

The slide features a background image of two hands, one older and one younger, clasped together. A large, faint watermark 'BCSG4J2019' is oriented diagonally across the center. A blue wavy line separates the header from the main content area.

Front Door Geriatrics

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Contents

- Frailty definitions
- Identification
- Significance
- What difference can you make?
- Being a Frailty Consultant

What do we mean by Frailty?



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Frailty?

- Patient A – Margaret
– 91 years old
- Patient B – Arthur
– 68 years old



Who is living with frailty?



Liverpool University Hospitals
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Frailty?

- Patient A – Margaret
 - Lives alone
 - No POC
 - Lunch club/knitting group/volunteers at local hospital
- Patient B – Arthur
 - POC TDS (W&D, meal prep, back to bed)
 - Mobile with Delta frame
 - Mild Cognitive Impairment



Who is living with frailty?

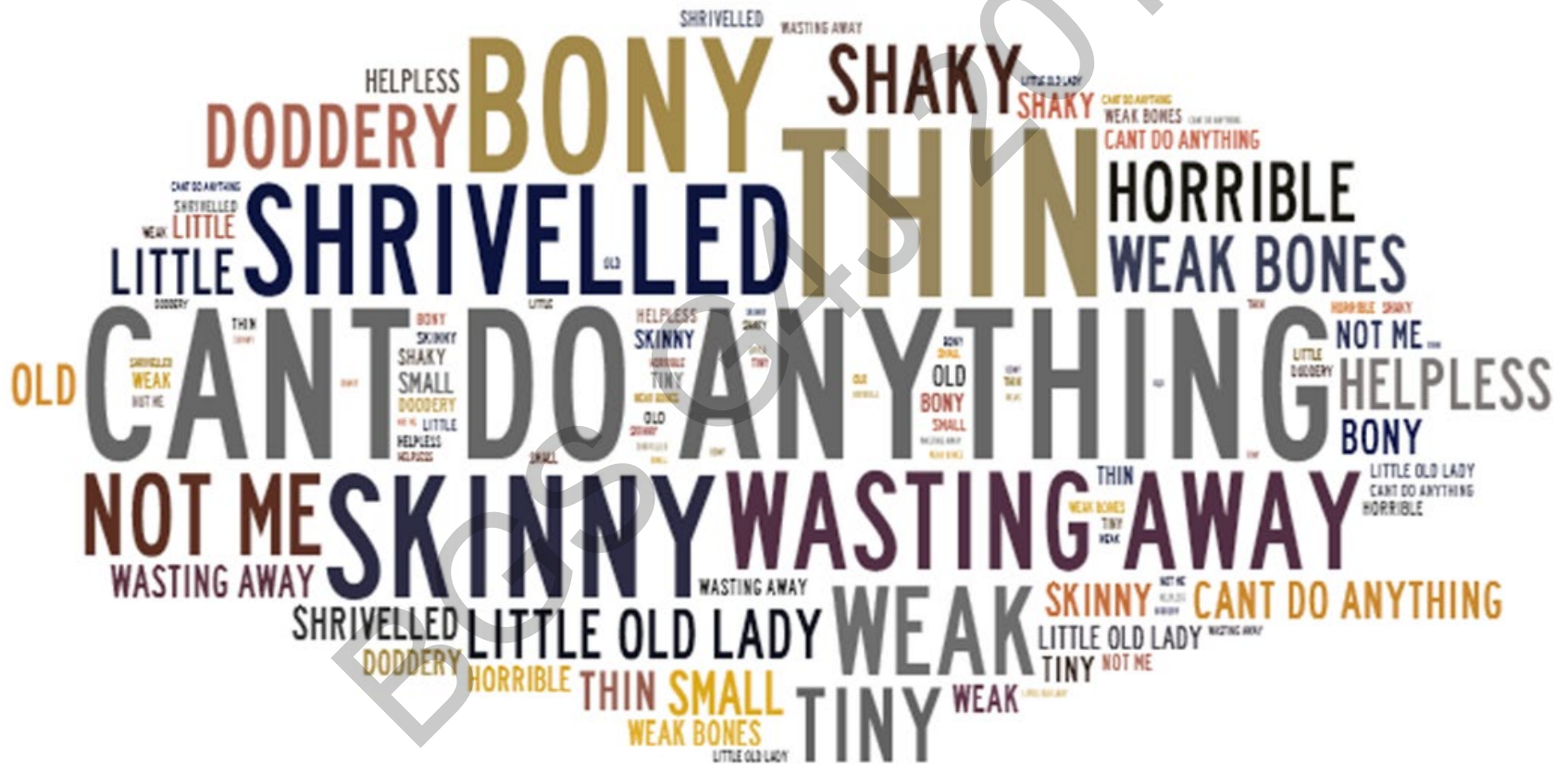


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Definition

- Oxford English Dictionary
 - frailty
 - ['freɪlti]
 - NOUN
 - 'the condition of being weak and delicate'



Definition

- a clinically recognizable state of increased vulnerability resulting from ageing-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with everyday or acute stressors is comprised

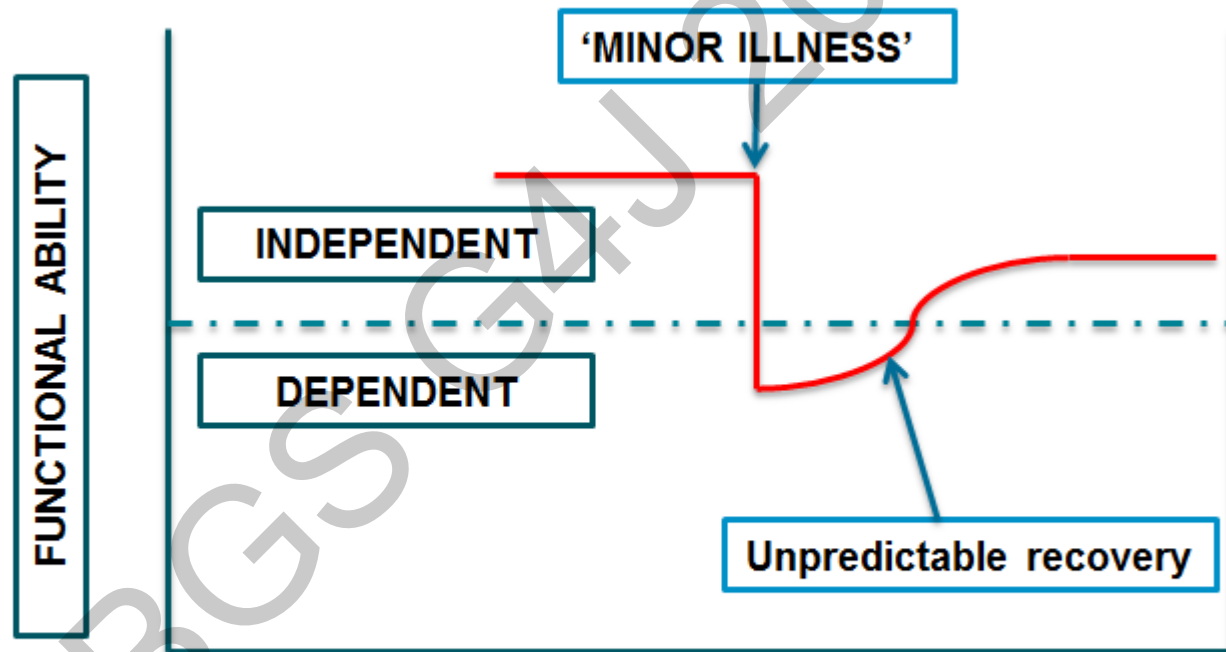
It's an inevitable part of ageing?

**AGE IS NO BARRIER. IT'S A LIMITATION
YOU PUT ON YOUR MIND.**



Not all older people are frail; not all people with frailty are older

Frailty – What is it?



Gold Standards Framework

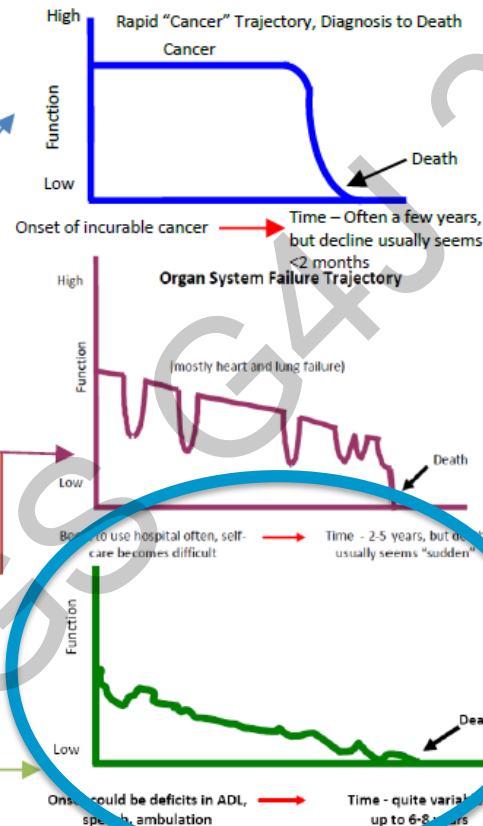
Average GP's workload – average 20 deaths/GP/year approx. proportions

Sudden
Unexpected
Death
1-2

Frailty / Co-
morbidity /
Dementia
8

Cancer
5

Organ
Failure
5-6



Typical Case Histories



1) Mrs A – A 69 year old woman with cancer of the lung and known liver secondaries, with increasing breathlessness, fatigue and decreasing mobility. Concern about other metastases. Likely rapid decline



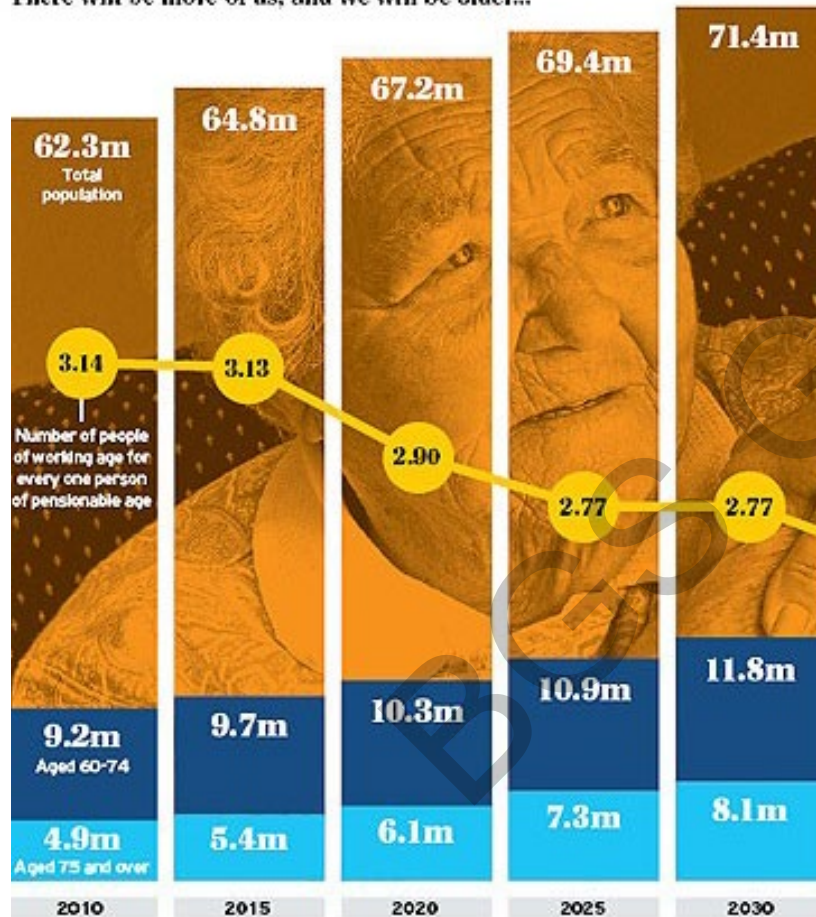
2) Mr B – An 84 year old man with heart failure and increasing breathlessness who finds activity increasingly difficult. He had 2 recent crisis hospital admissions and is worried about further admissions and coping alone in future. Decreasing recovery and likely erratic decline



3) Mrs C – A 91 year old lady with COPD, heart failure, osteoarthritis, and increasing signs of dementia, who lives in a care home. Following a fall, she grows less active, eats less, becomes easily confused and has repeated infections. She appears to be 'skating on thin ice'. Difficult to predict but likely slow decline

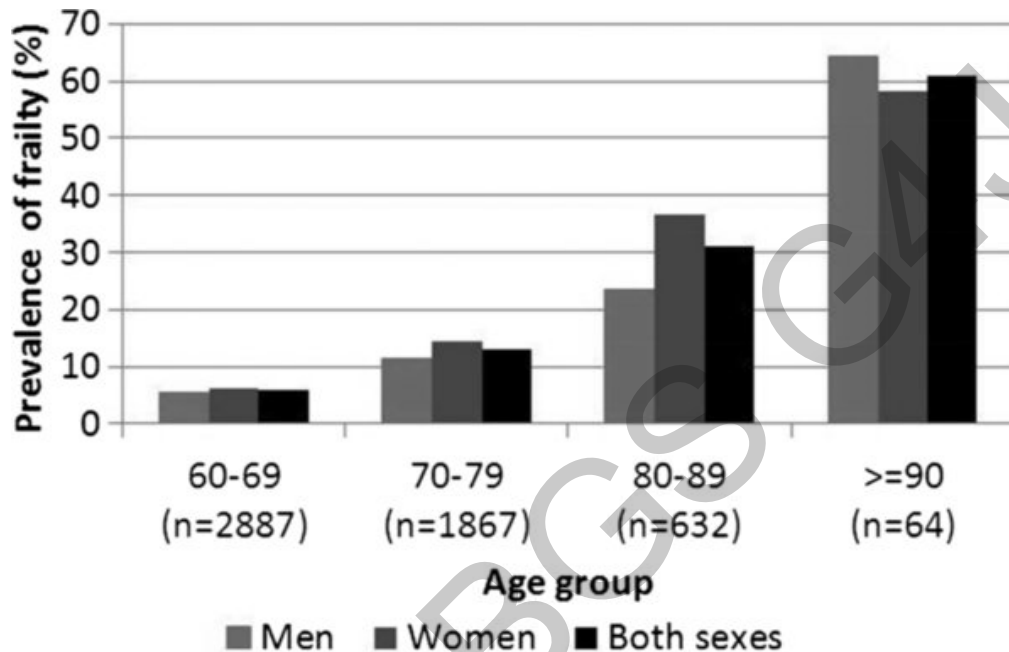
Ageing Population

There will be more of us, and we will be older...



- 1998 – 1 in 6 over 65yrs (15.9%)
- 2018 – 1 in 5 over 65yrs (18.3%)
- 2038 – 1 in 4 over 65yrs (24.2%)

Prevalence



- Approx 10% over 65yrs
- 25-50% over 85 yrs
- It is estimated that there are 1.8 million people aged over 60 living with frailty in England (ELSA 2016)

Phenotype Model

- Reduced grip strength
- Reduced Walking speed
- Prolonged Timed up and go test
- Weight loss (>10% and involuntary)
- Exhaustion (self-reported)

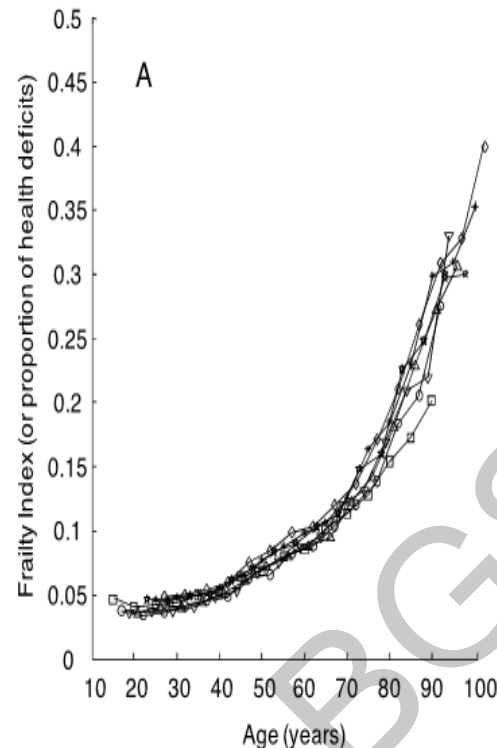
Cumulative Deficit Model: Frailty Index (Rockwood et al)

- ‘The more things that are wrong with you, the more likely you are to be frail’
- Frailty Index counts deficits (symptom, sign, disease or disability)
- The result of a lifetime accumulation of a number of physiological, medical and functional deficits

Electronic Frailty Index

- GP eFI
 - 36 deficits based on read codes
 - strongly predictive of adverse outcomes and has been validated in large international studies
 - presented as a score (e.g. if 9 deficits are present out of a possible total of 36 the FI score = 0.25)
 - on average, those with an eFI > 0.36 have a six-fold increased risk of admission to a care home in the next 12 months and a five-fold increased mortality risk, compared to fit older people

Frailty Index



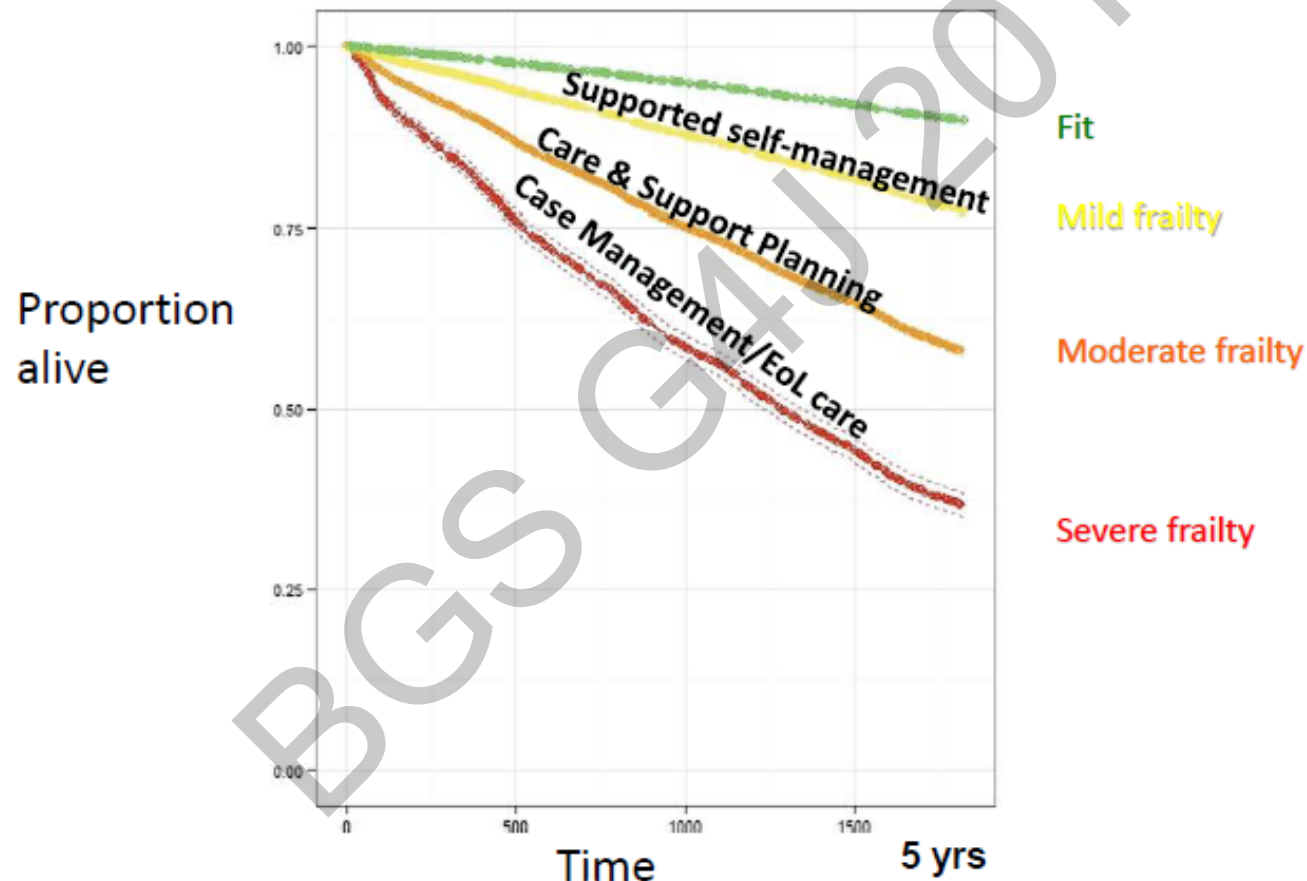
CMAJ, Rockwood et al, 2011

- Community dwelling people accumulate deficits at about 3% per year
- Can be demonstrated from age 15 onwards

Cumulative Deficit Model

Frailty level	Score	Percentage
Fit	0-0.12	50%
Mild	0.13-0.24	35%
Moderate	0.25-0.36	12%
Severe	>0.36	3%

Frailty & Mortality



Survival plots ($n=227,648$; $>65y$) (Clegg *et al*)

Frailty Scales

The Edmonton Frail Scale

NAME : _____

d.o.b. : _____ DATE : _____

Frailty domain	Item
Cognition	Please imagine that this circle is a clock. I would place the numbers in the positions then place the indicate a time of 'ten af
General health status	In the past year, how ma you been admitted to a l In general, how would y your health?
Functional independence	With how many of the fo activities do you require preparation, shopping, ti telephone, housekeepin managing money, taking
Social support	When you need help, ca on someone who is willi meet your needs?
Medication use	Do you use five or more prescription medications basis? At times, do you forget t prescription medications
Nutrition	Have you recently lost w that your clothing has be
Mood	Do you often feel sad or
Continence	Do you have a problem control of urine when yo

Name :

Assessed by :

Date :

A score of three or mo

1. Are you more than 8
2. Male?
3. In general do you ha
4. Do you need someo
5. In general do you ha
6. In case of need can
7. Do you regularly use

Score :

GFI (Groningen Frailty Index)

Circle the appropriate answer and add scores

	YES	NO
Mobility. Can the patient perform the following tasks without assistance from another person (walking aids such as a can or a wheelchair are allowed)		
1. Grocery shopping	0	1
2. Walk outside house (around house or to neighbour)	0	1
3. Getting (un)dressed	0	1
4. Visiting restroom	0	1
Vision		
5. Does the patient encounter problems in daily life because of impaired vision?	1	0
Hearing		
6. Does the patient encounter problems in daily life because of impaired hearing?	1	0
Nutrition		
7. Has the patient unintentionally lost a lot of weight in the past 6 months (6kg in 6 months or 3kg in 3 months)?	1	0
Co-morbidity		
8. Does the patient use 4 or more different types of medication?	1	0
	YES	NO
Cognition		
9. Does the patient have any complaints on his/her memory (or diagnosed with dementia)?	1	0
Psychosocial		
10. Does the patient ever experience emptiness around him? <i>e.g. You feel so sad that you have no interest in your surroundings. Or if</i>	1	0

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using the same questionnaire and social interaction.

oderate dementia, recent memory is very impaired, even gh they seemingly can remember their past life events well. can do personal care with prompting.

In severe dementia, they cannot do personal care without help.



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.

- * 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.

Rockwood (2014)



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.

What do we see?

- Falls/collapses
- Delirium (acute confusion)
- Immobility/worsening mobility
- Incontinence (new/worsening)
- Susceptibility to medication side effects



Potentially modifiable risk factors

- Alcohol excess
- Cognitive impairment
- Falls
- Functional impairment
- Hearing problems
- Mood problems
- Nutritional compromise
- Physical inactivity
- Polypharmacy
- Smoking
- Social isolation and loneliness
- Vision problems

Targeted interventions for those at most risk :

- Good foot care
- Home safety checks
- Vaccinations
- Keeping warm
- Readiness for winter

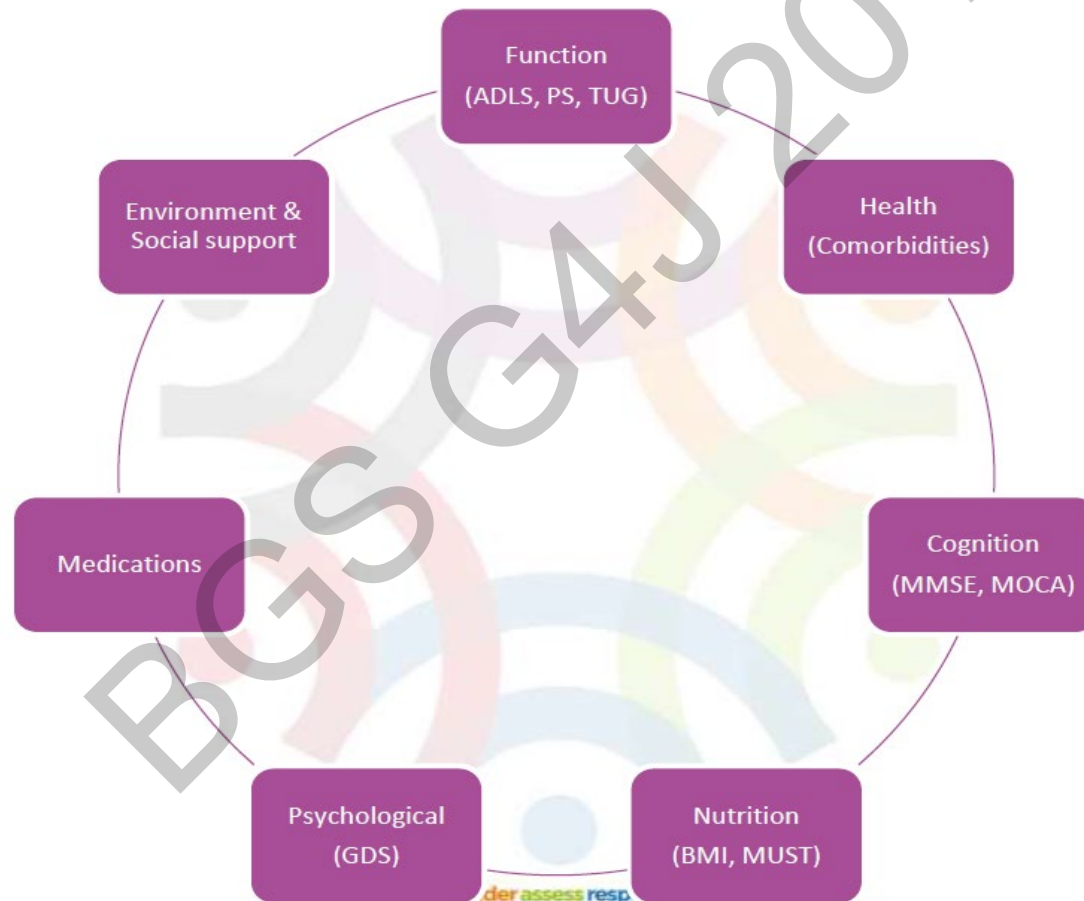
Comprehensive Geriatric Assessment (CGA)

- multidimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up
- It is both a diagnostic and therapeutic process

CGA

- Can only be delivered by the MDT
- Focus on what is important to the patient
- Aim to enhance recovery and promote independence

CGA



CGA - Outcomes

- 12 times more likely to be alive and living in your own home 6 months after assessment by a specialist in hospital when compared with usual medical care

What is the NNT for CGA?



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CGA - Outcomes


- 12 times more likely to be alive and living in your own home 6 months after assessment by a specialist in hospital when compared with usual medical care
- NNT is 17 to avoid 1 unnecessary death or deterioration and 20 for institutionalisation
 - At 12 months NNT is 25

Frailty Units

- Purpose-designed, MDT run and focussed on the patient
- Multitude of different approaches
- Delivery of CGA at the front door

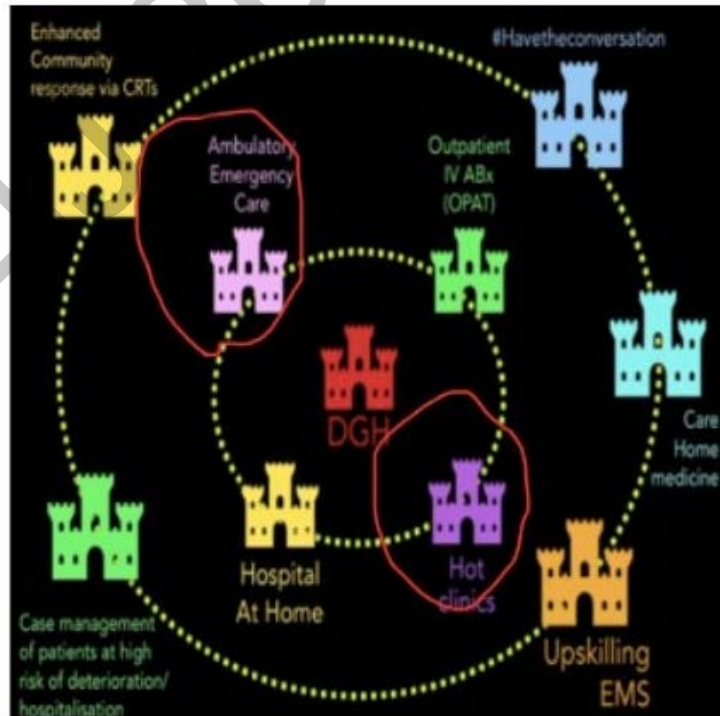
COTE Bangor introduces

The First Law of Admission Avoidance



Hospitals are like black holes.

The effort required to overcome the hospital's gravitational pull is inversely related to the distance the patient is from hospital when you assess them



Frailty & EOL

- People in their last year of life are admitted to hospital on average 3.5 times
- 30% people in hospital are in their last year of life
- >40% of people who died in hospital had no medical issue keeping them there. Almost 25% had been in > 1 month

Last 1000 days

- If you had 1000 days left to live, would you choose to spend it in hospital?
- Patient time is the most important currency
- Would you do things differently for you patients?

Be Brave!

- Treatment and false reassurance are easy at the time
- Decisions to not initiate treatment and the conversations underpinning them are far harder
- They are often the right thing to do so be brave!

Risk

- Front door geriatrics involves taking risks
- Avoid a paternalistic attitude
- Focus on what is right for that patient, at that time
- Try not to be risk averse

Frailty Consultant

Ambulatory Care

Palliative Care

ED In Reach

Clinics

Silver Trauma

Mental Health

Capacity/
ethical Issues

Admission
Avoidance

Specialty In Reach

Short Stay
Patients

Training & Education

Advance Care
Planning

MDT Working

Community

Leadership &
Management



In Summary

- Frailty is increasingly common
- Not everyone who is old is frail or who is frail is old
- Patient Centred Care
- You can do something about it
- Think 'what would you want?'



Thank You