



NHS

England

**Toolkit for general
practice in supporting
older people living with
frailty**

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Update to 2014 document

OFFICIAL

NHS England INFORMATION READER BOX

Directorate

Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference: 06509

Document Purpose	Guidance
Document Name	Toolkit for general practice in supporting older people living with frailty
Author	NHS England/LTC Team
Publication Date	March 2017
Target Audience	Allied Health Professionals, GPs
Additional Circulation List	Allied Health Professionals, GPs
Description	Updated guidance to support delivery of the GP contract 2017
Cross Reference	N/A
Superseded Docs (if applicable)	Toolkit for general practice in supporting older people with frailty and achieving the requirements of the unplanned admissions enhanced service (2014)
Action Required	N/A
Timing / Deadlines (if applicable)	N/A
Contact Details for further information	Long Term Conditions, Older People and EOLC Team Medical Directorate Quarry House (5W25) Quarry Hill, Leeds LS2 7UE 0113 TBC

Document Status

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Toolkit for General Practice in Supporting Older People Living With Frailty

Version number: 2
First published: 2014
Updated: March 2017
Classification: OFFICIAL

Equality and Health Inequalities

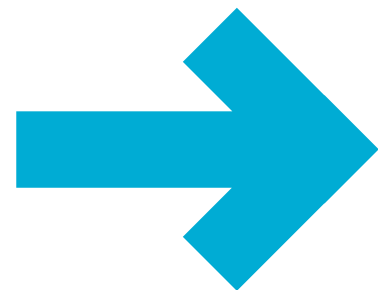
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Toolkit for general practice in supporting older people living with frailty





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ONE: INTRODUCTION

The aim of this toolkit is to provide GPs, practice nurses and the wider primary care workforce with a suite of tools to support the case finding, assessment and case management of older people living with frailty.

This toolkit was originally developed through collaborative work undertaken in 2014 between New Devon CCG, NHS Kernow and the NHS England Devon, Cornwall and Isles of Scilly Local Area Team. Its core objective is to assist practitioners in taking a common approach to case finding, assessment, care planning and case management of older people living with frailty. Since then, there have been significant developments including publication of key clinical and practical guidance, notably [Fit for Frailty](#), [Validation of the electronic Frailty Index](#) and NICE guidance [NG56](#) on multimorbidity. The toolkit has been updated to reflect these developments and the inclusion of routine frailty identification in the [General Practice contract](#) for 2017/18.

Frailty can be considered as a long-term health condition characterised by loss of physical, emotional and cognitive resilience as a result of the accumulation of multiple health deficits. Frailty is progressive, typically erodes functional, cognitive and/or emotional reserves and increases vulnerability to sudden loss of independence and adverse health outcomes following a comparatively minor stressor event such as an acute infection or injury. While severe frailty can be comparatively easy to recognise and diagnose, lesser degrees of frailty may be more difficult to differentiate from normal ageing.

People living with severe frailty comprise around 3% of the population aged 65 and older in England. For moderate frailty it is 12% of those aged 65 and older and 35% for mild frailty (ref: [Validation of the electronic Frailty Index](#)). These individuals are frequent users of services across health and social care and are particularly vulnerable to adverse outcomes, in particular health outcomes such as unplanned admissions to hospital, care home admission, acquisition of new disability or death. However there is evidence that for some of this group, these adverse outcomes could be avoided through proactive case finding, timely comprehensive assessment, care planning and targeted proactive use of services outside of hospital (Mytton *et al*, 2012).

Like other long-term conditions, frailty can be effectively managed within primary care. It takes five to ten years to develop and there is often a trajectory of slow functional deterioration. Currently older people with mild, moderate or severe frailty often present in crisis and, as clinicians, we may manage the acute crisis but not recognise and address the underlying vulnerabilities. However we know that with early identification of frailty and clear consideration of ways to optimise care and support for adults with multimorbidity, there are interventions that can be used to manage its progression effectively at key stages. These focus on reducing the likelihood of, or planning for the impact of, crisis and promote earlier and optimal recovery.



TWO: CASE FINDING

Routine frailty identification using health record data, and direct patient assessment, more accurately targets older people at greater risk of adverse outcomes than previous risk stratification techniques. The identification of frailty can be both opportunistic, by assessing for frailty in people who present to health and care services, or population based, where a more systematic approach is taken to proactively identifying people who might be living with the condition. Traditional risk stratification may be relatively insensitive and has the potential to miss 25% of older patients living with frailty because it relies on numbers of completed admissions and so may not identify patients with underlying risk of adverse health outcomes prior to admission.

Effective case finding of older people living with frailty should be done as part of a multi-disciplinary approach in primary care with the three aims of:

- Identifying individuals aged over 65 years who are living with frailty, and the degree of their condition (mild, moderate, severe).
- Identifying an individual from within the primary care team who will coordinate frailty care for those people who are living with the condition.
- Identifying the principle needs of the person living with frailty and selecting the most appropriate care to meet those needs. This is likely to require holistic and comprehensive assessment of need, care and support planning to promote self-management where feasible, community care and support to address issues such as social isolation and loneliness, and social care and support to meet care needs.



Approach to Frailty Case Finding in General Practice in England:

The 2017/18 General Practice Contract sets out the requirements in England for frailty as follows:

- Practices will use an appropriate tool e.g. electronic Frailty Index (eFI) to identify patients from their practice population aged 65 and over who are living with moderate and severe frailty.
- For those patients identified as living with severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions.
- In addition, where a patient does not already have a Summary Care Record (SCR) the practice will promote this, seeking informed patient consent to activate the SCR.

Data and monitoring

- Practices will code clinical interventions for this group appropriately.
- Data will be collected on:
 - the number of patients recorded with a diagnosis of moderate frailty
 - the number of patients with severe frailty
 - the number of patients with severe frailty with an annual medication review
 - the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months, and
 - the number of severely frail patients who provided explicit consent to activate their enriched SCR.
- NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally.
- This data will not be used for performance management purposes.

Suggested methods for case finding

1 electronic Frailty Index

The electronic Frailty Index (eFI) was developed in collaboration between the University of Leeds, TPP, the University of Bradford, the University of Birmingham and Bradford Teaching Hospitals NHS Foundation Trust. Yorkshire & Humber AHSN's Improvement Academy has supported the roll out of the eFI through its Healthy Ageing Collaborative.

The eFI uses routinely collected primary care data, coded within general practice electronic patient records, to calculate a frailty index and to identify older people with mild, moderate and severe frailty. A higher eFI score suggest a higher degree of frailty, which is associated with increased risk of care home admission, hospitalisation, and mortality. The tool identifies patients who would benefit from further assessment. The eFI is now embedded within the main primary care systems.

Practices who have access to the eFI in the electronic patient records system should use this to stratify their population aged 65 and over by degree of frailty into those who are fit (not frail) and those who are living with mild, moderate or severe frailty.

- For those patients in the moderate and severe groups, a clinician from the primary care team should verify the frailty diagnosis by direct assessment using the Clinical Frailty Scale (CFS) [appendix one] or similar validated tool.
- For patients who are living with mild frailty this equates to a CFS score of 4 to 5.
- For patients who are living with moderate frailty this equates to a CFS score of 6.
- For patients who are living with severe frailty this equates to a CFS score of 7 or above.
- Patients living with moderate and severe frailty should have their frailty diagnosis coded in their electronic health record system.

Individual practices may choose to do this verification systematically or opportunistically, for example by using the CFS at every consultation for patients aged 65 years and over for whom the eFI has identified moderate or severe frailty.

In addition, frailty verification could be undertaken within appropriate clinics, e.g. flu/shingles vaccine clinics, chronic disease clinics. CFS can also be completed by-community nurses/community matrons, or appropriate allied health professionals and fed back to the practice.

2 Practices without access to the eFI

For the small number of practices who do not have access to this tool it is suggested that the primary care record be used to identify patients aged over 65 years in the following groups who may be considered for the gait speed test or PRISMA7 score for initial identification, followed by the completion of the CFS for diagnostic decision, if necessary:

- a. People who are resident in care homes.
- b. People known to be living with dementia.
- c. People aged over 65 who have experienced one of the major frailty syndromes, which are:
 - Falls (e.g. collapse, legs gave way, 'found lying on floor').
 - Immobility (e.g. sudden change in mobility, 'gone off legs', 'stuck in toilet').
 - Delirium (e.g. acute confusion, sudden worsening of confusion in someone with previous dementia or known memory loss).
 - Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).
 - Susceptibility to side effects of medication.
- d. Those aged 65 or above with multimorbidity due to 4 or more long term conditions.
- e. Those on over 10 medications.
- f. Those with complex neurological conditions, e.g. stroke, MS, Parkinson's disease.
- g. Those housebound or known to community nurses – this data could be obtained from those community nurses who visit for flu vaccines, if not read coded.
- h. Those on community matron, district nursing caseload, end of life (EOL) register or cancer care lists.
- i. Those known to adult social care and support services with continuous support needs.
- j. All people aged over 85.

3 Read coding for frailty

There are read codes available to enable frailty to be recorded as a diagnosis and for frailty registers to be populated. They are:

CTV3

X76Ao | Frailty
XabdY | Mild frailty
Xabdb | Moderate frailty
Xabdd | Severe frailty

Read V2

2Jd.. | Frailty
2Jd0. | Mild frailty
2Jd1. | Moderate frailty
2Jd2. | Severe frailty

SNOMED CT concepts for frailty:

All linked to the concept 248279007 | Frailty (finding):
925791000000100 | Mild frailty (finding)
925831000000107 | Moderate frailty (finding)
925861000000102 | Severe frailty (finding)



THREE: ASSESSMENT

The gold standard approach for people living with moderate or severe frailty is comprehensive geriatric assessment, as detailed in resources available from the BGS [website](#)

The 2017/18 General Practice Contract focusses on 2 key evidence-based interventions: a falls risk assessment; and annual medication review. These form the key components of the comprehensive geriatric assessment and are supported by a good evidence base.

Falls risk identification and next steps

This should follow the guidance set out in NICE CG 161: (Falls in older people, assessing risk and prevention)

<https://www.nice.org.uk/guidance/cg161>

The falls and fracture consensus statement sets out the key elements of effective falls service for commissioners and strategic leads:

<https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement>.

Annual medication review and next steps

The STOPP START criteria may be used when reviewing medications for an older person with severe frailty

[Stopp Start Toolkit Supporting Medication Review, NHS Cumbria CCG 2013 edition](#)

For patients with frailty and multimorbidity (2 or more long term conditions) NICE NG56 provides guidance on tailoring care for people with multimorbidity:

<https://www.nice.org.uk/guidance/ng56>

Practices and their local primary care services may wish to go further in assessing patients with moderate and severe frailty based on individual patient need and professional judgement as set out below.

Further assessment

- a. Completion of brief CGA (Appendix four) and generation of a problem list.
- b. Holistic medical review aimed at optimising management of long-term conditions and referral to other disciplines if needed. Underlying diagnoses and reversible contributors to frailty should be addressed.
- c. A full medication review using STOPP START methodology (Appendix five).

- d. Individualised goal setting in collaboration with the patient and carers if appropriate.
- e. Generation of a personalised care plan. The NHS England and Coalition for Collaborative Care handbook on [personalised care and support](#) planning provides further details.

Completion of the brief CGA enables you to create a problem list and this will inform your care-planning activity. Appendix four is an example of a brief CGA tool which has been produced by a steering group of clinicians across Devon and Cornwall. It takes approximately 8-10 minutes to complete.

It is suggested that after the brief CGA is completed, there is discussion at the multi-disciplinary team meeting and core group members should then decide which patients require a more in-depth CGA and who will be involved in carrying it out. In-depth CGA involves a holistic, multi-dimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health, often including a geriatrician (BGS, 2014).

REFERENCES

-  British Geriatrics Society (2014). Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings.
-  British Geriatrics Society (2016) Comprehensive Geriatric Assessment <http://www.bgs.org.uk/cga-toolkit/cga-toolkit-category/what-is-cga/cga-what>
-  Clegg et al (2016) Development and validation of an electronic frailty index using routine primary care electronic health record data. Age and Aging Vol 45, issue 3
-  Mytton et al (2012). Avoidable acute hospital admissions in older people. British Journal of Healthcare Management, 18(11). Pp 597-603
-  NHS England, Coalition for Collaborative Care, (2016) Personalised care and support planning handbook: <https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf>
-  NICE guidance (2016) NG56 Multimorbidity



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Appendix one: 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.

Appendix two: Gait speed test

Average gait speed of longer than 5 seconds to walk 4 metres is an indication of frailty. The test can be performed with any patient able to walk 4 metres using the guidelines below.

1. Accompany the patient to the designated area, which should be well-lit, unobstructed and contain clearly indicated markings at 0 and 4 metres.
2. Position the patient with his/her feet behind and just touching the 0-metre start line.
3. Instruct the patient to "Walk at your comfortable pace" until a few steps past the 4-metre mark (the patient should not start to slow down before the 4-metre mark).
4. Begin each trial on the word "Go".
5. Start the timer with the first footfall after the 0-metre line.
6. Stop the timer with the first footfall after the 4-metre line.
7. Repeat three times, allowing sufficient time for recuperation between trials.

Appendix three: PRISMA7 questions

A score of three or more indicates frailty.

1. Are you more than 85 years?
2. Male?
3. In general do you have any health problems that require you to limit your activities?
4. Do you need someone to help you on a regular basis?
5. In general do you have any health problems that require you to stay at home?
6. In case of need can you count on someone close to you?
7. Do you regularly use a stick, walker or wheelchair to get about?

Appendix four: Brief CGA form

Initial Comprehensive Geriatric Assessment Form

Patient Contact	
<input type="checkbox"/>	Home
<input type="checkbox"/>	Care Home
<input type="checkbox"/>	GP
<input type="checkbox"/>	OPD
<input type="checkbox"/>	ED
<input type="checkbox"/>	Frailty
<input type="checkbox"/>	

Clinical Frailty Score (Rockwood Scale):

Patient's Details		Patient's Address	
Title		Add 1	
Name		Add 2	
Date of Birth		Add 3	
NHS Number		Town	
GP Practice		Postcode	

Cognition	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Mild Cognitive Impairment	<input type="checkbox"/> Dementia	<input type="checkbox"/> Delirium	
	<input type="checkbox"/> Abbreviated Mental test (AMT) Score: <input type="text"/>		<input type="checkbox"/> Mental Capacity Assessment required		
	Main lifelong occupation: _____				
Emotional	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> ↓Mood	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Delusion <input type="checkbox"/> Other				
Motivation	<input type="checkbox"/> High	<input type="checkbox"/> Usual	<input type="checkbox"/> Low		
Health Attitude	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Couldn't say
Communication	Speech: <input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Impaired	Hearing: <input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Impaired	
	Vision: <input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Impaired	Understanding: <input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Impaired	
Strength	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Weak	Upper: <input type="checkbox"/> Proximal	<input type="checkbox"/> Distal	Lower: <input type="checkbox"/> Proximal <input type="checkbox"/> Distal
Exercise	<input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Not				
Balance	Balance <input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Impaired		<input type="checkbox"/> Within Normal Limits	
	Falls <input type="checkbox"/> Falls Number: <input type="text"/>			<input type="checkbox"/> Falls Number: <input type="text"/>	
Mobility	Walk inside <input type="checkbox"/> Independent	<input type="checkbox"/> Slow	<input type="checkbox"/> Assisted	<input type="checkbox"/> Can't	
	Walk outside <input type="checkbox"/> Independent	<input type="checkbox"/> Slow	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent	
	Transfers <input type="checkbox"/> Independent	<input type="checkbox"/> Standby	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent	
	Bed (in/out) <input type="checkbox"/> Independent	<input type="checkbox"/> Pull	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent	
	Aid use <input type="checkbox"/> None	<input type="checkbox"/> Stick	<input type="checkbox"/> Frame	<input type="checkbox"/> Chair	
Nutrition	Weight <input type="checkbox"/> Normal	<input type="checkbox"/> Under	<input type="checkbox"/> Over	<input type="checkbox"/> Obese	
	Appetite <input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Fair		<input type="checkbox"/> Poor	
	Swallow <input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Impaired Fluids		<input type="checkbox"/> Impaired Solids	
Elimination	Bowel <input type="checkbox"/> Continent	<input type="checkbox"/> Constipated	<input type="checkbox"/> Incontinent		
	Bladder <input type="checkbox"/> Continent	<input type="checkbox"/> Catheter	<input type="checkbox"/> Incontinent		
ADLS	Feeding <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Bathing <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Dressing <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Toileting <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
IADLS	Cooking <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Cleaning <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Shopping <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Medications <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Driving <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
	Banking <input type="checkbox"/> Independent	<input type="checkbox"/> Assisted	<input type="checkbox"/> Dependent		
Sleep	<input type="checkbox"/> Disrupted		<input type="checkbox"/> Daytime drowsiness	Socially Engaged <input type="checkbox"/> Frequent	<input type="checkbox"/> Occasional <input type="checkbox"/> Not
Social	Marital Status <input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Single	Lives <input type="checkbox"/> Alone
		<input type="checkbox"/> Spouse	<input type="checkbox"/> Other		<input type="checkbox"/> House...
					<input type="checkbox"/> Steps...
					<input type="checkbox"/> Apartment
					<input type="checkbox"/> Supported Living
					<input type="checkbox"/> Care Home
					<input type="checkbox"/> Other
					Number of levels: <input type="text"/>
					Number of steps: <input type="text"/>
					<input type="checkbox"/> Informal
					<input type="checkbox"/> Other
					<input type="checkbox"/> Requires more support
					<input type="checkbox"/> None
					Caregiver Relationship <input type="checkbox"/> Spouse
					<input type="checkbox"/> Sibling
					<input type="checkbox"/> Offspring
					<input type="checkbox"/> Other
					Caregiver Stress <input type="checkbox"/> None
					<input type="checkbox"/> Low
					<input type="checkbox"/> Moderate
					<input type="checkbox"/> High
					Caregiver Occupation: _____
Advance directive in place:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
CPR decision:	<input type="checkbox"/> Allow a natural death		<input type="checkbox"/> Resuscitate		

Assessor: _____
(Name, Grade & Signature)

Date: _____

PLEASE TURN OVER

Initial Comprehensive Geriatric Assessment Form

Associated Medication (mark meds started in hospital with an asterisk) – consider Stopp Start		
Medication	Dose	Date Commenced
Problem List	Action Required	Action By
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
Long term conditions		
1		
2		
3		
4		
5		
Notes		

For MDT Discussion consider long CGA Long CGA **not** required, copy of Clinical Frailty score to GP

Outpatient Appointments	
Department	Date and Time

Assessor
 (Name, Grade & Signature)
 Date

Appendix five: STOPP START Medication Review Tool

STOPP START Information

STOPP: Screening Tool of Older People's Potentially Inappropriate Prescriptions

The following drug prescriptions are *potentially* inappropriate in persons aged \geq 65 years of age

Drug name or class (+ examples)	+ Condition	= Risk / reason
Cardiovascular		
Digoxin >125µg/day	Low GFR	Toxicity
Diuretic (monotherapy)	Hypertension	Safer, more effective alternatives
Thiazides (bendroflumethiazide)	Gout	Exacerbation of gout
Non-cardioselective Beta-blocker (propranolol, carvedilol, sotalol etc)	Wheeze (COPD/asthma)	Bronchospasm
Beta blocker + verapamil	Any	Heart block
Diltiazem or verapamil	Heart failure	Exacerbation of heart failure
Calcium channel blockers	Chronic constipation	Exacerbation of constipation
Aspirin + Warfarin	Without gastro-protection	Gastrointestinal bleeding
Dipyridamole (monotherapy)	Stroke	No evidence for efficacy
Aspirin	Peptic ulcer	Bleeding
	>150mg/day	Bleeding, no evidence for increased efficacy
	Without arterial occlusive disease	Not indicated
	Dizziness, without stroke as cause	Not indicated
Warfarin >6 months	1 st deep vein thrombosis	No proven benefit
Warfarin >12 months	1 st pulmonary embolus	No proven benefit
Aspirin, clopidogrel, dipyridamole or warfarin	Any bleeding disorder	Bleeding
Central Nervous System & Psychotropics		
Tricyclic antidepressants (amitriptyline, imipramine etc)	Cognitive Impairment	Worsening cognitive impairment
	Glaucoma	Exacerbation of glaucoma
	Cardiac arrhythmia	Pro-arrhythmic effects
	Constipation	Exacerbation of constipation
	+ Opiate or calcium channel blocker	Severe constipation
	Prostatism or urinary retention	Urinary retention
Benzodiazepines >1 month	Any	Prolonged sedation, confusion, impaired balance, falls
Neuroleptics >1 month (haloperidol, risperidone etc)	If used as hypnotics	Confusion, hypotension, extrapyramidal side effects, falls
	Parkinsonism	Extra-pyramidal symptoms
Prochlorperazine & chlorpromazine	Epilepsy	Lower seizure threshold
Anticholinergics (Procyclidine, orphenadrine, trihexyphenidyl)	To treat extra-pyramidal side-effects of neuroleptics	Anticholinergic toxicity
Selective serotonin re-uptake inhibitors (SSRIs, fluoxetine etc)	Current or <2 months Hyponatraemia	Further hyponatraemia
Old antihistamines (cyclizine, chlorpheniramine, alimemazine etc)	>1 week use	Sedation & anti-cholinergic side effects
Gastrointestinal		
Constipating drugs (Loperamide or codeine phosphate)	Unexplained diarrhoea	Delayed diagnosis, exacerbate constipation + overflow diarrhoea,

STOPP: Screening Tool of Older People's Potentially Inappropriate Prescriptions

The following drug prescriptions are *potentially* inappropriate in persons aged \geq 65 years of age

Drug name or class (+ examples)	+ Condition	= Risk / reason
		<i>toxic megacolon in inflammatory bowel disease, delayed recovery in unrecognised gastroenteritis</i>
	Severe infective gastroenteritis	<i>Exacerbation or protraction of infection</i>
Prochlorperazine (Stemetil) or metoclopramide	Parkinsonism	<i>Exacerbating parkinsonism</i>
High dose proton pump inhibitor > 8 weeks	Peptic Ulcer	<i>Dose reduction or earlier discontinuation indicated</i>
Anticholinergic antispasmodics (hyoscine, atropine)	Chronic constipation	<i>Exacerbation of constipation</i>
Chest		
Theophylline (monotherapy)	COPD	<i>Safer, more effective alternatives</i>
Systemic corticosteroids (instead of inhaled)	COPD	<i>Unnecessary exposure to longterm side-effects</i>
Ipratropium (nebulised)	Glaucoma	<i>Exacerbation of glaucoma</i>
Musculoskeletal		
Non-steroidal anti-inflammatory without gastric protection	Peptic ulcer /gastrointestinal bleeding	<i>Peptic ulcer relapse</i>
Non-steroidal anti-inflammatory drugs (NSAIDs) (ibuprofen, naproxen, diclofenac etc)	Mod-severe hypertension	<i>Exacerbation of hypertension</i>
	Heart failure	<i>Exacerbation of heart failure</i>
	>3 months in mild osteoarthritis	<i>Simple analgesics preferable & usually as effective for pain relief</i>
	Chronic kidney disease	<i>Deterioration in renal function</i>
	+ Warfarin	<i>Gastrointestinal bleeding</i>
Corticosteroids (>3 months, monotherapy)	Rheumatoid Arthritis	<i>Major side-effects</i>
NSAIDs or colchicine	To prevent gout	<i>Allopurinol first choice prophylactic drug in gout</i>
Urogenital		
Bladder antimuscarinics (oxybutinin, tolterodine, solifenacin etc)	Cognitive impairment	<i>Increased confusion, agitation</i>
	Glaucoma	<i>Exacerbation of glaucoma</i>
	Constipation	<i>Exacerbation of constipation</i>
	chronic prostatism	<i>Urinary retention</i>
Alpha-blockers (doxazosin, tamsulosin, terazocin etc)	Male & urinary incontinence >1 daily	<i>Urinary frequency & worsening of incontinence</i>
	Long-term urinary catheter	<i>Not indicated</i>
Endocrine		
Glibenclamide or chlorpropamide	Type 2 diabetes mellitus	<i>Prolonged hypoglycaemia</i>
Beta-blockers (atenolol, bisoprolol etc)	Hypoglycaemia \geq 1 per month	<i>Masking hypoglycaemic symptoms</i>
Oestrogens	Breast cancer	<i>Recurrence</i>
	Venous thromboembolism	<i>Recurrence</i>
Oestrogens without progestogen	Intact uterus	<i>Endometrial cancer</i>
Falling		
Benzodiazepines	Recurrent falls disorder	<i>Sedative, may cause reduced sensorium, impair balance</i>
Neuroleptic drugs	Recurrent falls disorder	<i>Gait dyspraxia, parkinsonism</i>
First generation antihistamines	Recurrent falls disorder	<i>Sedative, may impair sensorium</i>

STOPP: Screening Tool of Older People's Potentially Inappropriate Prescriptions

The following drug prescriptions are *potentially* inappropriate in persons aged \geq 65 years of age

Drug name or class (+ examples)	+ Condition	= Risk / reason
Vasodilator antihypertensives (hydralazine, minoxidil, sildenafil etc)	>20mmHg drop in systolic blood pressure	<i>Syncope, falls</i>
Long-term opiates	Recurrent falls disorder	<i>Drowsiness, postural hypotension, vertigo</i>
Analgesia		
Long-term strong opiates	Mild-moderate pain	<i>World Health Organisation analgesic ladder not observed</i>
Regular opiates >2 weeks + no laxative	Constipation	<i>Severe constipation</i>
Long-term opiates	Dementia + not palliative + not managing specific pain syndrome	<i>Exacerbation of cognitive impairment</i>
Any duplicate drug class		
	Any	<i>Optimisation of monotherapy within a single drug class should be observed prior to considering a new class of drug</i>

Screening Tool to Alert Doctors to Right, i.e. appropriate, indicated Treatments

These medications should be considered for people \geq 65 years with the following conditions, where no contraindication to prescription exists

Condition	Drug
Cardiovascular	
Atrial fibrillation	Anticoagulant
Vascular disease & in sinus rhythm	Aspirin or clopidogrel
Blood pressure >160 mmHg (consistently)	Antihypertensive
Vascular disease + independent for activities of daily + life expectancy >5 years	Statin
Chronic heart failure	Angiotensin Converting Enzyme inhibitor
Acute myocardial infarction	Angiotensin Converting Enzyme inhibitor
Chronic stable angina	Beta-blocker
Chest	
Mild to moderate asthma or COPD	Regular inhaled beta 2 agonist or anticholinergic
Moderate-severe asthma or COPD & FEV1 <50%.	Regular inhaled corticosteroid
Chronic type 1 respiratory failure (pO ₂ < 8.0kPa, pCO ₂ <6.5kPa) ^a	Continuous oxygen
Chronic type 2 respiratory failure (pO ₂ < 8.0kPa, pCO ₂ > 6.5kPa)	Continuous oxygen
Neuro	
Parkinson's Disease with definite functional impairment & resultant disability	Levo-dopa
Depression, moderate-severe <3 months	Antidepressant
Gastro	
Severe gastro-oesophageal acid reflux disease	Proton Pump Inhibitor
Peptic stricture requiring dilatation	Proton Pump Inhibitor
Diverticular disease with constipation	Fibre supplement
MSK	
Active moderate-severe rheumatoid disease > 12 weeks	Disease-modifying anti-rheumatic drug
Maintenance corticosteroid therapy	Bisphosphonates
Osteoporosis (previous fragility fracture, acquired dorsal kyphosis)	Calcium & Vitamin D
Endocrine	
Type 2 diabetes +/- metabolic syndrome	Metformin
Diabetes + proteinuria or microalbuminuria + GFR <50ml/min	ACE inhibitor or Angiotensin Receptor Blocker
Diabetes mellitus + major cardiovascular risk factors	Statin

Key:

COPD = Chronic obstructive pulmonary disease
GFR = Glomerular filtration rate

FEV1 = forced expiratory volume in one second
MSK = Musculoskeletal

This document was amended from the original with the kind permission of the authors. For more detail & references, see: Gallagher P, Ryan C, Byrne S, Kennedy J, O'Mahony D. STOPP (Screening Tool of Older Persons' Prescriptions) & START (Screening Tool to Alert Doctors to Right Treatment): Consensus Validation. Int J Clin Pharmacol Ther 2008; 46(2): 72 –83. PMID 18218287



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