A Primary Care-Based Model for Frailty

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New Care Paradigm for Older People & Frailty

**TODAY**

‘The Frail Elderly’
(i.e. a label)

Presentation late & in crisis
(e.g. delirium, falls, immobility)

Hospital-based: episodic,
disruptive & disjointed

**TOMORROW**

“An older person living with frailty"
(i.e. a long-term condition)

Timely identification for preventative, proactive care by supported self-management & personalised care planning

Community-based: person-centred & co-ordinated
(Health + Social + Voluntary + Mental Health)
Frailty as a driver for clinical practice change in primary care

- Some bad news: It’s not a disease
- Some more bad news: It affects the whole body
- Even more bad news: Every person is different
- The worst of news: Several things wrong at once
- So, living with frailty is just like living with advanced multiple comorbidity

The majority of people >75yrs have 3 or more LTCs
Frailty as an abnormal health state
(Loss of physiological reserve)

Clegg, Young, Iliffe, Olde-Rikkert, Rockwood. Frailty in elderly people. Lancet 2013; 381: 752-762
The 4m walking speed test detects frailty

Taking more than 5 seconds to walk 4m predicts future:

- Disability
- Long-term care
- Falls
- Mortality

Van Kan et al. JNHA 2009; 13:881
Systematic Review of 21 cohorts
Primary care electronic Frailty Index (eFI): survival plots (n=227,648; >65y)
Candidate Preventable Components for “Frailty”

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

(Systematic review of 78 studies)

Additional topics:
- Look after you feet
- Make your home safe
- Vaccinations
- Keep warm
- Get ready for winter
- Continence
- ........others........??

Supported-Self Management Plan for Healthy Living in Later Life
A Programme of Action for General Practice
(Admission Avoidance DES)

• Improved access (same day telephone consultation)
• Regular Risk Profiling (case finding)
• Name Accountable GP and Care Co-ordinator
• ‘One-to-one discussions’ and ‘holistic care plan’
• Post hospital follow-up care (reduce readmissions)
• Internal reviews of unplanned admissions
What is care and support planning?
Care and support planning encourages clinicians and people with long-term conditions to work together to clarify and understand what is important to that individual. They agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a planned and continuous process, not a one-off event.

http://coalitionforcollaborativecare.org.uk/
Mrs Greenaway was a Bradford lady through and through. A hard life working in a textile mill as a burler & mender (hand finishing the woven cloth) had given her a patient and measured approach to life.

She had brought up four children pretty much on her own, her husband having died young.

She had approached her older age with quiet resourcefulness but still sparkling with humour.

Local friends had moved away or died, and there were fewer and fewer reasons to go out, so that she had gradually drawn more into herself and become housebound.

Her daughters had lovingly rallied round for support. Secretly, Mrs Greenaway quite liked the fuss and attention – but would never have said so!
Another view of Mrs Greenaway ........

- 85 years
- Lives alone
- Recently in hospital following a fall
- Taking 8 medications
- Broken hip 2011
- Chronic heart failure
- Diabetes
- CKD

System designed to fragment care into packages
And yet another view of Mrs Greenaway....... 

What are the most important things you’d like to discuss today?

1. The pain in my feet
2. Difficulty sleeping
3. Getting out for a chat
4. I don’t like all these tablets; do I really need them all?
GUIDELINE BASED MEDICINE GUIDELINE BASED MEDICINE or CARE & SUPPORT PLANNING?

- Guideline medicine
- Care & Support Planning

People with a single LTC → People with multiple LTCs/Frailty
Care and Support Planning

Person's Story

Information gathering

Information Sharing

Goal Setting and Action Planning

Agreed & shared ‘care plan’

Professional Story

© Year of Care
Key Deliverables (n=10)

• Develop a tiered approach to coding for frailty to support primary and secondary care to understand the impact of frailty as a diagnosis supporting targeted and supported self-management by March 2015

• Co-produce with patients and carers a supported self-management guide for people with complex care needs and frailty by June 2014

• Develop practical tools and commissioning guidance to support the delivery of everyone with a long term condition being offered a personalised care plan by April 2015

• Publish a web-based dynamic toolkit and a long term condition (LTC) dashboard to support the implementation of the House of Care
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