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What can GPs do with the Electronic Frailty Index?

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ABTRACT

Introduction

UK GPs are required to apply the electronic frailty index (eFI) to their patients, yet there is limited advice about what to do to the patients having done so. We sought GP's views of what they thought might be feasible and useful to do based on eFI scores.

Method

The Nominal Group Technique was applied to ascertain the views of 70 GPs and other primary care professionals.

Result

The most frequently prioritised potential actions the participants agreed on were: a multi-agency approach; access to a single point of access; easy access to respite care; matron involvement; promotion of sick day rules (such as stopping diuretics or antihypertensives when ill); and support for nutrition and hydration.

Discussion

The findings of this study could form the basis for a toolkit to support the management of frailty in primary care.

INTRODUCTION

Frailty is a state of increased vulnerability to poor resolution of homeostasis after a stressor event [1]. This reduction in reserve puts people with frailty at a higher risk of adverse outcomes, including falls, disability, hospital admission and death [2]. As frailty is a syndrome affecting many physiological systems, a holistic approach to its prevention and management is likely to be required. This is reflected in the British Geriatrics Society's Fit for Frailty campaign, which recommends a holistic review of needs, medication reviews, shared care plan, and developing local guidelines for care of those with frailty [3].

Frailty is a long term condition affecting many people in later life. Diagnosis is a necessary step before considering interventions to modify the progression of frailty. Several conceptual models have been applied to the diagnosis of frailty. One diagnostic approach is based upon the phenotype model, which defines frailty in terms of 5 factors: unintentional weight loss; self-reported exhaustion; weakness (grip strength); slow walking speed, and low physical activity [2]. A difficulty of using this approach to diagnosis, particularly in primary care, is that special effort and time is required to make these measurements. An alternative approach has been to devise a method based upon the cumulative deficit model of frailty using factors [4] already available to primary care practitioners within their online systems. The tool developed using this approach for use in UK primary care databases is the electronic Frailty Index, eFI, [5] which uses 36 different deficits drawn from Read codes built into UK GP databases. The eFI classifies people into those with mild, moderate, or severe frailty. Being derived automatically from routine data, the diagnosis of a frailty state is easily achievable within a typical 8-10 minute GP consultation.

In the UK, the General Medical Services contract from mid-2017 requires GPs to prospectively identify frailty in patients aged 65 and over [6] using the eFI. If a person is identified as having severe frailty, GPs are advised to ensure that an annual medication review and a falls assessment are undertaken. In addition, the contract suggests that practitioners use 'clinical judgement for other relevant and appropriate interventions' [6]. As yet, there are no more specific guidelines on what such relevant and appropriate services are, particularly for those with mild or moderate frailty. We decided to ask what GPs themselves think are relevant and appropriate actions to take on the basis of an EFI assessment.

METHOD

We took advantage of an educational session attended by GPs and other primary care clinical staff of the Nottingham North and East Clinical Commissioning Group (CCG) at which one of the authors (JRG) had agreed to provide an educational session on frailty in January 2018 – when the eFI was already in use. A general talk on the frailty concept and background on the eFI frailty was given.

A consensus method, the nominal group technique was used [7]. Participants (70 primary care practitioners, around 2/3 of whom were GPs, with the remainder comprising practice nurses, matrons, and community allied health professionals) were asked to consider their responses to the question "what do you think you could usefully do, or could usefully be done, for a patient identified with mild, moderate or severe frailty?"

Step 1- Each participant was given up to 10 minutes, in silence, to come up with their own ideas for the above question.

Step 2- After this period of silence, all ideas were collated as brief statements and recorded and displayed in real time on a screen

Step 3 - The participants were then given the opportunity to ask questions to clarify or elaborate on these brief statements to ensure that they were understood. Statements were modified and some duplicates were removed in line with this discussion and numbered.

Step 4 – Each participant was then asked to select what they felt were the best 3 statements, using voting papers where they entered the numbers of their chosen statements. They were not asked to rank these three statements

The analysis approach taken was first to combine results from some statements which on reflection were duplicates that had not been removed at the time and then simply to calculate the number of votes cast for each.

RESULTS

35 statements were generated in stage 3. Several had overlapping concepts, and so were combined. This included 'hearing and vision' and 'new hearing aid battery', as well as 'medication review' and 'medication review with pharmacist' and also 'easy appointment' with 'longer appointment'. This left a total of 32 separate statements, shown in Table 1 with the number of votes for each.

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Table 1 Ideas put forward by the primary care practitioners and how many votes each received.

Multi agency approach - social/medical	22
Single point of access	21
Easy access to respite	20
Matron involvement	16
Sick day rules (such as stopping diuretics or antihypertensives when ill)	16
Nutrition and hydration	15
Longer appointment	13
Comprehensive medication review / Medication review with pharmacist	13
Befriending and voluntary services	11
Long Term Care nurses involved	11
Group exercise schemes	7
More day centres	7
Care plan at home	5
Personal trainers	4
Mobility assessment	4
Supported living	4
Special notes for out of hours use	4
Care packages	3
Carers assessment	3
Improved transport	3
Flu and pneumonia vaccinations	3
Vision and hearing	2
Electronic Palliative Care Co-ordination Systems (EPaCCS)	2
Mental Health assessment	1
Assisted technology	1
Health check	1
Involve family in care planning	1
Advocacy and MCA	0
Fire service- Health and wellbeing check	0
Visiting schools	0
Smoking cessation	0
Electronic platforms	0

DISCUSSION

This simple and quick process yielded a large number of potential proactive and reactive responses that GPs and other primary care staff could take to respond to a frailty diagnosis. The most common choice was for the use of a multidisciplinary or multi-agency approach, which is likely to reflect both its generic nature but also reflect the fact that doing so might be a particular challenge for GPs in their typical surgery settings. Allied to this was the second choice, the "single point of access" referring to simple means through which a GP or practitioner could reach the various and multiple agencies that would be required to generate a multi-agency response. Of note is that the participants ranked social issues (need for respite, and loneliness) as of great importance, as well as responses to basic care such as hydration and nutrition. They also noted the need for longer appointments than are traditional in primary care, and the selection of the need for sick day rules (such as stopping diuretics or antihypertensives when ill) and medication reviews with pharmacists illustrate the difficulties associated with polypharmacy experienced by these participants.

Clearly there are limitations to this study. The process was done quickly and so more time may have led to a wider range of statements, and greater consideration of them. The options may have been influenced by the preceding lecture and hence biased by the views of the presenter (JRG). For example the omission of advance care planning in the list generated by the participants may reflect the fact that the presenter proposed this response in his preceding lecture. The statements generated and their relative importance to participants was likely to reflect local deficiencies in provision, and hence might not be widely generalizable. However, it was a reasonably sized sample, and of practicing clinicians attending their routine educational system, and thus is likely to reflect the typical view of GPs and practitioners rather than more selected groups as seen in specific research projects. We argue that despite the limitations, this is likely to be a fair snap shot of GPs views, showing them to be familiar with a large range of potential options for frailty care and of constructive ideas that might drive welcome service improvement.

We believe that these findings are sufficient to support continued effort in the elusive area of integration of health and social care. The notion of a single point of care has been around for many years, so it disappointing that (in this locality at least) the need for it was amongst the highest ranked statements. The availability of a functional single point of access to services might allow access to many of the interventions listed in the table, and hence might be the single most important response to these findings.

We also think that these findings also justify revisiting the provision of respite care. Over recent years there has been increased focus in the NHS on active, rehabilitation, style of care such as intermediate care and in social care with "re-ablement". Passive forms of care such as respite care have had lesser policy promotion. For example, the NHS National Service Framework for Older People (2000-2010) strongly promoted intermediate care but barely mentioned respite care. Respite care has been considered part of social care responsibility, yet social care budgets have been particularly squeezed of late. But if ordinary practitioners such as these feel there is a need for access to respite services then this is likely to mean that patients end up being sent to hospital inappropriately instead. Respite care might be cheaper, more acceptable, and safer than hospital care.

In conclusion, this exercise has demonstrated that the use of a simple and usable tool to identify and diagnose frailty such as the eFI is likely to have value for individual patient management – in addition to the role of the tool as a population segmentation approach in service planning and evaluation. Further, the findings in Table 1 (with the addition of advance care planning) could provide the basis for the development of a primary care frailty toolkit.

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