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Frailty symposium

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DECLARATION OF INTERESTS No conflict of interests declared

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INTRODUCTION

Frailty is a multimodal concept that increases vulnerability for developing dependency or death.[1] Common models focus on the development of a phenotype or the gradual accumulation of deficits over time, but there is no clear consensus on the best form of measurement.[1-3]

With an ageing population, we need to be aware of the challenges surrounding this concept. Being able to anticipate and support their care needs adequately in different settings ensures that optimal care is delivered.

This symposium was delivered by well-renowned speakers, summarising their experiences, views and research in this broad area. It was well received by delegates, and webstreamed to various international locations.

SESSION 1 – FROM BENCH TO BEDSIDE

Dr Andrew Clegg (University of Leeds) made the audience aware that frailty is the most common condition leading to death in older age. He explained how various body systems were affected and understanding this pathophysiology was key to understanding the events that lead to frailty. Dr Clegg outlined a model, based on the results of a primary care cohort, which would allow professionals to stratify levels of care. This includes supported self-management in those with mild frailty, care and support planning in those with moderate frailty and a comprehensive geriatric assessment (CGA) plus anticipatory care planning (ACP) in the more severely frail.

SESSION 2 – FROM POPULATION TO PERSON

Professor David Oliver (Royal Berkshire) described the impact of the ageing population on the NHS. Six million people in the UK are carers for older people. In 1947, 45% of the population died before the age of 65, compared with only 12% now, and 78% of patients in care homes have a diagnosis of dementia and 67% need help with their mobility. This is 'core business' in modern healthcare.

The Marjorie Robertson lecture was delivered by Professor Linda Fried (Columbia University) who described the 'cycle of frailty' where several factors intertwine with each other to create a vicious cycle that can be precipitated at any point to cause a downward spiral. This was further supported with study data that have shown that, with increasing frailty criteria, there is a dramatic increase in activities of daily living dependency.

The key message from this session was that there must be a shift to prevention and anticipation of frailty, using guidelines that are non-age discriminatory and support patient autonomy.

SESSION 3 – LIVING WELL

The speakers in this session described three key aspects in ensuring that the frail elderly 'live well': reducing inappropriate medication use; caring for patients in their own home; and ACP.

The percentage of inappropriate medication prescribing is worrying (13–18% in primary care, 30% in secondary care, and 33%–50% in nursing home residents). Professor Denis O'Mahony (Cork University Hospital) outlined randomised controlled evidence on 'STOPP' and 'START' criteria[4] in modifying the number of drugs prescribed to patients, resulting in both reduced drug costs and average number of falls. He emphasised the need for high quality trials, clinical decision support systems and multidisciplinary interventions to reduce adverse drug reactions.
Dr Angela Wilkinson (NHS Fife) described the Fife

Hospital at Home (HAH) service. This model has been shown to be safe, effective and can result in significant cost savings. An ongoing trial comparing CGA in HAH versus as an inpatient should provide us with further data on feasibility.

Professor Scott A Murray (University of Edinburgh) described multidimensional trajectories (physical, psychological, social and spiritual) involved in end of life care in the frail older person. He outlined the benefits of electronic recording of ACP and Key Information Summaries by GPs, and how collaboration of primary and secondary care is imperative in optimal future planning.

SESSION 4 – AN AID TO DECISION-MAKING

Dr Simon Conroy (University Hospitals of Leicester) described robust evidence demonstrating that frailty screening and CGA at the hospital 'front door' reduces 90 day readmission rate. The integration of acute and community care, health and social care and information systems; with reduction in 'hyper-specialism' could be the answer to delivering holistic care.

Professor Margot Gosney (University of Reading) painted a realistic picture of age being seen as a barrier to cancer treatment. Professor Gosney's successful collaborative work with COCOC (Comprehensive Care of Older people with Cancer) supports the Macmillan recommendation of involving geriatricians in cancer care to balance survival gain with end of life, life expectancy and support needs.

TAKE HOME MESSAGE

Frailty is a common, complex multisystem long term condition. Measures should be taken to address the complex needs of our current and future patients. CGA and multidisciplinary teamworking are core components in ensuring holistic care. Further collaborative work in anticipatory care planning and end of life care are key areas in promoting patient autonomy.

REFERENCES

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