National Ambulance LGBT Network Conference 2018

Frailty and End of Life Workshop: What is frailty, what are the challenges and what can we do?

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Intentions of this workshop

What is frailty and how does this relate to end of life care?

What are the global and national challenges for ambulance services?

What are ambulance services doing to manage frailty and what can we do?

Pledges and future networking

So what is frailty?

Frailty is a syndrome that combines the effects of natural ageing with the outcomes of multiple long-term conditions, a loss of fitness and reserves.

Lyndon 2014

It is not.....

A given for all older people or those living with disability

Limited to older people

Un-manageable or even non-reversible

It is categorised

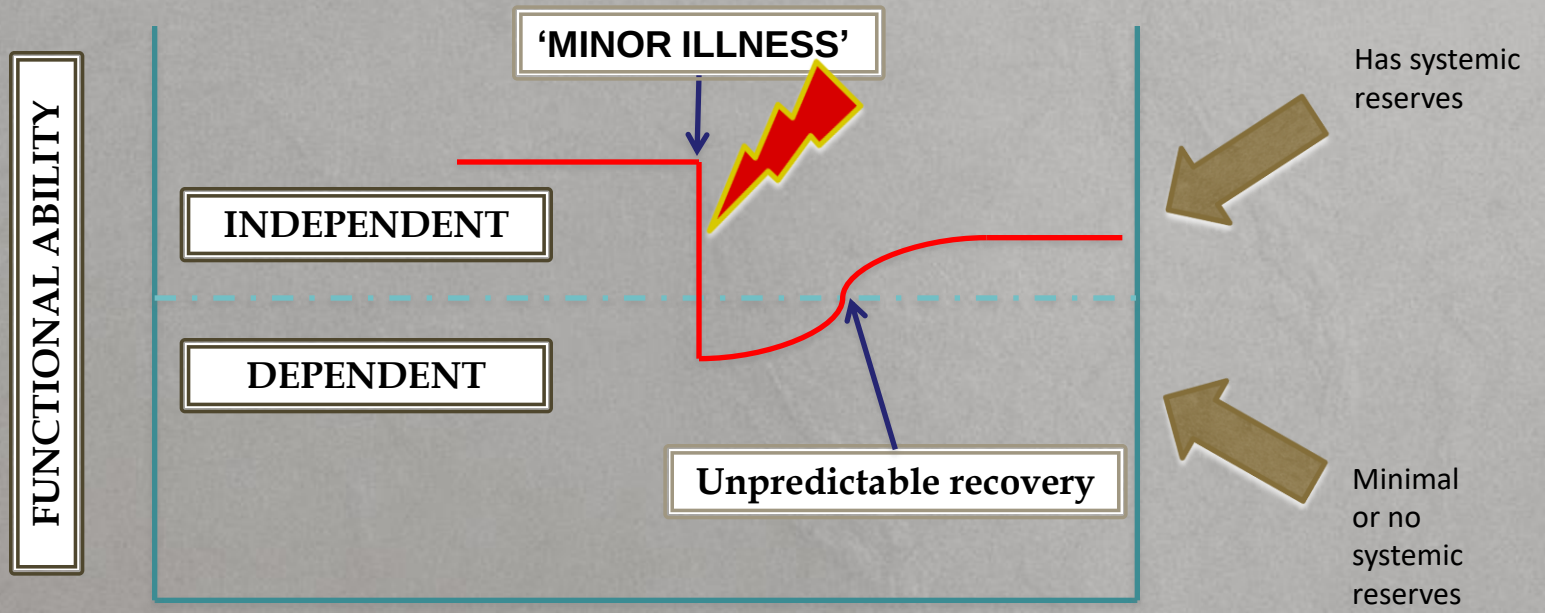
Pre frail Mildly frail Moderately frail Severely frail End of Life

FRAILTY IS PALLIATIVE

What is Frailty?

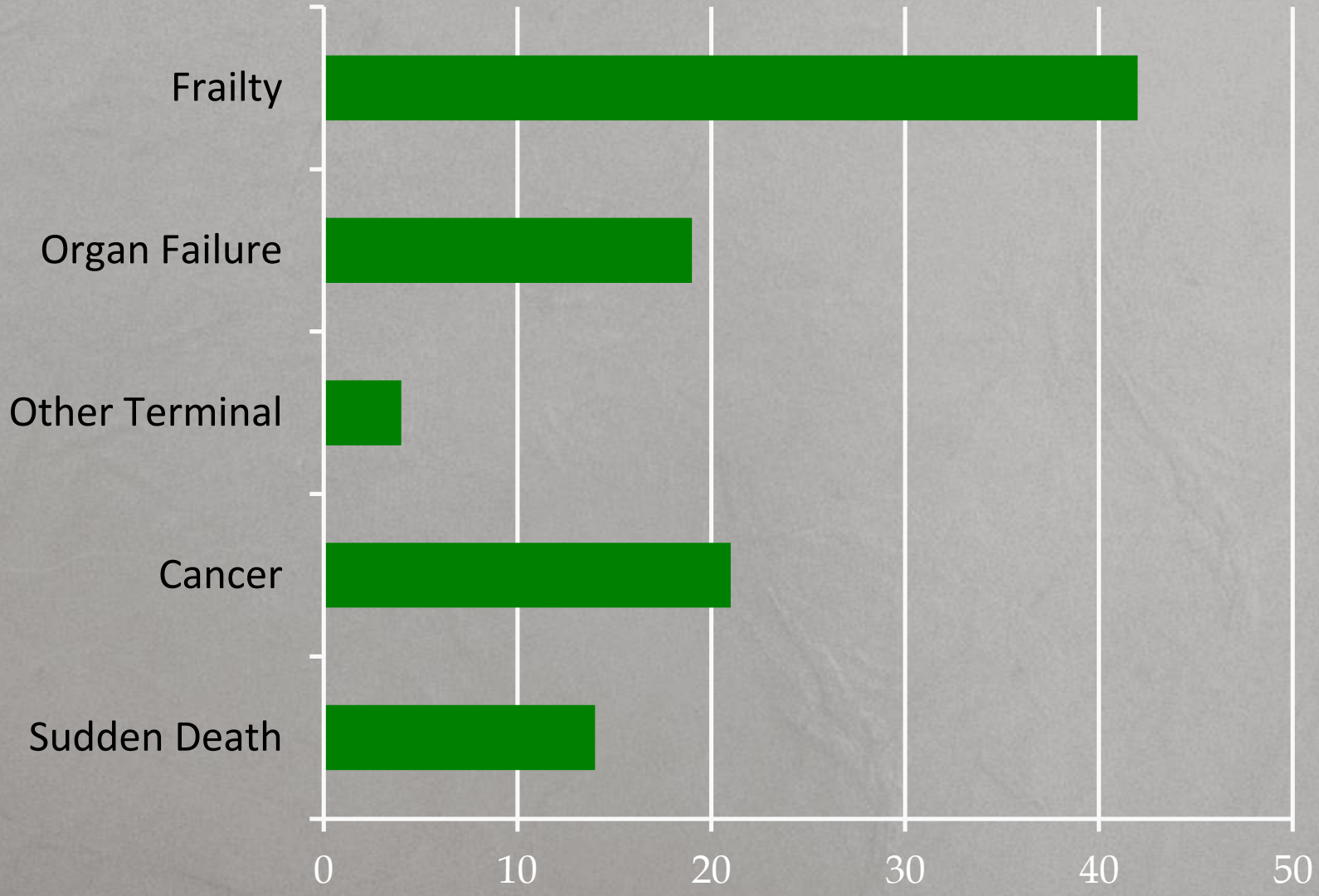
Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.

British Geriatrics Society



Fried (2001)

Frailty and End of Life



How many people are frail?

- 10% of people over 65
- 25 -50% of people aged 85+
- Patients aged 65-69 “baby boomers” single largest group admitted to hospital = 1.3 million of which 10% are live with frailty (NHS Digital, 2015-16)
- Year 2000 = 600 million over 60 predicted to <2 Billion by 2050

BGS/RCGP Fit for Frailty 1 (2014)

Baby boomers

2030

UN predict a world population of 9.15 billion by 2050: ⇧32.69% from 2010 *United Nations, Dept. of Economic and Social Affairs (2017)*

Responsible care from Ambulance Services

* Every 10 days in hospital leads to the equivalent 10 years ageing in the muscle of people over 80. Impact of bed rest in Older People in first 24 hrs loss of 2-5% muscle power.

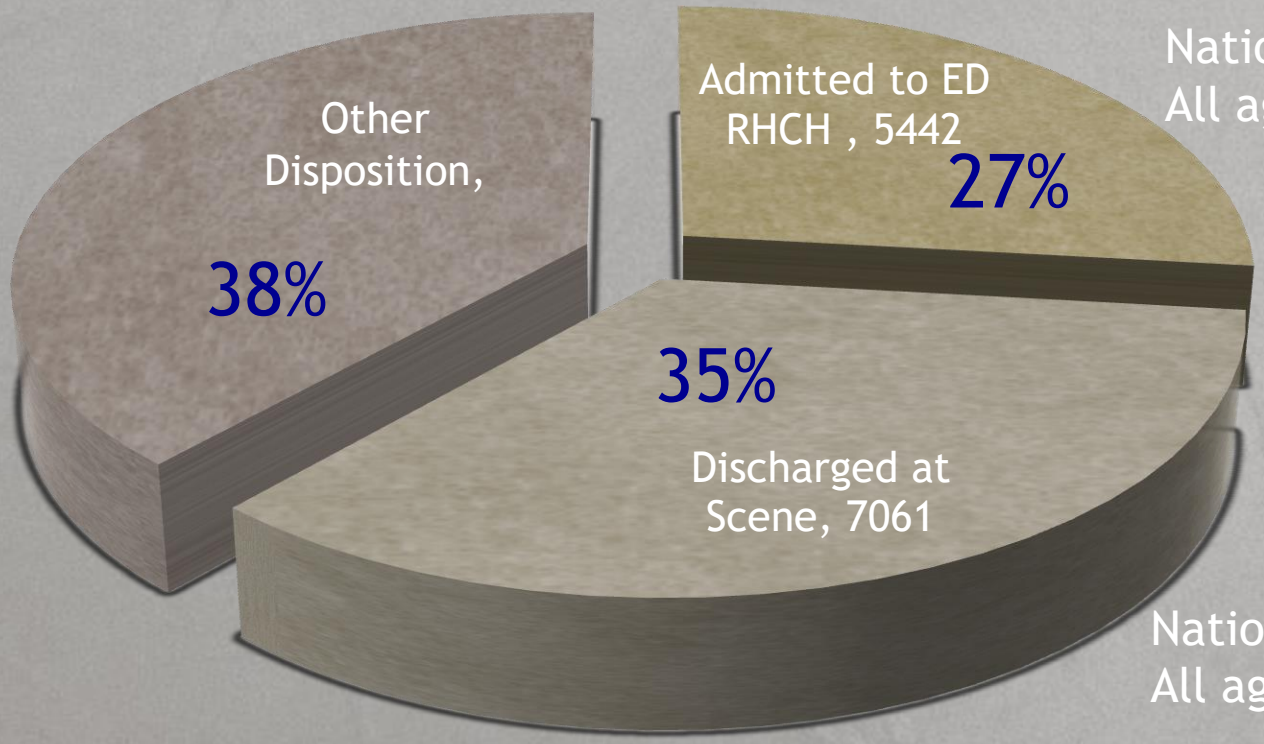
* 48% of people over 85 in a hospital bed (acute or community) die within 1 year of admission.

* Identifying frailty saves lives. It can lead to appropriate referral pathways, specialist multi-disciplinary assessments and person-centred are that improves quality of life- not necessary length of life.

* We are starting to recognise frailty (informally) and admit fewer patients to emergency departments than we treat at scene/refer to primary/social care/community teams.

* NHS Five Year Forward View/Fit for Frailty 1 and 2

SCAS Dispositions of Patients over 65 Years
July 2016-June2017



Total number of patients =20,312

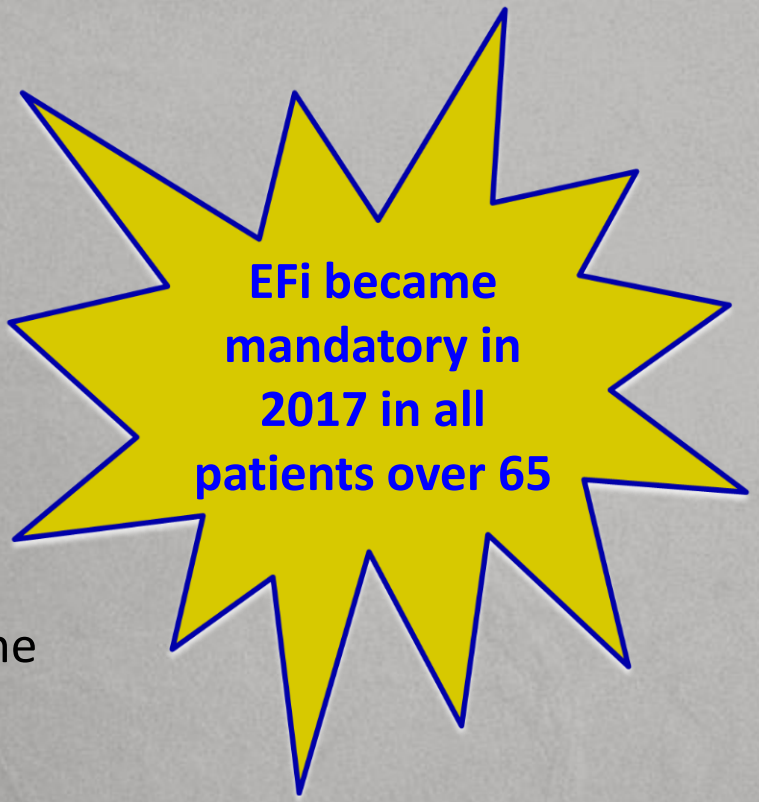
Identifying frailty

Frailty Index – cumulative deficits

- Falls
- Immobility
- Delirium
- Incontinence
- Medication

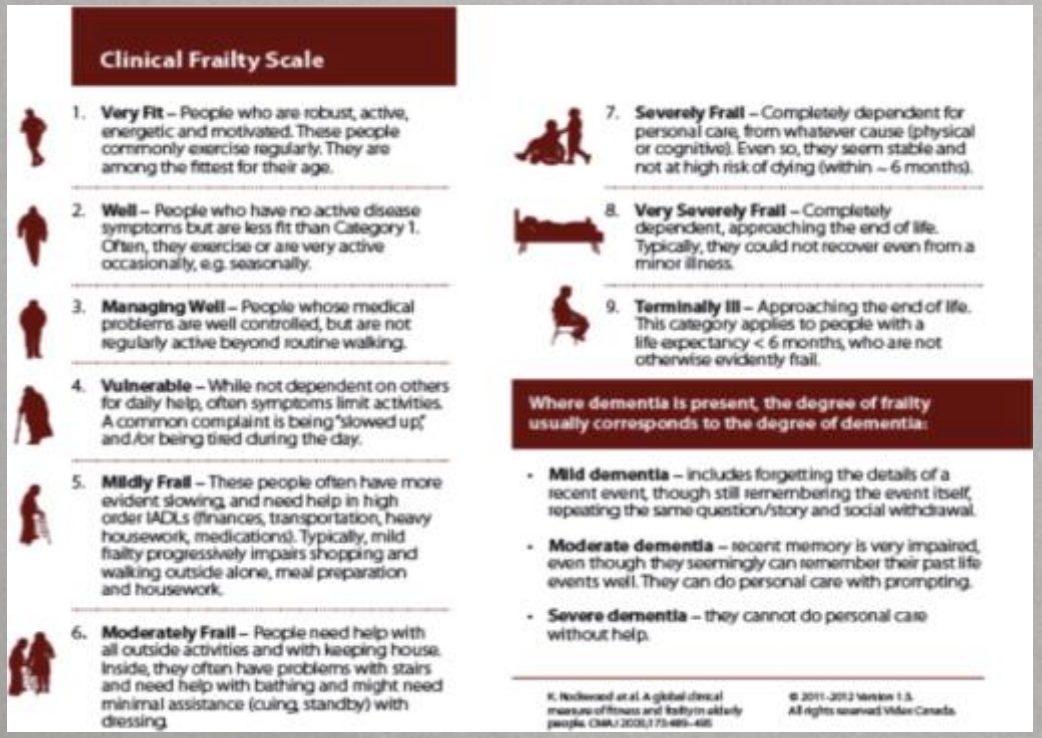
Frailty Phenotype – distinct clinical syndrome

- Involuntary weight loss
- Exhaustion
- Slow gait-speed
- Poor handgrip strength
- Sedentary behaviours



One Simple Intervention
One Significant Impact

Dr Ken Rockwood recommends we complete a frailty score for ‘current time’ and where possible, compare to 2 weeks earlier to demonstrate a decline in frailty, particularly when not conveying our patient.



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 well. They can do personal care with prompting.
- **Severe dementia** – they cannot do personal care without help.

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

So what is happening in SCAS?

Version 4– May 2018

Framework for identifying patients with Frailty using eFI and Rockwood

NHS

eFI and Rockwood equivalent scores + using clinical judgment		
eFI score	**Rockwood score**	**Advice**
0-0.12 Fit	1 Very Fit, 2 Well, 3 Managing well	Information and advice for those who are independent and are able to manage their own needs
0.13-1.24 Mild Frailty	4 Vulnerable, 5 Mild Frailty	Prevention and early intervention services for people at risk of deteriorating physical and mental health, Activities of Daily Living (ADLs) and who have multiple or complex needs
0.25-0.36 Moderate Frailty	6 Moderate Frailty	Intermediate services for people with deteriorating functional skills and abilities; in need of rehabilitation, recovery or reablement; at risk of admission to a care home
>0.36 Severe Frailty	7 Severe Frailty, 8 Very Severe Frailty, 9 Terminally Ill	Out of Hospital services care for people who are acutely ill and at risk of admission to hospital or are in, or have recently been admitted to, acute hospital

F orward thinking
R esilient
A ctive
I nformed in
L ater life

	eFI 0-0.12 and Rockwood 1-3 **Managing Well**	eFI 0.13-0.24 and Rockwood 4-5 **Vulnerable / Mild Frailty**	eFI 0.25-0.36 and Rockwood 6 **Moderate Frailty**	eFI >0.36 and Rockwood Score 7-9 **Severe Frailty**
Patient Criteria	• Reducing mobility or increase falls • Comorbidities and conditions relating to ageing • Age 65+ is a guide but not a restricting criteria • No active disease symptoms/ medical conditions at risk of not being well controlled • While not dependent on others for daily help, often symptoms limit activities • Subtle impairment of ADLs • Social isolation • Emerging memory or behavioural issues	• Increased falls • Memory loss • Often have more evident slowing and need help in high order ADLs (finances, transportation, heavy housework, medications) • Identified organic and/ or functional mental health problems that affect functionality and ability to recover and rehabilitate. • Malnutrition (MUST score) • Dehydration risk	• History of unscheduled admissions • Multiple planned care appointments • Require help and assistance with ADLs (especially mobility)	• More dependent for personal care, from whatever cause (physical or cognitive) • Patient at risk of admission to acute hospital • Require facilitated discharge from hospital • Lack of capacity • Severe impairment of ADLs • End of Life care
Interventions	• Consider best place for care (home, residential, nursing) • Start care planning. Consider DNACPR or ReSPECT. Understand what is important to them (assets based) • Patient education: #FrailtyFocus/ Patient Activation Measure (PAM)/ self-care and self-management • Signposting to various voluntary/faith groups • Smoking weight and alcohol programmes • Vaccination programmes (Influenza, pneumococcal and shingles) • Effective medicines optimisation e.g. bone health and polypharmacy • Engagement with voluntary sector • Carer support and assessment • Regular long-term condition reviews • Maintain strength and balance • Primary Prevention Services (e.g. Healthy Home) • Adaptations, equipment and practical support in the home • Continence	Plus this ... • Out of hours service access • Social care assessment for help • Prevention and early intervention for mental health (MH) conditions such as depression and anxiety through access to Improvement Access to Psychological Therapies (IAPT), to prevent decline in both physical and mental health conditions • Holistic assessment/ Comprehensive Geriatric Assessment (CGA) and wellbeing plan • Frailty Clinic • Falls prevention • Use of Telecare and Telehealth to support self-care	Plus this ... • Rapid assessment clinic • Access reablement services to reduce dependence on high intensity, long term support (Enhanced Recovery and Support at Home, Community Response Team) • End of Life early planning • Lasting Power of Attorney discussions	Plus this ... • Facilitated discharge from hospital if admitted • Funeral planning
Roles delivering Interventions	GP, Nurse Practitioner, Mental Health Practitioner, voluntary and faith sector, Hampshire Fire and Rescue, Hampshire County Council, Community Pharmacist, Practice Support Pharmacist, Hampshire Constabulary, talking therapies (iTalk), social groups, Community Transport Services, voluntary wellbeing lines, Allied Health Professionals (occupational therapists, physiotherapists, dieticians, speech and language therapists), Citizens Advice Bureau, Continence team, friends, family and loved ones.	Plus this ... Interface Geriatrician (Mid Hants), Proactive Care (Mid Hants), Integrated Care Team (ICT), Specialist Nurses, Consultant Nurse for Frailty, Social Workers, South Central Ambulance Service	Plus this ... Enhanced Recovery and Support at Home, Interface Geriatrician (Mid Hants), Palliative Care Team (awareness and planning), Hospice, care agencies, specialist medical teams, nursing and care homes, South Central Ambulance Service, Admiral Nurses	Plus this ... Palliative Care Team (actively involved)

Developed by North Hampshire CCG and Southern Health

Table top exercise

Q1. How can your trust ensure that frailty becomes everyone's business?

Q2. What 1 thing will you pledge to do to when you return to your trusts? Please write your pledge on the luggage label

Feedback

Questions and contact

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