

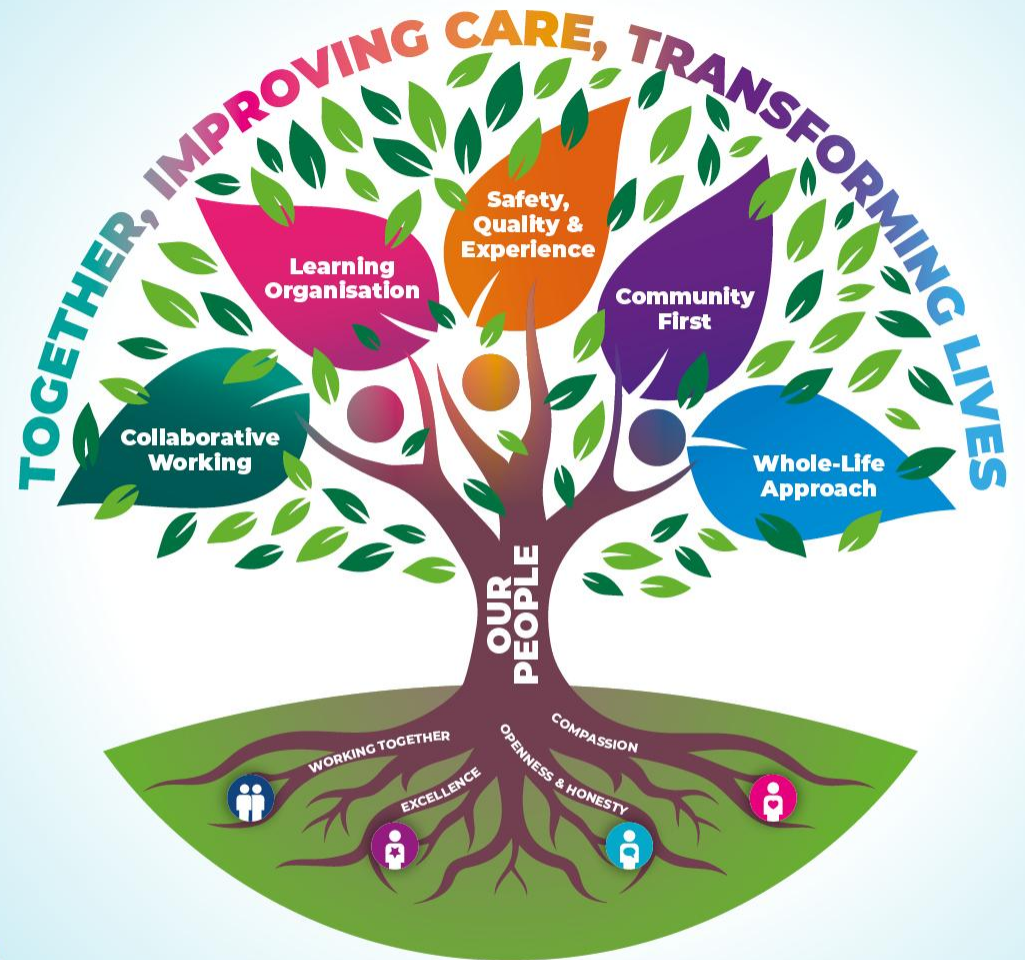
Management of Frailty in Older Persons

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What is Frailty?

- Frailty is defined by the World Health Organisation as “*a progressive age-related decline in physiological systems that results in decreased reserves of intrinsic capacity, which confers extreme vulnerability to stressors and increases the risk of adverse health outcomes*”.
- With frailty, even minor events can trigger disproportionate changes in health status after which the patient fails to recover to their previous level of health. Frailty is a spectrum disorder, which ranges from mild to severe frailty.

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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Current Position in N Ireland

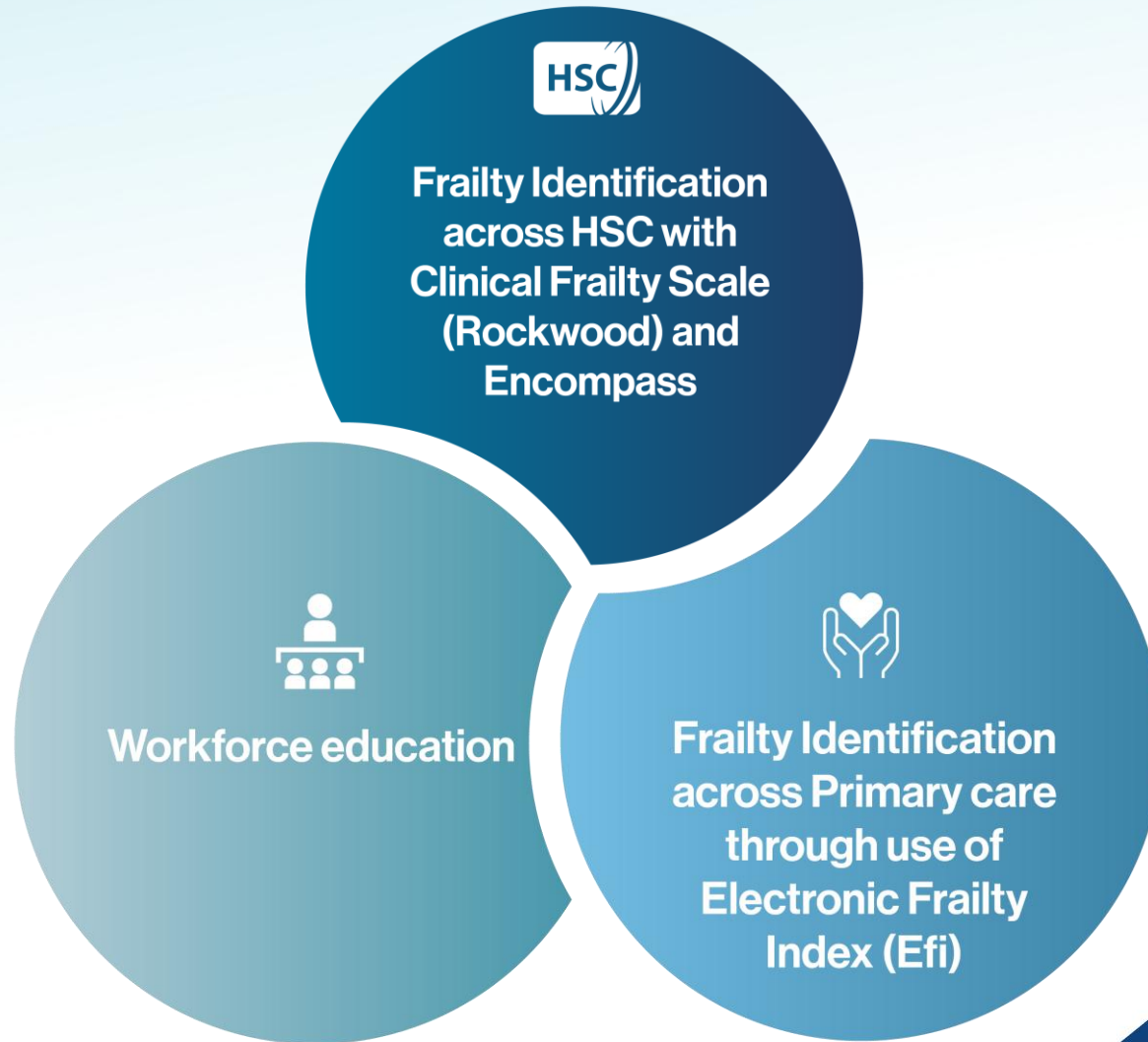
- Population of over 65+yrs grew by 54% in the 20 years to 2020 - expected to grow by further **57%** from 2020 to 2043.
- Population of over 85+yrs grew by 87% in the 20 years to 2020 - expected to grow by a further **115%** from 2020 to 2043.
- Primary Care practices across NI are not currently contracted to identify frailty in their 65+yrs population using a validated tool.
- The wider HSC (Inpatient and community services) do not routinely identify frailty in their 65+yrs population using a validated tool.
- The Clinical Frailty Scale (CFS, Rockwood), is built into encompass, however is not a hard stop, nor easily accessible within the system.
- We have no Prevalence data for Frailty in NI.
- Limited education/awareness for workforce in terms of the significance of Frailty.



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Outline of Workstreams to Deliver on Objectives



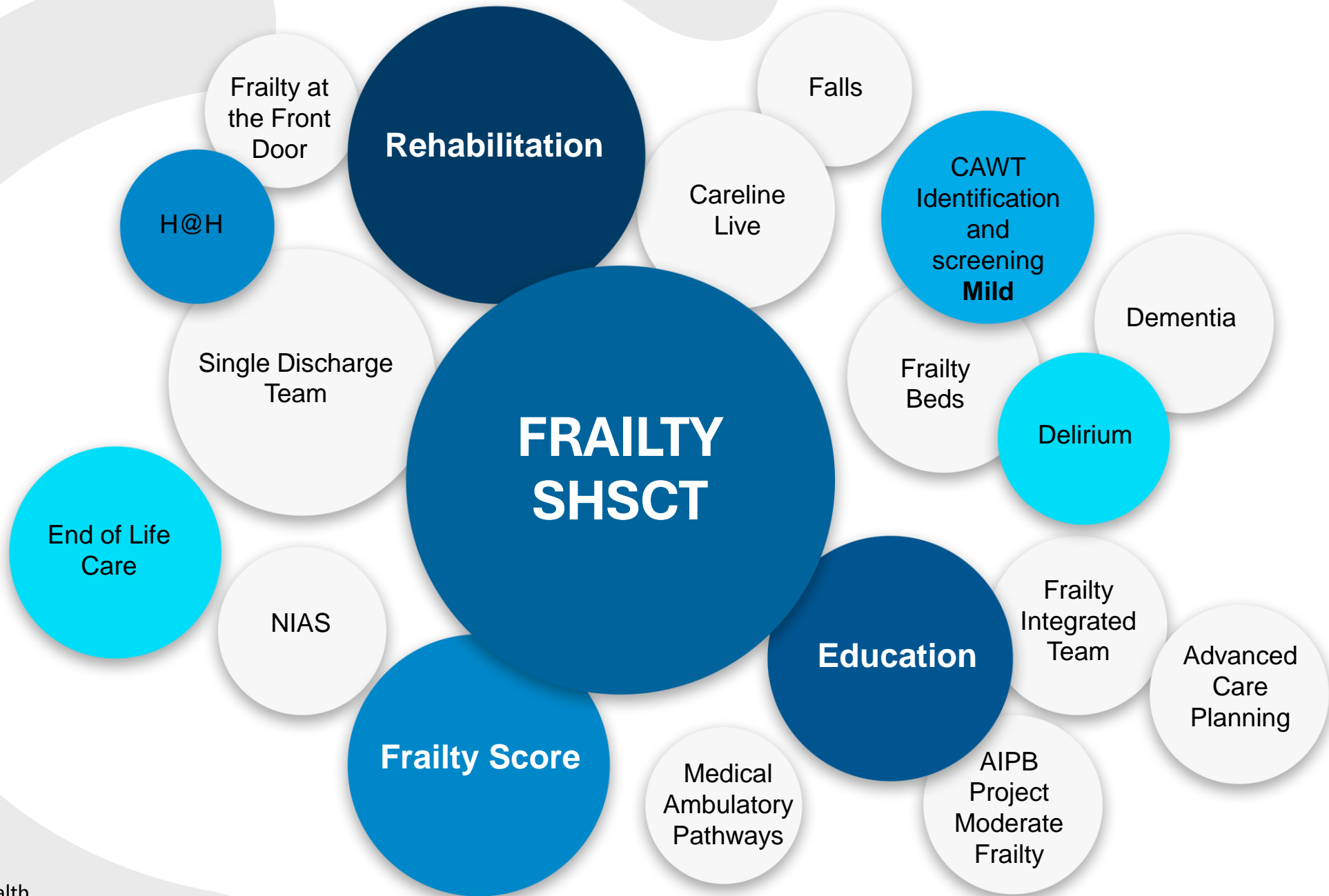
SHSCT Frailty Vision

- Setting up of Frailty Steering Group
- Develop and oversee implementation of a comprehensive frailty strategy
- Ensure systematic identification of frailty across all care settings
- Promote integrated care pathways that support comprehensive geriatric assessment and personalised care planning.
- Facilitate collaboration between primary care, secondary care, community services.
- Promote staff education and training in frailty recognition and management
- Support research and innovation in frailty prevention and management.
- Advocate for resources and funding to support frailty initiatives



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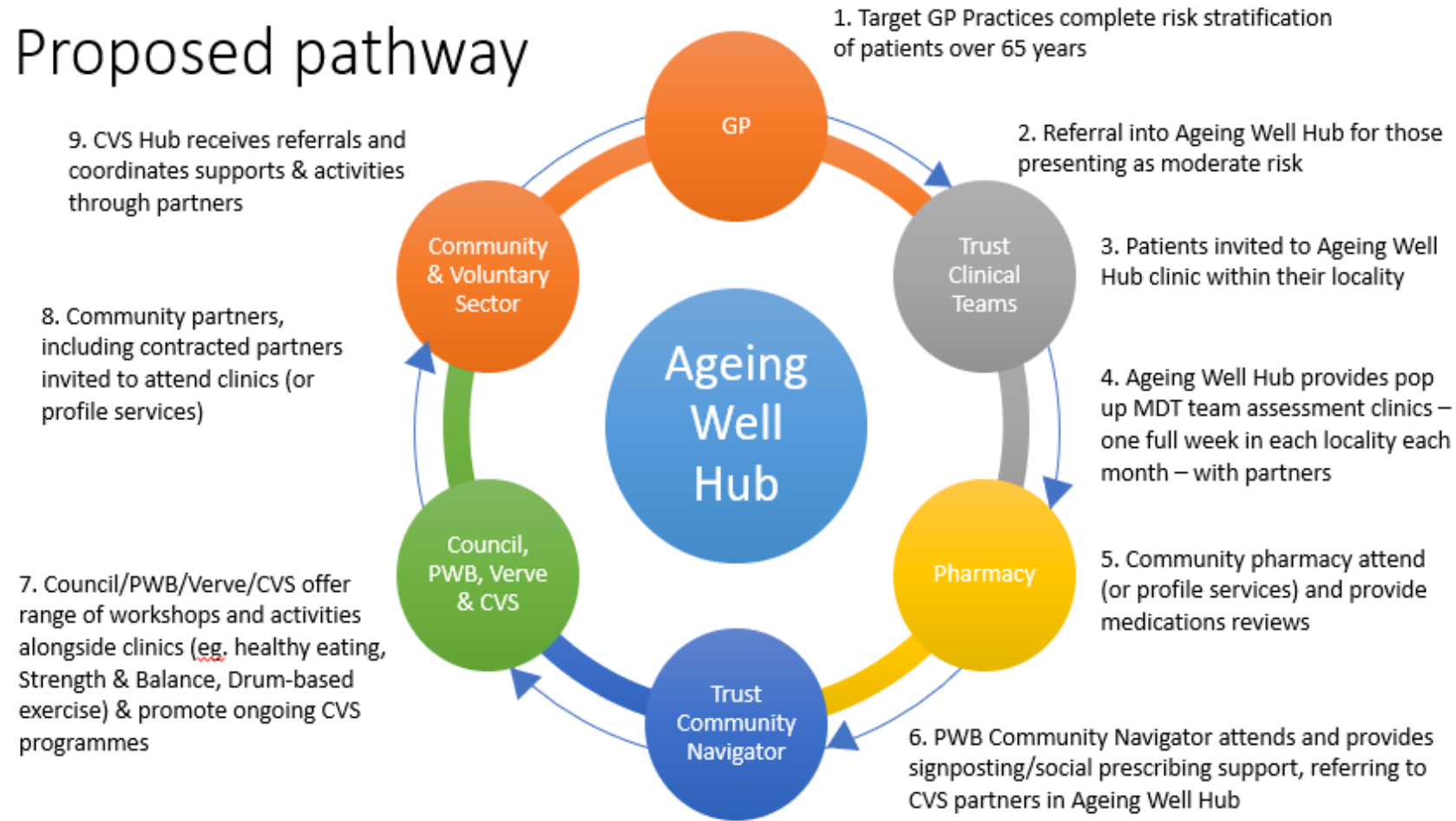
CAWT Frailty Programme

The main outputs from the project will be:

- 8,300 older people across the border region between NI and RoI will be provided with community/homebased Early Intervention episodes of care such as:
 - screening for frailty and/or
 - frailty education sessions and/or
 - onward referral to health practitioner and/or
 - monitoring by telephone or other device if deemed necessary
 - onward referral for community social prescribing, exercise, etc...
- 2075 beneficiaries in SHSCT.

AIPB Frailty Project

Proposed pathway



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Trust Service Improvements

Community

- Core Physiotherapy
- Reablement
- Intermediate Care
- Single Discharge Team
- Day Hospitals
- Rapid Access Clinics
- Hospital at Home
- Frailty at the Front Door
- Frailty Hub
- Hospital at Home

Bed Based Care

- Non-Acute Hospitals
- Frailty Wards

Issues

- Older people with frailty are in all settings.
- Need to streamline processes.
- Consolidate current resources e.g. falls, rapid access, geriatric outpatient clinics to create frailty hubs.

Next Steps

- Continued focus on Frailty.
- Community First approaches supported.
- Effective use of resources across services/Directorates.
- Communication Engagement Plan across Primary, Community and Voluntary, Secondary Care and our Public.