**From Frailty to Resilience**

*Friday 31 May 2019*

**@WEAHSN**

**1 Overview**

**About the West of England Academic Health Science Network**

The [West of England AHSN](https://www.weahsn.net/news-views/newsletter-sign-up/) is an NHS body and one of 15 across England. We are commissioned by NHSE, NHSI and Office for Life Sciences to delivers positive healthcare outcomes locally and nationally. We do this by driving the spread and adoption of tried and tested initiatives and new innovations.

As the only bodies that connect NHS and academic organisations, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

**Developing the Frailty Community of Practice**

The West of England Patient Safety Collaborative Board asked the Patient Safety Collaborative team to discuss and scope out the potential to incorporate a project on frailty into the Patient Safety Collaborative work plan for 2017/18.

A focus group was held on 16 March 2017 and the project lead attended the national AHSN sharing day on frailty. Discussions have taken place with individuals who have expressed an interest in working on improving safety for people with frailty.

Following an expert reference group meeting on 16 June the first frailty Community of Practice meeting was held on 1 September 2017 and saw 14 attendees from 11 member organisations including acute Trusts, CCGs, community providers and mental health Trusts. 16 attendees from 10 organisations attended on 3 November in Gloucester with a topic focus on MDTs.

The group agreed the Community of Practice would be called “From Frailty to Resilience” and agreed to share resources and experience via meetings every two to three months. Four meetings have been held so far.

There are currently 67 members of the frailty community of practice distribution list covering 25 organisations.

**2 What is Frailty?**

NHS England have defined frailty as a progressive, long term condition characterised by a loss of physical and/or cognitive resilience that means people living with frailty do not bounce back quickly after an acute stressor event such as a physical illness, an accident or other stressful event.

**Why Frailty is Important**

The population of England is ageing. By 2040, nearly one in seven people are projected to be over 75. Whilst frailty is associated with age it is not the same: not all older people live with frailty and not all people living with frailty are old. Many of the factors that cause people to age differently are amenable to population-level interventions based on lifestyle choices and exercise. Frailty (rather than age) is effective as a means of identifying people who may be at greater risk of future hospitalisation, care home admission or death. For example, people living with severe frailty have a four times greater one-year hazard ratio for these outcomes. This means population-level frailty identification can help anticipate future health and social care demand.

Accelerating population ageing coupled with existing health system pressures means it is important for local areas to take action to provide a more sustainable, whole-system approach to managing frailty that ensures that we have the rights types of services in the right quantities to meet demand. For example, the number of people aged 65 to 69 has grown by 34% in the last 10 years, with corresponding hospital admissions growing by 57%.

**3 Meeting 31 May 2019**

3 attendees from 3 organisations attended on 31 May. The topic for discussion is mental health in frailty.

**Mental Health - Dementia**

Cognitive impairment is known to be one of the core components of frailty. The group discussed that dementia is the most common and complex mental health issue to manage in individuals with frailty. Several key issues with identified were:

1. Dementia is severely undiagnosed; a recent study shows that over 60% of individuals living with dementia are not diagnosed. This is often due to the social isolation of this population group
2. Following diagnosis of dementia in a memory less clinic it is common to have no specific follow up with minimal support, for both the individual and the carer. In Sirona, a number of these individuals are picked up by the frailty MDT, otherwise it is likely that they would have no additional support and would not be effectively signposted.
3. Training for dementia in primary care is often limited, with the majority of GP’s not having the skills needed to effectively manage dementia and the multi-faceted nature of its management. Similarly, there are no known examples of clinical champion GPs with a specialist interest in dementia management and diagnosis.

Having a CPN (Community Psychology Nurse) within frailty teams is seen as best practice, and is effective in aiding with the diagnosis and management of these patients, alongside a biopsychosocial model. This model is utilised effectively in Sirona. Alternatively, in North Somerset the Consultant Community Geriatrician works alongside a specialist in cognitive function/memory to aid with the diagnosis of dementia. However it was recognised that the cross-trust working that is required (between mental health and community trusts) provides challenges to setting up these models.

Tools such as the [Dementia Severity Rate Scale](https://www.alz.org/media/Documents/dementia-severity-rating-scale.pdf) were also acknowledged as being under-utilised in many clinical settings.

As it stands, there are no specific services for managing dementia. The group discussed that ideally this would not be part of normal mental health services which are already overstretched; this should be an additional service.

**Pain scale in dementia**

A range of pain scales are utilised in patients with dementia, the one used depends on which is most appropriate to the individual. These range from Abbey Pain Score, HADS, BDI, GDS 15, PAINAD, VAS and the Smiley Face. The most commonly utilised across attendees was the Abbey Pain Score.

**eFI**

The group discussed that the eFI (electronic frailty index) is being increasingly adopted however the general consensus is that the eFI is not being properly utilised, with the coding needing some adjustments. There is a concern that mental health problems are not being identified as well as not all individuals being identified as being ‘frail’ as these patients are often home bound and therefore do not attend the GP to be picked up.

**Primary Care**

It was highlighted that in line with the development of the new Primary Care Networks (PCN), the [GP Quality and Outcome Frameworks](file:///C:\Downloads\megan.kirbyshire\Downloads\Contract%20agreement%20QOF%20guidance-Jan2019%20(1).pdf) (QOFs) have also been revised. The relevant changes include the creation of two new Quality Improvement modules, both of which are relevant to frailty.

1. Prescribing safety: This module will cover the safe prescribing of NSAIDs, lithium and

valproate in women of child bearing age and will dovetail with the expansion of clinical pharmacists in general practice;

1. End-of-life care. The current QOF indicator on end of life care has been retired, and instead this module will focus on the wider aspects of care for patients who are expected to die within the coming months as well as support for their carers.

**AHSN Healthy Aging programme**

The group were updated on a new Healthy Aging Programme across the Academic Health Science Network. The purpose of this group is to share healthy aging initiatives across the network, to promote sharing of resources and work that is being undertaken.

As part of this new network, the West of England AHSN is developing a new work stream; The Healthy Aging Programme. The objectives and structure of the Healthy Aging Programme are yet to be defined; however it is important that these are developed in conjunction with the Frailty Community of Practice. We will propose to discuss this at the next September meeting.

**A change of terminology needed?**

NHS England has recognised that there is stigma associated with the term ‘frailty’; health professionals, carers and patients have identified it as a negative term. There has been some consideration of the need to find alternatives to the words that we are using to discuss frailty.

As part of this conversation, the group discussed whether the name of the group, ‘From Frailty to Resilience’ should be altered to reflect this emerging change of terminology to incorporate Healthy Aging. The participants raised the concern regarding a potential concern to ‘Healthy Aging’ as they feel it does not incorporate those who present with severe frailty, and perhaps only involves those who are less further along the frailty spectrum.

Further concerns were raised regarding ‘An Older Person living with frailty’ in the below slide from NHS England. The group agree that this terminology neglects the fact that an individual does not need to be ‘older’ to be frail, and excludes the younger population living with frailty.

This conversation was limited due to time constraints but will be revisited at the next meeting.

**4 Helpful Links**

* New Frontiers in Frailty – Annual Conference 2019 <https://www.eventsforce.net/nhselect/frontend/reg/thome.csp?pageID=4721&ef_sel_menu=96&eventID=13>
* The State of Aging <https://www.ageing-better.org.uk/publications/state-of-ageing-2019>
* Resilience in Aging Greater Manchester <https://www.ambitionforageing.org.uk/resilience>

**5 Outcomes and next steps**

* **All** to sign up for the frailty hive on HYVR <https://www.hyvr.co.uk/>
* Megan to organise date for December meeting.
* Megan to share report of the QIP that was undertaken in relation to the MDT working and Frailty in NSCP
* ***Next meeting:*** *Friday 20th September, 13:00-15:00 at* Hawking Room at Future Space, UWE Bristol, North Gate, Filton Rd, Stoke Gifford, Bristol BS34 8RB.*Topic: ‘Aging Well’ – prevention and developing resilience/living well with frailty linking into the new competency framework for providers.*

**Thank you to everyone involved in the session – please do share details with colleagues and encourage them to join the mailing list and hyvr!**