Appendix E – Frailty – developing a meaningful and accurate register – first steps

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Frailty has been defined “a state of vulnerability to poor resolution of homoeostasis after a stressor event and is a consequence of cumulative decline in many physiological systems during a lifetime.”

It has also been describe as: “a condition or syndrome which results from a multi-system reduction in reserve capacity to the extent that a number of physiological systems are close to, or past, the threshold of symptomatic clinical failure; and as a consequence the frail person is at increased risk of disability and death from minor external stresses.”

The response to frailty needs to be multi-dimensional and inter-disciplinary and needs to appreciate the social context and situation of the person concerned. There is a growing appreciation that one of the problems that frailty brings is social isolation, which in itself exacerbates the health problems that frailty brings. The consequence of failing to address this is more and more medical intervention that provides less and less benefit, indeed is often harmful and further exacerbates the problem for the individual.

There are a multitude of tools that have been developed to identify people that might have frailty that could have significant consequence for health services. The GP contract for 2017 (effective 1st July 2017) has moved the funding for the old Avoiding Unplanned Admissions DES into the core contract and requires that: “Practices must use ‘an appropriate tool, e.g. Electronic Frailty Index (eFI)’ to identify patients aged 65 and over who are living with moderate and severe frailty.”

The eFI is made up of 36 deficits comprising around 2,000 Read codes and as such effective coding needs to be in place if an accurate frailty score is to be generated. As with any screening tool it is neither 100% sensitive nor is it 100% specific. However it presents the best way to use the life-long medical record to approach the identification of people that might be developing frailty in a structured way.

Interpreting eFI

1. eFI >0.36 ‘severe frailty’
2. eFI 0.25 to 0.36 ‘moderate frailty’

Both the GP clinical Systems in use in Dorset will calculate an eFI for any patient (regardless of age).

In order to develop a comprehensive and useful frailty register, other ‘measures’ need to be used and clinician correlation will ensure only the correct patients are added to the register.

For standardization reasons and to remain consistent with the core contract it is proposed that an electronic frailty score should be calculated for all registered patients aged 65 years and over. However there will be patients with a significant degree of frailty not identified by the eFI and these can be added to a practices register using clinical intelligence. Equally, there will be those with a high eFI score that is at odds

with the physical and social picture that they present. People with dementia are also likely to have their vulnerability under-estimated by the eFI.

To determine whether the person needs to be on a register, use the knowledge of the clinicians involved in their care to determine their Rockwood scoring and their degree of frailty. It also recommends scoring people with dementia depending on the level of severity of their dementia.

To add value and share understanding it is proposed that practices are encouraged to work collaboratively and are supported by the Business Intelligence team in the CCG to collate the information on frailty as it develops. This would also inform the development of service specifications that will be necessary to deliver the system transformation outlined in the Clinical Services Review and Integrated Community and Primary Care Services work programme, both of which are fundamental elements in the Dorset System Transformation Plan.

Phase One

System One	EMIS
1. eFI Guidance SystemOne Notes	1. Create a search population of all patients aged 65 and over 2. Run batch report to add eFI calculation to all patients in the search population 3. Export report as a CSV or Excel file 4. Open file and remove any patient identifiers. 5. Send file to [*add BI e-mail address*]
BI to collate the information and produce an information tool to facilitate dialogue at localities on the emerging picture across Dorset	
Localities to reflect their dialogue in their plans for utilization of the 'Over 75s' funding in coming years	
The CCG to assimilate the locality proposals into a coherent service specification for the Dorset Population	

Phase Two: Validation & Refinement

1. People on practice lists identified as having a high eFI (>0.36) to be reviewed (primarily notes/MDT) and a Rockwood score agreed
2. 'Reconciliation' of the eFI and Rockwood scores to agree on a frailty coding:
    a. Severe Frailty [*2Jd2*]
    b. Moderate Frailty [*2Jd1*]
    c. Mild Frailty [*2Jd0*]
    d. Not Frail/Fit, when no code will be added to the notes
3. Run practice search against patient list to include the following coded elements
    a. Rockwood score

   i. Score of 7 or 8 equates Severe Frailty
   ii. Score of 6 equates to Moderate Frailty
   iii. Score of 5 equates to Mild Frailty
b. Frailty coding
   i. Severe
   ii. Moderate
   iii. Mild
   iv. Not Frail
c. Code patients in care homes
   i. Lives in a nursing home[13F61]
   ii. Lives in a Residential Home [13FK]
d. MUST Score

4. Provide anonymized report to CCG BI team to enhance the frailty tool.

Maintaining the register

New patients for frailty register will be identified through enhanced MDT processes. See Appendix G Frailty Toolkit for further guidance.

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From work undertaken in Weymouth and Portland through Health Education Wessex frailty fellowship it has been recognized that there are three different registers of patients needing appropriate follow-up and intervention/support:

1. Frailty Register
2. Vulnerable Patients Register (previously the admission avoidance register)
3. Palliative Care Register (GSF)

Each register will suggest a set of actions that would be appropriate [can be delivered by any person involved in providing support/care]:

Frailty register - Severe Frailty

1. Baseline assessment – ***consider asking for a*** comprehensive geriatric assessment (CGA). It is not envisaged that practices should do the CGA, rather they should 'pull in' the expertise of local 'hub based'
2. Enter relevant information using the Dorset Care Plan template [*including DNAR*] This is a structure template that has all the SCR relevant codes. Only the relevant information need be added / recorded and it should NOT be seen as a 'tick box' exercise.
3. Attempt to gain consent for enriched summary care record **
4. Annual clinical review to include**
    a. Any falls in the previous 12 months**
    b. Medication review**
    c. Review of Dorset Care Plan
    d. Identify unpaid carers and add to carers register
    e. MUST Score
    f. Provide any other clinically relevant interventions**
    g. Chronic disease follow up (addressed as multi-mordibity rather than multiple disease specific contacts)
5. Determine frequency of follow up required
6. Set up recall system

Frailty register - Moderate Frailty (Particularly those with evidence of increasing frailty e.g. increasing eFi score)

1. Baseline assessment – ***consider*** need for CGA
2. Consider use of Dorset Care Plan [*including DNAR*] to record relevant information
3. Attempt to gain consent for enriched summary care record
4. Annual clinical review to include
    a. Any falls in the previous 12 months
    b. Medication review
    c. Review of Dorset Care Plan (if applicable)
    d. Identify unpaid carers and add to carers register
    e. *Consider MUST score*
    f. Provide any other clinically relevant interventions
    g. Chronic disease follow up (this could be addressed as multi-mordibity rather than disease specific)
5. Determine frequency of follow up required
6. Consider if recall system required

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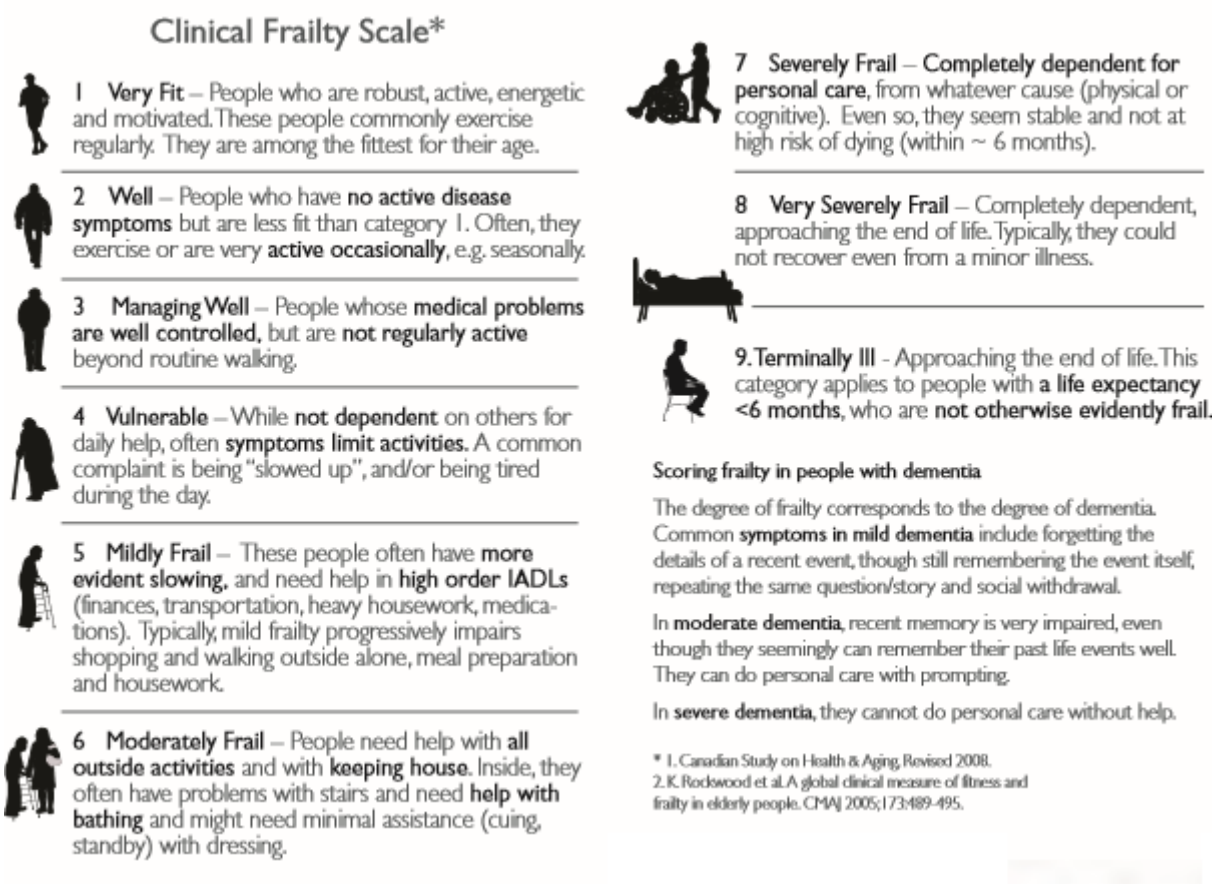
Vulnerable patients

1. Use Dorset Care Plan [*including DNAR*] to record relevant information
2. Attempt to gain consent for enriched summary care record
3. Annual review
    a. Any falls in the previous 12 months
    b. Medication review
    c. Review of Dorset Care Plan (if applicable)
    d. Identify unpaid carers and add to carers register
    e. MUST score
    f. Provide any other clinically relevant interventions
    g. Chronic disease follow up
4. Determine frequency of follow up required

The Rockwood Clinical 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 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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Example template of a frailty register:

Patient Name	Rockwood score	Frailty (mild/moderate/ Severe)	Review needed?	Dorset Care Plan needed?	Would this patient benefit from regular follow up?	Ideally how often do you think they should be followed up (if there were no barriers to providing this)