

Ageing Well

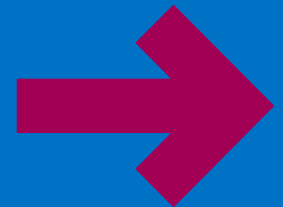
Quality Healthcare in Later Life

**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



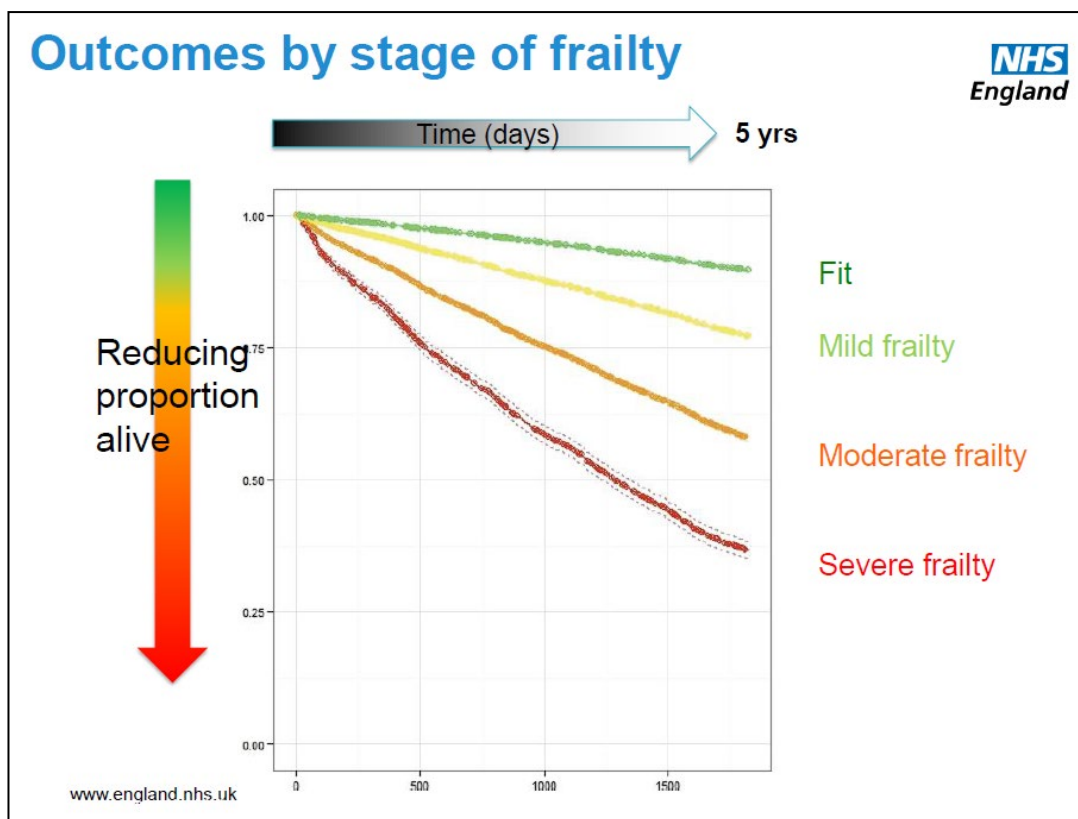
Context: Population

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

Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study: *Guzman-Castillo et al, Lancet Public Health 2017*

Context: Frailty & Mortality



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

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





Managing Frailty as Long Term Condition

Managing frailty as a long-term condition FREE

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

Age Ageing (2015) 44 (5): 732-735. DOI: <https://doi.org/10.1093/ageing/afv085>

Published: 13 July 2015 [Article history](#) ▾

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Abstract

Frailty is a distinctive late-life health state in which apparently minor

stressors are associated with adverse health outcomes. This



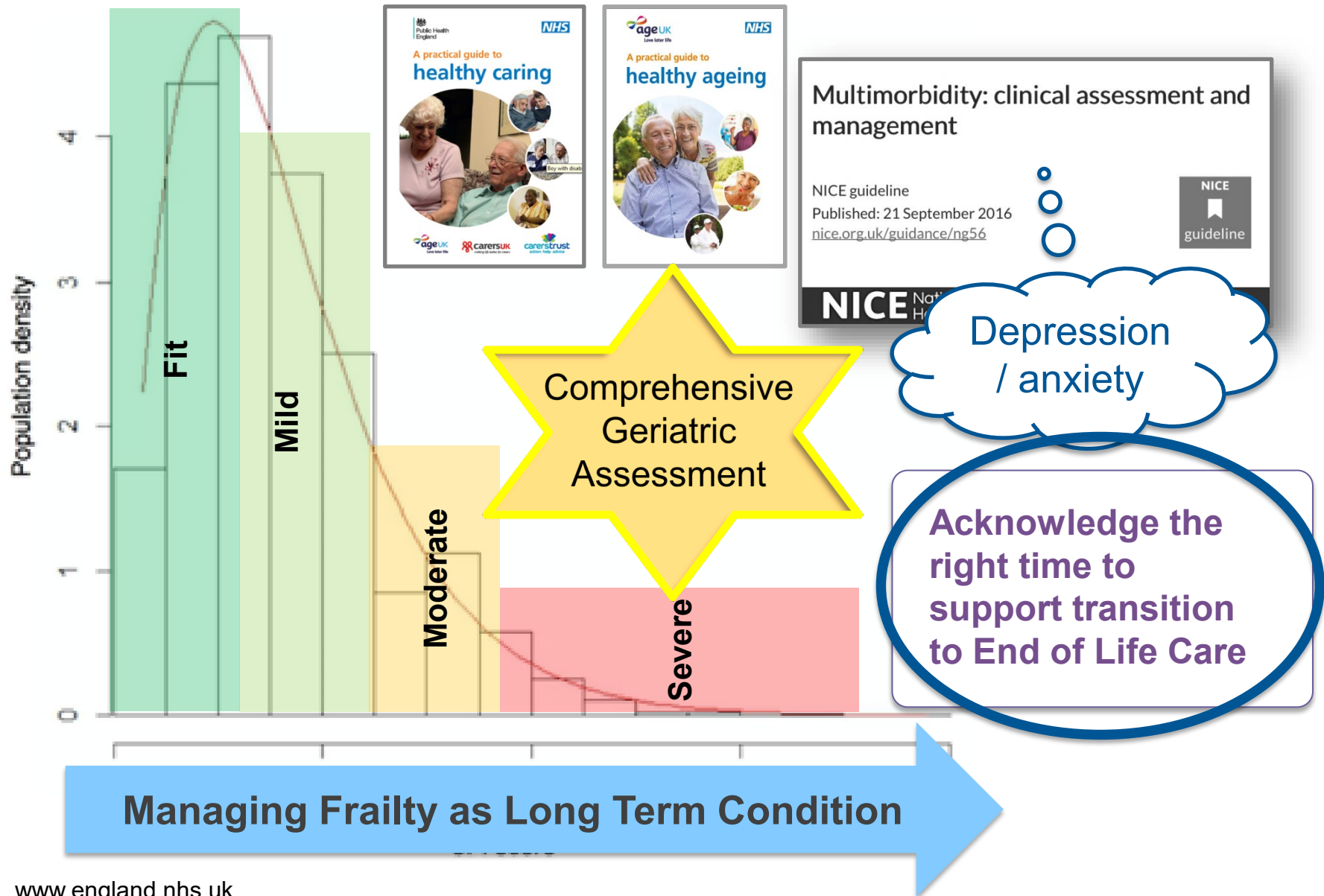
Blog

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



What can we do at a national level to support the changes needed to improve care for individuals?



Ageing Well

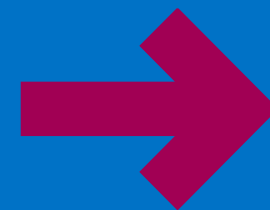
Quality Healthcare in Later Life

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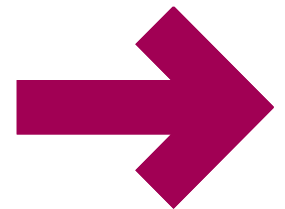
National Clinical Director Older People

6th March 2018



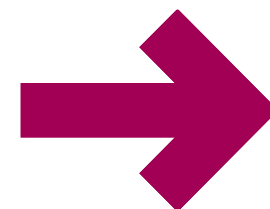
Ambition for frailty..

***Everybody should know what to do next
when presented with a person living with
frailty and/or cognitive disorder'***



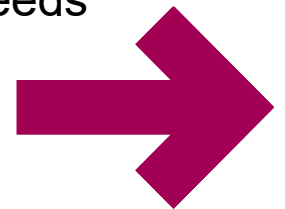
In other words...

Its 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%**

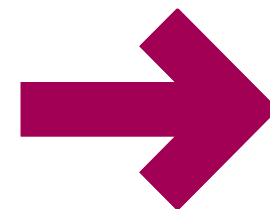
82% of increase (2013/14 to 2016/17) caused by people who did not stay overnight.

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

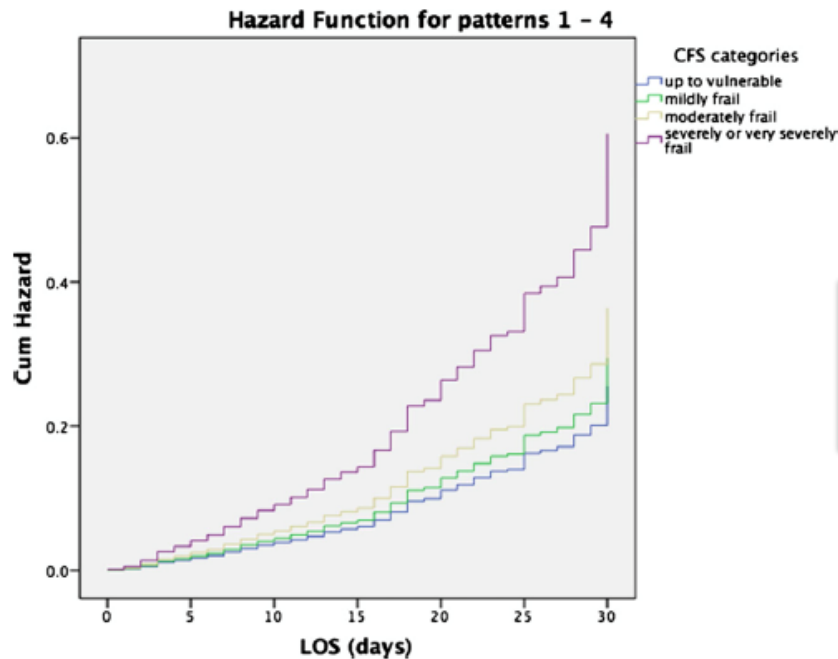


TABLE 4. Results of Multivariate Regression Models

Dependent variable: LOS ≥ 10 d (n = 5546); chi-square = 708.1; P < 0.001; AUC = 0.71)

	Unstandardized coefficients		OR	95% CI for OR		P
	B	Std. error		Lower bound	Upper bound	
Age	0.01	0.01	1.01	1.00	1.03	0.009
Gender	0.07	0.06	1.08	0.95	1.22	0.234
ED-MEWS	0.11	0.02	1.12	1.08	1.16	<0.001
CCI	0.09	0.01	1.09	1.07	1.11	<0.001
CFS ≥ 6	0.44	0.07	1.55	1.36	1.77	<0.001
HoD	0.77	0.10	2.16	1.79	2.61	<0.001
ACS	1.20	0.12	3.31	2.64	4.15	<0.001
Dc gen med	-0.87	0.09	0.42	0.35	0.51	<0.001
Dc geri med	0.00	0.10	1.00	0.83	1.21	0.995
Dc surgery	0.08	0.10	1.09	0.89	1.32	0.411

NOTE: The reference category for gender is male (male = 0; female = 1). Abbreviations: ACS, acute confusional state; AUC, area under the curve; CFS, Clinical Frailty Scale; CCI, Charlson Comorbidity Index; CI, confidence interval; Dc, discharge; ED-MEWS, Emergency Department Modified Early Warning Score; Gen Med, General Medicine; Geri Med, Geriatric Medicine; HoD, history of dementia; LOS, length of stay; n, number; OR, odds ratio.

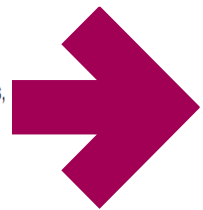
Clinical frailty adds to acute illness severity in predicting mortality hospitalized older adults: An observational study[☆]

Roman Romero-Ortuno^{a,b,*}, Stephen Wallis^a, Richard Biram^a, Victoria Keevil^{a,b}

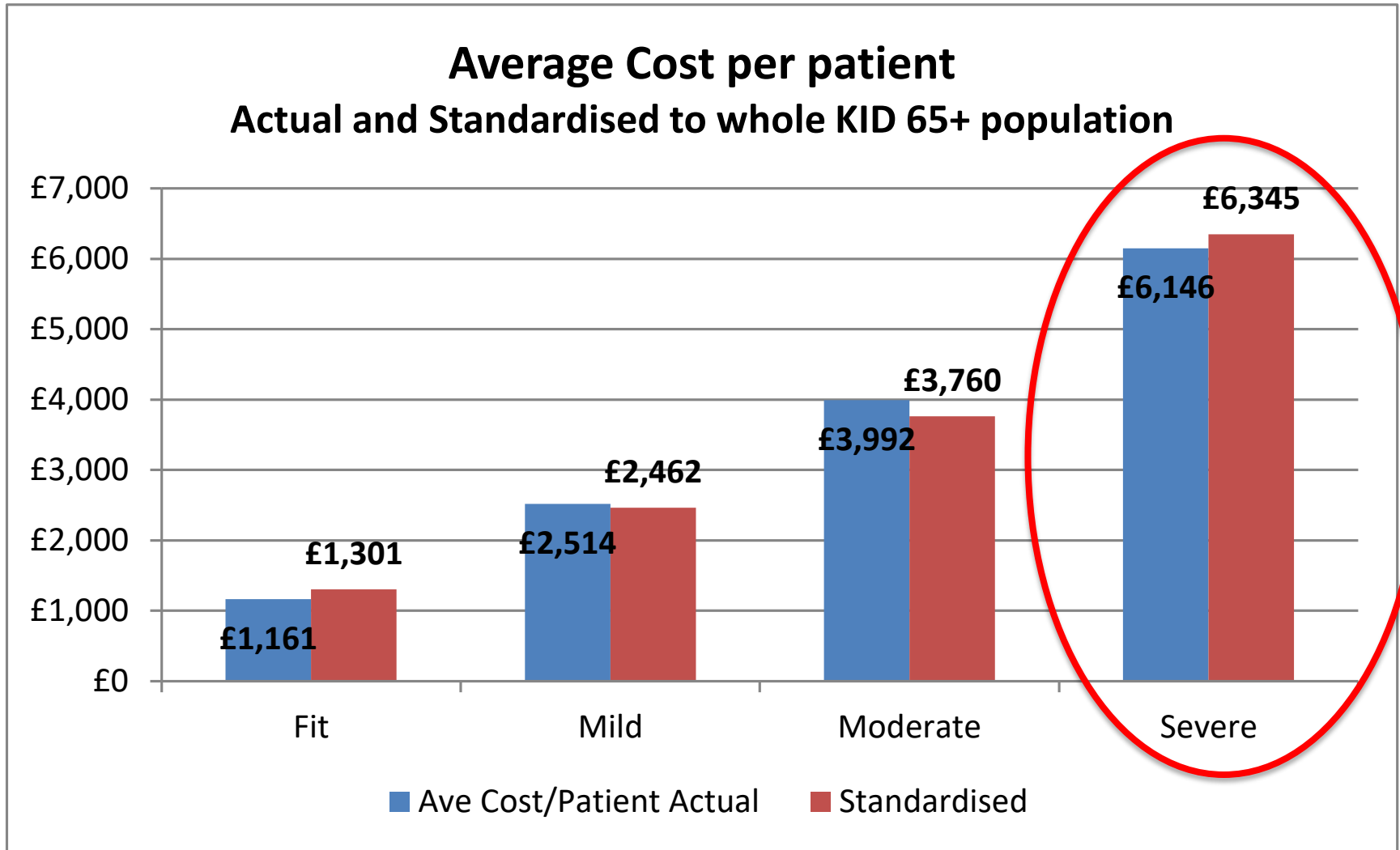
^a Department of Medicine for the Elderly, Addenbrooke's Hospital, Cambridge, United Kingdom
^b Clinical Gerontology Unit, Department of Public Health and Primary Care, University of Cambridge, United Kingdom

The Association of Geriatric Syndromes with Hospital Outcomes

Roman Romero-Ortuno, PhD^{1,3*}, Duncan R. Forsyth, MA¹, Kathryn Jane Wilson, MBBS¹, Ewen Cameron, MD², Stephen Wallis, MB BChir¹, Richard Biram, MBBS¹, Victoria Keevil, PhD^{1,3}

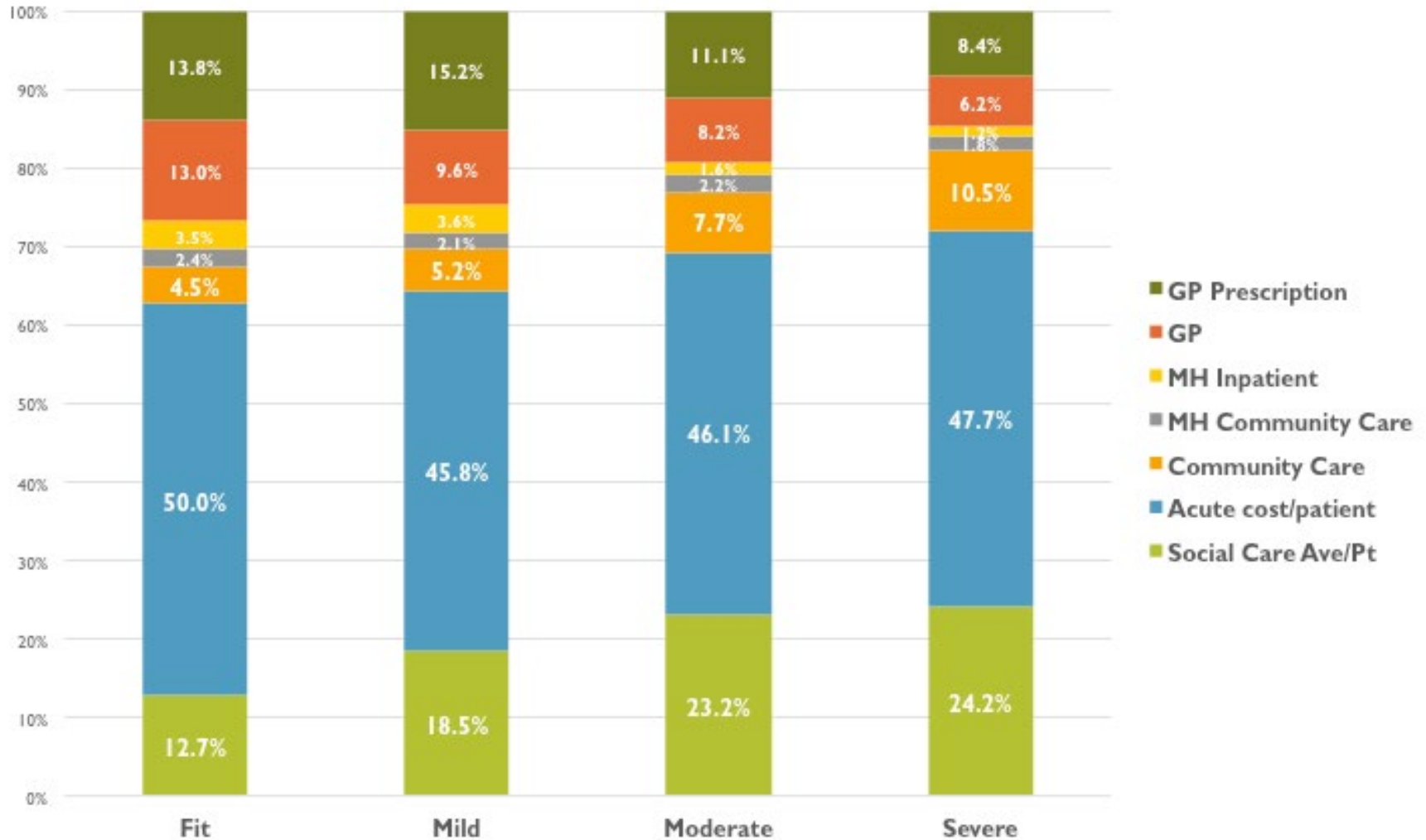


Frailty is expensive when severe



Cost is distributed across the system

Percent total spend by category within eFI band
Patients 65+ KID Jan - Oct 2017 activity data



NHS England Next Steps-Priorities

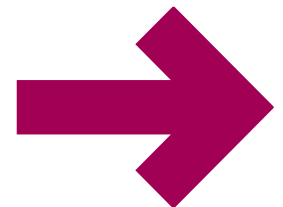
'Health and high quality care –now and for future generations'

- ❑ **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**



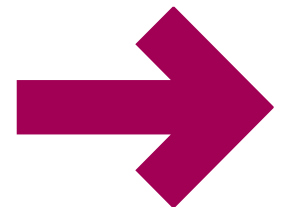
Three priorities for frailty

- 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**

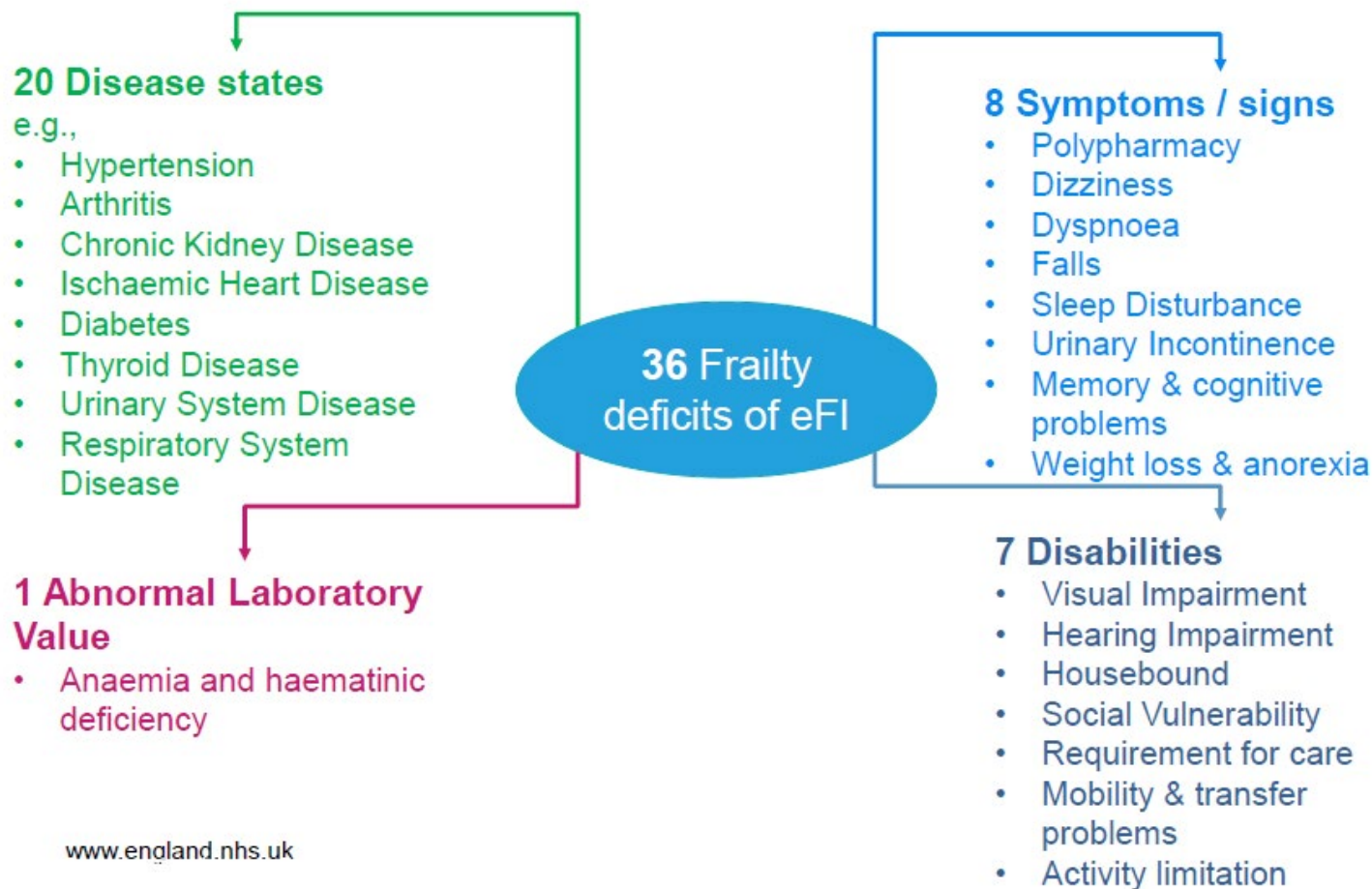


Routine timely frailty identification

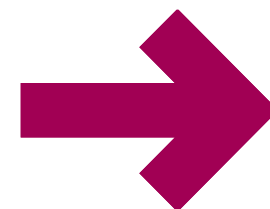
- Routine frailty identification in primary care has 2 potential merits:
 1. Population risk stratification
 2. Targeted individualised interventions for optimal outcomes



Electronic Frailty Index (eFI)



www.england.nhs.uk



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 Ill - 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.

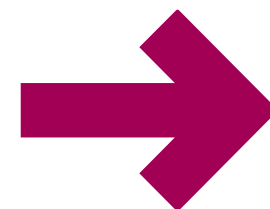
In **severe dementia**, they cannot do personal care without help.

* 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.

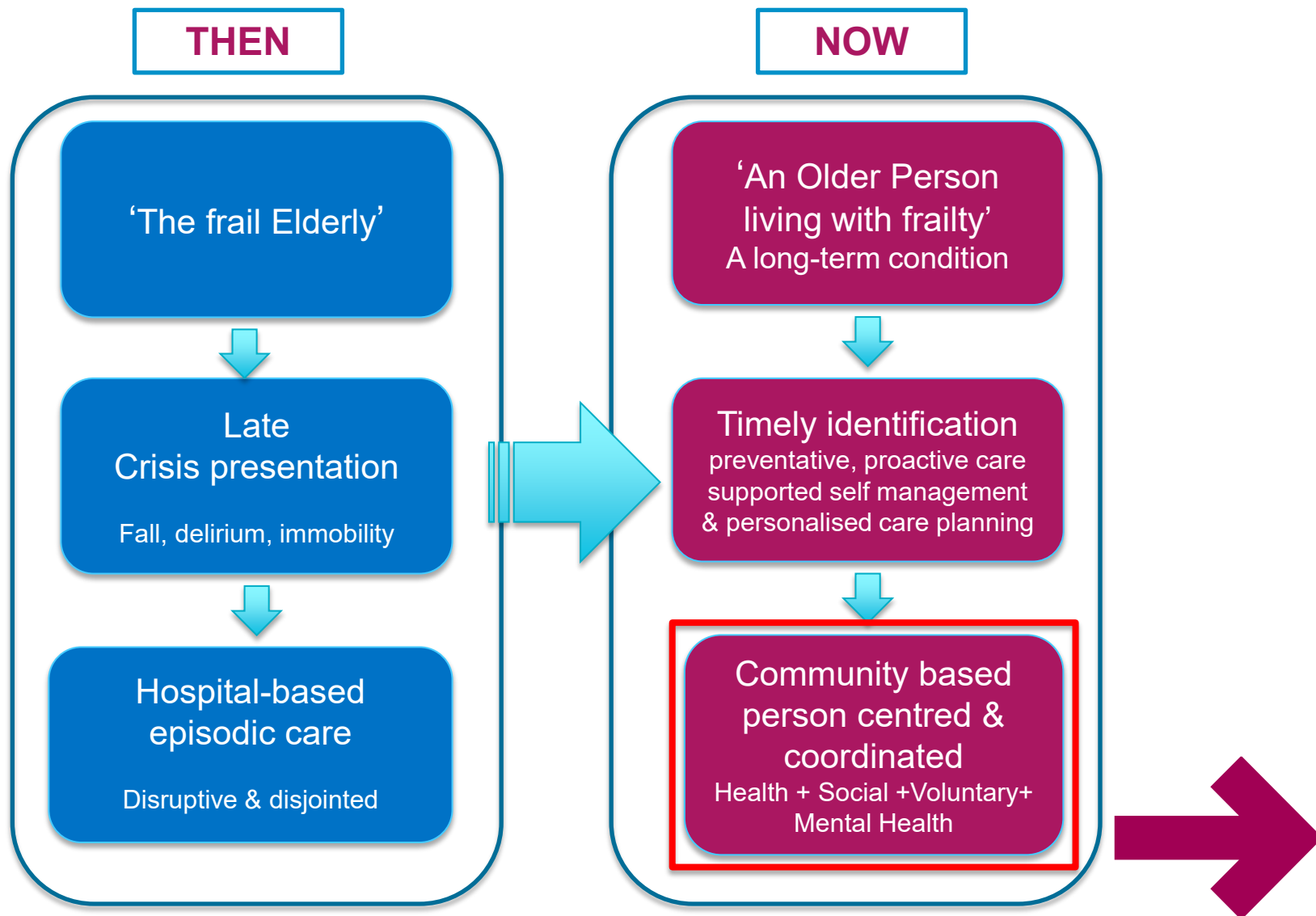
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GP Contract 2017/18 Data [Q3]

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



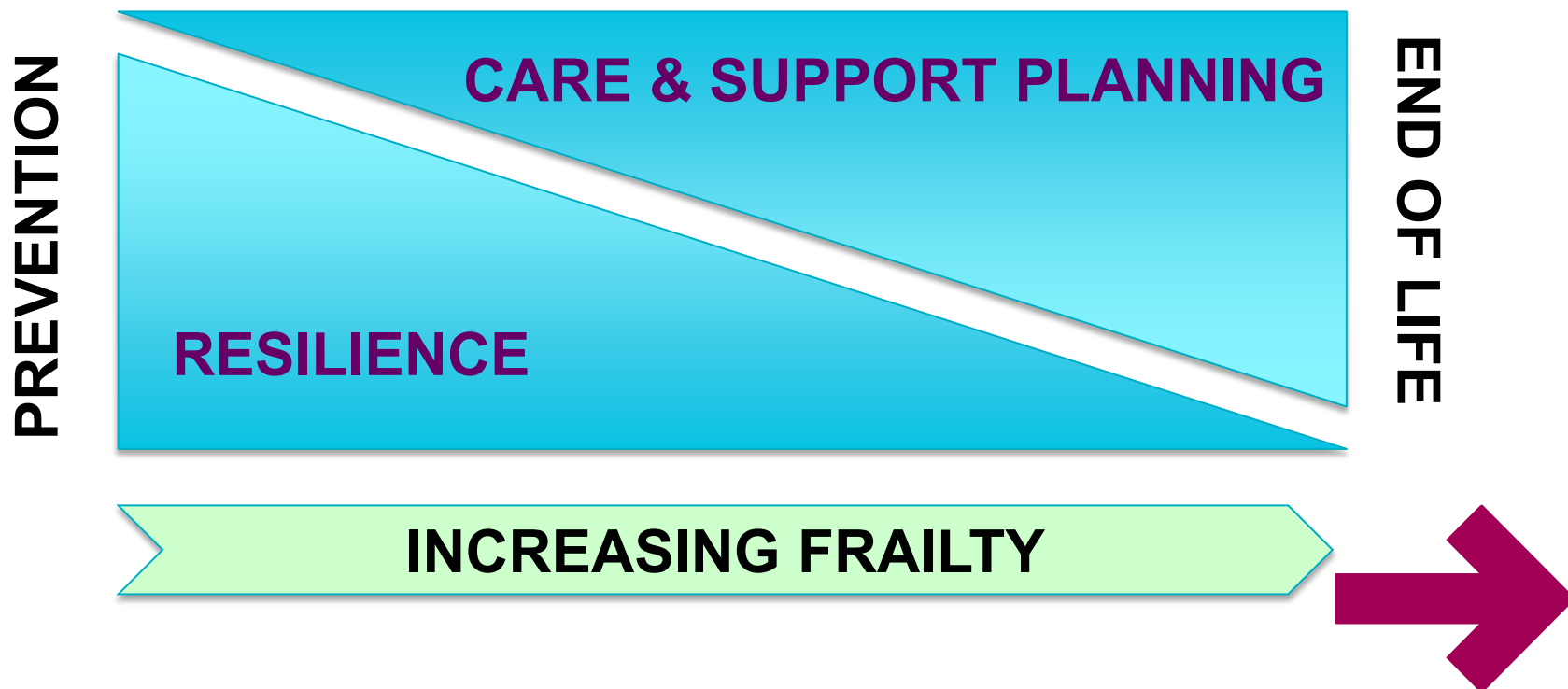
Paradigm shift



From: 'What's the matter with you?'

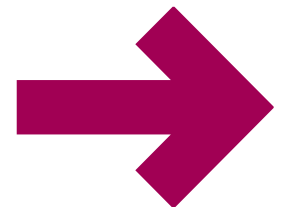
To: 'What matters to me?'

- ❑ 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



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



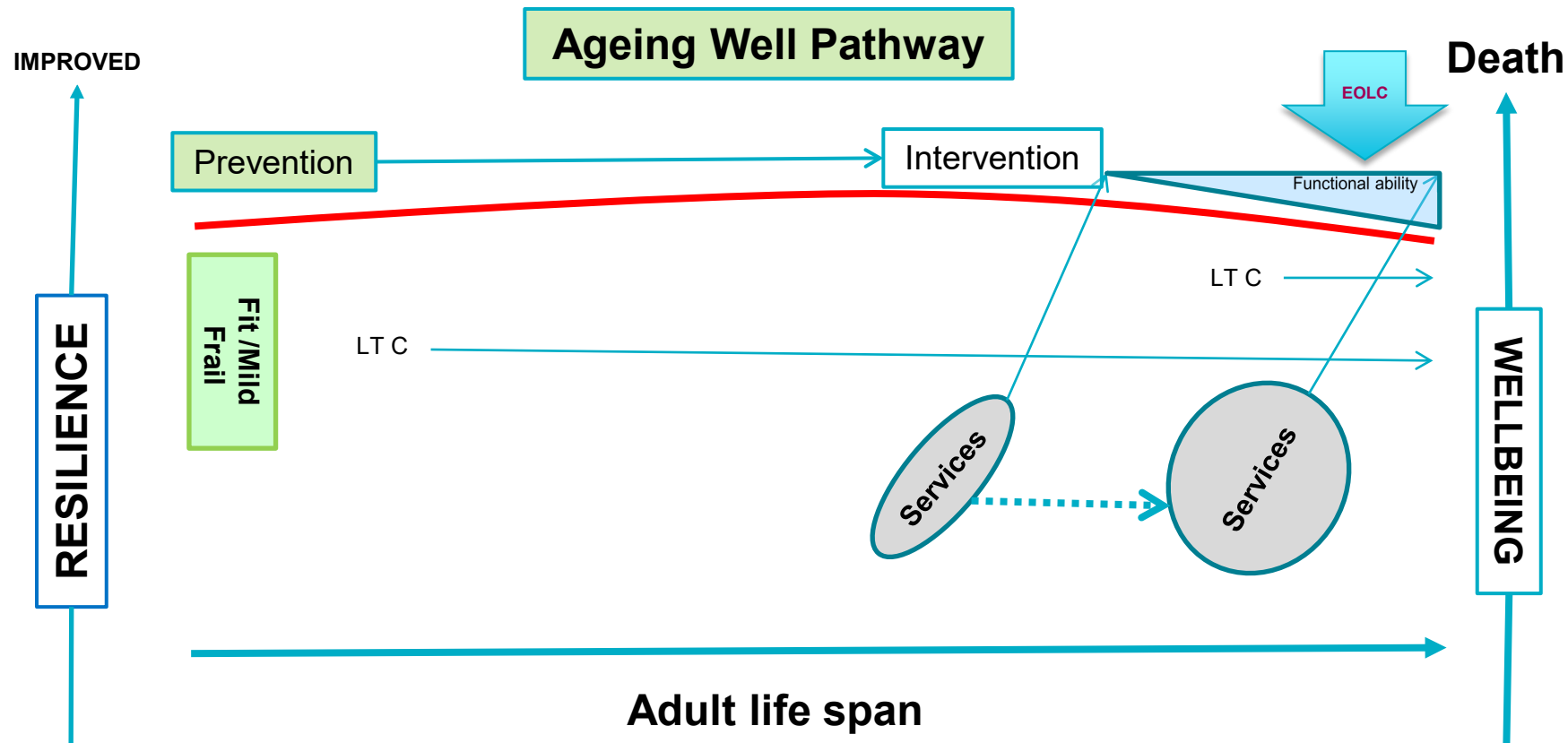
So how do we get there?



***We know what good looks like...
The task is how to deliver it at scale?***



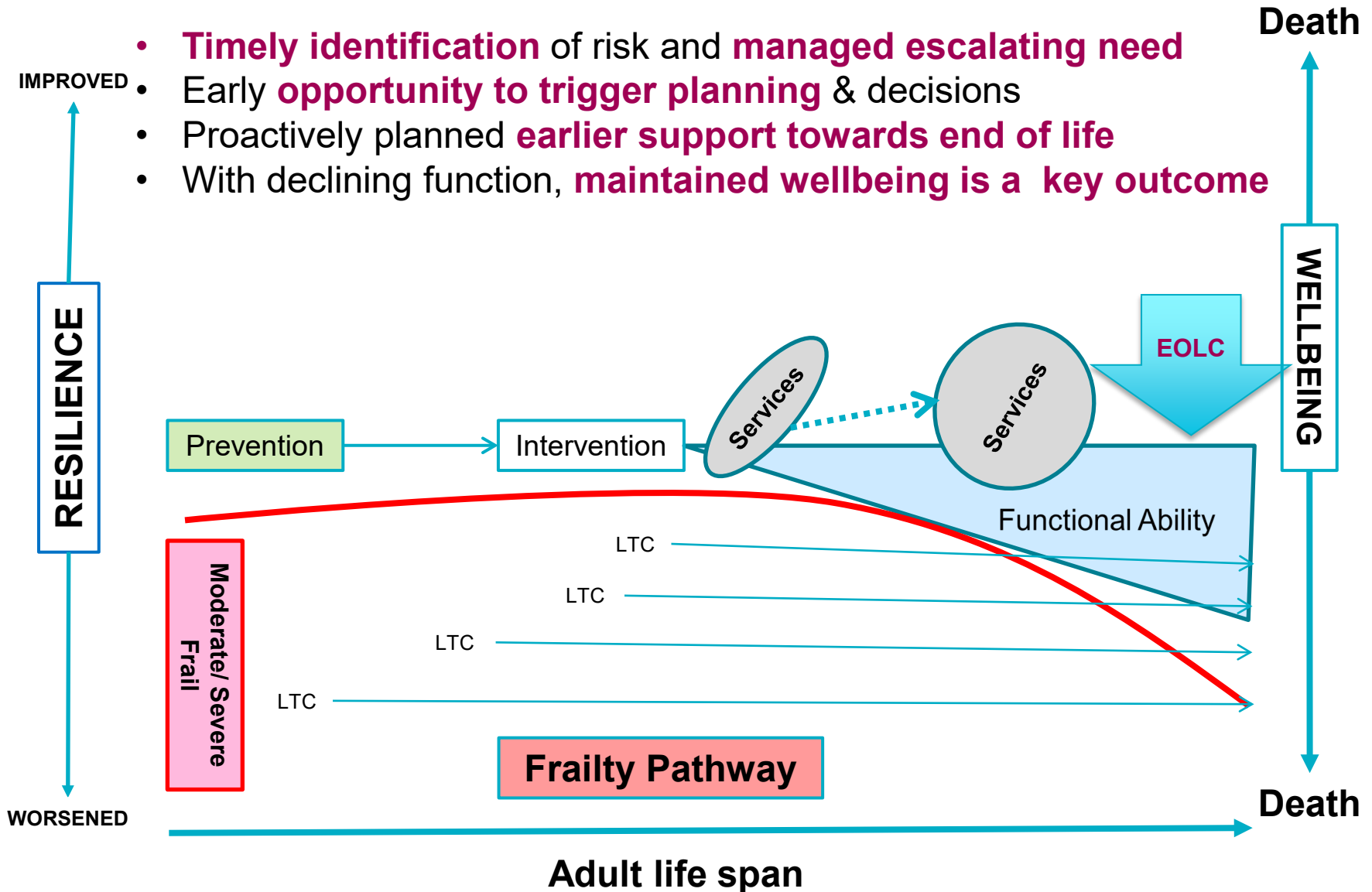
Population sub-stratification: Prevention



- **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**

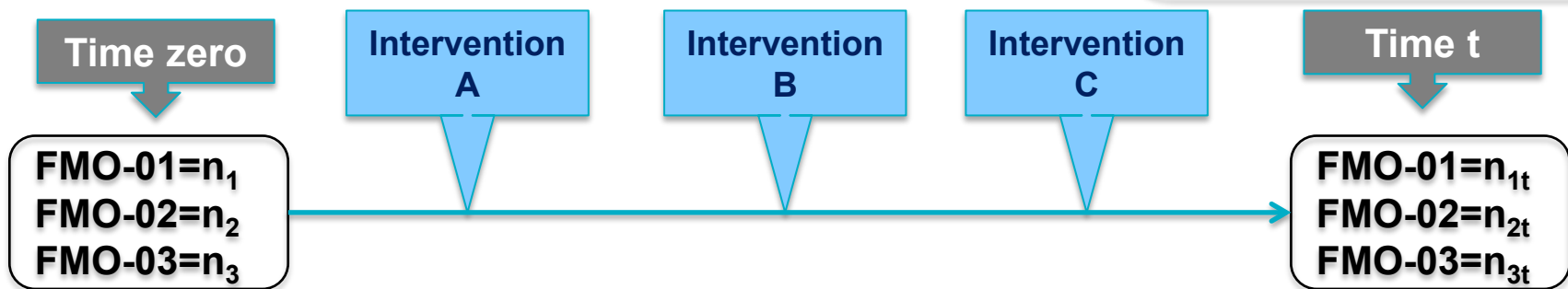


Integration: testable currency (moderate frailty)

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

Incurred costs
Outcome metrics

Recoverable

Stable

Progressive

- 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.
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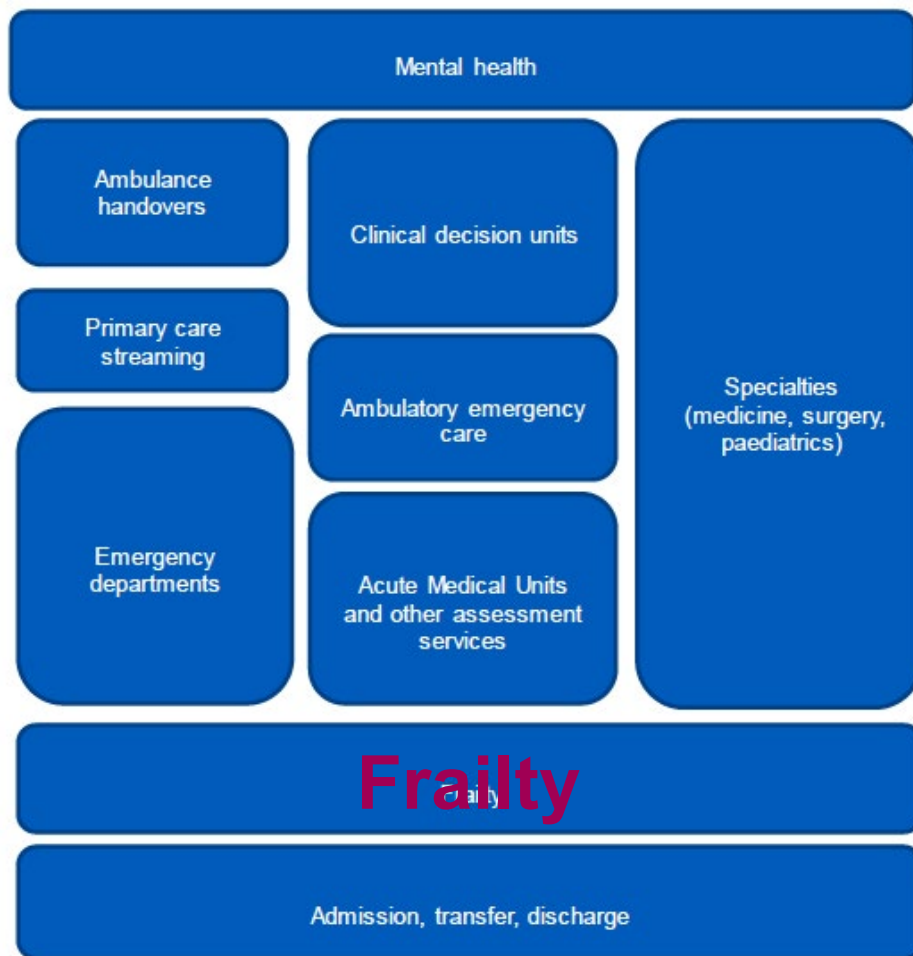
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Getting it Right First Time (GIRFT)

10 key areas for acute care focus

End of life Care

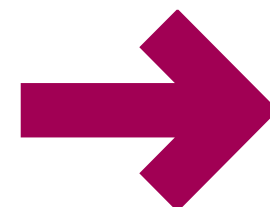


National priorities for acute hospitals 2017

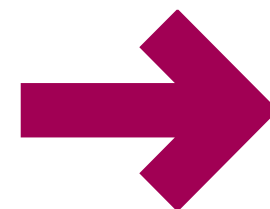
Good practice guide: Focus on improving patient flow

July 2017

Produced in collaboration with and endorsed by:

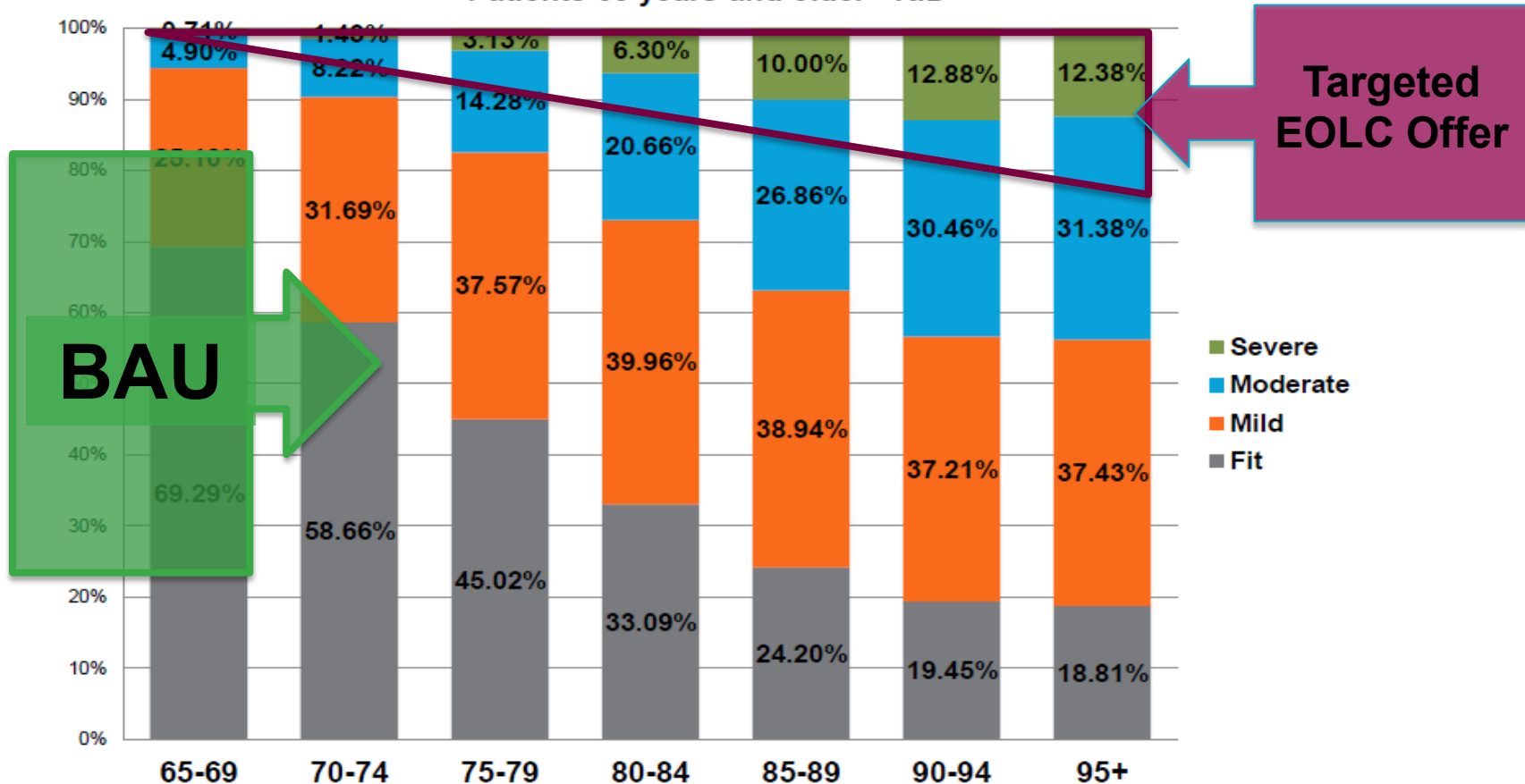


And in summary..



Frailty data to commission a new integrated personalised care offer for those NOT ageing well

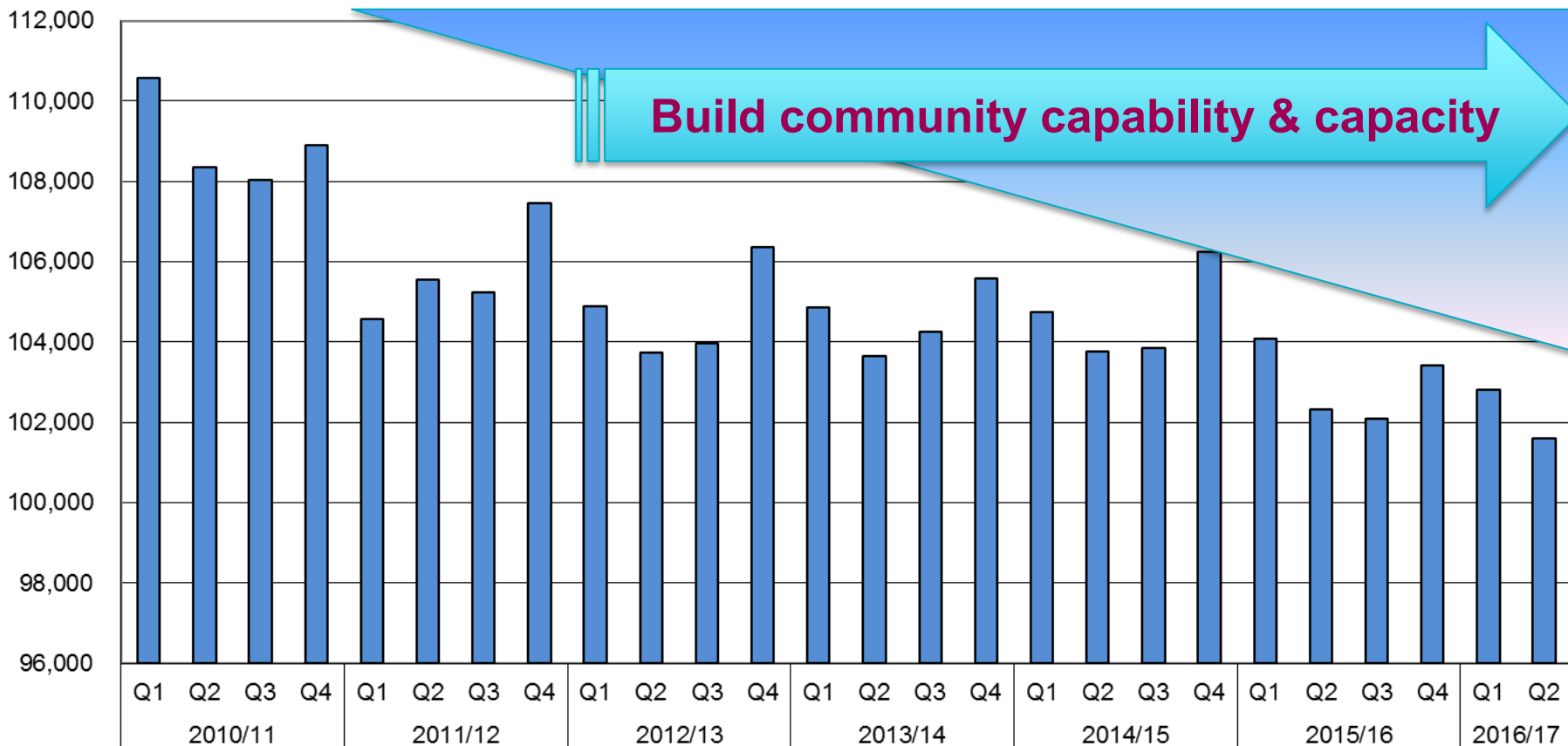
Percent Frailty Category Within Each Age Band
Patients 65 years and older - KID



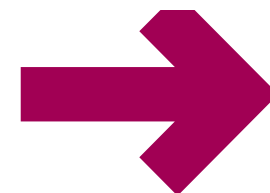
Proactive & Reactive Community MDT care

Integrated care system offer provides the alternatives to hospital care

General and acute beds open overnight - 2010/11 onwards



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



What we're doing nationally

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



ENGLAND.longtermconditions@nhs.net

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

