Frailty and cancer across Wessex

Frailty and cancer conference
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Overview

- **Frailty and cancer workshops across Wessex**
- **Frailty and cancer education and training needs across Wessex**
- **Frailty teams across Wessex**
- **Implementing frailty assessment and management in oncology services – national guidance**

Frailty and cancer workshops

Three workshops – April 2023-August 2023

- Preventing frailty, Identification of pre-frailty and frailty assessment in people with cancer
- Management of frailty in people with cancer – considerations, impact of frailty on cancer and impact of cancer on frailty
- Learning from others and sharing best practice in the management of frailty in

What can/do you do to support the prevention of frailty in your everyday work?

- Recognising symptoms and knowing what to look out for.
- Frailty assessment, intervention and referring to classes to improve strength. Signpost to other available services.
- Empowering individuals and reviewing holistically so they have knowledge.
- Education for students specifically for frailty.
- Right treatment plan - what patient wants and goal specific for them.
- Interesting to hear today that people have become frail from treatments - would like regional pre-frailty support availability.

How do you support people with cancer who are frail?

- MDT approach and push back for next steps.
- Preventing patients getting frail from treatment.
- Different options for treatment after shared decision making.
- Referral signposting e.g. exercise prescription.
- Advanced care planning.
- Involve GP and referral to other health services e.g. PT, OT, dietetics, etc to avoid hospital admission
- Quality of Life ICHOM (International Consortium for Health Outcome Measurement) – What is important to the patient.
- Acute wards psychological support crucial and time spent with patients including signposting.

What do you observe in your role about the impact of frailty on cancer and the impact of cancer on frailty?

- The physiology of the cancer and the actual treatment toxicities and side effects which can increase frailty.
- Impact of treatment decisions (oncological) to patient choice, being informed and needing time.
- Patients unaware sometimes on the impact of treatment on frailty and quality of life.
- Impact on prognosis, quality of life, deconditioning and co-morbidities.
- Professional teams are treating a cancer, not a specific patient and their holistic needs. Patients can end up with a cancer cure but as a result a poor quality of life.
- MDT working need more input in decisions and can be challenging with communications especially with patients and families understanding terminology and goals.
- Fear from patient and professionals on safe exercising levels.

- Options for treatment may need to be reduced if increased frailty. Symptoms need careful management. Varying levels of how individuals cope with frailty and what matters to them. HCP must personalise approach accordingly.
- Impact of institutionalised care especially on personalised care.
- Significance of holistic assessment.
- Speed of change can be rapid and not always have time for complex decision making. Numerous dynamics to consider with decision making: -
  - rigid thinking, 'cognitive' rigidity.
  - 'Dr knows best'
  - family pressure.
- Loss of regular reviews for other conditions when have cancer diagnosis/frailty especially as cancer often impacts on other conditions.
- Shorter life expectancy.

What factors do you each need to consider in your roles when supporting people with cancer who are frail?

- Important to listen to what is important to the patient and it's never too late to ask their wishes. Making time for patients to express needs/fears/concerns/plans
- Discuss logistics of getting to appointments e.g, cost, time and mobility.
- Information about nutrition and supplements.
- Empower health care professionals to ask questions and dig deeper.
- Use baseline measures and resources available, assessment tools and co-morbidities to ensure quality of referral.
- Holistic assessment documentation to be communicated between teams.
- Quality of life and considering the impact of treatment including symptom control, syringe drivers, moving and handling.
- Rapport with staff/patient. Signposting access to other services and resources.

What have you found has helped/could help you in your role to support people with cancer who are frail?

- Collaboration with other health care professionals, MDT links and accessing local services.
- Investment in services and streamlining services. Growing prehab and rehab services.
- Oncology records need access to other health records.
- Training from specialist nurses.
- Sharing knowledge and information with patients and professionals.
- Acknowledging ‘we don’t always get it right’. Allow space to reflect and learn.
- Being explicit about signs and symptoms to look for if patient is unable to tell us. Involve other agencies who work with the patient e.g., learning difficulties.
- Joint visits with cancer nurses.

- Frailty has an impact on treatment decisions at MDT.
- Advance/Anticipatory care planning consideration of how it is communicated across sectors and unforeseen circumstances
- Rehab for ‘frailty’ as opposed to individual conditions like cancer.
- Elderly personal trainers needed using MDT approach and include the family and support network.
- Education health promotion difficult to achieve for the elderly population and it is usual that we need to hit a crisis to make changes.
- Need to change the patients mind set to self-management.
- Access to rural communities limited due to the geography of specialist services.

Frailty and cancer Training and Education needs

- 128 responses (115 support people with a cancer diagnosis and 13 do not)

- More than 30 organisations represented.

Highest number of responses from Dorset County Hospital (22) , Solent NHS Trust (17), Dorset Healthcare (13) and Hampshire County Council (12).

Department/team/service respondents work within

Job role

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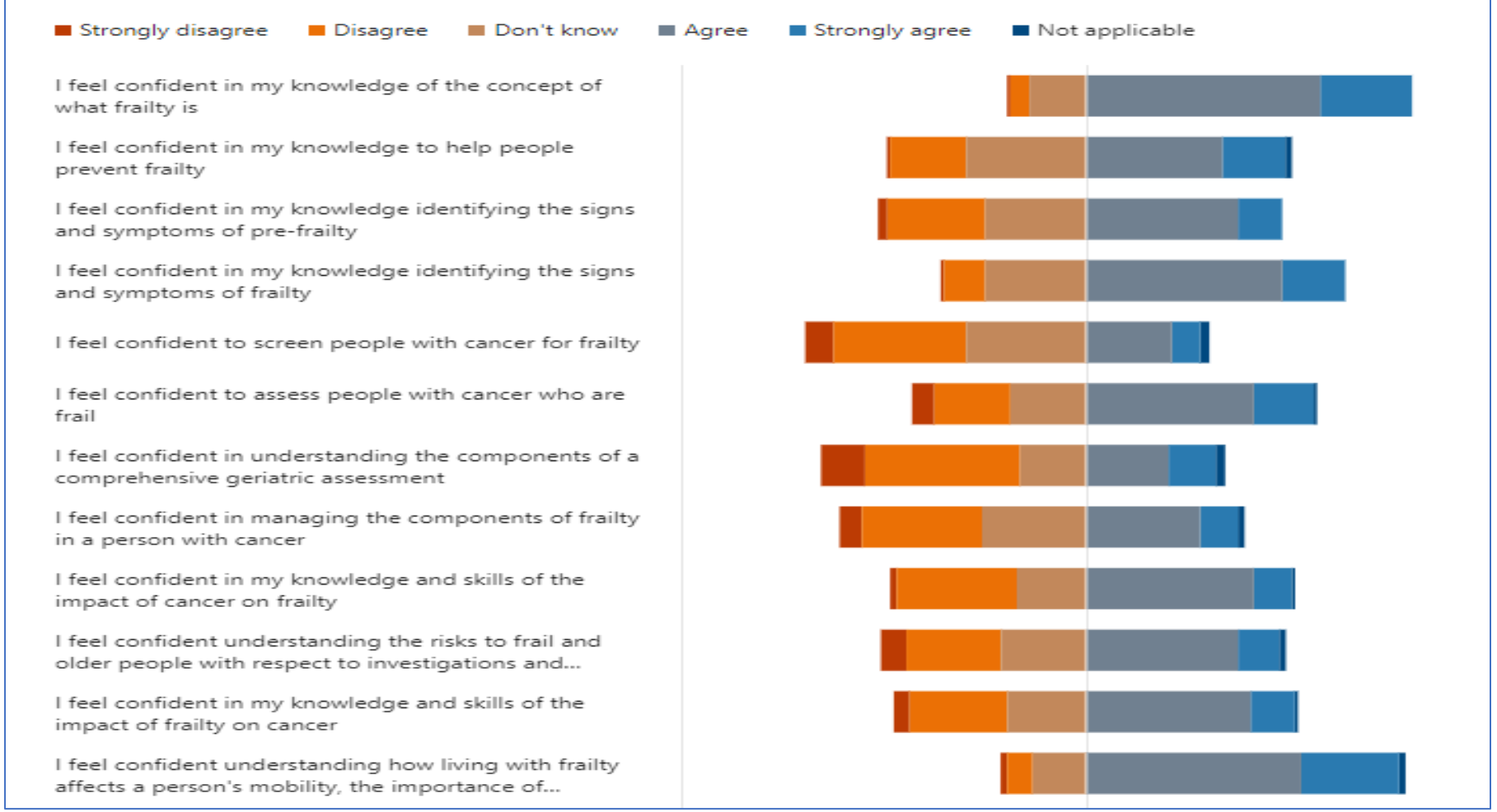
Confidence



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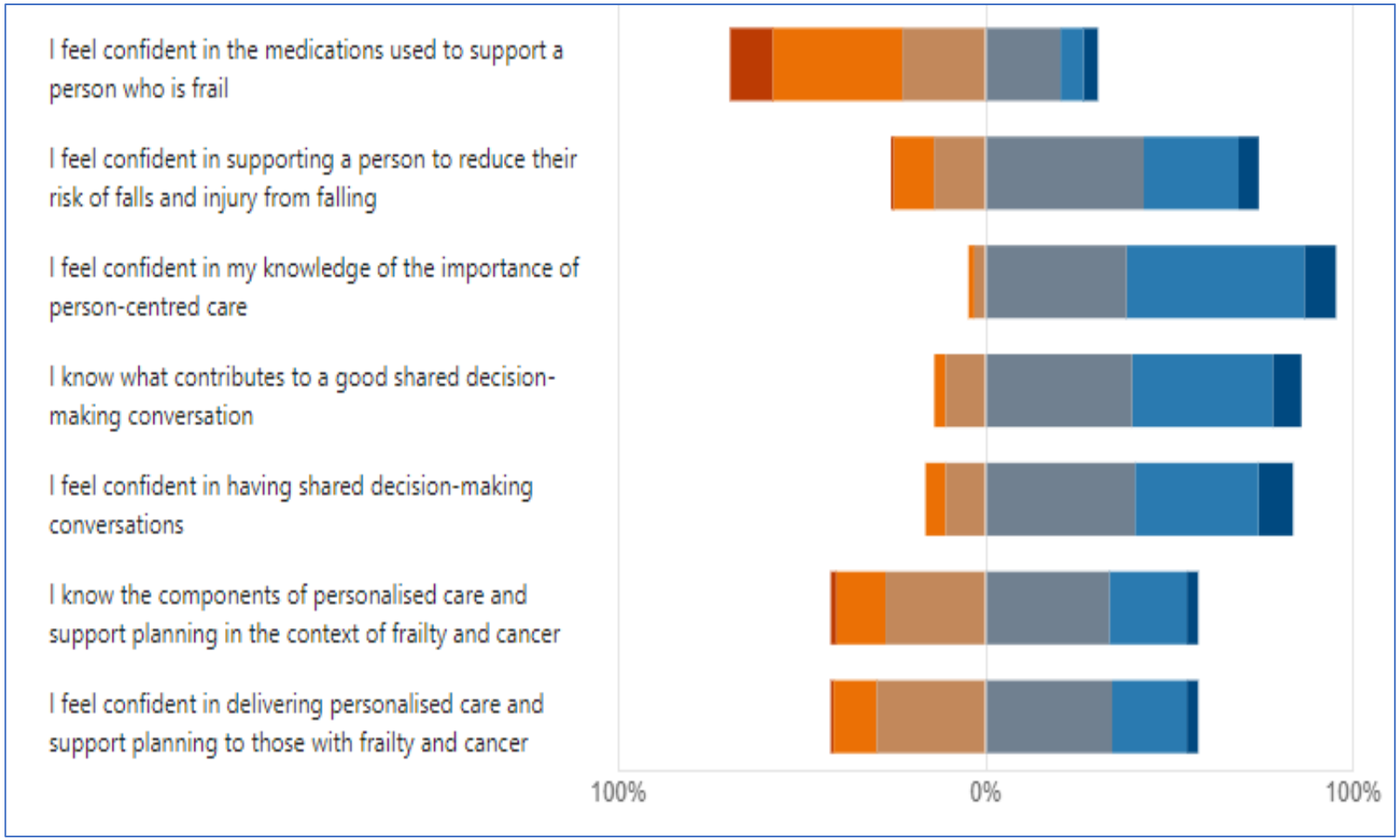
Confidence



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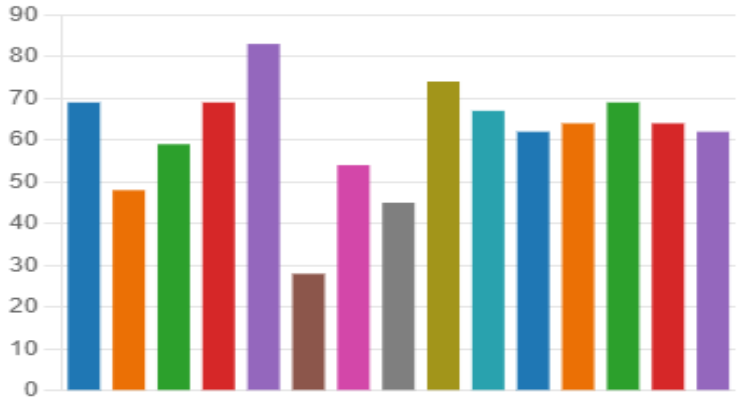
Training topics

18. From the list below, please select those topics you would welcome training on to support people with cancer who are frail (tick all that apply)

More Details

How to have a good shared dec...	69
Supportive care	48
Anticipatory care planning	59
Understanding frailty	69
Frailty identification and assess...	83
Person-centred approaches	28
Communication skills to support...	54
Families and carers as partners i...	45
Preventing and reducing the ris...	74
Living well with frailty and cance...	67
Prehabilitation and personalised...	62
Rehabilitation and personalised ...	64
Managing frailty and cancer thr...	69
Managing medication with frailt...	64
Personalised care and support p...	62



Frailty Teams across Wessex

Across HIOW and Dorset:

- **Professions/role involved**
- Service description
- Geographical coverage
- **Referral pathways**
- **Links to oncology services**

Frailty Teams across Wessex

Primary care:

HIOW – 16 PCNs with frailty hubs/services

Dorset – 7 PCNs with frailty hubs/services

Community care:

Acute care:

Professions/roles involved

Referral routes into frailty teams

Primary care teams

Care homes

Secondary care

Community services

Frailty Teams across Wessex

Primary care:

HIOW – 16 PCNs with frailty hubs/services

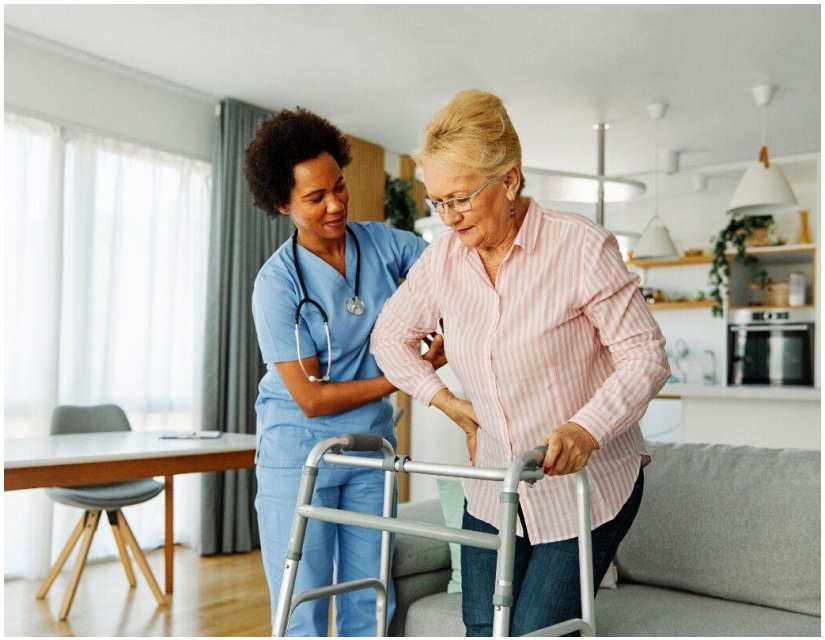
Dorset – 7 PCNs with frailty hubs/services

Community care

Acute care

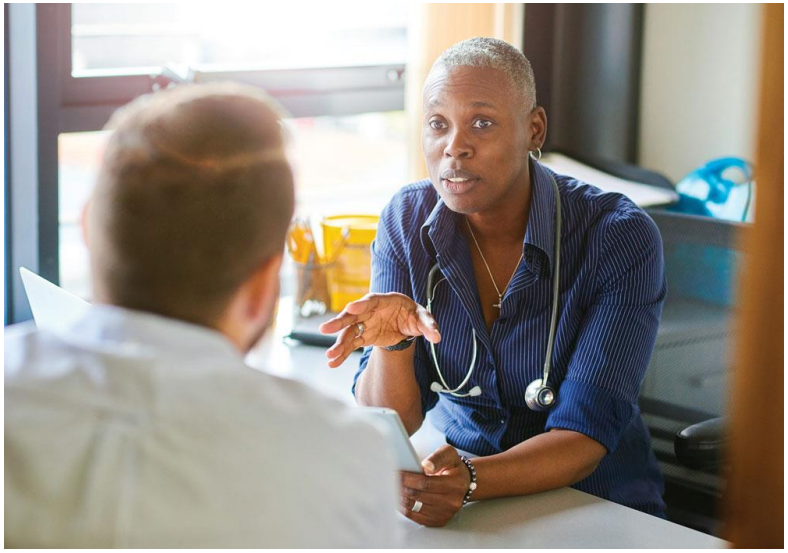
Links to oncology services

'If a patient with cancer was referred to the team they (the team) would visit and carry out holistic assessment which would include assessing whether they required any equipment or onward referral. If a patient was EOL I do not think they would accept the patient as alternative services would be more appropriate. They are aware of our Cancer Care Coordinator and Social Prescribing Team and know how to refer into these teams as appropriate.' (HIOW)



'Patients contacted when diagnosed and support offered directed to the individual needs of the patient and their carers/family members. Enhanced Care Team developing a neighbourhood model to aid in patient centred care. Home visiting offered by this service. Patients contacted when diagnosed and support offered directed to the individual needs of the patient and their carers/family members. Enhanced Care Team developing a neighbourhood model to aid in patient centred care. Home visiting offered by this service.' (HIOW)

'Frailty services can sometimes be helpful with diagnostics, but waiting times can be a barrier to this. Often two week wait services can adapt to frail patients for example completing CT diagnostics rather than invasive gold standards such e.g. scopes. We have found they are good at accommodating this if the right info is included on the referral form.(Dorset)



'The approach to patients with cancer is not necessarily any different to other referrals into the service however they can involve quite complex conversations around conservative management. The hub approach is to focus on symptom control, maintaining quality of life and avoiding unplanned admissions. Due to a multidisciplinary structure the team are able to support effectively and communicate regarding care needs with social services and palliative support. This ensures timely care and avoids duplication.' (Dorset)

Implementing frailty assessment and management in oncology services

[Implementing frailty assessment and management in oncology services | The Royal College of Radiologists (rcr.ac.uk)]

Key messages

- Frailty is common in patients with cancer, is associated with worse outcomes and should be assessed and proactively managed throughout the cancer diagnosis and treatment pathway

- Each step in the cancer pathway is an opportunity for assessing and managing frailty. Assessments should start as early as possible. Key time-points for frailty assessment are alongside 2-week wait referral/diagnostic work-up, prior to multi-disciplinary meeting discussions, alongside clinic appointments where an initial cancer treatment plan is made and at subsequent points in the treatment pathway when there is a change in a patient's performance status or proposed cancer management.

- A number of validated tools are available for assessing frailty. Clinical Frailty Scale may be a good starting point. Patients identified with frailty should be flagged for more comprehensive, multi-domain frailty assessments.

Key messages

- Frailty-informed care involves detecting frailty and considering it alongside shared decision-making, taking account of what really matters to patients and their families, as well as working to recognise and optimise potentially reversible frailty-related issues such as polypharmacy and problems with nutrition. This has been demonstrated to improve outcomes that matter to patients, including toxicity and tolerance of treatment, and quality of life.

- Frailty is everyone's business. Everyone involved in caring for adults with cancer has a role. To succeed in optimising cancer care for older people and those living with frailty we must utilise and upskill the whole MDT, including doctors, nurses and other allied health professionals across a range of specialities, from primary care to oncology, surgery, geriatric medicine and palliative care.

Recommendations

Effective care of frail and older adults with cancer requires tailored services with the following characteristics:

1. **Patient-focus** regardless of the location or structure.
2. **Strong clinical leadership** of multi-professional teams, with distinct roles and responsibilities for all members.
3. **Strong working relationships** between oncologists, geriatricians and the wider members of the MDT, including primary care.
4. **Clearly defined clinical pathways** for onward referral.
5. Systems to enable **comprehensive data collection.**
6. Ongoing **service evaluation and development** utilising patient feedback/patient-reported outcomes.

Individual

- All healthcare professionals involved in the care of older and frailer adults with cancer should:
    - Have the basic skills to assess frailty and manage common frailty-related issues (or flag to someone that can) - and apply these skills in their routine practice.
- Consider frailty alongside other assessments and patient values when making decisions about cancer investigation and treatment.

Local

Local cancer teams/services should:

- **Ensure patient frailty is assessed at key time points in the cancer pathway when making decisions about cancer investigation and management,** including alongside 2-week wait referral, MDT discussions and during or ahead of clinic appointments for all patients, but especially for older patients).

- **Ensure that the whole MDT, including nursing teams (acute oncology, chemotherapy and site-specific specialist nurses), pharmacists and allied health professionals are up-skilled and empowered** to recognise and assess frailty, optimise frailty-related issues and support shared decision-making.

- Develop local processes and pathways for patients with frailty to undergo multi-domain frailty assessment and ensure targeted proactive (rather than reactive) management of frailty-related issues. This should be undertaken alongside expert geriatricians and patients, to meet local needs and service requirements.

- Integrate frailty assessments into electronic patient records and consider auditing uptake of frailty assessments and spread of frailty within their service (this must be facilitated by NHS Trusts and IT teams).

Regional

Cancer Alliances (and their equivalent) should:

- **Have a formal frailty or older adult clinical group, with multi-disciplinary representation across primary and secondary care, and patient representatives.**
- **Expand the inclusion of frailty measures within two-week wait referral forms to prompt the assessment of frailty alongside the work-up of a patient with suspected cancer, so it can be considered within decision-making around appropriate early investigation and management.**
- **Mandate frailty assessment** (Rockwood CFS or an alternative) and documentation prior to the MDT for all patients aged over 65 at diagnosis to facilitate the consideration of frailty during initial care planning.(Note that Rockwood CFS is validated for use in patients over 65 years -

National

National bodies and policy-makers should:

- Ensure frailty and the needs of older adults with cancer are considered in the national cancer plan to optimise holistic cancer care and better meet the needs of an ageing population.
- Make assessment of frailty (using the Rockwood CFS or similar) a measured Key Performance Indicator (KPI) in all tumour groups.
- Consider embedding automated frailty measures such as EFI and HFRS into cancer registries
- Ensure training in frailty and geriatric oncology is incorporated within undergraduate and postgraduate curricula and in revalidation for all members of the MDT involved in caring for older patients with cancer.