Ageing Well
Quality Healthcare in Later Life

Using population sub-segmentation to promote tailored end of life care in later life

Dawn Moody
Associate National Clinical Director Older People

6th March 2018
Context: Population
2015-2025: Age 65 and over

- Number of people will increase by 19.4%: from 10.4M to 12.4M
- Number with disability will increase by 25.0%: from 2.25M to 2.81M
- Total life expectancy at 65 will increase by 1.7 yrs (to 21.8 yrs)
- Disability-free life expectancy at 65 increase by 1 yr (to 16.4 yrs)
- Life expectancy with disability will increase from 4.7 yrs to 5.4 yrs

## Context: Frailty & Mortality

### Outcomes by stage of frailty

![Chart showing outcomes by stage of frailty](chart.png)

**1 year outcome (HR)** | Mild | Moderate | Severe  
-------------------------|------|----------|---------  
Mortality                | 1.92 | 3.1      | 4.52    
Hospitalisation         | 1.93 | 3.04     | 4.73    
Nursing home admission  | 1.89 | 3.19     | 4.76    

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BGS EoLC 2018
Describing the Challenge
Audit of End of Life Care

1. Was the person’s death ‘predictable’?

2. If ‘predictable’ had the person been recognised as approaching the end of their life?

3. If recognised, had the person’s needs had been appropriately identified and provided for?

4. Was there any association between approaching end of life and certified cause(s) of death (Parts 1 & 2)?
Describing the Challenge
Audit of End of Life Care

1. Was the person’s death ‘predictable’? 69%
2. If ‘predictable’ had the person been recognised as approaching the end of their life? 70%
3. If recognised, had the person’s needs had been appropriately identified and provided for? 87%
4. Was there any association between approaching end of life and certified cause(s) of death (Parts 1&2)? Yes
**Cause(s) of death**

- **Cancer** as a main cause of death was associated with 100% recognition of approaching end of life.
- **Cancer** as a secondary cause of death also associated with very high recognition.
- People not recognised as approaching end of life were more likely to have *pneumonia*, *dementia*, and *cardiovascular disease* as main cause of death.
- People not recognised as approaching end of life were very much more likely to have secondary causes of death recorded, in particular *dementia* and *frailty*. 
Opportunity for improvement

For people with non-cancer diagnoses, particularly dementia, frailty & multimorbidity:

• Better recognition of approaching end of life
• Better recognition of pneumonia as a last illness
‘Fit for Frailty’
The British Geriatric Society, 2014/2015

- Identifying frailty
- Managing frailty

- Managing services
- Developing & commissioning services
Frailty identification

Opportunistic / Reactive
Frailty identification

Opportunistic / Reactive

Systematic / Proactive

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Managing Frailty as Long Term Condition

Managing frailty as a long-term condition

Jennifer K. Harrison; Andrew Clegg; Simon P. Conroy; John Young

Published: 13 July 2015 Article history

Abstract
Frailty is a distinctive late-life health state in which apparently minor (subclinical) changes in health status (e.g., fatigue, loss of muscle mass,

Blog

We must recognise frailty as a long term condition – John Young

📅 7 May 2014 ⏰ John Young

Long term conditions
Frailty as a Long Term Condition

Managing Frailty as Long Term Condition

Fit
Mild
Moderate
Severe

Depression / anxiety

Comprehensive Geriatric Assessment

Recognize the right time to support transition to End of Life Care

NICE guideline
Published: 21 September 2016
nice.org.uk/guidance/ng56

www.england.nhs.uk
What can we do at a national level to support the changes needed to improve care for individuals?
Ageing Well
Quality Healthcare in Later Life

Using population sub-segmentation to promote tailored end of life care in later life

Martin Vernon
National Clinical Director Older People

6th March 2018
Ambition for frailty.

‘Everybody should know what to do next when presented with a person living with frailty and/or cognitive disorder’
In other words…

It's something we can all get around locally
Why is frailty so important right now?

- Timely identification of people at risk with complex care needs
- It permits sub-stratification by needs, not age
- It crosses health & social care, so can drive integration
- Its predictive: finding those who benefit from active and healthy ageing
- It will guide & track commissioning, design & service delivery
- It directs towards key outcomes: maintained functional ability & wellbeing
- It provides opportunity to standardise care for people with similar needs
Key Facts: Emergency Admissions

Cost £13.7Bn in 2015/16

5.8m in 2016-17.

Between 2015/16 & 2016/17 increased by 2%

82% of increase (2013/14 to 2016/17) caused by people who did not stay overnight.

65% of hospital emergency bed days occupied by patients aged 65+ in 2016/17.

53% of growth in emergency admissions came from people aged 65+ (2013/14 to 2016/17)

32% areas reported reduced emergency admissions by target set in BCF plans 2016/17

Emergency 30 day readmissions increased by 17% 2013/14 to 2016/17
Impact of frailty on hospital mortality and LOS

- Severe frailty adversely impacts mortality in acute care
- Severe frailty, acute illness, delirium & dementia all lead to longer LOS

Clinical frailty adds to acute illness severity in predicting mortality hospitalized older adults: An observational study

The Association of Geriatric Syndromes with Hospital Outcomes

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Frailty is expensive when severe

Average Cost per patient
Actual and Standardised to whole KID 65+ population

- Fit: £1,161
- Mild: £2,514
- Moderate: £3,992
- Severe: £6,345

Ave Cost/Patient Actual vs Standardised
Cost is distributed across the system
NHS England Next Steps-Priorities
‘Health and high quality care –now and for future generations’

- **Urgent and emergency care 24/7**: Admitting sicker patients & discharging home promptly
- Next 2 years hospitals to free up 2-3K beds through close community services working
- **Cancer**: will affect 1 in 3 in lifetime: survival at record high (LTC)
- **Mental health**: loneliness, depression and anxiety in older people
- **Older people**: Help older people and those with frailty stay healthy & independent.
- **Integration**: GP, community health, MH & hospitals: Integrated Care Systems
- **Workforce development** & continue drive to improve safety
- **Technology & innovation**: enable patients to take greater role in self care
Three priorities for frailty

1. Change in approach to health & social care for older people
2. Preventing poor outcomes through active ageing
3. Quality improvement in acute & community services
Routine timely frailty identification

- Routine frailty identification in primary care has 2 potential merits:
  1. Population risk stratification
  2. Targeted individualised interventions for optimal outcomes
Electronic Frailty Index (eFI)

20 Disease states
e.g.,
- Hypertension
- Arthritis
- Chronic Kidney Disease
- Ischaemic Heart Disease
- Diabetes
- Thyroid Disease
- Urinary System Disease
- Respiratory System Disease

8 Symptoms / signs
- Polypharmacy
- Dizziness
- Dyspnoea
- Falls
- Sleep Disturbance
- Urinary Incontinence
- Memory & cognitive problems
- Weight loss & anorexia

7 Disabilities
- Visual Impairment
- Hearing Impairment
- Housebound
- Social Vulnerability
- Requirement for care
- Mobility & transfer problems
- Activity limitation

36 Frailty deficits of eFI

1 Abnormal Laboratory Value
- Anaemia and haematinic deficiency

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Direct Clinical Verification

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 III - 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.


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## GP Contract 2017/18 Data [Q3]

<table>
<thead>
<tr>
<th>Definition</th>
<th>Cumulative Q3 total</th>
<th>Cumulative Q3 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count 65+ with frailty assessment</td>
<td>2,302,355</td>
<td>23.48% 65+</td>
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<tr>
<td>65+ without frailty assessment</td>
<td>7,501,842</td>
<td>76.52% 65+</td>
</tr>
<tr>
<td>Total moderately frail</td>
<td>569,828</td>
<td>5.8% 65+</td>
</tr>
<tr>
<td>Total severely frail</td>
<td>295,180</td>
<td>3% 65+</td>
</tr>
<tr>
<td><strong>Total moderate and severely frail</strong></td>
<td><strong>865,008</strong></td>
<td><strong>8.82% 65+</strong></td>
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<tr>
<td>Severe frailty w/medication review</td>
<td>151,130</td>
<td>51.2% (severe frailty)</td>
</tr>
<tr>
<td>Moderate or severe frailty w/fall</td>
<td>71,142</td>
<td>8.22% (moderate/severe frailty)</td>
</tr>
<tr>
<td>Moderate or severe frailty w/falls clinic</td>
<td>18,024</td>
<td>2.1% (moderate/severe frailty)</td>
</tr>
<tr>
<td>Moderate or severe frailty w/consent to SCR</td>
<td>91,813</td>
<td>10.61% (moderate/severe frailty)</td>
</tr>
</tbody>
</table>
Paradigm shift

**THEN**

- ‘The frail Elderly’
- Late Crisis presentation
  - Fall, delirium, immobility
- Hospital-based episodic care
  - Disruptive & disjointed

**NOW**

- ‘An Older Person living with frailty’
  - A long-term condition
- Timely identification
  - preventative, proactive care
  - supported self management & personalised care planning
- Community based person centred & coordinated
  - Health + Social +Voluntary+ Mental Health
Frailty is a long term condition: it can be diagnosed, is not usually curable but can be managed and persists.

As resilience is lost, assessment, care and support planning become more important through to the end of life.

From: ‘What’s the matter with you?’
To: ‘What matters to me?’
Key enablers to better EOLC

- Population sub-segmentation by need to guide planning
- Industrialising best practice through national frailty standards
- Workforce development (core skills, capability, competencies)
- Data: integrated, linked health and social care data
- Existing best practice models and frameworks
- Community currencies
- Right care (prevention & response pathways aligning key services)
- GIRFT for selected, linked pathways: up/downstream
- Devolution, localised strategic planning and delivery
So how do we get there?

We know what good looks like…
The task is how to deliver it at scale?
Population sub-stratification: Prevention

- Maintained functional ability & wellbeing throughout life
- Emphasis on activation and self help
- Timely, well planned & proportionate service support for needs
- Later and planned support towards end of life
Population sub-stratification: Intervention

- Timely identification of risk and managed escalating need
- Early opportunity to trigger planning & decisions
- Proactively planned earlier support towards end of life
- With declining function, maintained wellbeing is a key outcome

Prevention → Intervention → Services → Functional Ability → EOLC → Death

Resilience

Improved

Worsened

Moderate/Severe Frail

Frailty Pathway

Adult life span
Integration: testable currency (moderate frailty)

Moderate frailty cohort

- FMO-01: Moderate – recoverable
- FMO-02: Moderate – Stable
- FMO-03: Moderate – Progressive

Suggested metrics:
- Number recoverable = \(n_{1t} - n_1\)
- Number stable = \(n_{2t} - n_2\)
- Number progressive = \(n_{3t} - n_3\)
- Number community contacts
- Number outpatient attends
- Days spent in hospital in time \(t\)
- Days spent in own home in time \(t\)
- Patient wellbeing index

Baseline costs
Baseline characteristics

Recoverable

Stable

Progressive

Baseline characteristics:
- Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.
- Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowly up”, and/or being tired during the day.
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Getting it Right First Time (GIRFT)

10 key areas for acute care focus

- Frailty
- Mental health
- Clinical decision units
- Specialties (medicine, surgery, paediatrics)
- Ambulatory emergency care
- Acute Medical Units and other assessment services
- Emergency departments
- Primary care streaming
- Ambulance handovers
- Admission, transfer, discharge

National priorities for acute hospitals 2017

Good practice guide: Focus on improving patient flow
July 2017

Produced in collaboration with and endorsed by:

- Royal College of Physicians
- Association of Ambulance Chief Executives
- Emergency Care Improvement Programme

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And in summary..
Frailty data to commission a new integrated personalised care offer for those NOT ageing well
Proactive & Reactive Community MDT care
Integrated care system offer provides the alternatives to hospital care

8% reduction in general and acute beds since 2010: NHSB 2017

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What we’re doing nationally

- Regional meetings
- Core Capabilities framework
- Economic frailty modelling
- A suite of national frailty products
- Research & Innovation

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www.england.nhs.uk/ourwork/ltc-op-eolc