Why should GPs use data to measure frailty and what then?

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Overview

- Why am I talking about this?
- What is frailty?
- To whom does frailty matter?
- Why does it matter?
- Can anyone or anything change its trajectory?
- What do GPs bring to this?
- What does GP contract ask us to do?
- How else could GPs be involved?

What is Frailty?

- Functional level
- Multi-morbidity
- Cumulative deficits
- Poor reserve and delayed and incomplete recovery from minor stresses “failure to integrate response to stress”

What is frailty (2)

- A longterm condition in its own right?
- Something patients, public and non-specialist healthcare professionals intuitively can understand but don't like to describe themselves as!
- Significant overlap and correlation between these

To whom does frailty matter?

- People affected by it
- Their families and community.
- Healthcare professionals
- Data from eFI is also being collected for service design including by NHS England
- There is more frailty, it looks slightly different and it occurs earlier in areas of greater socio-economic deprivation

Why does it matter?

- Frailty gets commoner with age and the population is getting older
- Health and care cannot go on doing more of what we're already doing
- There need to be new ways to approach older people living with frailty
- Evidence on whether these new ways of working are effective needs some measures

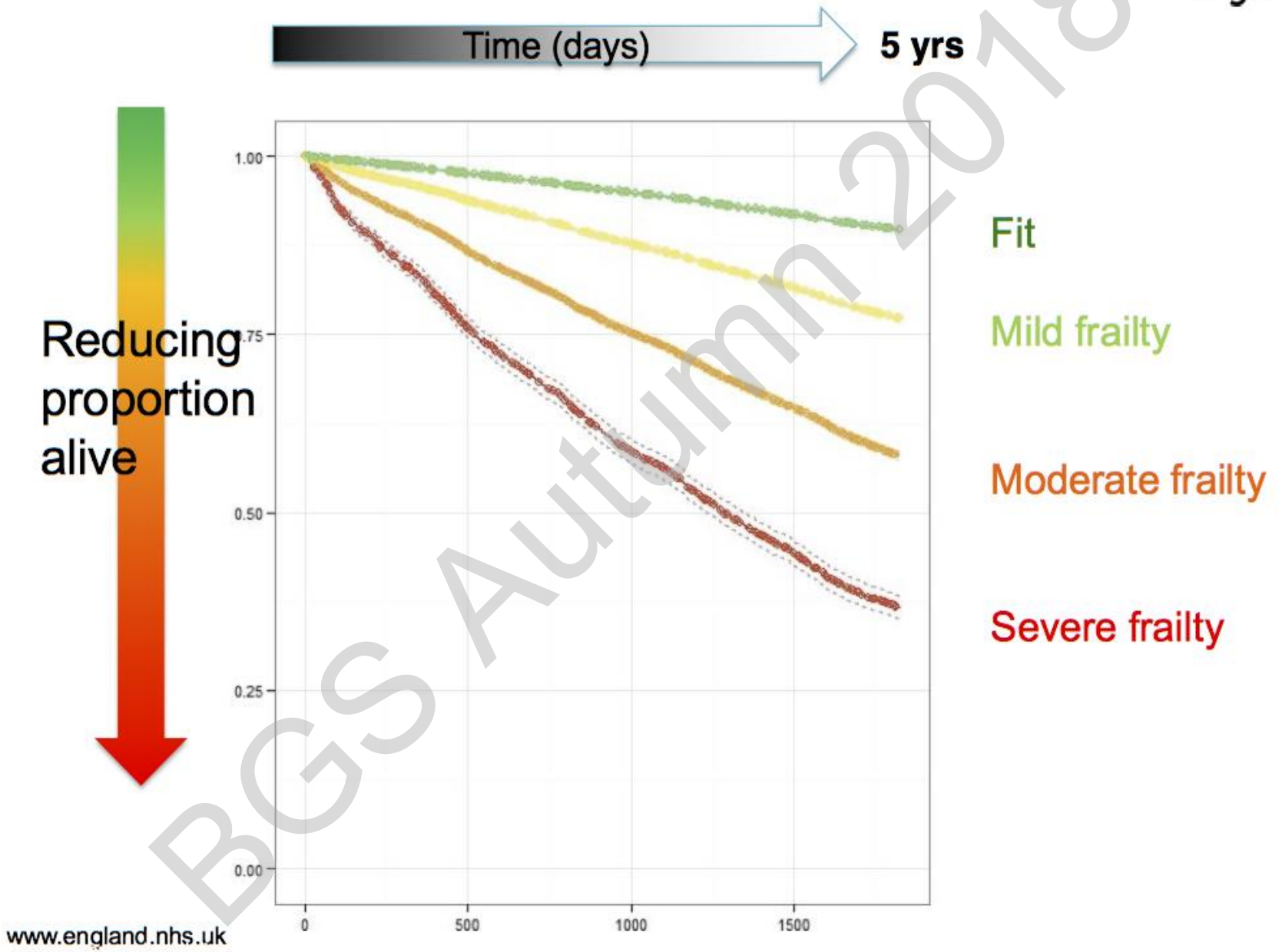
Outcomes by stage of frailty

NHS England

One year outcome (hazard ratio)	Mild frailty	Moderate frailty	Severe frailty
Mortality	1.92	3.1	4.52
Hospitalisation	1.93	3.04	4.73
Nursing home admission	1.89	3.19	4.76

Outcomes by stage of frailty

NHS England



Can anyone or anything change its trajectory? (1)

- Some mixed results and much too much to cover in this talk
- But interventions targeting frailty fairly consistently improve patient/carer satisfaction and possibly professional satisfaction—GeriGPs! "old fashioned medicine"

Can anyone or anything change its trajectory? (2)

- Some interventions do reduce hospital admissions
- Often trial multi-disciplinary interventions containing elements of Comprehensive Geriatric Assessment(CGA) outcome.
- Cost effectiveness variable depending on target population and intervention.

Even if we cannot reverse the trajectory?

- CGA in various settings best evidence—what is it? Person centred holistic care?
- “Cure sometimes, relieve often and comfort always” Very much applicable to frailty
- Recognise and share what seems to be going on with the patient, those nearest to them and other relevant organisations
- Fix the fixable eg hearing aids, dentures, falls assessments, medication reviews

How does knowledge about frailty add to patient's journey

- Benefits of traditional interventions eg hospital admission, surgery, drugs diminishing
- Harms of some interventions increase with frailty eg surgery leading to delirium, side effects of medication
- Informs discussion and evaluation of evidence about medical and other interventions

What do GPs specifically offer?

- Multisource electronic patient record spanning many years.
- See most of population each year—especially those affected by frailty
- Knowledge of patient in their home context
- They can and should be part of community Multi-disciplinary team providing healthcare

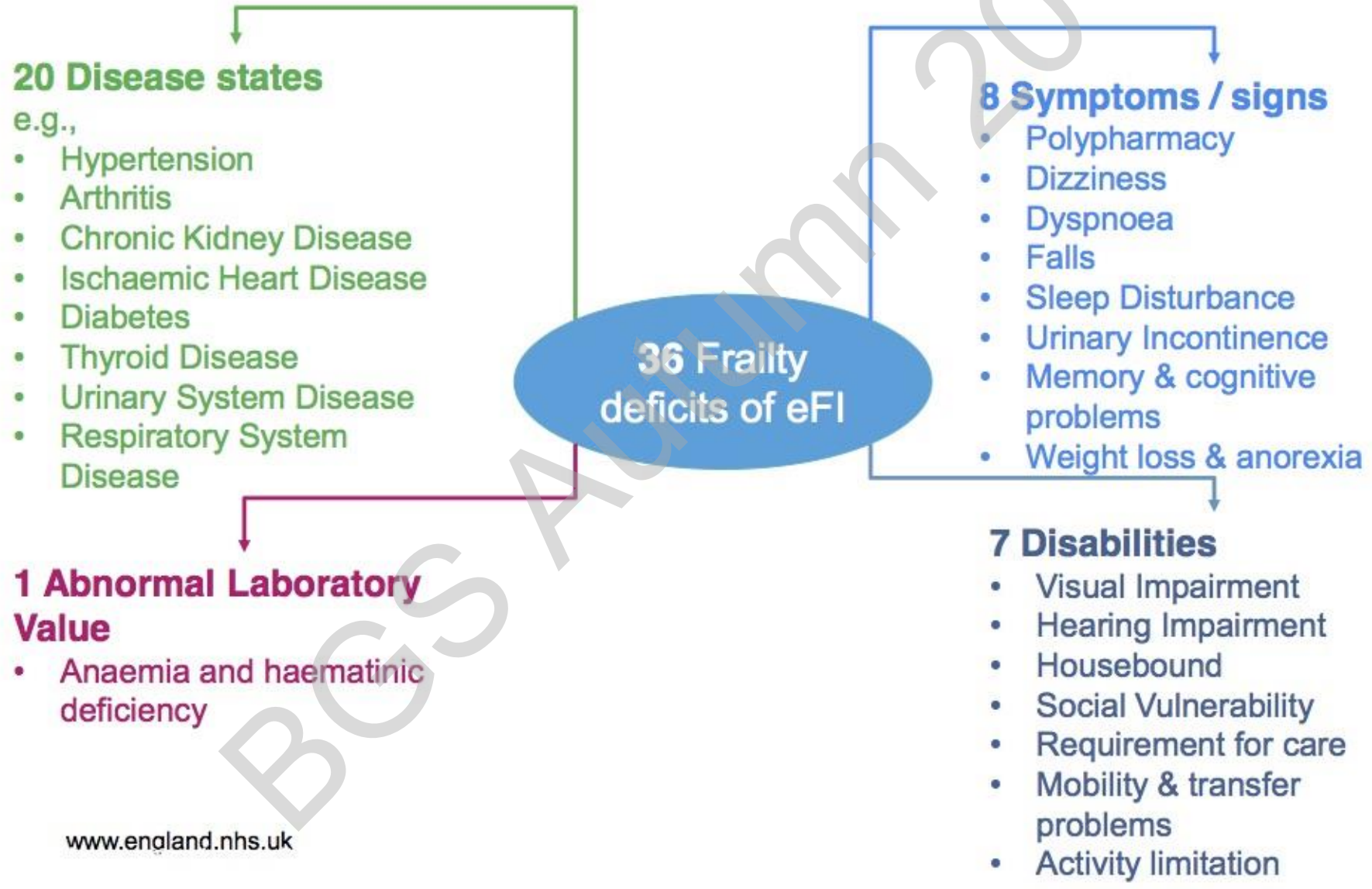
Challenges to GPs measuring frailty

- May not actually know much about functional level particularly for mild frailty.
- Time constraints!
- eFI in current GP contract depends on good quality electronic records.
- Needs clinical (maybe personal?) correlation with statistical measure.

Electronic frailty index--eFI

- Combines 36 conditions each with multiple underlying Read codes
- Generates number which identifies person as having no, mild, moderate or severe frailty
- GP pushes button to incorporate into record
- Based on idea that at some point the number of problems becomes more important than the individual problems themselves.

Deficits that make up the eFI



Is eFI useful?

- Validated against outcomes which matter:
- Emergency admissions
- Emergency bed days
- Nursing home admission
- Mortality
- But is it a valid “screening” tool?
- And should all conditions have equal weight?

GP Contract

- Core primary care should identify moderately and severely frail and for those with severe frailty undertake:
- 1. Clinical medication review
- 2. Falls review and
- 3. Request consent to upload to Summary Care Record

Future primary care involvement in frailty identification and management

- Contract being discussed now.
- Single disease targets being phased out
- Cannot ask GPs to do “another thing” but maybe this is where multi-disciplinary teams including GeriGPs and community geriatricians can provide appropriate enhanced care

What else?

- Advance care planning—priorities of care
- Hospital for crisis in severe frailty?
- Comprehensive Geriatric Assessment for someone with chronic, stable frailty is money saving
- Continuity of care…
- In absence of personal continuity of care communicate with all who need to know

What else (2)

- Polypharmacy—lots of medicines based on individual conditions—problematic if doing more harm than good or more than patient wants
- Personalised medicine—change options offered based on what you know about patient

Case study—frailty/dementia

- Pam is 93
- She lives alone with carers x3/day
- Family local and supportive
- Housebound—2 recent falls, partially sighted
- PMH: CKD, DM, IHD, moderate vascular dementia, hypertension,
- Polypharmacy ++
- Severe frailty. Eating and drinking reduced for >3/12

Pam's story (2)

- Whole family go on long awaited special holiday
- Usual carer goes off sick
- New carer—Pam is sleepy and is refusing food, drinks and pills on Tuesday morning
- 999 to local A and E
- Cannot contact family—admit
- Ten days later her UTI and mild dehydration have been treated but…

Pam's story (3)

- Acute medical ward—Pam is screaming
- Refusing food, drink and medication
- Nurses are patiently trying to wash and change her
- "non-compliant" and continued weight loss
- Naso-gastric tube for food supplements
- Restraint—mittens, cots-sides, single room, mild tranquiliser administered

Pam's story (4)

- The good news!
- Pam's GP and care agency consulted
- Family return from holiday and visit
- Best interests decisions taken in context of severe frailty, previously expressed wish to die at home and likely short life expectancy

Pam's story (5)

- Patients' time is precious
- Pam may still be delirious following infection but is no longer benefitting from acute hospital
- Advance care decisions made
- Medication reviewed in context of severe frailty
- Family will stay with her as much as possible—care needs can be met
- Acceptance that she may fall, not eat or drink or take medication

Pam's story (6)

- Pam is sitting in own clothes next to bed
- NG tube, mittens etc removed
- She is eyeing a cup of tea on her table suspiciously
- Family waiting with her for porter to bring wheelchair to take her to their car and home
- But what if there had been a widely accessible multi-professional care plan and support for carers at time of admission based on Pam's severe frailty and her previously expressed wishes?

Acknowledgements and references

- Dr Dawn Moody. Associate National Clinical Director for Older People and Integrated Person-Centred Care for NHS England
- British Geriatric Society—and now GeriGPs! Fit for Frailty jointly commissioned by BGS and RCGP
- Professor Joanne Reeve. Clinical Professor of Primary Care Research, Hull York Medical School

- NICE Multimorbidity--clinical assessment and management NG56
- NICE Dementia, disability and frailty in later life—Mid-life approaches to delay or prevent onset NG16