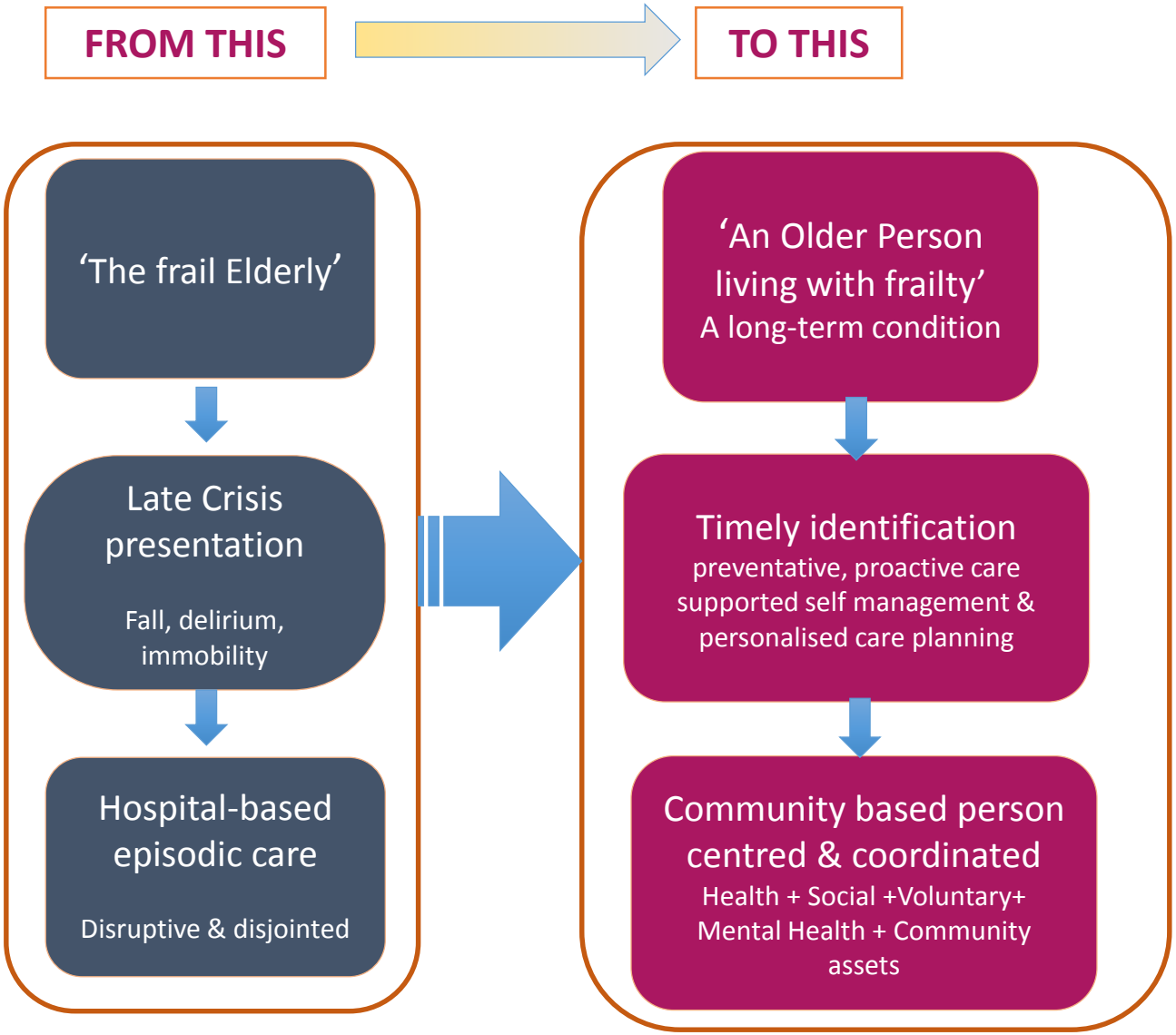
Same Day Emergency Care & Acute Frailty

Regional Event, Leeds: May 24th 2019

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

Putting SDEC in policy context

What's the national approach?



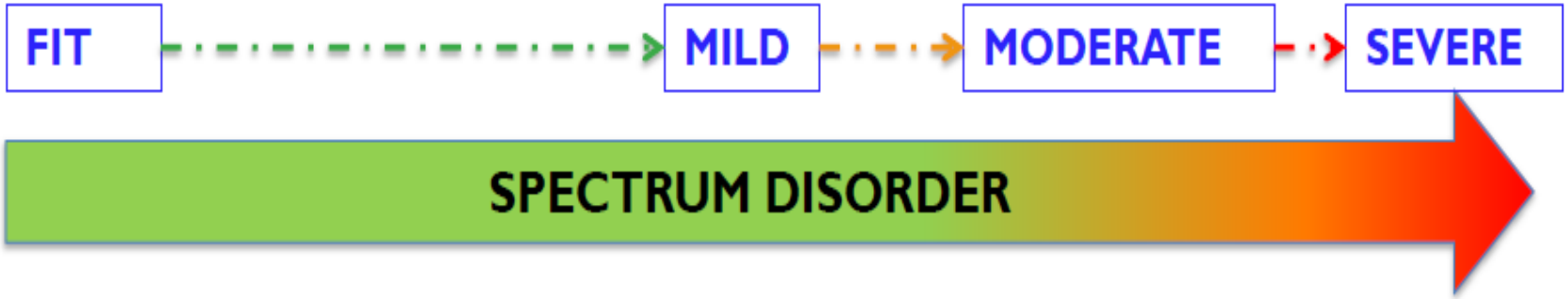
Slide courtesy of Martin Vernon and NHS England

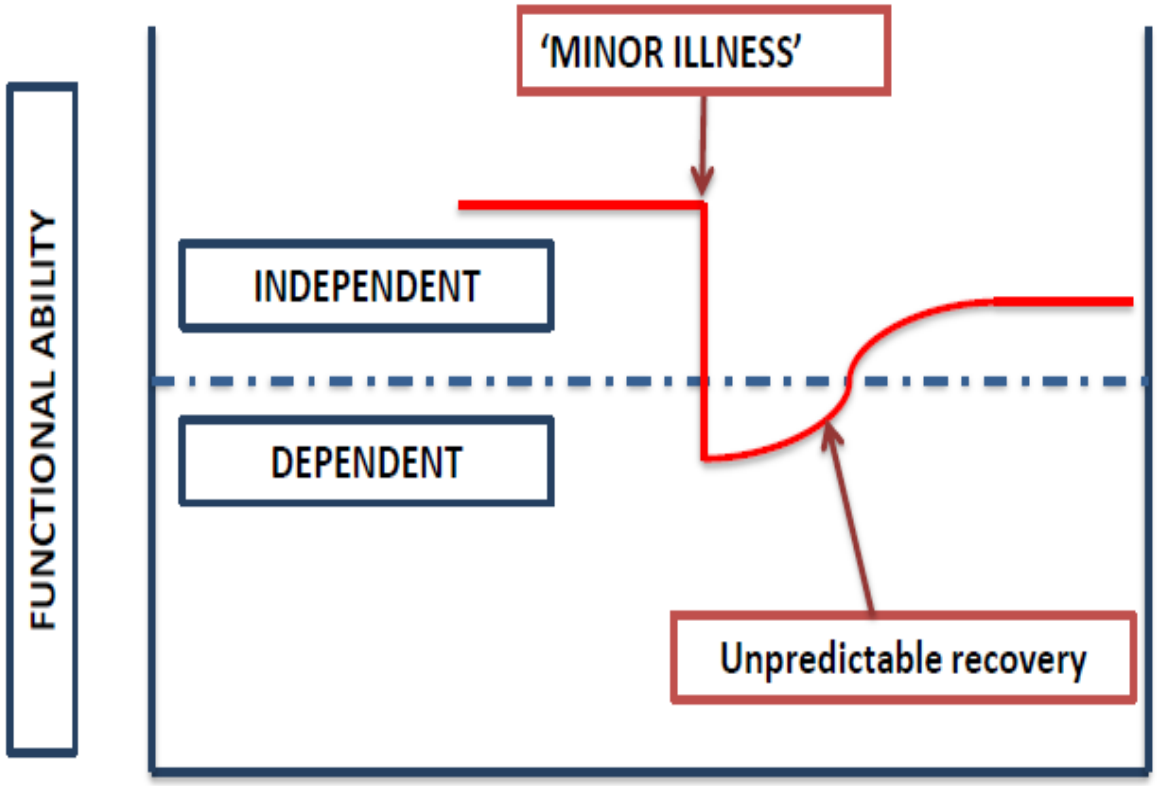
What is frailty?

- *“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

What are we trying to avoid ?

Implications of not identifying frailty

Implications of not identifying frailty

Frail and acutely ill	**Admission is probably useful and necessary** • Harms from delirium, falls and deconditioning
	Admission is probably NOT useful
	Admission might be useful but is not necessary
Frail + not acutely ill	

20% of the75+ patients experience 80% of the harm

10 days in acute hospital leads to the equivalent of 10 years' muscle ageing in 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.
Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

Implications of not identifying frailty

Frail and acutely ill	Admission is probably useful and necessary • Harms from delirium, falls and deconditioning • **20% of the75+ patients experience 80% of harms**
	Admission is probably NOT useful • the wrong priorities! harms and no benefits
	Admission might be useful but is not necessary
Frail + not acutely ill	

1000 days…

- 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*

Focus on

- **what matters to the patient –**
- **not what is the matter with the patient**

Implications of not identifying frailty

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	Admission might be useful but is not necessary • Risk of hospital induced harm • Flow problems persist • Money wasted
Frail + not acutely ill	• **If admitted: Ditto** • **If NOT: Risks of readmission not addressed**

SDEC can help us achieve

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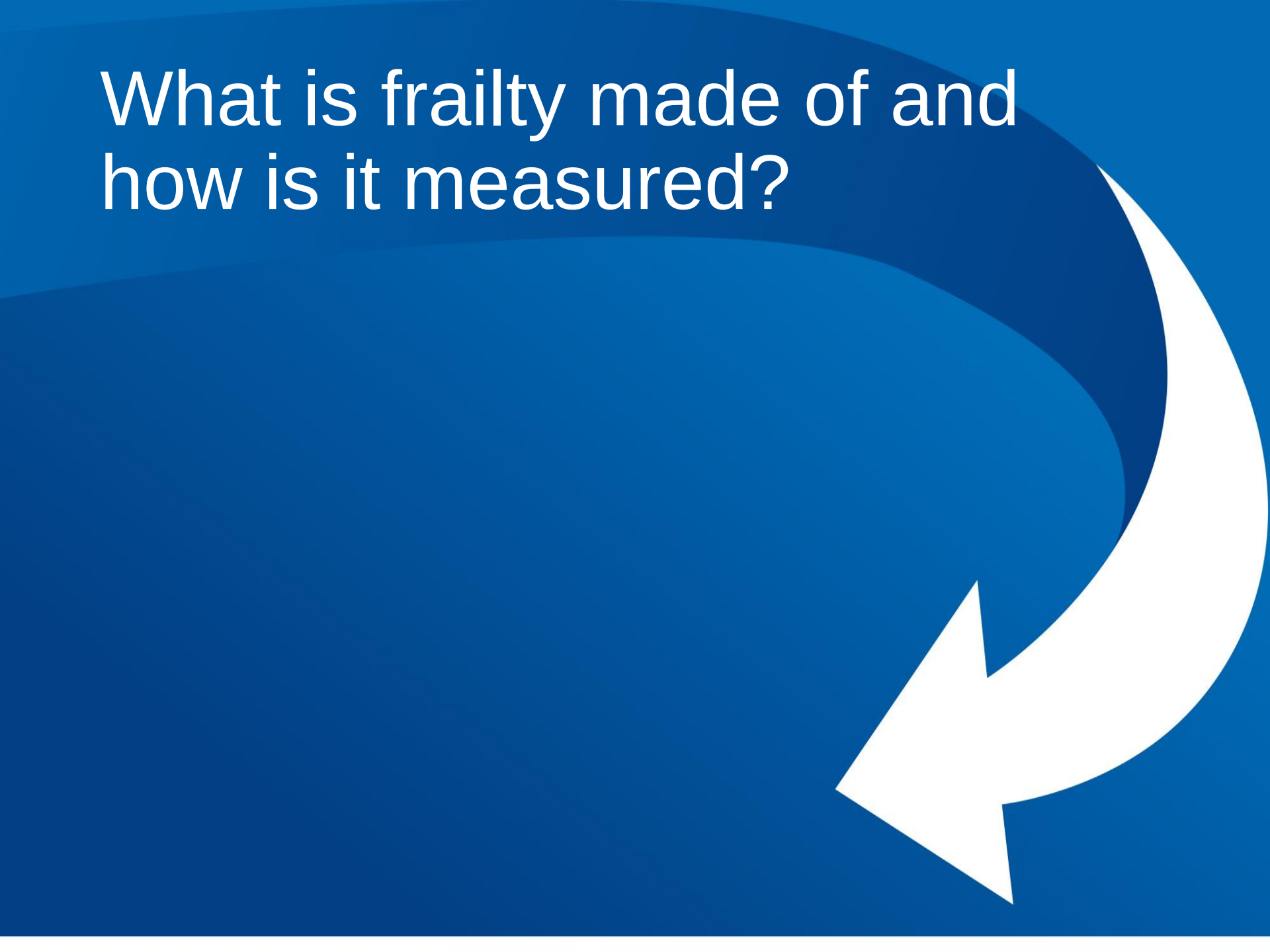
SDEC

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)

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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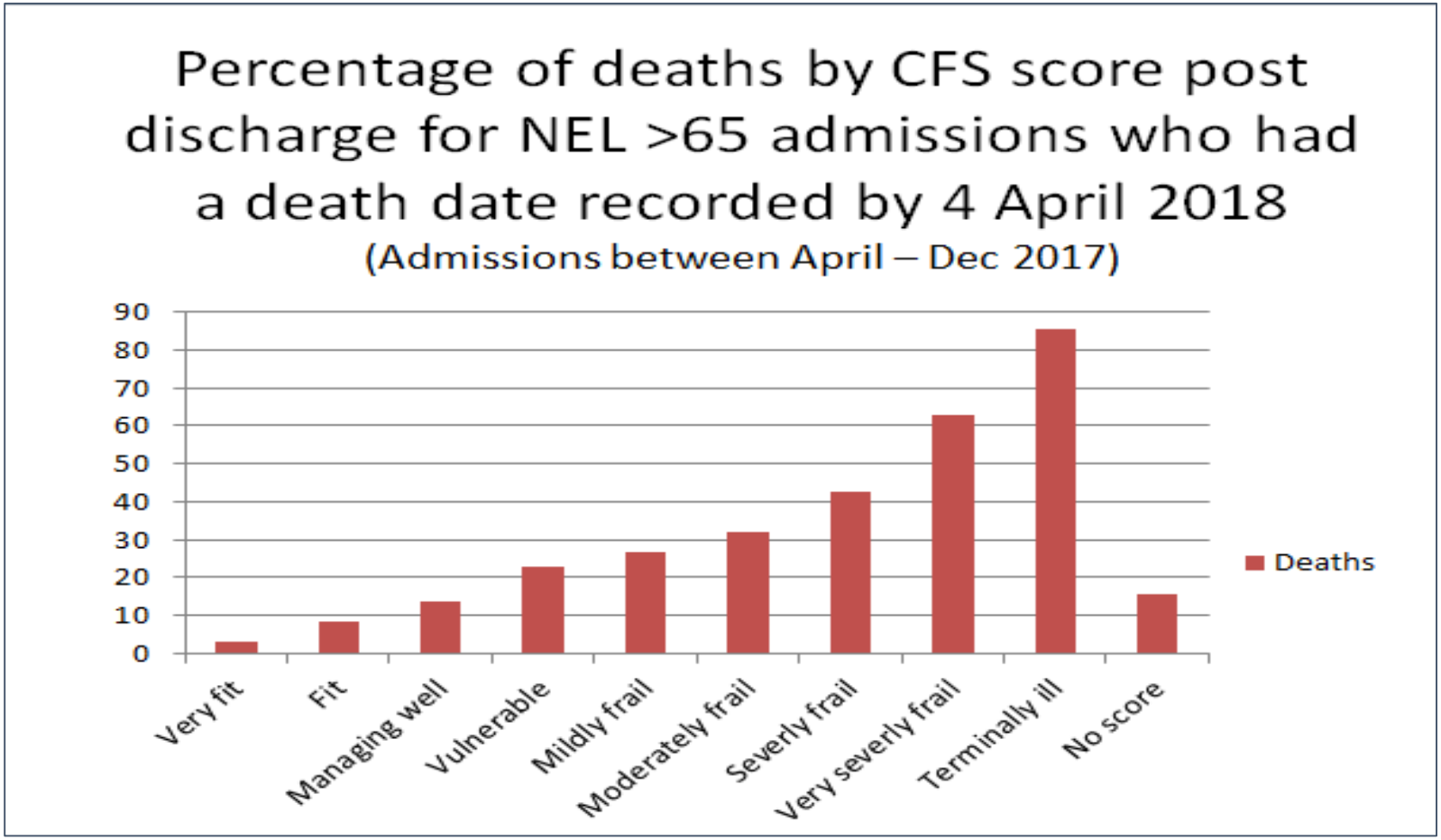
How does this help?

- Provides a guide to the *likely* clinical course now and over the following year or so



Courtesy of David Hunt from West Sussex Hospitals

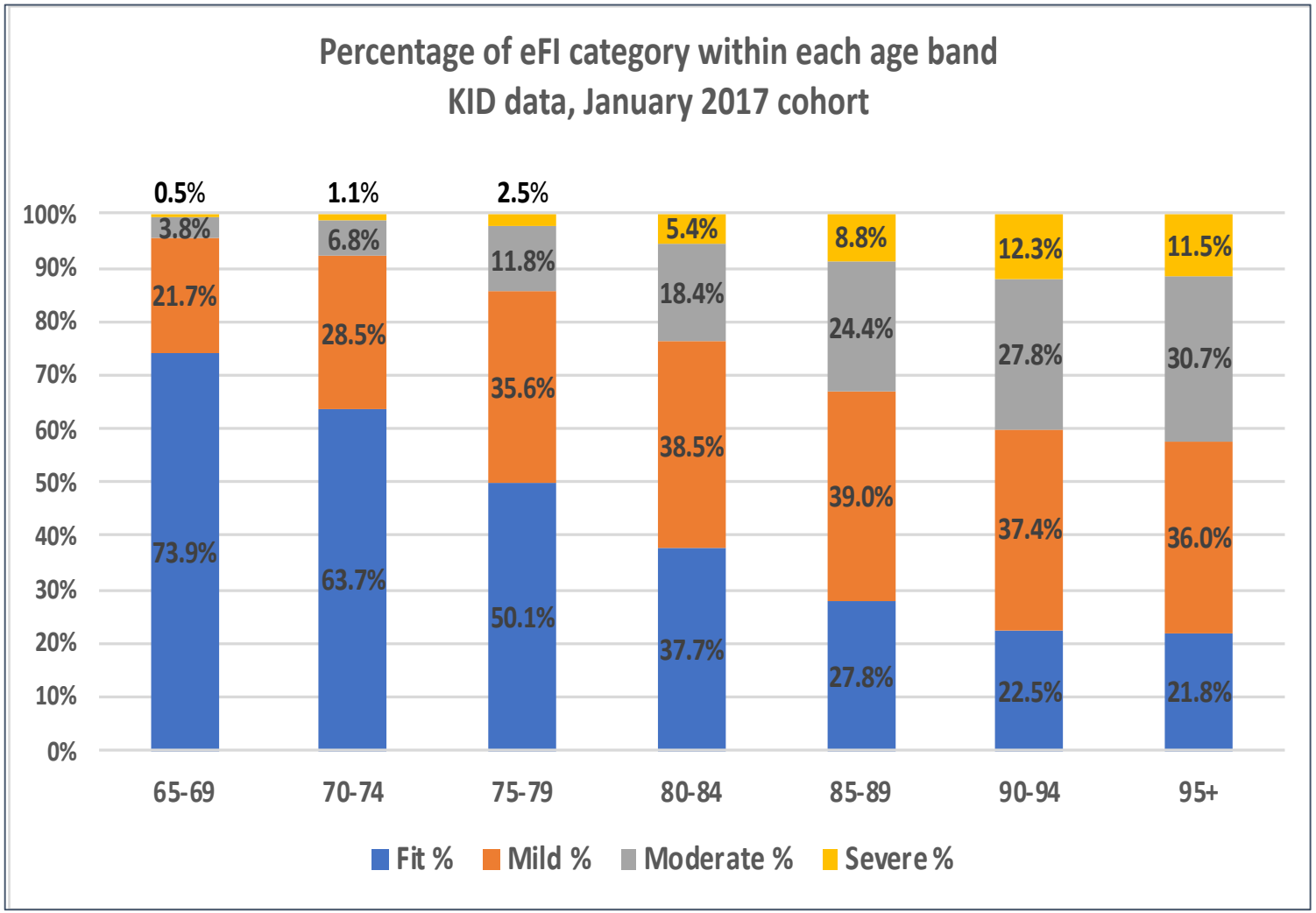
How does this help?

- 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 clinical approach, where and what *skills* may be needed (MDT)

How common is frailty?

Distribution of Frailty in old age (eFI)



NHS England analysis- KID 2017-18

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

Examples (see the AFN website)

Examples of acute frailty services

- 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

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)

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