NHS RightCare

NHS RightCare: Frailty Toolkit

Optimising a frailty system

Increasing numbers of people are at risk of developing frailty. People living with frailty are experiencing unwarranted variation in their care.

This toolkit will provide you with expert practical advice and guidance on how to commission and provide the best system wide care for people living with frailty.

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GIRFT GETTING IT RIGHT FIRST TIME

Informed by relevant NICE recommendations

NICE National Institute for Health and Care Excellence

NHS RightCare Frailty Toolkit

This NHS RightCare system toolkit will support systems to understand the priorities in frailty care and key actions to take. It provides a way to assess and benchmark current systems to find opportunities for improvement. It is produced with reference to an expert group of stakeholders and is supported by NICE. Wider consultation has taken place with patient representatives, clinicians, social care organisations, professional bodies and other key stakeholders.

The national challenges:

- Increasing numbers of people are at risk of developing frailty. A person living with mild frailty has twice the mortality risk of a fit older person.
- More people living with mild, moderate or severe frailty are attending emergency departments, with over 4000 admissions daily for people living with frailty.
- Older people living with mild, moderate or severe frailty are more likely to have delayed transfers of care. 45% of people experiencing delayed transfers of care are over 85 (approximately 50% of people aged 85 and over will encounter frailty).
- People living with mild, moderate or severe frailty could often have their needs met best in settings outside of acute hospital care. Severe frailty often brings over four times the costs of non-frailty.

The national NHS RightCare opportunity

29,000 fewer injuries due to falls in people aged 65 or over if CCGs achieved the rate of their lowest five peers.

25,000 fewer long stay patients aged 85 or over if CCGs achieved the rate of their lowest five peers.

Links to other NHS RightCare products

NHS RightCare has a comprehensive frailty support offer which includes:

- **NHS RightCare Frailty Focus Pack:** This provides each CCG in England with the most relevant frailty data, compared to their most similar ten CCGs. To access please contact your local Delivery Partner.
- **NHS RightCare Frailty Scenario:** This provides Janet's story of living with frailty in a sub-optimal pathway compared to an optimal pathway.

This NHS RightCare toolkit supports the delivery of the NHS Long Term Plan for frailty:

The NHS Long Term Plan sets out an evidence-based framework of care for older people with frailty to be delivered through the national Ageing Well programme. This focuses on delivering integrated personalised care in communities and addresses the needs of older people with three inter-related service models centred on clearly identifiable patient cohorts:

1) **Community multidisciplinary teams** -targets the moderate frailty population10, people whose annual risk of urgent care utilisation, death and care home admission is 3 times that of an older person of the same age who is fit. This group are considered to be the most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.

2) **Urgent Community Response**–crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.

3) **Enhanced health in care homes**–for which there is not a consistent health care support offer across England despite care home beds outnumbering NHS hospital beds by 3:1 and being an increasingly important place for end of life care;

The Ageing Well programme and framework aim to support commissioners and providers of acute and community health services, social care and the voluntary sector to work together, turning what is currently urgent care into planned care for key groups of vulnerable older people.

Professor Martin J Vernon, National Clinical Director for Older People and Person Centred Integrated Care

NHS RightCare Frailty Toolkit:

System improvement priorities

- Population segmentation, identification and stratification of frailty
- Supporting people living with mild frailty and encouraging people to 'age well'
- Supporting people living with moderate frailty
- Supporting people living with severe frailty
- Reducing hospital length of stay
- Falls and fragility fractures
- Delirium, dementia and cognitive disorder
- Personalised care
- Experience of care
- Self-assessment questionnaire

System improvement priority:
Population segmentation, identification and stratification of frailty

Segmentation, identification and stratification of the population living with frailty by needs and not age is essential. This allows use across health and social care, that can support joint priorities, and integrated and personalised care. This part of the toolkit contains support for commissioners and providers of health and social care across the system in all settings; from care homes to primary care to hospital care.

Key areas for focus:

System wide recognition of the signs of frailty Everyone in a system who could encounter people living with frailty knows what the signs are. This includes health and social care workers, family, carers, emergency services, and voluntary sector workers.	**Guidance and best practice**
Know what to do when signs of frailty are found It is critically important that when signs of frailty are suspected that people know what to do. This is important in a variety of settings, from emergency departments to community exercise classes to patients' homes.	**Guidance and best practice**
Standardised way of stratifying frailty Having a strategy to consistently stratify frailty is key to an organised system. The GP contract supports the use of a standardised approach to frailty stratification and population segmentation. This could be done through the electronic frailty index (eFI).	**Guidance and best practice**
Identify frailty and frailty risk Ensure that when appropriately trained health and care staff suspect frailty, that they can then undertake an individual frailty score to identify frailty status. Using tools such as the PRISMA-7 questionnaire.	**Guidance and best practice**

Actions to take

System improvement priority: **Population segmentation, identification and stratification of frailty**

Actions to take:	
System wide recognition of the signs of frailty	• Have a network of 'frailty champions' or a 'frailty forum' identified, with a role in promoting a consistent and universal awareness and understanding of frailty. • Take a systematic approach to promoting the awareness and understanding of frailty with individuals, carers, families and partners in health, care, voluntary sector and wider public services. • Align understanding of frailty to the Frailty Core Capabilities Framework's Domain A, 'Understanding, identifying and assessing frailty'.
Know what to do when signs of frailty are found	• Use a systematic approach to identifying which people living with frailty are most at risk and are therefore most likely to benefit from a comprehensive geriatric assessment (CGA) – or targeting CGA to those most likely to benefit. • Communicate across the system the outcome of a CGA and associated action plan. • Do you have a universal referral process? How do services refer to each other?
Standardised way of stratifying frailty	• Use an appropriate risk stratification or population segmentation tool such as the electronic frailty index (eFI) in accordance with the GP contract. • Ensure clinical correlation of eFI results is undertaken. • Consider implications of resource modelling based on stratification of frailty population.
Identify frailty and frailty risk	• Ensure that you identify frailty as a trigger so that people are referred and supported appropriately within the health and social care system. • Do this in a way that is acceptable for older people and enables them to work in partnership with their health professionals. • Align understanding of frailty to the Frailty Core Capabilities Framework 'understanding frailty' criteria at Tier 1 across all services.

Guidance and best practice examples

System improvement priority:
Supporting people living with mild frailty and encouraging people to 'age well'

It is important to prevent or delay the onset of mild frailty and to be proactive in supporting people living with or at risk of mild frailty. Rehabilitation or reablement and stopping progression in functional ability are key objectives for this group. When people are ageing well it is important to encourage and support people to maintain this status, especially considering that frailty starts earlier and progresses more rapidly in socio-economically deprived areas. This section of the toolkit supports community and primary care to take preventative and proactive approaches to the provision of frailty care.

Key areas for focus:		Actions to take
Define the local healthy lifestyle offer for: Physical activity, weight management, smoking cessation and alcohol Keeping active, maintaining a healthy weight and not smoking will go a long way to preventing or reversing the progression of frailty. Understanding the local offer for these priorities in terms of access and capacity and demand is of key importance.	**Guidance and best practice**	
Education and understanding of frailty (in the population as well as in health and social care) What is the education and training strategy around frailty for your population? How do you plan to support development of core capabilities across all three tiers, and all four domains of the Frailty Core Capabilities Framework?	**Guidance and best practice**	
Supported self-management Support for people to maintain active and healthy ageing in both physical and mental health is key for systems to reduce risk of frailty progression. This can come through numerous modes such as exercise groups, befriending services, health navigation, and information in a variety of formats.	**Guidance and best practice**	
Nutrition Maintaining a healthy weight helps people to avoid frailty and reverse the effects of mild frailty. Being underweight can put people at risk of frailty as well as being significantly overweight. Nutrition support and advice tailored to people with frailty is key.	**Guidance and best practice**	

System improvement priority:
Supporting people living with mild frailty and encouraging people to 'age well'

Actions to take:	
Define the local healthy lifestyles offer	• Define the local offer for weight management, smoking cessation, physical activity and alcohol reduction, and how it specifically supports people at risk of or living with frailty. • Define the referral process into these services. • Support and educate people living with, or at risk of, frailty in how to make lifestyle adjustments and challenge barriers a healthy lifestyle • Undertake strategies such as making every contact count.
Education/ understanding of frailty	• Have a shared awareness and understanding of frailty. • Align understanding of frailty to the Frailty Core Capabilities Framework's Domain A, 'Understanding, identifying and assessing frailty'. • Create a communications strategy to target the whole population about frailty.
Supported self-management	• Understand what self-management education and services are available within the local community to enhance patient activation and empowerment. Ensure statutory services can easily make referrals and receive feedback on progress where these are lead by third sector organisations. • Have a local directory of services and support available which enables ease of signposting or referral for people living with frailty to the services they may find useful. • Have a commissioned social prescribing service across the whole locale. • Ensure strategies for routinely assessing older people's mental health, including the identification of depression, anxiety and loneliness, together with appropriate interventions are in place. • Ensure strategies are in place for the routine identification of carers and that they are appropriately supported (linking to long term plan carers commitments).
Nutrition	• Routine screening for risk of malnutrition across health and social services in people at risk of developing frailty. • Provide nutrition education specifically for people at risk of or living with frailty.

Guidance and best practice examples

System improvement priority:
Supporting people living with moderate frailty

It is estimated that 12% of people aged 65 or over are living with moderate frailty. Key aims for this group are to provide integrated multidisciplinary teams (MDT) to support people in rehabilitation and reablement and prevent further progression of their frailty. This part of the toolkit should be used as a system. It is a means of supporting the management of people with moderate frailty in the community rather than them needing to access hospital based care.

Key areas for focus:

Multidisciplinary team assessment of risk stratified patients When it is identified that an individual is living with moderate frailty there should be a response from the MDT. A needs based assessment of both physical and mental health should be undertaken and an intervention or signposting to be instigated as appropriate. MDT meetings should continue for individuals on an on-going basis until frailty status stabilises or improves, and/or until identified risks are appropriately managed.	**Guidance and best practice**	**Actions to take**
Home and community based rehabilitation Home or both out-patient and in-therapy led patient rehabilitation depending on the needs of the individual. This facilitates the primary aim to support people living with moderate frailty to 'age well'. Aiming at 'step-up' care to avoid admissions, and 'step down' care to support post hospital care.	**Guidance and best practice**	
Recognition of deterioration It is important to recognise when people living with moderate frailty (or any level of frailty) are at risk of, or have, a deteriorating frailty status. Prompt response to deterioration can reduce the impact of increased frailty primarily for the individual but also for health and care systems.	**Guidance and best practice**	

System improvement priority:
Supporting people living with moderate frailty

Actions to take:	
MDT team assessment of risk stratified patients	• Services involved in a patient's care are able to access and contribute to that person's current Comprehensive Geriatric Assessment document. • Services use experience of care feedback from patients and carers to improve services using co-production and co-design. • Map the skills required in the MDT and align workforce to skills assessment. • Understand numbers of people living with frailty in the system and match MDT team capacity to this demand. • Ensure that carers are routinely identified and offered support. • Ensure that mental health needs of patients and carers are assessed and specifically addressed.
Home and community based rehabilitation	• Services address both the 'routine' and proactive management of frailty as a long term condition and have responsive management of exacerbations and changes that occur in common frailty syndromes. • Have an up to date map or directory of all services with service leads, potentially related to frailty care and support that deliver across the health, social care and voluntary sector, e.g., falls prevention, NHS Health check and activity groups (social or medical related). • Know what the capacity of services are including community rehabilitation and intermediate care (bed and home based).
Recognition of deterioration	• Have a strategy and action plan that is adopted across the system so everyone involved in frailty knows 'what to do' when deterioration of frailty status is found. • People living with moderate or severe frailty have access to a patient-centred MDT review when need changes involving all partners in care, including the individual. • People living with frailty should be encouraged to review their ongoing support needs and personal planning when a change is noted in their support requirements either by themselves or carers or by support staff, clinicians and key workers. • All relevant commissioners and providers of services are aware of the Frailty Core Capabilities Framework • How is the framework being used or implemented in relation to services offering support to people and their carers living with frailty?

Guidance and best practice examples

System improvement priority:
Supporting people living with severe frailty

Indications from GP contract data suggest that 3% of over 65 year olds are living with severe frailty. Severe frailty has a significant impact on individuals. Support and prevention of deterioration are key priorities. This section of the toolkit is important for the whole system to consider, however a specific focus is on social care. Some of the priorities below can also be adopted to support people with progressing moderate frailty.

Key areas for focus:		Actions to take
Training and capabilities of social care staff People living with severe frailty are more likely to be supported in care homes. It is therefore important that staff in care homes have capabilities to support people living with severe frailty.	**Guidance and best practice**	
Management of urgent care situations A significant amount of admissions to hospital from care homes are avoidable. People from socioeconomically deprived areas are more likely to be admitted to hospital from care homes, and could potentially be avoided if suitable alternatives are in place.	**Guidance and best practice**	
Enhanced health in care homes Using work from the new models of care programme it is important to focus on strategies that will enhance health care in care homes for people living with severe frailty.	**Guidance and best practice**	
End of life care People with severe frailty can be moving towards the end of their life. When an individual is identified as having severe frailty their preferences and needs around their end of life care should be fully understood.	**Guidance and best practice**	

System improvement priority:
Supporting people living with severe frailty

Actions to take:	
Training and capabilities for whole health and social care workforce	• Have a shared awareness and understanding of frailty. • Have an approach of managing frailty as a long term condition embedded across the system. • All relevant commissioners and providers of services should be aware of the Frailty Core Capabilities Framework. • How is the framework being used or implemented in relation to services offering support to people and their carers living with frailty? • Frailty workforce development plans are linked to education and skills for dementia, end of life care skills and any other skills frameworks that are relevant.
Management of urgent care situations	• Know how many people with moderate or severe frailty have had planned or unplanned hospital admissions in the last year. Look for any general trends or patterns of activity. • Have a recognised rapid or crisis response service.
Enhanced health in care homes	• Consult the enhanced health in care homes framework to guide improvements. • Are the following principles and conditions present: person-centred change, co-production, quality and leadership? • Map workforce across the area, ensuring innovative roles and those covered by 'new models of care' are captured with a focus on frailty services. • Ensure strategies to routinely identify, assess and manage mental health needs are instigated.
End of life care	• Have a baseline of preferred place of death recorded. • Services and staff are equipped to support people to undertake or update an advance care plan in a timely manner and ensure that this is known to the family and carers as well as held by all agencies the person engages with. • Staff working with people with frailty are confident to recognise that a person is approaching the end of their life and act on this understanding. • Staff working with people with frailty are confident in recognising that a person is approaching the end of their life and feel equipped to engage effectively with patients and carers to discuss end of life care. • If not, are quality improvement plans in place to address this?

Guidance and best practice examples

System improvement priority:
Reducing hospital length of stay

Older people are more likely to be admitted following an emergency department contact. If admitted it is well understood that people should be in hospital for the shortest amount of time. Reducing hospital length of stay should be seen as a system wide issue, starting in the community and primary care and supporting people here so they do not need hospital. This is also the case in supporting people living with frailty when they are medically fit for discharge but require rehabilitation. Considering priorities in specific settings and at interfaces between these settings is of equal importance.

Key areas for focus:	Actions to take
Crisis and rapid response These services aim to anticipate or support people living with frailty in crisis. Services have been established that have significantly reduced emergency department admissions due to common frailty syndromes such as urinary tract infections and falls.	**Guidance and best practice**
First 24 hours Appropriate management in the first 24 hours of admission is crucial for people living with frailty. Optimal care should be established which includes consideration of whether community or primary care options would be more appropriate.	**Guidance and best practice**
Effective rehabilitation If admitted it is essential that effective rehabilitation is commenced at the earliest opportunity to decrease the impact of deconditioning as an inpatient. Utilising the skills of the MDT, especially allied health professionals, is key to this.	**Guidance and best practice**
Transfer of care to a new care setting How care is transferred from hospital to other settings is important. Optimising this key interface within the system will provide integrated support for patients whilst supporting efficiency in health and care services.	**Guidance and best practice**
Coordination of care through sharing information Knowing an individual is living with frailty, knowing individual choices, knowing what health and care input individuals with frailty are receiving is important for the whole system.	**Guidance and best practice**

System improvement priority:
Reducing hospital length of stay

Actions to take:	
Crisis and rapid response	• Identify how many people with moderate or severe frailty have fallen in the last year, or have fallen resulting in fracture and how this associates with the input of falls services. • Have a recognised crisis or rapid response service. • Have a specific strategy to manage crisis situations on a needs basis according to frailty stratification. • Use NEWS2 to recognise acute illness and onset of delirium.
First 24 hours	• Know if frailty identification is undertaken in urgent care settings and how this information is shared. • Know how many people with moderate or severe frailty have had planned or unplanned hospital admissions in the last year. Are there any general trends or patterns of activity you have identified? • All services involved in patients' care should be able to access and contribute to that person's current Comprehensive Geriatric Assessment document.
Effective rehabilitation	• All hospital based staff recognise responsibility for supporting people with frailty to maintain usual activity levels. • The whole team supports the rehabilitation goals and preferences of people living with frailty whilst an in-patient. • Communication of usual functional levels and updated goals should occur between hospital and community.
Transfer of care to a new care setting	• Have seamless communication between hospitals and the new care setting. • Have a shared and integrated system approach to supporting transfer of care. • Know what the capacity of services are including community rehabilitation and intermediate care (bed and home based).
Coordination of care through sharing information	• Ensure all the services working with people living with frailty in your area have access to the enhanced summary care record. • Staff of all services should routinely access the enhanced summary care record (or equivalent) to support patient care, with particular reference to frailty identification.

Guidance and best practice examples

NHS RightCare has a comprehensive stand-alone pathway to support development of a falls and fragility fracture system. Click on this icon to access the pathway.

System improvement priority:
Delirium, dementia and cognitive disorder

This section is not exhaustive, it seeks to highlight that people living with frailty will often live with or experience dementia and delirium. They are specific conditions that require attention across a system to support prevention, identification, support and management. Recognition of the signs of delirium and dementia is key. Links can be found in the guidance and best practice examples section.

Key areas for focus:		
Delirium Delirium is preventable and treatable if dealt with urgently, however delirium is associated with increased hospital stay, hospital acquired complications and higher mortality rates. People encountering other frailty syndromes such as falls are more at risk of developing delirium.	**Guidance and best practice**	**Actions to take**
Dementia and cognitive disorder The progression and experience of dementia will vary from person to person. This means that care and support must be person-centred meeting the specific needs of individuals. Families and health and care professionals must have access to training and support, to improve care and coordination.	**Guidance and best practice**	

System improvement priority:
Delirium, dementia and cognitive disorder

Actions to take:	

Delirium	• Have strategies in place to regularly observe people with risk factors of delirium to look for signs of the condition, using an agreed tool to assess for delirium.
	• If delirium is suspected try to identify a cause, have a supportive and quiet environment, and involve carers. Assess the need for sedation using the NICE guidance under CG103.
	• Ensure appropriately trained staff undertake an assessment. Consider:
	  • Where are these professionals in your system?
	  • How are people in care homes and the community supported?
	  • What is your incidence of delirium?
	  • What is the system response?
	• Ensure communication across the system takes place if someone is found to have delirium.

Dementia and cognitive disorder	• Recognise people with cognitive impairment using an agreed tool. • Distinguish dementia from delirium and consider delirium if there is a change in dementia status. • For diagnosis consider specialist referral (e.g., memory clinic), derive a local diagnostic pathway. • Recognise that adherence to routine treatments may be affected by cognitive impairment, have strategies to take action. • Ensure the application of the mental capacity act.
Guidance and best practice examples	

System improvement priority: **Personalised care**

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on what matters to them and their individual strengths and needs (NHS England, 2018).

Key areas for focus:

Effective personalised care planning with patients and shared decision making Personalised care planning should address the full needs of the individual, taking steps to address loneliness, isolation, healthy behaviours etc. The process should involve shared decision-making between the individual and the professionals supporting them, putting the patient at the centre of decisions about their own care. Voluntary sector organisations can also play an important role in effective care planning and providing follow up support.	**Guidance and best practice**	**Actions to take**
Advance care planning This is the process of people expressing their preferences, values and goals about their future wishes and priorities for their own health and care. It enables better provision and planning of care, helping people to live well and die well in a place and manner of their choosing (Gold standards framework, 2018).	**Guidance and best practice**	

System improvement priority: **Personalised care**

Actions to take:	
Ensure effective personalised care planning with patients and shared decision making	• Ensure that people are actively involved in shared decision-making and are supported to undertake self-management for their condition • Personalised care planning should address the full needs of the individual, including wider social issues such as housing problems that may impact on health. • Ensure that staff are aware of local services that they can refer / signpost people with frailty, to provide support for them outside of primary or secondary care • Use patient decision aids to help people make informed choices about their healthcare and treatment options
Advance care planning	• Is there a baseline of preferred place of death recorded? • Are people living with frailty encouraged to review their ongoing support needs and personal planning when a change is noted in their support requirements either by themselves, carers or support staff, and clinicians or key workers? • Which services actively encourage people they work with to complete an advance care directive in a timely manner and ensure this is known to the family and carers as well as held by all agencies the person engages with? • Are staff working with people with frailty confident in recognising that a person is approaching the end of their life and feel equipped to engage effectively with patients and carers to discuss end of life care?

Guidance and best practice examples

System improvement priority: **Experience of care**

Experience is important in a number of different, but related ways:

- As a key part of providing high quality care - those providing health and care services view experience as a natural part of providing high quality care, and a good experience is now seen as an important 'outcome' in its own right.
- As a way of improving outcomes - there is strong evidence about the links between experience and the other aspects of high-quality care (clinical effectiveness and safety).
- As a way of indicating value for money and whether services are appropriate - only by understanding what people want from their services and continually focusing on their experiences will we truly be sure we are delivering value for money.
- As a way of supporting staff engagement - there is strong evidence to show the links between staff engagement and the experience of service users.

Key areas for focus:

Improving the experience of care for people and their carers who live with frailty

The poorest care is often received by those least likely to make complaints, exercise choice or have family to speak up for them, such as people living with frailty. Also, there are concerns about unfair discrimination in access to care. People who use services have vital insights into their care and many are experts in managing their own conditions, genuine partnerships gives patients parity of esteem with health professionals and both improve health outcomes and contribute to more cost-effective use of services.

'Good' experience of care will result in people who use services being more engaged with their own healthcare, leading to improved patient service user outcomes and productivity gains for NHS services.

Guidance and best practice

Actions to take

System improvement priority: **Experience of care**

Actions to take:	
Improving the experience of care for people and their carers who live with frailty	• How many older carers living with frailty are supporting people with moderate or severe frailty are identified and supported to live well? • Have a systematic approach to identifying older carers who are supporting people living with frailty who are at risk of frailty themselves, and are therefore most likely to benefit from a Comprehensive Geriatric Assessment (CGA) – or targeting CGA to those carers most likely to benefit. • Services use experience of care feedback from patients and carers to improve services using co-production and co-design. • Are there plans to improve experience of care? • Ensure that you identify frailty as a trigger so that people are referred appropriately within the health and social care system. • Do this in a way that is acceptable for older people and enables them to work in partnership with their health professionals. • Staff working with people with frailty should be confident in recognising that a person is approaching the end of their life and feel equipped to engage effectively with patients and carers to discuss end of life care.

Guidance and best practice examples

Guidance and best practice

This section contains all the relevant guidance, evidence and case studies aligned to each of this toolkit's system improvement priorities and key areas for focus. It supports development of improvement actions when system priorities have been identified.

Guidance

Implementation and practical examples

System improvement priority: **Population segmentation, identification and stratification**

System wide recognition of the signs of frailty

Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (**NICE, NG16**)

QTUG for assessing falls risk and frailty (**NICE, MID73**)

Osteoporosis: assessing the risk of fragility fracture (**NICE, CG146**)

Dementia: support in health and social care, statement 4 (**NICE, QS1**)

Falls in older people: assessing risk and prevention (**NICE, CG161**)

Falls in older people (**NICE, QS86**)

Making every contact count (Health Education England), for help and guidance when implementing MECC.

Updated guidance on supporting routine frailty identification and frailty care through the GP Contract 2017/2018 (NHS England)

Technical Requirements for GMS/PMS (2018/19) core contract data collection (NHS Employers), identification and management of patients with frailty and named GP (p. 36).

Fit for Frailty part 1 (British Geriatrics Society and Royal College of General Practitioners), Consensus best practice guidance for the care of older people living in community and outpatient settings

Fit for Frailty part 1 (British Geriatrics Society and Royal College of General Practitioners), see case study examples in appendix 2.

Fit for Frailty part 2 See appendix for:

- Case study 1 – signposting over 75's to support services EASYCare approach – Warwickshire
- Case study 2 – Birthday card project – developing care plans for 75 and over – Gnosall
- Case study 6 – Using Age UK volunteers to promote participation – Cheshire

Routine frailty identification in the GP contract webinar (NHS England), presentation by Dr Dawn Moody, Associate National Clinical Director for Older People and Integrated Person-centred Care, NHS England

Identifying and understanding frailty (NHS England), Dr Dawn Moody

Using population sub-segmentation to promote tailored end of life care in later life (British Geriatrics Society), Dr Dawn Moody and Prof Martin Vernon.

A Life Course Approach to Healthy Aging, Frailty, and Capability (Oxford Academic), Diana Kuh, The Journals of Gerontology.

Making Every Contact Count, How NICE resources can support local priorities (NICE)

Improving care and support for people with frailty, How NICE resources can support local priorities (NICE)

Guidance	Implementation and practical examples
System wide recognition of the signs of frailty (continued)	
Fit for Frailty part 2 (British Geriatrics Society and Royal College of General Practitioners), developing, commissioning and managing services for people living with frailty in community settings	Bone Health Programme: A Proactive Population Approach to Bone Health (NICE), this innovative programme supports primary care in identifying patients at risk of fragility fracture and osteoporosis.
Know what to do when signs of frailty are found	
Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (**NICE, NG16**) Multimorbidity: clinical assessment and management (**NICE, NG56**), please see **recommendation 1.4** How to assess frailty Dementia: support in health and social care, statement 1 (**NICE, QS1**) Fit for Frailty part 1 (British Geriatrics Society and Royal College of General Practitioners), this guidance is intended to support health and social care professionals in the community, outpatient clinics, community hospitals and other intermediate care settings including older people's own homes. Preventing excess winter deaths and illness associated with cold homes (**NICE , QS117**)	Top tips: frailty in older people (Guidelines in Practice), Dr Sunil Angris offers top tips on the identification, assessment, and management of frailty in people aged 65 years and over. Wakefield Connecting Care Hubs (Wakefield CCG), health and social care services across Wakefield are focusing on delivering a new integrated care co-ordination model, in partnership with other voluntary and community sector agencies, through the Connecting Care Hubs. Bone Health Programme: A proactive population approach to bone health (NICE), this innovative and unique programme supports primary care in identifying patients at risk of fragility fracture and/or osteoporosis.

Guidance	Implementation and practical examples
Standardised way of stratifying frailty	
Updated guidance on supporting routine frailty identification and frailty care through the GP Contract 2017/2018 (NHS England), this document provides updated guidance for general practices to support implementation of the new frailty requirements in the 2017/18 GP contract. Technical Requirements for GMS/PMS (18/19) core contract data collection (NHS Employers), identification and management of patients with frailty and named GP (pg36). Osteoporosis: assessing the risk of fragility fracture (**NICE, CG146**) Osteoporosis (**NICE, QS149**) Multimorbidity: clinical assessment and management (**NICE, NG56**), see **recommendation 1.4** How to assess frailty	Rockwood clinical frailty scale (CGA Toolkit), a toolkit for evaluating frailty. Edmonton Frailty Scale (CGA Toolkit), a further toolkit for evaluating frailty. Developing an Electronic Frailty Index (eFI) (British Geriatric Society), blog post that includes information on how the eFI is being used, contains practice examples. Age and Aging - Development and validation of an electronic frailty index using routine primary care electronic health record data (Oxford Academic), a study in 2008 using real patient data to develop an electronic frailty index.
Identify frailty and frailty risk	
What is the Comprehensive Geriatric Assessment (CGA) and why is it done? (British Geriatrics Society) Supporting routine frailty identification and frailty through the GP Contract 2017/2018 (NHS England) Technical Requirements for GMS/PMS (18/19) core contract data collection (NHS Employers), identification and management of patients with frailty and named GP (p. 36). Multimorbidity: clinical assessment and management (**NICE, NG56**), see **recommendation 1.4** How to assess frailty	Healthcare passport (Royal College of Physicians), passport template providing vital information about a patient when they go into hospital. The passport provides key information on medication, personal needs etc. Comprehensive Geriatric Assessment (CGA) (CGA Toolkit), a tool for undertaking multidimensional holistic assessment of an older person. It considers health and wellbeing and formulates a plan to address issues which are of concern to the older person.

Guidance	Implementation and practical examples
Identify frailty and frailty risk (continued)	
Emergency and acute medical care in over 16s: service delivery and organisation (**NICE, NG94**) Transition between inpatient hospital settings and community or care home settings for adults with social care needs (**NICE, QS136**) Guide to reducing long hospital stays (NHS Improvement)	What is Comprehensive Geriatric Assessment (CGA) and why is it done? (British Geriatrics Society) Acute care toolkit 3: Acute medical care for frail older people (Royal College of Physicians), a toolkit that recommends procedures for both initial assessment on admission and later comprehensive geriatric assessment of older people entering hospital. Better transfers of care for older people: How to improve transitions from hospital (The Kings Fund), presentations that explore new ways of ensuring older people experience a safe, appropriate and timely discharge that is right for them and their health needs. PRISMA-7 Questionnaire (BCGuidelines), an identification tool, with scores of 3 and above indicating frailty.
System improvement priority: Supporting people living with mild frailty and encouraging people to 'age well'	
Best practice guidelines for the management of frailty (Oxford Academic), a British Geriatrics Society, Age UK and Royal College of General Practitioners report.	

Guidance	Implementation and practical examples
Support for physical activity, weight management, smoking cessation and alcohol	
Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (**NICE, NG16**) Physical activity guidelines for older adults aged 65 and over (NHS Choices) Physical Activity: applying all our health (Public Health England Guidance) Getting every adult active every day (Public Health England) Physical activity: brief advice for adults in primary care (**NICE, PH44**) Multimorbidity: clinical assessment and management (**NICE, NG56**) Obesity prevention (**NICE, CG43**) Physical activity: exercise referral schemes (**NICE, PH54**) Multimorbidity (**NICE, QS153**) Chronic obstructive pulmonary disease in over 16s: diagnosis and management (**NICE, NG115**) Smoking: supporting people to stop (**NICE, QS43**) Smoking: harm reduction (**NICE, QS92**) Nutrition support in adults (**NICE, QS24**) Alcohol use disorders: diagnosis and management (**NICE, QS11**) Foot care (**NICE QS6**) Chronic kidney disease in adults: assessment and management (**NICE CG182**) Cardiovascular disease: risk assessment and reduction, including lipid modification (**NICE, CG181**) Atrial fibrillation: management (**NICE, CG180**)	Obesity and weight management in the elderly (Oxford Academic), a British Medical Bulletin article on the adverse consequences of obesity in older people and guidelines on treatment. General practice physical activity questionnaire (Department of Health and Social Care), a questionnaire used by GPs to assess patient levels of physical activity. One Croydon alliance (NHS Croydon Health Services), partnership between the local NHS, Croydon Council and Age UK Croydon to improve the health and wellbeing of older people in the borough. Choose to Change service delivered by ABL Health (ABL) (NICE), adults about to complete a lifestyle weight management programme agree a plan to prevent weight regain. The Alive approach to providing meaningful activities for older people living in care, particularly those living with dementia (NICE)

Guidance	Implementation and practical examples
Education and understanding of frailty (in the population as well as in health and social care)	
Frailty Core Capabilities Framework (Skills for Health), the framework will aim to identify and describe the skills, knowledge and behaviours required to deliver high quality, compassionate care and support. Falls in older people: assessing risk and prevention (**NICE, CG161**), please see **recommendation 1.1.10**. Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (**NICE, NG16**) A Practical Guide to Healthy Aging (NHS England), a practical guidance to those age 70 and over on how to keep fit and active in old age. A Practical Guide to Healthy Caring (NHS England and Public Health England), a practical guide for carers, particularly those over 65 and new to caring.	Fit for Frailty 1 (British Geriatrics Society), this guidance is intended to support health and social care professionals in the community, in outpatient clinics, in community hospitals and other intermediate care settings and in older people's own homes. Fit for Frailty 2 (British Geriatric Society), advice and guidance on the development, commissioning and management of services for people living with frailty in community settings. Please see case study 7 – development of an education project for the frailty medical work force in the New Forest.
Supported self-management	
Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (**NICE, NG16**) Mental wellbeing and independence for older people (**NICE, QS137**) Mental health in older people: A Practice Primer (NHS England and NHS Improvement), support for primary care professionals to support mental health in older people. Valued care in Mental Health: Improving for excellence (NHS Improvement), a national mental health improvement model. Care and support of people growing older with learning disabilities (**NICE, NG96**)	Working together to improve public health and wellbeing (NHS England), emergency services consensus statements aimed at encouraging local areas to develop joint strategies for opportunity and intelligence-led prevention and health improvement. Befriending Services (Age UK), tackling loneliness in later life through befriending, or 'visiting' services, where a volunteer visits or talks to an older person once a week in their own home.

Guidance	Implementation and practical examples
Nutrition	
Eat Well (NHS Choices), eight tips for healthy eating. The Eat Well Guide (Public Health England) Advice on identifying and managing malnutrition (NHS Choices) Keep your bones strong over 65 (NHS Choices) Eating well when you are over 70 (Royal Voluntary Service) Nutritional care and older people (Social Care Institute for Excellence), standards of nutritional care for older people. Top tips for healthy aging (British Nutrition Foundation) Defining the specific nutritional needs of older persons (World Health Organisation) Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition (**NICE, CG32**) Nutrition support in adults, statement 1, Screening for the risk of malnutrition (**NICE, QS24**)	Kitchen Kings (Age UK), helping older men to learn how to cook. When they get older, independent website with advice and support on a range of topics including diet and nutrition for older people. Meals on wheels locator website, find your nearest service. The North Derbyshire Nutrition Support Project: Increasing appropriate Oral Nutrition Supplement prescriptions (NICE, QS24) MUST Toolkit (BAPEN), the 'Malnutrition Universal Screening Tool' (MUST) was developed by the Malnutrition Advisory Group and is the most commonly used screening tool in the UK. Implementing a policy for identifying and managing malnutrition in Care Homes (NICE), shared learning database - case study from City Healthcare Partnership CIC.

Guidance

Implementation and practical examples

System improvement priority: **Supporting people living with moderate frailty**

Multidisciplinary assessment of risk stratified patients

Next Steps for Risk Stratification in the NHS (NHS England)

Updated guidance on supporting routine frailty identification and frailty care through the GP Contract 2017/2018 (NHS England)

Technical Requirements for GMS/PMS (18/19) core contract data collection (NHS Employers), identification and management of patients with frailty and named GP (p. 36).

Nutrition support in adults (**NICE, QS24**)

Multimorbidity: clinical assessment and management (**NICE, NG56**), see recommendation 1.4 How to assess frailty

Helping older people maintain a healthy diet: a review of what works (Public Health England)

Dysphagia management for older people towards the end of life (British Geriatric Society), a good practice guide.

Mental health in older people: A Practice Primer (NHS England and NHS Improvement), support for primary care professionals to support mental health in older people.

Valued care in Mental Health: Improving for excellence (NHS Improvement)

Care Navigator (Age UK), Care Navigator Service that assists with personal action plans.

Age UK Warwickshire - primary care navigator pilot, (Care and Repair England), a case study on the care navigator pilot scheme.

Improving Access with Primary Care Navigators for dementia, Oxford Terrace and Rawling Road Medical Group Gateshead (NHS England), case study.

Undernutrition Service (Academic Health Science Network), development of an innovative digital method of monitoring patients prescribed with oral nutritional supplements – the Health Call Undernutrition Service.

Telehealth - Health Call undernutrition service (Academic Health Science Network), overview of Health Call – an electronic system using telephone technology to monitor nutritional needs in older people.

Helping older people maintain a healthy diet: a review of what works (Public Health England)

Hertfordshire independent living service (Hertfordshire Independent Living Service), provide a range of services to help older and vulnerable people stay happy, healthy, and independent.

Using Nutrition Support NICE Quality Standards as a basis to improve management of malnourished care home residents with a Food First approach (NICE), shared learning database.

Guidance	Implementation and practical examples
Multidisciplinary assessment of risk stratified patients (continued)	
Intermediate care including reablement (**NICE, NG74**) Mental wellbeing and independence for older people (**NICE, QS137**) Comprehensive Geriatric Assessment (CGA) (CGA Toolkit), a tool for undertaking multidimensional holistic assessment of an older person. It considers health and wellbeing and formulates a plan to address issues which are of concern to the older person.	New Models of Care – Livewell South West (NHS England), case study on a new model service designed to improve quality of care for patients in nursing and residential homes. Reablement - A review of evidence and example models of delivery (NHS Doncaster CCG), literature review relating to the long-term impact of reablement services, the role of the occupational therapist, rapid response services, providing key pointers for implementation and improvement. Practice examples from around the country are included.
Home and community based rehab	
Intermediate care including reablement (**NICE, NG74**) National audit of intermediate care (NHS Benchmarking Network)	An Integrated Frailty Pathway (Lincolnshire West CCG), development and implementation of a frailty pathway prioritising community and home based solutions. Which? Elderly Care - Housing Options (Which?), find out what housing and residential options are available for older people together with care services and products to help improve quality of life. The economics of housing and health: The role of housing associations (The Kings Fund), a report looking at the economic case for closer working between the housing and health sectors. The Alive approach to providing meaningful activities for older people living in care, particularly those living with dementia (NICE), shared learning database.

Guidance	Implementation and practical examples
Recognition of deterioration	
Frailty core capabilities framework (Skills for Health), the framework will aim to identify and describe the skills, knowledge and behaviours required to deliver high quality, compassionate care and support. Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (**NICE, NG16**) Acutely ill adults in hospital: recognising and responding to deterioration (**NICE, CG50**) Comprehensive Geriatric Assessment (CGA) (CGA Toolkit), a tool for undertaking multidimensional holistic assessment of an older person. It considers health and wellbeing and formulates a plan to address issues which are of concern to the older person.	Care Navigator (Age UK), Care Navigator Service - the Care Navigator assists with personal action plans supporting individuals to self-manage their needs. Fire service 'Safe & Well' visits (Hampshire Fire and Rescue Service), this service is now provided by many fire services across the country.

Guidance	Implementation and practical examples
System improvement priority: **Supporting people living with severe frailty**	
Training and capabilities of social care staff	
Dementia: assessment, management and support for people living with dementia and their carers (**NICE, NG97**)	EOL Awareness Training for Care Home and Domiciliary Care Staff (Academic Health Science Network)
The framework for enhanced healthcare in care homes (NHS England)	Learning and development for Adult Social Care staff and carers (Brighton and Hove City Council), a good example of a council providing a range of funded and paid for training, qualifications and e-learning for adult social care services.
Framework for maximising the use of care homes and use of therapy-led units for patients medically fit for discharge (NHS England), the purpose of this framework is to supplement local escalation plans by describing standards of care and ways of working, which are in use and making a difference to discharging patients and maximising use of beds outside the hospital setting.	Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England (Skills for Care), a comprehensive code of conduct for healthcare support workers and adult social care workers describing the standards of conduct, behaviour and attitude that the public and people who use health and care services should expect.
Frailty Core Capabilities Framework (Skills for Health), the framework will aim to identify and describe the skills, knowledge and behaviours required to deliver high quality, compassionate care and support.	Older Persons Fellowship (Health Education England), the Older Person's Fellowship for Nurses and Allied Health Professionals (AHPs), sponsored by HEE, is a programme aimed at driving clinical excellence, innovation and quality improvement in care for older people.
Dementia Training Standards Framework (Skills for Health), the framework supports workforce development, building upon the original objectives of the National Dementia Strategy and specific to implementation of the Prime Minister's Challenge on Dementia and HEE Mandate.	Fit for Frailty 1 (British Geriatrics Society), this guidance is intended to support health and social care professionals in the community, in outpatient clinics, in community hospitals and other intermediate care settings and in older people's own homes.

Guidance	Implementation and practical examples
Management of urgent care situations	
Quality care for older people with urgent and emergency care needs (Royal College of Emergency Medicine), the focus of this guide is on care for older people in the first 24 hours of an urgent care episode. Ambulatory emergency care guide: same day emergency care — clinical definition, patient selection and metrics (NHS Improvement) Sepsis: recognition, diagnosis and early management (**NICE, NG51**) Sepsis (**NICE, QS161**)	Elderly Patients in Hospital, a patient publication, advice on the support of older patients when in hospital. Acute Frailty Network case studies (Acute Frailty Network), a series of case studies on improving the management and support of frail and older patients when attending A&E and admitted. Integrated care clinical pharmacist for frail older people: Case management and enhanced rapid response (NICE), shared learning database. Your hospital stay (AgeUK) Advice and support for people if they need to stay in hospital.
Enhance health in care homes	
Commissioning Guidance for Rehabilitation (NHS England), this guidance is intended for use by CCGs to support them in commissioning rehabilitation services for their local population Intermediate care including reablement (**NICE, NG74**) Intermediate care including reablement (**NICE, QS173**) Mental wellbeing of older people in care homes (**NICE, QS50**) Mental wellbeing and independence for older people (**NICE, QS137**) Rehabilitation after critical illness in adults (**NICE, CG83**) Managing medicines in care homes (**NICE, SC1**) Medicines optimisation (**NICE, QS120**)	New Models of Care (NHS England), Livewell South West case study on a new model service to improve quality of care for patients in nursing and residential homes. Reablement - A review of evidence and example models of delivery (NHS Doncaster CCG), literature review relating to the long-term impact of reablement services, the role of the occupational therapist, rapid response services, providing key pointers for implementation and improvement. Practice examples from around the country are included. Assuring Quality of Care in Nursing Homes – Hydration Monitoring Solution (Academic Health Science Network) Improving Medicines Optimisation for Care Home Residents and Providing Medicines Management Support to Care Homes - The Wigan Borough CCG Approach (NICE), shared learning database.

Guidance	Implementation and practical examples
Enhanced healthcare in care homes (continued)	
Medicines management in care homes (**NICE, QS85**) Pressure ulcers (**NICE, QS89**) Mental wellbeing in over 65s: occupational therapy and physical activity interventions (**NICE, PH16**) Collaborative approaches to treatment: Depression among older people living in care homes (British Geriatrics Society) Multimorbidity (**NICE, QS153**) GP services for older people: a guide for care home managers (Social Care Institute for Excellence)	Improving the mental and social wellbeing of the elderly in residential care – a case study from Mellifont Abbey Residential Care Home (NICE), shared learning database. Pharmacists and GP surgeries (General Pharmaceutical Council), the benefits of providing primary care patients with pharmacy clinical expertise. Scenario five details how pharmacists can be assigned to care homes. Pharmacy and Care Homes (General Pharmaceutical Council), a report to inform and support understanding of the use of medicines in care homes. Vanguard pilot projects (Pulse), article detailing a number of examples from around the country of new models of care. The Alive! approach to providing meaningful activities for older people living in care, particularly those living with dementia (NICE), shared learning database. Peer Support Meetings for Pharmacists Undertaking Medication Reviews for Older People in Care Homes and Domiciliary Settings (NICE), shared learning database. Medicines Optimisation for Older People in Care Homes and the Intermediate Care Setting: Developing and Reproducing new Models of Care (NICE), shared learning database. Neighbourhood Integrated Medicines Optimisation Team: Improving medicines use at home (NICE), shared learning database.

Guidance	Implementation and practical examples
End of life care	
End of life care for adults (**NICE, QS13**), quality statement 1: People approaching end of life are identified in a timely way. Care of dying adults in the last days of life (**NICE, NG31**) Recognition of patients nearing end of life (The Gold Standards Framework), guidance on early identification of people nearing the end of their life to ensure earlier planning and better co-ordinated care.	EOL Awareness Training for Care Home and Domiciliary Care Staff (Academic Heath Science Network), training aims to improve the care delivered by care staff at the end of life, both in care homes and in the wider community. Palliative and End of Life Care Toolkit (Royal College of General Practitioners), toolkit for use by any general practice in the UK. Its resources can be used by healthcare professionals, informal carers, patients, and those close to someone nearing the end of life. Ageing well - Quality Healthcare in later life - Using population sub-segmentation to promote tailored end of life care in later life Presentation by Dr Dawn Moody and Dr Martin Vernon, NHS England. To develop new partnerships to achieve best practice in End of Life Care (EOLC) through the provision of education programmes (NICE), shared learning database. Let's talk about death and dying (Age UK), booklet designed to start conversations to help everyone feel empowered and positive to talk about death.

Guidance	Implementation and practical examples
System Improvement Priority: Reducing hospital length of stay	
Crisis and rapid response	
Recognising frailty in an emergency situation (British Geriatric Society) Ambulatory emergency care guide (NHS Improvement) Intermediate care including reablement (**NICE, NG74**), see **section 1.5.1**, entering intermediate care. Sepsis: recognition, diagnosis and early management (**NICE, NG51**) NEWS2 (Royal College of Physicians), National Early Warning Score.	Livewell South West, link to the crisis response team website including referral form and information leaflets. Frailty Interface team in emergency care (Acute Frailty Network) Crisis response falls team: reducing admissions and repeat falls (NICE), quality and productivity case study from East Midlands Ambulance Service NHS Trust.
First 24 hours	
Emergency and acute medical care in over 16s: service delivery and organisation **(NICE, NG94)** Transition between inpatient hospital settings and community or care home settings for adults with social care needs (**NICE, QS136**) Ambulatory emergency care guide (NHS Improvement) Ambulatory emergency care guide: same day emergency care — clinical definition, patient selection and metrics (NHS Improvement) Silver Book (Acute Frailty Network), an overview of many of the most pressing and clinical and social problems met by older people when they present in an emergency. Frailsafe: a safety checklist for frail older patients entering acute hospital care (The Health Foundation)	Rapid improvement guide: managing emergency admissions (NHS Improvement), manage emergency admissions by implementing and monitoring the six A's. Improving Patient Flow (The Health Foundation), case study showing emergency department's older peoples patient flow work. Bed-based intermediate care (NICE), shared learning database. Fit for Frailty 2 (British Geriatrics Society), see appendix for case study 3 – acute hospital care for older people in Southampton. National Audit of Inpatient Falls Audit report 2017 (Healthcare Quality Improvement Partnership), a report including data about the leadership responsibilities, policies and procedures of acute hospital trusts and LHBs in England and Wales. Multifactorial interventions can reduce harm from falls in Acute Hospital settings (NICE), shared learning database.

Guidance	Implementation and practical examples
Effective rehabilitation	
Rehabilitation after critical illness in adults (**NICE, CG83**) Intermediate care including reablement (**NICE, NG74**) Intermediate care including reablement (**NICE, QS173**) Mental wellbeing and independence for older people (**NICE, QS137**) Rehabilitation after critical illness in adults (**NICE, CG83**)	Encouraging patients to be active when in hospital, see Twitter, #EndPJParalysis "Get up, Get Dressed" (NICE), shared learning database - Frailty Care on a Surgical Ward. Patient information leaflets about preventing falls in hospital and the use of bedrails (NICE), shared learning database. Activity Coordinator Role (Hampshire Hospitals NHS Foundation Trust), Working mostly with older patients, and patients with long term conditions, the activity coordinators help stimulate patients both mentally and physically through a range of activities. Good practice case study: rehabilitation and older patients (HSJ), NHS Lanarkshire trains nursing teams from acute hospital wards in older patient rehabilitation and enablement. Inpatient elderly rehabilitation services (St Georges University Hospitals NHS Foundation Trust)
Transfer of care to new care setting	
Transition between inpatient hospital settings and community or care home settings for adults with social care needs (**NICE, QS136**) Allied Health Professions (AHPs) supporting patient flow (NHS Improvement), publication on improving patient flow.	Delayed transfer of care (DTOC) improvement tool (NHS Improvement): A tool that allows trusts, CCGs and local authorities understand their most common reasons for delayed transfers of care and to develop appropriate interventions. Guide to reducing long hospital stays (NHS Improvement), a 'how-to' guide offering practical steps and tactics to support the NHS and partners to manage hospital length of stay. Managing frailty and delayed transfers of care (NHS Benchmarking Network) Improving transfer of care (NICE), how NICE resources can support local priorities. Moving on, The Lunch Club experience (NICE), shared learning database.

Guidance	Implementation and practical examples
Co-ordination of care through sharing information	
Personalised care and support planning (British Geriatrics Society)	Personalised care and support planning handbook (Coalition for collaborative care and NHS England), this handbook provides an introduction to care and support planning and contains links to practical guidance, case studies and theory on how to introduce care and support planning.
Supporting routine frailty identification and frailty through the GP Contract 2017/2018 (NHS England), see section on information sharing.	
Technical Requirements for GMS/PMS (18/19) core contract data collection (NHS Employers), identification and management of patients with frailty and named GP (p. 36).	Toolkit for general practice in supporting older people living with frailty (NHS England), this document provides 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.
Red bag pathway (NICE Shared Learning Database), red bag integrated pathway to support the transfer of care between hospital in patient settings and the community or care homes.	
NHS Benchmarking: National Community Services Audit (NHS Benchmarking Service), community services play a key role in supporting service users at home and reducing unnecessary hospital admissions. There is limited information on these services, but this website provides information on access, activity, workforce, finance and quality metrics.	

Guidance	Implementation and practical examples
System Improvement Priority: **Delirium, dementia and cognitive disorder**	
Delirium	
The recognition and diagnosis of delirium needs improving (Guidelines in Practice), publication that highlights how implementation of NICE guidelines on delirium could help prevent up to one third of episodes. Delirium in adults (**NICE, QS63**) Delirium: prevention, diagnosis and management (**NICE, CG103**)	Dementia Awareness Training for Care Home and Domiciliary Care Staff: Case Study (Health Education England – North East and Academic Health Science Network NENC), the training aims to improve the care delivered by care staff to people with dementia, both in care homes and in the wider community. North East Dementia Innovation Hub: RCGP Dementia Roadmap and Sound Doctor Dementia Films (Academic Health Science Network North East and North Cumbria), Newcastle University's North East Dementia Innovation Hub supports and stimulates the delivery of world-class interventions and support for people with dementia and their families. Thinking Delirium in Herts and Beds Critical Care Units (NICE), shared learning database - Herts and Beds Critical Care Network. Recognising and preventing delirium (NICE), quick guide for care home managers.

Guidance

Implementation and practical examples

Dementia and cognitive disorder

Dementia: assessment, management and support for people living with dementia and their carers (**NICE, NG97**)

Dementia: independence and wellbeing (**NICE, QS30**)

Dementia management pathway (NICE)

Dementia: support in health and social care (**NICE QS1**)

After diagnosis of dementia: what to expect from health and care services (Department of Health and Social Care), for anyone diagnosed with dementia, or supporting someone with dementia, this information is to help the understanding of the kind of support and services that are available in England.

A Practical Guide to Healthy Ageing (Age UK), the advice in this booklet will help improve the health and general fitness of people of any age, but it is written to be particularly relevant for people who are 70 years or older. See sections on 'looking after your mental health' and 'looking after your brain'.

A Practical Guide to Healthy Caring (Public Health England and NHS England), the advice in this booklet will help you if you look after a friend or family member or have any form of caring responsibilities, but it is written to be particularly relevant for those who are about 65 years or older and are new to caring.

MindMate – An app based platform empowering people with dementia (Academic Health Science Network North East and North Cumbria), MindMate is an award-winning application (app) that has been designed to provide an assistance platform for people with dementia, their carers and family members. The app has been designed and optimised specifically for older people and is being used by thousands of people worldwide.

Derby Dementia Support Service (NICE), shared learning database.

The role of Private domiciliary care for dementia care (NICE), shared learning database.

The Alive! approach to providing meaningful activities for older people living in care, particularly those living with dementia (NICE), shared learning database.

Guidance	Implementation and practical examples
System Improvement Priority: Personalised Care	
Effective personalised care planning with patients and shared decision making	
What is shared decision making? (NICE) Shared decision making (NHS England) MAGIC: shared decision making (The Health Foundation)	Improving decision-making in the care and support of older people (Joseph Rowntree Foundation), how does risk and trust affect decision making in care of older people?
Advance care planning	
Home care: delivering personal care and practical support to older people living in their own homes (**NICE, NG21**) Transition between inpatient hospital settings and community or care home settings for adults with social care needs (**NICE, QS136**) Personalised care guidance sheet (NHS and Department of Health) Social care for older people with multiple long-term conditions (**NICE, QS132**), see **statement 4** Older people with social care needs and multiple long-term conditions (**NICE, NG22**), see **recommendations 1.2.2 and 1.2.3.**	Personalised care and support planning handbook (Coalition for collaborative care and NHS England), an introduction to care and support planning. Advance Care Planning (Gold Standards Framework), advance care planning explained. Advance Care Planning: a guide for health and social care staff (NHS England) My future wishes: Advance Care Planning (ACP) for people with dementia in all care settings (NHS England), to assist practitioners, providers and health and social care commissioners develop an Advance Care Plan (ACP). Managing Frailty Through Personalised Care Planning (GP View), example from Central Gateshead of using personalised care planning to reduce hospital admissions Better Together – ASSIST Hospital Discharge Scheme (NICE), shared learning database.

Guidance	Implementation and practical examples
System improvement priority: **Experience of care**	
Improving experience of care for people living with frailty and their carers	
Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (**NICE, CG138**) Improving Experiences of Care: Our shared understanding and ambition (National Quality Board) The Government's mandate to NHS England for 2018/19 (Department of Health and Social Care), see objective two, 'To help create the safest, highest quality health and care service'. Five Year Forward View Commitment to Carers (NHS England), commitment to carers to give them the recognition and support they need to provide invaluable care for loved ones.	Patient Experience Improvement Framework (NHS Improvement) A Co-production Model (Coalition for collaborative care) Improving Experience of Care through people who use services (NHS England) Always Events Methodology (NHS England) Always Events Case Studies (Picker) Carers Toolkit (NHS England) Patient Experience Resources (The Beryl Institute) Insight resources (NHS England) Case studies (Patient Experience Network) Understanding and improving transitions of older people: a user and carer centred approach (National Institute for Health Research) Who knows best? Older people's contribution to understanding and preventing avoidable admissions (University of Birmingham) Older people's and relatives' experiences in acute care settings: Systematic review and synthesis of qualitative studies. (Bridges J, Flatley M, Meyer J)

Frailty self-assessment questionnaire

These self-assessment questions (SAQ) are designed to help local areas (including STPs, ICSs and PCNs) gain enhanced understanding of their frailty system. The NHS RightCare Frailty Toolkit provides a benchmark to enable understanding of the key components of a frailty system. The questions should be used alongside the Toolkit to facilitate discussion and identify improvement opportunities or exemplars of good practice. The SAQs have been developed in partnership with the NHS England Clinical Policy Unit.

Specifically these questions are designed to:

- Assess the existing system to support ageing well and provide quality care for people living with frailty.
- Identify any current gaps in provision and current opportunities to enhance or develop services and systems to support ageing well and quality care in older life, including working with key partners.
- Consider future demand from population ageing based on current care models, using local intelligence alongside projected data to ensure accuracy and consistency.
- Assess the progress of any system improvements over time.

Rating Key: 1 = fully met, 2 = partially met, 3 = not met, 4 = not applicable

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Data and information sharing *Linked to toolkit Priority:* • *Population segmentation, identification and stratification of frailty*	1. Do all the services working with people living with frailty in your area have access to the enhanced Summary Care Record (eSCR)?	
	2. For General Practice staff, when the practice identifies someone is living with frailty are the benefits of updating the eSCR explained and permission requested to record the information on this?	
	3. Do staff of all services routinely access the eSCR (or equivalent) to support patient care, with particular reference to frailty identification?	
	4. Do you communicate across the system the outcome of a comprehensive geriatric assessment (CGA) and associated action plan?	

Frailty self-assessment questionnaire

Section		Self-assessment questions	Rating (1, 2, 3, 4)
Awareness and understanding *Linked to toolkit priorities:* • *Population segmentation, identification and stratification* • *Support people living with mild frailty and encouraging people to 'age well'*	5.	Do you have a shared awareness and understanding of frailty?	
	6.	Does everyone in the system understand what frailty is?	
	7.	Do you have a communications strategy to target the whole population about frailty?	
	8.	Do you have a network of 'frailty champions' or a 'frailty forum' identified, with a role in promoting a consistent and universal awareness and understanding of frailty?	
	9.	Have you taken a systematic approach to promoting the awareness and understanding of frailty including with individuals, carers, families and partners in health, care, voluntary sector and wider public services?	
	10.	Does the understanding of frailty align with the Frailty Core Capabilities Framework's Domain A, 'Understanding, identifying and assessing frailty'?	
Identification of frailty *Linked to toolkit priorities:* • *Population segmentation, identification and stratification of frailty* • *Support people living with moderate frailty*	11.	Have you looked at the frailty data for your area for primary care? (This is published by NHS Digital, updated at each quarter end, and accessible at https://digital.nhs.uk/data-and-information/publications/statistical/gp-contract-services/gp-contract-services-england-2017-18 To ensure you are viewing the latest data scroll down the landing page to GP Contract Services 2017-18 .csv files v3.0. Click on this to open up a series of spreadsheets, then select the bottom line and this will open up the latest data set. There is also a heatmap view of some analysis: http://fusion48.net/frailty/frailty-contract-analysis/frailty-care-heatmaps)	
	12.	Do you use an appropriate risk or stratification and population segmentation tool such as the electronic frailty index (eFI) in accordance with the GP contract?	
	13.	How do you ensure clinical correlation of the eFI is undertaken?	
	14.	What does the data tell you about frailty identification in your area?	
	15.	In addition to frailty identification in primary care, what other approaches to frailty identification are being used in your area? For example, you may want to look at how frailty identification is undertaken in urgent care settings and how this information is shared.	
	16.	How is this information shared? For example, what percentage of the population aged over 65 years have had a frailty assessment?	
	17.	Do you routinely access the enhanced Summary Care Record (or equivalent) to support patient care, in particular to share information about frailty identification?	

Frailty self-assessment questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Prevention of frailty and prevention of the progression of frailty *Linked to toolkit priorities:* • *Encourage people to age well* • *Support people living with mild, moderate and severe frailty* • *Reduce hospital length of stay* • *Falls and fragility fractures* • *Delirium, dementia and cognitive disorder*	18. Do you have a network of care coordinators and facilitators (or equivalent role) to support patient journeys?	
	19. What self-management education and services are available within the local community to enhance patient activation and empowerment? Can statutory services easily make referrals and receive feedback on progress where these are lead by third sector organisations?	
	20. What is the local offer for weight management, smoking cessation, activity and alcohol reduction, and how does it specifically support people at risk of or living with frailty, including referral pathway?	
	21. Is there support and education for people living with, or at risk of, frailty in how to make lifestyle adjustments?	
	22. Do you undertake strategies such as making every contact count?	
	23. Is routine screening for risk of malnutrition across health and social services in people at risk of developing frailty undertaken?	
	24. Do you provide nutrition education specifically for people at risk of or living with frailty?	
	25. Is there a local directory of services and support available which enables ease of signposting or referral for people living with frailty to the services they may find useful?	
	26. Is there a strategy or action plan adopted across the system so everyone involved in frailty knows what to do when deterioration of frailty status is found?	
	27. Do you have a universal referral process that confirms how services refer to each other?	
	28. Do all hospital based staff recognise responsibility for supporting people with frailty to maintain activity levels?	
	29. Does the whole team aim to support the rehabilitation goals and preferences of people living with frailty whilst an inpatient?	
	30. Does communication of usual functional levels and updated goals occur between hospital and community?	

Frailty self-assessment questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Prevention of frailty and prevention of the progression of frailty (*Cont.*)	31. If you are not a GP, when registering or reviewing a person's support if they present with moderate or severe frailty do you routinely refer to the eSCR for information about falls or medication review?	
	32. How many people with moderate or severe frailty have had planned or unplanned hospital admissions in the last year? Are there any general trends or patterns of activity you have identified?	
	33. Can you identify how many people with moderate or severe frailty have fallen in the last year, or have fallen resulting in fracture and how this associates with the input of falls services?	
	34. To maximise the benefit of falls screening for the individual, where your service undertakes a falls screen is the outcome shared with other services that the individual may access (with their permission)?	
	35. How many older carers living with frailty supporting people with moderate or severe frailty are identified and supported to live well?	
Management of frailty *Linked to toolkit priorities:* • *Encourage people to age well* • *Support people living with mild, moderate and severe frailty* • *Reduce hospital length of stay* • *Falls and fragility fractures* • *Delirium, dementia and cognitive disorder* • *Personalised care* • *Improving experience of care*	36. Are the following principles and conditions for success in enhanced health in care homes present; person-centred change; co-production; quality and leadership?	
	37. Has the enhanced health in care homes framework been used?	
	38. Is the approach of managing frailty as a long term condition embedded across the system?	
	39. Do services address both the 'routine' and proactive management of frailty as a long term condition and the responsive management of exacerbations and changes such as the frailty syndromes?	
	40. How many people are living with frailty in the system? Is this matched to MDT team capacity?	
	41. What is the capacity of services including community rehabilitation and intermediate care (bed and home based)?	
	42. To what extent are relationships developed with wider partners in care, for example housing providers, fitness services, and non-commissioned voluntary services locally?	

Frailty self-assessment questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Management of frailty (*cont.*) *Linked to toolkit priorities:* • *Encourage people to age well* • *Support people living with mild, moderate and severe frailty* • *Reduce hospital length of stay* • *Falls and fragility fractures* • *Delirium, dementia and cognitive disorder* • *Personalised care* • *Improving experience of care*	43. Is there a shared and integrated system approach to supporting transfer of care?	
	44. Do you have seamless communication between hospitals and the new care setting?	
	45. Is there an up to date map or directory of all services, with service leads, potentially related to frailty care and support that are delivering across the health, social care and voluntary sector e.g., falls prevention, NHS Health check and activity groups (social or medical related)?	
	46. What is the specific strategy to manage crisis situations on a needs basis according to frailty stratification?	
	47. Is there a recognised rapid or crisis response service?	
	48. Is there a commissioned social prescribing service across the whole locale?	
	49. Is there a systematic approach to identifying which people living with frailty are most at risk and are therefore most likely to benefit from a CGA – or 'targeting CGA' to those most likely to benefit?	
	50. Is there a systematic approach to identifying older carers supporting people living with frailty who are themselves at risk and are therefore most likely to benefit from CGA – or 'targeting CGA' to those carers most likely to benefit?	
	51. For people living with moderate or severe frailty, is there access to a patient centred MDT review when need changes involving all partners in care, including the person?	
	52. Are all services involved in a patient's care able to access and contribute to that person's current CGA document?	
	53. How are the services using experience of care feedback from patients and carers to improve services using co-production and co-design?	
	54. Are there plans to improve experience of care?	
	55. How do you ensure that you identify frailty as a trigger so that people are referred appropriately within the health and social care system?	
	56. How do you do this in a way that is acceptable for older people and enables them to work in partnership with their health professionals?	

Frailty self-assessment questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Delirium, dementia and cognitive disorder	57. Do you have strategies in place to observe people with risk factors of delirium to be observed regularly for signs of the condition, using an agreed tool to assess for delirium?	
	58. If delirium is suspected, is the following undertaken; identify a cause; have a supportive, quiet environment and involve carers; and sedation is only used when needed in some patients?	
	59. Ensure appropriately trained staff undertake an assessment. Consider: • Where are these professionals in your system? • How are people in care homes and the community supported? • What is your incidence of delirium? • What is the system response?	
	60. Does communication across the system take place if someone is found to have delirium?	
	61. Do you recognise people with cognitive impairment using an agreed tool?	
	62. Is dementia distinguished from delirium and consider delirium if there is a change in dementia presentation?	
	63. For diagnosis, is a specialist referral (e.g., memory clinic) used? Has a local diagnostic pathway been devised?	
	64. Is there recognition that adherence to routine treatments may be affected by cognitive impairment? What strategies are there to take action?	
	65. Do you ensure the mental capacity act is applied?	

Frailty self-assessment questionnaire

Section	Self-assessment questions	Rating (1,2,3,4)
Dying well with frailty *Linked to toolkit priorities:* • *Support people living with severe frailty* • *Personalised care*	66. Do you ensure actively involve people living with frailty in shared decision-making and support them to undertake self-management strategies for their condition?	
	67. When undertaking personalised care planning, do you consider the full needs of the individual, including wider social issues such as housing problems that may impact on health?	
	68. Are staff aware of the local services that they can refer / signpost people with frailty, that will provide support for them outside of primary or secondary care?	
	69. Do you use patient decision aids to help people make informed choices about their healthcare and treatment options?	
	70. Is there a baseline of preferred place of death recorded?	
	71. Are people living with frailty encouraged to review their ongoing support needs and personal planning when a change is noted in their support requirements either by themselves/carers or by support staff, and clinicians or key workers?	
	72. Which services actively encourage people they work with to complete an advance care directive in a timely manner and ensure this is known to the family and carers as well as held by all agencies the person engages with?	
	73. Are staff working with people with frailty confident in recognising that a person is approaching the end of their life and acting on this understanding and feel equipped to engage effectively with patients and carers to discuss end of life care?	
	74. If not, are quality improvement plans in place to address this?	

Frailty self-assessment questionnaire

Section	Self-assessment questions	Rating (1,2,3,4)
Workforce *Linked to toolkit priorities:* • *Encourage people to age well* • *Support people living with mild, moderate and severe frailty in the community* • *Reduce hospital length of stay*	75. Are all relevant commissioners and providers of services aware of the Frailty Core Capabilities Framework?	
	76. How is the framework being used or implemented in relation to services offering support to people and their carers living with frailty?	
	77. Has workforce mapping across the area been undertaken including innovative roles and those covered by 'new models of care' are captured with a focus on frailty services?	
	78. Have you mapped the skills required in the MDT, and aligned workforce to skills assessment?	
	79. Are frailty workforce development plans linked to education and skills for dementia, end of life care skills and any other skills frameworks that are relevant to the area of work?	

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