Frailty and P&EOLC

Care Homes and Community

15th Feb 2023

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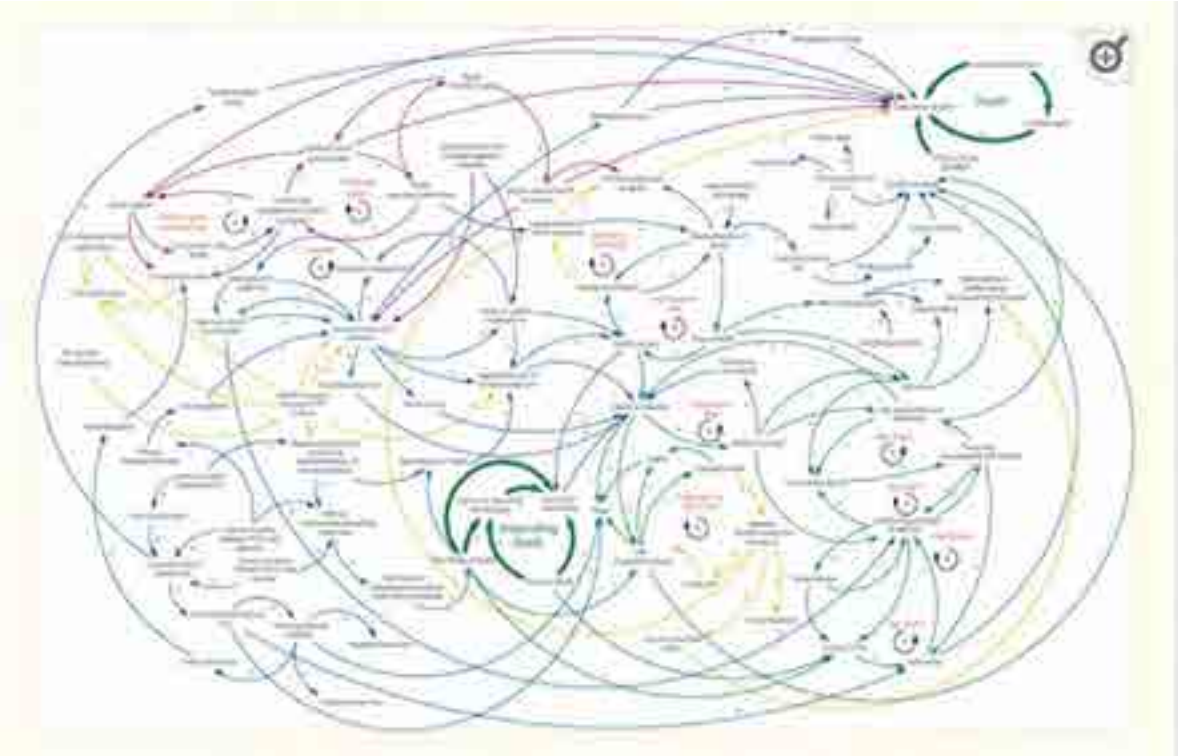
How well would our systems and processes support Betty…?

96 years old lives independently alone at home
Retired nurse
Hypertension IHD AF TIA CKD DMT2 COPD Osteoporosis
Polypharmacy
Falls Mobility Issues
Cognitive Impairment
WHO Performance Status 3
Metastatic Breast Cancer with liver and bony metastases

Emergency Call
Paramedics on scene at 2 am
Fall, mobility issues and new onset back pain
Refusing to go to hospital
No TEP/ReSPECT or DNAR
What matters to her..?
What are the likely outcomes..?

Report of the Lancet Commission on the Value of Death: bringing death back into life

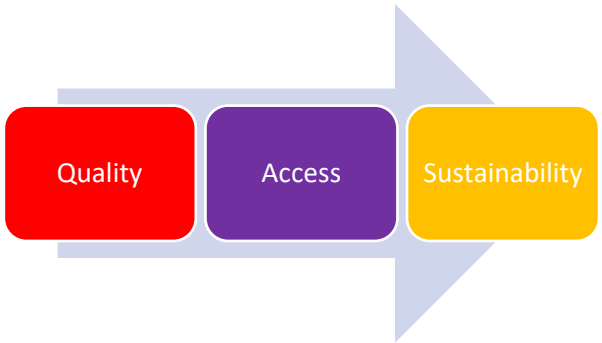
Frailty and P&EOLC GP Perspectives and Aims

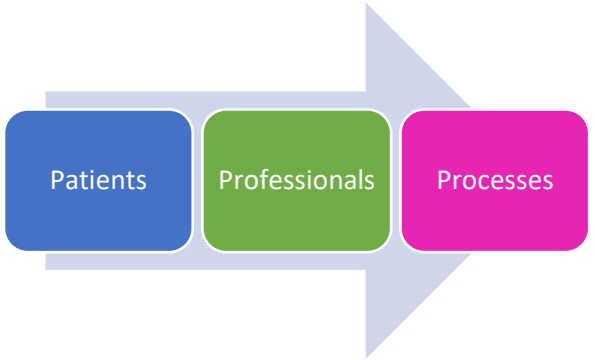


- Personal
- Patients
- Professionals
- Processes
- Population
- ART of the Possible …Pandemic Pragmatism to Prevail?

P&EOLC Ambitions

Personalised care planning	Shared records
Education and training	24/7 access
Evidence and information	Involving, supporting and caring for those important to the dying person
Co-design	Leadership

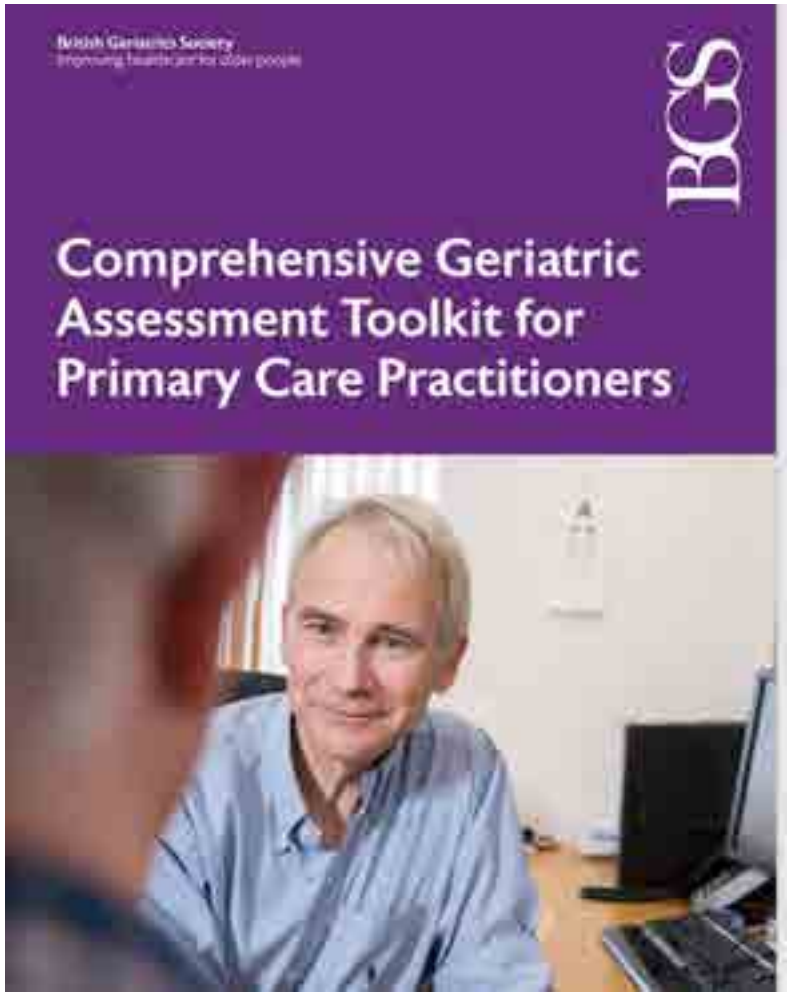




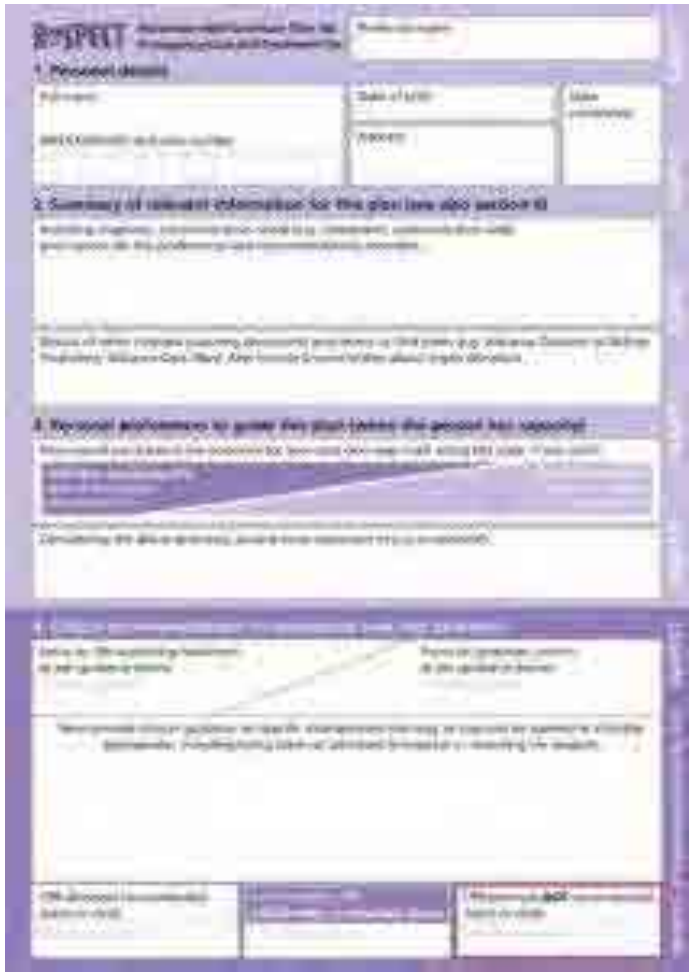
ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

ReSPECT | Resuscitation Council UK

Two sides of the same coin?



CGA Toolkit for Primary Care Practitioners_0.pdf (bgs.org.uk)



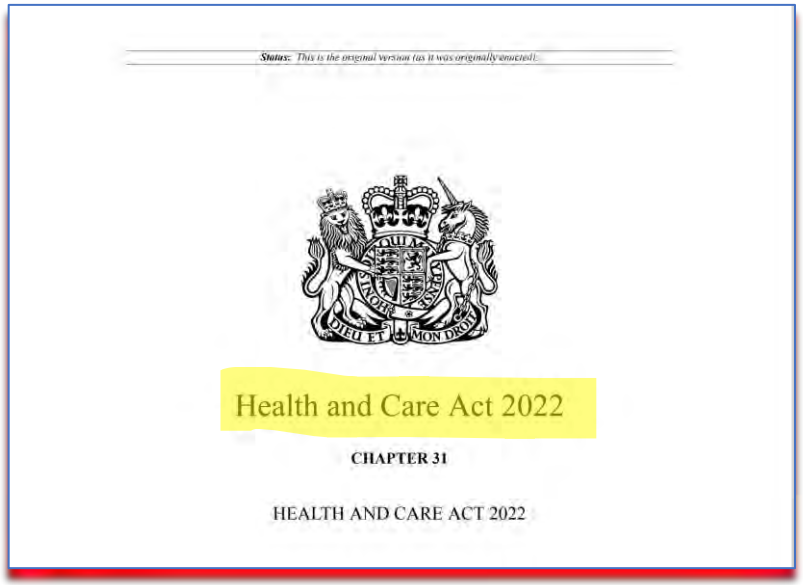
ReSPECT | Resuscitation Council UK

Philosophy of Partnership…


The Lancet Commissions

Report of the Lancet Commission on the Value of Death: bringing death back into life


Letter from the 42 Integrated Care System CEO-designates to CEO NHS England



Next steps for integrating primary care: Fuller Stocktake report

Commissioned by NHS England and NHS Improvement from Dr Claire Fuller, CEO (designate) Surrey Heartlands ICS

MAY 2022

Our vision for integrated primary care

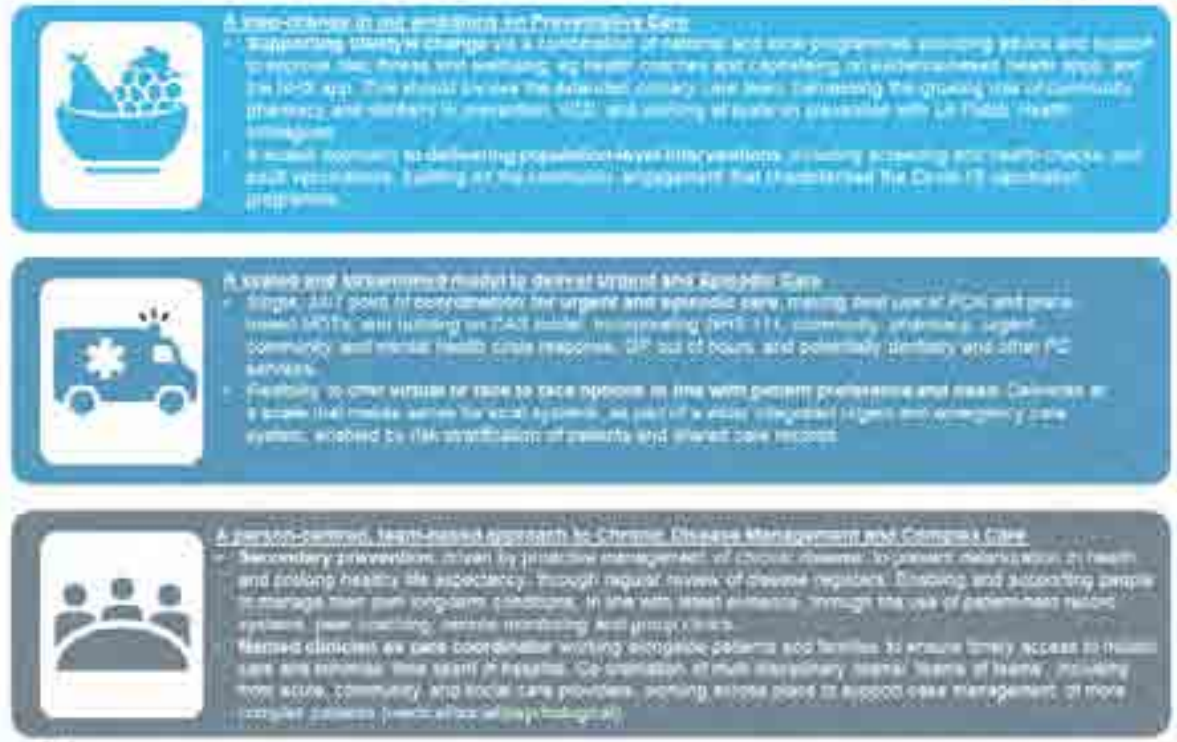
Individual access: for people and carers to professional support
Individual Primary Care Providers and sites such as GP Practices will continue to play a critical role in providing ongoing support for individuals and their families.

PCNs as part of Neighbourhood Care Teams
Delivering integrated primary care via multidisciplinary Neighbourhood Care Teams, with a focus on providing holistic care and working closely with local people and communities in order to improve health outcomes and address the wider determinants of health

Partnership working at place
Delivering scaled approach to population-level primary prevention and care alongside key system partners, including outside of the health and care system, focusing on system-wide pressure points such as admission avoidance, patient discharge and flow.

Creating the conditions for success
establishing an enabling leadership culture and ways of working, as well as the practical infrastructure and support to implement the vision, including through estates, workforce, data, digital and funding initiatives.

The three functions of primary care



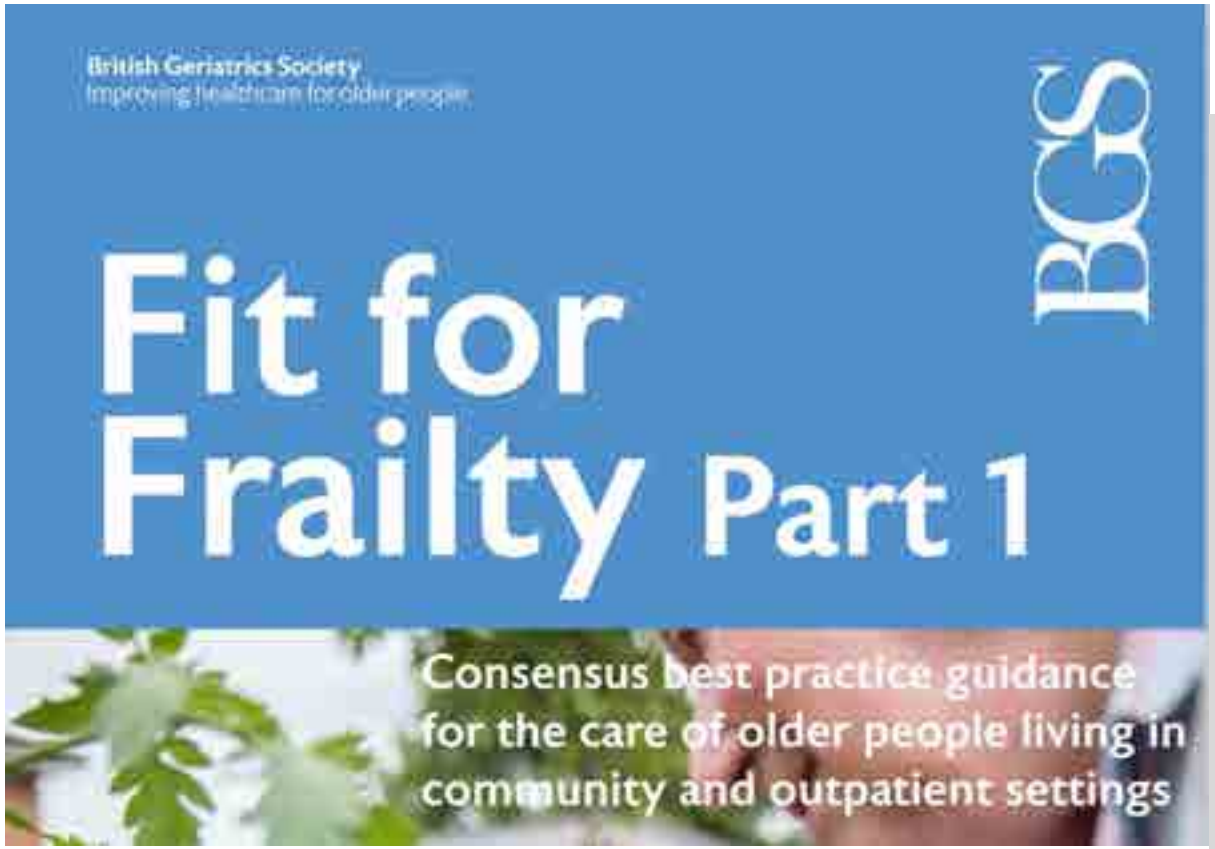
[Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)]

Betty @ 3 pm/am…

- Primary Care
- Community Care
- Acute & Secondary Care
- Ambulance Services & OOH
- Hospices & 3rd Care Sector

David Oliver | The King's Fund (kingsfund.org.uk)

PowerPoint Presentation (wao.gov.uk)



Full list of BGS recommendations for the recognition and management of frailty in community and outpatient settings

- Older people should be assessed for the presence of frailty during all encounters with health and social care professionals. Gait speed, the timed-up-and-go test and the PRISMA questionnaire are recommended assessments.
- Provide training in frailty recognition to all health and social care staff.
- Do not offer routine population screening for frailty.
- Look for a cause if an older person with frailty shows decline in their function.
- Carry out a comprehensive review of medical, functional, psychological and social needs based on the principles of comprehensive geriatric assessment.
- Ensure that reversible medical conditions are considered and addressed.
- Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control.
- Consider referral to old age psychiatry for those people with frailty and complex co-existing psychiatric problems, including challenging behaviour in dementia.
- Conduct evidence-based medication reviews for older people with frailty (e.g. STOPP/START criteria).
- Use clinical judgment and personalised goals when deciding how to apply disease-based clinical guidelines to the management of older people with frailty.
- Generate a personalised shared care and support plan (CSP) outlining treatment goals, management plans and plans for urgent care. In some cases it may be appropriate to include an end of life care plan.
- Where an older person has been identified as having frailty, establish systems to share health record information (including the CSP) between primary care, emergency services, secondary care and social services.
- Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Wherever the patient is managed, there must be adequate diagnostic facilities to determine the cause of the change in function. Ensure that the pathways build in a timely response to urgent need.
- Recognise that many older people with frailty in crisis will manage better in the home environment but only with appropriate support systems.

[Frailty Hub: Introduction to frailty | British Geriatrics Society (bgs.org.uk)]

What is frailty?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years.

Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication.

Please beware..!

- The language and management of frailty can act as barriers to engaging with older people who may not perceive themselves, or wish to be defined, by a term that is often associated with increased vulnerability and dependency.

Background - causes and prevention of frailty

There are two broad models of frailty

- **Phenotype model**-describes a group of patient characteristics (unintentional weight loss, reduced muscle strength, reduced gait speed, self-reported exhaustion and low energy expenditure) which, if present, can predict poorer outcomes. Generally individuals with three or more of the characteristics are said to have frailty (although this model also allows for the possibility of fewer characteristics being present and thus pre-frailty is possible).
- A central feature of physical frailty, as defined by the phenotype model is **loss of skeletal muscle function (sarcopenia)** and there is a growing body of evidence documenting the major causes of this process. The strongest risk factor is age and prevalence clearly rises with age.

- **Cumulative Deficit model-**Described by Rockwood in Canada, it assumes an accumulation of deficits (ranging from symptoms e.g. loss of hearing or low mood, through signs such as tremor, through to various diseases such as dementia) which can occur with ageing and which combine to increase the 'frailty index' which in turn will increase the risk of an adverse outcome.
- Rockwood also proposed a clinical frailty scale for use after a comprehensive assessment of an older person; this implies an increasing level of frailty which is more in keeping with experience of clinical practice.

Modifiable influences

- **Physical activity** particularly resistance exercise, which is beneficial both in terms of preventing and treating the physical performance component of frailty.
- **Diet** is less extensive but a suboptimal protein/total calorie intake and vitamin D insufficiency have both been implicated
- Emerging evidence that frailty increases in the presence of **obesity** particularly in the context of other unhealthy behaviours such as inactivity, a poor diet and **smoking.**

Recognising and identifying frailty in individuals

Recommendations

- Older people should be assessed for the possible presence of frailty during all encounters with health and social care professionals. Slow gait speed, the PRISMA questionnaire, the timed-up-and-go test are recommended as reasonable assessments. The Edmonton Frail Scale is recommended in elective surgical settings.
- Provide training in frailty recognition to all health and social care staff who are likely to encounter older people.
- Do not offer routine population screening for frailty.

Why do we need to identify frailty?

- The central problem with frailty is the potential for serious adverse outcomes after a seemingly minor stressor event or change.
- It is important to remember however, that:
- Frailty varies in severity (individuals should not be labelled as being frail or not frail but simply that they have frailty
- The frailty state for an individual is not static; it can be made better and worse.
- Frailty is not an inevitable part of ageing; it is a long term condition in the same sense that diabetes or Alzheimer's disease is.

In what circumstances does it help to understand that the patient has frailty

- Any interaction between an older person and a health or social care professional should include an assessment which helps to identify if the individual has frailty.

How can we recognise frailty in an individual?

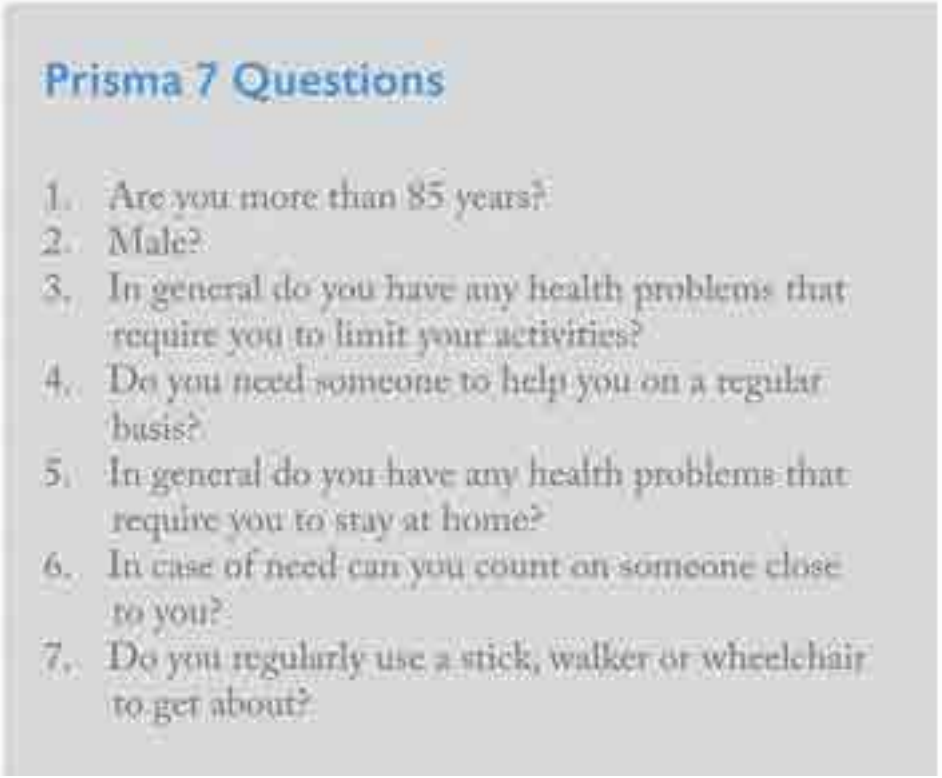
(could also present in a crisis situation)

Table 1: Frailty syndromes

1. Falls (e.g. collapse, legs gave way, 'found lying on floor').
2. Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck in toilet').
3. Delirium (e.g. acute confusion, 'muddledness', sudden worsening of confusion in someone with previous dementia or known memory loss).
4. Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).
5. Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

Recognising frailty in a more routine situation

- PRISMA 7 Questionnaire - which is a seven item questionnaire to identify disability that has been used in earlier frailty studies and is also suitable for postal completion. A score of > 3 is considered to identify frailty



Prisma 7 Questions

1. Are you more than 85 years?
2. Male?
3. In general do you have any health problems that require you to limit your activities?
4. Do you need someone to help you on a regular basis?
5. In general do you have any health problems that require you to stay at home?
6. In case of need can you count on someone close to you?
7. Do you regularly use a stick, walker or wheelchair to get about?

Recognising frailty in a more routine situation

- **Walking speed (gait speed)** - Gait speed is usually measured in m/s and has been recorded over distances ranging from 2.4m to 6m in research studies. In this study, gait speed was recorded over a 4m distance.
- **Timed up and go test - The TUGT measures**, in seconds, the time taken to stand up from a standard chair, walk a distance of 3 metres, turn, walk back to the chair and sit down.
- **Self-Reported Health** - which was assessed, in the study examined, with the question 'How would you rate your health on a scale of 0-10'. A cut-off of < 6 was used to identify frailty.
- **GP assessment** - whereby a GP assessed participants as frail or not frail on the basis of a clinical assessment.
- **Multiple medications (polypharmacy)** - where frailty is deemed present if the person takes five or more medications.

Recognising frailty in a more routine situation

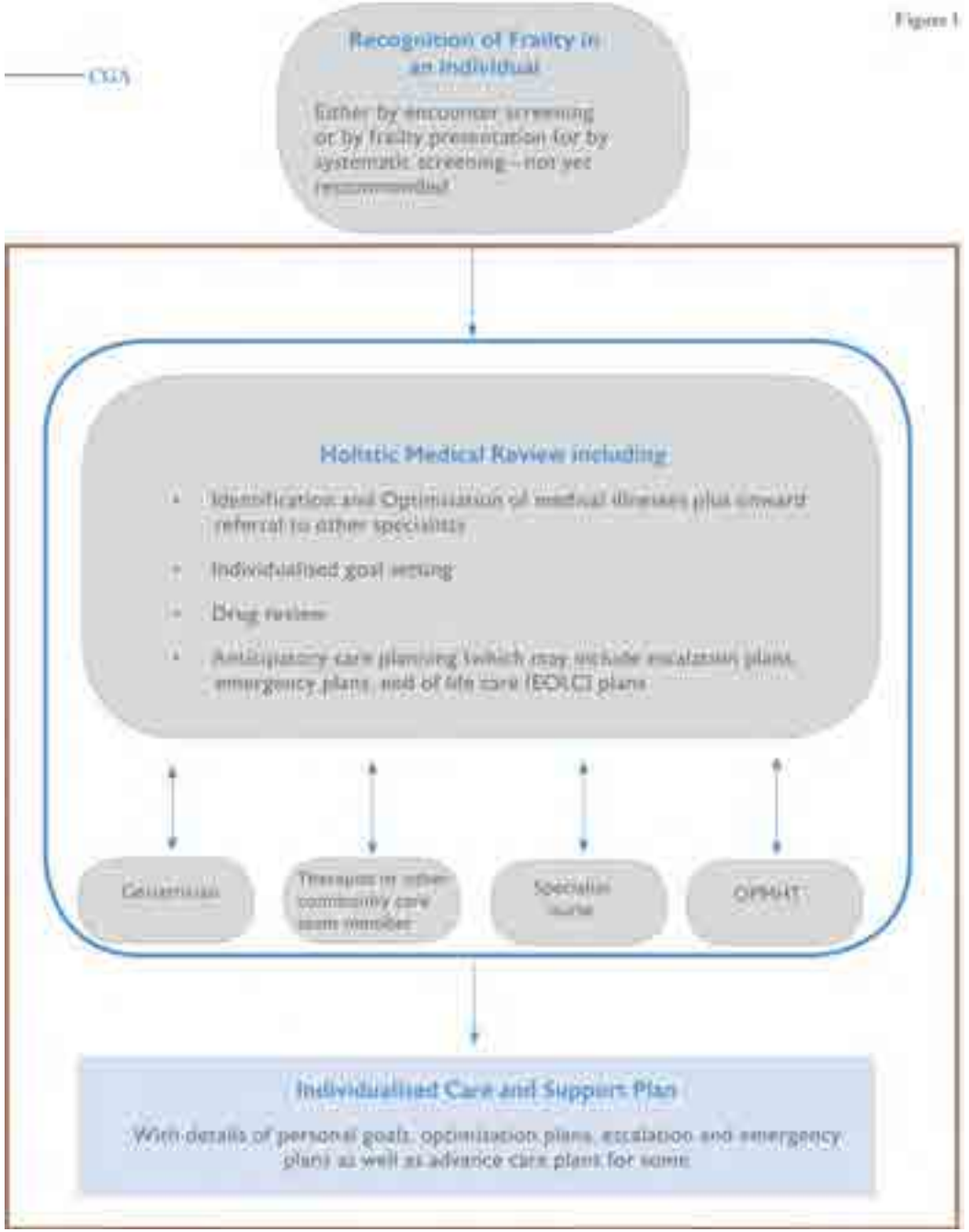
- **The Groningen Frailty Indicator questionnaire** - which is a 15 item frailty questionnaire that is suitable for postal completion. A score of > 4 indicates the possible presence of moderate-severe frailty
- **Slow walking speed** (less than 0.8m/s or taking more than five secs to walk 4m)
- PRISMA 7 questionnaire and the timed-up-and-go test (with a cut off score of 10 secs) had very good sensitivity but only moderate specificity for identifying frailty.
- This means that there are many fitter older people who will have a positive test result (false positives). For example, only one in 3 older people (over 75 years) with slow walking speed has frailty

Managing frailty in an individual

Recommendations

1. Carry out a comprehensive and holistic review of medical, functional, psychological and social needs based on comprehensive geriatric assessment principles in partnership with older people who have frailty and their carers.
2. Ensure that reversible medical conditions are considered and addressed.
3. Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control. Old age psychiatry should be considered for those with frailty and complex co-existing psychiatric problems including challenging behaviour in dementia.
4. Conduct personalised medication reviews for older people with frailty, taking into account number and type of medications, possibly using evidence based criteria (e.g. STOPP START criteria).
5. Use clinical judgement and personalised goals when deciding how to apply disease based clinical guidelines in the management of older people with frailty.
6. Generate a personalised shared care and support plan (CSP) which documents treatment goals, management plans, and plans for urgent care which have been determined in advance. It may also be appropriate for some older people to include end of life care plans.
7. Establish systems to share the health record information (including the CSP) of older people with frailty between primary care, emergency services, secondary care and social services.
8. Ensure that there are robust systems in place to track CSPs and the timetables for review.
9. Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Ensure that the pathways build in a timely response to urgent need.
10. Recognise that many older people with frailty in crisis will manage better in the home environment but only with support systems which are suitable to fulfil all their health and care needs.

Comprehensive Geriatric Assessment (CGA)



Rockwood Frailty Scale

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 obviously 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 questions/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.

Figure 1.Clinical frailty scale. Adapted with permission from Moorhouse P, Rockwood K. Frailty and its quantitative clinical evaluation R Coll Physicians Edinb. 2012;42:333-340.

[rockwood-frailty-scale .pdf (england.nhs.uk)]

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

Falls
Mobility
Polypharmacy
Alcohol excess
Social isolation and loneliness
Cognitive Impairment
Weight loss/nutrition
Physical inactivity
Vision problems
Continence
Low mood
Smoking

Assessment of Capacity

- The principles of the Adults with Incapacity (Scotland) 2000 and Mental Capacity Act (England and Wales) 2005 are:
- Assume Capacity
- Help people to have capacity in all practical ways before deciding they do not have capacity
- People are entitled to make unwise decisions
- Decisions for people without capacity should be in their best interest and the least restrictive possible

The 4 point capacity test

- Can they understand the information given?
- Can they retain the information given?
- Can they balance, weigh up or use the information?
- Can the person communicate their decision?

Assessment and management in an urgent situation

- **Assess clinical condition –** measure vital signs and consider if any red flags are present which suggest the patient needs acute hospital care - such as hypoxia, significant tachycardia or hypotension (if possible compare readings with what is usual for the patient – these should be recorded in the care and support plan).
- **Assess current function-**can they get out of bed, can they walk, have they been able to use the toilet? Is there any evidence of a frailty syndrome – falls, immobility, new onset incontinence?
- **Are they confused** – is this usual (may need help from carers to assess this) or worse than usual? The patient may have delirium even if they have a prior dementia. This would also signal frailty

Conclusion

- Many older people live with frailty and its prevalence increases with age.
- Frailty means that an individual is at greater risk of an adverse outcome after a minor change in their circumstances or health and it is important therefore that health and social care staff recognise it.
- Once recognised, the best management strategy for frailty is comprehensive geriatric assessment.
- Each individual living with frailty should have their own care and support plan which should be made available to other health and social care professionals with whom the individual interacts.

What matters...?

Measuring quality of life

Is quality of life determined by expectations or experience?

Alison J Carr, Barry Gibson, Peter G Robinson

This is the first in a series of five articles

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The way we think about health and health care is changing. The two factors driving this change are the recognition of the importance of the social consequences of disease and the acknowledgement that medical interventions aim to increase the length and quality of survival. For these reasons, the quality, effectiveness, and efficiency of health care are often evaluated by their impact on a patient's "quality of life."

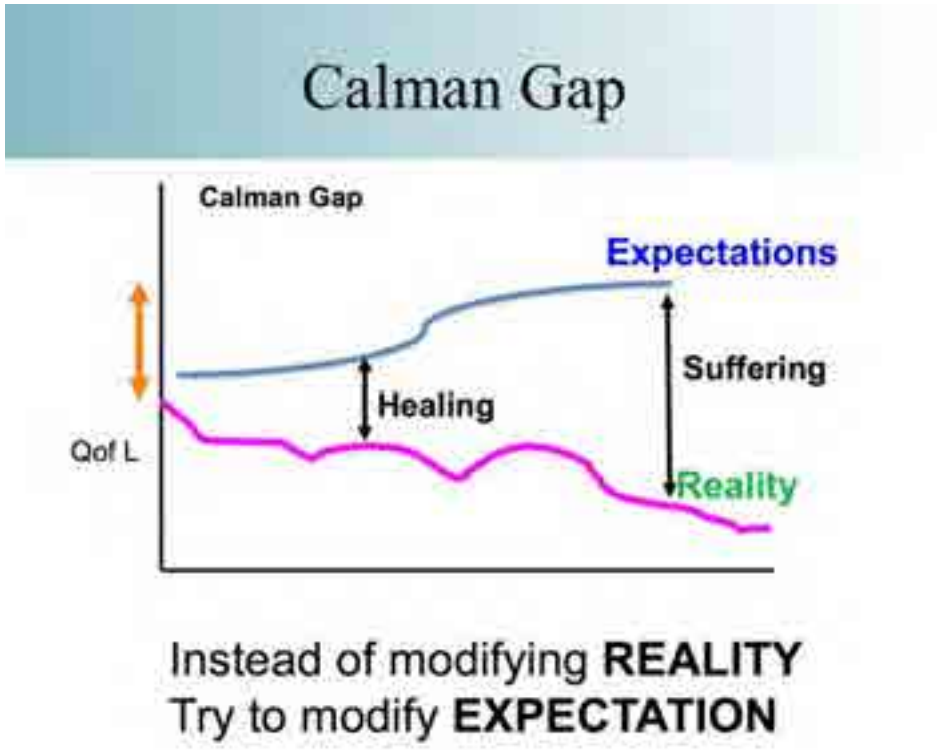
There is no consensus on the definition of quality of life as it is affected by health (health related quality of life). Definitions range from those with a holistic emphasis on the social, emotional, and physical well-being of patients after treatment[1] to those that describe the impact of a person's health on his or her ability to lead a fulfilling life.[2] This article assumes it to be those aspects of an individual's subjective experience that relate both directly and indirectly to health, disease, disability, and impairment. The central concern of this paper is the tendency to regard the quality of life as a construct. We contend that perceptions of health and its meaning vary between individuals and within an individual over time. People assess their health related quality of life by comparing their expectations with their experience. We propose a model of the relation between expectations and experience and use it to illustrate problems in measuring quality of life. The implications of these concepts for the use of quality of life as an indication of the need for treatment and as an outcome of care are discussed.

Summary points

- Health related quality of life is the gap between our expectations of health and our experience of it
- Perception of quality of life varies between individuals and is dynamic within them
- People with different expectations will report that they have a different quality of life even when they have the same clinical condition
- People whose health has changed may report the same level of quality of life when measures are repeated
- Current measures do not take account of expectations and cannot distinguish between changes in the experience of disease and changes in expectations of health

measures of quality of life) may highlight ways in which it can be maximised.

A primary aim of treatment, particularly in chronic disease, is to enhance the quality of life by reducing the impact of the disease. Yet patients with severe disease do not necessarily report having a poor quality of life.[3] Therefore the relation between symptoms and quality



British Medical Journal (nih.gov)

Development and validation of an electronic frailty index using routine primary care electronic health record data

Andrew Clegg, Chris Bates, John Young, Ronan Ryan, Linda Nichols, Elizabeth Ann Teale, Mohammed A. Mohammed, John Parry, Tom Marshall

People living with severe frailty comprise around 3% of the population aged 65 and older in England.
For moderate frailty it is 12% of those aged 65 and older and 35% for mild frailty
(ref: Validation of the electronic Frailty Index).

These individuals are frequent users of services across health and social care and are particularly vulnerable to adverse outcomes, in particular health outcomes such as unplanned admissions to hospital, care home admission, acquisition of new disability or death. However there is evidence that for some of this group, these adverse outcomes could be avoided through proactive case finding, timely comprehensive assessment, care planning and targeted proactive use of services outside of hospital (Mytton et al, 2012).

Conclusions: *the eFI uses routine data to identify older people with mild, moderate and severe frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission. Routine implementation of the eFI could enable delivery of evidence-based interventions to improve outcomes for this vulnerable group.*

https://doi.org/10.1093/ageing/afw039

Practices who have access to the eFI in the electronic patient records system should use this to stratify their population aged 65 and over by degree of frailty into those who are fit (not frail) and those who are living with mild, moderate or severe frailty.

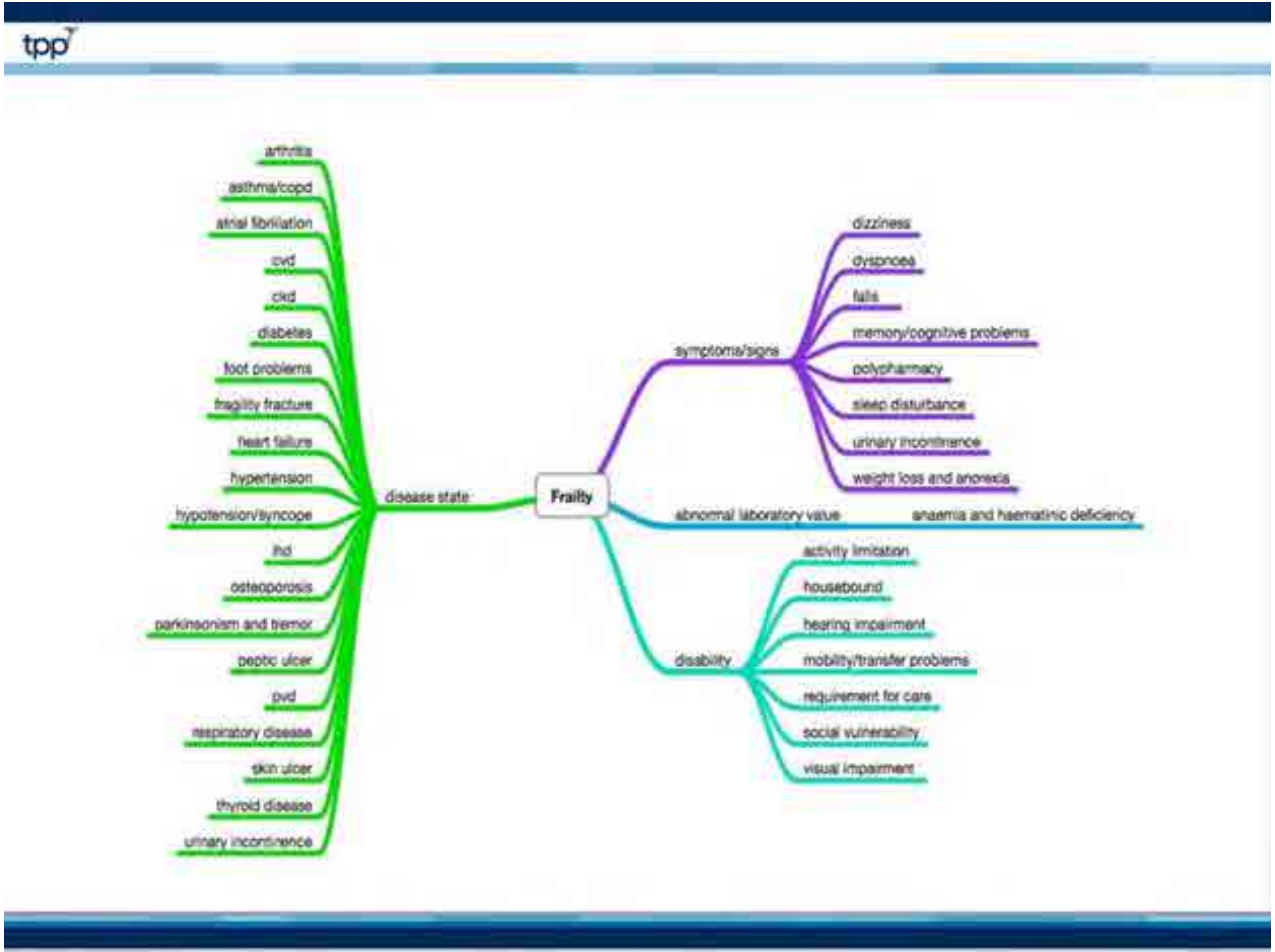
For those patients in the moderate and severe groups, a clinician from the primary care team should verify the frailty diagnosis by direct assessment using the Clinical Frailty Scale (CFS) or similar validated tool.

For patients who are living with mild frailty this equates to a CFS score of 4 to 5.
For patients who are living with moderate frailty this equates to a CFS score of 6.
For patients who are living with severe frailty this equates to a CFS score of 7 or above.

Patients living with moderate and severe frailty should have their frailty diagnosis coded in their electronic health record system. Individual practices may choose to do this verification systematically or opportunistically, for example by using the CFS at every consultation for patients aged 65 years and over for whom the eFI has identified moderate or severe frailty.

toolkit-general-practice-frailty-1.pdf (england.nhs.uk)

[Integrated healthcare IT for better care (kingsfund.org.uk)](https://www.kingsfund.org.uk)



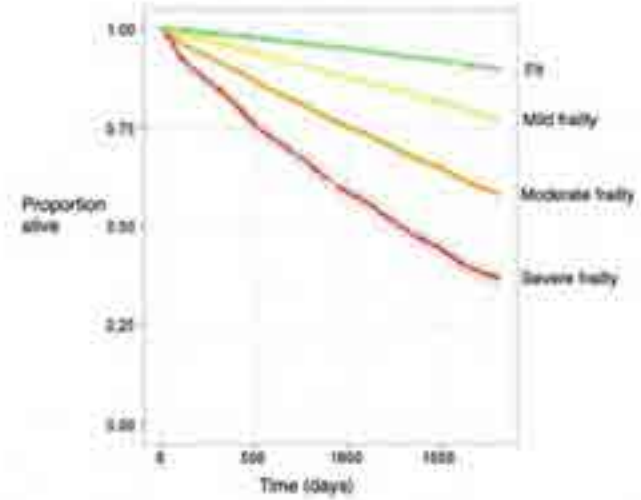


Figure 1. Five-year Kaplan–Meier survival curve for the outcome of mortality for categories of fit, mild frailty, moderate frailty and severe frailty (internal validation cohort).

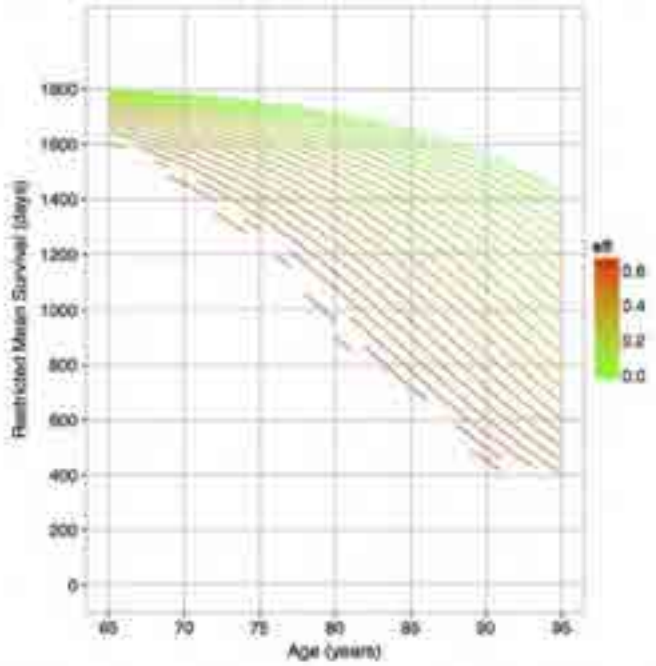


Figure 2. Relationship between age, electronic frailty index score and mortality (internal validation cohort).

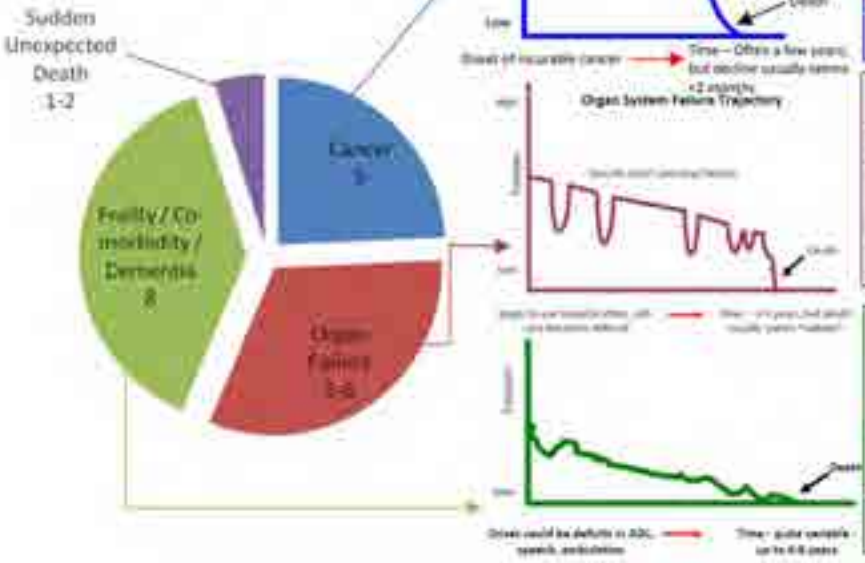
The Trajectories…

[Prognostic Indicator Guidance October 2011.pdf (goldstandardsframework.org.uk)]

Three triggers that suggest that patients are nearing the end of life are:

1. **The Surprise Question: 'Would you be surprised if this patient were to die in the next few months, weeks, days'?**
2. **General indicators of decline - deterioration, increasing need or choice for no further active care.**
3. **Specific clinical indicators related to certain conditions.**

Average GP's workload – average 20 deaths/GP/year approx. proportions



Typical Case Histories

1) Mrs A - A 69 year old woman with cancer of the lung and known liver secondaries, with increasing breathlessness, fatigue and decreasing mobility. Concern about other metastases. Likely rapid decline

2) Mr B – An 84 year old man with heart failure and increasing breathlessness who finds activity increasingly difficult. He had 2 recent crisis hospital admissions and is worried about further admissions and coping alone in future. Decreasing recovery and likely erratic decline

3) Mrs C – A 91 year old lady with COPD, heart failure, osteoarthritis, and increasing signs of dementia, who lives in a care home. Following a fall, she grows less active, eats less, becomes easily confused and has repeated infections. She appears to be 'skating on thin ice'. Difficult to predict but likely slow decline

Prognostic Indicator Guidance (PIG) 4th Edition Oct 2011 © The Gold Standards Framework Centre in End of Life Care CIC, Thomas K et al

The SPICT Tool…

SPICT-4ALL™ – SPICT

Supportive and Palliative Care Indicators Tool (SPICT-4ALL™)

The SPICT™ helps us to look for people who are less well with one or more health problems. These people need more help and care now, and a plan for care in the future. Ask these questions:

Does this person have signs of poor or worsening health?

- Unplanned (emergency) admission(s) to hospital.
- General health is poor or getting worse: the person never quite recovers from being more unwell. (This can mean the person is less able to manage and often stays in bed or in a chair for more than half the day)
- Needs help from others for care due to increasing physical and/ or mental health problems.
- The person's carer needs more help and support.
- Has lost a noticeable amount of weight over the last few months: or stays underweight.
- Has troublesome symptoms most of the time despite good treatment of their health problems.
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Does this person have any of these health problems?

Cancer

Less able to manage usual activities and getting worse.

Not well enough for cancer treatment or treatment is to help with symptoms.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less: difficulty with swallowing.

Has lost control of bladder and bowel.

Not able to communicate by speaking; not responding much to other people.

Frequent falls; fractured hip.

Heart or circulation problems

Heart failure or has had attacks of chest pain. Short of breath when resting, moving or walking a few steps.

Very poor circulation in the legs; surgery is not possible.

Lung problems

Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest is at its best.

Needs to use oxygen for most of the day and night.

Has needed treatment with a breathing machine in the hospital.

Kidney problems

Kidneys are failing and general health is getting poorer.

Stopping kidney dialysis or choosing supportive care instead of starting dialysis.

Liver problems

Worsening liver problems in the past year with complications like:

- fluid building up in the belly
- being confused at times
- kidneys not working well
- infections
- bleeding from the gullet

A liver transplant is not possible.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

What's the cost of an ambulance trip to A&E?

£292

In 2019/20, the average cost of a patient being taken to A&E by ambulance was £292. Ambulance call-outs that didn't result in a trip to A&E cost an average of £206.

What's the cost of going to A&E?

£77-£359

The cost of an individual going to A&E depends on the type of A&E an individual attends – from a major, consultant-led department in a hospital to an urgent care centre or walk-in clinic – and the type of treatment they receive. For someone who attends an urgent care centre and receives the lowest level of investigation and treatment the average cost in 2021/22 is £77. For an individual at a major A&E department who receives more complex investigation and treatment the costs start at £359.

Care element four:

High quality palliative and end-of life, mental health, and dementia care

Individuals who are approaching the end of their life often experience profound physical and emotional changes. Palliative care and end-of-life care is therefore seen as a priority for every care home, and this should address the needs not only of the individual themselves but also of their family, their carers, and their community.

the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)

Quality Outcomes Framework

- **Additional Roles Reimbursement Scheme**
- **Quality and Outcomes Framework**
- **Investment and Impact Fund**
- **Delivering PCN specifications**

[Quality and Outcomes Framework guidance for 2022/23 (england.nhs.uk)]

QOF guidance for 2022/23

Contents

The prevalence of multimorbidity is on the rise, with 44% of people over 75 now living with more than one long-term condition.

Around 10% of people over 65 will also be living with frailty, a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves, putting them at greater risk of adverse outcomes after apparently minor events.

[RCGP-Integrated-care-for-older-people-with-frailty-2016.pdf (bgs.org.uk)]

[Multimorbidity: clinical assessment and management (nice.org.uk)]

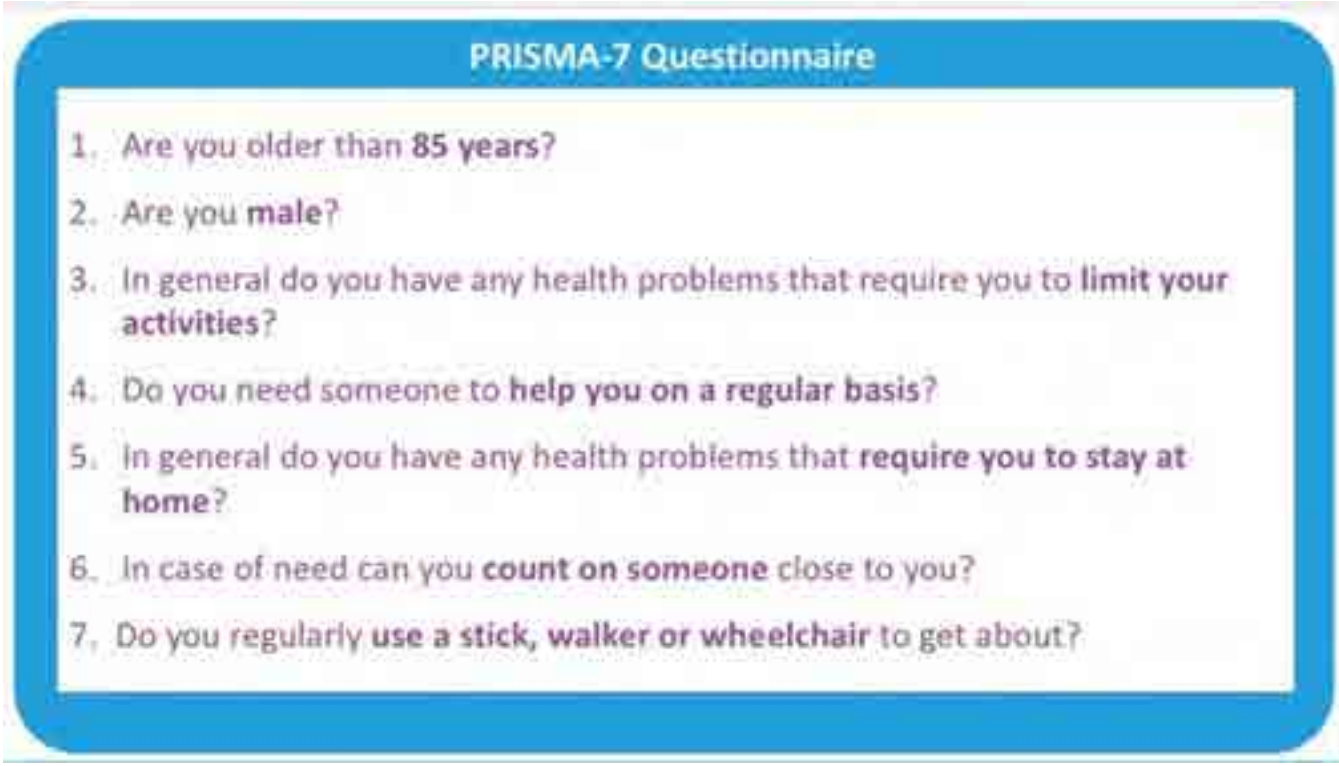
Primary care and community care settings

1.4.4 When assessing frailty in primary and community care settings, consider using 1 of the following:

- an informal assessment of gait speed (for example, time taken to answer the door, time taken to walk from the waiting room)

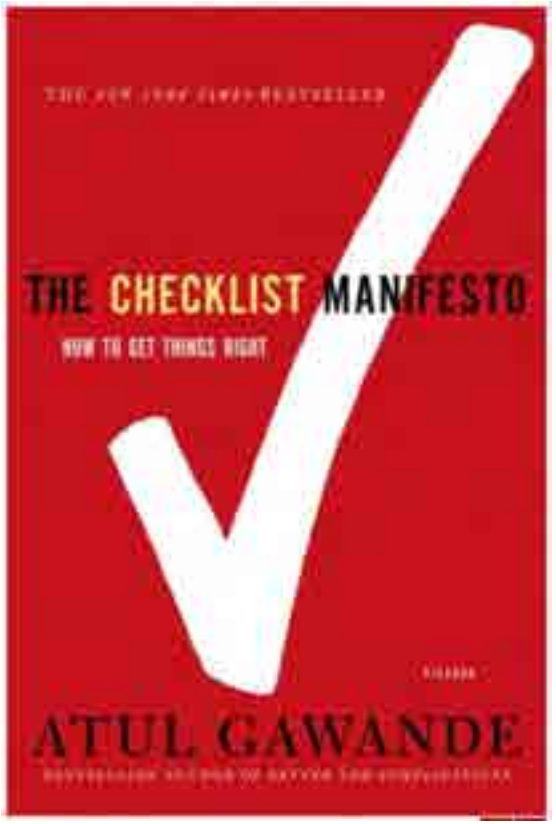
- self-reported health status (that is, 'how would you rate your health status on a scale from 0 to 10?', with scores of 6 or less indicating frailty)
- a formal assessment of gait speed, with more than 5 seconds to walk 4 metres indicating frailty
- the PRISMA-7 questionnaire, with scores of 3 and above indicating frailty.

[PRISMA-7 Questionnaire : Frailty Toolkit]



Top Tips …Frailty and P&EOLC in General Practice

- Identification and Stratification- Population Health Management
- Personalisation through duality of CGA and ACP
- Patient & Community Empowerment and Social Prescribing
- Data of Clinical Significance/Sentinel Events
- Hospital Admissions and Length of Stay
- Acute Response Team SPOA UCR VW Social Care
- **Holistic Whole Systems Joined Up Health and Care 24/7**



…Distinction between errors of ignorance (mistakes we make because don't know enough)

And

…errors of ineptitude (mistakes we made because we don't make proper use of what we know)

Thank You