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GUIDELINES

Best practice guidelines for the management of frailty: a British Geriatrics Society, Age UK and Royal College of General Practitioners report

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Abstract

Older people are majority users of health and social care services in the UK and internationally. Many older people who access these services have frailty, which is a state of vulnerability to adverse outcomes. The existing health care response to frailty is mainly secondary care-based and reactive to the acute health crises of falls, delirium and immobility. A more proactive, integrated, person-centred and community-based response to frailty is required.
The British Geriatrics Society Fit for Frailty guideline is consensus best practice guidance for the management of frailty in community and outpatient settings.
Recognition of frailty The BGS recommends that all encounters between health and social care staff and older people in community and outpatient settings should include an assessment for frailty. A gait speed <0.8m/s; a timed-up-and-go test >10s; and a score of ≥3 on the PRISMA 7 questionnaire can indicate frailty. The common clinical presentations of frailty (falls, delirium, sudden immobility) can also be used to indicate the possible presence of frailty.
Management of frailty The BGS recommends an holistic medical review based on the principles of comprehensive geriatric assessment (CGA) for all older people identified with frailty. This will: diagnose medical illnesses to optimise treatment; apply evidence-based medication review checklists (e.g. STOPP/START criteria); include discussion with older people and carers to define the impact of illness; work with the older person to create an individualised care and support plan.
Screening for frailty The BGS does not recommend population screening for frailty using currently available instruments.

Keywords: *older people, frailty, best practice guidelines*

Introduction

Modern health-care systems have largely been designed around single organ disease-based services, with increasing specialism notable within hospital care [1, 2]. Historically, this has also been reflected in primary care, because general practitioner (GP) incentivisation schemes such as the UK Quality and Outcomes Framework (QOF) are constructed using disease-based targets, and clinical guidelines are usually designed around single long-term conditions. However, it is older people who are the majority users of health and adult social care services in the United Kingdom and internationally [3]. Many of these older people who access health and social services have frailty, which requires a different approach to care that is more person-centred and addresses individual need through a goal-orientated care planning process structured around Comprehensive Geriatric Assessment [4].

The existing health-care response to frailty is mainly secondary care based and reactive to the acute health crises of falls, delirium (acute confusion) and immobility. Older people with frailty typically have weak muscles (sarcopenia), are frequently prescribed five or more medications (polypharmacy) and may also have visual/hearing impairment and cognitive impairment so are especially vulnerable to in-hospital harm. Furthermore, older people with frailty may be subject to extended discharge planning and delayed transfers of care out of hospital, which adds further complexity [5, 6]. It is therefore important to recognise that many of the

acute crises affecting older people with frailty might be more safely managed in ways other than admission to hospital, while remaining mindful that a clinical assessment to identify the cause, or combination of causes, that precipitated the acute decline is of core importance. Of course, hospital admission may sometimes be necessary if the person is very unwell or unstable and needs investigation or treatment which is best delivered in an acute setting.

However, increasing emergency admissions, particularly among older people, and consequent pressure on acute services have resulted in a realignment of geriatricians towards hospital-based care with potential loss of links with community teams. This situation is exacerbated by the reduction in geriatrician-led rehabilitation beds in community settings, which further reduces geriatrician input outside acute hospitals. Hence, the decision about whether someone needs to be sent to hospital or could be managed at home or in a step-up community facility is often made by non-specialist health and social care staff, working in relative isolation in community settings, without the backup of a geriatrician or other specialist in the health care of older people to share the perceived risks.

There is increasing recognition of the importance of providing integrated services for older people with frailty that are person-centred and coordinated. A recent Kings Fund article [7] describes a more proactive, integrated pathway of care for an older person with frailty and the types of services which might be employed to manage each stage of the pathway.

But what does this mean for a GP, community nurse, therapist, social worker or ambulance crew working in a community setting? Staff will need to understand what frailty is and how to recognise it. They will then need to address frailty so as to mitigate the risk of recurrent crises and repeated visits to the emergency department and know when to consider alternatives to a conveyance to hospital.

The British Geriatrics Society (BGS) has produced guidance to help. 'Fit for Frailty' is a consensus best practice guidance for the management of frailty in community and outpatient settings. It is published in two parts: Part 1 (available now at http://www.bgs.org.uk/index.php/fit-for-frailty) addresses the recognition and management of older people living with frailty and has been produced in association with Age UK and the Royal College of General Practitioners. Part 2 (to be published in late 2014) will address the development, commissioning and management of services for frailty. This article summarises the key messages of the guideline, including the key guideline recommendations.

Summary of guidance

What is frailty?

- Frailty describes a condition in which multiple body systems gradually lose their in-built reserves.
- Older people with frailty are at significant risk of sudden and dramatic changes in their physical and mental well-being after a seemingly small event that challenges their health, such as a minor infection or new medication. Falls, delirium and immobility are the usual sudden, dramatic changes observed in frailty.
- Older people with frailty are also at increased longer term risk of disability, care home admission and mortality.
- There is an emerging evidence that appropriate exercise and nutrition can stabilise frailty and thus reduce the resulting vulnerability [8].

Recognition of frailty

- Frailty might not be apparent unless actively sought in an individual. Many people with multiple long-term conditions will also have frailty which may be overlooked if the focus is on disease-based, long-term conditions such as diabetes or heart failure.
- The BGS recommends that all encounters between health and social care staff and older people should include an assessment for frailty as this will affect the way health care is organised for that person.
- Frailty can be recognised in various ways.
    - In a routine encounter, there are several ways to recognise frailty. A gait speed <0.8 m/s (taking >5 s to walk 4 m) or a timed-up-and-go-test (TUGT) >10 s are simple assessments. A score of ≥3 on the PRISMA 7 questionnaire [9] can also indicate the possible presence of frailty. The accuracy (sensitivity and specificity) of these tools is variable compared with a gold standard [10].
    - Different tools will be better for different circumstances —for example, gait speed and TUGT will be useful for clinical staff during routine assessment, and the PRISMA 7 questionnaire could be used as a self-assessment test. Although evidence on diagnostic accuracy is unavailable, the BGS consensus recommendation is that the Edmonton Frail Scale may be a useful tool to identify frailty when considering a surgical intervention as it might help with pre-operative optimisation [11, 12].
    - The common clinical presentations of frailty (falls, delirium and sudden immobility) can themselves be used to alert health and social care professionals to the possible presence of frailty. They often mislead carers and emergency personnel, because an apparently straightforward symptom can mask a serious underlying illness.

Recognising that an older person has frailty can direct a more appropriate assessment to enable diagnosis of an underlying cause, or combination of causes, for a sudden deterioration in health. This may then enable provision of appropriate support to allow an older person with frailty to remain at home and prevent an avoidable and potentially disruptive visit to the emergency department.

Management of frailty

- The gold standard for the care of people with frailty is Comprehensive Geriatric Assessment (CGA) [4].
- CGA is a multidimensional assessment, treatment plan and regular review delivered by a multidisciplinary team (MDT)

that usually includes doctors, nurses, physiotherapists, occupational therapists and social workers.
- Much of the evidence about CGA comes from hospital settings, but there is evidence that provision of complex interventions (including CGA) to older people with frailty in community settings could reduce hospital admissions, admissions to nursing homes and increase the chance of continuing to live at home [13]. CGA in community settings will of necessity be different from that in hospital [14]—arguably it will be of more relevance since the inputs will be able to continue for much longer. The BGS guidance presents a consensus view of the vital features.
- A core feature of CGA is a holistic medical review. Due to the resource implications of MDT-led CGA and associated opportunity cost, the BGS recommends a holistic medical review for all older people identified as living with frailty. The holistic medical review does not need to be done by a geriatrician but by an individual with appropriate knowledge and time set aside. In community settings, this would usually be the GP or a specialist nurse who can then refer to a geriatrician (or other community-based specialist such as old age psychiatrists, therapists and community nurses) for help if there is an uncertainty about diagnoses or particular complexity.
- The holistic medical review will
    - Diagnose medical illnesses to optimise treatment and formulate a plan for care
    - Apply evidence-based medication review checklists (e.g. STOPP/START criteria) and take account of personal priorities and severity of frailty to rationalise medications so that only appropriate medications are prescribed, not necessarily what is recommended in disease-specific guidelines.
    - Include discussion with older people with frailty and their carers to define the impact of illness and symptoms on a day-to-day life.
    - Work with the older person to create an individualised comprehensive care and support plan (CSP) to manage all of the above. This will summarise who is responsible for doing what. It will also ensure that the individual with frailty has the opportunity to say what is important to them and their family in terms of their future care.
    - The CSP should therefore describe an optimisation and maintenance plan including the self-care plans, an escalation plan (what to look out for and who to call) and an urgent care plan that may include whether or not hospital care is appropriate/desirable and what alternative plans are in place).

Population screening for frailty

Systematic screening for frailty using currently available instruments would be an expensive venture and the consensus development group felt that it is currently unlikely that population screening for frailty will result in better outcomes or save money in the United Kingdom, although this approach has been recommended in earlier international guidance [15]. The current Direct Enhanced Service for avoiding unplanned admissions as part of the UK GP contract for 2014(http://www.nhsemployers.org/~/media/Employers/Publications/Avoiding%20unplanned%20admissions%20guidance%202014-15.pdf) requires GPs to identify the top 2% of their patients who are most at risk of hospital admission and to offer them a care plan. Many of these patients will have frailty, but there is no tool currently available to reliably identify this group and existing risk stratification tools are likely to be insensitive to frailty. An electronic frailty index that uses practice health-care record information to identify and severity score frailty could be helpful and is currently in development but requires further evaluation before its use could be recommended.

There is also debate about the feasibility and opportunity cost of comprehensive assessment and care planning (which, done properly, will take up to 2 h per patient not including the 6 monthly review) for 2% of the practice population (~40 patients per GP). A preferable approach would reduce the target population initially until the concept of care planning was better established.

Conclusion

The BGS 'Fit for Frailty' guidance presents a framework for providing the core principles of CGA in community and outpatient settings and will enable a care planning approach to direct a move away from the current focus on disease-based systems of care towards a more appropriate goal-orientated approach to care for older people living with frailty.

The guidance will help staff working within the health and social care services to deliver integrated, person-centred care by providing guidance on the recognition and management of frailty in these settings.

Understanding the role that frailty plays in the lives of their patients will help them to understand what is needed.

> *I found the part (of the BGS guidance) about formally recognising frailty really useful—otherwise we are just making judgements about whether people are frail based on what they look like and we don't always know what to do then (Community Care Team Member, 2014).*

Key points

- Older people are the majority users of health and social care services in the UK and internationally
- Many older people have frailty and are at increased risk of sudden and disproportionate changes in health following minor illness
- All encounters between health and social care staff and older people in community and outpatient settings should include a frailty assessment
- Gait speed <0.8 m/s; timed-up-and-go test >10s and PRISMA 7 questionnaire ≥3 can indicate frailty
- The BGS recommends an holistic medical review based on comprehensive geriatric assessment for those with frailty

Supplementary data

Supplementary data mentioned in the text are available to subscribers in *Age and Ageing* online.

Conflicts of interest

None declared.

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