Living and dying well with frailty

A National Collaborative
Living Well in Communities

Enabling people to live well in their community for longer

Identifying people before crisis
Planning for the future
Accessing preventative support
Frailty

A form of complexity, associated with developing multiple long-term conditions over time leading to low resilience to physical and emotional crisis and functional loss leading to gradual dependence on care.

<table>
<thead>
<tr>
<th>Frailty Level</th>
<th>45% not frail</th>
<th>35% mild frailty</th>
<th>15% moderate frailty</th>
<th>5% severe frailty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average length of stay per unplanned admission</td>
<td>13.5</td>
<td>23.4</td>
<td>36.4</td>
<td></td>
</tr>
<tr>
<td>Average days lost to delayed discharge per admission</td>
<td>1.2</td>
<td>3.3</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Average GP appointments in a year</td>
<td>10</td>
<td>14</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Average number of individually prescribed items per year</td>
<td>9</td>
<td>12</td>
<td>15</td>
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</tr>
</tbody>
</table>
### Why Focus on frailty?

<table>
<thead>
<tr>
<th>Service</th>
<th>All frailty groups</th>
<th>mild</th>
<th>moderate</th>
<th>severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned bed days</td>
<td>£1,172m</td>
<td>£396m</td>
<td>£482m</td>
<td>£293m</td>
</tr>
<tr>
<td>Community prescribing</td>
<td>£430m</td>
<td>£231m</td>
<td>£137m</td>
<td>£62m</td>
</tr>
<tr>
<td>Outpatient appointments</td>
<td>£412m</td>
<td>£240m</td>
<td>£118m</td>
<td>£54m</td>
</tr>
<tr>
<td>GP appointments</td>
<td>£394m</td>
<td>£212m</td>
<td>£127m</td>
<td>£55m</td>
</tr>
<tr>
<td>Community nursing</td>
<td>£138m</td>
<td>£84m</td>
<td>£44m</td>
<td>£10m</td>
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</tbody>
</table>

Extrapolated costs over 12 months for people 65 and over with frailty.
The purpose of the Living and Dying Well with Frailty Collaborative is for participating teams to improve how they identify and enable people aged 65 and over to live and die well with frailty in the community.
Measures of success

- Reduce hospital bed days for people aged 65 and over by 10%, per 1,000 population.

- Reduce unscheduled GP home visits for people aged 65 and over by 10%, per 1,000 population.

- Increase percentage of anticipatory care plans in the Key Information Summary (KIS) for people living with frailty by 20%, per 1,000 population.
Drivers for change

Identify people before a crisis
Plan for the future
Access preventative support
Multidisciplinary team working
Identifying people before a crisis

Community

Planned population

Current planned population tools

Acute
Planning for the future

Jean’s experience

- Hospital admission for 32 days in August
- Social Care Assessment in September
- Moved to care home for 39 days in October
- Death in Care home in December

52 bed days and total costs of £18,000

Margaret’s experience

- Hospital admission for 4 days in May
- Social Care assessment in June
- Care package provided in July
- Social Care assessment in August
- Moved to care home for 73 days in September
- Death in Care home in October

4 bed days and total costs of £7,100

Data provided by ISD.
<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional interventions</td>
<td>Reablement</td>
<td>Bed based intermediate care</td>
</tr>
<tr>
<td>Exercise and physical activity</td>
<td>Polypharmacy review</td>
<td>Community-based geriatric services</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Primary care MDT</td>
<td>Palliative care</td>
</tr>
<tr>
<td>Reduce alcohol</td>
<td>Falls management</td>
<td>Hospital at home</td>
</tr>
<tr>
<td>Reduce social isolation</td>
<td>Anticipatory care planning</td>
<td>Anticipatory care planning</td>
</tr>
<tr>
<td>Housing adaptations</td>
<td>Immunisation</td>
<td>Adult carers support planning</td>
</tr>
</tbody>
</table>
An MDT case review meeting is a structured conversation with a range of practitioners about a person who has complex issues, to ensure timely and individualised care and to agree a plan of action based on intended outcomes for the patient.
Drivers for change

**Outcome**

- People 65 years and over with frailty, will experience a good life and death, including more time at home or in a homely setting.

**Primary driver**

- Identify people aged 65 and over living with frailty in the community.
- Support people living with frailty to plan for their future care needs, and when appropriate, death.
- Support people living with frailty to access preventative support in the community.
- Develop effective multidisciplinary team working focused on person-centred, preventative care.

**Secondary drivers**

- Case find people at risk using the eFrailty Index
- Multi-dimensional assessment
- Monitor change and deterioration over time
- Anticipatory care planning conversations, including recording information in the Key Information Summary
- Communication and collaboration within a multi-disciplinary team, including a multidisciplinary review
- Understand what support is available in communities and how to access support
- Use quality improvement methods, including data over time, to drive improvement

**Support people living with frailty**

- Key worker
- Exercise interventions and physical activity
- Lifestyle and nutritional interventions
- Polypharmacy review
- Reablement
- Vaccinations
- Community-based geriatric services
- Palliative and end of life care

**Support people living with frailty**

- Key worker
- Exercise interventions and physical activity
- Lifestyle and nutritional interventions
- Polypharmacy review
- Reablement
- Vaccinations
- Community-based geriatric services
- Palliative and end of life care

**People 65 years and over with frailty, will experience a good life and death, including more time at home or in a homely setting.**

- Reduce unplanned hospital bed days
- Reduce unscheduled GP home visits
- Increase use of anticipatory care planning and Key Information Summary

**Support people living with frailty**

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Benefits you will receive

Clinical care benefits

• Support to use and interpret the eFI through SPIRE
• Improve quality of life for people living with frailty
• Guidance on multi-disciplinary working
• Guidance and materials to improve anticipatory care approaches
• Guidance for adopting a realistic medicine approach
• Improvement and analytical expertise
Benefits you will receive

Professional development

- Recognition for innovating identification and support in a community setting
- Learn from clinical and topic experts
- Opportunities to meet and learn from others
- A structure to learn about quality improvement and how to apply it in your work
Participating teams

**Home Team** – health and social care professionals involved in implementing the change ideas in the community

**Away Team** – represents and provides leadership to the Home Team throughout the collaborative.

**Away team membership:**
- Health and Social Care Partnership Lead
- GP Representative
- Quality Improvement Lead Role
- Data Lead Role
- Two team members from GP practices and community teams

**Sponsors**

**Coordinator**
Timescales for application process

- Collaborative launched: 29 April 2019
- Applications open: 17 June 2019
- Application close: 19 July 2019
- Teams informed and MoU issued: 16 August 2019
Collaborative key dates

- Introductory WebEx: 27 or 28 August 2019
- Learning session 1: 19 September 2019
- Learning session 2: 27 February 2020
- Learning session 3: June 2020
- Learning session 4: October 2020
How to apply

hcis.livingwell@nhs.net

https://ihub.scot/living-and-dying-well-with-frailty

@LWiC_QI
National collaboratives

Living and dying well with frailty

- Planned population

Frailty at the front door

- Individuals at the front door

Community

Acute
Thoughts and questions
<table>
<thead>
<tr>
<th>Disease State</th>
<th>Symptoms / Signs</th>
<th>Disability</th>
<th>Abnormal Lab Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Valve Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Ulcer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>Polypharmacy</td>
<td>Activity Limitation</td>
<td></td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>Sleep Disturbance</td>
<td>Requirement for Care</td>
<td></td>
</tr>
<tr>
<td>Foot Problems</td>
<td>Dyspnoea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>Sleep Disturbance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peptic Ulcer</td>
<td>Dyspnoea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke and TIA</td>
<td>Sleep Disturbance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Urinary Incontinence</td>
<td>Housebound</td>
<td></td>
</tr>
<tr>
<td>Fragility Fracture</td>
<td>Falls</td>
<td>Social Vulnerability</td>
<td></td>
</tr>
<tr>
<td>Hypotension /Syncope</td>
<td>Falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>Urinary Incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disorders</td>
<td>Hearing Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>Hearing Loss</td>
<td>Vision Problems - Blindness</td>
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<tr>
<td>Heart Failure</td>
<td>Hearing Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Memory and Cognitive Problems</td>
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</tr>
<tr>
<td>Respiratory Disease</td>
<td>Weight Loss and Anorexia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary System Disease</td>
<td>Mobility and Transfer problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaemia &amp; Haematinic Deficiency</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
How the eFI works
Electronic Frailty Index

- 35% Mild frailty
- 15% Moderate frailty
- 5% Severe frailty

Risk of hospitalisation:
- 20%
- 40%
- 70%

People registered with test GP practices aged 65 and over
The electronic frailty index (eFI) is a seventy grading of frailty of older patients based on patterns of frailty coded in your clinical system. This report provides an overview of the patients in each eFI category in your practice, and highlights those whose eFI has increased over the past six months.

A full list of older (65+) patients and their eFI can be accessed here.

### eFrailty Index Grouping

<table>
<thead>
<tr>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Not frail</th>
</tr>
</thead>
<tbody>
<tr>
<td>97</td>
<td>203</td>
<td>490</td>
<td>368</td>
</tr>
</tbody>
</table>

### High Priority Patients

- Increasing severe: 3
- Escalation to severe: 8
- Moderate but increasing: 2
- Escalation to moderate: 22
# eFrailty Report

**Patient list: Escalation to severe**  
**Data as of 01/01/2016**  
**18 records found**

<table>
<thead>
<tr>
<th>CHI Number</th>
<th>Clinical System ID</th>
<th>Surname</th>
<th>Forenames</th>
<th>Age</th>
<th>Gender</th>
<th>Frailty group</th>
<th>Current eFl</th>
<th>Priority group</th>
<th>Change last 6 months</th>
</tr>
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<tbody>
<tr>
<td>7770005056</td>
<td>Clinical System ID_5056</td>
<td>Sumame_5056</td>
<td>Forenames_50 56</td>
<td>76</td>
<td>M</td>
<td>Severe</td>
<td>0.40</td>
<td>Escalation to severe</td>
<td>0.06</td>
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<td>Forenames_99 95</td>
<td>67</td>
<td>F</td>
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<td>0.40</td>
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<tr>
<td>7770001060</td>
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<td>Sumame_1060</td>
<td>Forenames_10 60</td>
<td>65</td>
<td>M</td>
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<td>0.37</td>
<td>Escalation to severe</td>
<td>0.03</td>
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<td>Forenames_12 23</td>
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<td>0.37</td>
<td>Escalation to severe</td>
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<tr>
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<td>Sumame_3540</td>
<td>Forenames_35 40</td>
<td>81</td>
<td>M</td>
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<td>7770005996</td>
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<td>7770006642</td>
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<td>M</td>
<td>Severe</td>
<td>0.37</td>
<td>Escalation to severe</td>
<td>0.03</td>
</tr>
</tbody>
</table>
eFl on SPIRE

![Graph showing eFrailty Report data as of 01/01/2016](image)

<table>
<thead>
<tr>
<th>Date</th>
<th>eFl</th>
<th>DeMort</th>
</tr>
</thead>
<tbody>
<tr>
<td>26/05/1982</td>
<td>0.020571</td>
<td>Hypotension/Syncope</td>
</tr>
<tr>
<td>26/02/2002</td>
<td>0.057142</td>
<td>Osteoporosis</td>
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<td>28/11/2002</td>
<td>0.085714</td>
<td>Ischemic Heart Disease (CHD)</td>
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<td>19/03/2004</td>
<td>0.114286</td>
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</tr>
<tr>
<td>13/07/2012</td>
<td>0.142857</td>
<td>Fracture</td>
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<td>07/12/2012</td>
<td>0.171429</td>
<td>Respiratory Disease</td>
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<td>30/05/2013</td>
<td>0.200000</td>
<td>Arthritis</td>
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<tr>
<td>09/01/2014</td>
<td>0.228571</td>
<td>Housebound</td>
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<td>26/01/2015</td>
<td>0.257143</td>
<td>Visual Impairment</td>
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<tr>
<td>21/05/2015</td>
<td>0.314286</td>
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<tr>
<td>03/06/2015</td>
<td>0.342857</td>
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<tr>
<td>24/09/2015</td>
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<td>Foot Problems</td>
</tr>
<tr>
<td>17/12/2015</td>
<td>0.400000</td>
<td>Anaemia and haematological deficiency / Deficit</td>
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</table>
eFI on SPIRE
Breakthrough Series Collaborative

An improvement method that focuses on spread and adaptation of existing knowledge to multiple settings to accomplish a common aim.

IHI Breakthrough Series whitepaper, 2003