A Regional Frailty Toolkit

North East and North Cumbria

Preventing Frailty and Supporting Older People, Carers, Families and Communities Living with Frailty

Involve **Consider** **Assess**

Respond **Evaluate**

Acknowledgements

Development of the Frailty iCARE toolkit was led by the North East and North Cumbria Care Closer to Home Programme (part of the Integrated Care System) in collaboration with the Academic Health Science Network for the North East and North Cumbria.

Additional support and input were provided by:

- The Regional Frailty Community of Practice
- The North East Quality Observatory (NEQOS)
- The North of England Commissioning Support Unit (NECS)

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Helpful feedback on early drafts was provided by multiple stakeholders across the North East and North Cumbria health and care economy, together with national frailty experts.

EXPLANATORY NOTES

This frailty toolkit is an iterative, live document (digitally based) that will continually evolve over time, with each section of the toolkit being 'shaped' by work from local care economies and 'steered' through our regional Community of Practice (CoP). There are sections of the toolkit that are in very early development or yet to be commenced - they will form part of a core programme of work for our regional Community of Practice over the next 2 years.

1. **Why use the word 'Frailty'?** More and more policies, strategies and literature are using the phrase 'living with frailty'. It is the terminology used by NHS England and the British Geriatric Society has an agreed definition. Furthermore, while it has been documented that the words 'frail' and 'frailty' are poorly perceived by some older people, there is emerging evidence that these views change with improved understanding.

2. **Why focus on older people (65 years and over)?** Focussing on the over 65s is in line with NHS England's approach to frailty and also with other strategic directives such as those outlined in the General Practice GMS Contract and integrated care initiatives. Although younger people with complex needs can be frail, it is accepted that the majority of those living with frailty are older people and there is evidence that younger adults with complex needs are likely to be having their needs met in other ways such as via learning disability and specialist services.

3. **Why do we need to know if someone is frail?** Those living with frailty often have worse outcomes compared to those living without. When we identify those who are frail, we can increase the likelihood of them living with optimum health and wellbeing and maximised levels of independence by adopting a comprehensive and integrated approach, such as the one suggested in this toolkit. While traditional disease-oriented approaches might be considered appropriate for people with chronic diseases who are not experiencing frailty, a more comprehensive and integrated approach is necessary for those in whom chronic diseases and frailty co-exist.

4. **What is *Frailty iCARE*?** ***Frailty iCARE*** is the acronym of the frailty toolkit and reflects the components needed for successful care, given its focus on empowerment and engagement (Involve) and the need for a systematic approach to care (Consider, Assess, Respond). Importantly it also emphasises the need for robust collection and analysis of data and intelligence (Evaluate) to determine whether a positive difference is being made for people, communities and local health and care systems.

5. **What is the Electronic Frailty Index [eFI]?** The eFI is a screening tool which uses general practice electronic health record data to identify those who might be living with frailty. Its use is promoted by NHS England which highlights its role as a population **screening tool**. It is important to recognise that the eFI does not diagnose frailty; it is crucial that a clinical 'verification' step is carried out. NHS England have released guidance for general practice to advise against batch coding of people identified as frail based on eFI data alone, emphasising the vital importance of the clinical 'verification' step. Therefore, for people identified through the eFI as possibly being frail, clinical verification should take place at an individual level using clinical judgement and a tool such as the Clinical Frailty Scale (CFS).

6. **What is the Clinical Frailty Scale [CFS]?** The CFS is an easy to use visual tool that can be applied in all settings. Although originally used to assess the severity of frailty, there is growing

recognition that its use to verify the presence of frailty is practical and easily adaptable to everyday health and care practice. The national frailty team in NHS England recommend the CFS to both verify frailty and grade a person's severity of frailty.

7. **What is Care and Support Planning (CSP)?** CSP is a systematic approach of which preparation is a key step, to ensure that people living with frailty have better, solution focused conversations with care professionals based on what matters to them. These identify what is most important to the person, discuss and explore issues and develop priorities, goals and actions to support them to live well. This brings together physical, mental, spiritual and social / healthcare issues into a single, personally tailored, care and support plan which links traditional clinical care with support for self-management, signposts to activities in a supportive community and coordinates across health and social care. CSP can be used across the whole spectrum of ageing to assess needs and is currently being rolled out across primary care as part of the Year of Care programme.

8. **Do all people need a Comprehensive Geriatric Assessment (CGA)?** CGA is currently the best evidence base we have for diagnosing and assessing a person with frailty. The process can be multi-disciplinary and can be carried out over a period of time. Not all people with frailty will require a CGA but it is likely that as a person's level of frailty becomes more severe, then a CGA will need to be undertaken, prior to a case management approach to ongoing care delivery. As part of the Care and Support Planning approach, it will become clear in the 'conversation step' whether a wider professional conversation is required based on a person's increasing complex needs resulting in an onward referral for a CGA.

9. **Is there an evidence base for frailty?** There is a definition of frailty and recognition of it as a syndrome but while there is robust evidence for some elements of care delivery, there is still much to learn about the condition and the optimal ways to prevent and care for those living with frailty. Recommendations included in the toolkit are based on actual and emerging evidence as well as national guidance and policy. It is anticipated that the evidence base will grow through the establishment of a Community of Practice where local knowledge, skills and experience of care delivery for older people living with frailty will be shared.

10. **What is a Community of Practice?** A Community of Practice is a group of people who all care about a particular issue and who get together regularly (face to face and/or online) to learn together and improve their practice. There are 3 key elements: the Domain - the area of shared interest and the key issues; the Community - the relationships between members, built through collective discussions, activities and learning; and the Practice - the body of knowledge, methods, stories, cases, tools and documents developed by the community [1].

11. **Will the frailty toolkit make a positive difference?** Any transformation programme such as this depends upon excellent leadership and a whole system, strategic approach. Senior personnel at a regional level are committed to supporting local health and care economies (LHEs) to use this toolkit to develop and improve local services. There is commitment to the Community of Practice, and it is accepted that there are other considerations such as workforce, IT and technology that may need to be influenced elsewhere. If this regional commitment is matched with local commitment and local system thinking, then the toolkit should make a real difference to the lives of those living with frailty.

12. **How will we measure the impact?** Currently there are a large number of measures within the care system and around 20 have been selected that best reflect the broad recommendations within the toolkit. They represent impact at a person, community and local system level with a

combination of outcome and proxy process measures to allow understanding of people, carer, families and local care system outcomes.

13. **Geographical area:** Our region covers the North East and North Cumbria. The abbreviation NENC has been used.

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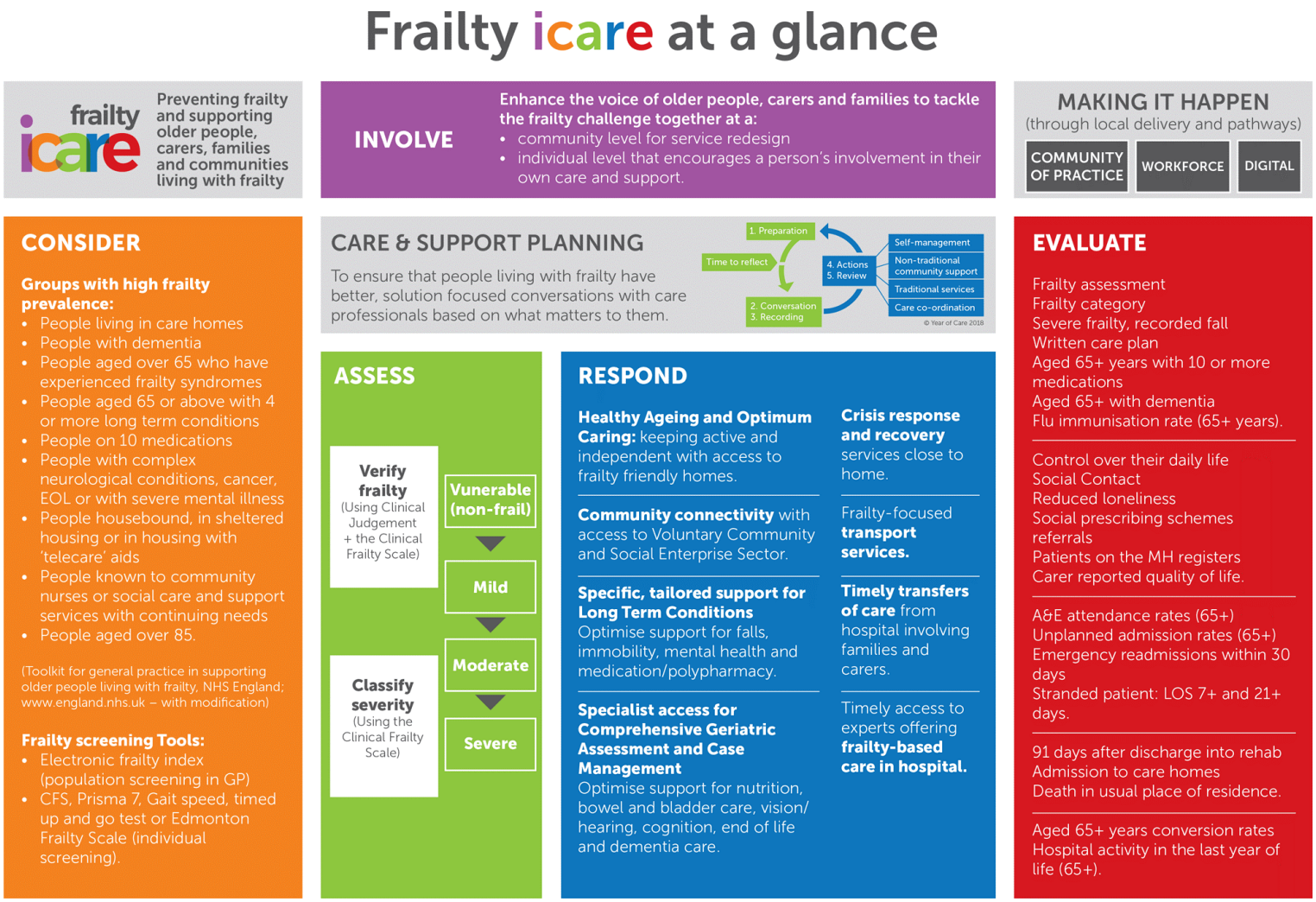
I. The Frailty iCARE Toolkit at a glance



II. Introduction

A new regional frailty approach is underway, led by the Care Closer to Home Programme (part of the region-wide shadow Integrated Care System work programme) and the Academic Health Science Network for the North East and North Cumbria. The aim is to develop a 'whole system' approach to frailty across the region and drive the development of better ways of preventing frailty and supporting those living with frailty. A regional frailty toolkit is being developed - ***Frailty iCARE'*** - reflecting the components of effective care 'Involve, Consider, Assess, Respond and Evaluate'. The toolkit will incorporate evidence-based approaches to care across the frailty journey, key resources and local examples of good practice and will be underpinned by key outcome metrics. Local health and care economies will be able to benchmark existing care provision and metrics against others in the region, identify their priorities and then draw on the toolkit to introduce new initiatives and improve the care and support they offer. A regional frailty 'community of practice' has been established to drive the work forwards, bringing together a wide range of professionals from across the region that understand frailty and older people's services.

The ***Frailty iCARE'*** - toolkit is a useful resource that can be used by local areas as they promote ageing wellness and plan ageing well services for their local populations. Frailty iCARE is aligned to the NHS Long Term Plan Ageing Well priorities (i.e. Enhanced Healthcare in Care Homes, Anticipatory Care and Urgent Community Response) and the NHS Universal Personalised Care programme. For more information visit the FutureNHS Collaboration platform.

III. Our Aim

The aim of the toolkit is to develop a common understanding of frailty and establish a supportive way for learning and sharing best practice. It is understood that local health and care systems will have, or will be developing, their own plans but the common vision for these plans should be to:

'Enable people, carers and communities to look after themselves and remain well, independent and healthy, but when needed offer care and support at or close to their homes, in a way that identifies issues early, resolves them quickly and prevents people going into hospital unnecessarily or supports them through transfers of care when needed'.

A robust learning system will be built that recognises people who are vulnerable to becoming frail as well as those living with mild, moderate and severe frailty across the region using:

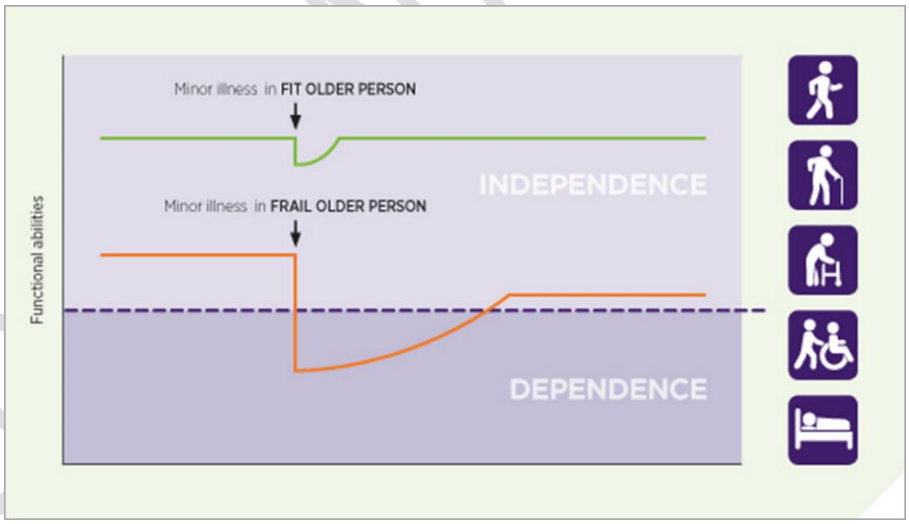
1. ***A Frailty Toolkit*** that incorporates evidence-based approaches to care across the frailty journey, key resources and local examples of good practice, underpinned by a dashboard of key outcome metrics.
2. ***A Community of Practice*** where initiatives are shared, learning and recommendations agreed, plans made for wider sharing through local forums and the toolkit constantly developed.

The toolkit is *not mandated* as it is recognised that design and delivery should be locally determined and driven**.** It will however offer standards and outcomes that will allow variation to be explored across the region and help focus priorities.

IV. Background

Frailty is a distinctive state related to the ageing process, but it is not an inevitable consequence of ageing [2]. Not all older people are frail and not all people living with frailty are old; younger people with complex needs can also be classified as frail, although the majority of those living with frailty are old. Frailty is related to but distinct from ageing, co-morbidity and disability. As multiple body systems gradually lose their in-built reserves (physical and psychological), people start to develop frailty, making them vulnerable to sudden changes in their health and social needs [3]. These changes are often triggered by seemingly small events such as a change in medication or a breakdown in carer support. A person with frailty therefore typically presents in crisis with a fall, confusion or the inability to walk. These presentations are examples of the 'classic' frailty syndromes [3].

NHS England has defined frailty as a progressive, long term health condition characterised by a loss of physical and/or cognitive resilience. Therefore, people living with frailty can deteriorate unexpectedly and do not recovery quickly after a simple illness or other stressful event [4].



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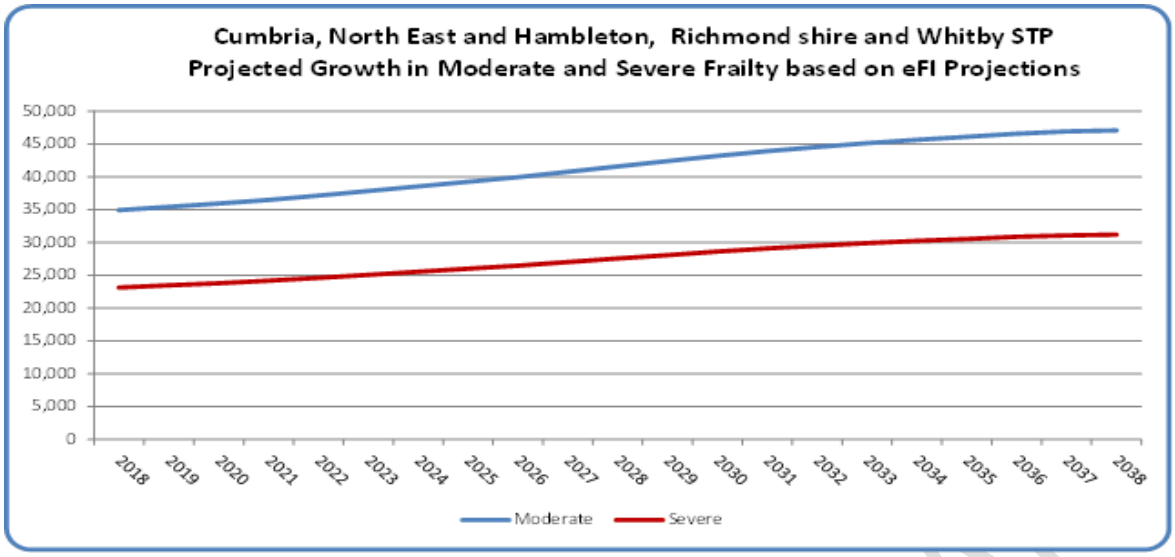
In recent years, as the understanding of the impact of frailty on people, communities and services has grown, there has been a range of guidance and policies aiming to support health and care systems tackle the challenge of frailty. The following are provided as examples linked to the ***iCARE*** approach of the toolkit:

INVOLVE	• The Care Act [2014]: a preventative approach to the management of older people - https://www.scie.org.uk/prevention/people/older-people
CONSIDER	• Transforming Primary Care: safe, personalised and proactive care for those who need it most [Department of Health, NHS England. April 2014 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf]. Aims to drive up quality for older people through collaborative working and integrated provision of services.
ASSESS	• NICE Guidelines: Multimorbidity: clinical assessment and management [2016 - https://www.nice.org.uk/guidance/ng56/resources]; Dementia, Disability and Frailty in Later Life: mid-life approaches to delay or prevent onset [2015 - https://www.nice.org.uk/guidance/ng16].
RESPOND	• Transforming Primary Care: safe, personalised and proactive care for those who need it most [Department of Health, NHS England. April 2014]. Aims to drive up quality for older people through collaborative working and integrated provision of services. • NHS Five Year Forward View [NHSE 2015 - https://www.england.nhs.uk/five-year-forward-view/]: more support for frail older people living in care homes; primary care of the future will build on the traditional strengths of expert generalists, proactively targeting services at registered patients with complex on-going needs.
EVALUATE	• NHS Outcomes Toolkit [DH 2018 - https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current]: a set of indicators to monitor the health outcomes of adults and children in England.

Frailty Challenge

Whilst frailty isn't found exclusively in older people, it is more common in this age group with an overall prevalence of frailty in people aged over 60 of 14%. Frailty prevalence increases with age, with 5% of people aged 60-69 living with frailty and up to 65% of people aged over 90 [5]. Frailty is more common in women (16% versus 12% in men). In England, there are 1.8 million people aged over 60 living with frailty, including 0.8 million people aged over 80 [5]. The presence of frailty, and its severity, correlates with poor outcomes, such as poor quality of life, institutionalisation, mortality and increasing cost to health and care systems [2, 4].

In 2018, our region's population of people aged 65 years and over is 682,100. This is due to rise by 35% in in the next 20 years. Therefore, based on eFI frailty predictions, this equates to an increase of 12,174 in the number of people aged 65 and over living with moderate frailty and 8,065 with severe frailty.



National eFI data for people 65 year and older suggests a frailty prevalence of 35% mild, 12% moderate and 3% severe. [6] [Please note further work is underway to accurately quantify the frailty eFI prevalence estimates].

This may underestimate the impact of our ageing population. Over the next 20 years the population aged 70-79 is predicted to grow by 32.5%, the population aged 80 to 89 by 57% and the population aged 90 and over by 121% [5]. Since prevalence of frailty increases by age the true increase in frailty in the STP region may be as high as 54%.

Our regional village is derived from the GMS contract published data projected forward using ONS population projections.

If our region was a 1,000 person village, there would currently be 30 people aged 65 and over with mild frailty, 11 with moderate frailty and 7 with severe frailty.

By 2038 there will 45 people aged 65 and over with mild frailty, 16 with moderate frailty and 11 with severe frailty.

Therefore, if we don't act, we will expect to see adverse outcomes for people aged 65 years and over.

The table below summarises the adverse impact of the predicted growth in the population aged 65 and over and the associated growth in the number of people living with frailty between 2018 and 2038. A low estimate of impact is given based on the projected 65 and over population rise of 34%

and a high estimate of impact is given based on the projected growth in frailty of 54%. This represents the ***'do nothing'*** position. For example,

- If we do nothing by 2038 there will be between 59,548 and 91,874 more emergency admissions than now across the region per year.
- If nothing changes by 2038 there will be between 15,623 and 24,104 more people receiving 10 or more medications than now across the region.

The metrics included in the table below are drawn from a sample of our regional frailty measures and will be expanded upon as further metrics are baselined.

Adverse Impact of Population and Frailty Growth between 2018 and 2038 – 'Do Nothing' Scenario

Metric	Baseline	Baseline Period	Adverse Impact (Low)	Adverse Impact (High)	Do Nothing Description
Number of unplanned admissions per 100,000 of the population	273.1	2017/18	59,548	91,874	Number of additional emergency admissions
Number of patients with 10 or more unique medications	44,637	March 2018 Snapshot	15,623	24,104	Number of additional patients

* Impact based on ONS projected growth rate in mortalities

Based on local and national (NHS England – KENT dataset) economic modelling, our region currently (2017/18) spends £1,167,642,288 on people aged 65 years and older in the following frailty categories. In the next 20 years by 2037/38 (if we 'do nothing') this is expected to be £1,802,243,268 equating to a rise in spend of £634,600,980 per year.

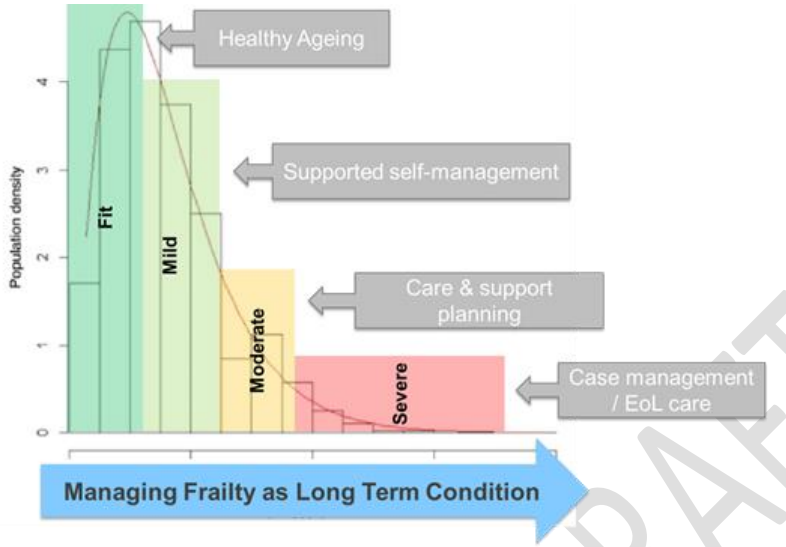
Whole System Current and Expected Spend by Frailty Category (people aged 65+)

Category	2017/18	2037/38	Increase*
Fit	£573,685,964	£740,424,111	£166,738,147
Mild	£277,410,744	£428,180,489	£150,769,745
Moderate	£155,711,205	£240,338,564	£84,627,359
Severe	£160,834,375	£248,246,122	£87,411,747
Total	**£1,167,642,288**	**£1,802,243,268**	**£634,600,980**

**54% increase in frailty, 29% increase in fit cohort equating to 35% increase in population aged 65 and over*

Frailty opportunities for people, carers, families and health and care communities

Frailty is progressive in nature, typically developing over 5 to 15 years [3, 4], and the onset of early frailty can predate crisis by a decade or more. It often presents with episodic deteriorations (delirium; falls; immobility). The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse depending on the intervention provided [7].



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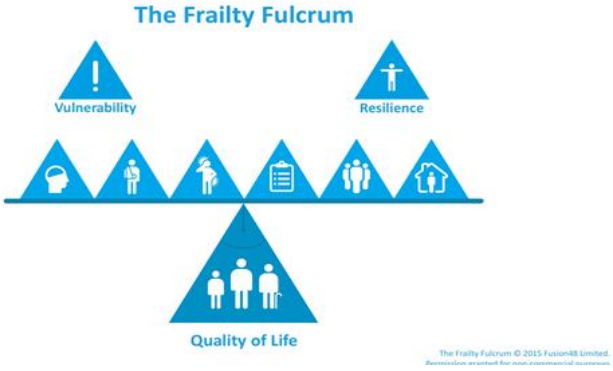
Frailty as a Long-Term Condition

Considered as a long-term condition (LTC), frailty can be characterised by slow functional deterioration due to loss of physical, emotional and cognitive resilience and, like other LTCs, frailty care can be effectively planned for within the community. Hospital care may still be required at times. However, a better understanding of vulnerabilities and the best practice interventions for supporting people with multimorbidity and frailty at key stages can reduce the likelihood of crisis and promote earlier and optimal recovery [8].



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Frailty Fulcrum

The frailty fulcrum is a visual representation of all the parts of a person's life that affect their overall wellbeing. It shows how each domain can contribute to an individual's resilience or vulnerability, and how collectively they can create an overall picture of a person's level of frailty. Over time, the balance and interactions between these individual domains can change. Using the frailty fulcrum and having a better understanding of these balances will enable a much more proactive, community-based approach to frailty care [9].

Considering national evidence and local intelligence for frailty interventions the following benefits could be released across the region:

- If 10% of the severely frail had remained moderately frail the gross savings across the STP would be £5,767,375 over 12 months
- If 10% of the mildly frail had remained fit, gross savings would be more than £15m (owing to higher patient numbers)

NB: Gross estimates- these figures do not account for the costs of interventions to prevent frailty progression.

Gross cost savings if 10% of cohort were less frail by One EFI Stage (based on Q4 2017/18 cohort numbers)

Category	Savings per Patient	Number of Patients (10%)	Potential Saving
Mild	£1,571	9,879	£15,520,380
Moderate	£1,653	3,491	£5,769,797
Severe	£2,494	2,313	£5,767,375

The table below shows the potential improvement in each of our regional frailty outcomes. The table will be expanded as additional metrics are baselined. Improvement is shown against two scenarios, firstly the opportunity offered by moving STP performance to the England aggregate position and secondly the opportunity offered by moving CCGs below the STP aggregate position to the STP position.

Opportunity for Improvement in Outcomes Framework Metrics

Metric	Baseline	Baseline Period	STP Movement to England Aggregate	CCG Movement to STP Aggregate	Improvement Description
Number of unplanned admissions per 100,000 of the population	273.1	2017/18	11,954	8,758	Reduction in emergency admissions
Number of patients with 10 or more unique medications	44,637	March 2018 Snapshot	6,245	3,350	Reduction in patients receiving 10 or more medicines
The proportion of people who use services who reported that they had as much social contact as they would like	48.0%	2016/17	0	20	Increase in positive responses
Number of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home	85.3%	2016/17	0	76	Increased number of patients expected to be discharged back to own home
Proportion of deaths in usual place of residence*	48.60%	Rolling annual 2016/17 Q3 - 2017/18 Q2	0	199	Number of additional deaths in usual place of residence

The North East Quality Observatory (NEQOS) and the North of England Commissioning Support Unit (NECS) have both contributed to the development of the challenges and opportunities section of the frailty toolkit.

necs
NHS
North East Quality Observatory Service

V. The *Frailty iCARE* Toolkit: Summary

The following section outlines the Frailty iCARE toolkit:

Preventing frailty and supporting older people, carers, families and communities living with frailty through Frailty iCARE (involve, consider, assess, respond, evaluate).

People and families should be offered advice and support tailored to their needs and based on 'what matters to them' through a Universal Personalised Care approach which includes Personalised Care and Support Planning.

Involve: establish partnerships with people, carers and families to tackle the challenge of frailty together, both at:

- A community level: to make the decisions of today that inform the care and support of tomorrow.
- An individual level: so people, carers and families are actively engaged and involved in shaping their own care.

Consider: identify people who may be living with frailty [mild, moderate and severe] by understanding populations with a high prevalence of frailty and using frailty screening tools:

The following groups of people have high rates of frailty [8, with modification]:

- People who are resident in care homes.
- People known to be living with dementia.
- People aged over 65 who have experienced one of the major frailty syndromes:
  - Immobility (e.g. sudden change in mobility)
  - Delirium (e.g. acute confusion, sudden worsening of confusion in someone with previous dementia or known memory loss).
  - Incontinence (e.g. change in continence - new onset or worsening of urine or faecal incontinence).
  - Susceptibility to side effects of medication.
- People aged 65 or above with multimorbidity due to 4 or more long term conditions.
- People on over 10 medications.
- People known to community nurses or social care and support services with continuous support needs.
- People on end of life (EOL) register or cancer care lists or with complex neurological problems (stroke, MS, Parkinson's disease) or older people with severe mental illness.
- All people aged over 85.
- People who are housebound or living in sheltered schemes or extra care or in 'ordinary' housing with telecare aids (e.g. 'life alarms').

Frailty screening tools

The Electronic Frailty Index (eFI) can be used for population screening in general practice settings. Tools for screening individuals include Clinical Frailty Scale, PRISMA-7, Gait Speed, Timed Get up and Go Test and the Edmonton Frailty Scale.

Assess: individuals who may be living with frailty to verify the presence of frailty and grade the severity by using clinical judgement and the Clinical Frailty Scale (CFS). Then offer, an individual assessment as part of preparation within a CSP approach ('preparation, conversation and recording)

***Respond**:* to respond appropriately to needs, goals and priorities identified as part of the CSP approach ('actions and review'), the following should be readily available in local health and care systems to prevent frailty and support people, carers, families and communities living with frailty:

- Healthy ageing and optimum caring approaches with signposting to keeping active, engaged and independent, including access to frailty-friendly living and homes.
- Community connectivity with access to and involvement of the Voluntary, Community and Social Enterprise sector.
- Specific, tailored support for Long Term Conditions, including supportive self-management and shared decision making to develop a *self-management plan (with contingency planning)* optimising:
    - falls and immobility,
    - medicine/polypharmacy
    - mental health.
- Access to specialist inter-agency teams for a comprehensive geriatric assessment [CGA] and case management including the development of an *emergency health care plan* to coordinate care and optimise:
    - nutrition and hydration,
    - bowel and bladder care,
    - vision and hearing,
    - cognition, dementia
    - end of life
- Access to community crisis and recovery services with active recuperation, rehabilitation and reablement and including:
    - frailty-focused transport
    - timely transfers of care from hospital, involving carers and families.
- Access to experts offering frailty-based care in hospital with frailty assessment, diagnostics and pathways.

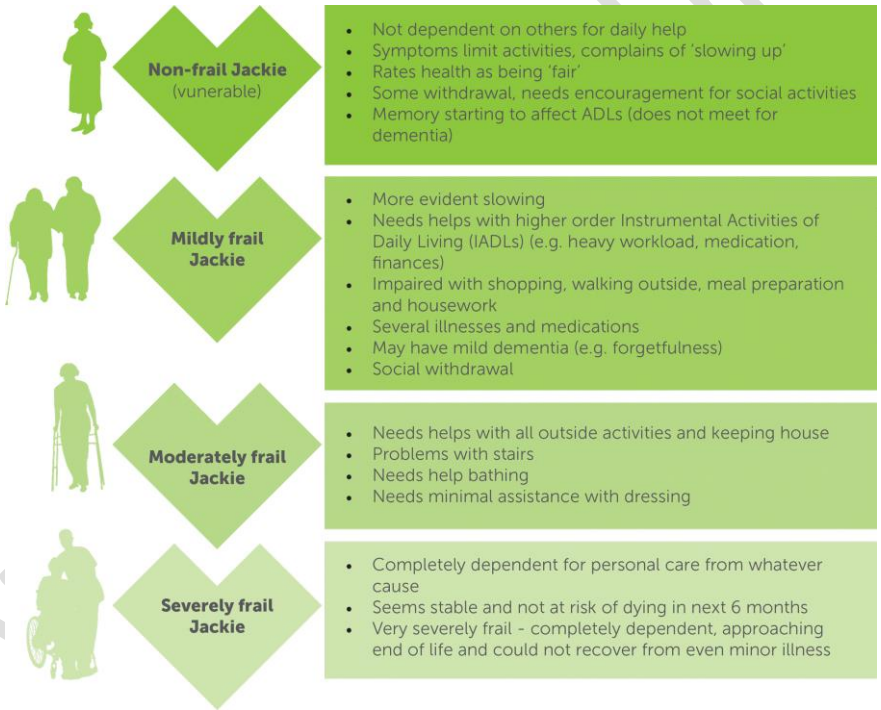
Evaluate the impact of frailty on people, populations and services through regional frailty outcomes and measures.

Making it happen: each local health and care economy should develop their own 'local frailty delivery strategy' which will include local pathways around workforce and digital solutions with support from a regional Frailty Community of Practice.

VI. Applying the *Frailty iCARE* Toolkit

Frailty profiles

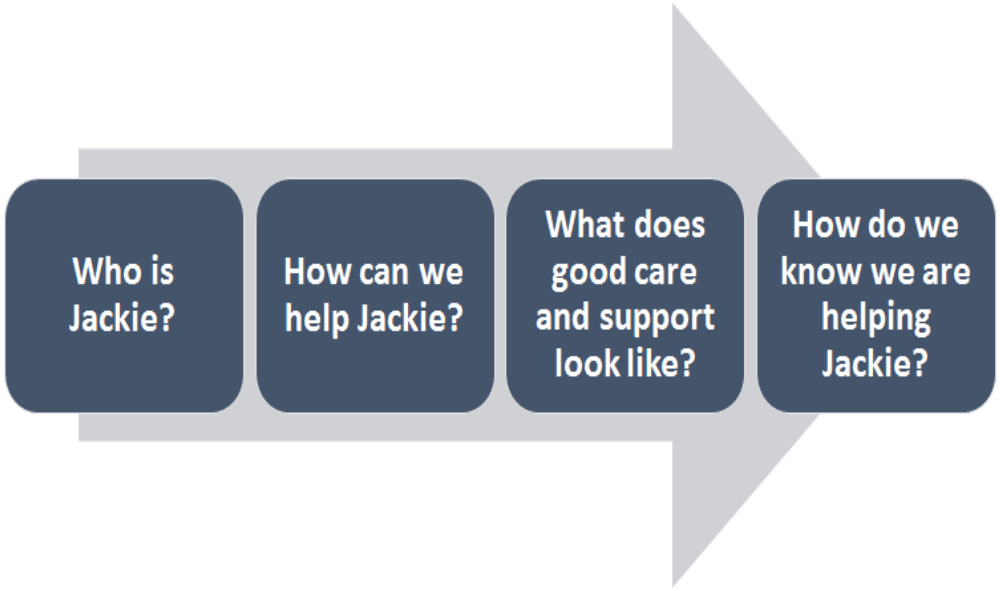
We have recognised four frailty profiles based on the Clinical Frailty Scale: Vulnerable (CFS category 4); mildly frail (CFS category 5); moderately frail (CFS category 6); and severely frail/very severely frail (CFS categories 7/8). http://geriatricresearch.medicine.dal.ca/clinical_frailty_scale.htm



These diagrams are based on the Clinical Frailty Scale as developed by Dalhousie University. For the full Clinical Frailty Scale, or permission to use or reproduce the Clinical Frailty Scale, please contact gmru@dal.ca .

Jackie's story

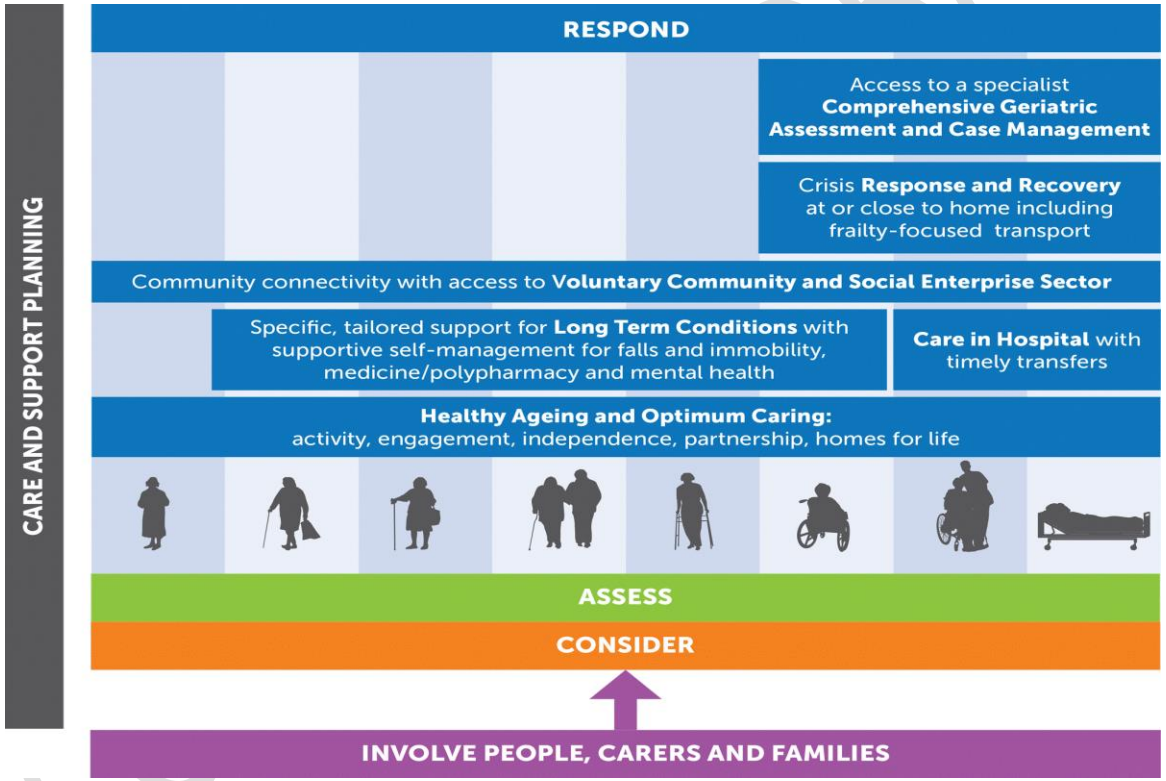
Using these frailty profiles, we can start to consider how we can apply the frailty toolkit to a person (called Jackie) living in the North East and North Cumbria. Jackie's story demonstrates a journey from fitness to frailty. Reflecting on Jackie's journey prompts four questions:



Jackie's Journey

The following shows Jackie's Journey from fitness to frailty in which recognisable stages can be seen and if identified early, the ***Frailty iCARE*** toolkit can be applied to support Jackie, his/her carers and the wider family at different stages of frailty severity.

Please see Jackie's story, an infographic that aims to takes the user on an 'ageing well' journey through the life-course of Jackie. It can be used front-line professionals supporting older patients living with frailty and their families, as well as by health and care managers and all those promoting ageing wellness and planning ageing well services - https://www.rawtest.co.uk/ (up date link when finished)



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VII. The *Frailty iCARE* Toolkit: Detail

The following section outlines the ***Frailty iCARE*** Toolkit in detail. Each section of the ***Frailty iCARE*** toolkit is divided into:

- ICARE - statements
- What works
- Resources
- Benefits
- Evidence
- Local stories (case studies)
- Impact and measures

Overall our approach is underpinned by evidence from a variety of sources, including the European Union ADVANTAGE JA Managing Frailty Programme (www.advantageja.eu/), and aligned to national policy and guidance on healthy ageing, multimorbidity and integrated care delivery for older people:

- https://stpsupport.nice.org.uk/frailty/index.html
- https://www.rcgp.org.uk/-/media/Files/News/2016/RCGP-Integrated-care-for-older-people-with-frailty-2016.ashx?la=en
- http://chrodis.eu/wp-content/uploads/2015/04/D01-01.1Dissemination-Strategy.pdf
- https://www.nice.org.uk/guidance/ng56/resources/multimorbidity-clinical-assessment-and-management-pdf-1837516654789
- https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf
- https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/
- https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf
- https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_april11_evidence_review_healthy_ageing.pdf
- https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/7-living-well-in-older-years
- https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf
- https://www.bgs.org.uk/resources/age-and-ageing-collection-frailty-in-older-people
- https://doi.org/10.1093/ageing/afz103.76 - Meta-analysis of Primary Care Interventions to Address Frailty Among Adults Aged 65+
- Advantage – EU, frailty models of care - http://www.advantageja.eu/images/WP7-Models-of-Care-a-Systematic-Review.pdf

- Effective Matters. https://www.york.ac.uk/crd/publications/effectiveness-matters/frailty-primary-care/
- https://www.eahsn.org/wp-content/uploads/Safer-care-for-frail-older-people-1.pdf - safer care for frail people. Rapid Research review

People and families should be offered advice and support tailored to their needs and based on 'what matters to them' through a Universal Personalised Care approach which includes Personalised Care and Support Planning. A **Care and Support Planning (CSP)** approach aims to understand the person's, carers' and family's needs, goals and priorities enabling appropriate support and care to be determined.

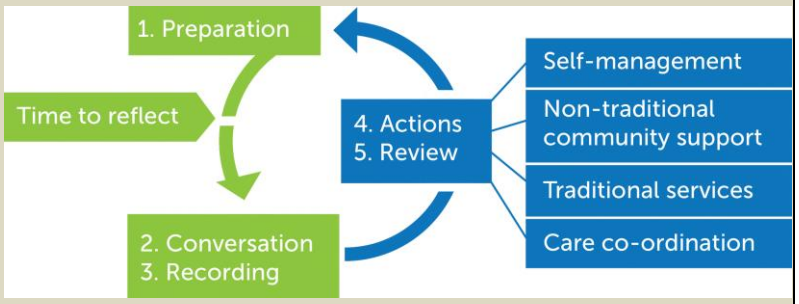
Care and Support Planning (CSP)

Our Frailty iCARE toolkit is underpinned by a care and support planning (CSP) approach which can be applied across the whole spectrum of ageing and frailty with the aim of improving health and wellbeing and optimising independence at any stage. The core aim is to involve the person (and carers) in planning the future, by wrapping the traditional components of clinical care around what is important to them in living their life. CSP consists of a systematic series of steps to bring together all the issues the person may live with in a more productive consultation (conversation) with a trained professional enabled by preparation. The person receives personally relevant information, explanations and prompts (with support if necessary) with time to reflect on the key issues for them ahead of the conversation. The professional collects and collates the 'technical' information from the clinical and medication record, from others involved with the person and organises assessments including self-assessments, so these can be included and debated as part of developing joint plans with the person during the conversation itself.

CSP will usually, but not always, take place in general practice. The actions agreed may range from ongoing self-management, links with activities in a supportive community directly or via link workers (social prescribing) to specific interventions addressing falls, immobility, mental health, complex medications etc. For those with the most complex combinations of issues or diagnostic problems referral to the local specialist multidisciplinary team for comprehensive geriatric assessment (CGA) may be an important outcome of CSP so that further in-depth assessments, conversations and planning can take place. The exact distribution of these elements across primary and specialist care will be determined locally as part of care pathway development.

For more information on CSP, please see the following resources and useful links:

- Year of Care Partnerships – https://www.yearofcare.co.uk/care-and-support-planning
- Care and Support Planning (CSP) across a lifetime.
- http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/Summary%20of%20201718%20GMS%20contract%20negotiations.pdf
- Year of Care Partnership: Care Planning across a lifetime. https://www.yearofcare.co.uk/sites/default/files/pdfs/Care%20and%20Support%20Planning%20across%20a%20lifetime%20V1.0%20June%202016_0.pdf
- Personalized care and support handbook (NHS England, 2016). The journey to person-centered care - https://www.england.nhs.uk/wp-content/uploads/2016/04/exec-summary-care-support-planning.pdf
- The Carlisle Story. Care and support planning at the heart of an integrated care community - https://www.yearofcare.co.uk/sites/default/files/pdfs/The%20Carlisle%20Story%20-%20a%20case%20study%20for%20integrated%20care%20teams%20-%20V1.0%20Apr%2017.pdf



Involve people, carers, and families to introduce the concept of frailty and build a relationship between them and care professionals. Ensure that the voice(s) of the person and/or carer are paramount, both at a community level for making decisions today and informing the care and support of tomorrow; and at an individual level so people, carers and families are actively engaged and involved in shaping their own care.

What works	Resources
Community Involvement Real involvement for our patients and public is fundamental to all aspects of service redesign. It is vital that the views of people, their carers and families must come first. People must be treated as equals and 'best practice' methodology sought for engaging, involving and co-producing services that are right for our local people. Aim to achieve 'being involved', which is 1 of the 8 Healthwatch principles [10]: *'I want to be an equal partner in determining my own health and wellbeing. I want the right to be involved in decisions that affect my life and those affecting local services in my community'.* **Individual, carer and family involvement** The core aim of a CSP approach is to involve the person (and carers) in planning the future, by wrapping the traditional components of clinical care around what is important to them in living their life. This involves a 'conversation between experts', i.e. those with technical expertise and those with lived experience i.e. the person, their carers and family.	➢ Healthwatch website – https://www.healthwatch.co.uk/ ➢ Healthwatch England's new strategy to put people in charge of their health and care (2018) https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20180321_-_healthwatch_england_strategy_final_-_one_page.pdf ➢ National Voices - 'I'm still me' – coordinated support for older people - https://www.nationalvoices.org.uk/sites/default/files/public/publications/im_still_me.pdf ➢ Think local, act personal - https://www.thinklocalactpersonal.org.uk/ ➢ How-to guides for creating an asset based area - https://www.thinklocalactpersonal.org.uk/Browse/Building-Community-Capacity/how-to-guides-for-creating-an-asset-based-area/ ➢ Six principles for engaging people and communities: putting them into practice - https://www.nationalvoices.org.uk/sites/default/files/public/publications/six_principles_-_putting_into_practice_-_web_hi_res_-_updated_nov_2016.pdf ➢ Six principles for engaging and involving people and communities: Definition, evaluation and measurement - https://www.nationalvoices.org.uk/sites/default/files/public/publications/six_principles_-_definitions_evaluation_and_measurement_-_web_high_res_0_1.pdf

	➢ Inequalities report in later life - https://www.ageing-better.org.uk/blogs/we-cannot-allow-inequalities-2020-become-entrenched-later-life?
Benefits	

Evidence
 	
IN DEVELOPMENT
 	
• The evidence is increasingly clear that better involvement in community activities benefits health. There is a growing body of knowledge and practice demonstrating that engagement is do-able and has real impact.
  ○ https://www.nationalvoices.org.uk/sites/default/files/public/publications/six_principles_-_definitions_evaluation_and_measurement_-_web_high_res_0_1.pdf
• In tackling frailty, consideration should be given to the low awareness of empowerment of older people, some of whom may be unhappy with the term "frail", although evidence is emerging that this changes with improved understanding.
  ○ Advantage – management of frailty at an individual level: Systematic review - http://advantageja.eu/images/WP6-Managing-frailty-at-individual-level-a-Systematic-Review.pdf	

COVID-19 and Frailty

Best Practice

- **Community level** – social distancing and shielding must be adhered to protect those most frail. However, we must be mindful of implicit ageism and the possible infringement on the human rights of older people during these times. Human rights must be upheld when making decisions about care and support for people with frailty and COVID-19. The likelihood of recovery and return to a good quality of life should be the only determinant in decision-making. Policies should not be designed on age and disability alone. Frailty is linked with poorer outcomes in COVID-19, but also associated with inequality and poverty. We must not exacerbate inequality through our decision-making.

- **Individual level** – the Care Support and Planning approach is to involve the person (and carers) in planning the future, by wrapping the traditional components of clinical care around what is important to them in living their life. The core of the current UK COVID-19 strategy is 'social distancing' and to shield those most vulnerable. This is clearly sensible, life saving and based on evidence. However, these actions must not result in 'social isolation', as the potential for long-term, worsening of health and wellbeing will be catastrophic for those most vulnerable. Therefore, in parallel with technological, it is crucial we promote and support health and wellbeing in new, creative and innovate ways that maintain 'social distancing' benefits, but reduce the risk of social isolation.

Useful resources

- Strengthening the health system response to COVID-19. Recommendations for the WHO European Region. Policy brief (1 April 2020) http://www.euro.who.int/__data/assets/pdf_file/0003/436350/strengthening-health-system-response-COVID-19.pdf
- Healthwatch and COVI-19. https://www.healthwatch.co.uk/coronavirus-advice-and-guidance
- National voice. Joint statement on COVID-19 - https://www.nationalvoices.org.uk/sites/default/files/public/publications/final_-_joint_statement_270420.pdf
- Age platform Europe - COVID-19 and human rights concerns for older persons https://www.age-platform.eu/sites/default/files/COVID-19_%26_human_rights_concerns_for_older_persons-April20.pdf
- Oxford COVID-19 evidence service - What is the evidence for social distancing during global pandemics? A rapid summary of current knowledge https://www.cebm.net/wp-content/uploads/2020/03/What-is-the-evidence-for-social-distancing-during-global-pandemics-final-1.pdf
- IRISS. ESSS Outline Covid-19, social isolation and Loneliness - https://www.iriss.org.uk/sites/default/files/2020-04/iriss_esss_outline_social_isolation_22042020.pdf
- COVID-19: BGS statement on research for older people during the COVID-19 pandemic - https://www.bgs.org.uk/resources/covid-19-bgs-statement-on-research-for-older-people-during-the-covid-19-pandemic
- GOV.UK. COVID-19. Review of disparities in risk and outcomes - https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

- PHE. Beyond the data - Understanding the impact of COVID-19 on BAME groups - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
- COVID-19 monthly survey- Impact of COVID-19 on health and care - https://www.understandingsociety.ac.uk/sites/default/files/downloads/general/ukhls_briefingnote_covid_health_final.pdf
- GOV.UK. Carers report 2020 - https://www.carersweek.org/images/CW%202020%20Research%20Report%20WEB.pdf
- Nothing about us without us - Five principles for the next phase of the Covid-19 response https://www.nationalvoices.org.uk/publications/our-publications/nothing-about-us-without-us
- LESS COVID-19, report on 'affects' on care home sector - https://www.nationalcareforum.org.uk/wp-content/uploads/2020/10/LESS-COVID-19-v2.pdf
- NHIR rapid review – living with COVID-19 (symptoms of long COVID) - https://evidence.nihr.ac.uk/themedreview/living-with-covid19/

Local stories (case studies)

IN DEVOPMENT

Consider people who may be living with frailty [mild, moderate and severe] by understanding populations with a high prevalence of frailty and using frailty screening tools.

What works	Resources
The mode of identification of people who may be living with frailty will be dependent on circumstances and can be done opportunistically or systematically. It should be undertaken by all professionals in contact with older people (e.g. health and social care workers, third sector, voluntary and support workers, wardens and staff in sheltered and extra care schemes). **Groups with high frailty prevalence** [8, (Toolkit for general practice in supporting older people living with frailty, NHS England; www.england.nhs.uk – with modification)]:	➢ Updated guidance on supporting Routine Frailty Identification and Frailty Care through the GP Contract 2017/2018 - https://www.england.nhs.uk/wp-content/uploads/2017/04/supportin

➢ People who are resident in care homes.
➢ People known to be living with dementia.
➢ People aged over 65 who have experienced one of the major frailty syndromes:
  o Immobility (e.g. sudden change in mobility)
  o Delirium (e.g. acute confusion, sudden worsening of confusion in someone with previous dementia or known memory loss).
  o Incontinence (e.g. change in continence - new onset or worsening of urine or faecal incontinence).
  o Susceptibility to side effects of medication.
➢ People aged 65 or above with multimorbidity due to 4 or more long term conditions.
➢ People on over 10 medications.
➢ People known to community nurses or social care and support services with continuous support needs.
➢ People on end of life (EOL) register or cancer care lists or with complex neurological problems (stroke, MS, Parkinson's disease) or older people with severe mental illness.
➢ All people aged over 85.
➢ People who are housebound or living in sheltered schemes or extra care or in 'ordinary' housing with telecare aids (e.g. 'life alarms').
 	
Frailty screening tools
The Electronic Frailty Index (eFI) can be used for screening the population of people aged 65 years and over on a GP register. Other methods to identify frailty in individuals include:
• PRISMA-7 (with a cut-off score of >3),
• Gait Speed (taking more than 5 seconds to walk 4 m using usual walking aids if appropriate),
• Timed Get up and Go Test (with a cut off score of 10s to get up from a chair, walk 3m, turn around and sit down, with walking aids if used).
• Edmonton Frailty Scale
• Clinical Frailty Scale
	g-guidance-on-frailty-update-sept-2017.pdf
	
	➢ Toolkit for general practice in supporting older people living with frailty 2017 - https://www.england.nhs.uk/wp-content/uploads/2017/03/toolkit-general-practice-frailty.pdf
	
	➢ Fit for Frailty (part 1), section 3 http://www.bgs.org.uk/campaigns/fff/fff_full.pdf
	
	➢ iHUB (Health improvement Scotland) - slide deck 'frailty tools' screening and assessment comparators - https://ihub.scot/media/3023/frailty-screening-and-assessment-tools-comparator.pdf
	
	➢ NICE guidance: Multimorbidity: Clinical Assessment and Management. https://www.nice.org.uk/guidance/ng56/resources/multimorbidity-clinical-assessment-and-management-pdf-1837516654789
	
	➢ Australian tool – prevalence estimates - https://uofadel.maps.arcgis.com/ap

	ps/MapSeries/index.html?appid=ab3ffe3e59c34053acf6f56d3368fb78 ➢ A frailty-case finding tool (Durham) published - https://academic.oup.com/ageing/advancearticle/doi/10.1093/ageing/afaa119/5868063?guestAccessKey=36ef3bd2-df98-4b44-a7fe-9a47e9f64350 ➢ Frailty Index changes predicted mortality independently of baseline FI differences - https://academic.oup.com/biomedgerontology/advance-article-abstract/doi/10.1093/gerona/glaa266/5939950?redirectedFrom=fulltext ➢ Predictors of frailty and vitality study. Overlap with some markers. Understand both could help with population predictions - https://www.karger.com/Article/FullText/512049 ➢ Frailty and immigration - highest frailty risk - https://link.springer.com/article/10.1007/s10903-021-01169-9 ➢ Socioeconomic status affects the risk of multimorbidity, frailty, and

	disability independently - https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30226-9/fulltext ➢ Hospital Frailty Risk Score - Scripts to generate Hospital Frailty Risk Scores have been written in SAS and are available open-access at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30668-8/fulltext ➢ AHSN NENC. Is my patient unwell communication tool - https://www.ahsn-nenc.org.uk/ahsn-nenc-launch-is-my-resident-unwell-communication-tool/

Evidence

IN DEVELOPMENT

Groups of people with high prevalence of frailty

- **IN DEVELOPMENT**

Frailty 'screening tools'

- There is no "gold standard" tool to both screen for and diagnose frailty. Therefore, in the absence of a "gold standard", the instrument(s) to screen for and diagnose frailty should be chosen according to the clinical context. Potential tools include:
    - Electronic Frailty Index (eFI) in general practice setting; Clinical Frailty Scale; Edmonton Frailty Scale; FRAIL Index
    - Frailty phenotype; Inter-Frail; Prisma-7; Sherbrooke Postal Questionnaire
    - Short Physical performance Battery (SPPB); Study of Osteoporotic Fractures Index (SOF); and
    - Gait speed

- Advantage – Frailty at a population level: systematic review - http://advantageja.eu/images/WP5-Frailty-at-Population-Level-a-Systematic-Review-.pdf

COVID-19 and Frailty

Best Practice

- IN DEVELOPMENT

Resources

- Ageing, frailty and symptoms of COVID-19 - https://covid.joinzoe.com/post/frailty
- COVID-19 app, discussing symptoms including frailty - https://covid.joinzoe.com/post/webinar-covid-research
- BGS. Atypical Covid-19 presentations in older people - https://www.bgs.org.uk/blog/atypical-covid-19-presentations-in-older-people-%E2%80%93-the-need-for-continued-vigilance
- University of Toronto. Atypical COVID-19 presentations in frail older adults - https://www.rgptoronto.ca/wp-content/uploads/2020/04/COVID-19-Presentations-in-Frail-Older-Adults-U-of-C-and-U-fo-T.pdf
- CEBM, evidence. In patients of COVID-19, what are the symptoms and clinical features of mild and moderate cases - https://www.cebm.net/covid-19/in-patients-of-covid-19-what-are-the-symptoms-and-clinical-features-of-mild-and-moderate-case/
- Age and Frailty are Independently Associated with Increased Mortality in COVID-19: Results of an International Multi-Centre Study - https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3709847
- Learning Disability Mortality Review (LeDeR) – 3x higher than general population https://www.gov.uk/government/publications/covid-19-deaths-of-people-with-learning-disabilities/covid-19-deaths-of-people-identified-as-having-learning-disabilities-summary

Local stories (case studies)

IN DEVOPMENT

Frailty risk factors and signs of frailty
To include Andrea Browns document – NEQOS report

Social class	• The prevalence of frailty is significantly more common in those with low income compared to high income. For example, 7% in household's income over 60,000 versus 32.4% in households on less than 20,000. • Higher wealth was associated with lower frailty incidence (e.g. HR = 0.56, CI = 0.48–0.65) - *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • Education and wealth emerged as strong non-modifiable risk factors for quicker development of frailty, suggesting a link between lower wealth and frailty [70,71] and highlighting the importance of making available health care and education for all strata of society. Negative health outcomes and behaviours have been linked with lower wealth, such as low use of preventive care [72], which may contribute to frailty, especially at older age when individuals are more vulnerable to stressors [73,74]. The protective effect of educational attainment lends credence to the cognitive reserve hypothesis [77] and the link between lower wealth, low educational attainment and negative health outcomes [78] - *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799*
Leaving school early	• The prevalence of frailty is significantly more common in those with low level of education compared to high levels. For example, 10.8% in college graduates versus 33.4% in those not graduating from high school. BMC family practice – https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-018-0851-1 • In people aged 50 years and older, any formal education compared to no education showed a protective effect against early development of frailty (HR = 0.84, CI = 0.77–0.92). For example, 84% reduced annual incidence of frailty *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799*
Manual trade	• There is a significant relationship between frailty risk and life-course occupations in advanced age (e.g. intrinsically harder, manual or blue-collar employment). *Archives of gerontology and geriatrics. The contribution of occupational factors on frailty. https://www.sciencedirect.com/science/article/pii/S0167494317303321* • People 50 years and over with poor lower body strength was identified as being associated with a 7% annual higher frailty incidence (HR = 1.07, CI = 1.06–1.08) compared to those with normal body strength - https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799
Obesity and exercise	• *The prevalence of frailty is significantly higher is those who are obese. For example, 32.7% versus 22.8% respectively. Frail people are more likely to have sedentary lifestyles (exercise less than once per week) compared to non-frail people. For example, 30.2% versus 9.3% respectively. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • People 50 years and over who were classed as obese (HR = 1.33, CI = 1.18–1.50) have a 33% higher annual risk of by becoming frail compared to people with a normal BMI. People over 50 years with a high waist-hip ratio have a 25%

	annual increased risk (HR 1.2.5, CI = 1.13–1.38) of becoming frail compared to those with healthy ratios .*https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • People 50 years and over engaging in moderate (HR = 0.59, CI = 0.48–0.71) or vigorous physical activity (HR = 0.46, CI = 0.36–0.57) were less likely to become frail compared to people with sedentary lifestyles. For example, 59% reduced annual risk and 46% reduced annual risk respectively - *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799*
Nutrition, alcohol and smoking	• Moderate alcohol consumption may have a protective effects on developing frailty in older community dwelling people - *https://academic.oup.com/ageing/article/47/1/26/3854659* • High consumption in midlife predicted both frailty (odds ratio = 1.61, 95% confidence interval = 1.01-2.56) and prefrailty (1.42; 1.06-1.92) - https://www.ncbi.nlm.nih.gov/pubmed/29088316 • Smoking is a predictor of worsening frailty status in community-dwelling population. Smoking cessation may potentially be beneficial for preventing or reversing frailty - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4618730/ • People 50 years and over who abstinence from tobacco (HR = 0.78, CI = 0.71–0.85) was associated with a reduced risk of frailty by 78% annually.://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799 • Among community-dwelling older adults, an increasing adherence to the Mediterranean Diet was associated with decreasing risk of frailty. Compared with individuals in the lowest tertile of the MEDAS score (lowest MD adherence), the OR (95% CI) of frailty was 0.85 (0.54–1.36) in those in the second tertile, and 0.65 (0.40–1.04; P for trend = .07) in the third tertile. Corresponding figures for the Mediterranean Diet Score were 0.59 (0.37–0.95) and 0.48 (0.30–0.77; P for trend = .002) - https://www.sciencedirect.com/science/article/abs/pii/S1525861014003934
Combined (smoking and exercise)	• These results show that a person with an average age of 67, who takes part in mild physical activity or is sedentary and is a current or previous smoker has a 59% chance of becoming frail by the time they are roughly 79 years old. In contrast, a person of the same age, who takes part in moderate or vigorous physical activity and has never smoked has a 22% chance of becoming frail over the same period. Similarly, a 67-year-old individual who is overweight or obese and smokes or has a smoking history has a 37% chance of becoming frail, whereas a person with a healthy weight that has never smoked has a 19% chance of developing frailty - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4618730/
Multiple LTC risk	• Frail people are four times more likely than non-frail people to say they have a physical health problem moderately interfering with their daily activities. For example, 80.1% versus 18.8% respectively. • Frail people are nearly six times more likely than non-frail people to say they have emotional or mental health problems moderately interfering with their daily activities. For example, 80.1% versus 18.8% respectively.

	• Frail people are over five times more likely than non-frail people to say they have three or more chronic diseases. For example, 55.9% versus 10.1% respectively. • There is an inverse association between frailty/pre-frailty and quality of life among community-dwelling older people. Interventions targeted at reducing frailty may have the additional benefit of improving corresponding quality of life - https://pdfs.semanticscholar.org/914b/41d07d8ea280f319d083061e34a9bce02f54.pdf?_ga=2.177592357.1014573198.1579702309-686684488.1579702309 • Multi-morbidity is present 10-15 years earlier with deprivation - https://richmondgroupofcharities.org.uk/sites/default/files/multimorbidity_-_understanding_the_challenge.pdf
Deafness and senses	• Frail people are four times more likely to have vision problems affecting ADLs, 2.5 times more likely to have hearing problems and over 5 times more likely to have poor oral health affecting eating and speech - *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • Hearing Loss is independently associated with the risk of frailty in older adults and with greater odds of falling over time. Moderate-or-greater HI is associated with increased risk of developing frailty over time, independent of age, demographic characteristics, and cardiovascular risk factors. We also found that HI was associated with an increased annual risk of falling - https://jhu.pure.elsevier.com/en/publications/association-of-hearing-impairment-with-incident-frailty-and-falls
Polypharmacy	• Twice the number of frail people compared to non-frail people take medication that increases their fall risk. *BMC family practice- https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • People have nearly 2 times the odds of frailty with polypharmacy (5 or more medicine) and nearly 5 times the odds of frailty with excessive polypharmacy (10 or more medicines) respectively. *https://www.ncbi.nlm.nih.gov/pubmed/25858336 and https://www.ncbi.nlm.nih.gov/pubmed/28024089*
Depression and anxiety	• Frailty is also associated with psychiatric disorders in older persons (Andrew & Rockwood, 2007). • The associations between frailty and depression are taken to be bidirectional in the clinical and research literature - https://www.ncbi.nlm.nih.gov/pubmed/28366616 • The causal relationships and extent to which the phenomena are overlapping or distinct syndromes remains unclear - http://www.scielo.br/scielo.php?pid=S1414-32832019000100306&script=sci_arttext&tlng=en • Supporting frail older people with depression and anxiety: a qualitative study - https://www.tandfonline.com/doi/full/10.1080/13607863.2019.1647132: • Mental health is often overlooked in these definitions, despite psychological resilience being seen as an important part of managing physical frailty (Shaw et al., 2018).

	• Reductions in mobility and independence can strongly impact mood – frail older adults are four times more likely to experience clinically significant anxiety or depression (Ni Mhaolain et al., 2012), with up to half experiencing depressive symptoms (Vaughan, Corbin, & Goveas, 2015). • Depression and anxiety are commonly underdiagnosed in this population (Mitchell, Rao, & Vaze, 2010). • Older patients with depression, where it is found to be associated with severity of depressive symptoms (Buigues et al., 2015; Collard, Comijs, Naarding, & Oude Voshaar, 2014; Collard et al., 2015; Soysal et al., 2017; Vaughan, Corbin, & Goveas, 2015). • Functional impairment (seen in frailty) is a risk factor as well as a consequence of depression in older adults (Bruce, 2001; Lenze et al., 2001) and inpatients with psychotic or bipolar disorder (Auslander et al., 2001; Bowie, Reichenberg, Patterson, Heaton, & Harvey, 2006; Harvey & Bellack, 2009; Sanchez-Moreno et al., 2009).
Reduced mobility and musculoskeletal problems	• Frail people are 11 times more likely to have mobility limitation, balance and walking problems compared to non-frail people and are nearly 9 times more likely to use a walking aid - *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • Frail people are nearly 3 times more likely to have had one fall or 4 more likely to have had two falls in the last year compared to non-frail people. BMC family practice *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • Frail people are 2.5 times more likely to have headaches, musculoskeletal pain compared to non-frail people. Two thirds of frail people experience frequent or ongoing pain and 80% indicate it interfered moderately with daily living activities. BMC family practice- *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • People aged 50 years and over who were consider to have high levels of pain intensity were associated with a 38% annual increased risk of developing frailty (HR = 1.39, CI = 1.34–1.45) compared to those without pain - https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799
Social isolation	• The prevalence of frailty is significantly higher in those not in relationship, widowed, divorced or separated compared to those who are married or in a relationship. For example, 19.7% versus 11.5% respectively. *BMC family practice. David R. Lee* • Frail people are over 5 times more likely to say they feel lonely or socially isolated, 4 times more likely to feel depressed or sad much of the time and over 5 times more likely to feel dissatisfied with life - *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799* • Currently, 30% of over 75-year olds live lone (approximately 2million people in UK). *file:///Users/Danielcowie/Downloads/deloitte-uk-better-care-for-frail-older-people%20(2).pdf* • People aged 50 years and over who were considered lonely (HR = 1.19, CI = 1.16–1.22) were associated with a 19% annual higher risk of developing frailty compared to those who were not lonely - On the other hand, social isolation was

	not associated with the progression or development of frailty, confirming that loneliness and social isolation are distinct states- https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799 • Frail older adults have a smaller network size and higher levels of loneliness. There social vulnerability of physical frail older adults should always be considered in planning care provision. Adverse effects of frailty on social functioning in older adults: Results from the Longitudinal Aging Study Amsterdam-Emiel O.HoogendijkabBiancaSuanetcElsaDentdDorly J.H.DeegeMarja J.Aartsenc • Social isolation is the leading cause of loss of independence and loneliness (15). Chronic loneliness poses a greater risk to long term health than smoking and increases risk to early admission to care homes (16). *https://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/better-care-for-frail-older-people.html*
Bereavement	• Frail people who suffer a life-event (bereavement) are 2.6 times increase risk of mortality compared to non-frail people suffering a life-event. *https://academic.oup.com/gerontologist/article/56/Suppl_3/286/2574452*
Functional dependence	• Frail people are nearly 20 times more likely to say they need help with ADLs (e.g. bathing, dressing toileting, eating) and over 48 times more likely to say they need help with IADLs (e.g. shopping, cutting toenails, laundry, managing medication and money) - *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223799*
Housing and supportive living	• One in three houses where the oldest person is aged 75 years and over have failed the official decent homes standard (17). *https://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/better-care-for-frail-older-people.html* • 96,000 people over 65 years provide unpaid care for a partner, family member or other, but less than 10% receive carer-specific support. *https://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/better-care-for-frail-older-people.html* • There is a causal link between housing and the main long-term conditions (e.g. heart disease, stroke, respiratory, arthritis) whilst risk of falls, a major cause of injury and hospital admission amongst older people, is significantly affected by housing characteristics and the wider built environment. Decent, suitable housing for older people can reduce the costs of health care. It can decrease GP visits by older people with chronic conditions, enable timely hospital discharge, extend independence for patients with dementia and provide end of life care at home. Therefore inclusion of housing is critical to better coordinated services for older people and their carershttps*://www.housinglin.org.uk/_assets/Resources/Housing/HAA/HAAllianceTopic_Statements_Health.pdf* • *People who live in homes with ≥1 poor conditions have more than twice the chance of developing frailty (odds ratio [OR] = 2.02; CI 1.09–3.75) compared to those not living in poor conditions - https://academic.oup.com/jpubhealth/article/40/3/e252/4812607*

	• *Housing report and older people - https://ageingbetter.resourcespace.com/pages/view.php?search=%21collection305+&k=78cbcbeecf&modal=&display=xlthumbs&order_by=collection&offset=0&per_page=240&archive=&sort=ASC&restypes=&recentdaylimit=&foredit=&ref=6846#* • As high as about one-half of the nursing home patients were frail. Approximately 40% were still prefrail and could be targeted by interventions for frailty prevention or treatment to avoid its negative health outcomes - *Prevalence of Frailty in Nursing Homes: A Systematic Review and Meta-Analysis. Gotaro Kojima, MD*.* • A large number of care home hospital admissions may be avoidable: 41% were for conditions that are potentially manageable or preventable outside of a hospital setting, or that could have been caused by poor care or neglect - https://www.health.org.uk/publications/reports/emergency-admissions-to-hospital-from-care-homes
Hospital stays	• Half of all reasons why people are discharge earlier is due to internal processes within hospitals. 39% of people delayed could be managed in another environment more suited to their needs. *NHSI. Guide to reducing long hospital stays. 2018 - https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf* • One-fifth of beds are occupied by people who have been in hospital for over three weeks. Most of these people have frailty (e.g. reduced functional ability and/or cognitive impairment)- *https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf* • *Although frailty or vulnerability before becoming ill may affect outcomes after discharge, patients in hospital may also experience an acquired, transient period of risk for adverse events that is harmful in addition to the stress of the acute illness. This "post hospital syndrome" is a multidimensional construct that incorporates sleep deprivation, cognitive stress, poor nutrition and physical pain. Patients who are already frail before hospital admission may be more sensitive to the stresses of this syndrome and at higher risk of readmission and poor outcomes - https://www.cmaj.ca/content/cmaj/187/11/799.full.pdf* • People with a high frailty score are 1.6 times more likely to die in hospital, 1.3 times more likely to a transfer to Geriatric ward and 1.2 times more likely to have a length of stay 10 days https://academic.oup.com/qjmed/article/108/12/943/1889634 • NHS Improvement. National priorities for acute hospitals 2017—good practice guide: focus on improving patient flow. July 2017. https://improvement.nhs.uk/documents/1426/patient_Flow_Guidance_2017___13_July_2017.pdf . • British Geriatrics Society, NHS Benchmarking Network. Managing frailty and delayed transfers of care in the acute setting. 2018. https://bit.ly/2JGUYav . • Edge R, NHS Providers. Delayed transfers of care—the story of 2017/18. 24 May 2018. http://nhsproviders.org/news-blogs/blogs/delayed-transfers-of-care-the-story-of-201718 .

	• Around a third of adult patients in an NHS acute bed are in the last year of their lives, although many won't know it, and nor can doctors necessarily predict it. About 40% of over 65s will die within 12 months of leaving hospital. https://www.bmj.com/content/351/bmj.h4266/rr . • Those with severe frailty are four times more likely to die within 12 months. http://endoflifestudies.academicblogs.co.uk/how-manypeople-in-hospital-today-will-die-within-a-year .
Recovery after long stays	• A stay in hospital over 10 days leads to 10 years of muscle ageing. *NHSI. Guide to reducing long hospital stays. 2018 - https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf* • 35% of 70-year olds experience functional decline during hospital admissions (compared to baseline). For 90-year olds this is 65% reduction. *https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf* • People with moderate to severe frailty (31.0% event rate) was an independent risk factor for 30-day readmission or death (adjusted odds ratio 2.19, 95% confidence interval 1.12–4.24) after being discharged from medical hospital wards compared to non-frail people. For example, Patients with moderate or severe frailty (n = 71) were more likely than non frail patients to be readmitted or to die within 30 days after discharge (31.0% [22/71] v. 13.8%; OR adjusted for age and sex 3.19, 95% CI 1.70–6.00; OR adjusted for age, sex and LACE score 2.19, 95% 1.12–4.24)- *https://www.cmaj.ca/content/cmaj/187/11/799.full.pdf* • People seen in hospital with a high frailty risk had a higher adjusted odds of 30-day mortality than those in the low-risk group (OR 1·71, 95% CI 1·68–1·75). They also had a higher adjusted odds of a long hospital stay (6·03, 5·92–6·10) and of emergency readmission within 30 days (1·48, 1·46–1·50) - https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30668-8/fulltext
Complications in A&E	• After adjustment for age, gender, comorbidity index and history of dementia and/or current cognitive concern, the CFS was an independent predictor of in-patient mortality [odds ratio (OR) = 1.60, 95% confidence interval (CI): 1.48 to 1.74, P < 0.001], transfer to Geriatric ward (OR = 1.33, 95% CI: 1.24 to 1.42, P < 0.001) and LOS ≥ 10 days (OR = 1.19, 95% CI: 1.14 to 1.23, P < 0.001). The CFS was not a multivariate predictor of 30-day readmission - https://academic.oup.com/qjmed/article/108/12/943/1889634 • Half of frail older people discharged home within 72 h from such settings are readmitted and one-third die within a year [2], with the majority of these events occurring in the first 90 days. Woodard J, Gladman J, Conroy S. Frail older people at the interface, Age Ageing , 2010, vol. 39 https://www.ncbi.nlm.nih.gov/pubmed/21616954 • Individuals with frailty who are discharged from hospital experience increased mortality and resource use, even after short 'ambulatory' admissions - https://bjgp.org/content/69/685/e555

	• A systematic review (26 studies) of older adults discharged from emergency departments reported readmission rates as high as 40% at 6 months - McCusker J, Verdon J. Do geriatric interventions reduce emergency department visits? A systematic review. J Gerontol A Biol Sci Med Sci 2006 - https://www.ncbi.nlm.nih.gov/pubmed/16456194
End of Life quality of care	• Acute care providers need to be prepared to recognise and respond to the needs of older people with frailty (Gardiner et al., 2013). Although there is a high and growing demand for health care from this group, frail older people in hospital receive suboptimal care compared to other patient groups (Patterson et al., 2011). Care is deficient in terms of clinical outcomes such as mortality and morbidity compared to other groups of older people (Finnbakk et al., 2012). Quality of the experience of care is also poorer, as reported in studies of patient and carer experiences of hospital care (Tadd et al., 2011) – • https://www.sciencedirect.com/science/article/pii/S0020748916302346 • Optimal hospital treatment for the frail patient typically includes coordinated assessment and multidisciplinary team interventions using preventive, life-prolonging, rehabilitative, and palliative measures in varying proportion and intensity based on the individual patient's needs (Goldstein et al., 2012, Nicholson et al., 2012). However, hospital staffing levels, skill mix and volumes of work (Griffiths et al., 2014), together with the fast pace and organisation of hospital care, and organisational cultures (O'Hare, 2004) can mean the clinical skills and time required to work with older people with frailty are undervalued (Patterson et al., 2011) - https://www.sciencedirect.com/science/article/pii/S0020748916302346 • Compared with non-frail patients, death and hospital readmission rates of frail patients were increased. Frailty was an independent predictor of 3-year death (adjusted hazard ratio (HR): 2.09; 95% confidence interval (CI): 1.20 to 3.63) and readmission (adjusted HR: 1.40; 95% CI: 1.04 to 1.88) after adjusting for several potential confounders. Frailty is prevalent among older inpatients and is a valuable predictor of 3-year mortality and hospital readmission in an acute care setting. • https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6362215/

Assess individuals who may be living with frailty to verify the presence of frailty and grade the severity by using clinical judgement and the Clinical Frailty Scale (CFS). Then offer an individual assessment as part of preparation within a CSP approach ('preparation, conversation and recording')

What works	Resources
Verifying frailty and assessing a person's level of frailty: Verification should always be carried out for those people identified by screening tools as possibly being frail. This can be done both opportunistically and systematically. Professionals should use clinical judgement and a validated tool either face-to-face with the person or non-face-to-face with knowledge of the person's health, social and emotional status. Therefore, • **Verify** the presence of frailty using clinical judgement and the Clinical Frailty Scale • Grade the **severity** of frailty using the Clinical Frailty Scale **Offer a further assessment of needs (CSP – 'preparation, conversation and recording')** As part of the CSP approach, the preparation step is a systematic way to identify all the relevant issues from both the person's and the professional's perspective, so nothing is missed, everything can be considered together within a genuinely holistic conversation /discussion that leads into priority setting, developing specific goals if relevant (and it will not always be) and then jointly developing the solutions.	➢ Clinical Frailty Scale - http://geriatricresearch.medicine.dal.ca/clinical_frailty_scale.htm ➢ Fusion48 - http://fusion48.net/frailty ➢ To understand a person's needs and inform care and support *consider* the need for a Comprehensive Geriatric Assessment (CGA) - http://www.bgs.org.uk/cga-toolkit/cga-toolkit-category/what-is-cga/cga-what ➢ BGS blog framing of frailty - https://britishgeriatricssociety.wordpress.com/2017/06/26/framing-the-narrative-of-frailty-differently-will-help-to-promote-wellbeing/ ➢ Frailty: Language and Perceptions A report prepared by Britain Thinks on behalf of Age UK and the British Geriatrics Society. 2015 http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Policy/health-and-wellbeing/report_bgs_frailty_language_and_perceptions.pdf?dtrk=true For more information on CSP, please see the following resources and useful links: ➢ Year of Care Partnerships – https://www.yearofcare.co.uk/care-and-support-planning

	➢ Care and Support Planning (CSP) across a lifetime; http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/Summary%20of%20201718%20GMS%20contract%20negotiations.pdf ➢ Year of Care Partnership: Care Planning across a lifetime. https://www.yearofcare.co.uk/sites/default/files/pdfs/Care%20and%20Support%20Planning%20across%20a%20lifetime%20V1.0%20June%202016_0.pdf ➢ Personalized care and support handbook (NHS England, 2016). The journey to person-centered care - https://www.england.nhs.uk/wp-content/uploads/2016/04/exec-summary-care-support-planning.pdf ➢ The Carlisle Story. Care and support planning at the heart of an integrated care community - https://www.yearofcare.co.uk/sites/default/files/pdfs/The%20Carlisle%20Story%20-%20a%20case%20study%20for%20integrated%20care%20teams%20-%20V1.0%20Apr%2017.pdf ➢ NHSE frailty heat maps - http://fusion48.net/frailty/frailty-contract-analysis/frailty-care-heatmaps ➢ Population Health management Sheffield DPH (designing systems for multi-morbidity) - https://gregfellpublichealth.wordpress.com/2018/02/02/multi-morbidity-population-management-blended-with-a-person-centred-approach/ ➢ State of care CQC - https://www.cqc.org.uk/publications/major-report/state-care ➢ RESTORE2 tool - https://wessexahsn.org.uk/img/projects/CS49286-RESTORE2-full-version%20(WHCCG).pdf

	➢ NHSI. SBAR communication tool - https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf ➢ RCP. NEWS2 and deterioration in COVID-19 - https://www.rcplondon.ac.uk/news/news2-and-deterioration-covid-19 ➢ CSF training, Specialised Clinical Frailty Network - https://www.scfn.org.uk/clinical-frailty-scale-training
Evidence **Verifying the presence of frailty and grading frailty severity** • When screening is positive, the European Union ADVANTAGE JA Managing Frailty Programme (www.advantageja.eu/) recommends performing a CGA to enable a global assessment of a person's needs and to diagnose frailty by the use of validated scales derived from the CGA (Frailty Index of accumulative deficits and Frailty Trait Scale). However, in current UK clinical practice this may prove to be too time consuming and not viable. Therefore, the NHS England national frailty team, through national guidance, recommend the use of the Clinical Frailty Scale (CFS) for both verification and grading of frailty severity. ○ Advantage – Knowing Frailty at an individual level: systematic review - http://advantageja.eu/images/WP4-Knowing-frailty-at-individual-level-a-Systematic-Review.pdf **Care and Support Planning** • **Add Year of Care Report**	
Frailty and assessing for COVID-19 **Best practice** **IN DEVELOPMENT** **Useful resources** ➢ New resource for GPs and practice managers implementing remote consultations and digital triage - https://www.eastlondonhcp.nhs.uk/ourplans/new-resource-for-gps-and-practice-managers-implementing-remote-consultations-and-digital-triage.htm	

- Remote consultation with COVID-19 - https://www.nice.org.uk/guidance/ng163/resources/bmj-visual-summary-for-remote-consultations-pdf-8713904797
- NEWS (or NEWS2) score when assessing possible COVID-19 patients in primary care? - https://www.cebm.net/covid-19/should-we-use-the-news-or-news2-score-when-assessing-patients-with-possible-covid-19-in-primary-care/
- Video on CFS and COVID-19 - https://www.youtube.com/watch?v=9ip__8IPlcA&feature=youtu.be
- COVID-19 rapid guideline: critical care in adults, NICE - https://www.nice.org.uk/guidance/ng159/chapter/2-Admission-to-critical-care
- COVID-19 and SOP Primary Care https://www.england.nhs.uk/coronavirus/publication/managing-coronavirus-covid-19-in-general-practice-sop/
- COVID-19. A remote assessment in primary care - https://www.bmj.com/content/368/bmj.m1182
- Delirium a key sign of COVID-19 in frail, older people (article) - https://www.sciencedaily.com/releases/2020/09/200930110120.htm -
- PHE. COVID-19, investigation and possible clinical management of possible cases - https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
- NHSE. Primary Care and COVID-19, patient assessment - https://www.england.nhs.uk/coronavirus/primary-care/assessment-diagnosis/patient-assessment/
- NHS testing for corona virus - https://www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/ask-for-a-test-to-check-if-you-have-coronavirus/
- BGS response – COVID-19 risk calculator. Think frailty (isolation, functional issues) NOT just Multiple Morbidity – https://www.bgs.org.uk/resources/identifying-older-people-most-vulnerable-to-covid-19
- Care home rapid COVID-19 testing pilot - https://www.gov.uk/government/news/pilot-for-family-members-to-get-regular-testing-for-safer-care-home-visits

Local stories (case studies)

IN DEVOPMENT

***Respond**:* to respond appropriately to needs, goals and priorities identified as part of the universal personalised care offer (including CSP), the following should be readily available in local health and care systems to prevent frailty and support people, carers and families living with frailty:

- **Healthy ageing and optimum caring** approaches with signposting to keeping active, engaged and independent, including access to frailty friendly living and homes.

- **Community connectivity** with access to and involvement of the Voluntary, Community and Social Enterprise sector.

- **Specific, tailored support for Long Term Conditions**, including supportive self-management and shared decision making to develop a *self-management plan (with contingency planning)*, to optimise:
  - falls and immobility,
  - medicine /polypharmacy
  - mental health.

- **Access to specialist interagency teams for a comprehensive geriatric assessment [CGA] and case management** including the development of an *emergency health care plan* to coordinate care and optimise;
  - nutrition and hydration,
  - bowel and bladder care,
  - vision and hearing,
  - cognition and dementia care,
  - end of life.

- **Access to community crisis and recovery services** with active recuperation, rehabilitation and reablement and including:
  - frailty-focused transport
  - timely transfers of care from hospital, involving carers and families.

- **Access to experts offering frailty-based care in hospital** with frailty assessment, diagnostics and pathways.

What works	Resources
Encourage healthy ageing and optimum caring with signposting to keeping active, engaged and independent, including access to frailty friendly living and homes. • Look after your feet, mouth, teeth • Get moving - including aerobic, resistance, balance and flexibility training • Stop smoking • Eat well, consider nutritional supplements (e.g. vitamin D) • Drink alcohol sensibly • Get a hearing and eye test • Keep an active mind, sleep well • Keep safe at home, keep warm • Get vaccinated We can consider healthy ageing 'as the promotion of healthy living and the prevention and management of illness and disability associated with ageing' [11]. A person's well-being could be explored across the following domains: resilience, independence,	• **Healthier for Longer – BGS** • https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-11-04/BGS%20Healthier%20for%20Longer.pdf • **Impact of healthy ageing - Advantage managing Frailty** • http://advantageja.eu/images/WP6-Managing-frailty-at-individual-level-a-Systematic-Review.pdf • **Living Well in Communities with frailty – NHS Scotland** • https://ihub.scot/media/1892/lwic-frailty_evidence-for-what-works_jul18.pdf • Fire and rescue service NHSE website - https://www.england.nhs.uk/2016/06/working-together/ • Encourage Healthy Ageing with a healthy living passport for empowerment and self-care • https://www.england.nhs.uk/wp-content/uploads/2015/09/hlthy-ageing-brochr.pdf • European Innovation Partnership on active and healthy ageing. Prevention and diagnosis of frailty and functional decline https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/gp_a3.pdf • WHO clinical consortium on healthy ageing – https://apps.who.int/iris/bitstream/handle/10665/272437/WHO-FWC-ALC-17.2-eng.pdf

health, income and wealth, and having a role and having time [12]. We know community connectivity through social interaction is crucial to enable people to live meaningful lives. Therefore, a person's environment is fundamental to successful healthy ageing. The following are examples of what to consider when thinking about healthy ageing based on National guidance - https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf**:** ➢ Influenza and pneumococcal pneumonia vaccination ➢ Adequate treatment for 'minor conditions' which may limit independence ➢ Life-course approaches: regular exercise, not smoking, reducing alcohol consumption, healthy eating and preventing obesity ➢ Housing right for older people ➢ Cold weather planning ➢ National screening programmes The following are examples of what you should consider when thinking about healthy caring based on National guidance- https://www.england.nhs.uk/wp-content/uploads/2016/04/nhs-practcl-guid-caring.pdf ➢ Seek help and support from others (e.g. services, associations) ➢ Seek an assessment for your own health and care needs ➢ Look after your own health and wellbeing (e.g. understand health conditions) ➢ Taking a break ➢ Making better use of technology ➢ Preparing for the end of caring	• NICE. Strategy, policy and commissioning to delay or prevent onset of dementia, disability and frailty (pathway)- https://pathways.nice.org.uk/pathways/dementia-disability-and-frailty-in-later-life-mid-life-approaches-to-delay-or-prevent-onset • PHE guide to community-centred approaches for health and wellbeing - https://publichealthmatters.blog.gov.uk/2018/02/28/health-matters-community-centred-approaches-for-health-and-wellbeing • A decade of Healthy Ageing • https://www.who.int/ageing/decade-of-healthy-ageing • Housing and independence • https://www.gov.uk/government/publications/jointaction-on-improving-health-through-the-homememorandum-of-understanding • Frailty Prevention Site. Ageing with confidence • https://www.frailtyprevention.co.uk/prevention.html • Encourage Healthy Ageing with a healthy living passport for empowerment and self-care https://www.england.nhs.uk/wp-content/uploads/2015/09/hlthy-ageing-brochr.pdf • Practical Guide to Healthy Caring: companion guide to the healthy ageing guide which provides information and advice to older carers about staying healthy whilst caring and identifies the support available to help carers maintain their health and wellbeing. • Be active for Life. BHF guide https://www.bhf.org.uk/publications/being-active/be-active-for-life • 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 • Obesity prevention (**NICE, CG43**) • Physical activity: exercise referral schemes (**NICE, PH54**) • 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**) • 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 • Prevention Package for Older People, Department of Health, 2009 - http://profound.eu.com/the-prevention-package-for-older-people-doh-2009/ • Let's Get Moving, Department of Health, 2009 -

	https://www.gov.uk/government/news/let-s-get-moving-resources-help-promote-physical-activity • NICE. Strategy, policy and commissioning to delay or prevent onset of dementia, disability and frailty (pathway)- https://pathways.nice.org.uk/pathways/dementia-disability-and-frailty-in-later-life-mid-life-approaches-to-delay-or-prevent-onset • PHE guide to community-centred approaches for health and wellbeing - https://publichealthmatters.blog.gov.uk/2018/02/28/health-matters-community-centred-approaches-for-health-and-wellbeing • World Health Organisation's Active Ageing Policy Framework - Active Ageing: A policy framework, World Health Organization, 2002 http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4080994 • BMA. Healthy Ageing site - https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/healthy-ageing • European Innovation Partnership on active and healthy ageing. Prevention and diagnosis of frailty and functional decline https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/gp_a3.pdf • The prevention of frailty should include both the promotion of **healthy lifestyles** among the middle-aged and older people and emphasize enablement and maintaining independence. • Age UK. Healthy Ageing evidence review. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--

	wellbeing/rb_april11_evidence_review_healthy_ageing.pdf • National Voices, a national coalition of health and care charities, developed a person-centred 'narrative' on integration with. Think Local Act Personal • A further partnership created a Memorandum of Understanding to support joint action on improving health through the home, setting out a shared commitment to integrated working across health, social care and housing - https://www.gov.uk/government/publications/joint-action-on-improving-health-through-the-home-memorandum-of-understanding • Housing for Health website http://www.salixandco.com/new/new-news/client-news/health-must-begin-at-home-stronger-collaboration-with-housing-could-save-the-nhs-billions-of-pounds-a-year/ • The cost of poor housing to the NHS - http://www.bre.co.uk/filelibrary/pdf/87741-Cost-of-Poor-Housing-Briefing-Paper-v3.pdf • Housing Health Cost Calculator - www.housinghealthcosts.org. • Housing for Older People in Wales: An Evidence Review. Public Policy Institute for Wales, June 2015 • *Housingforhealth* NHS alliance website http://www.housingforhealth.net/ • NICE links to resources and tools around excess winter deaths and illness and the health risks associated with cold homes. NICE Guidance: https://www.nice.org.uk/guidance/ng6; • NICE Quality standard on reducing winter deaths and illness associated with cold homes: https://www.nice.org.uk/guidance/qs117

	• Reducing Health Inequalities for People Living with Frailty. A resource for commissioners, service providers and health, care and support staff https://www.collectivevoice.org.uk/wp-content/uploads/2020/10/HWA-frailty-Report-FINAL.pdf • Flu-vaccination video (easily explained) - https://www.youtube.com/watch?v=9nS6U88e7zs • Housing for health –West Yorkshire and Harrogate 'Innovation in Housing' - https://www.wyhpartnership.co.uk/our-priorities/population-health-management • Centre for better ageing – new resource website - https://cop.ageing-better.org.uk/resources • Reducing Health Inequalities for People Living with Frailty. A resource for commissioners, service providers and health, care and support staff - https://www.gypsy-traveller.org/wp-content/uploads/2020/10/health_ineq_final.pdf • Health inequalities statement (PHE and Centre for Better Ageing – 5 commitments to make England the best place to grow old- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882847/Healthy_Ageing_Consensus_Statement-GW-1165.pdf • Deafness and Hearing Loss Toolkit – RCGP for primary care - https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/deafness-and-hearing-loss-toolkit.aspx • Centre for Ageing Better – BLOG, learning lessons from coronavirus (obesity, housing conversation and links) - https://www.ageing-better.org.uk/blogs/how-can-we-learn-lessons-coronavirus • Village Life: Later living to the full – interesting video on 'housing and living' (Linked to Housing LIN – network for

	housing, health and social care) - https://www.housinglin.org.uk/HLINSummit2020/agenda/village-life-later-life-living-to-the-full/ • WHO. Decade of Healthy Ageing PLATFORM – video for utilization – https://www.who.int/initiatives/decade-of-healthy-ageing • Inclusion Health Tool for PCN – addressing inequalities – online tool, 10mins to complete with report - https://www.inclusion-health.org/pcn/ • Health Creation paper: Useful guides for PCN to reduce Health inequalities - https://thehealthcreationalliance.org/wp-content/uploads/2021/02/PCNs-workshop-series-report-FINAL-_-2-February-2021-.pdf • Mental Health and Housing. Calculating an investment case – framework for combined data collection - https://www.nhsconfed.org/-/media/Confederation/Files/Networks/MentalHealth/MHEC-supported-housing-2021.pdf • Article. Frailty final common pathway for premature death due to chronic disease – prevention at disease onset is crucial - https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-021-01904-x • Chartered Society of Physiotherapy. Self-Management: Older people and falls management - https://www.csp.org.uk/news/coronavirus/clinical-guidance/supporting-patients-stay-active-during-covid-19/older-people • Move it or loose it – video, older people - https://www.facebook.com/MoveItOrLoseIt1/videos/2774237176006853/?v=2774237176006853

Evidence

IN DEVELOPMENT

COVID-19, frailty and healthy ageing

Best practice

IN DEVELOPMENT

Useful resources

- BGS and COVID-19. Keeping older people safe and well at home – https://www.bgs.org.uk/resources/keeping-older-people-safe-and-well-at-home
- Age UK, corona virus, a short guide - https://www.ageuk.org.uk/globalassets/age-uk/documents/information-guides/ageukig59_coronavirus_inf.pdf
- Exercise - a table of 'social distancing' activity https://reader.elsevier.com/reader/sd/pii/S1525861020303534?token=9183C9FB8CE3056DD7AFB38839BF7F4915089721221B5557BF33B90C9C6561A2C79B8A9FB749BC29EE01BB9811354EED
- CEBM. The Centre for Evidence-Based Medicine develops, promotes and disseminates better evidence for healthcare. Maximizing mobility in older people when isolated with COVID-19 - https://www.cebm.net/covid-19/maximising-mobility-in-the-older-people-when-isolated-with-covid-19/
- Microbes and gut health – aging - https://journals.plos.org/plospathogens/article?id=10.1371/journal.ppat.1007727
- Alcohol and the immune system - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4590612/
- Non-alcoholic fatty liver diseases in patients with COVID-19: A retrospective study - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7141624/
- COVID-19 and Smoking. A systematic review of the evidence - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7083240/
- CEBM evidence. Vitamin D: A rapid review of the evidence for treatment or prevention in COVID-19 - https://www.cebm.net/covid-19/vitamin-d-a-rapid-review-of-the-evidence-for-treatment-or-prevention-in-covid-19/
- WHO – HealthyAtHome guides (mental health, physical health, quitting tobacco) - https://www.who.int/campaigns/connecting-the-world-to-combat-coronavirus/healthyathome
- GOV.UK. Guidance for the public on the mental health and wellbeing aspects of coronavirus (COVID-19) https://www.gov.uk/government/publications/covid-19-guidance-for-the-public-on-mental-health-and-wellbeing/guidance-for-the-public-on-the-mental-health-and-wellbeing-aspects-of-coronavirus-covid-19

- Every Mind Matters website - https://www.nhs.uk/oneyou/every-mind-matters/coronavirus-covid-19-staying-at-home-tips/
- Prevention of COVID-19 in older people (article) - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7156899/
- RCGP. Delivery mass vaccination during COVID-19 - https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2020/covid19/RCGP-guidance/RCGP-Mass-Vaccination-at-a-time-of-COVID-V15.ashx?la=en
- Centre for Ageing Better report - One in five excess deaths during winter are attributed to cold housing - https://www.ageing-better.org.uk/news/millions-cold-and-damp-homes-could-be-greater-risk-covid-19-winter
- Health inequalities : time to act - https://www.nhsconfed.org/resources/2020/09/health-inequalities-time-to-act
- Poor housing and outcomes report -https://www.ageing-better.org.uk/news/millions-cold-and-damp-homes-could-be-greater-risk-covid-19-winter
- Keeping well at home – local videos - https://www.youtube.com/playlist?list=PLQGYqB77iQkYico8aKB0sTpHFJ3gA2keE
- National COVID-19 resilience programme (Centre for Aging Better) - https://static.physoc.org/app/uploads/2020/11/09152548/A-National-Covid-19-Resilience-Programme-report-web-version.pdf
- NHSE COVID-19 vaccination specification - https://www.england.nhs.uk/coronavirus/publication/ess-vaccination-programme/

Local stories (case studies)

IN DEVELOPMENT

Impact and measures

We know that the frailty has a significant impact of people, populations and health and care systems. Frail older people are highly susceptible to adverse health and care outcomes. Trying to understand this impact on people, populations and systems is challenging. The following examples are of possible benefits to healthy ageing, outcomes measures to be considered as well as impact estimates based on current intelligence.

Healthy Ageing possible benefits

- A protective effect into retirement
- Increase physical activity, reduce long-term exhaustion and improve energy intake
- Prevent frailty progression
- Prevent fractures (for vitamin D and calcium supplementation)
- Reduce hospital admissions and mortality

Potential Impact

- In the North East and North Cumbria region, an additional 2,400 people could progress to mild frailty as a result of obesity, a further 2,400 due to smoking and nearly 3,000 more mildly frail people as a result of excess alcohol consumption.

Potential measures

- People aged 65 years or over who have had a frailty assessment
- Dementia: 65+ years old estimated diagnosis rate
- Flu immunisation rate in people aged 65 years and over

Approach	**Resources**
Encourage community connectivity through strengthening access to and involvement of the Voluntary, Community and Social Enterprise sector (VCSE). • Adopt shared decision making to enable choice and engagement to build learning and relationships • Focus on and invest in recognised ways of working that embrace 'relationship and asset-based approaches' and 'everyone doing their bit' to improve the health and wellbeing • Enable healthcare professionals to refer patients to non-clinical pathways that are co-designed to improve their health and wellbeing (e.g. social prescribing via link workers in line with PCN contract). An asset-based approach seeks to mobilise and strengthen the skills, capacities or resources available to individuals and communities and allows people to gain more	➢ Making Sense of Social Prescribing': publication from the Social Prescribing Network https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network ➢ Social prescribing and link workers in PCN (NHS England) ➢ https://www.england.nhs.uk/personalisedcare/social-prescribing/support-and-resources/ ➢ All the lonely people: lonely in later life ➢ https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-report_final_2409.pdf ➢ Public Health England. Community-centered public health ➢ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/857029/WSA_Briefing.pdf ➢ **Falls – NICE older people** ➢ pathways.nice.org.uk/pathways/preventing-falls-in-older-people ➢ Social Value Act https://www.gov.uk/government/publications/social-value-

control over their lives and circumstances and reduce the risk of loneliness. The impact of loneliness and isolation is well evidenced and its impact on use of health and social care services is significant. Our VCSE organisations are locally rooted having a wealth of local knowledge and connections (especially with hard-to reach groups), giving them unique insight into the challenges as well as opportunities within local 'places' to tackle inequalities. The following are examples of what to consider when thinking about community connectivity based on National guidance - https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf: ➢ Focus on and invest in recognised ways of working that embrace 'relationship and asset-based approaches' and 'everyone doing their bit' to improve the health and wellbeing of our society. ➢ Enable healthcare professionals to refer patients to non-clinical pathways that are co-designed to improve their health and wellbeing (e.g. social prescribing). ➢ A community navigator/link worker, who could come from a range of sectors (e.g. VCSE, housing) will work with the individual to co-produce solutions that best suit their needs.	act-information-and-resources/social-value-act-information-and-resources ➢ Social Prescribing Network contact email: socialprescribing@outlook.com ➢ Making Sense of Social Prescribing': publication from the Social Prescribing Network https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network ➢ Supporting self-management: Supporting self-management: A guide to enabling behaviour change for health and wellbeing using person – and community- centred approaches. https://www.nesta.org.uk/report/supporting-self-management-a-guide-to-enabling-behaviour-change-for-health-and-wellbeing-using-person-and-community-centred-approaches/ ➢ The role of advice services on health outcomes – http://www.lowcommission.org.uk/dyn/1435582011755/ASA-report_Web.pdf ➢ Altogether Better Working Together to Create Healthier People and Communities- http://www.altogetherbetter.org.uk/Data/Sites/1/--altogether-better-evaluation-report---working-together-to-create-healthier-people-and-communities-2015.pdf ➢ The Deloitte Centre for Health Solutions, (2015) The Primary Care Navigator programme for dementia, two organisations transforming primary care by working differently http://napc.co.uk/wp-content/uploads/2017/09/PCN_Case_Study_Report.pdf ➢ National Institute for Health and Care Excellence, (2015) Older People: Independence and Mental Wellbeing. https://www.nice.org.uk/guidance/ng32 ➢ New Economics Foundation, (2008) Five Ways to Wellbeing. Available from: http://neweconomics.org/five-ways-to-wellbeing-the-evidence/?_sft_project=five-ways-to-wellbeing

	➢ VCSE Health and Wellbeing Fund: information pack for voluntary, community and social enterprise (VCSE) sector organisations www.nationalarchives.gov.uk/doc/open-government-licence/ ➢ Fire and Rescue Service as a health asset support - https://www.england.nhs.uk/blog/jacquie-white-3/ ➢ Encourage Healthy Ageing with a healthy living passport for empowerment and self-care https://www.england.nhs.uk/2015/01/healthy-ageing/ ➢ E-frailty project – supporting people to live independently http://www.cm2000.co.uk/News/ArtMID/2529/ArticleID/73/E-frailty-project-–-supporting-older-people-to-live-independently ➢ Working with older people. Asset Based Community Development – enriching the lives of older citizens. Deborah Klee. Marc Mordey- http://deborahklee.org.uk/VintageCommunities/pdf/asset_based.pdf ➢ Head, hands and heart: asset-based approaches in health care, Health Foundation (2015) https://www.health.org.uk/publication/head-hands-and-heart-asset-based-approaches-health-care ➢ VCSE Review: Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector, Representatives of the VCSE sector and the Department of Health, NHS England, and Public Health England (2016) - https://vcsereview.org.uk/ ➢ Developing Asset Based Approaches to Primary Care: Best Practice Guide, Innovation Unit / Greater Manchester Public Health Network (2016) https://www.innovationunit.org/wp-content/uploads/2017/05/Greater-Manchester-Guide-090516.pdf ➢ A new relationship with people and communities, People and Communities Board (NHSE, National Voices and partners)

	[2017] outlines a set of 'high impact actions' for accelerating the adoption of person and community-centred approaches to health and care https://www.nationalvoices.org.uk/publications/our-publications/new-relationship-people-and-communities ➢ Public health working with the voluntary, community and social enterprise sector: new opportunities and sustainable change, LGA (2015) https://www.local.gov.uk/public-health-working-voluntary-community-and-social-enterprise-sector-new-opportunities-and ➢ Realising the value programme - tools and resources, NHSE / NESTA 2015 http://www.nesta.org.uk/realising-value-programme-reports-tools-and-resources ➢ People powered health co-production catalogue, NESTA 2014 http://www.nesta.org.uk/publications/co-production-catalogue ➢ BGS loneliness and isolation http://www.bgs.org.uk/policy-digest-m/resources/policy-digest/wales-loneliness-isolation ➢ Measuring National Well-being: insights into loneliness, older people and well-being, 2015, ONS https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/2015-10-01 ➢ Evidence Review: loneliness in later life, Age UK, 2015 https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Age%20UK%20Evidence%20Review%20on%20Loneliness%20July%202014.pdf?dtrk=true ➢ Rural Poverty in Wales: Existing Research and Evidence Gaps, Public Policy Institute for Wales, 2016 http://ppiw.org.uk/files/2016/06/An-introduction-to-Rural-Poverty.pdf ➢ Reducing social isolation across the life course. Public Health England, UCL Institute of Health Equity, 2015

	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf ➢ No one should have to care alone, Carers UK, 2017 https://www.carersuk.org/search/no-one-should-have-to-care-alone-for-carers ➢ Campaign to End Loneliness https://www.campaigntoendloneliness.org/references/ ➢ Combating loneliness, a guide for local authorities. LGA, Campaign to end Loneliness, Age UK, 2016 ➢ https://www.local.gov.uk/sites/default/files/documents/combating-loneliness-guid-24e_march_2018.pdf ➢ Green SP (call to actions) - https://www.england.nhs.uk/personalisedcare/social-prescribing/green-social-prescribing/ ➢ Social Prescribing Plus Programme – training and education website - https://www.networks.nhs.uk/news/socialprescriberplus-2013-essential-training-for-social-prescribing-link-workers-care-coordinators-and-health-coaches-11 ➢ SP NE&NC approaches – reading coach programme - https://www.theguardian.com/books/2020/sep/02/stories-healing-funding-bibliotherapists-ann-cleeves ➢ VSCE sector recruiting SPLW on behalf of PCNs ➢ A North East and North Cumbria ICS Personalised Care Programme training offer. Upskilling staff (e.g. Health coaching, PSP, SP, mental health) ➢ The NE&NC SP lead is leading the National Academy for SP and Thriving Communities programme (support and networking programme in England) - https://socialprescribingacademy.org.uk/thriving-communities/

	➢ Qualitative COVID19 Health Inequalities Impact Report published as part of a COVID-19 Health Inequalities Impact Assessment (HIIA) for the North East. ➢ North East and North Cumbria Regional Social Prescribing Facilitator, Jane Hartley. Jane can be contacted at jane.hartley@vonne.org.uk ➢ ROI tool – NHS and Social Care return investment tool, PHE – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/860616/Older_Adults_NHS_and_Social_Care_ROI_Tool_-_Technical_Report__2_.pdf ➢ Frailty and social isolation – increased risk of mortality - https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.16716 ➢ New relationship between NHS and people and communities (introduction) - https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/REPORT_People-and-communities-Reset_FNL.pdf ➢ How health and care systems can work better with VCSE partner (5 ways and case studies - https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Working-better-with-the-VCSE_FNL.pdf
Evidence **IN DEVOPMENT**	
COVID-19, frailty and community connectivity **Best Practice** **IN DEVOPMENT**	

Useful resources

- Useful website – social prescribing with COVID-19 https://elementalsoftware.co/strengthening-community-support-through-digital-social-prescribing-during-covid-19/
- IRISS report – ESSS Outline Covid-19, social isolation and loneliness https://www.iriss.org.uk/sites/default/files/2020-04/iriss_esss_outline_social_isolation_22042020.pdf
- EU website AGE platform Europe, useful examples of community connectivity - https://www.age-platform.eu/age-news/covid-19-good-practices-initiatives
- NECS - How care homes are keeping their residents active, happy and in good spirits during COVID-19 https://www.necsu.nhs.uk/news/how-care-homes-are-keeping-their-residents-active-happy-and-in-good-spirits-during-covid-19/
- Local government – practical advice (loneliness and social isolation) - https://www.local.gov.uk/sites/default/files/documents/Loneliness%20social%20isolation%20and%20COVID-19%20WEB.pdf
- British Red Cross. Life after COVID-19, tackling loneliness https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/life-after-lockdown-tackling-loneliness##
- New relationship between NHS and people and communities - https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/REPORT_People-and-communities-Reset_FNL.pdf
- How health and care systems can work better with VCSE partner (5 ways and case studies) - https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Working-better-with-the-VCSE_FNL.pdf

Local stories (case studies)

IN DEVELOPMENT

Impact and measures

We know that the frailty has a significant impact of people, populations and health and care systems. Frail older people are highly susceptible to adverse health and care outcomes. Trying to understand this impact on people, populations and systems is challenging. The following examples are of possible benefits to embracing community connectivity, outcomes measures to be considered as well as impact estimates based on current intelligence.

Community Connectivity possible benefits

- Improves the experience of care, health and wellbeing and prevents mental health

- Reduces crises that lead to unplanned hospital or institutional care admissions.
- Reduces unnecessary GP/primary care appointments
- Benefits fitness, activities of daily living and quality of life
- Improves physical function and muscle strength
- Reduces the rate and risk of falling
- Delays the progression to frailty

Potential Impact

- In the North East and North Cumbria region, mildly frail people are 2.6 times more likely to have fallen in the last 12 months than fit people aged over 65.

Potential measures

- The proportion of people (aged 65+ years) who use services who reported that they had as much social contact as they would like
- Carer reported quality of life
- Measurement of loneliness / reduced loneliness
- Number of people referred into social prescribing schemes

What works	**Resources**
Offer specific, tailored support for Long Term Conditions, including supportive self-management and shared decision making to develop a self-management plan (with contingency planning) to optimise falls and immobility, medicine/polypharmacy and mental health. • Involve everyone in co-ordinating support. • Offer education tailored to need and literacy. • Consider TECS to self-manage long-term condition(s). • Consider personal care budgets and direct payments.	➢ **Multiple Morbidly NICE** ➢ https://www.nice.org.uk/guidance/ng56/resources/resource-impact-statement-2615256685 ➢ **Multiple Morbidly and polypharmacy** ➢ www.nice.org.uk/advice/ktt18 ➢ **PCN briefing for pharmacy** ➢ - https://www.england.nhs.uk/wp-content/uploads/2019/06/pcn-briefing-for-pharmacy-teams.pdf ➢ **Mental Health – NICE older people** ➢ pathways.nice.org.uk/pathways/mental-wellbeing-and-independence-in-older-people

• Offer support and care planning for multiple morbidity and frailty (in line with PCN contract on personal care and anticipatory planning) • Screen and advise about falls, encouraging strength and balance training • Tackle polypharmacy with specialist pharmacists (e.g. SMR in line with PCN contract) • Identify and manage depression and anxiety, linking to community services and VCSE Self-care/ self-management is the actions individuals take to lead a healthy lifestyle; to meet their social, emotional and psychological needs; to care for their long-term condition; and to prevent further illness or accidents. Support for self-management is the actions by the professional (formal and informal) that assist this. It includes helping people to gain the necessary knowledge, skills and confidence to manage the physical, emotional and social demands placed on them by LTCs (or ageing) in the context of their everyday lives. The following are examples of what to consider when thinking about supporting people with Long Term Conditions based on National guidance - https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf: ➢ Involving people, their carers and their families in planning and co-ordinating their own care. ➢ Providing support and education for family and volunteer carers, tailored to their level of health literacy.	➢ https://www.mentalhealth.org.uk/sites/default/files/promoting_mh_wb_later_life.pdf ➢ Falls quality statements NICE - https://www.nice.org.uk/guidance/qs86/chapter/Quality-statements ➢ https://www.rcn.org.uk/clinical-topics/older-people/falls ➢ Kings Fund. Making care system fit for an ageing population- ➢ https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/makinghealth-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf: ➢ Age UK – personalised integrated care - https://www.ageuk.org.uk/our-impact/programmes/integrated-care/ ➢ Universal personalised care, implementing the comprehensive model - https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf ➢ Supporting self-management: Supporting self-management: A guide to enabling behaviour change for health and wellbeing using person – and community- centred approaches. https://www.nesta.org.uk/report/supporting-self-management-a-guide-to-enabling-behaviour-change-for-health-and-wellbeing-using-person-and-community-centred-approaches/ ➢ The challenge of ageing populations and patient frailty: can primary care adapt? - http://sro.sussex.ac.uk/id/eprint/78985/3/BMJ%20Frailty%20article%20300518.pdf ➢ Managing frailty as a Long Term Condition - www.ncbi.nlm.nih.gov/pubmed/26175349 ➢ Type 2 diabetes mellitus in older people: a brief statement of key principles of modern day management including the assessment of frailty. A national collaborative stakeholder initiative - https://www.ncbi.nlm.nih.gov/pubmed/29633351

➢ Technology enabled care solutions [TECS] should be considered as part of the menu of options in place for patients to effectively self-manage their long-term condition(s). ➢ Personal care budgets and direct payments. ➢ A specific, tailored approach with best practice support and care for the following should be undertaken: o Falls and Immobility - frail older people have access to services to prevent falls with proactive screening. o Polypharmacy o Mental health – depression and anxiety	➢ Primary care nursing role for frail people, as exists in some other countries and with which some UK services are experimenting - http://www.ahsn-nenc.org.uk/wp-content/uploads/2016/11/Primary-Care-Frailty-Nurse-Presentation.pdf ➢ Mental wellbeing in over 65s: occupational therapy and physical activity interventions, independence and quality standards – https://www.nice.org.uk/guidance/ph16; https://www.nice.org.uk/guidance/ng32; https://www.nice.org.uk/guidance/qs137 ➢ Medicine Safety in Polypharmacy - https://apps.who.int/iris/bitstream/handle/10665/325454/WHO-UHC-SDS-2019.11-eng.pdf?ua=1 ➢ Impact of training and structured medication review on medication appropriateness and patient-related outcomes in nursing homes - https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-019-1263-3 ➢ Harrison JK, Clegg A, Conroy SP, Young J. Managing frailty as a Long-Term Condition. Age & Ageing 2015 44(5). 732-5. https://www.ncbi.nlm.nih.gov/pubmed/26175349Long Term Conditions Year of Care Commissioning Programme – To develop the evidence base for a capitated budget approach within long term conditions (LTC) for people with complex needs https://www.england.nhs.uk/wp-content/uploads/2017/02/ltc-yoc-handbook.pdf ➢ Coulter A et al. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database Syst Rev 2015 https://www.ncbi.nlm.nih.gov/pubmed/25733495 ➢ Frailty Fulcrum. Concept model aiming to provide a 'common language' for frailty that can be shared between individuals, carers and professionals to better self-care - https://www.england.nhs.uk/blog/dawn-moody/

	➢ NICE links to resources and tools for social care for older people with multiple long-term conditions https://pathways.nice.org.uk/pathways/social-care-for-older-people-with-multiple-long-term-conditions. Guidance - https://www.nice.org.uk/guidance/ng22. **Policy:** ➢ Department of Health (2014) Better care for people with 2 or more long term conditions ➢ Department of Health (2014) Care Act 2014 ➢ Department of Health (2014) Care and support statutory guidance ➢ Department of Health (2014) Carers strategy: the second national action plan 2014–2016 ➢ NHS England (2014) Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders ➢ Department of Health (2013) Integrated care: our shared commitment ➢ 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**) ➢ NICE links to resources and tools to prevent falls in older people - https://pathways.nice.org.uk/pathways/preventing-falls-in-older-people. Guidance - https://www.nice.org.uk/guidance/cg161. Quality

	statements - https://www.nice.org.uk/guidance/qs86/chapter/Quality-statements ➢ NICE links to resources and tools on mental wellbeing and independence in older people - https://pathways.nice.org.uk/pathways/mental-wellbeing-and-independence-in-older-people. Guidance - https://www.nice.org.uk/guidance/ph16; https://www.nice.org.uk/guidance/ng32; https://www.nice.org.uk/guidance/qs137 ➢ NICE quality standard on mental wellbeing for older people in care homes - https://www.nice.org.uk/guidance/qs50 ➢ NHS Pharmacy Integration Fund - Pharmacy Integration Fund - https://www.england.nhs.uk/commissioning/primary-care/pharmacy/integration-fund/ ➢ Polypharmacy and medicines optimisation: making it safe and sound, The King's Fund (2013) - https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/polypharmacy-and-medicines-optimisation-kingsfund-nov13.pdf ➢ Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE guideline [NG5] (2015) - https://www.nice.org.uk/guidance/ng5 . ➢ NICE quality standard on medicine optimisation - https://www.nice.org.uk/guidance/qs120 ➢ NICE document summarising the evidence-base on multimorbidity and polypharmacy - https://www.nice.org.uk/advice/ktt18 ➢ Managing medicines in care homes, NICE guideline [SC1] - https://www.nice.org.uk/Guidance/SC1 ➢ Nice quality standard on medicine management in care homes - https://www.nice.org.uk/guidance/qs85

	➢ Medication safety in care homes, NCF (2013) - http://www.nationalcareforum.org.uk/medsafetyresources.asp ➢ Medication - slide pack proxy medication ordering or care homes (setting it up) - https://future.nhs.uk/DigitalPC/view?objectID=72672357 ➢ Structured Medication Reviews for PCN (needed those with severe frailty and others) - https://www.england.nhs.uk/wp-content/uploads/2020/09/SMR-Spec-Guidance-2020-21-FINAL-.pdf ➢ Minds that matter: understanding mental health in later life (interesting report) - https://www.independentage.org/policy-and-research/mentalhealth/minds-matter-report ➢ National NHS Discharge Medicines Service – cross sector toolkit for medicines on discharge from hospital - https://www.england.nhs.uk/primary-care/pharmacy/nhs-discharge-medicines-service/ ➢ NIHR website' Medication burden on older and their families (MEMORABLE study) - https://evidence.nihr.ac.uk/alert/managing-medication-lder-people-need-support-hidden-burden/ ➢ The Poly-pharmacy Prescribing Comparator tool is to highlight variation and to support CCGs and GP practices in addressing their poly-pharmacy work (video/ how to access) - https://wessexahsn.org.uk/projects/323/nhs-bsa-polypharmacy-prescribing-comparators ➢ Delirium and COVID – interesting article - https://academic.oup.com/ageing/advance-article/doi/10.1093/ageing/afab014/6106229 ➢ Primary Care 'top tips' dealing with COVID - https://elearning.rcgp.org.uk/pluginfile.php/149508/mod_page/content/101/Coronavirus%20-

	%20what%20to%20do%20in%20primary%20care_18_02_21.pdf ➢ NHS National Assembly. Technology Enabled Care Services. Resource for Commissioner - https://www.england.nhs.uk/wp-content/uploads/2014/12/TECS_FinalDraft_0901.pdf
Evidence **IN DEVELOPMENT**	
COVID-19, frailty and specific tailored support for LTCs **Best Practice** **IN DEVELOPMENT** **Useful resources** ➢ COVID-19: guidance Staying alert and safe (social distancing) - https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing/staying-alert-and-safe-social-distancing ➢ GOV.UK. Get corona virus support as an extremely vulnerable person - https://www.gov.uk/coronavirus-extremely-vulnerable ➢ NHS England. TECS evidence based for LTCs - https://www.england.nhs.uk/tecs/strategic-planning/ ➢ RCGP and BMA - RCGP Guidance on workload prioritisation during COVID-19 - https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2020/covid19/RCGP%20guidance/202003233RCGPGuidanceprioritisationroutineworkduringCovidFINAL ➢ Evidence summary - What conditions could we prioritise in the primary care setting to reduce non-COVID-related admissions to hospital? - https://www.cebm.net/covid-19/what-conditions-could-we-prioritise-in-the-primary-care-setting-to-reduce-non-covid-related-admissions-to-hospital/ ➢ BGS and COVID-19 - medicines advice for older people - https://www.bgs.org.uk/resources/covid-19-and-medicines-advice-for-older-people ➢ Home care: Delivering personal care and practical support to older people living in their own homes - https://www.nice.org.uk/guidance/ng21	

- NICE. COVID-19 rapid guideline: community-based care of patients with COPD - https://www.nice.org.uk/guidance/ng168
- NICE. MyCOPD for self-care COPD - https://www.nice.org.uk/advice/mib214/chapter/Summary
- Age UK and mental health impact of COVID-19 - https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/the-impact-of-covid-19-on-older-people_age-uk.pdf
- Mental health support package ask - https://www.nhsconfed.org/-/media/Confederation/Files/Networks/MentalHealth/MHPG-Winter-Support-Package-2020.pdf
- RCGP slide pack – Management of the Long Term affects of COVID-19 (top tips) - https://elearning.rcgp.org.uk/pluginfile.php/160164/mod_page/content/6/V2GA%20for%20publication%20updated%20Management%20of%20the%20long%20term%20effects%20of%20COVID-19_formatted_29.10.20.pdf
- NICE. COVID-19 rapid guideline: severe asthma - https://www.nice.org.uk/guidance/ng166
- COVID-19 rapid guideline: rheumatological autoimmune, inflammatory and metabolic bone disorders - https://www.nice.org.uk/guidance/ng167

Local stories (case studies)

IN DEVELOPMENT

Impact and measures

We know that the frailty has a significant impact of people, populations and health and care systems. Frail older people are highly susceptible to adverse health and care outcomes. Trying to understand this impact on people, populations and systems is challenging. The following examples are of possible benefits to personalised LTC support, outcomes measures to be considered as well as impact estimates based on current intelligence.

Specific, tailored support for Long Term Conditions possible benefits

- Improves a person's knowledge about their conditions, coping ability and use of health care
- Streamlines management of LTCs
- Fewer unnecessary GP appointments

- Fewer medicines prescribed, adverse drug reactions and hospitalisation (adverse reactions)
- Improve medication use (when staff trained in SMR receive training)
- Reduce the risk of falls

Potential Impact

- In the North East and North Cumbria region, nearly 10, 000 more people may progress to mild frailty as a result of increasing diagnoses of hypertension

Potential measures

- People aged 65 years and over with 10 or more unique medications
- Dementia: 65+ years old estimated diagnosis rate
- The proportion of people (aged 65+ years) who use services who have control over their daily life

What works	**Resources**
Access to specialist interagency teams for a comprehensive geriatric assessment [CGA] and case management including the development of an *emergency health care plan* to coordinate care and optimise nutrition and hydration, incontinence, vision and hearing, cognition, end of life and dementia care. • Proactive comprehensive geriatric assessment (CGA) [general practice/community-based] and follow-up for people identified as moderately or severely frail (in line Anticipatory Planning Model in PCN contract) • An identified keyworker who acts as a case manager and coordinator of care across the system – community, primary and inpatient hospital care. • Case management delivered through integrated locality-based teams (access to community geriatrics). • The case manager or MDT designs the care plan with the person and carer (informed decisions), if appropriate. The care plan is shared	➢ CGA BGS toolkit (primary care) ➢ http://www.bgs.org.uk/cga-toolkit/cga-toolkit-category/what-is-cga/cga-what ➢ King's Fund – case management ➢ https://www.kingsfund.org.uk/sites/default/files/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf ➢ NHS Scotland – Anticipatory Care Planning ➢ https://www.nhsinform.scot/campaigns/anticipatory-care-planning ➢ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507981/PM_Dementia-main_acc.pdf ➢ https://www.rcn.org.uk/clinical-topics/older-people/delirium ➢ Scotland delirium toolkit - https://ihub.scot/project-toolkits/delirium-toolkit/delirium-toolkit/video-toolkit/ ➢ To understand a person's needs and inform care and support *consider* the need for a Comprehensive Geriatric Assessment

across the system and implemented by MDTs and updated appropriately (e.g. in response to a crisis). • Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role. • A comprehensive service for those with palliative care needs must be available and accessible (via GP lists, not one-off, access to specialist teams) • For those people living in care homes, implementation of the Enhanced Health in Care Homes (EHCH) framework should be considered (In line with PCN contract). **Comprehensive geriatric assessment (CGA)** is a multidimensional, interdisciplinary (usually) process to understand a person's needs to be able to develop a holistic plan for treatment, rehabilitation, support and long term follow up. **Case management** is a way of coordinating care around a person with long-term conditions and complex needs, normally used for those at risk of adverse outcome such as hospital admissions. It should be targeted, community-based and pro-active. The following are examples (based on National guidance) of what to consider when thinking about supporting people with multimorbidity and increasing complex care needs *(implementation and delivery will vary depending on local circumstances and care pathways. It is likely that with increasingly needs a person will be referred to a specialist interagency team for a CGA and onwards case management)*: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf: ➢ Proactive comprehensive geriatric assessment (CGA) [general practice/community-based] and follow-up for people identified as moderately or severely frail, with a	(CGA) - http://www.bgs.org.uk/cga-toolkit/cga-toolkit-category/what-is-cga/cga-what ➢ Case Management. Kings Fund. What is it and how it is best implemented. 2011. https://www.kingsfund.org.uk/sites/default/files/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf ➢ NICE clinical guideline on multi-morbidity: Assessment, prioritisation and management of care for people with commonly occurring multimorbidities. ➢ Older people with social care needs and multiple long-term conditions [ng22], Guideline, NICE (2015) - https://www.nice.org.uk/guidance/ng22 ➢ Frail older people – Safe, compassionate care summarises the evidence of the effects of an integrated pathway of care for older people and suggests how a pathway can be commissioned effectively using levers and incentives across providers. ➢ British Geriatrics Society (2014). Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings www.bgs.org.uk/index.php/fit-for-frailty ➢ Integrated care for older people with frailty: Innovative approaches in practice, BGS/RCGP (2016) http://www.rcgp.org.uk/about-us/news/2016/november/joining-up-care-for-older-people-with-frailty.aspx ➢ MDT Development – working toward an effective multidisciplinary/multiagency team, NHS England (2015) - https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf ➢ Characteristics of an effective MDT. National Cancer Action Team. 2010

specific focus as part of CGA on medication review and falls assessment – see below. ➢ An identified keyworker who acts as a case manager and coordinator of care across the system – community, primary and inpatient hospital care. ➢ Case management delivered through integrated locality-based teams. ➢ A multi-disciplinary care team led by clinician, usually a GP, wraps around the patient and is responsible for the patient from pre-admission, during admission and post admission. ➢ The case manager or MDT designs the care plan with the patient and carer (informed decisions), if appropriate. The care plan is shared with providers across the system and implemented by MDTs and updated appropriately (e.g. in response to a crisis). ➢ Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role. ➢ A comprehensive service for those people with dementia and mental health problems must be available and accessible. ➢ A comprehensive service for those with palliative care needs must be available and accessible ○ Identification through GP lists ○ Tools are used systematically to identify frail older people at the end of their life ○ IT systems support coordination ○ Advance care planning is not seen as a one-off event ○ Equitable access to specialist palliative care services ➢ Services are available to reduce polypharmacy in frail older people. ➢ For those people living in care homes, implementation of the Enhanced Health in Care Homes (EHCH) framework should be considered.	http://www.ncin.org.uk/view?rid=136 ➢ Personalised Care Planning templates and guidance, including templates for advance care plans, emergency care and treatment plans, NHS England - https://www.nhs.uk/conditions/social-care-and-support/care-plans/ ➢ Age UK report. Supporting older people – Improving later life. Services for older people what works https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Services-what_works_spreads.pdf?dtrk=true ➢ Hidden in Plain Sight by Age UK https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Policy/health-and-wellbeing/Hidden_in_plain_sight_older_peoples_mental_health.pdf?dtrk=true ➢ Quest for Quality - a call for leadership, partnership and quality improvement, British Geriatrics Society (2011) - http://www.bgs.org.uk/campaigns/carehomes/quest_quality_care_homes.pdf ➢ NHS England: Enhanced Health in Care Homes site. Useful tools for implementation and building new care model. https://future.nhs.uk/connect.ti/carehomes/grouphome ➢ Effective Healthcare for Older People Living in Care Homes, British Geriatrics Society (2016) - http://www.bgs.org.uk/pdfs/2016_bgs_commissioning_guidance.pdf ➢ GP services for older people: a guide for care home managers, Social Care Institute for Excellence [SCIE] (2013) - https://www.scie.org.uk/publications/guides/guide52/gp-roles/relationships.asp ➢ Clinical input to care homes, NHS England Quick Guide (2016) - https://www.nhs.uk/NHSEngland/keogh-

	review/Documents/quick-guides/Quick-Guide-clinical-input-to-care-homes.pdf ➢ NICE quality standard on nutrition support in adults - https://www.nice.org.uk/guidance/qs24 ➢ 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. ➢ Malnutrition Universal Screening Tool (MUST), British Association of Parenteral and Enteral Nutrition [BAPEN] (2003) - http://www.bapen.org.uk/pdfs/must/must_full.pdf ➢ Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, NICE guideline [CG32] - https://www.nice.org.uk/guidance/cg32 ➢ Health toolkit to support the development of a hospital food and drink – https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ ➢ Commissioning excellent nutrition and hydration, Guidance, NHS England (2015) - https://www.england.nhs.uk/commissioning/nut-hyd/ ➢ Oral health for adults in care homes, NICE guideline [NG48] - https://www.nice.org.uk/guidance/ng48 ➢ Malnutrition Matters: A commitment to act - A three-step guide to improving nutritional care in England, British Association of Parenteral and Enteral Nutrition [BAPEN] (2004) - http://www.bapen.org.uk/pdfs/malnutrition-matters-a-commitment-to-act.pdf ➢ Hydr8 app case study, November 2016 - https://future.nhs.uk/connect.ti/carehomes/view?objectId=26525637 ➢ Faecal incontinence in adults: management. Clinical guideline [CG49] June 2007 https://www.nice.org.uk/guidance/cg49

	➢ Self-reported hearing impairment and the incidence of frailty in English Community-Dwelling Older Adults: A 4-Year Follow-Up Study https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5484326/ ➢ Naomi Feil, founder of Validation Therapy, shares a breakthrough moment of communication with Gladys Wilson, a woman who was diagnosed with Alzheimer's in 2000 and is virtually non-verbal. Learn more at www.memorybridge.org. https://www.youtube.com/watch?v=CrZXz10FcVM ➢ Delirium: prevention, diagnosis and management. Clinical guideline [CG103] July 2010 https://www.nice.org.uk/guidance/cg103 ➢ NICE quality standard on delirium - https://www.nice.org.uk/guidance/qs63 ➢ NICE quality standard on dementia: support in health and social care - https://www.nice.org.uk/guidance/qs1 ➢ NICE quality standard on dementia: independence and wellbeing - https://www.nice.org.uk/guidance/qs30 ➢ Joint declaration on post-diagnostic dementia care and support, Department of Health and partners (2016) - https://www.gov.uk/government/publications/dementia-post-diagnostic-care-and-support/dementia-post-diagnostic-care-and-support ➢ Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (**NICE, NG16**) ➢ Making a Difference in Dementia - Nursing Vision and Strategy, Department of Health (2016) - https://www.gov.uk/government/publications/dementia-nursing-vision-and-strategy ➢ Prime Minister's Challenge on Dementia 2020: Implementation Plan, Department of Health (2016) - https://assets.publishing.service.gov.uk/government/uploads

	/system/uploads/attachment_data/file/507981/PM_Dementia-main_acc.pdf ➢ Fix Dementia Care: NHS and care homes report, Alzheimer's society (2016) - https://www.alzheimers.org.uk/our-campaigns/fix-dementia-care ➢ Dementia: supporting people with dementia and their carers in health and social care, NICE Clinical guideline [CG42] - https://www.nice.org.uk/guidance/cg42 ➢ Dementia Core Skills Education and Training Framework, Skills for health, HEE (2015) - http://www.skillsforhealth.org.uk/services/item/176-dementia-core-skills-education-and-training-framework ➢ Shared Lives Plus scheme – supporting older people (including those with dementia) with day support and short breaks to aid living independently longer - https://sharedlivesplus.org.uk/ ➢ Deciding Right, a north east solution for making care decisions in advance. http://www.necn.nhs.uk/common-themes/deciding-right/ ➢ EPACCs - electronic systems that improve end of life care, Marie Curie - https://www.mariecurie.org.uk/globalassets/media/documents/commissioning-our-services/strategic-partnerships/rcgps/epaccs-electronic-systems-that-help-improve-care.pdf ➢ Commissioning toolkit for person centred end of life care. https://www.england.nhs.uk/publication/commissioning-person-centred-end-of-life-care-a-toolkit-for-health-and-social-care/ ➢ Specialist Palliative Level Care information for commissioners sets out what good SPC looks like from a system perspective - https://www.england.nhs.uk/wp-content/uploads/2016/04/speclst-palliatv-care-comms-guid.pdf

	➢ Information and links for professionals who support people and their families at the end of life, SCIE - https://www.scie.org.uk/adults/endoflifecare/ ➢ NICE quality standard on EOL care in adults - https://www.nice.org.uk/guidance/qs13 ➢ Hospice services: provider handbook, Care Quality Commission (2015) - http://www.cqc.org.uk/sites/default/files/20160422_ASC_hospice_provider_handbook_April%202016_update.pdf ➢ NICE quality standard on pressure ulcers - https://www.nice.org.uk/guidance/qs89 ➢ NICE impact study on End of Life care (in adults, last 2-3 days in acute settings) - https://www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/measuring-uptake/End-of-life-care-impact-report/nice-impact-end-of-life-care.pdf ➢ Minds that matter: understanding mental health in later life (interesting report) - https://www.independentage.org/policy-and-research/mentalhealth/minds-matter-report ➢ New EHCH guide (care provider alliance). This guide provides advice for care home managers on how to support their residents to benefit from the service - https://careprovideralliance.org.uk/enhanced-health-in-care-homes-cpa-guide ➢ King's Fund. Remote working Toolkit for GP and PCNs - https://www.kingsfund.org.uk/publications/remote-working-toolkit-general-practices-pcns

Evidence

IN DEVELOPMENT

COVID-19, frailty and access to CGA and case management

Best Practice

IN DEVELOPMENT

Useful resources

- NHS. Novel coronavirus (COVID-19) standard operating procedure: Community health services - https://www.england.nhs.uk/coronavirus/community-social-care-ambulance/community-health-services/
- GOV.UK guidance. COVID-19: guidance on home care provision - https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-on-home-care-provision
- COVID-19: Guidance for supported living - https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-for-supported-living-provision
- NICE. Advanced care planning. A quick guide for registered managers of care homes and home care services - https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/advance-care-planning
- NECS. Care home 'capacity bed tracker' - https://carehomes.necsu.nhs.uk/?ReturnUrl=%2Fhome
- Advanced care planning, escalation planning e.g. ReSPECT form - https://www.resus.org.uk/respect/
- RCGP. Joint statement on advance care planning - https://www.rcgp.org.uk/about-us/news/2020/april/joint-statement-on-advance-care-planning.aspx
- NHSE. My COVID-19 'advanced care plan' https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0485-appendix-acp-template-110520.pdf
- Specialist Pharmacy Service. COVID-19 - https://www.sps.nhs.uk/articles/summary-of-covid-19-medicines-guidance-palliative-and-end-of-life-care/
- BDA. Recommendations for community action by dietitians for older and vulnerable people living in their own home - https://www.bda.uk.com/resource/covid-19-recommendations-for-community-action-by-dietitians-for-older-and-vulnerable-people-living-in-their-own-home.html
  - SPS. COVID-19. Care Home: Clinical pharmacy - https://www.sps.nhs.uk/articles/care-homes-clinical-pharmacy/
  - COVID-19: Dementia and cognitive impairment, BGS -https://www.bgs.org.uk/resources/covid-19-dementia-and-cognitive-impairment

- ‘Challenging Behaviour’ and dementia in Gateshead:a guide to understanding, coping and responding - http://www.twca.org.uk/documents/Generic%20Documents/Dementia/Understanding%20and%20improving%20the%20care%20of%20a%20person%20with%20challenging%20behaviour%20V4%2018%2008%2010.pdf
- BGS. COVID-19: Dementia and cognitive impairment (look beyond the words) - https://www.bgs.org.uk/blog/atypical-covid-19-presentations-in-older-people-%E2%80%93-the-need-for-continued-vigilance and https://www.bgs.org.uk/resources/covid-19-dementia-and-cognitive-impairment
- Dementia UK. Video. Calming techniques (e.g. wearing PPE and assessing) https://www.dementiauk.org/get-support/maintaining-health-in-dementia-videos/#calming
- The 4AT can be downloaded from: http://www.the4AT.com
- COVID-10: Managing delirium in confirmed and suspected cases, BGS - https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases
- BGS. Coronavirus: Managing delirium in confirmed and suspected cases - https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases
- BGS webnair - Delirium and considerations during the Covid-19 pandemic (webinar) - https://www.bgs.org.uk/delirium-and-considerations-during-the-covid-19-pandemic
- GOV.UK looking after people who lack capacity during a pandemic - https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity
- Macmillan have produced a series of videos ‘Courageous Conversations’.
    - Scenario 1: Older patient with co-morbidities but currently well, GP calls phones to discuss advance care planning
    - Scenario 2: Patient at home with multiple co-morbidities, elderly and COVID symptoms
    - Scenario 3: Daughter of a patient in a care home phones her mother's GP on learning that her mother has COVID-19
- COVID-19, End of life care in older people, BGS https://www.bgs.org.uk/resources/covid-19-end-of-life-care-in-older-people
- COVID-19: End of life care and dementia, BGS - https://www.bgs.org.uk/resources/covid-19-end-of-life-care-and-dementia
- The Daffodil standards (RCGP and Marie Curie), EOL - https://www.rcgp.org.uk/daffodilstandards
- NICE. COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community - https://www.nice.org.uk/guidance/ng163
- Online training package (NENY – ACP training) - The package comprises:
    - One-hour recorded training session, delivered by the education hub leads from St Gemma’s Hospice in Leeds and Wakefield Hospice – link to access recording is here: https://vimeo.com/421448975
    - Supporting slide pack (see attached) – this will be uploaded to the Network website and the link will be made available
    - A guide to Advance Care Planning: http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/WYH%20STP/Advance%20Care%20Planning-a%20guide%20(002).pdf
    - My Future Wishes document (editable Advance Care Plan) http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Care%20Planning/ACP%20Resources/Advance_Care_Plan_May2020_editable.pdf
    - My Future Wishes Conversation Starter Pack – tool to enable people with any long term health condition to discuss and plan future wisheshttp://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Care%20Planning/Alzheimers%20resource/My%20Future%20Wishes%20Ca

re%20Pack%20PDF%20READ%20VIEW.pdf

Local stories (case studies)

IN DEVELOPMENT

Impact and measures

We know that the frailty has a significant impact of people, populations and health and care systems. Frail older people are highly susceptible to adverse health and care outcomes. Trying to understand this impact on people, populations and systems is challenging. The following examples are of possible benefits to offering access to a CGA and case management, outcomes measures to be considered as well as impact estimates based on current intelligence.

CGA and Case Management possible benefits

- Reduces mortality /improve independence after admission to hospital
- Reduce nursing home admission
- Improve functioning
- Likely to die in preferred place of death
- Reduces emergency, inpatient admissions and occupied bed days
- Improve patient and family satisfaction with care

Potential Impact

- In the North East and North Cumbria, an additional 506 people may develop dementia due to increasing numbers of people with frailty.
- Comprehensive Geriatric Assessment (CGA) is estimated to avoid one long-term care placement for every 20 people with a CGA.

https://www.england.nhs.uk/wp-content/uploads/2017/03/toolkit-general-practice-frailty-1.pdf

Potential measures

- People aged 65 years and over with moderate or severe frailty who are recorded as having had a fall in the preceding 12 months

- People aged 65 years and over, with depression or dementia, and who have moderate or severe frailty
- Measurement of loneliness / reduced loneliness
- The proportion of people (aged 65+ years) who use services who have control over their daily life
- A&E attendance rates for patients aged 65 years and over
- Emergency hospital admission rates for patients aged 65 and over

What works	**Resources**
Access to community crisis and recovery services with active recuperation, rehabilitation and reablement and including: • **frailty-focused transport** • **timely transfers of care from hospital, involving families and carers** • Offer crisis response with access to multi-disciplinary teams within 2 hours. • Single point of access with specialist opinion and diagnostics • Design adequate and flexible step-up and step-down home-based and bed-based rehabilitation and re-ablement services • Implement assertive discharge planning, early senior review, 'discharge to assess', a clear focus on flow and sharing information – 'date of discharge' within 2 hours and care package available within 24 hours of referral • Adopt a trusted assessor approach with access to step-up and step-down home-based and bed-based services - 2 days target • Adequate and timely information must be shared between services whenever there is a transfer of care between individuals or services	➢ Where Best – NHS England ➢ https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/reducing-long-term-stays/ ➢ IC audit NHS benchmarking ➢ https://www.nhsbenchmarking.nhs.uk/news/national-audit-of-intermediate-care-naic-2017-opens ➢ NAO report: discharging older people from hospital ➢ https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf ➢ NICE guidance: Transition of care ➢ https://www.nice.org.uk/guidance/ng27 ➢ A positive view of intermediate care for older people, John Young, Consultant Geriatrician www.wbna.org.uk/documents/Prof.%20John%20Young.pps ➢ Mytton et al (2012). Avoidable acute hospital admissions in older people. British Journal of Healthcare Management, 18(11). Pp 597-603. ➢ Updated provisions on the discharge of hospital patients with care and support needs contained in Schedule 3 to the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014 ➢ Person's capacity to consent, the principles of the Mental Capacity Act must be followed.

Intermediate care is a range of integrated services that offer crisis response to prevent hospital admission, safe and timely discharge from hospital as well as promoting robust recovery, recuperation and rehabilitation. There are 3 main aims: • Help people avoid going into (or remaining in) hospital unnecessarily; • Help people be as independent as possible after a stay in hospital; and • Prevent people from having to move into a care home until they really need to. Generally, services are categorised into bed-based and home-based services. The following are examples (based on National guidance) of what to consider when thinking about creating a responsive system outside of hospital that supports crisis intervention, recovery and recuperation. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf: ➢ Continuity of primary care with same day access. ➢ Co-ordinated social care. ➢ Adequate and flexible provision of step-up and step-down home-based and bed-based rehabilitation and re-ablement services ➢ Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics – including virtual/community wards and telecare. ➢ Ambulatory emergency pathways with access to multi-disciplinary teams should be available in less than 4 hours. ➢ Mental health services should contribute with specialist mental health assessments if appropriate. ➢ Specialist support through physiotherapy, occupational therapy, speech and language and dietetics should be readily available. ➢ An interface or community geriatrician service is available to provide expert clinical opinion. ➢ A personalised care plan ideally including (if appropriate) an emergency contingency plan, advanced care plan and 'allow a natural death' order	➢ National Intermediate Care (2015) summary report - https://static1.squarespace.com/static/58d8d0ffe4fcb5ad94cde63e/t/58fdcee4ebbd1a41121eab37/1493028638949/NAICReport2015FINALA4printableversion.pdf ➢ NHS website national intermediate care audit - https://www.nhsbenchmarking.nhs.uk/news/national-audit-of-intermediate-care-naic-2017-opens ➢ Commissioning Guidance for Rehabilitation, NHS England (2016). Includes and number of top tips including specific reference to care homes as settings for rehabilitation - https://www.england.nhs.uk/ahp/improving-rehabilitation/ ➢ Allied Health Professionals into Action - the potential and role of AHPs within the health, social and wider care system - https://www.england.nhs.uk/ahp/ ➢ Reablement: a guide for frontline staff. England. North East Improvement and Efficiency partnership, Office for public management (2010) – https://www.scie-socialcareonline.org.uk/reablement-a-guide-for-frontline-staff/r/a11G00000017so8IAA ➢ Resources for home care providers, GPs, commissioners and families on how to deliver - https://www.scie.org.uk/reablement/ ➢ NHSE website – what's next for England's Ambulance services. https://www.england.nhs.uk/2017/08/what-next-for-englands-ambulance-services/ ➢ The Acute Frailty Network is a multi-professional initiative that seeks to optimise secondary care of frail older people in England - https://www.acutefrailtynetwork.org.uk/ ➢ Transforming urgent and emergency care services in England. Update on the Urgent and Emergency Care Review, NHS England (2014) - https://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf

documentation. The care plan should ideally include known baselines, physical and mental health and functional status. ➢ There are shared care protocols with ambulance organisations that can enable older people to remain at home. ➢ There is a hospital based multi-disciplinary team located at the front door of the hospital integrated with the community team and focused on the facilitation of discharge. ➢ Early senior assessment, assertive discharge planning, and a clear focus on patient flow. ➢ Discharge to an older person's normal residence should be possible within 24 hours, seven days a week. ➢ Older people being admitted following an urgent care episode should have an expected discharge date set within two hours. ➢ Care packages to support discharge should be available within 24 hours of referral to Adult Care and Support. ➢ Adequate and timely information must be shared between services whenever there is a transfer of care between individuals or services. ➢ When preparing for discharge, older people and carers should be offered details of local voluntary sector organisations. ➢ Voluntary sector services should be available to provide a 'welcome home' 7 days a week. ➢ Strengthening post-discharge assessment and support. ➢ Rapid access to housing adaptations and aids.	➢ Improving referral pathways between urgent and emergency services in England: Advice for Urgent and Emergency Care Networks, NHS England (2015) – https://www.nhs.uk/NHSEngland/keogh-review/Documents/improving-referral-pathways-v1-FINAL.PDF ➢ Quality care for older people with urgent and emergency - http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf ➢ Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27], Guideline, NICE (2016) - https://www.nice.org.uk/guidance/ng27 ➢ The Keogh Urgent Care Review - Quick guides, NHS England - https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx ➢ High Impact Change Model for reducing delayed transfers of care, LGA, ADASS, NHSI, NHSE, DH - https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model ➢ Supporting patients' choices to avoid long hospital stays, NHS England Quick guide - https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf ➢ Discharge to assess, NHS England Quick guide - https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf ➢ Improving hospital discharge into the care sector, NHS England Quick guide - https://www.nhs.uk/NHSEngland/keogh-

	review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf ➢ Identifying local care home placements, NHS England Quick guide - https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Identifying-local-care-home-placements.pdf ➢ Hospital2Home resource pack, Housing LIN - information to support hospital discharge - https://www.housinglin.org.uk/hospital2home_pack/ ➢ Coordinate my care - http://coordinatemycare.co.uk/ ➢ NICE guideline: Intermediate care including reablement [NG74] https://www.nice.org.uk/guidance/ng74 ➢ NICE links to resources and tools for home care for older people - https://pathways.nice.org.uk/pathways/home-care-for-older-people#content=view-info-category%3Aview-about-menu. Guidance: https://www.nice.org.uk/guidance/ng21 ➢ NICE quality standard on transition between inpatient hospital settings and community or care home settings for adults with social care needs - https://www.nice.org.uk/guidance/qs136 ➢ For more on medicines-related communication and medicines reconciliation during transitions, see sections 1.2 and 1.3 in NICE's guideline on medicines optimisation and section 1.3 in NICE's guideline on managing medicines in care homes. ➢ NHSE hospital discharge service policy (4 pathways, single co-Ordinator and home first policy) https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model and action cards (for staff) - https://assets.publishing.service.gov.uk/government/uploads

	/system/uploads/attachment_data/file/911214/Hospital_discharge_service_requirements_action_cards.pdf ➢ Social Care 'winter plan' - BGS support plan (chief nurse, free PHE, funds transport for staff, test results prior to discharge https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021 ➢ HealthWatch and BRC survey (DTA model) - https://www.healthwatch.co.uk/news/2020-10-27/hospital-discharge-must-be-improved-manage-covid-19-second-peak ➢ NHS confederation. Case studies of learning in community service delivery (8 themes) - https://www.nhsconfed.org/networks/community-network/shared-learning-in-community-health-services
Benefits • Reduce the likelihood of living in residential care at six months' follow-up when avoiding acute hospital admission • Decrease treatment costs compared with admission to acute hospital when excluding caregiver costs • Increase patient satisfaction • Reduce length of stay for people who can be safely discharged early from acute hospital • Increase the number of patients discharged home, rather than to an institution, after three months (although this was not sustained at six months) • Reduce ongoing care needs • Improve functional status when compared with usual home care	
Evidence **IN DEVELOPMENT**	

COVID-19, frailty and community crisis and recovery services

Best Practice

IN DEVELOPMENT

Useful Resources

- COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community, NICE - https://www.nice.org.uk/guidance/ng165
- NHSE/Social Care guidance – step down care COVID-19 https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings
- London 'Care home' resource pack – COVID-19 - https://healthinnovationnetwork.com/wp-content/uploads/2020/05/Care-Home-Resource-Pack-1.1-FINAL3.pdf
- Moving between hospital and home, including care homes - https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/moving-between-hospital-and-home-including-care-homes
- Admission and Care of residents during COVID-19 incident in care homes - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880274/Admission_and_Care_of_Residents_during_COVID-19_Incident_in_a_Care_Home.pdf
- BGS. COVID-19. Managing the COVID-19 pandemic in care homes for older people - https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes
- HEE - New online video training for care home staff (deteriorating patient) - https://uclpartners.com/news-item/new-online-video-training-for-care-home-staff/?utm_source=partnership-press&utm_medium=email
- RCGP clinical management resources - https://elearning.rcgp.org.uk/mod/page/view.php?id=10550
- ASHN videos – supporting patients - https://www.ahsnnetwork.com/new-online-video-training-launched-for-care-home-staff
- Useful local videos
  - Use of a Pulse Oximetry - https://vimeo.com/425543209
  - Understanding care needs in a recovering COVID 19 patient - https://vimeo.com/423176181/8abd9b5422
  - Use of PPE in a care home or home care setting - https://vimeo.com/408471512
- NHSE. Pulse oximetry to detect early deterioration of patients with COVID-19 in primary and community care settings https://www.england.nhs.uk/coronavirus/publication/pulse-oximetry-to-detect-early-deterioration-of-patients-with-covid-19-in-primary-and-community-care-settings/
- BGS. Rehabilitation of older people (policies and guidance) - https://www.bgs.org.uk/resources/covid-19-rehabilitation-of-older-people
- NICE corticosteroids in COVID-19 - https://www.nice.org.uk/guidance/ng159/resources/covid19-prescribing-briefing-corticosteroids-pdf-8839913581
- NHSE Community Rehabilitation Toolkit - https://www.england.nhs.uk/rightcare/products/pathways/community-rehabilitation-toolkit/

- Age and Ageing. The COVID-19 rehabilitation pandemic - https://academic.oup.com/ageing/article/doi/10.1093/ageing/afaa118/5848215
- NHS online – REHAB service (information) - https://www.england.nhs.uk/2020/07/nhs-to-launch-ground-breaking-online-covid-19-rehab-service/)
- SPIKES, breaking bad news principles - https://ubccpd.ca/sites/ubccpd.ca/files/SPIKES%20Protocol%20for%20Breaking%20Bad%20News.pdf
- COVID-19: guidance for care of the deceased - https://www.gov.uk/government/publications/covid-19-guidance-for-care-of-the-deceased
- NHS England - Pulse oximetry to detect early deterioration of patients with COVID-19 in primary and community care settings https://www.england.nhs.uk/coronavirus/publication/pulse-oximetry-to-detect-early-deterioration-of-patients-with-covid-19-in-primary-and-community-care-settings/
- BGS links to all things 'rehab' post COVID-19 - https://www.bgs.org.uk/resources/covid-19-rehabilitation-of-older-people
- NHSE aftercare needs of inpatients recovering from COVID-19 - https://www.cambscommunityservices.nhs.uk/docs/default-source/luton-adults-general/c0388_after_care_needs_of_inpatients_recovering_from_covid-19_5_june_2020.pdf
- Virtual Wards (roll out pulse COVID oximetry @home service https://www.weahsn.net/wp-content/uploads/2020/10/Covid-Virtual-Wards-Briefing-October-2020.pdf
- LONG COVID - taskforce, clinics, online recovery hub, New NICE guidance and Research funding):
    - NHSE - National Guidance for post-COVID syndrome assessment clinics - https://www.england.nhs.uk/coronavirus/publication/national-guidance-for-post-covid-syndrome-assessment-clinics/
    - Patient safety learning – LONG COVID-19 - https://www.patientsafetylearning.org/press-releases/nhs-announces-five-point-package-to-support-long-covid-patients
    - Living with COVID-19 – NHIR theme review - https://evidence.nihr.ac.uk/themedreview/living-with-covid19/
- Urgent Community Response (technical guidance) – 2h/2d - file:///Users/Danielcowie/Downloads/UCR_CSDS_TechnicalGuidance_FINAL.pdf

Local stories (case studies)

IN DEVELOPMENT

Impact and measures

We know that the frailty has a significant impact of people, populations and health and care systems. Frail older people are highly susceptible to adverse health and care outcomes. Trying to understand this impact on people, populations and systems is challenging. The following examples are of possible benefits to offering access to community crisis and recovery services and frailty-based hospital care, outcomes measures to be considered as well as impact estimates based on current intelligence.

Access to community crisis and recovery services and frailty-based care in hospital possible benefits:

- Reduce length of stay for people who can be safely discharged early from acute hospital
- Increase the number of patients discharged home, rather than to an institution, after three months (although this was not sustained at six months)
- Reduce ongoing care needs
- Improve functional status when compared with usual home care
- Reduction in falls, medication errors, VTEs, and delirium
- Reduced functional decline
- Improved experience of care
- Improved survival at home after discharge

Potential Impact

- The frail population (moderate and severe combined) makes up 2.44% of the population across the North East and North Cumbria, but account for 19.1% of general and acute bed usage.
- In the North East and North Cumbria region the average length of stay in hospital was 7.9 days for a person with frailty compared to 4.4 days for a non-frail person and the 30-day emergency readmission rate for the frail population was 20.7% compared to 16.9% for the non-frail population.

Potential measures

- People aged 65 years and over with severe frailty who have received an annual medication review
- A&E attendance rates for patients aged 65 years and over
- Emergency hospital admission rates for patients aged 65 and over
- Proportion of stranded patients in hospital: Length of stay 7+ and 21+ days
- Emergency readmissions within 30 days of discharge from hospital (patients aged 65 years and over)
- Hospital activity in the last year of life (patients aged 65+ years)
- Hospital Trust indicator set (Falls with harm, Pressure ulcers, Patient experience of hospital care, A&E waiting time 4 hour standard)

Approach	**Resources**

Timely access to experts offering frailty-based care in hospital with frailty assessment, diagnostics and pathways. • Implement a front door MDT to assess frailty, commence CGA with links to community teams and VSCE for robust discharge – 24/7 • Implement strategies to avoid unexpected deaths - warning scores, critical care outreach, regular senior review and adequate access to high dependency beds. • Create safer care - prevention and treatment of falls, pressure sores, hospital-acquired infection, medication errors, deep vein thrombosis and malnutrition, delirium and immobility as a result of bed rest. • Minimise in-patient moves (especially in patients with delirium) • Offer frailty liaison and in-reach services Hospital care requires a caring frailty environment that allows for front door recognition of frailty, followed by Comprehensive Geriatric Assessment and best practice care for frailty syndromes (falls, immobility, incontinence, polypharmacy, delirium), together with early inter-agency planning for discharge home to optimise care and prevent hospital related complications and deconditioning. The following are examples (based on National guidance) of what to consider when thinking about developing specialist frailty care, pathways and services within the hospital setting. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf: ➢ Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week.	**N.B. Many of the resources in the previous section are also relevant here.** ➢ Acute frailty on the AMU: The challenges. 2018 (slide deck AFN) - https://www.acutemedicine.org.uk/wp-content/uploads/2018/06/Acute-Frailty-Network.pdf . ➢ Health Foundation. Flow cost quality. https://www.health.org.uk/funding-and-partnerships/programmes/flow-cost-quality ➢ Healthcare Improvement Scotland. Care for older people hospital standards - http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/opah_standards.aspx ➢ NHS elect. Website with access to acute frailty care and case studies - https://www.nhselect.nhs.uk/ ➢ Toolkit – acute care of frail older people - http://www.acutemedicine.org.uk/wpcontent/uploads/2016/05/4.1-Managing-Acute-Frailty.pdf ➢ Acute care of older patients in the emergency department: strategies to improve patient outcomes - https://www.dovepress.com/acute-care-of-older-patients-in-the-emergency-department-strategies-to-peer-reviewed-fulltext-article-OAEM ➢ NHS Confederation, Growing old together: A report by the independent Commission on Improving Urgent Care for Older People - http://www.nhsconfed.org/resources/2016/01/growing-old-together-sharing-new-ways-to-support-older-people ➢ The Acute Frailty Network is a multi-professional initiative that seeks to optimise secondary care of frail older people in England - https://www.acutefrailtynetwork.org.uk/ ➢ Presentation from Prof Simon Conroy AFN (Acute Frailty Network) -

➢ Specialist assessment should be available within 12 hours of admission, seven days a week (ideally, proactive identification of frailty within 4 hours). ➢ The presence of one or more frailty syndromes should trigger a comprehensive geriatric assessment. ➢ Sufficient specialty and community hospital beds to look after all frail older patients with complex needs and enough relevantly trained staff to deliver high-quality care and assessment for them. ➢ Employ 'trusted assessment' to identify those who will benefit from intermediate care. ➢ Strategies to reduce avoidable unexpected mortality should be in place - warning scores, critical care outreach, regular senior review and adequate access to high dependency beds. ➢ Hospitals make safer care for older people a key priority - prevention and treatment of falls, pressure sores, hospital-acquired infection, medication errors, deep vein thrombosis and malnutrition, delirium and immobility as a result of bed rest. ➢ Minimising in-patient moves for those older people identified as frail especially those with delirium. ➢ Liaison and in-reach services for frail older people under other medical and surgical specialities including psychiatric services (e.g. dementia and mental health problems). ➢ An identified Frailty Unit/Service may be considered and desirable with staff trained in how to look after frail people focusing on rapid assessment, treatment and rapid discharge. ➢ Adequate and timely information must be shared between services whenever there is a transfer of care between individuals, carers (paid or unpaid) and services. ➢ The recognition of carers (formal and informal) as crucial parts of the team. ➢ Advice on appropriate housing and adaptations.	https://www.acutefrailtynetwork.org.uk/uploads/files/1/Events/AFN%20Conference%20Presentations%202017/Professor%20Simon%20Conroy.pdf ➢ Silver Book. Guidelines for the emergency care of older people. https://britishgeriatricssociety.wordpress.com/2012/06/21/the-silver-book-guidelines-for-the-emergency-care-of-older-people/ ➢ Acutely ill adults in hospital: recognising and responding to deterioration. NICE - http://www.nice.org.uk/CG50 ➢ British Geriatric Society. BLOG discussing acute care for older people in hospital - https://britishgeriatricssociety.wordpress.com/category/acute-care/ ➢ NHS elect. Website with access to acute frailty care and case studies - https://www.nhselect.nhs.uk/ ➢ Toolkit – acute care of frail older people - http://www.acutemedicine.org.uk/wp-content/uploads/2016/05/4.1-Managing-Acute-Frailty.pdf ➢ Comprehensive care. Older people living with frailty in hospital. NIHR themed review (2018) - https://www.dc.nihr.ac.uk/themed-reviews/frailty-in-hospital-research.htm ➢ The Older People's Commissioner for Wales is an independent voice and champion for older people across Wales, and 1000 Lives Improvement Falls Prevention program for Older People supports NHS Wales - http://www.olderpeoplewales.com/en/Home.aspx ➢ HSJ Commission on Hospital Care for Frail Older People (November 2014) - https://www.hsj.co.uk/download?ac=1292263 ➢ The Royal College of Physicians partnered three NHS organisations across England and Wales with the specific aim of improving the care of frail older patients as part of its

	Future Hospital programme - www.rcplondon.ac.uk/projects/future-hospital-programme ➢ NHS England (2013). Bed availability and occupancy - https://data.england.nhs.uk/group/bed_availability ➢ Covinsky, K. Loss of independence in activities of daily living in older adults hospitalised with medical illnesses Journal of the American Geriatric Society 20013;51(4):451-458. DOI:10.1046/j.1532-5415.2003.51152.x ➢ NICE guideline CG103 (2010). Delirium: prevention, diagnosis and management - https://www.nice.org.uk/guidance/cg103 ➢ NHS elect – principles and characteristics of 'same day care' – based on CSF and CGA MDT assessment - file:///Users/Danielcowie/Downloads/Acute_Frailty_Principles_and_Characteristics.pdf ➢ Acute Frailty Network – series of webnairs. Useful viewing - https://future.nhs.uk/connect.ti/SDEC_CommunityofPractice/view?objectId=24775536 ➢ BGS silver book II - Quality urgent care for older people ://www.bgs.org.uk/policy-and-media/leading-experts-in-frailty-launch-the-silver-book-ii-in-collaboration-with-the
Evidence **IN DEVELOPMENT**	
COVID-19, frailty-based care in hospital **Best Practice** **IN DEVELOPMENT**	

Useful Information

- COVID-19 rapid guideline: critical care in adults, NICE - https://www.nice.org.uk/guidance/ng159/chapter/2-Admission-to-critical-care
- Identification of frailty in over 65 year olds in an urgent care setting, why, what and how? Practical guide - https://static1.squarespace.com/static/5e7b2eaa0722746ffd56200a/t/5e958c17d955c310893427d8/1586859034233/Frailty.pdf
- Clinical management of persons admitted to hospital with suspected COVID-19 infection - https://www.england.nhs.uk/coronavirus/secondary-care/management-confirmed-coronavirus-covid-19/clinical-medical-management/
- Scottish Government. COVID19 Guidance: Clinical Advice - https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2020/04/coronavirus-covid-19-clinical-advice/documents/covid-19-cmo-clinical-advice-3-april-2020/covid-19-cmo-clinical-advice-3-april-2020/govscot%3Adocument/
- NICE. Sepsis: recognition, diagnosis and early management - https://www.nice.org.uk/guidance/ng51
- Guidelines on the management of acute respiratory distress syndrome - https://www.ficm.ac.uk/sites/default/files/ficm_ics_ards_guideline_-_july_2018.pdf
- BTS. BTS Guideline for oxygen use in healthcare and emergency setting - https://brit-thoracic.org.uk/quality-improvement/guidelines/emergency-oxygen/
- GOV UK - COVID-19: infection prevention and control (IPC) - https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control#anchor
- NHSE. COVID-19 hospital discharge service requirements - https://www.england.nhs.uk/coronavirus/publication/covid-19-hospital-discharge-service-requirements/
- COVID-19. Hospital Discharge Service Requirements - https://www.gov.uk/government/collections/hospital-discharge-service-guidance
- GOV. UK – Guidance for step-down of infection control precautions and discharging COVID-19 patients - https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/

Local stories (case studies)

IN DEVELOPMENT

Impact and measures

We know that the frailty has a significant impact of people, populations and health and care systems. Frail older people are highly susceptible to adverse health and care outcomes. Trying to understand this impact on people, populations and systems is challenging. The following examples are of possible benefits to offering access to community crisis and recovery services and frailty-based hospital care, outcomes measures to be considered as well as impact estimates based on current intelligence.

Access to community crisis and recovery services and frailty-based care in hospital possible benefits:

- Reduce length of stay for people who can be safely discharged early from acute hospital
- Increase the number of patients discharged home, rather than to an institution, after three months (although this was not sustained at six months)
- Reduce ongoing care needs
- Improve functional status when compared with usual home care
- Reduction in falls, medication errors, VTEs, and delirium
- Reduced functional decline
- Improved experience of care
- Improved survival at home after discharge

Potential Impact

- The frail population (moderate and severe combined) makes up 2.44% of the population across the North East and North Cumbria, but account for 19.1% of general and acute bed usage.
- In the North East and North Cumbria region the average length of stay in hospital was 7.9 days for a person with frailty compared to 4.4 days for a non-frail person and the 30-day emergency readmission rate for the frail population was 20.7% compared to 16.9% for the non-frail population.

Potential measures

- People aged 65 years and over with severe frailty who have received an annual medication review
- A&E attendance rates for patients aged 65 years and over
- Emergency hospital admission rates for patients aged 65 and over
- Proportion of stranded patients in hospital: Length of stay 7+ and 21+ days
- Emergency readmissions within 30 days of discharge from hospital (patients aged 65 years and over)
- Hospital activity in the last year of life (patients aged 65+ years)

- Hospital Trust indicator set (Falls with harm, Pressure ulcers, Patient experience of hospital care, A&E waiting time 4 hour standard)

VIII. Evaluate

It is crucial that the 'Community of Practice' creates an environment that supports reflection, development and collaborative actions to enable measurement to be used to advance health and care and minimise unintended consequences.

Regional frailty outcomes and improvement measures will be evaluated across the categories of:

- health and wellbeing
- care and quality
- sustainability of services
- transformational care delivery

There is growing recognition that measures should be based upon health and wellbeing as that is what is most important to people and communities. For example, measures such as independence, empowerment and social connection.

There is a balanced dashboard of standards and outcome measures in development relating to care and support of older people, families and communities living with frailty. The outcomes should reflect multilevel health and care outcomes around integration and coordination of care, and ongoing relationships (individuals, families, and communities) with principles of inclusion and equity.

The following table is based on a review of regional and national work. The outcome measures are evidence based and will complement those outcomes being used currently (or in the future) by CCGs, LAs and Public Health to incentivise 'best practice' service redesign in older people's care and support.

The Frailty iCARE evaluation strategy needs to meet the requirements of the toolkit and the purpose of the Community of Practice. The initial outcomes metrics report will provide a clear picture of the current achievement level and degree of variation for each metric at organisation level across the NE&NC. Relevant national targets and standards will be included in addition to appropriate benchmarks, with a one-page summary at the start. It is anticipated that the report will help to identify opportunities and challenges. It is important to obtain the continued involvement of Community of Practice members for feedback and input to help identify good practice and priority areas for development. The list of metrics will be refined in line with improved data availability as this is an evolving process. Community of Practice members will also contribute to the development of the outcomes metrics by highlighting key interventions that have been introduced and are planned through the various care approaches across the NE&NC.

Regional Frailty Outcomes and Measures

No.	Part of system	Metric	Organisation level
1	Primary Care	Number of patients who have had a frailty assessment	GP practice / CCG
2	Primary Care	Number of patients who are identified as living with frailty, and the degree of their condition (mild, moderate, severe)	GP practice / CCG
3	Primary Care	Number of patients with severe frailty, recorded as having had a fall in the preceding 12 months	GP practice / CCG
4	Primary Care	Proportion of people with severe frailty who have their written care plan reviewed with them regularly (minimum requirement annually)	GP practice / CCG
5	Primary Care	Number of patients aged 65+ years with 10 or more unique medications	GP practice / CCG
6	Care in the community	The proportion of people who use services who have control over their daily life	Local authority
7	Care in the community	The proportion of people who use services who reported that they had as much social contact as they would like	Local authority
8	Mental Health	The rate of those aged 65+ with a recorded diagnosis of dementia compared to those estimated to have dementia based on the CFAS II model	CCG
9	Emergency care	A&E attendance rates for patients aged 65+ years	GP practice / CCG
10	Emergency care	Unplanned admission rates for patients aged 65+ years	GP practice / CCG
11	Emergency care	Emergency readmissions within 30 days of discharge from hospital for those aged 65+ years	GP practice / CCG
12	In hospital delays	Stranded patient: LOS 7+ and 21+ days	GP practice / CCG
13	Social care - discharge	The proportion of older people (aged 65+years) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Local authority
14	Social care - discharge	Long-term support needs of older adults (aged 65+ years) met by admission to residential and nursing care homes, per 100,000 population	Local authority
15	Mortality	Percentage of deaths in usual place of residence for those aged 65+ years	CCG
16	Primary care	Flu immunisation rate in people aged 65+ years	CCG
17	Care in the community	Reduced loneliness	to be determined
18	Care in the community	Number of people referred into social prescribing schemes and number of people rejecting a referral (patients aged 65+ years)	CCG
19	Primary Care	Patients on the MH registers (dementia, depression and anxiety) and with frailty	GP practice / CCG

20	Care in the community	Carer reported quality of life	Local authority
21	Emergency care	Conversion rates (A&E attendance to emergency admission) for patients aged 65+ years	GP practice / CCG
22	Emergency care	Hospital activity in the last year of life for those aged 65+ years	GP practice / CCG
23	Secondary care	Composite quality bundle: A&E 4 hr compliance, Falls, pressure ulcers, improved patient experience, discharge to normal place of care.	Hospital trust

The following is links to the current available metrics reports (http://frailtyicare.org.uk/making-it-happen/measures/metrics/)

The North East Quality Observatory (NEQOS) and the North of England Commissioning Support Unit (NECS) have both contributed to the development of the regional frailty measures section of the frailty toolkit.
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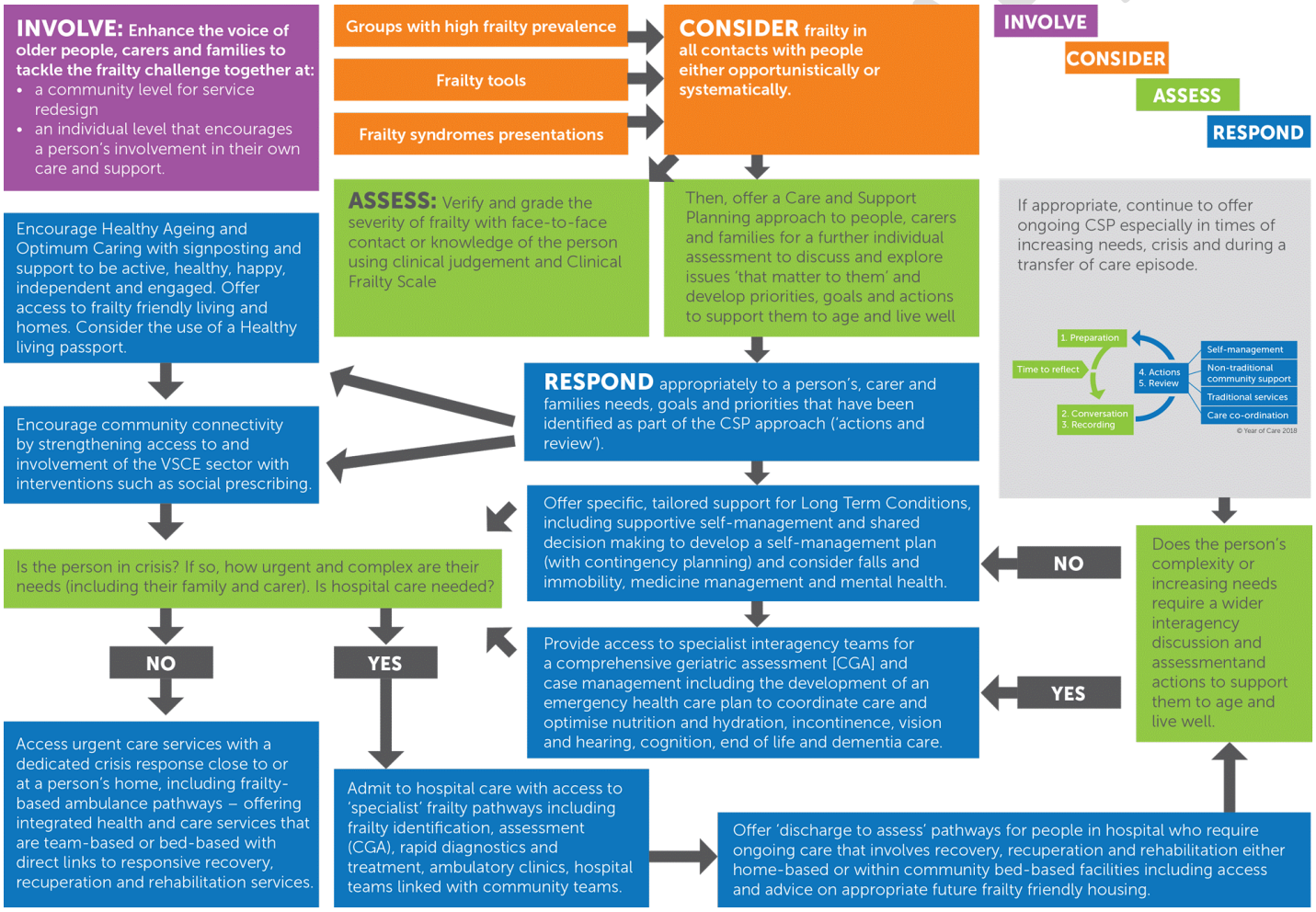
Research and evaluation

To fully realise the ***Frailty iCARE*** toolkit and measure its wider impact across various aspects, including and beyond the measures listed here, we have started to collaborate with our local universities and NHS research & evidence teams to help with evidence synthesis and to explore the evaluation and research potential for the future. As part of this work we are working closely with the regional NIHR ARC (Applied Research Collaboration) NENC team).

IX. An Example of a Frailty Pathway

The following is an example of how we can see our ***Frailty iCARE*** Toolkit translated into a 'pathway' of care. Clearly, each local health and care economy (LHE) would have an approach that is locally unique in delivery. It is crucially important that each LHE starts to 'map out' local delivery underpinned by consideration of the workforce, skills and training implications.



X. Making it Happen

Making it happen by implementing new ways of working (or new care models) is not easy. It is accepted that coordinated care and support is what people need but it is understood that implementation requires *real* sustainable partnerships. Importantly it is also acknowledged that evidence for cost effectiveness and longer-term outcomes is still emerging for some elements of care delivery and service developments. Nevertheless, collective challenges need to become collective opportunities.

The Regional Frailty Community of Practice

The *Regional Frailty Community of Practice* will explore the challenges of frailty, not just those directly related to care delivery but related matters such as engagement and involvement, workforce development and digital solutions. In turn, this will improve our collective understanding of frailty and maximise efforts so that recommendations are made based on a robust evidence base. The community will be created by bringing together frailty experts, from across the system, who are willing to learn, share and push the boundaries of knowledge about frailty. They will be leaders in their own localities and will be able to influence care delivery and service developments there, as well as drive regional progress. For ***Frailty iCARE*** to be successful, system leaders have to agree that the community of practice is supported and that its recommendations will be prioritised in regional planning.

In order to establish and nurture our Community of Practice, 3 key elements will be developed [1]:

Working together, this community will:

- Develop a strategic voice and vision for frailty.
- Drive transformation in preventing frailty and supporting people, families and communities living with frailty.
- Collate and curate a body of knowledge around frailty, which can be shared across the region and more widely.

They will achieve this by:

- Sharing and learning from existing knowledge
- Identifying gaps, priorities and common challenges
- Generating and sharing new knowledge and new ways of working; better tools and processes; and innovative solutions to common challenges.

A key part of the Community of Practice's work will be to seek out examples of good practice to incorporate into the *Frailty iCARE* Toolkit. These might be proven good practice models, which could be readily replicated at a local, regional and national level; emerging evidence from pilot projects which show early promise; or ideas for models that should work but are as yet untested. Where examples are included in the *Frailty iCARE* toolkit, it will be made clear which of those categories they fall into, what their current evidence base is (including cost-effectiveness) and what the key success factors/pitfalls are. The 'how to' detail to support implementation will be included.
The community will also explore interventions that have not worked particularly well, from which others can learn.

Workforce development (including training and education)

To fully realise the ***Frailty iCARE*** toolkit, a robust workforce infrastructure is required for people, staff and commissioners that is fit-for-purpose. There are two huge challenges facing the care system today; an ageing population and a resource challenge. These challenges are compounded by the fact that we have capacity and capability gaps within our existing workforce that cares for older people, not least because traditionally only medicine had speciality focussed training. Other care disciplines most often had to become experts by experience, very often working closely with their geriatrician and old age psychiatry medical colleagues to glean specialist knowledge in order to become specialist and expert within their own field and in their own right. Furthermore, because specialist medical services have always understood the need for multidisciplinary team working then inter-professional learning occurred with therapists and nurses developing an appreciation for both the things they had in common as well as the uniqueness of their discipline. The modern day challenge of these specialist departments however is that they remain secondary care focussed which means that there is a risk of specialist knowledge being trapped within secondary care institutions. This risk must be mitigated against because in an ageing population world, where not all those living with frailty are in hospital, specialist knowledge and skills needs to be available right across the care system. Hence, it is fundamental we work in partnership across the region with our universities, colleges, training institutes and employers to make training and a career in older people's care an attractive and rewarding choice. This last point presents a leadership challenge of shifting the culture away from older people's care either not being viewed as specialist or of being seen as an unattractive career option.

What works	Resources
	➢ Skills for Health, NHS England, and Health Education England are developing a core capabilities framework to support development of the workforce caring for older people living with frailty - http://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework ➢ Enhanced Health in Care Homes (NHSE) – learning guide on 'workforce development' - https://future.nhs.uk/connect.ti/carehomes/view?objectId=8962320&exp=e1 ➢ Fusion48 - http://fusion48.net/frailty ➢ Teaching Care Home, a ground-breaking, nurse-led pilot to improve the learning environment for staff

	working in homes, undergraduate nurse apprenticeships and all learning placements in care homes. Care England / Department of Health - http://www.careengland.org.uk/teaching-care-home ➢ Skills for Care learning and development pages - https://www.skillsforcare.org.uk/Learning-development/Learning-and-development.aspx ➢ SCIE care provider pages - https://www.scie.org.uk/care-providers/ ➢ Royal College of GPs (RCGP) eLearning resources (may require registration or log-in) - http://elearning.rcgp.org.uk/mod/page/view.php?id=3927 ➢ Skills for Care - finding and keeping staff - https://www.skillsforcare.org.uk/Recruitment-retention/Finding-and-keeping-workers/Finding-and-keeping-workers.aspx ➢ The Calderdale Framework - Provides a systematic, objective method of reviewing skill, role and service redesign - http://www.calderdaleframework.com/ ➢ Resources on values based recruitment, Health Education England (2016) - https://hee.nhs.uk/our-work/values-based-recruitment ➢ Nursing times / Care England Microsite • Resources for Older People Nurses - https://www.nursingtimes.net/roles/older-people-nurses • Resources for Learning Disability Nurses - https://www.nursingtimes.net/roles/learning-disability-nurses • Care sector resources - https://www.nursingtimes.net/careengland ➢ Report - creating a workforce for the future – new collaborative approach between NHS and colleges of England - https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Report_Creating-the-workforce-of-the-future_FNL.pdf ➢ - https://www.kingsfund.org.uk/publications/remote-working-toolkit-general-practices-pcns ➢ Personalized Care – training support and embedding PC roles in PCNs - https://future.nhs.uk/PCCN/view?objectid=96252581
Local stories	
EnCOP - http://frailtyicare.org.uk/making-it-happen/workforce/ The Enhanced Care of Older People Competency Framework (EnCOP)] was the result of collaborative research undertaken through the leadership of Northumbria University 2016–18. The aim was to really understand workforce development needs and challenges and since 2018 the framework has been able to progress via the Ageing Well Network of North East and North Cumbria. EnCOP defines three levels of practice; essential, specialist and advanced and includes four inter-related domains all underpinned by a set of competencies:	

1. Values and attitudes
2. Workforce collaboration, co-operation and support
3. Leading, organising, managing and improving care
4. Knowledge and skills for care delivery

The vision to further develop the framework, which is standardised and evidence based, has been possible following investment by the Integrated Care System Workforce Transformation and Strategy Board. The funding allowed for the introduction of two Strategic Workforce Development posts which are shared by four health care professionals each with expertise in the care of older people.

Using a cascade model the postholders are working with colleagues and local leaders across the region to support the development of local competency assessor roles in order to ensure they can validly and reliably assess others within their teams. Care has been taken to involve all parts of the care sector and a variety of staff and disciplines are included in this year one roll out.

Evidence

Advantage JA site – building workforce capacity on frailty prevention - http://advantageja.eu/images/WP8-1-Building-workforce-capacity-on-frailty-prevention-a-Systematic-Review.pdf

- ADVANTAGE JA were not able to identify evidence on efficacy, effectiveness or sustainability of training programs for any profession involved in the prevention of frailty, neither from scientific literature nor from European Union (EU) funded projects.
- ADVANTAGE JA recommend further structured funding of innovation and research for education and training of healthcare work force involved in the ageing process of European citizens.

Information sharing (including data, IT and technology)

To fully realise the ***Frailty iCARE*** toolkit, a digital infrastructure is required for people, staff and commissioners that is fit-for-purpose. It must permit appropriate access to care records, allow data-sharing for planning of provision and commissioning, and support the use of assistive technology and telemedicine.

Regional Digital Care programme

The vision for the digital care enabling programme is "to enable the delivery of high quality, efficient health and care services, to the populations of the North East and Cumbria through the adoption of digital solutions and services".

This will be delivered through:

- Enabling robust, secure and appropriate infrastructure
- Mature Digital Providers and associated services
- Interoperable and Collaborative systems and resources
- Promotion of digital first, self-sufficient care delivered closer to home in neighbourhoods and communities (Care closer to home)
- Dynamic system planning & delivery underpinned through evidence, driven through data and analytical services

The programme will

- Maximise use of existing infrastructure, investments and assets to achieve greatest benefit from our limited budgets.
- Align to and facilitate local delivery of national IT systems, and national strategies e.g. Paper Free at Point of Care by 2020.
- Carefully plan and manage information governance to avoid privacy concerns and pitfalls of previous national programmes.
- Work in partnership and collaborate, realising economies of scale by fully utilising available workforce and technologies

What works	Resources
	➢ NHSE enhanced health in care homes – learning guide on data, IT and technology - https://future.nhs.uk/connect.ti/carehomes/view?objectId=8962352&exp=e1 ➢ Great North care Record website - https://www.greatnorthcarerecord.org.uk/ ➢ Great North Care Record network (Connected Cities) - https://www.connectedhealthcities.org/news-and-events/events/great-north-care-record-network-launch/ ➢ GNCR technical report Nov 2017 - https://www.greatnorthcarerecord.org.uk/wp-

	content/uploads/2017/01/CHC-GNCR-Final-Report-0v20-clean-1.pdf ➢ Personalised Care Planning templates and guidance, including templates for advance care plans, emergency care and treatment plans, NHS England - https://www.nhs.uk/conditions/social-care-and-support/care-plans/ ➢ EPACCs - electronic systems that improve end of life care, Marie Curie - https://www.mariecurie.org.uk/globalassets/media/documents/commissioning-our-services/strategic-partnerships/rcgps/epaccs-electronic-systems-that-help-improve-care.pdf ➢ Sharing patient information, NHSE Quick guide - https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-sharing-patient-information.pdf ➢ Information Governance toolkit, NHS Digital - https://www.igt.hscic.gov.uk/ ➢ Guidance for Care Homes completing their first IG toolkit - https://www.igt.hscic.gov.uk/WhatsNewDocuments/Guidance%20for%20Care%20Homes%20on%20Completing%20their%20first%20IG%20Toolkit%20v2.0.pdf ➢ Technology Enabled Care Services, NHS England - https://www.england.nhs.uk/tecs/ ➢ Transforming social care through technology, LGA / Institute of Public Care (2016) - https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/transforming-care-through-technology ➢ Technology in care homes, NHSE Quick Guide - https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Technology-in-care-homes.pdf ➢ Technology Enabled Care Services Resource for Commissioners, NHS England (2015) – https://www.england.nhs.uk/digitaltechnology/ ➢ NHSE (ageing well) - digital maturity in community health care - file:///Users/Danielcowie/Downloads/Ideas_on_national_digital_transformation_in_the_community.pdf ➢ Health and care – Digital support website (videos) - https://healthandcarevideos.uk/eol ➢ NHS reset – what we have learnt through COVID-19 - https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/NHS-Reset_Best-practice-and-innovation_FNL.pdf ➢ NHSE/I guidance –proxy access to GP records - https://www.england.nhs.uk/ourwork/clinical-policy/proxy-access-to-gp-online-services-by-care-

	home-staff-guidance-for-care-homes-and-gp-practices/ ➢ Age briefing Paper. Digital excluded review - https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/digital-inclusion-in-the-pandemic-final-march-2021.pdf

Local stories

Digital Comprehensive Geriatric Assessment (iCGA) Pilot - http://frailtyicare.org.uk/making-it-happen/information-sharing/

- Comprehensive Geriatric Assessment (CGA) is the cornerstone of 'best practice' to support people and families living with increasing levels of frailty.
- i-CGA is based upon the well evidenced CGA and the design includes the recommendations of the British Geriatric Society *CGA Toolkit for Primary Care Practitioners* [2019]. This tool aims to facilitate an integrated MDT approach with use of a single system digital tool (being developed by Health Call, the North East NHS regional digital platform). Health Call will provide the technological solution to enable:
    - A range of disciplines with insights beneficial to the care planning procedure to record information in one central repository
    - The named care coordinator to remotely coordinate the collection of data from the most appropriate individuals in each scenario
    - The automatic calculation of assessment tool scores
    - The automatic triggering of recommendations for further discussion with clinical or other (for example, local authority) specialists
    - The amalgamation of data into a digital format that usefully informs the MDT
    - The integration of the data into GP systems
    - Overall, the digital tool will facilitate workforce development around improving a MDT model for care delivery, as well as offering an environment for learning through expertise and knowledge sharing.

Evidence

There is lack of robust evidence to suggest 'whole system transformation' of digitally aided are to support frail elderly population - *The Evidence Base for an Ideal Care Pathway for Frail Multimorbid Elderly: Combined Scoping and Systematic Intervention Review -* https://www.jmir.org/2019/4/e12517/

XI. Conclusion

Frailty is an increasing challenge for the whole care structure and while individual local areas have started their journey, the ***Frailty iCARE*** Toolkit provides a unique opportunity for whole system change at a regional level. It is well documented that embracing good leadership methodologies and working in partnership is crucial, but so too is establishing a good evidence base for practice. Only then will we prevent frailty, improve the lives of those living with frailty and build a sustainable model for the future. A regional toolkit, with underpinning standards and outcomes, embedded within a community of practice

will prompt LHEs to move from seeing the ageing population as a challenge to a once in a lifetime opportunity to really get it right.

XII. References

Please note, the majority of the reference sources can be found as links from the 'resources' sections of the toolkit and not listed here.

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