GP with Extended Role in Frailty and Dementia

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Coordinated, proactive and person-centred care for people living with frailty

QUESTIONS

- What is a GP w ER in frailty
- What is frailty
- Why is it important

  NHS England » Best practice guide for NHS frailty pathways
- Multiprofessional teams across organisations
  - Neighbourhoods
- Person centered care



The challenge of an ageing population

- Number of **people aged 85 and over is projected to almost double** from 1.7 million in 2022 to 3.3 million in 2047.

- **Life expectancy is generally increasing,** healthy life expectancy is decreasing.

- **Older people are the main users of health and social care services** – people over 65 account for around 40% of hospital admissions and around 60% of hospital bed days.

Frailty clinical definition

Frailty is a clinical state that is more common with increasing age.

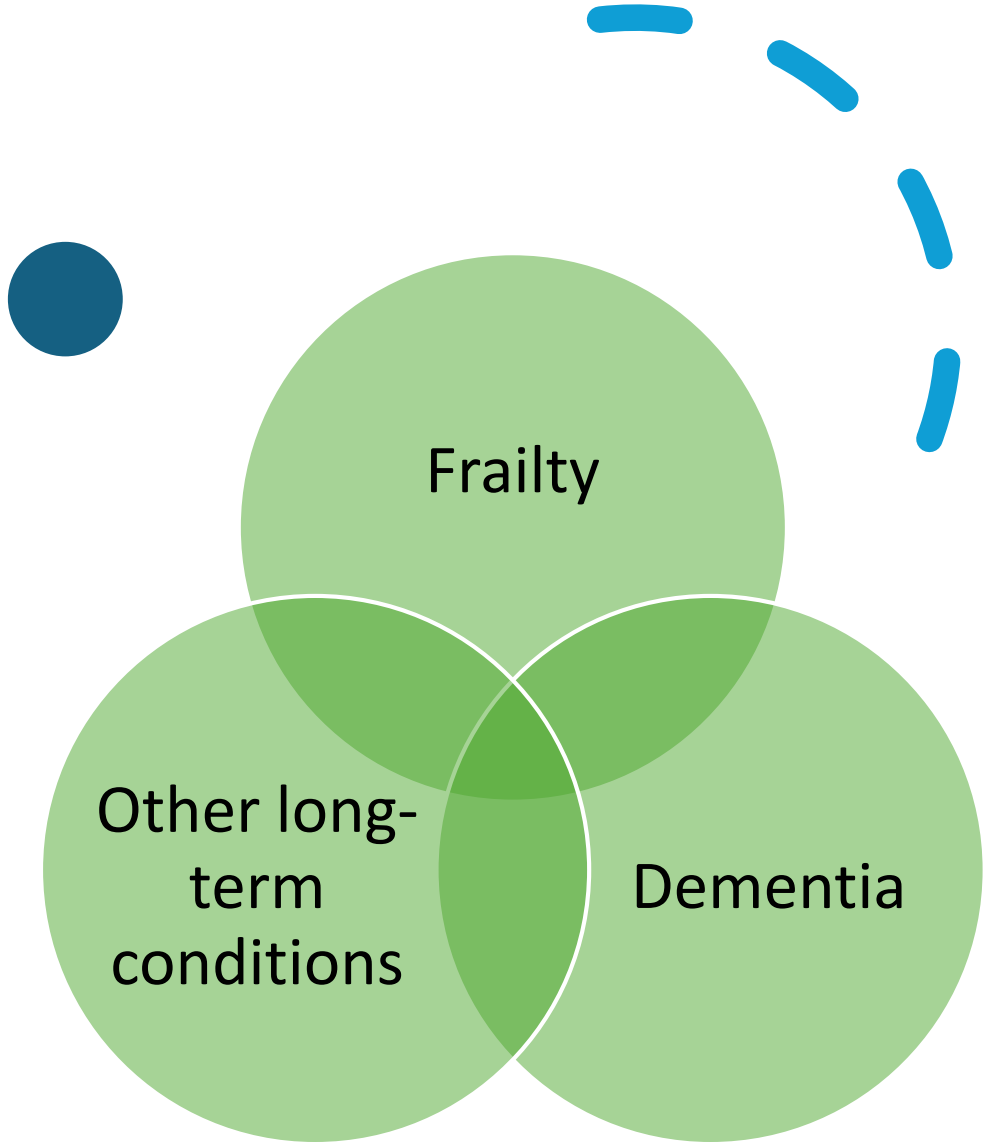
It is characterised by decreased physiological reserve, an increased vulnerability to stressors, and an increased risk of adverse outcomes such as falls, delirium, loss of function or independence, hospitalisation, long-term care needs and premature mortality.

NHS England, 2026

10% of people aged over 65 and up to half of those over 85 are living with frailty.

Frailty costs UK healthcare systems £5.8billion per year.

People over 75 living with frailty occupy around 20% of hospital beds.



Clinical Frailty Scale*



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 **active occasionally**, e.g. seasonally.



3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.



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.



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.



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.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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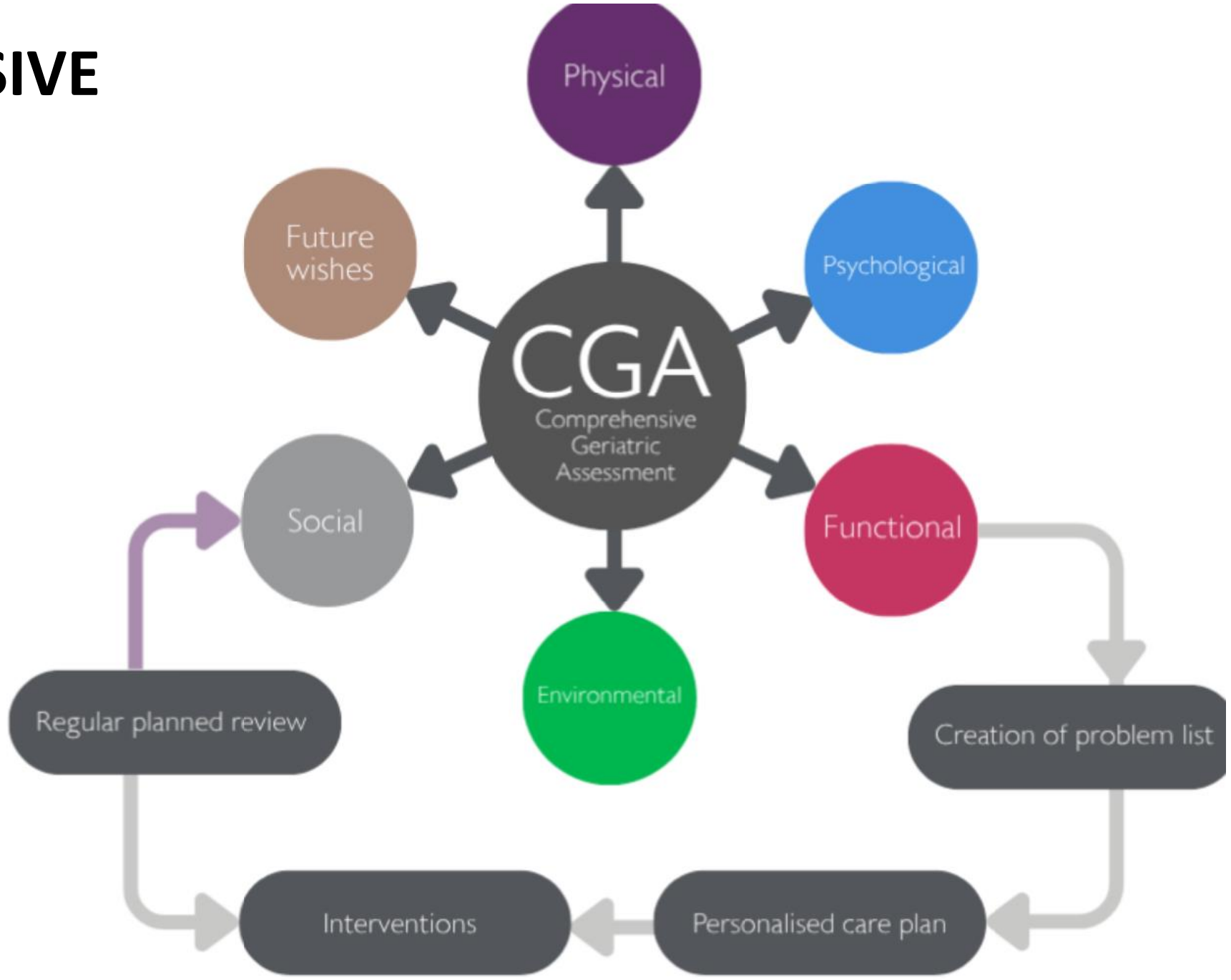
Inspiring Minds

COMPREHENSIVE GERIATRIC ASSESSMENT



British Geriatrics Society
Improving healthcare for older people

Pragmatic prescribing to reduce harm for older people with moderate to severe frailty

British Geriatrics Society
Improving healthcare for older people

Moderate frailty (CFS 6)

Individual needs help with some aspects of personal care (e.g. washing or dressing), may struggle on stairs, may no longer go out alone



Severe frailty (CFS 7-9)

Individual needs help will all personal care or receiving palliative care



Key aims		• Use shared decision-making to establish patient goals. • More lenient therapeutic targets may better balance medication harms and benefits.	• Symptom control.
Common conditions	**Potential harm from medicines**	**Adjustment**	**Adjustment**
Hypertension	• Falls Fractures • Electrolyte imbalance • Acute kidney injury	More lenient target – average systolic BP in range 140-160 mmHg.[1] Measure BP when sitting and one minute after standing – use lower value for therapeutic decisions.[2]	No BP target – harms likely to exceed benefits. Deprescribing advised.
Type 2 Diabetes	• Hypoglycaemia, leading to cognitive decline/falls	HbA1c target 60 to 75 mmol/mol.[3]	Avoid symptomatic hyper/hypoglycaemia. Simplify prescription.
Cholesterol	• Myalgia • Sarcopenia • Functional decline	Primary prevention: deprescribing advised. Secondary prevention: NNT likely to exceed 100/year to prevent one cardiovascular event – discuss stopping.[4]	Harms likely to exceed benefits. Deprescribing advised.
Heart failure with reduced ejection fraction	• Hypotension • Volume depletion • Falls	Limiting prescribing to fewer than the 'four pillars' may be a better balance of risks and benefits.[5] **ARNI/ACEi** Hypotension, hyperkalaemia. **Beta-blocker** Orthostatic hypotension. **MRA** Dehydration, hyperkalaemia. **SGLT2i** Dehydration, urinary tract infection, thrush.	Continue loop diuretics for fluid overload only.
Osteoporosis	• Therapeutic burden	If on bisphosphonate >3 years, then little evidence of benefit of continuation for next 3 years - discuss stopping.[6]	Treatment unlikely to be beneficial if immobile or in last year of life.
Cognitive impairment	• Accelerated cognitive decline • Falls • Fractures	Minimise exposure to anticholinergic medicines.[7] Evaluate ongoing risk/benefit of any antipsychotic or sedative medications, favouring deprescribing if possible.	Continue anti-dementia drugs if ongoing symptomatic benefit.

CFS = Clinical Frailty Scale,[9] BP = blood pressure, NNT = number needed to treat, ARNI = angiotensin receptor neprilysin inhibitor, ACEi = ACE inhibitor, MRA = mineralocorticoid antagonist, SGLT2i = sodium glucose co-transporter 2 inhibitor

Clinical Frailty Scale (CFS) icons reproduced with permission from The Geriatric Medicine Research Team, Dalhousie University.

General guidance

Use shared decision making (NICE NG197)
Ensure clear communication with patient (or representative): the aim is that each patient is taking only medicines that have real value for them and avoiding medication-related harm. Decisions can be supported by NNT data.[8] But very few people with moderate or severe frailty have been included in clinical trials of medicines. Reduced life expectancy will attenuate prognostic benefits seen in less frail people.

Benefits
Medicines taken for prognostic reasons should be re-evaluated and deprescribing offered.

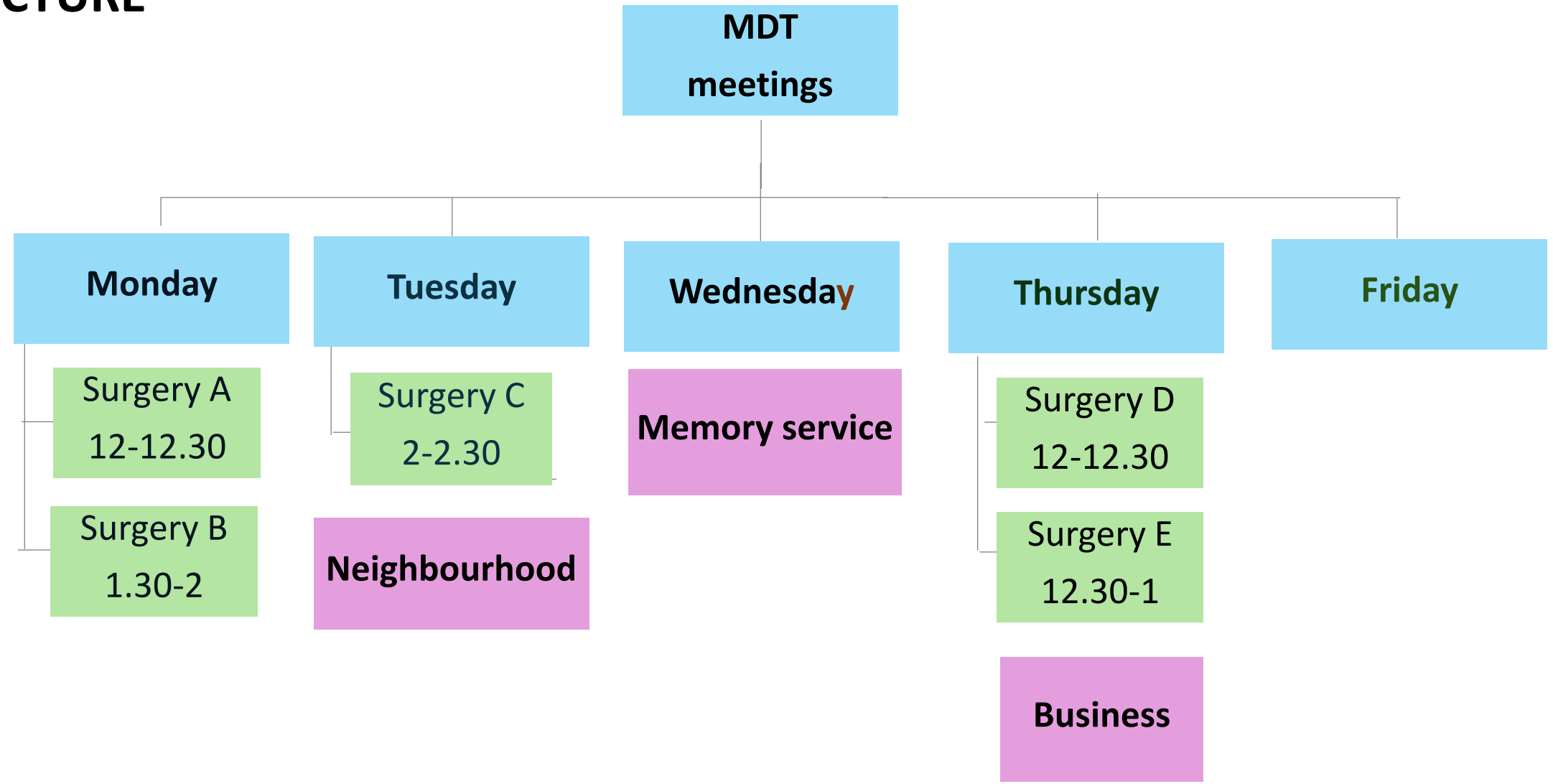
Risks
Polypharmacy increases the risk of drug adverse effects and therapeutic burden. Frailty increases the risk of adverse drug effects e.g. via weight loss or renal impairment.

Alternatives
Harms may exceed benefits for medicines. Anticholinergic/antipsychotic/sedative medicines are very likely to cause adverse effects. Symptomatic hypo/hyperglycaemia and fluid overload/dehydration should be avoided. Deprescribing should be offered for medicines that are not providing on-going symptomatic benefit.

What if I do nothing?
Not addressing problematic polypharmacy exposes patients to avoidable harm.

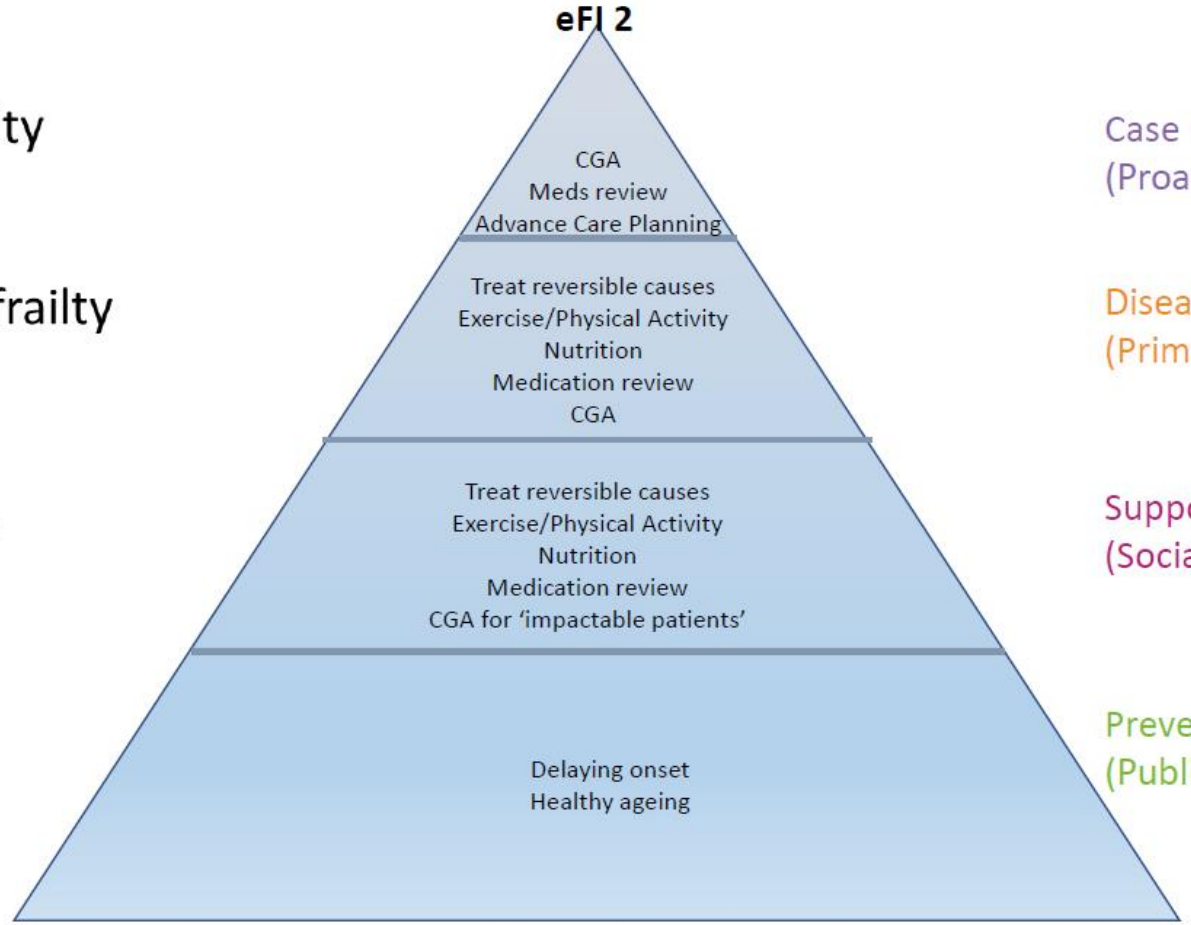
Evaluate adherence (NICE CG76). Follow guidance for multimorbidity (NICE NG56) and medicines optimisation (NICE NG5).

STRUCTURE


MDT meetings
Monday
Surgery A 12-12.30
Surgery B 1.30-2
Tuesday
Surgery C 2-2.30
Neighbourhood
Wednesday
Memory service
Thursday
Surgery D 12-12.30
Surgery E 12.30-1
Business
Friday

Principle 4: Deliver integrated proactive care closer to home





Case management
(Proactive and reactive Frailty Care)

Disease management
(Primary Care, INTs)

Supportive self- care
(Social Prescribing, INTs)

Prevention & wellness promotion
(Public Health)

Source: Adapted from Professor Andrew Clegg presentation HNY ICB Frailty Summit Oct 2024, Adapted from Kim D, Rockwood K. NEJM 2024


Ambulance
Police
Housing
In patient team
General Practice
GP/ACP Key Worker
Pharmacy
People Family Carers
Students
Adult Social Care
Older Person Mental Health
District Nurses
Therapy Teams
Village Agents VCFSE
ALZ SupportWorker
Memory Service

Introduction and overview of GPwER in frailty

Purpose

Acknowledgements

Declarations of interests by authors

Framework review

Frailty in general practice

Undertaking an extended role in frailty

Search this area

Introduction and overview of GPwER in frailty

Publication date: 14 August 2023

British Geriatrics Society

GPs look after

1. increasingly complex population living with
2. multiple health conditions,
3. with multiple medications,
4. managing risk safely,
5. co-ordinating care.

Is this not core GP work?

Role of GPwER

Early Frailty Identification

GPwER uses specialized tools and clinical expertise to identify frailty in patients early for timely intervention.

Comprehensive Patient Assessment

The role involves physical, psychological, and social evaluations to create tailored care plans for patients.

Medication Optimization

GPwER addresses polypharmacy risks by reviewing and optimizing patient medications to improve safety and outcomes.

Leadership and Coordination

Leading multidisciplinary teams, the GPwER ensures coordinated care and strategic planning for frailty management.



REDUCING HEALTHCARE INEQUALITIES AMONG OLDER PEOPLE

The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement for people aged over 65 in community and acute care.

Target population

CORE20

The most deprived 20% of the national population as identified by the Index of Multiple Deprivation



PLUS

Groups chosen by the ICS from those aged over 65 who may experience poorer-than-average access to or experience of healthcare and worse health outcomes, owing to social isolation, poverty, low health literacy or other factors not captured by the Core20 population alone. These groups may benefit from a tailored healthcare approach e.g. LGBTQ+ or minoritised ethnic groups.

CORE20 PLUS 5

Key clinical areas of health inequalities

1 FRAILTY

Identification of those living with mild, moderate or severe frailty to enable (a) proactive care in the community; (b) systematic frailty-attuned care; and (c) acute assessment for frailty syndromes including delirium.

2 DEMENTIA

Quicker diagnosis of dementia and more access to support services for the individual and carers.

3 FALLS PREVENTION & MANAGEMENT

Reducing the impact of falls and fractures by preventative approaches and appropriate treatments.

4 MULTIPLE LONG-TERM CONDITIONS AND POLYPHARMACY

Holistic biopsychosocial assessment of physical and mental health needs through CGA, including appropriate deprescribing.

5 END OF LIFE CARE

Increased focus on Advance Care Plans and shared decision-making, ensuring that more people have access to good care at the end of life.

Measuring success - tracking progress

- Increase in patient records with CFS score recorded and personalised care plan in place.
- Increase in primary care records showing eFI status.
- Increase in number of people with frailty receiving CGA
- Decrease in avoidable ED attendances and admissions.

- Increase in number of cognitive assessments using validated tool (4AT, MoCA, MMSE).
- Decrease in length of time from referral to diagnosis and the start of treatment.
- Increase in uptake of dementia support services for patients and carers.

- Decrease in number of patients with 2 or more falls in one year.
- Decrease in number of patients presenting with fragility fractures.
- Increase in uptake of strength and balance services.
- Increase in number of patients prescribed bone protection medications.

- Increase in number of structured and documented medication reviews.
- Increase in number of patients with MLTC receiving CGA.

- Increase in number of Advance Care Plans completed and documented.
- Increase in number of people accessing end of life care support services.
- Increase in people dying in their preferred place of death.

Produced by: BGS British Geriatrics Society Improving healthcare for older people

Endorsed by: RCGP Royal College of General Practitioners

ENTRY POINTS



Setting direction

- The willingness to try something new/innovation
- Improving services
- Breaking down barriers to care, building relationships/culture change
- They provide medical leadership in managing risk and complexity and resolve competing priority

Neighbourhood diagnosis of dementia

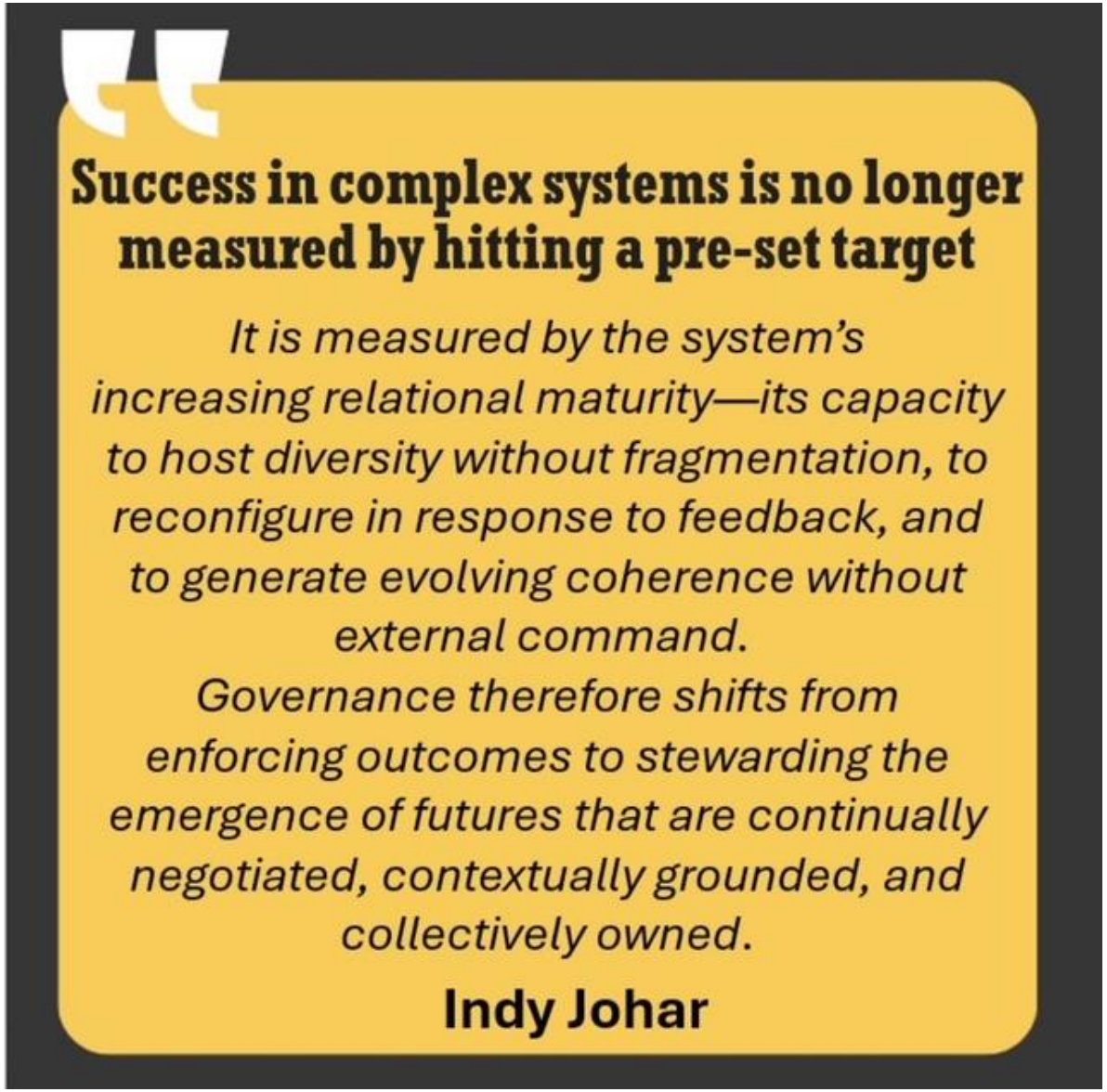
Area	January 2026	August 2026	Change
Pilot area South Somerset population 175,000	171	132	-39 (-22.8%)
Similar-sized area Population 155,800	210	291	+81 (+38.6%)

Key Findings

- The pilot area reduced its DAS waiting list by 39 patients, representing a 22.8% reduction between January and August 2026.
- The comparator area's waiting list increased by 81 patients, a 38.6% increase over the same period.
- One of the PCN's in S Somerset pilot has reduced it's wait list to 1-2 weeks.

CULTURE

REDUCING WASTE



IMPACT
PEOPLE
STAFF
SYSTEM

STAFF
IDENTIFY
AROUND
Community

Resources to help

- Frailty e-learning – aimed at Tier 3 health and social care free until June 2026: https://www.bgs.org.uk/frailtyelearning
- Joining the dots: A blueprint for preventing and managing frailty in older people: https://www.bgs.org.uk/blueprint
- Be proactive – evidence and delivery for proactive care and support for older adults with moderate to severe frailty. https://www.bgs.org.uk/be-proactive
- BGS Frailty Hub: https://www.bgs.org.uk/resources/resource-series/frailty-hub



THANK YOU

ANY QUESTIONS

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