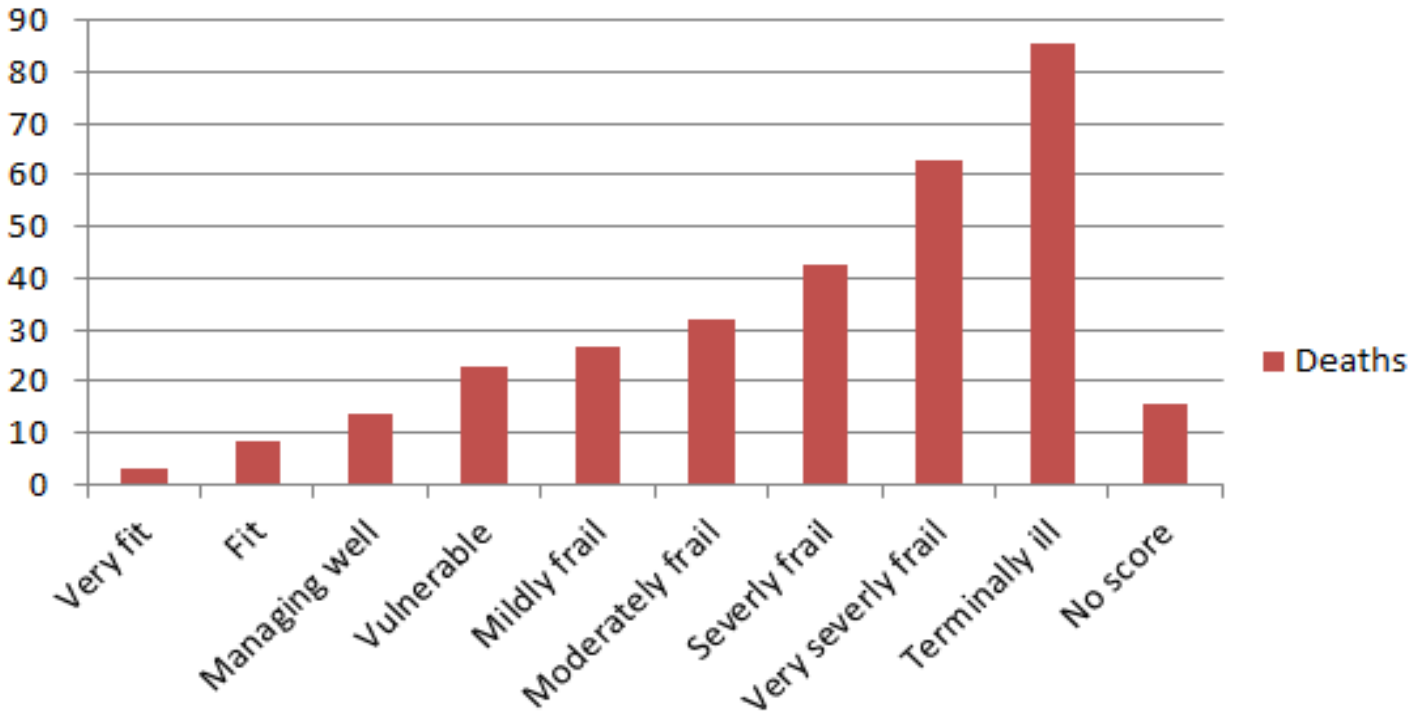
How does this help?

- Provides a guide to the *likely* clinical course now and over the following year or so
- Alerts you to the *possibility* of very different priorities for care

  ..What matters to you?
- Therefore what *skills* may be needed (MDT)

Percentage of deaths by CFS score post discharge for NEL >65 admissions who had a death date recorded by 4 April 2018

(Admissions between April – Dec 2017)



Courtesy of David Hunt from
West Sussex Hospitals

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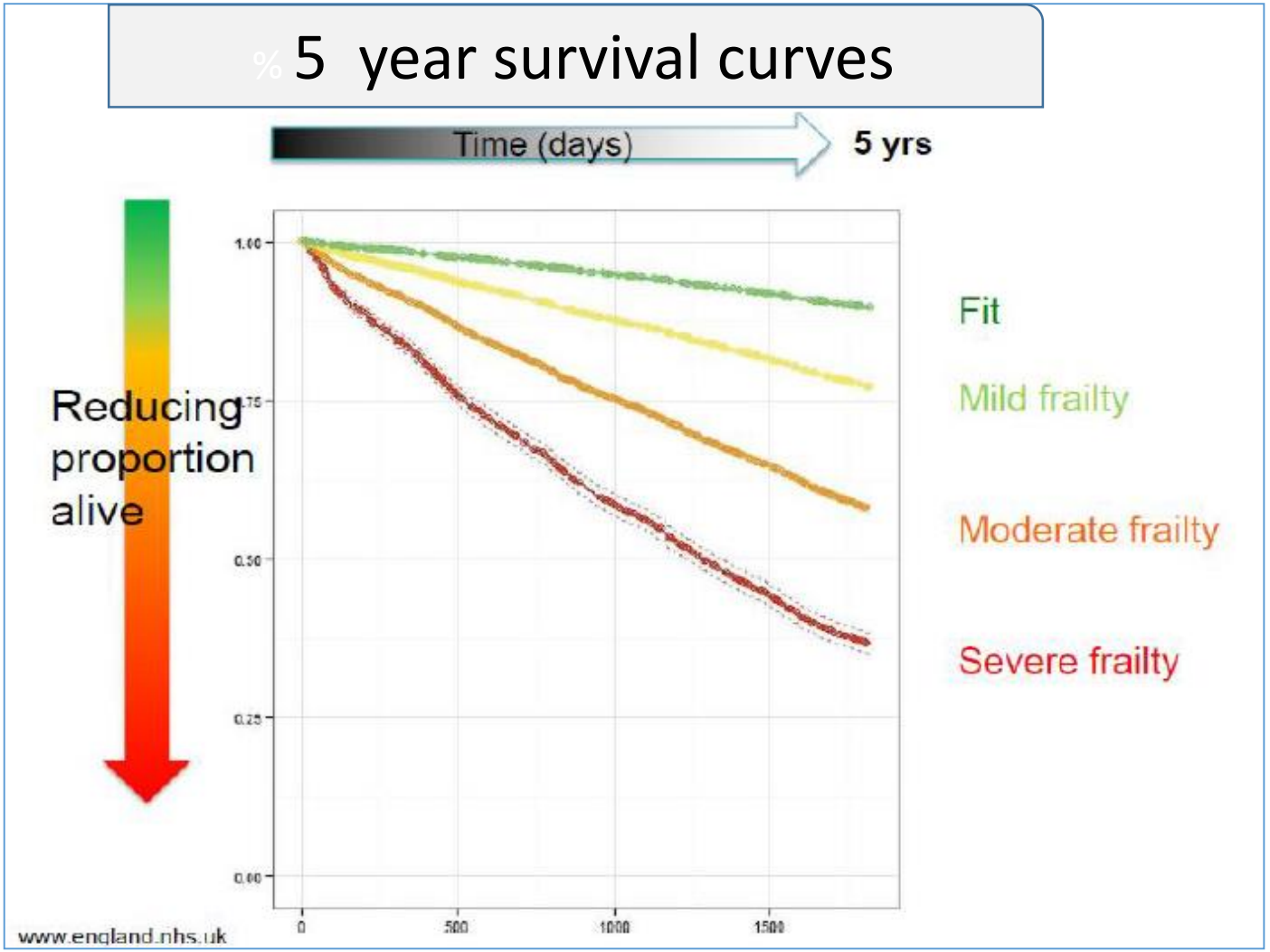
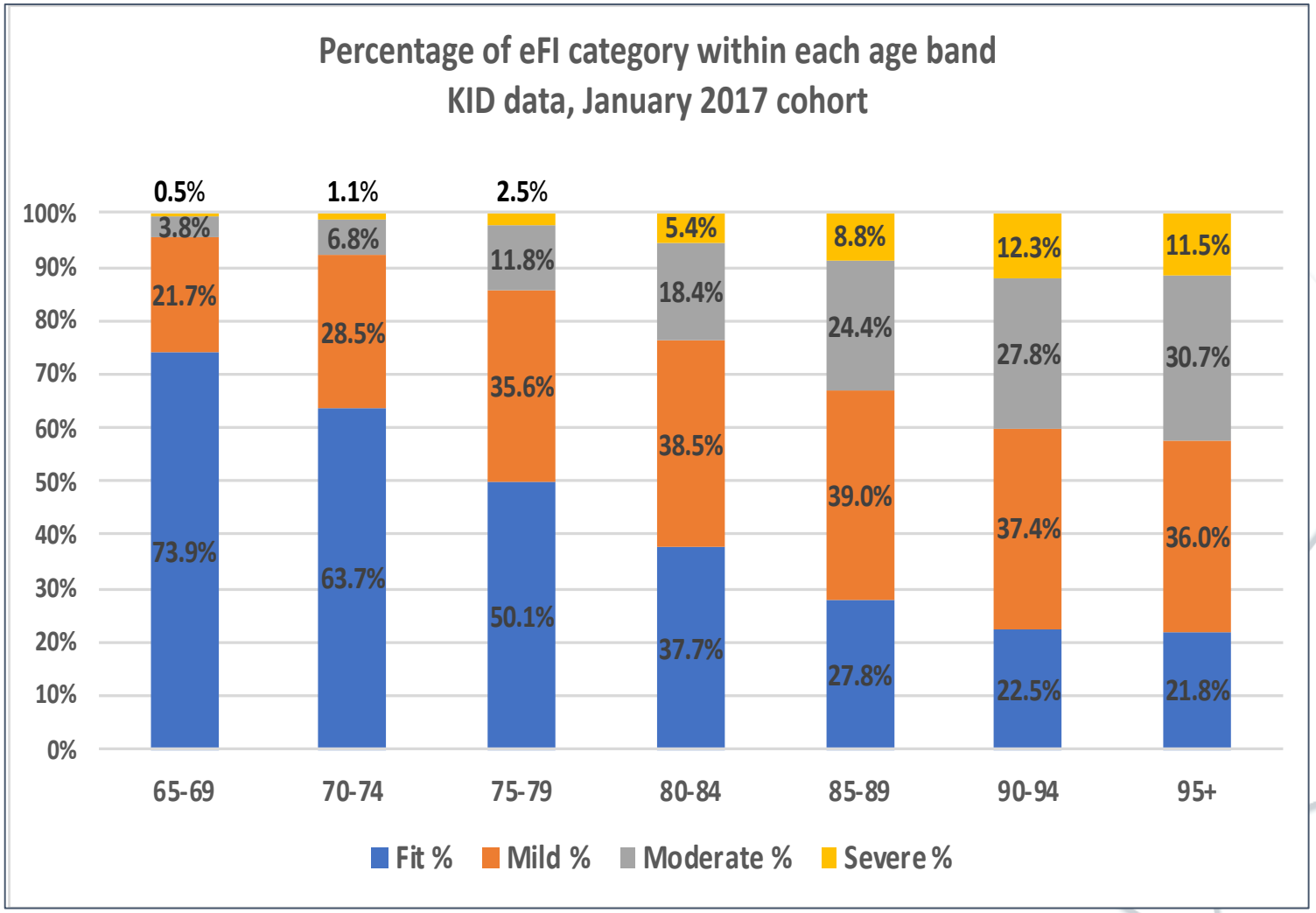
How common is frailty?

eFI: the deficit approach from routine primary care data



Distribution of Frailty in old age (eFI)



NHS England analysis- KID 2017-18

Older people, frailty, hospital use and outcomes

- Older People: HES codes to identify frailty:
  - - Unspecified protein-energy malnutrition
  - - Dementia+ or Incontinence+
  - - Somnolence, Very low level of personal hygiene
  - - Difficulty in walk Senility, Falls
  - - 'Z-codes' – functional limitations

Activity type (frail older people)	England
Percentage of total admissions	57%
Percentage of total bed days	87%
Percentage of emergency readmissions within 90d	84%
Percentage of deaths within 90 days of admission	84%

- **Frailty associated c delirium, falls and deconditioning**
- **20% experience 80% of harms (75+patients)**

Slide courtesy of the Acute Frailty Network

What we know what makes a difference

Comprehensive Geriatric assessment for the older or frail patients

Cochrane Review 2017 of CGA for older people admitted to acute hospital vs usual care

- 29 trials recruiting 13,766 participants across nine, mostly high-income countries.
- alive and at home in 3-12 months: risk ratio (RR) 1.06, 95% confidence interval (CI) 1.01 to 1.10
- Reduced likelihood of being in a nursing home at 3 to 12 months follow-up: RR 0.80, 95% CI 0.72 to 0.89
- Small increase in costs: very likely is cost-effective

Ellis G et al 2017

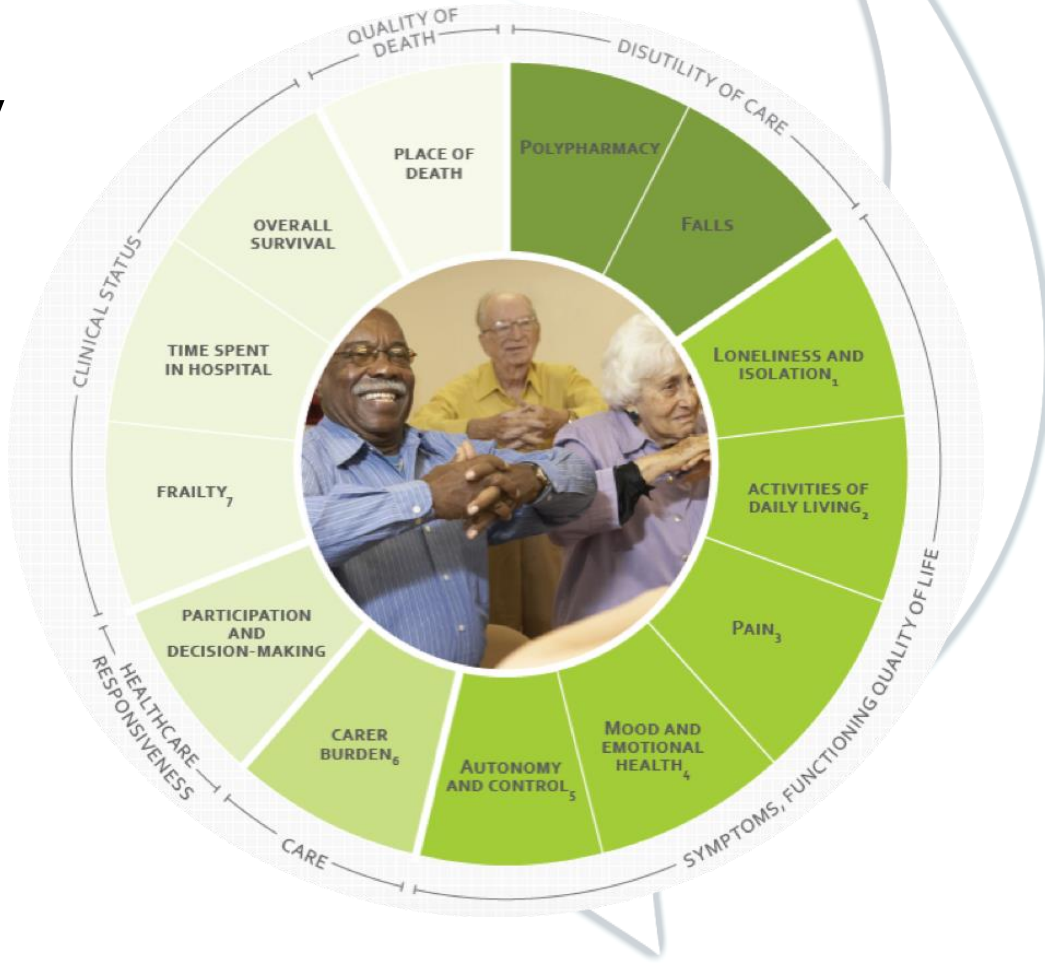
Lessons from the Acute Frailty Network

- Early identification of frailty with the Clinical Frailty Scale can become as routine as early identification of acuity with the NEWS
- Any trained staff member can do this
- Reliable timely responses need clear professional working standards
- ***A flexible multi-disciplinary approach works and helps address staffing gaps***
- Improving responses to frail older people can avert unnecessary admissions and reduces bed use
- Patient experience of ED/AMU can improve

Individualise the focus – What matters?

- **Domains:**
- Symptoms, functioning, quality of life
- Disutility in care
- Care
- Healthcare responsiveness
- Clinical status
- Quality of death

- http://www.ichom.org/medical-conditions/older-person/



Examples (see the AFN website)

Styles of responses to frail patients

- Frailty (CFS) assessed by paramedics or ED nurse practitioners and directs patient to specific place or team
  (but needs to be accompanied by acuity assessment)
- “Frailty” MD team pulls selectively from ED
- Assessment space without beds to avoid immobility and encourage speedy responses
- Frailty used to divide the work in AMUs, with/without dedicated space
- OPAL type assessments in AM ward “next day”

Summary points

RECAP- Why identify frailty?

- ***For those admitted***, rapid access to MDT approach to minimise harms etc
- ***For the uncertain ones***, to factor in frailty to clinical decisions about priorities and discharge plans etc
- ***For those who go home***, to flag up need for interventions to

➢ reduce the frailty factors

➢ reduce frailty associated risks (eg falls)

Risks for patients if frailty is not recognised and taken into account

- Delirium, falls and pressure sores not prevented
- Deconditioning and slower recovery
- MDT input delayed
- Appropriate goals of care not decided
- Polypharmacy not managed
- Readmissions not prevented
- End of life care missed

Risks for patients if frailty is taken into account without individual assessment

Frailty

- becomes a nihilist connotation
- obscures need for prompt medical response
- everybody's business becomes anybody can do it

Frailism takes the place of ageism

New Frontiers in Frailty conference
Book your place **27th June 2019**

An international conference provided by the Acute Frailty Network supported by NHS Improvement.

27th June 2019

9am – 4.30pm, Central London

"The essential event for anyone interested in improving care for older people"
Professor Simon Conroy
University Hospitals of Leicester

Early Bird Rate

Only £125 ~~£149~~
For members of AFN or NHS Elect
(or £400 ~~£496~~ for 4)

Only £149 ~~£189~~
For non-members
(or £500 ~~£596~~ for 4)

Early bird available until 30th April 2019

Places are limited so please book soon:
www.acutefrailtynetwork.org.uk

To book your place follow this link: https://www.eventsforce.net/acutefrailtyconference2019
If you have any questions, please email the AFN team at frailtyevents@nhselect.org.uk or call 020 7520 9091