The Greater Manchester DRAFT Clinical Frailty Charter

Version 5.2: August 2018
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1. Introduction

Context

There is much ongoing work in GM to develop system-wide initiatives that will take a comprehensive approach to addressing a person’s biological, psychological and social needs. This involves Greater Manchester (GM) residents, patients, health and social care stakeholders, local government and the third sector. The GM Ambition for Ageing work sits within this context and this Charter provides an important clinical contribution to this overarching strategic approach. The GM Frailty Collaborative recognises that there are a wide range of determinants that affect a person’s outcomes and experience. Through this Charter, it seeks to set out a framework for addressing the condition of clinical frailty within this context of wider work and as a key contribution to improving the lives of the people living with the condition.

Introduction

Frailty is a long term condition characterised by declining resilience and increased vulnerability to minor stressor events associated with, but not specifically caused by ageing. Around 5% of people aged 60-69 are moderately or severely clinical frail, rising to over a third of those aged over 85. Yet over 20% of those aged 90 or over remain fit. This Charter will challenge any stigma that surrounds frailty and it recognises the continuing value of people who develop the condition. We need challenge negative stereotypes and support people who are living with frailty so that they can continue to play an active part in the community and maintain wellbeing for as long as possible.

The systematic identification and assessment of clinical frailty facilitates proactive intervention and care to promote optimal outcomes for individuals. Some factors that contribute towards frailty can be reversed and some interventions will slow its progress. When frailty persists, proactively supporting people with moderate and severe forms of the condition will improve their quality of life and wellbeing. Undertaking this at scale entails tackling wider determinants of frailty such as social isolation, housing, deprivation and transport infrastructure which underpin the Greater Manchester Age-friendly Strategy.

What do we mean by frailty?

It is important to be clear about what we mean (and don’t mean) by frailty.

“Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves diminishing the ability to carry out important practical and social activities.”

British Geriatric Society

Focus groups with members of the public indicate that they consider frailty, more informally, as not having the ability to do the things that they once did because of a lack of strength or energy. This is a phenotype view of frailty which can be described by using validated tools such as the Clinical Frailty Scale (Appendix 1). Two of the points on this nine point scale are:
**Point 6: Moderately Frail**
People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance with dressing.

**Point 7: Severely Frail**
Completely dependent for personal care, from whatever cause (physical or cognitive).

Another phenotype assessment of frailty is based on the Fried\(^1\) which focusses on five indicators using objective measures (weight loss, weakness, poor endurance, slowness, low physical activity level).

Population risk stratification can be carried out using a cumulative deficits measurement provided by screening tools such as the electronic Frailty Index\(^2\) (eFI). The eFI is based on 36 deficits (Appendix 1) eg foot problems, incontinence, sleep disturbance, social vulnerability, and gives an indication of whether a person may be frail which then needs to be validated through clinical assessment.

The World Health Organisation defines health as a ‘*state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity*’. This serves to highlight the point that the causes and impacts of frailty include mental health and socioeconomic factors.

**Frailty models & definitions**

Frailty is described in a number of ways and quite a number of models have been proposed based on different concepts of frailty. Of the several ways in which frailty may be characterised, two particular concepts have become widely accepted as having utility:

1. Frailty index (characterised by the accumulation of health deficits which may suggest frailty).
2. Frailty phenotype (characterised by an individual’s assessed condition).

The Frailty Index quantifies the comparative risk than an individual may be living with frailty by summating the number of deficits they have accumulated as a proportion of the total number of possible deficits within the model. This model recognises frailty as a multidimensional risk state that can be measured more by the quantity than by the nature of health problems of the individual.

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\(^1\) https://academic.oup.com/biomedgerontology/article/56/3/M146/545770#8608074

\(^2\) https://academic.oup.com/ageing/article/45/3/353/1739750
The Frailty Phenotype defines specific physical symptoms of frailty. This model sees frailty as a biological syndrome resulting from cumulative decline across multiple physiological systems and defined through individual assessment.

Other operational concepts of frailty can be considered on a range between these two approaches and it is inappropriate to consider the frailty index and the frailty phenotype as alternatives or substitutable models. They are different tools which should be considered as complementary. The Frailty Index can be used to derive an indication of the likelihood of a person living with frailty whereas the frailty phenotype can be used to describe where a person’s frailty sits on the clinical frailty scale following assessment.

NHS England requires all general practices in England annually to identify people over 65 who are severely, and where possible, moderately frail using a validated population stratification tool, such as the eFI. Following identification, there is a requirement for direct clinical assessment of the individuals to verify that they do exhibit frailty and to what degree.

It is important that any consideration of frailty does not focus solely on medical determinants however. To be comprehensive, we need to reflect on social and psychological factors as well as physical (Figure 1). This will require consideration of the effects of social and environmental policy on those who are or may be living with frailty.

Clinical frailty in context

Clinical frailty is experienced, although not exclusively, by many people as they age. In GM there are a number of initiatives aimed at ensuring people age as well as possible. There are also a number of stakeholder groups who with a key interest in the condition. Addressing the issues related to frailty need to be considered, therefore, within the context of initiatives including:

- GM population health outcomes (Figure 2).
- The GM Age-Friendly Strategy.
- GM work to reduce the number of people over 65 admitted to hospital due to falls to the projected England average by 2021.
- The development of the LCOs and their oversight of primary care.
- The GM Population Health Plan.
- The GM framework to improve palliative and end of life care.
- GM common standards for core public health functions.
- Urgent & emergency care planning.
- GM housing, homelessness and transport policy.

### Figure 2: Frailty in GM context.

The strategic population health outcomes set out in **Taking Charge**, the GM health & Social Care Plan, include:

**AGE WELL**

**Outcome:** More people will be supported to stay well and live at home for as long as possible.

**Measure:** Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.
What is happening now in GM?

While there are a range of approaches and good practice in GM, services vary in different areas and between different programmes of work. Devolution in GM has seen the adoption of ageing as a key area of focus, with GM now being recognised as an age-friendly city. An effective approach to systematically identifying and supporting people to live with frailty has the potential to strongly support this work and its desired outcomes. A shift is required from the current more opportunistic and reactive approach to one in which this is supplemented with a systematic and proactive one (Figure 3).

Language also matters. Frailty is largely viewed as a medical, deficit-based and negative term. Identifying and engaging with people who are or would be classified as frail would be improved by addressing this issue and taking a person-centred approach which highlights positive opportunities to improve people’s lives and wellbeing.

Identification & coding of frailty

From October 2017 all GP practices in England have been required routinely to identify severe, and where possible moderate frailty, in patients aged 65 years and over using ‘an appropriate tool’³. Analysis on the resulting data is carried out nationally in relation to the metrics set out in Appendix 2. The reported figures, for quarters 1 to 3 of 2017/18, show variation within and between localities in GM. This is the first year of data collection/analysis but data quality checks still need to be carried out. Some general practice electronic patient record systems permit identification and coding of people at risk of living with frailty to be carried out as a batch process run on the GP practice register. Such batch running of the Electronic Frailty Index is appropriate but should not lead automatically to batch coding. Coding should only be done after further clinical assessment as the Electronic Frailty Index is not a diagnostic tool. Batch-coding a Read code diagnosis of frailty is deemed wholly inappropriate by NHS England⁴.

2. Vision, mission & objectives

Our vision for frailty services in Greater Manchester

Our vision for clinical frailty services is that Greater Manchester (GM) will be a place where health and social care services ensure that a system exists in which people can live as well as possible for as long as possible in an environment that suits them and their needs. People, including those who are living with frailty, should only ever be admitted to hospital when they are sick and need to be there, and should be discharged expediently and safely to recover in the community and/or their own home to reduce the risk of deconditioning and institutionalisation.

Our mission

Our mission is to identify clinical frailty and describe a system which includes a menu of interventions available to everyone who is identified as clinically frail and includes pathways that ensure they can access the services they need, when they need them and in a well-planned manner.

What we will do to achieve the vision

To achieve our vision we will:

1. Agree a set of common standards which will illustrate ‘what good looks like’ and when implemented as a whole across GM will drive sustainable improvement in patient outcomes and experience. Focus the standards on key strategic areas for improvement:
   a. Identification and assessment of frailty
   b. Care planning
   c. Interventions to tackle frailty across the spectrum of the condition

2. Establish a GM Frailty Network which will:
   a. Support benchmarking against the agreed common standards to identify variation
   b. Support localities in implementing improvements to achieve the standards.

Our strategic objectives

To realise the vision and achieve outcomes which demonstrate improvement, our strategic objectives are:

**Strategic objective 1:** People’s experience of clinical frailty services will be improved by better communication and care planning and coordination meaning they are better able to understand and influence their own care and their patient journey.
**Strategic objective 2:** People identified as living with frailty will experience improved outcomes through better access to appropriate interventions at the right time and in the right place.

**Strategic objective 3:** Better use of resources by increased identification, improved care planning and prompt intervention.

**A patient person-centred approach**

Services in GM should focus on the needs and wishes of people identified as living with frailty, their families, friends and carers. So, in delivering care and support to people who are or may become frail, we will:

- identify whether a person is living with frailty, and to what degree using an accepted methodology.
- ask the person what is most important to them.
- support people to develop individualised plans for their care tailored to their needs.
- offer specialist acute care in hospital if people need it and agree to it.

We will work to explain the language of frailty, improve the public understanding of the condition and its impact.

**The Scope of Frailty Charter and common standards**

The scope of this Charter includes the development of recommendations and common standards for the improvement of frailty services in GM. Implementation of these is excluded from the scope of the charter and would lie with localities, supported by the proposed GM Frailty Clinical Network.
3. Identification of frailty

Labelling

The development of policy requires clarity and the use of the term “frailty” assists in giving clarity. However, labelling individuals as frail may be associated with stigma for many; although there is evidence that label acceptors function better than label rejecters\(^5\). Identification should be accompanied by education (at both patient and clinician level) on what the term denotes and lead to personalised discussions that describe the vulnerabilities that a person has resulting from the frailty, whilst only using the term frail if the person self-identifies themselves as frail. Even when a person accepts the use of the frail label, it should not come with the acceptance that it is necessarily an irreversible state that older people enter into in the very final stages of their lives. People with hope also cope better than those with blind optimism\(^6\) but that hope should not be misplaced, although optimism is also helpful\(^7\). Despite frailty being a long-term condition, there are, at least partially, reversible health conditions that contribute to the development or progression of frailty, whilst some aspects of frailty can be ameliorated by making the social environment more accommodating to the needs of a person living with frailty.

Identifying Frailty

By identifying and then tracking people living with frailty, services will be better able to understand what happens (eg with regard to harms/mortality within hospital) and how such occurrences can be reduced or their effects mitigated. When harms do occur it should be checked whether those affected had been identified/assessed as frail. This will allow for later audit. Identification can overlap with other stages in a person’s frailty journey (Fig 4).

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\(^6\) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5209342/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5209342/)

Primary Care

Frailty can and should be identified in a range of different settings. To identify frailty in primary medical care, NHS England requirements included in the GP contract should be followed. This is a two stage process:

- For all patients over 65, use the Electronic Frailty Index (eFI) or other appropriate validated tools to identify patients who may be living with severe or moderate frailty.
- Apply clinical judgement to confirm, or where necessary, give further consideration to the use of tools to identify accurately people living with frailty. This requires the clinician (not necessarily a GP), to take into account an individual's complete clinical picture. This is done in Stockport by the ‘Birthday Review’ which uses motivational/aspirational interviewing and restorative conversations. Assessment of frailty may also be potentially supported by an appropriate tool such as PRISMA-7, Timed Up and Go test, Gait Speed Test, the Clinical Frailty Scale or a test of postural balance.

It should be noted that frailty is not exclusively related to age and, while not required on a routine basis by BNHS England, primary care services need to consider it as a possible diagnosis inpatients presenting with symptoms which may suggest it.

Secondary Care

To identify frailty in secondary care, patients should first be assessed on the Clinical Frailty Scale. This should usually be done as soon as possible (preferably within two hours) after admission but at times of crisis should be scored as if the patient was two weeks prior to the acute presentation.

Based on recommendations from NHS Improvement and the NHS in Scotland, patients admitted to secondary care who should be screened are:

- People aged 65+ AND presenting with one or more frailty syndromes (confusion, Parkinson’s disease, presenting with fragility fractures and/or falls, care home residents).
- People aged 75+ AND exhibiting either:
  - reduced mobility in last 3 months
  - 6 or more medicines
- People aged 85+

Consideration should also be given to those presenting electively to acute trusts who may not have been previously recognised as frail as this may impact on their care. Also, when a harm or death occurs in secondary care, the patient’s record should be checked to ascertain whether they had been diagnosed as frail.

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Social & Community Care

People who present to community services (eg social care, adult services, housing, community transport services, community/neighbourhood teams) exhibiting problems which may be associated with frailty (eg difficulty climbing stairs) need to be referred to primary care when appropriate. To identify frailty in these settings, different approaches are possible:

- Noting evidence of functional deterioration either by longitudinal observation or requests for help (eg requirement of walking aid), wish to move to housing without stairs or application for a blue badge.
- This may be supported by using an appropriate tool such as PRISMA-7\textsuperscript{10}, Timed Up and Go Test\textsuperscript{11}, Gait Speed Test\textsuperscript{12} or the Clinical Frailty Scale (Appendix 1) if there has been training to use these tools.

Other services where there are opportunities for identifying frailty may include ambulance services, dental practices, optometrists, audiologists, physiotherapists, podiatrists, pharmacies, specialist nurses and enhanced care planning teams. How this is best done will need to be considered for each group. For example, dentists may be especially adept at identifying possible frailty when a person has poor dental care or is unable to chew or swallow. Frailty should be considered as a possible reason for people not attending appointments, although it may require outreach teams to make contact with some of these individuals, particularly when culture or language may present additional barriers.

In the English Longitudinal Study of Ageing, the levels of frailty were higher in recent cohorts compared with earlier cohorts at the older ages probably due to an increased survival of frail individuals. This is could lead to an increase in the number of people who can be identified as frail.

\textsuperscript{10}\url{https://www.cgakit.com/fr-1-prisma-7}
\textsuperscript{11}\url{https://www.youtube.com/watch?v=IakVrSJ7vOs}
CASE STUDY: Reduction of frailty-related falls and fractures

Overview
This project aims to reduce falls and fractures related to frailty across Greater Manchester through early identification, treatment and management of patients at risk. Phase 1 activity will be undertaken in Tameside and Glossop from February to September 2018 with later scale and spread across GM.

Challenges/problems identified
For older people living with frailty, a trigger event, such as a fall, can result in a rapid deterioration in health and significant loss of independence. Approximately 65,000 hip fractures occur in the UK each year, costing the health and social care systems around £2 billion. Therefore, it is imperative for the health and social care systems to have mechanisms in place to help identify people, who are at risk of falls and fractures, to ensure there are appropriate treatments and services to manage these patients.

What are the aims and objectives of the programme?
The main objective of this programme is to support primary care with the case finding of patients at risk of falls and fractures, so that they can be treated with the appropriate bone-sparing therapies and supported with services in the community to help them manage their condition.

Potential impacts and outcomes expected
- Reduction in hip fractures
- Reduction in fragility fractures
- Decrease in mortality rates due to hip fractures
- Early and increased identification of osteoporosis and other high-risk patients
- Reduction in non-elective admissions related to falls and fractures
- Better outcomes for patients who have fractures or are at risk of fractures, with a reduced risk of disability, malnutrition, loss of independence, etc.
- Optimisation of eFI resulting in additional income for GPs
- Establish the use of fracture and falls risk assessment tools in primary care
- Reduction in costs related to hip fractures and fragility fractures across the health and social care systems
- Patient behavioural and lifestyle changes through patient education programmes leading to better outcomes for the patient and NHS

Which national clinical or policy priorities does this work address?
- According to NICE clinical guideline CG146 the following patients should be assessed for risk of a fragility fracture:
  - All women aged 65 years and over and all men aged 75 years and over;
  - Women aged under 65 years and men aged under 75 years in the presence of clinical risk factors such as a previous fracture, oral corticosteroids, family history of hip fracture, history of falls and alcohol intake;
  - People aged under 50 years if they have major risk factors such as a previous fracture, untreated premature menopause or oral corticosteroids.

As well as this, the five-year vision for Greater Manchester, Taking Charge of our Health and Social Care in Greater Manchester, which was endorsed by the Health and Social Care Strategic Partnership Board in 2015, sets out an ambition to reduce falls-related injuries admissions. Greater Manchester GP Localities have also identified falls as a priority and area for development. Our work now directly links with the GM HSCP.
4. Planning for care

Assessing for frailty

Having identified that a person is living with frailty, an appropriate assessment, such as the Comprehensive Geriatric Assessment\(^\text{13}\) (CGA), needs to be carried out to support care planning. A CGA involves a holistic, multidimensional, interdisciplinary assessment of an individual by specialists from a range of disciplines within the context of a number of domains (Fig 5).

A systematic review of the CGA found that older people were significantly more likely to be well and living at home up to 12 months after an unplanned stay in hospital if they had a CGA on a specialist ward. Compared to frail older patients cared for on general medical wards, those receiving CGA on a specialist ward were less likely to die, deteriorate or be admitted to institutional care. In addition, their mental functioning was more likely to improve.

The CGA results in the formulation of a list of needs and issues to tackle, together with an individualised care and support plan, tailored to an individual’s needs, wants and priorities. To do this, the person living with frailty needs to be asked what concerns them most before proceeding to the formal assessment. The results of the assessment need to be shared with those people that the person being assessed feels need to be aware of its contents.

Outside hospital, evidence for the effectiveness of CGA is weaker. However it is likely that there are important aspects of CGA that will contribute to improving the quality of life and wellbeing of people who have mild, moderate or severe frailty in the community. Such assessment needs to be done as soon as possible after identifying moderate or severe frailty and then at least annually\(^\text{14}\). Assessments will include the clinical team reviewing underlying diagnoses, identifying reversible causes, reviewing medication and identifying risk factors for preventable morbidities eg atrial fibrillation and fracture/falls risk. There should also be a social care assessment if relevant as part of integrated care in local neighbourhoods.

\(^{13}\) http://www.bgs.org.uk/cga-managing/resources/campaigns/fit-for-frailty/frailty-cga
Whether the full CGA is undertaken or other forms of assessment are used, an asset based approach should be used. In other words, the assessment should identify the strengths and resilience of the person who is frail as well as their deficits.

Communication is vital to enhance any assessment that is being made. When a patient is admitted to hospital, this may be from primary care or the ambulance service. Communication from the hospital to primary care when the patient is discharged is equally vital. Communication with the patient is also vital in order to understand their needs (as happens when using the ‘Goals of Care’ approach implemented in Stockport, see Appendix 3).

Plans for the person living with frailty should be comprehensive, including social, environmental and clinical aspects. This, for example, requires clinicians knowing about the social service and voluntary sector support available for the patient (or how to signpost for this). The plans should include what to do in a crisis, anticipatory care planning and end of life care, eg ReSPECT (Recommended Summary Plan for Emergency Care and Treatment).

Assessments should be recorded in the person’s notes AND be available to the person who should have their own copy either in hard form or electronically, possibly through an app. General practices should show they have explained the benefits of the enriched Summary Care Record (eSCR) to patients living with severe or moderate frailty and seek their consent to activate it. These measures will create transparency on why the assessment was carried out and what the patient can expect. Openness can be further enhanced by patients keeping their own records but this will also have the benefit of aiding communication between clinical staff when records are not immediately available.

NICE guidance NG56\(^\text{15}\) (Multimorbidity: clinical assessment & management) contains advice on the identification of frailty and on how to assess for frailty primary/community and hospital settings.

**Communications and consultations**

Good care will be enhanced by IT initiatives that will improve communication as well as prompting clinical staff to adhere to agreed pathways eg the prompting of Emergency Department staff to use the 4AT\(^\text{16}\) (rapid clinical instrument for delirium detection) screening tool to alert for the existence of delirium. This is already used in Salford Royal hospital (Box 2).

Group consultations or shared medical appointments are a relatively new way of practicing medicine that randomised controlled trials have shown to improve outcomes for long-term conditions. It should be offered to people who are living with frailty as an alternative to individual appointments.

\(^{15}\) https://www.nice.org.uk/guidance/ng56
\(^{16}\) https://www.the4at.com/
CASE STUDY: The Salford Early Detection for Delirium project

Salford Royal Hospital have introduced a delirium assessment for Emergency Department (ED) staff to use within the Allscripts Electronic Patient Record. The digital documentation was developed as part of a Global Digital Exemplar Programme. The 4AT is embedded into the ED admission documentation. This supports the clinical pathway to assess all non-elective admissions to hospital aged 65 years or over or newly confused using the 4AT. The digital 4AT auto-calculates the score and prompts a clinical decision around delirium diagnosis. If delirium is confirmed this will automatically be coded in the health issues and a delirium management bundle can be completed. The 4AT can be used to assess for delirium at any time following admission and again the documentation encourages a firm diagnosis that can be added to health issues.

Changing how delirium is viewed and assessed has been developed using Quality Improvement methodology. Since commencement of the project the proportion of patients aged 65 years and over who have been assessed in ED using the 4AT has increased from 2.5% (April 2017) to 46% (March 2018). The number of cases of delirium coded per month across the hospital has increased from 123 per month (April 2017) to 248 per month (May 2018). As part of an ongoing project other outcomes being assessed include length of stay, mortality and readmission rate.

Organisation of care

Specialist services required by people living with frailty should be available across GM were and when required. In secondary care, there should be a specialist frailty service regardless of whether there is a specialist ward if patients require an admission. The ethos should be one of “Home First” therefore there needs to be close working with community services such as hospital at home, age-specific, service emergency team (ASSET\textsuperscript{17}), whose responsibility includes providing immediate crisis response. ASSET or other similar provision can provide specialist advice to nursing homes with the aim of improving care and reducing unnecessary admissions to hospitals. There needs to be alignment of both the hospital frailty team and the specialist community services with the liaison mental health team, who often initially assess people who are frail presenting with confusion when they come to accident and emergency departments, but also work in the community.

Specialists in frailty care should also have responsibility for working with others, such as providing input to pre-operative assessment for people who are frail which leads to the avoidance of unnecessary surgery and better outcomes when surgery proceeds. This has sometimes be undertaken by a surgical elderly care assessment team (such as the SECAT in Edinburgh\textsuperscript{18}).

\begin{itemize}
\item \textsuperscript{17} \url{https://www.iriss.org.uk/resources/irissfm/asset-age-specialist-services-emergency-team}
\item \textsuperscript{18} \url{http://www.healthcareimprovementscotland.org/news_and_events/news/news_opac_rie.aspx}
\end{itemize}
CASE STUDY: Frailty MDTs in Tameside & Glossop

From January 2018, GP Practices in Stalybridge, Dukinfield and Mossley began to hold MDTs with attendees from different Neighbourhood disciplines. The aim was to identify people who may be severely frail using eFI and further risk-stratify them using FRAT and Q-Fracture scores, then provide timely support/interventions utilising new models of care and transformational schemes running in Tameside and Glossop. These included the Extensivist service, a community response linked to digital health, community physic, district nursing teams, neighbourhood pharmacists and the third sector.

Once the person is identified as potentially severely and has given consent to share information. The GP Practice identify other risk factors and discuss at the MDT. A standardised EMIS template has been developed for practices to input the outcomes MDTs with the scores from EFI, FRAT and Q-fracture. Outcomes/actions are recorded and the person receives an update with a potential plan. It is vital the patient’s GP is involved at MDT due to their depth of knowledge on their own patients. These patients where then held by the neighbourhood virtual MDT team monitoring their progress.

Since January 2018, there have been many positive outcomes, which have encouraged other neighbourhoods in T&G to adopt the same approach. The Team have also developed a frailty information leaflet for moderately frail patients and will be sending this out to everyone identified as potentially moderately frail using eFI. These patients will also be screened using a PRISMA-7 questionnaire and those scoring three or more will be included in the MDT for discussion.

Essential elements of effective hospital assessment and management include:
- The assessment must take place on the day of admission
- Maintaining appropriate fluid balance
- Senior, experienced people, able to make judgements and willing to take a degree of appropriate positive risk, should carry out the assessments.
- Frequent, multidisciplinary team discussion of each person’s care.
- Management plans should focus on discharge.
- Seek support and involvement from social work services from the start.

Many people who are living with frailty remain in hospital when this is inappropriate placing them at greater risk of unwarranted outcomes including de-conditioning. This may be because of delays in access to support at home, intermediate care or assessments of care needs in those who lack capacity. Where possible assessments should not occur in hospital, but rather a discharge-to-assess model should be followed allowing patients to be assessed preferably in their own home but, if necessary, in an intermediate care unit. A re-ablement service would then support patients, in the community or nursing/residential care, to maintain or regain as much independence as possible.

It seems logical to allocate a key worker to people who are living with frailty but there is very little robust evaluation of this approach. If key workers are to be allocated, it is important that when patient’s feels that another member of the multidisciplinary team is more focused on their specific needs, that member of staff can respond to their concerns. It is important that the presence of a key worker does not bring about damaging inflexibility.

Box 3: Frailty MDTs in Tameside & Glossop.
5. Potential interventions

Types of interventions

Interventions that lead to people identified as clinically frail having a better quality of life include social/environmental and clinical.

Social and environmental intervention

A place based approach is required. People mobilising the assets within their own community will be most effective in enabling continuing participation in activities that enhance peoples' lives and reduce loneliness. There are many examples of this in Greater Manchester whether it is enabling people to still go to the cinema, go out on day trips or use the local shops. These examples are being built on through health projects such as health hubs in each of the ten local authorities.

Frailty is associated with deprivation and deprivation makes it more difficult to cope with frailty. Therefore, when a person is identified as frail it is important that they can access advice and support to maximise income and mitigate the effects of deprivation. For instance, simple tools such as the ‘malnutrition armband’ being used in Salford (see case study box) can help identify whether frail people are underweight.

Supporting the inclusion of individuals should pay dividends. There have been many initiatives but they have been poorly evaluated. Social inclusion navigators who can identify the interests of a frail person and introduce them to a social environment where they can pursue those interests should reduce loneliness and isolation. If such an approach is to be adopted, it will need to be robustly evaluated.

The environment should be designed in partnership with local people at a neighbourhood level, to allow local facilities to continue to be accessible to people who are frail. This will include the availability of places to sit down and the use of defensible space. The availability and accessibility of transport is also a key factor in alleviating or exacerbating the impact of frailty. It is important, therefore, that social and environmental policy are developed in alignment and conjunction with health policy.

Clinical intervention

There are clinical conditions which are, at least partially, reversible after intervention. These include:

- Heart failure
- Reversible airways obstruction
- Malnutrition which may be exacerbated by poor dental health
- Muscle weakness

There are health related behaviours which, if changed can slow, or may even reverse\textsuperscript{20}, the progress of frailty. These include:

- Smoking
- Lack of physical activity
- Alcohol
- Poor diet

There are co-morbidities that can make it more difficult for a person to live with frailty but which can be managed optimally such as:

- Depression and anxiety
- Dementia
- Hearing impairment
- Visual impairment
- Incontinence

There are risks that are associated with, and can rapidly progress, frailty that can be reduced:

- Falls: the risk may be reduced after comprehensive assessment; clinical and environmental optimisation; sustained strength and balance training, resistance exercise training or Tai Chi; and encouraging the use of outdoor footwear in the home.
- Fractures: the risk may be reduced by the optimisation of bone health, including bone sparing medications where these are appropriate.

\textit{Box 4: Identifying malnutrition.}

**CASE STUDY: Identifying malnutrition in Salford with PaperWeight**

The PaperWeight Armband has been developed to help highlight the risk of malnutrition. It is a non-intrusive, non-medical intervention which can be used by healthcare providers and those in the voluntary sector to signpost people who are underweight to services and support to improve their dietary intake.

The armband is made up of a strip of paper that is wrapped around the bare arm of an older person, to measure their upper arm circumference and quickly identify a risk of malnutrition. If the band measures an upper arm measurement of less than 23.5cm, which indicates a body mass index (BMI) of less than 20 (the cut-off point for classification of underweight) this indicates it is likely that the person may be malnourished. For example, if an elderly person can easily slip the armband up and down their upper arm, this is a likely indication that their BMI is less than 20, which is a sign of malnutrition.

The aim of using the armband is to help people make improvements in their weight without the need for formal medical intervention. It is expected that this will help service users’ and carers increase the proportion of older people who feel supported to manage their own conditions and improve their quality of life.

The armband also includes instructions on the inside of the nutrition armband outlining how to use it, and a QR code which directs the user/carer/clinician to the Age UK Salford website, which provides resources including information, advice and support on simple dietary changes that could be made to increase calorie intake.

\textsuperscript{20} \url{https://www.ncbi.nlm.nih.gov/pubmed/25581779}
How to support interventions?

In Manchester, the High Impact Primary Care (HIPC) offer will establish dedicated and co-located multi-disciplinary teams, led by general practice. The team works with neighbourhood health and care colleagues to case find those people in the local area who are recognised as frail and who are at risk of hospital admissions and delayed transfers of care. The HIPC team proactively support people identified through assignment of key workers, establishment and implementation of patient and carer led care plans. Each HIPC team supports about 1000 patients with pro-active care meetings on a monthly basis with each person being supported through this service. Local delivery of clinical, mental and social care services are supported by rapid access to specialist advice, diagnostics and opinion from the wider health and care system.

In other areas, such as Rochdale, care navigators provide active signposting. Following guidance from NHS England, many general practices in Rochdale have trained receptionists to undertake this role. A recent review of care navigation\(^{21}\) found that it is difficult to draw conclusions regarding the effectiveness of navigators in primary care because only a small proportion of navigation interventions have been evaluated with suitable research designs including the recent evaluation from South Warwickshire. Health navigation is a promising but unproven development but the navigator service at Wythenshawe Hospital in south Manchester is showing some promising early results (Box 4).

Services such as those provided by navigator may help to address people’s needs so that crisis points are delayed or avoided. However, every locality’s integrated urgent and emergency care service should still include a crisis response service for frail people.

Liverpool employ healthy homes advocates visit properties with the greatest health and housing support needs and gather information about the occupants and their health needs, as well as the condition of their homes. They provide free help and advice to residents to remove or prevent hazards that can improve their health and well-being.

Transitions

Frailty is a long term condition marked by noticeable functional transitions eg giving up driving and becoming housebound. Transitions like this can be assisted by social support and measures like travel training. As people develop frailty, this is often accompanied by other transitions such as suffering bereavement, from which some people recover after a period of grief but others need bereavement counselling.

\(^{21}\) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5806255/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5806255/)
CASE STUDY: Impact of an acute care navigation service on hospital admissions in the vulnerable population

The Acute Care Navigation service was introduced at Wythenshawe Hospital in South Manchester in January 2018. The aim is to reduce hospital attendances and admissions in the target population, many of whom are believed to be moderately or severely frail. This will be achieved through regular contact with the navigator team and signposting patients to local services to help ensure their individual needs are met. The service proactively identifies patients in the community who are vulnerable, the majority of whom are older people. This is a non-clinical service comprising three care navigators who liaise with, and share information between, acute and community-based health services, social services and third sector groups. Although service, early results are promising.

Patients referred in January 2018

71 patients were referred to the service in January 2018.

A&E Attendances: In the three months before their referral, these 71 patients had 136 ED attendances (1.92 per patient). Three months post-referral, these patients had 57 ED attendances. This is a reduction of 58% or 1.11 attendances per patient.

Non-Elective Inpatient Spells: During the three months prior to referral, the patients accounted for 106 inpatient admissions. This equates to 1.49 admissions per patient. There was a reduction of 64 admissions in the 3 months post-referral, which is a 60.4% reduction, or 0.9 admissions per patient.

Non-Elective Bed Days: The above inpatient spells account for 612 bed days (length-of-stay => 1 day) prior to referral, and 312 post-referral. Prior to referral this is 8.62 bed days per patient. The reduction of 300 bed days brings this down to 4.4 bed days per patient, a 49% reduction.

Patients referred in February 2018

60 patients were referred to the service in February 2018.

A&E Attendances: In the three months before their referral, these 60 patients had 116 ED attendances (1.93 per patient). Three months post-referral, these patients had 62 ED attendances. This is a reduction of 47% or 0.9 attendances per patient.

Non-Elective Inpatient Spells: During the three months prior to referral, the patients accounted for 89 inpatient admissions. This equates to 1.48 admissions per patient. There was a reduction of 54 admissions in the 3 months post-referral, which is a 60.7% reduction, or 0.9 admissions per patient.

Non-Elective Bed Days: The above spells account for 839 bed days (length-of-stay => 1 day) prior to referral, and 361 post-referral. Prior to referral this is 13.98 bed days per patient. The reduction of 478 bed days brings this down to 6.02 bed days per patient, a 56.97% reduction.
6. Greater Manchester Clinical Frailty Standards

Introduction

To support achievement of our strategic objectives and deliver improvements in the areas of patient outcomes, patient experience and use of resources, we make a number of high level recommendations and propose the adoption of GM standards on identification and assessment, care planning and clinical frailty interventions.

Recommendations of the GM Frailty Collaborative

1. Clinical frailty should be recognised and managed as a long term condition by health and social care commissioners and providers in GM.

2. The GMCA and the GMHSCP should develop an economic business case to demonstrate the value of tackling inequalities resulting from determinants such as poor housing, deprivation and inadequate/inaccessible transport.

3. Commissioners should use both outcome and process measures when commissioning frailty services.

4. GM should develop a ‘brand’ for tackling clinical frailty (such as has been done with Dementia United).

5. GMHSCP should implement (through the Local Health & Care Record and the GM Interoperability Hub) a system to ensure clinicians and social care services can access and update the same central patient information.

6. Appropriately validated clinical frailty training and education (for instance through e-learning modules) should be developed and made available to the GM health and social care workforce.

7. All localities in GM should benchmark their current services against the standards set out below.

8. All people identified as living with frailty, and those important to them, should be invited to give feedback about their experience of care in a way that can be used and audited to help improve the care services that they and others receive in the future.

GM frailty standards

The proposed GM frailty standards are set out in Table 1 overleaf.
### Table 1: Frailty identification standards.

<table>
<thead>
<tr>
<th></th>
<th>DRAFT GM standards for identifying and assessing clinical frailty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>There should be systematic identification of frailty by degree of severity in those over 65 years of age in primary care who may be frail using a tool such as the eFI. This should then be validated by clinical assessment with the help of a tool such as the Clinical Frailty Scale. Other agencies should systematically identify people who may be frail, based on agreed triggers, in order to refer them for clinical assessment.</td>
</tr>
<tr>
<td>2</td>
<td>Patients will be assessed for common undiagnosed reversible conditions (eg heart failure, reversible airways obstruction, incontinence or sensory impairment).</td>
</tr>
<tr>
<td>3</td>
<td>Every person aged 65 years and over and frail will have a medications review and falls risk assessment including use of an appropriate tool (such as FRAX or QFracture) by their GP.</td>
</tr>
<tr>
<td>4</td>
<td>For every person over the age of 65 who attends urgent or emergency care there should be consideration as to whether or not they may be clinically frail. If it is considered that they may be frail, they should be assessed using an appropriate standard validated tool (such as the Clinical Frailty Scale). This information will be shared with primary care.</td>
</tr>
</tbody>
</table>

### Table 2: Frailty care planning standards.

<table>
<thead>
<tr>
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<th>DRAFT GM standards for clinical frailty care planning</th>
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<tbody>
<tr>
<td>5</td>
<td>When a person receives a confirmed diagnosis of clinical frailty, a personal care plan will be developed through a holistic needs assessment supported by a comprehensive geriatric assessment (or similar appropriate tool). This will include a crisis plan, anticipatory care planning, and the person’s individual goals of care. The views of frail people will be proactively sought with regard to end-of-life care, cardiopulmonary resuscitation, assisted ventilation, artificial feeding and other potential issues. This care plan will be shared with the person and their health and social care teams.</td>
</tr>
<tr>
<td>6</td>
<td>Wherever possible, patients and/or their carers will be supported to self-manage their long term-condition.</td>
</tr>
<tr>
<td>7</td>
<td>Every clinically frail person will have a single care record visible to all health &amp; social care teams.</td>
</tr>
<tr>
<td>8</td>
<td>When a clinically frail person at home requires crisis care, this will be available within 2 hours. When a clinically frail person requires access to intermediate care (step-up or step-down), this will be available within 2 days.</td>
</tr>
</tbody>
</table>

### Table 3: Frailty intervention standards.

<table>
<thead>
<tr>
<th></th>
<th>DRAFT GM standards for clinical frailty interventions &amp; care</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>All people who are diagnosed as frail will have the opportunity to participate in group consultations where appropriate.</td>
</tr>
<tr>
<td>10</td>
<td>All health and social care staff will have access to an up-to-date appropriately populated directory of services (including local, neighbourhood, voluntary and informal services).</td>
</tr>
<tr>
<td>11</td>
<td>All localities in GM will have community-based falls prevention service; and strength and balance services (and/or resistance exercise training and/or Tai Chi) available to all frail and potentially frail people.</td>
</tr>
<tr>
<td>12</td>
<td>All primary, community, secondary &amp; emergency care professionals working with clinically frail people will undergo appropriate frailty training/education.</td>
</tr>
<tr>
<td>13</td>
<td>When a patient presents to secondary care with frailty they will be assessed and managed by a specialist frailty service (unless another service is better placed eg orthopaedics for fractured neck of femur).</td>
</tr>
</tbody>
</table>
7. Greater Manchester Clinical Frailty Network

To promote the strategic objectives of this Charter and the implementation of the standards articulated within it, we will develop the Greater Manchester Clinical Frailty Network (CFN). The network will bring together important stakeholder groups to work together. It will engage with these groups to define what the healthcare and local government systems require in order to be able to improve performance, improve patient outcomes/experience and reduce unwarranted variation. The CFN will be driven by clinical leadership and will:

1. Provide a forum for engagement with people living with frailty including patients, family and carers.
2. Facilitate networking to discuss guidance, standards and potential service improvements.
3. Further develop clinical consensus based on the best evidence available.
5. Give advice on outcome and process measures to commissioners and other policy makers.
6. Support the development of validated clinical frailty training and education.
7. Link frailty work with work focused on other conditions to facilitate efficient treatment, care for people with co-morbidities and advanced care planning.
8. Provide links into GM governance mechanisms for frailty improvement project work.

*Figure 6: The GM Clinical Frailty Network model.*
Bibliography

Evidence and information referenced in this Charter (excluding NICE resources) and/or relevant to the topics below:

BMA: Identification & management of patients with frailty:

NHS England guidance on batch coding:

Acceptance of mental illness labels by psychotic patients:

Guidance on routine frailty identification through GP contract:

Comprehensive geriatric assessment:
- http://www.bgs.org.uk/cga-managing/resources/campaigns/fit-for-frailty/frailty-cga

Anticipatory care planning
- http://www.gov.scot/Publications/2010/04/13104128/1
- https://www.goodlifedeathgrief.org.uk/content/anticipatory_care_plan/
- https://ihub.scot/anticipatory-care-planning-toolkit/

Surgical elderly care assessment teams:

Delirium screening tool
- https://www.the4at.com/

Salford malnutrition armband:

Navigator delivery models in primary care:
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5806255/

**NICE guidelines (NG), clinical guidance (CG) and quality standards (QS) which are referenced in this Charter or are relevant to the identification, assessment and treatment of clinical frailty.**

Social care:
- Social care for older people with multiple long-term condition (QS132)
- Older people with social care needs and multiple long-term conditions (NG22)

Multimorbidity:
- Multimorbidity (QS153)
- Multimorbidity: clinical assessment and management (NG56)

Falls:
- Falls in older people (QS86)
- Falls in older people: assessing risk and prevention (CG161)

Pressure ulcers
- Pressure ulcers: prevention and management (CG179)
- Pressure ulcers (QS89)

Delirium:
- Delirium: prevention, diagnosis and management (CG103)
- Delirium in adults (QS63)

Sepsis:
- Sepsis: recognition, diagnosis and early management (NG51)
Sepsis (QS161)

Dementia:
- Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (NG16)
- Dementia: assessment, management and support for people living with dementia and their carers (NG97)
- Dementia: independence and wellbeing (QS30)

Medicines management:
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (NG5)
- Medicines optimisation (QS120)

Nutrition:
- Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (CG32)
- Nutrition support in adults (QS24)

Transition between settings:
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (QS136)

End of life:
- End of life care (multiple resources)

NICE clinical guidance and quality standards that are relevant to frailty prevention:
- Mental wellbeing and independence for older people (QS137)
- Mental wellbeing of older people in care homes (QS50)
- Dementia: independence and wellbeing (QS30)
- Preventing excess winter deaths and illness associated with cold homes (QS117)
- Diabetic foot care (QS6)
- Alcohol use disorders: diagnosis and management (CG100)
- Smoking: supporting people to stop and (QS43)
- Smoking: harm reduction (QS92)
- Falls in older people (QS86)
- Nutrition support in adults (QS24)
- Medicines optimisation (QS120)
- Managing medicines in care homes (QS85)

Additional resources and information.

NHS England advice & resources on supporting older people with frailty:
- https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/

NHS England resources for long-term conditions:
- https://www.england.nhs.uk/ourwork/ltc-op-eolc/ltc-eolc/resources-for-long-term-conditions/

FutureNHS Frailty Collaboration Platform:
- https://future.nhs.uk/connect.ti/frailtyinprimarycare/grouphome

PHE Falls And Fractures Consensus Statement:
Appendix 1: Frailty scale & index

The Phenotype scale

Clinical Frailty Scale*

1. Very Fit — People who are robust, active, energetic and motivated. They are among the fittest for their age.

2. Well — People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.

3. Managing Well — People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable — While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. Mildly Frail — These people often have more evident slowing, and need help in high order IADLS (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail — People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail — Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail — Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally III — Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

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The Frailty Index

![Frailty Index Diagram]

Disease states

- Arthritis
- Asthma/COPD
- Afib/atrial fibrillation
- CVD
- CKD
- Diabetes
- Foot problems
- Frailty stages
- Heart failure
- Hypertension
- Hypoglycemia

Symptoms/signs

- Dizziness
- Dyspnea
- Falls
- Memory/CoGNitive problems
- Polypharmacy
- Sleep disturbance
- Urinary incontinence
- Weight loss and anorexia

Abnormal laboratory value

- Anaemia & haematocrit deficiency

Disability

- Activity limitation
- Homebound
- Hearing impairment
- Mobility/transfer problems
- Frequent/urgent for care
- Social vulnerability
- Visual impairment

GM Frailty Charter v5.2 (August 2018)
Appendix 2: Identification & coding metrics in the GP contract

Metrics set out in the GP contract against which the identification and coding of clinical frailty are measured.

<table>
<thead>
<tr>
<th>Metric Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have had a frailty assessment using the appropriate tool up to the end of the reporting period.</strong></td>
</tr>
<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have not had a frailty assessment using the appropriate tool up to the end of the reporting period.</strong></td>
</tr>
<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of moderate frailty, diagnosed using the appropriate tool up to the end of the reporting period.</strong></td>
</tr>
<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of severe frailty, diagnosed using the appropriate tool up to the end of the reporting period.</strong></td>
</tr>
<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of severe frailty, diagnosed using the appropriate tool up to the end of the reporting period, who have received an annual medication review on or after their severe frailty diagnosis.</strong></td>
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<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of severe frailty, diagnosed using the appropriate tool up to the end of the reporting period, who have declined an annual medication review on or after their severe frailty diagnosis.</strong></td>
</tr>
<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of either moderate or severe frailty, diagnosed using the appropriate tool up to the end of the reporting period and who have had a fall up to the end of the reporting period.</strong></td>
</tr>
<tr>
<td><strong>Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of either moderate or severe frailty, diagnosed using the appropriate tool up to the end of the reporting period and who have had a referral to ‘falls clinic’, as clinically appropriate, up to the end of the reporting period.</strong></td>
</tr>
</tbody>
</table>
Appendix 3: Care Planning

Care planning needs to be a person-centred process involving, where appropriate, family and carers. It needs to consider the person’s own goals and address environmental factors as well as physical issues such as disease states, symptoms or disabilities. It also needs to anticipate and potential crisis points and how these would be addressed. An Anticipatory Care Plan (ACP) should be an evolving record that changes over time through ongoing conversation and shared decision making. It should summarise discussions between the person, those close to them and the practitioner. The should record the preferred actions, interventions and responses that care providers should make following a crisis point or clinical deterioration. It should be reviewed as a person’s circumstance and/or condition(s) evolve and progress. As condition(s) becomes more complex it may also be helpful to discuss the person’s preferred actions with regard to legal and practical issues. People’s end-of-life preferences will also need to be considered at an appropriate point. The ACP will need to incorporate information about the person’s:

- Personal concerns and goals
- Understanding about their condition(s) and their prognosis
- Preferences for end-of-life care (place of care, degrees of intervention, treatment and resuscitation).

One simple tool used in GM to initiate ACP conversations is the Stockport ‘Goals of Care form (reproduced below).

---

**Enhanced Case Management Goals of Care Record**

<table>
<thead>
<tr>
<th>Person's Name</th>
<th>NHS Number</th>
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<tr>
<th>Date Completed</th>
<th>Revisit Date</th>
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<table>
<thead>
<tr>
<th>Care Coordinator</th>
<th>Care Coordinator Contact Number</th>
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In the last six months, have you had enough support from your local services or organisations to help you manage your long-term conditions? (Yes: score 1 point. No: score 0 points.)

How confident are you that you can manage your own health? (Very confident: score 1 point. Fairly confident: score 0.5 points. Not confident: score 0 points.)

If total score is less than 1, or there has been a clinical judgement of cognition issues, consider doing a full Patient Activation Measure (PAM) assessment.

**MY GOALS**

- Things I want to change:
- Things that are important to me:
- What is normal for my body/health:
- How I cope at the moment:
- Things that might help me cope better:
- What I can do:
- What others can do (friends and family):
- What services could do:

**CONSENT**

- Consent to Goals of Care Record being shared with professionals involved in person’s care:
  - Yes
  - No
- Consent to share Goals of Care Record via Stockport Health and Care Record:
  - Yes
  - No
- Person, carer and GP/care coordinator have jointly developed Goals of Care Record and are happy with consent:
  - Yes
  - No

ECM/GOC v3.0 8.2.18

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### MY ACTION PLAN

Person’s Name:  
NHS Number:  

This plan is designed to help and support you and your carer/family should your condition change or you feel you need to speak to someone about your illness or care. It is aimed at helping you to manage your conditions better. You should use the plan to help you to decide when you should contact your care coordinator or GP. Any condition-specific management plans may also be attached if appropriate.

<table>
<thead>
<tr>
<th>Agreed needs and outcome as identified in my assessment</th>
<th>Agreed actions and who will do them</th>
<th>When/how often</th>
<th>Review date</th>
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### Triggers/Crisis and Risk Management Plan

Think about equipment, fire safety, and support network

<table>
<thead>
<tr>
<th>How I know when things aren’t going well</th>
<th>How others might know</th>
<th>What I can do</th>
<th>What others can do (friends and family)</th>
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Appendix 4: The brief CGA

### Brief Comprehensive Geriatric Assessment

<table>
<thead>
<tr>
<th>Patient Details</th>
<th>Clinical Frailty Score (Rockwood Scale):</th>
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<tbody>
<tr>
<td>Patient's Name</td>
<td>Add 1</td>
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<tr>
<td>Date of Birth</td>
<td>Add 2</td>
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<tr>
<td>NHS Number</td>
<td>Add 3</td>
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<tr>
<td>GP Practice Name</td>
<td>Town</td>
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<tr>
<td>Postcode</td>
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#### Cognition
- Within Normal Limits
- Mild Cognitive Impairment
- Severe Cognitive Impairment
- Dementia
- Delirium
- Mental Capacity Assessment needed

#### Emotional
- Within Normal Limits
- Mood
- Depression
- Anxiety
- Fatigue
- Hallucinations
- Delusions
- Other
- Could not say

#### Motivation
- High
- Usual
- Low

#### Health Attitude
- Excellent
- Good
- Fair
- Poor
- Could not say

#### Communication
- Speech: Within Normal Limits
- Impaired
- Understanding: Within Normal Limits
- Impaired

#### Strength
- Within Normal Limits
- Weak
- Upper Limb Proximal
- Upper Limb Distal
- Lower Limb Proximal
- Lower Limb Distal

#### Exercise
- Frequent
- Occasional
- Not

#### Balance
- Balance Falls: Within Normal Limits
- Impaired
- Falls Frequency: 1
- Falls Number: 0

#### Mobility
- Walk inside: Independent
- Slow
- Assisted
- Can't
- Walk outside: Independent
- Slow
- Assisted
- Can't
- Transfers: Independent
- Slow
- Assisted
- Can't
- Bed (in/out): Independent
- Slow
- Assisted
- Can't
- Aid use: None
- Stick
- Frame
- Chair
- Staircase (up/down): Independent
- Slow
- Assisted
- Can't

#### Nutrition
- Weight: Normal
- Under Weight
- Over Weight
- Obese

#### Elimination
- Bowel: Continence
- Constipation
- Incontinence
- Urinary: Continence
- Incontinence
- Medications: Independent
- Assisted
- Can't

#### ADLS
- Basic: Independent
- Assisted
- Can't
- Eating: Independent
- Assisted
- Can't
- Feeding: Independent
- Assisted
- Can't
- Bathing: Independent
- Assisted
- Can't
- Dressing: Independent
- Assisted
- Can't
- Toileting: Independent
- Assisted
- Can't
- Walking: Independent
- Assisted
- Can't
- Bending: Independent
- Assisted
- Can't

#### Sleep
- Marital Status: Married
- Lives alone
- Home: Number of levels: Informal
- House: Number of steps: Other
- Required more support
- Daytime drowsiness: None
- Socially engaged: Frequent
- Disrupted: Occasional

#### Advance directive in place:
- Yes
- No

#### CPR decision:
- Allow a natural death
- Resuscitate

---

Assessor: __________________________
(Name, Grade & Signature)

Date: ____________________________
# Initial Comprehensive Geriatric Assessment Form

**Associated Medication** *(Mark meds started in hospital with an asterisk)* - Consider STOPP / START

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date</th>
<th>Data Commenced</th>
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<tr>
<th>Problem List</th>
<th>Action Required</th>
<th>Action by</th>
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**Long Term Conditions:**

| 1            |                 |
| 2            |                 |
| 3            |                 |
| 4            |                 |
| 5            |                 |

**Notes:**

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

## Outpatient Appointments

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<thead>
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<th>Department</th>
<th>Date and Time</th>
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**Assessor:**

(Name, Grade & Signature)

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