Frailty at the acute front door

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Columnist, British Medical Journal

Hong Kong Hospital Authority Convention
May 16th 2017
I: Some key resources

Including many practical examples of service redesign and improvement
Acute Frailty Network

“Silver Book” QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Acute Frailty Network (AFN) – Supporting people with frailty and urgent care needs to get home sooner and healthier

Book your place at AFN’s Front Door Frailty National Conference 29 June 2017, London

The King's Fund

Ideas that change health care
Future Hospital Programme

The Future Hospital Programme (FHP) was established to implement the recommendations of the Future Hospital Commission. These recommendations are based on the very best of our hospital services, taking examples of existing innovative and patient-centred services to develop a comprehensive model of care.

What we are doing

The Future Hospital Programme, developed from the Future Hospital Commission (September 2013), aims to implement the vision of improving care for medical patients by bringing medical specialist care closer to the patient wherever they are, in hospital or in the community.

Our work is underpinned by the 11 principles of patient care around which future healthcare services should be designed:

1. Fundamental standards of care must always be met
2. Patient experience is valued as much as clinical effectiveness
3. Responsibility for each patient’s care is clear and communicated
4. Patients have effective and timely access to care
5. Patients do not move wards unless it is necessary for their clinical care

Details

Status: In progress
Date: 1 January 2016

Get involved

Join the FH Partners Network

Future Hospital Programme

Telephone: +44(0)30 3075 1583
Email: futurehospital@imperial.ac.uk

Associated projects

Future Hospital chief executive scheme
Future Hospital development

Healthcare Improvement Scotland

Older People in Acute Care Improvement Programme

Improving the care for older people in acute hospitals

Programme overview
VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Frailty in acute care

Growing old together
Sharing new ways to support older people

A report by the Independent Commission on Improving Urgent Care for Older People
II: Why this matters
Following the money.
NHS Constitution Technical Annexe 2013

Figure 13 - Chart showing indexed costs for each 5 year age bracket as a proportion of cost for those aged 85+ (General and Acute)
Figure 3: Population ageing increases healthcare services consumption – Average number of in-patients in HA hospitals by age (2010)

Source: Hospital Authority Administration System, 2010
Multimorbidity (Scotland)

*(Scottish School of Primary Care Barnett et al Lancet May 2012)*
Image 1: Distribution of long-term conditions by age of A&E attendee 2012/13, Focus on A&E attendances, QualityWatch

Figure 4.3: Distribution of long-term conditions (LTCs) by age of A&E attendee, 2012/13

Source: Nuffield Trust and Health Foundation (2014)
Dementia: 1 in 4 beds in General Hospitals UK.
40% of acute admissions in over 75s
Distribution of Electronic Frailty Index Codes (England) pop. C 227,000 >65
Clegg, Young et al Age Ageing 2016
## Electronic Frailty Index (England) n = c 227,648 (Clegg et al Age Ageing 2016)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mild frailty (HR, 95% CI)</th>
<th>Moderate frailty (HR, 95% CI)</th>
<th>Severe frailty (HR, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr care home admission</td>
<td>2.00 (1.68 to 2.39)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>5.94 (4.61 to 7.64)</td>
</tr>
<tr>
<td>3 yr care home admission</td>
<td>1.52 (1.37 to 1.69)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>3.42 (2.84 to 4.12)</td>
</tr>
<tr>
<td>5 yr care home admission</td>
<td>1.56 (1.43 to 1.70)</td>
<td>2.34 (2.10 to 2.61)</td>
<td>3.00 (2.42 to 3.70)</td>
</tr>
<tr>
<td>1 yr hospitalisation</td>
<td>1.85 (1.81 to 1.88)</td>
<td>2.96 (2.90 to 3.02)</td>
<td>4.62 (4.50 to 4.74)</td>
</tr>
<tr>
<td>3 yr hospitalisation</td>
<td>1.71 (1.69 to 1.73)</td>
<td>2.54 (2.51 to 2.58)</td>
<td>3.64 (3.57 to 3.70)</td>
</tr>
<tr>
<td>5 yr hospitalisation</td>
<td>1.63 (1.61 to 1.64)</td>
<td>2.43 (2.40 to 2.46)</td>
<td>3.59 (3.54 to 3.65)</td>
</tr>
<tr>
<td>1 yr mortality</td>
<td>1.91 (1.78 to 2.04)</td>
<td>3.39 (3.15 to 3.65)</td>
<td>5.23 (4.73 to 5.79)</td>
</tr>
<tr>
<td>3 yr mortality</td>
<td>1.74 (1.68 to 1.81)</td>
<td>3.02 (2.90 to 3.14)</td>
<td>4.56 (4.29 to 4.84)</td>
</tr>
<tr>
<td>5 yr mortality</td>
<td>1.66 (1.62 to 1.71)</td>
<td>2.73 (2.64 to 2.81)</td>
<td>3.88 (3.68 to 4.09)</td>
</tr>
</tbody>
</table>
Figure 1: Vulnerability of frail elderly people to a sudden change in functional status after a minor illness.
Frailty Syndromes (how people with frailty present acutely).

*Clegg A et al at Lancet*

- “Non-specific”
  - e.g. fatigue, weight loss, recurrent infection
- Falls/Collapse
- Immobility/worsening mobility
- Delirium (“acute confusion”)
- Incontinence (new or worsening)
- Fluctuating disability
- Increased susceptibility to medication side effects
  - e.g. Hypotension, Delirium

*The King's Fund*
Functional decline in acutely admitted patients > 75

So post acute rehab in and out of hospital Core
Modern Hospital Case mix

- Family Caregivers also crucial to many
- Older people suffer most poorly co-ordinated care
- Multiple care transitions poor communication & information-sharing
- Potential benefits from integration
By 2030 men aged 65 will live on average to 88 and women to 91

Workforce Implications

III: How we have to change
Hospitals not Islands: wider system

1. Age well and stay well
2. Live well with one or more long-term conditions
3. Support for complex co-morbidities/frailty
4. Accessible, effective support in crisis
5. High-quality, person-centred acute care
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and re-ablement
8. Person-centred, dignified long-term care
9. Support, control and choice at end of life

Shift to prevention and pro-active care

10 integrated services to provide person-centred care
Interventions outside hospital

- Patients with complex needs identified, care planning & care co-ordination “anticipatory care”
- Support for carers
- End of life care planning and support
- Rapid access multidisciplinary ambulatory care models
- Medical support in nursing homes to prevent admission
- Rapid crisis assessment & multidisciplinary support at home
- Intermediate care (home or community hospital)
- “Discharge-to-assess” and community “in-reach”
- Joint working with ambulance practitioners to prevent conveyance to hospital (e.g. for falls)
NHS Acute Frailty Network 10 principles

1. Establish a mechanism for early identification of people with frailty
2. Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour
3. Set up a rapid response system for frail older people in urgent care settings
4. Adopt a ‘Silver phone’ system
5. Adopt clinical professional standards to reduce unnecessary variation
6. Strengthen links with services both inside and outside hospital
7. Put in place appropriate education and training for key staff
8. Develop a measurement mind-set
9. Identify clinical change champions
10. Identify an Executive sponsor and underpin with a robust project management structure
To explore the "conventional" evidence further.....

Emergency care for frail older people—urgent AND important—but what works?
QI Approaches in action (Frailty Network/RCP Future Hospital)
1. Develop multi-disciplinary integrated elderly services across the continuum of HA care.

2. Promote patient-centred care and engage patients and their carers as active partners in their healthcare.

3. Greater collaboration with partners involved in elderly care outside of HA.

4. Enhance HA workforce capacity and engage staff.

5. Develop quality, outcomes-driven HA elderly services.
Thankyou. And questions/comments?

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