The Hospital Frailty Risk Score: response to Drs Soong, Shi and O’Caoimh

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Declaration of interests:

Professor Parker reports grants from National Institute for Health Research and other funders during the conduct of the study, outside the submitted work; all other authors - none to declare.

Ethics

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Contributions

TG: study design, data acquisition, analysis, interpretation, writing and revision of manuscript. AS: study design, interpretation, writing and revision of manuscript. SP: study design, interpretation, writing and revision of manuscript. HR: study design, interpretation, writing and revision of manuscript. SC: study design, interpretation, writing and revision of manuscript.

Response

We thank Drs Soong, Shi, O’Caoimh and colleagues for their careful consideration of our paper.

We note some anxieties about clinical utility; our approach is to position the Hospital Frailty Risk Score (HFRS) as a tool that can be implemented without the need for additional assessment or data collection, and direct high risk individuals towards frailty attuned interventions such as Comprehensive Geriatric Assessment (CGA).¹ We acknowledge that the HFRS can only be generated following an initial admission, so risk stratification information would not be possible at first presentation. Given that two thirds of older people access acute hospital more than once over a two year period, and that those who have not previously accessed hospital are typically at lower risk of hospital related adverse outcomes, we view the HFRS as being especially useful to identify those at the highest risk of hospital related harms and resource use. We accept
that manual scales, such as the Clinical Frailty Scale, could be used but the HFRS has the advantage of being automated and capturing all patients, not just a selected sample. Dr Shi and others comment on the limited discriminant ability of the HFRS; it should be noted that none of the existing frailty scales have sufficient discrimination to be able to direct individual patient care. The HFRS is particularly useful for estimating prevalence of frailty as well as outcomes, for commissioning and service planning. We note the suggestion to analyse elective and non-elective care separately, and we fully agree that future iterations could focus on one or more specific areas within the hospital, as well as incorporating other data sources such as physiological scores, medication and other data sources e.g. primary care. During our work, we did identify other clusters; these are described in Table 2 of our original article. These clusters merit further exploration, in particular the cardiovascular and cancer clusters, in which frailty were also prevalent.

Dr O’Caoimh et al are doubtful that CGA can be undertaken at scale for frail older people in acute hospitals. This remains unproven, but there is a strong research evidence base supporting the benefits of CGA, as well as a growing improvement evidence base that shows it is feasible to implement at scale in the urgent care context. We hope that the HFRS might help target scarce resources to those most likely to benefit.

References