Healthcare Improvement Scotland

Early identification and assessment of frailty webinar

Tuesday 05 December 2023

Question-and-answer session responses

The question-and-answer session generated a lot of questions. Some were put to the speakers directly which can be heard in the recording. These and any questions unanswered on the day can be found below.

Early identification and assessment of frailty

Joanne Payne, Occupational Therapy Service Lead, NHS Ayrshire & Arran

Theme	Question	Response
Identification tools	Were other means of practitioner identification of frailty, other than the eFI, considered? Such as the Rockwood Clinical Frailty Score (CFS)? My understanding is the two do not correlate, while the evidence is strong for the CFS, which does correlate well with other measures.	There are a number of tools in our toolkit to support the identification of Frailty. The team do use the Rockwood CFS routinely for everyone that is referred into the service. The eFI is a tool we use to identify individuals who are experiencing difficulties across a range of 36 potential deficits. As I intimated in my presentation, it is only as accurate as the

		information that is coded on the GP system, so I don't think we can rely on it alone, but it can supplement identification.
	Does the EFI correlate with Rockwood Frailty Scoring?	You can map the eFI against the Rockwood CFS, (Appendix A). I haven't found any evidence that the two correlate. My take is that they are two quite different tools that complement each other.
	Are you running the eFI across all GP practices?	One of the surgeries in South Ayrshire was involved in the frailty collaborative before this work started. I have direct access to the eFI lists in this one practice. We are working with Business Intelligence to set up an automated eFI report. This will generate a list of individuals (on a 3 monthly basis), whose eFI score has changed 2, 3 or 4 points in a 3, 6 or 12-month period. Until this is automated Business Intelligence have manually generated a report for my team, and we are proactively contacting these individuals and offering a conversation. We have lists for all of the surgeries that we cover (10/18).
Multidisciplinary team working	What do referrals onto other professionals come under? Is that community resources?	25% of individuals referred into the service are referred onto other health professionals. Physiotherapy, Pharmacy and Dietetics are the three most common health professionals that we would refer onto.
	How does the team work with local community rehabilitation teams?	I led on the development of the occupational therapy service in the community rehab team, so we work closely with them, and they are aware of the rationale for the work. I often use the Rockwood CFS as a way of supporting staff to visualise how the services align and to move referrals to the most appropriate service.
	The presentation was from an OT perspective, I wonder if there is a Dietitian involved in any frailty work with you?	Not at the moment, hopefully long term we will have a Dietician. The Dieticians did some really useful training with the team. The training highlighted common signs and symptoms of malnutrition and advice about eating well. This is

		supported by a resource recommended by the Dietician. Good links have been built, and the team have been encouraged to discuss any individuals with the Dietician if they have any concerns. At this point the referral can be discussed and made if appropriate.
Assessment and intervention	What training do the band 4 staff receive to support them completing the lifestyle questionnaire with patients?	The Assistant Practitioners have had lots of training, and the wellbeing review is developing all the time. We have also done some role play to practice carrying out these conversations with staff. Practice supervision is also really important.
	Is the leaflet shown a global leaflet regarding OT, Physiotherapy, as exercise PT group is shown? (Appendix B)	We have really good links into our local exercise programmes for older people, which we regularly signpost to. We don't have a Physiotherapist in the team but two of my team are Postural Stability Instructors and run a community falls education group. The team are about to be trained to carry out Functional Fitness MOTs (Later life training).
	Do the assessments include assessment of strength and balance?	Not at the moment, although I have got funding to take the assistant practitioners through the Functional Fitness MOT training. This would enable us to include assessments of strength and balance and offer 'drop-in clinics.' We have recently started a community falls group, run by the assistant practitioners who are both Postural Stability Instructors.
Outcomes and data	Are there plans to apply the routine pre-post outcomes across the population for all services in the pathway?	I think it is really important that the frailty work in South Ayrshire is as joined up as possible and we speak a common language around frailty. This would definitely be part of my long-term plan.
	Can I ask how you gathered the data around reduced GP appointments based on your input?	I manually collected the data. I accessed the GP EMIS system and reviewed how many GP appointments 29 individuals had in the 6 months before our input and then GP appointments used in the 6 months after they were discharged from our service. Our quality improvement team supported the analysis of the data.

	Do you have any measures of patient important outcomes?	EQ5D, IoRNs2 and Self Management Ability Scale show measurable impact. At present there is no evidence that it is reducing admissions or length of stay, however hopefully through time this will be the case.
Communication	If there is one piece of advice you would give to other teams interested in setting up similar work in their area, what would it be?	Engagement with stakeholders. This is really important because everyone needs to be on the same page about what you're trying to achieve and why it is so important. Time - really important to allocate time for project meetings to work out referral pathways and the information we were going to use for assessment and the evidence. You can never engage too much with people. Currently pulling together a communications strategy about how we then move this forward.
	Is this information communicated to secondary care, and do you use the eFI or CFS to do so?	Yes, we link in closely with secondary care services and these conversations are supported by using the CFS. In a previous post I managed the community rehab team so we have good links with them and meet with them fairly regularly. Started to collect data on the impact our service is having on referrals into secondary care. It's probably a bit too early but there seems to be a shift downwards in terms of those referrals. It's about relationships and engaging people and communicating. Proactive rather than reactive is a new way of thinking for some staff.

Update on Albasoft (Escro)/NSS Digital and Security in relation to eFI

Billy Davidson, Project Analyst, Clinical Informatics Team, NSS Digital and Security and Dave Kelly, Technical Director, Albasoft (EScro)

As well as knowing an eFI score for an individual at a specific point of time, it is also helpful to know how quickly an eFI score is changing. Will the new dashboard on ESCRO allow us to identify and focus on people whose frailty scores are deteriorating from one month to another?	As per previously in SPIRE local (practice based) reports will be available through Albasoft that further refines the population to focus on high priority individuals. The high priority groups include people who: • escalate to being moderately frail • are moderately frail and have experienced significant change • escalate to being severely frail • increasingly severely frail
Who would eventually have access to these new data platforms? Would Integrated Partnership data analysts be included in this access?	Yes. We are going to start up the GP editorial board which will be a GP from each of the LMCs, one extra from the RGPC and one from academia. These GPs will work to get consent from all 896 practices for us to use their data on a use case basis. We are looking to set up a domain zero, which will be direct care only and then we look to share the data on a use case basis with all of the boards, PHS, our LIST colleagues and anybody else that needs that downstream data and has got a legitimate use for this data and the IG in place to do so.
How do we access the eFI scores for our patient population in General Practice (Vision system)?	Every practice has a small Escro utility called the vaccination import tool. The efrailty tab is available in this tool. This still requires further development so I would encourage you not to use this tool at the moment. It will give individual patient data but it doesn't give the report

	yet provided by the previous SPIRE tool. That should happen soon, and we will let each practice know that it is available.
How/will academics be able to gain access to the eFI data on the new system?	Aggregated data will be extracted and made available to Public Health Scotland. Details on what and how this will be shared is to be established.
One of the areas for consideration is that frailty is not always linear, frailty can be delayed and/or reversed. How could EFI incorporate this? Early identification is key to access the right care at the right time. Read codes are not updated how could this be recognised?	The eFI report can be used alongside individual clinical assessment to support early intervention and prevention work, for example those identified as living with mild to moderate frailty. (Link: Living Well in Communities with Frailty: Evidence for what works, Healthcare Improvement Scotland, 2018.) It is important to recognise that eFI can only analyse codes which are entered onto a person's GP record. Therefore, GP practices may wish to consider how well the 36 deficits are coded locally. The team at Leeds University who developed the original eFI have developed an improved version of the eFI which introduces, amongst other things, time constraints on certain codes. Work is ongoing in Scotland to establish the case for introduction of this version of eFI.

Appendix A

Mapping eFI to services – guide for HCPs.

e-Frailty Index	Rockwood clinical frailty scale	
Fit	**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	
	3. Managing well – People whose medical problems are well controlled, but are not regularly active beyond routine walking	
Mild frailty	**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.	
Moderate frailty	**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.	
Severe frailty	**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.	

Early Frailty OT Assistant Practitioner Service

Early Intervention Primary Care Frailty Service

Community Rehab Team

Intermediate care team/District nursing

Appendix B


STAY AHEAD OF THE CURVE
Do you feel that you would benefit from a FREE health and wellbeing review from the comfort of your own home?
• Have you noted a decline in your appetite?
• Can you be unsteady on your feet at times?
• Are you easily tired?
• Do you feel lonely or isolated?
• Have you noticed any difficulties attending to your usual tasks?
• Has moving around your home become more of an effort?
As we age it may feel like our bodies are slowing down. Often this is accepted as normal part of the aging process.
However, we can make a difference to how we age, and getting older does not have to mean losing your independence.
We are here to help.
As an Occupational Therapy Team we understand how to support people to manage healthy ageing. With our help, you can make a difference to how you age well.
Please get in touch if you would like to have a chat with one of our team to see if we can help support you to live your life in a way that is important to you, a life as independent as possible.
Contact us today!
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