East Suffolk and North Essex NHS Foundation Trust

Supporting our population living with Frailty

Dr Selina Lim

Renée Ward

North East Essex and Suffolk's population is ageing

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- 1 in 5 of our population are currently aged 65 or older, and this is set to rise to closer to 1 in 3 by 2033
- 75% of 75-year-olds in the UK have more than one Long Term Condition, rising to 82% of 85-year olds
- the number of "oldest old" (over 85) has doubled in the past decade
- the percentage of people dying before 65 has remained constant for the past 20 years
- the number people living in Suffolk and North East Essex aged 85+ is set to increase by 39% in the next ten years (compared with 33% for England).
- there are 84 care homes across Ipswich and east Suffolk, providing 3604 bed places

What is frailty?

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Different people use the term frailty and frail to mean slightly different things

Frailty is now a recognised medical condition defined as a clinically recognised state of increased vulnerability among older adults

It is associated with a decline in an individual's physical and psychological reserves

In other words, a frail person is no longer to cope as well as they used to be able to

- e.g. they can't put the bins out on their own
- Or they can't change a duvet cover on their own

What is frailty?

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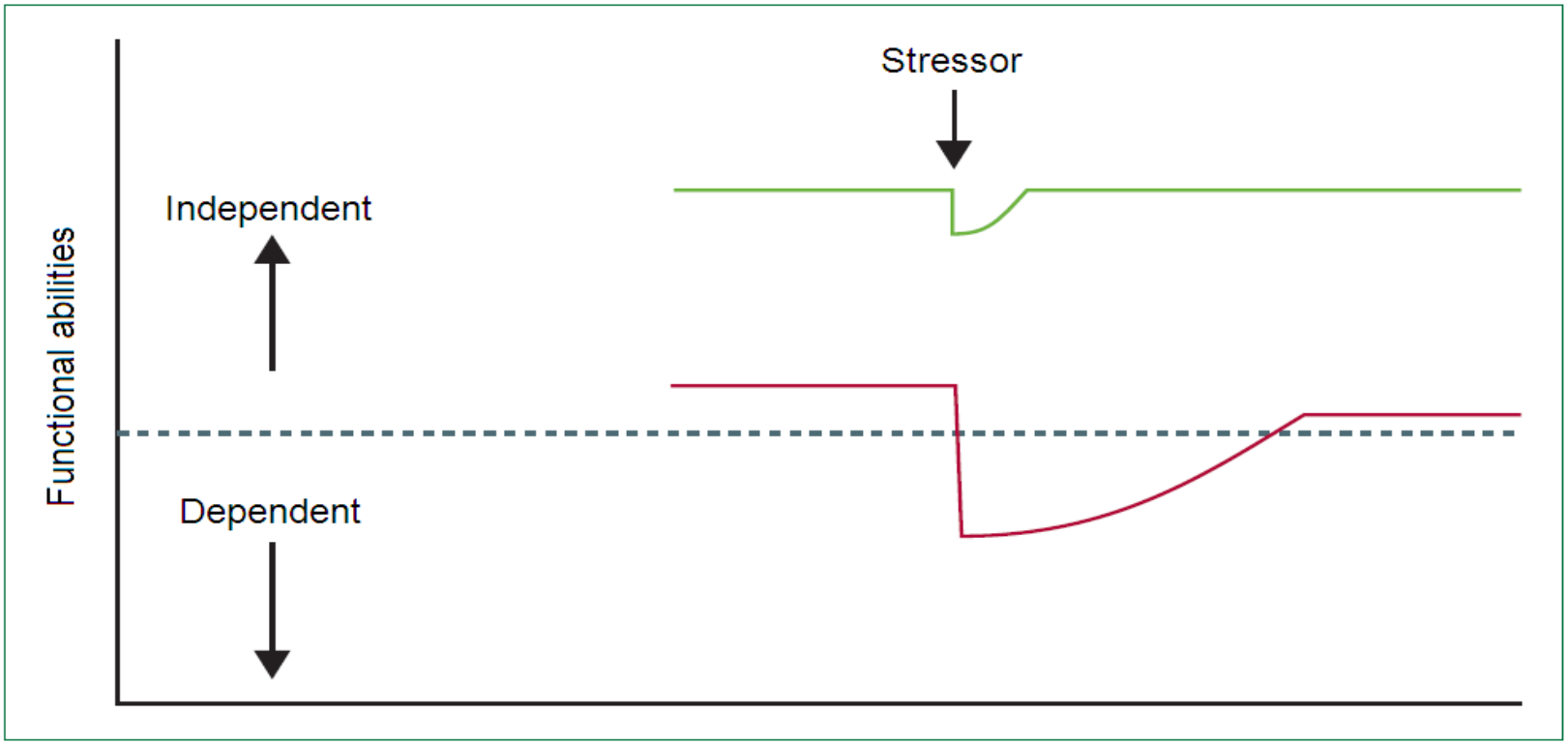

Green line – someone not frail who quickly bounces back from a stress event e.g. infection
Red line – someone with frailty who may become dependent as the result of loss of function due to a stress event, and who takes longer to recover, and may not return to their previous level of function. Eventually, they may no longer be able to cope at home independently.

Common problems in frailty which need to be addressed to reduce severity and improve outcomes:

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Falls *
Cognitive impairment
Continence *
Mobility *
Weight loss and poor nutrition
Polypharmacy *
Physical inactivity
Low mood
Alcohol excess
Smoking
Visual problems
Social isolation and loneliness

How many people are frail?

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In England, 1.8m people more than 60yrs old and 0.8M people more than 80 years old who live with frailty

93% of frail people have **mobility problems**

63% need a **walking aid**

71% of frail people **receive help**

Why is Frailty important ?

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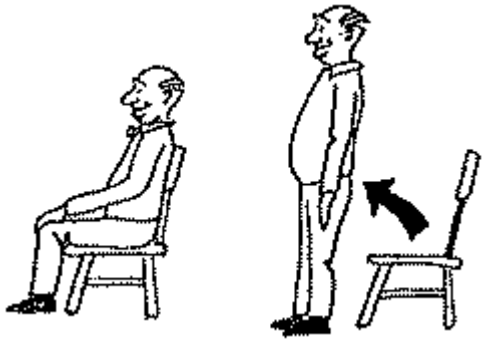
50% of long hospital stays can be the result of deconditioning
48% of people over 85 die within one year of hospital admission[2]
15% of women >75 years need maximum power to STS
10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80



How do we recognise frailty ?

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Rockwood Clinical frailty score

Widely recognised scoring system devised by Ken Rockwood and his team that means we are using the same definitions to define if someone is not frail, or who has mild, moderate or severe frailty

Free to use frailty app launched by NHS elect and acute frailty network is available on British Geriatric Society website

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CLINICAL FRAILTY SCALE

	1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT	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**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.
	4	LIVING WITH VERY MILD FRAILTY	Previously "vulnerable," this category marks early transition from complete independence. 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	LIVING WITH MILD FRAILTY	People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	6	LIVING WITH MODERATE FRAILTY	People who 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	LIVING WITH SEVERE FRAILTY	**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	LIVING WITH VERY SEVERE FRAILTY	Completely dependent for personal care and approaching 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 living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally 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.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

Frailty syndromes. Clusters of symptoms and signs that might prompt you to think someone is frail

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- Falls (e.g. collapse, legs give way, found lying on the floor)
- Immobility (e.g. sudden change in mobility, gone off legs, stuck on toilet)
- Delirium (e.g. acute confusion, worsening of pre-existing confusion/short-term memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants)

Ipswich and east Suffolk Frailty Framework – Plan on a page

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Vision Statement

In Ipswich and east Suffolk people with frailty live independently in their own homes for as long as possible, have a good quality of life and are empowered to take control of their own well-being, and have the tools and techniques to pro-actively manage their own care.

Our AIM

Alliance partners with service users to work collaboratively to co-produce and implement a frailty framework for Ipswich and East Suffolk that will facilitate the prevention of frailty, the identification of people with frailty and their needs, the support for people with frailty, their carers and for people in services providing care to them and education and training for people with frailty, their carers and for people in services providing care to them.

Frailty Pillars

Prevention	***Recognition of Frailty & needs***	***Support & Intervention***	***Education, Training of Individuals, Carer & Service Provider level***
Individuals & Carers	Individuals & Carers	Individuals & Carers	Individuals & Carers
Provider	Provider	Provider	Provider

Ipswich and east Suffolk Frailty Framework - Outcomes

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The Frailty Steering Board have identified the following outcomes for our population, but it will be expected that the INTs will develop their own indicators and measures of success, depending on the needs of their own population:

1) The best quality of life and to live well as we grow older
2) People are able to maintain their independence and supporting those who care for them
3) Supporting those who care for older people
4) Reduce the impact of frailty on the lives of older people in Suffolk
5) Provide a co-ordinated response to the challenges of dementia and depression in older people
6) Ensure that older people living in the community who have a known history of recurrent falls are referred for strength and balance training
7) Ensure Suffolk residents are supported at end of life
8) Patient and carer's should receive better care outcomes and improved care experiences, (will this be evidenced through their own self-reported measures of improvement?)
9) For people to only tell their story once
10) Improved MDT working between community and primary care professionals and reducing barriers between sectors, such information sharing and shared care arrangements

Services that support people living with Frailty in NEE

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- C015
- Community at the Front Door
- Virtual Wards
- UCRS
- Community Clinics
- Community nursing team

Future Services that support people living with Frailty in NEE

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- Integrated neighboured teams
- Locality Clinics based on ED data
- Proactive UTC model

Services that support people living with Frailty in I&ES

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- UCRS/REACT including CLERIC work, CHESS and work with St Elizabeth hospice and DIST
- FAB/frailty at the front door/virtual frailty ward
- GLINT
- Integrated neighbourhood teams
- Community matrons

Future Services that support people living with Frailty in NEE

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- INT local delivery plans
- Anticipatory care
- Proactive UTC model
- Training delivered to primary care and other providers

ESNEFT Community Health Services Medium Term Plan

‘Supporting adults and children to Live Well in their homes and communities’ 2023-25

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Be more preventative and enabling
Early identification of frailty and ensuring community workforce able to identify frailty
Work in integrated neighbourhoods and with PCNs that promote health ageing and the proactive support of people at risk or living with frailty.
Ensuring that community services provide equitable access helping to address health inequalities
Embedding the 'making every contact count' programme in our community services.

So what does this all mean?

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- Need to agree a common language around frailty
- Need to agree a common approach especially around early identification (so we can reverse, if possible , and ensure that we offer the right support)
- Everyone's problem and…..
- Everyone is part of the solution

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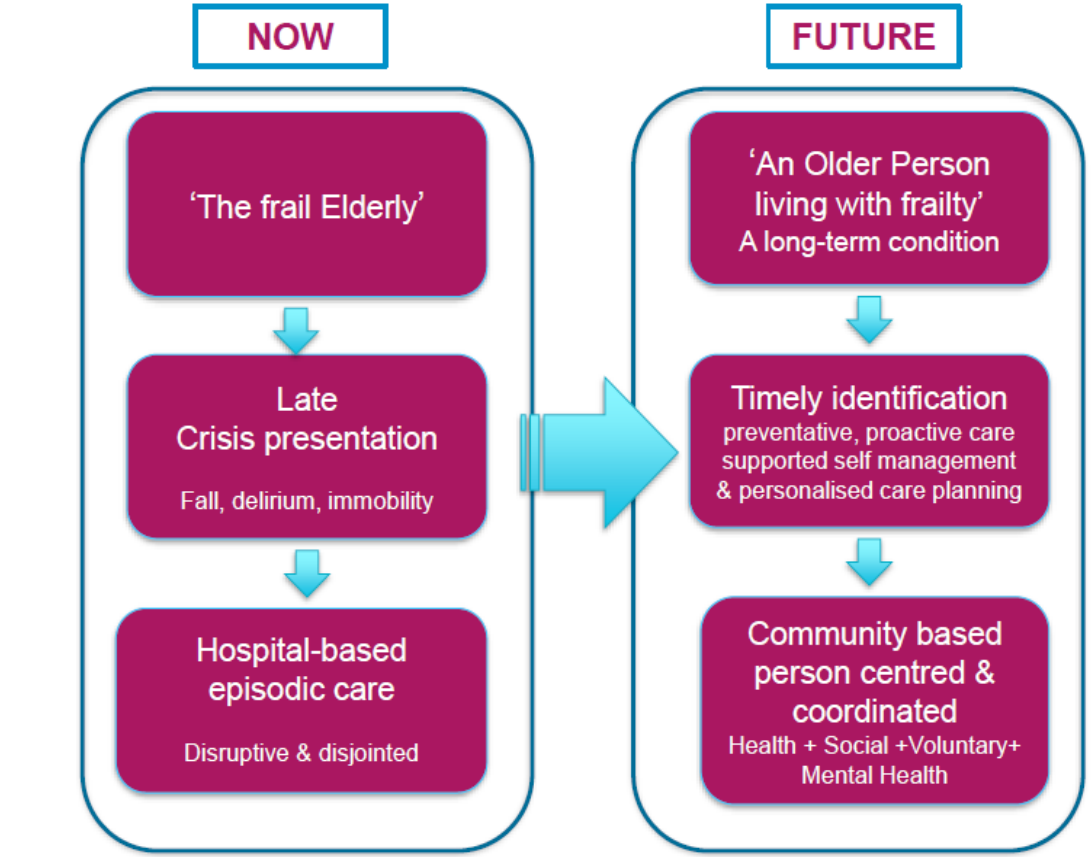
Frailty as a Long Term Condition



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