The HOUSE Journal

The newsletter for the Year of Care Community of Practice

Issue 9 – April 2018

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Welcome to The HOUSE Journal

Lindsay Oliver, National Director

In this edition of The House Journal we focus on frailty, which has all the features of a long term condition and is seen as an area by many where care and support planning could serve as the foundation of high quality care. If my own personal experience is anything to go by, people who are frail have potential to be the most 'done to' group of people who use health and social care services. I feel strongly that our community of practice should be moving towards approaches that include frailty as part of an overall care and support planning approach to population health. We hope you find the ideas, resources and video link useful and do get in touch if you would like to work with us to develop a local approach.

Introduction to Frailty

Frailty is a state of being affecting older people in which loss of inner reserves means that minor changes to health or everyday life lead to increased risk of serious adverse outcomes[1]. It is now possible to identify it, intervene early to prevent some aspects of deterioration, and provide focussed support to enable independent living for longer at later stages. It thus has many characteristics of a long-term condition (LTC) and can benefit from care and support planning.

[1] Clegg, Young, Iliffe, Olde-Rikkert, Rockwood. Frailty in elderly people. Lancet 2013; 381: 752-762

Advantages of CSP for this group

Care and support planning (CSP) for those who are 'fit' or 'mildly frail' can be an effective way to tailor support to slow down progression of frailty, based on what matters to the person. CSP conversations can help people to understand, plan activities which support active ageing and potentially slow down or delay progression of conditions.

With increased frailty come a number of increased challenges. People often do not recognise themselves as 'frail', and fear the term itself as it is associated with a loss of control and influence. A care and support planning approach with people affected by frailty has a number of potential advantages:

- By using preparation for the person to help them think through what matters to them, structuring CSP conversations around these priorities and agreeing a plan which the person and the healthcare professional have developed together, CSP can continue to recognise and value the expertise the person living with frailty brings to the conversation.

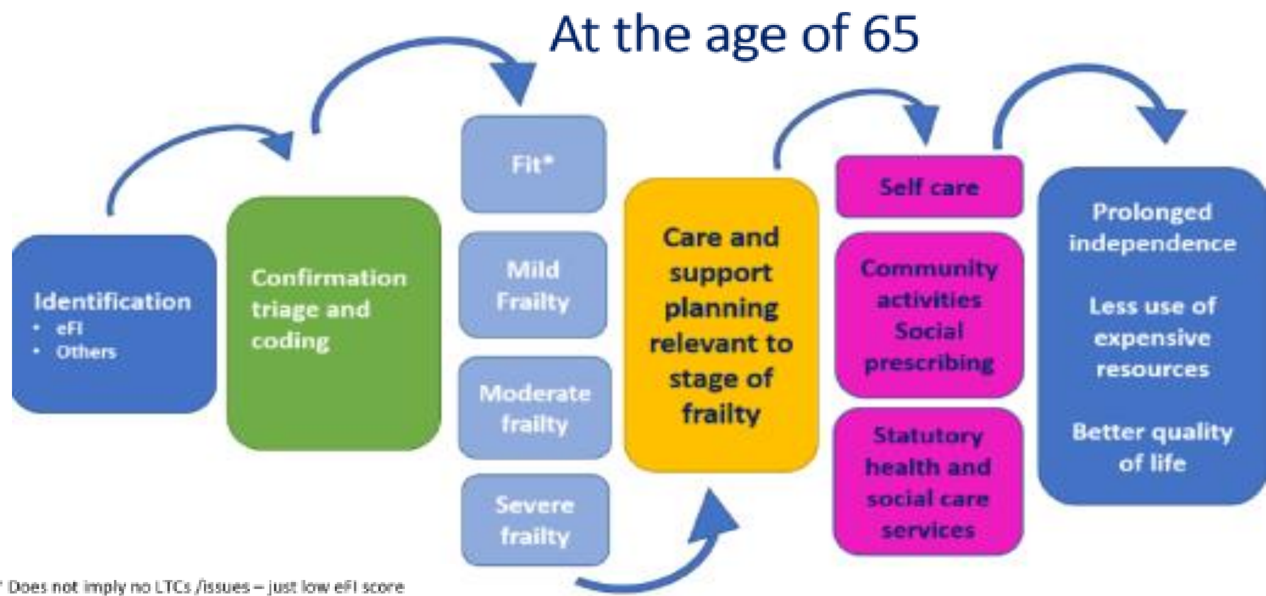
- CSP can help with care coordination, particularly where a range of different professionals are involved in providing support. The GP, acting as a 'gatekeeper/ co-ordinator', can ensure the person's wishes are taken into account, resulting in people accessing the sort of services or support which will make a difference to the things that matter to them.

- Frailty is often associated with increased medicalization and prescribing. Using CSP conversations to understand the person's priorities and individual circumstances can make sure decisions around medication and treatment are geared towards what is most important to the person.

- CSP preparation can prompt the person to think about the future. Since it is focused on what matters to the person, it enables discussions around prognosis, end of life etc. to be incorporated seamlessly into discussions, at a time suitable for each person, rather than being triggered by a timescale or target set within the healthcare system.

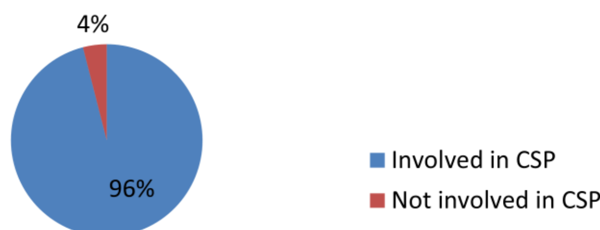
Overlap with current care and support planning

Most people living with frailty will already have one or more long term conditions (LTCs) and may already be involved in CSP as part of their LTC reviews. The current GP contract (see below) requires practices to use the electronic frailty index (efi) with clinical validation to identify those with moderate and severe frailty. The diagram below shows how this fits with CSP.



A review of Glenpark Medical Practice in Gateshead, which has implemented CSP for multi-morbidity, showed that 96% of people >65 years identified as mild/moderate/severely frail were already undergoing CSP. This highlights the opportunity, with some practice amendments to preparation and the content of the conversation, to include frailty as part of the CSP process for this population.

Of those over 65 identified as mild/moderate/severely frail, proportions of those already included in CSP in Glenpark practice at October 2017



Fit with national initiatives/schemes

GPs in England have been asked to develop approaches for their registered population of people living with frailty as part of the GP contract starting in July 2017. The GP contract specification[1] includes an obligation for annual review, medication review, falls assessment and a request to those with severe frailty to allow sharing of an enriched summary care record. CSP provides an ideal way to deliver all this using a patient centric approach; building on the joint recommendation of the RCGP and BGS[2] which said that such services should be built around care and support planning (CSP).

[1] http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/Summary%20of%20201718%20GMS%20contract%20negotiations.pd

[2] Fit for Frailty - consensus best practice guidance for the care of older people living in community and outpatient settings - a report from the British Geriatrics Society 2014

How would CSP be different?

The way each practice would implement CSP for frailty and ageing may differ based on local resources, teams available and current cohorts included in care and support planning. A number of areas would need to be considered:

1. **Pathways**
   How people are identified and categorised as frail (including clinical verification) would need to be included in the pathway. Some of the details might differ for different groups of people e.g. those who are 'fit' or 'mildly frail' with differing roles for volunteers, home visits and community teams.

2. **Who does CSP?**
   This may vary across a practice e.g. complex severely frail people may need information gathering via community nursing teams at home and CSP conversations with a GP, others may involve information gathering with a Health Care Assistant in a practice and CSP with a nurse practitioner. For those with care packages and complex medication, how social care and pharmacy are involved in the pathway would need to be defined.

3. **Preparation for the person**
   Allowing the person time to reflect and consider what matters to them prior to their conversation is critical to effective CSP. A range of preparation resources supporting CSP for frailty have been designed by Year of Care Partnerships to help with this.

4. **Preparation for the professional**
   Reviewing case notes, obtaining information from other services (e.g. pharmacy, social care, occupational therapy etc.), as well as identifying key clinical issues are all preparation activities for the professional undertaking CSP. The complexity of the activities will increase with increased frailty.

5. **Care plan/activities**
   The CSP conversation and plan will be developed around what matters to the person. The conversation may also involve, for example, carers or social care workers who know them best. Gathering local intelligence about what community support is available, including how to link actively with social prescribing/links workers. Careful thought needs to be given to how MDT meetings work so that no decisions are made ahead of care and support planning with the person. All activities agreed result in a plan which the person can take with them and also be included clinical records.

Robert Westgate – GP Carlisle Healthcare

An example of an area where people are benefitting from these differences is Carlisle.

Frailty, seen as a LTC, fits well into a CSP approach and a video summarising the experience of this in Carlisle can be seen here: https://youtu.be/F213eibSKNo

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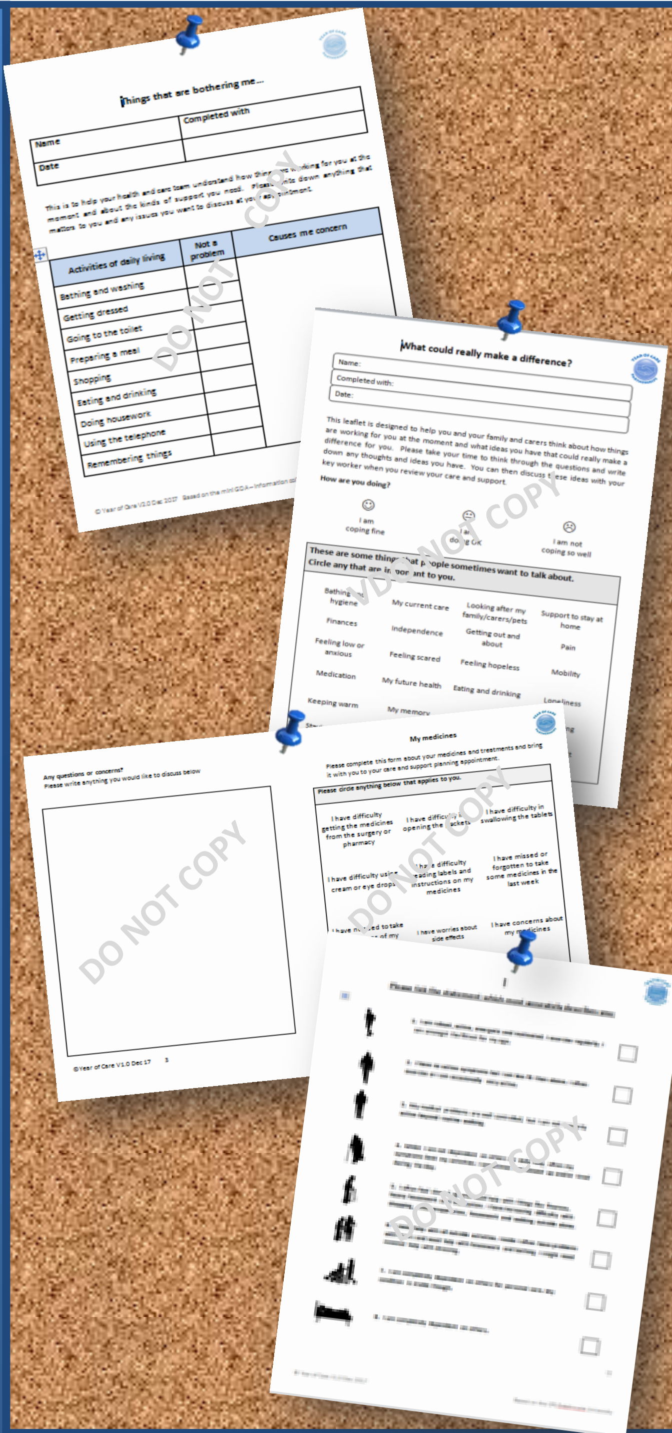
Resources- patient preparation



a. **What's bothering me** – a patient-friendly preparation tool including all the key questions a patient could answer themselves that are included within the British Geriatric Society's mini Comprehensive Geriatric Assessment (recommended for use in primary care).

b. **What could really make a difference?** – a preparation prompt which can help people identify what matters to them. This if focused on topics related to frailty and was designed based on our generic multi-morbidity preparation prompt.

c. **My medicines** – a summary of current medicines which prompts the person to consider what support/discussions they would need around their medicines. The design took into account recommendations from a Royal Pharmaceutical Society endorsed document 'Managing Medication Guidance'.

d. **Self-assessment tool** – a scale (based on the Rockwood Clinical Frailty Scale) which the person completes and can help validate electronic frailty scores allocated by, for example, eFi**.**

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