

**Care & Support Planning/Advanced
Care Planning for people living with
frailty**

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Longer lives: 1900s till who knows when?

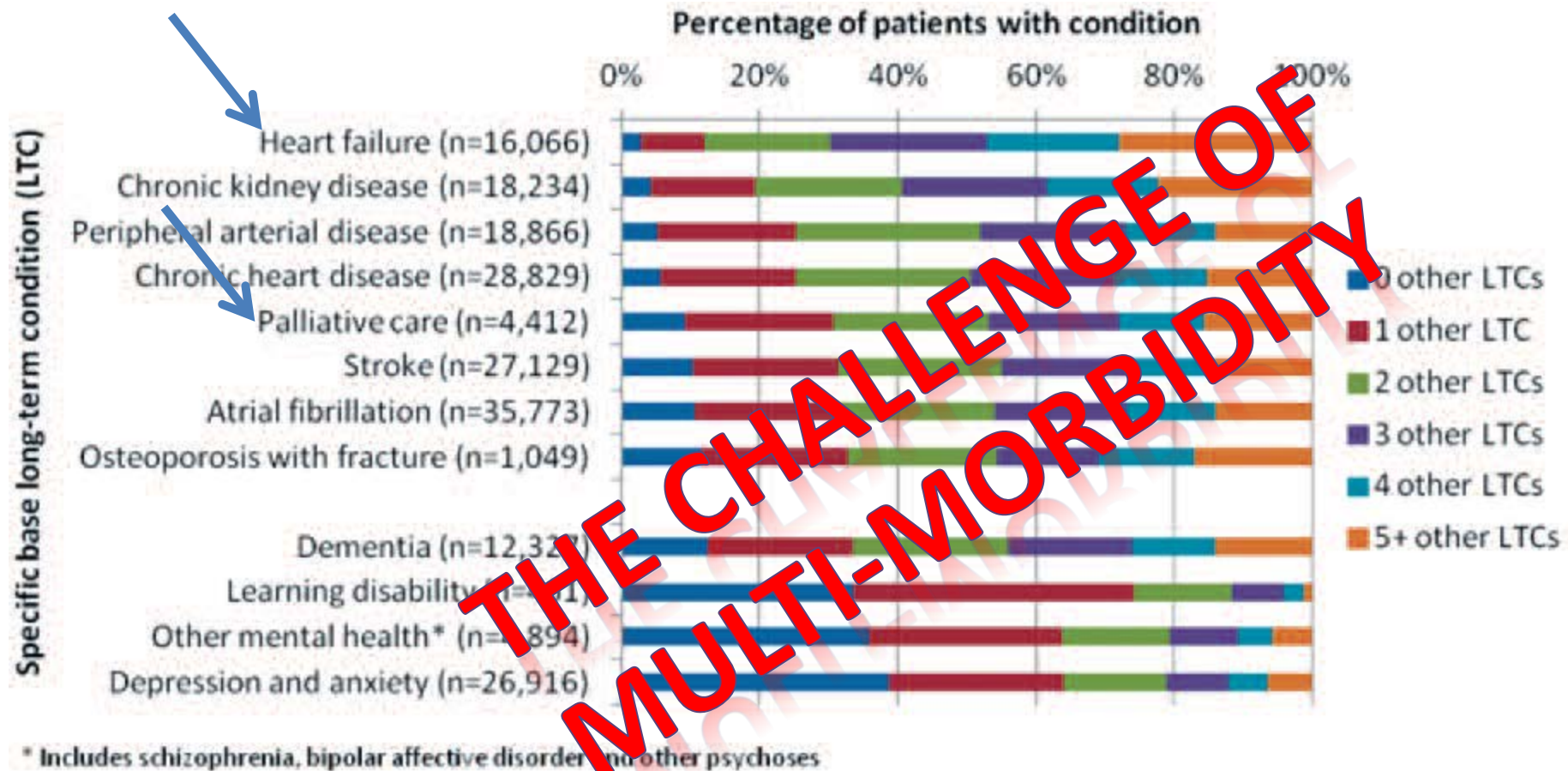
“It is a truth universally acknowledged that a single *society* in possession of a good *life expectancy* must be in want of a *sustainable health service*.”

(With apologies to Jane Austen!)

	<u>Man</u>	<u>Woman</u>
Av life expectancy 1900	<50y	<50y
Av life expectancy 2015	79.4y	83.1y
Remaining life expectancy at 65y	18y	21y
Disability Free Life Expectancy (DFLE)	10y	11y

(Source: Health & Social Care Information Centre 2014)

A LTC rarely travels alone



Kent Whole Population Dataset: Interim Report
2014

The burden of multimorbidity

Applying NICE guidelines to a 78 yr old woman with previous myocardial infarction; type-2 diabetes; osteoarthritis; COPD; and depression.....

- 11 drugs (and possibly another 10)
- 9 lifestyle modifications
- 8-10 routine primary care appointments
- 8-30 psychosocial interventions
- Smoking cessation appointments
- Pulmonary rehabilitation

(Hughes et al Age & Ageing 2013)

“I’d like my life back please!”

Frailty: key issues

- Related to the ageing process
(Clegg, Young et al Lancet 2013)
- Around 10% of over 65s have frailty
(Collard et al. JAGS 2012: 60; 1487-92)
- Increases to 25-50% of over 85s
(Collard et al. JAGS 2012: 60; 1487-92)
- Independently associated with adverse outcomes, which are expensive
(Falls; dependency; hosp admission; care home admission)
- Best understood as a long-term condition
(Harrison, Young, Clegg, Conroy Age & Ageing 2015)

Frailty is about people,
not a disease state

LIVING WITH FRAILTY: A GUIDE FOR PRIMARY CARE



This supplement was developed and produced in partnership with NHS England

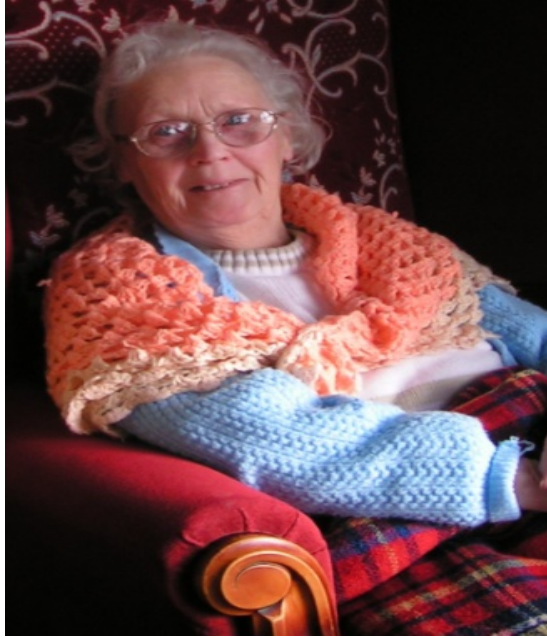
Understanding frailty as a LTC

Supported self-management
for frailty

Care & support planning

Advanced care planning

Frailty is



Mrs Greenaway was found on the floor (“FLOF”) with new confusion by the home care staff and taken to hospital where is was found to be poorly mobile.

“She was a fall waiting to happen.”
Home care staff

- ✓ Fall
- ✓ Delirium
- ✓ Immobility

Another view of Mrs Greenaway

85 years

Lives alone

Recently in hospital following a fall

Broken hip 2011

Chronic heart failure →

Review 1

Diabetes →

Review 2

Chronic Kidney Disease →

Review 3

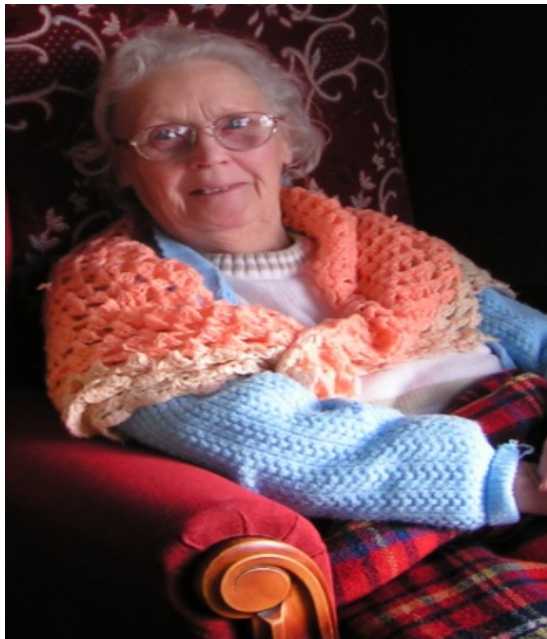
Taking 10 medications →

Review 4

System designed to fragment care into packages

..... and the frailty???

Yet another view of Mrs Greenaway



What are the most important things you'd like to discuss today?

1. The pain in my feet
2. Difficulty sleeping
3. Getting out for a chat
4. I don't like all these tablets; do I really need them all?

Identification of frailty

1 Comprehensive geriatric assessment (CGA)

(Structured, multi-disciplinary assessment)

2. Simple assessment

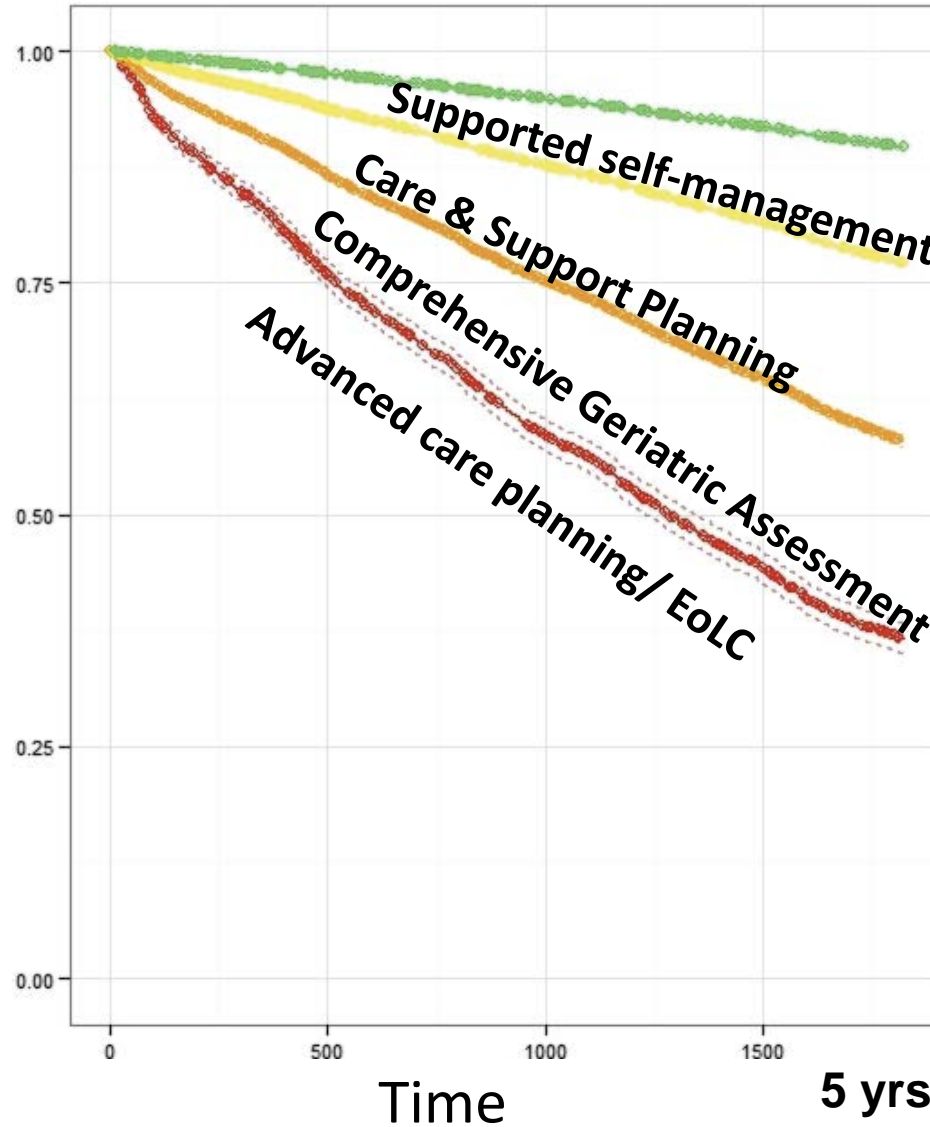
- Gait speed/timed-up-and-go test
- Questionnaires (e.g. PRISMA 7)
- Brief clinical tools (e.g. Edmonton frail scale)

3. Routine data

- Electronic Frailty Index (eFI)

Primary care electronic Frailty Index (eFI): survival plots ($n=227,648$; $>65y$)

Proportion
alive



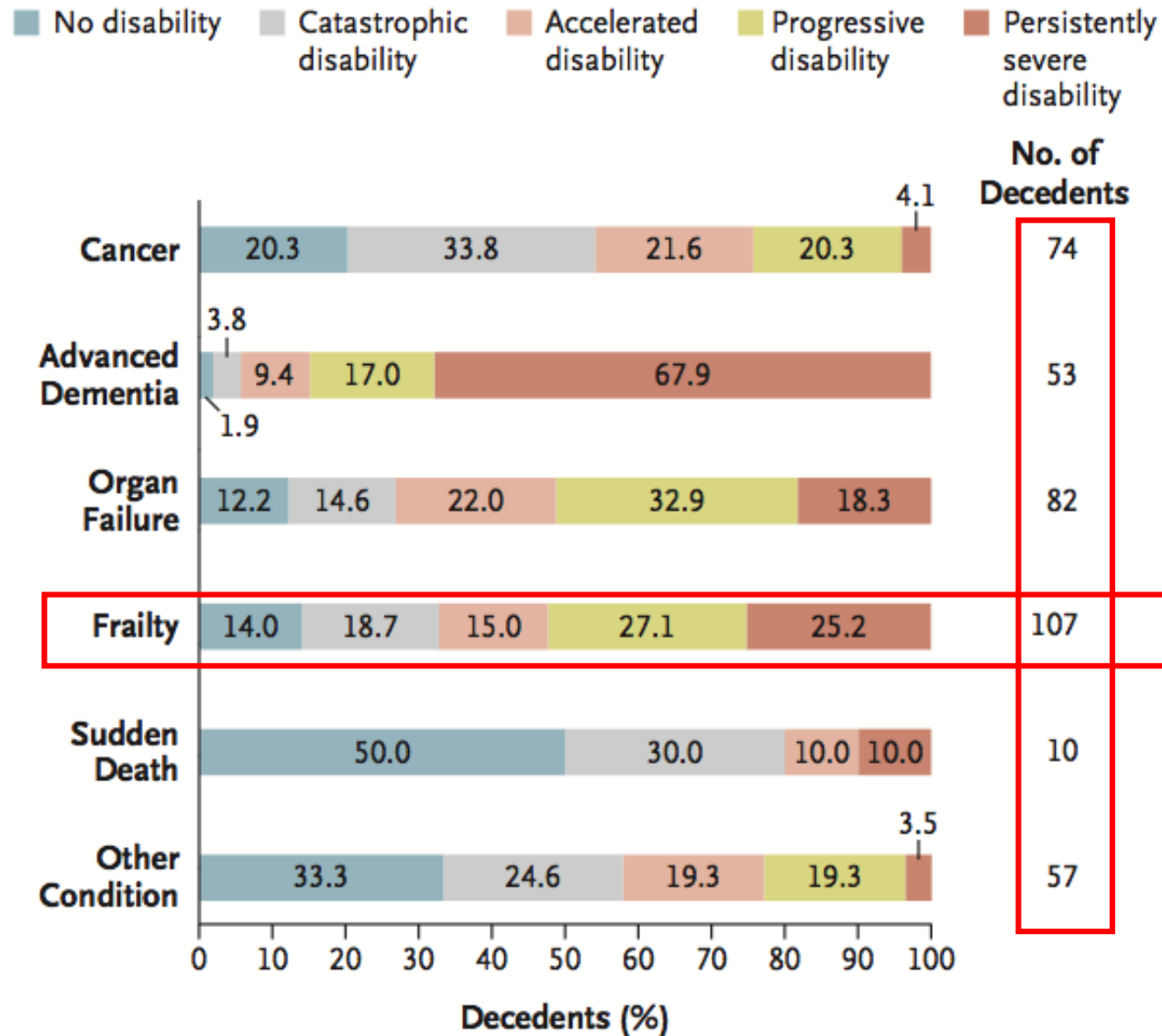
Fit

Mild frailty

Moderate frailty

Severe frailty

Frailty & palliative care

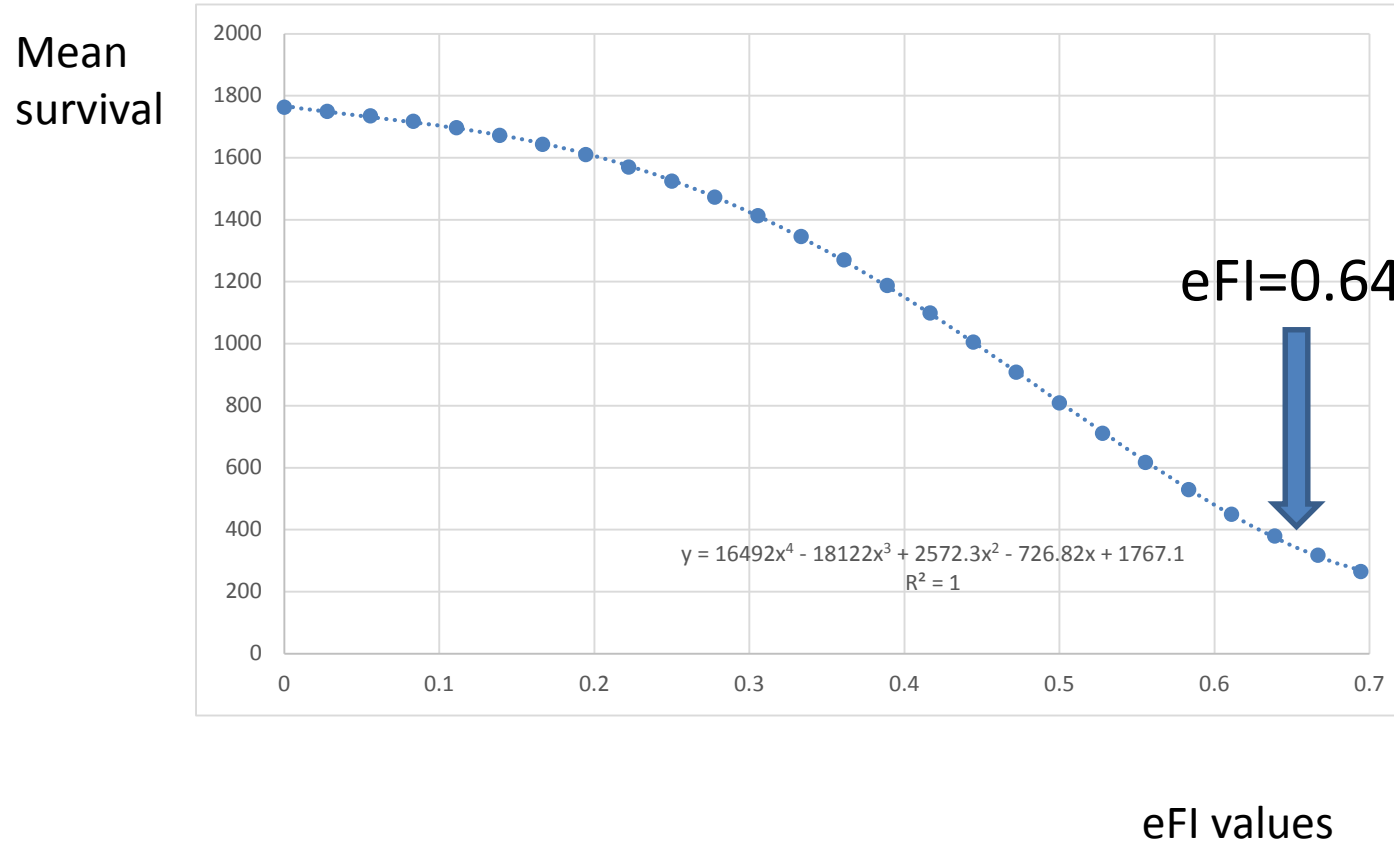


Frailty & End of Life Care

- People in their last year of life are admitted to hospital an average of 3.5 times
(Lyons & Verne 2011)
- 30% of patients in hospital in last year of life
(NAO 2008)
- >40% of people who died in hospital did not have medical needs that required them to be in hospital. Nearly a quarter had been in hospital for >1 month
(NAO 2008)

Identification of frailty?

Using eFI to identify last year of life



“4 Ts”: Reflective Practitioner Questions

- Think Frailty!
- Timid: Am I being timid?
- Timeliness: Is this the right time?
- Time: Do I need to make time?

Uncertainty causes anxiety
(for you; your patient and their families)

“Ambitions for Palliative and End of Life Care”

- 01 Each person is seen as an individual
- 02 Each person gets fair access to care
- 03 Maximising comfort and wellbeing
- 04 Care is coordinated
- 05 All staff are prepared to care
- 06 Each community is prepared to help

“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).”