GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Resilience & Independent Living in Greater Manchester

Best practice advice and standards for supporting people living with clinical frailty to live well and age well in an environment that meets their needs.

March 2019

CONTENTS

Contents:

Figures, boxes & tables:

Appendices & reference:

1. Context

A holistic approach to meeting people's needs

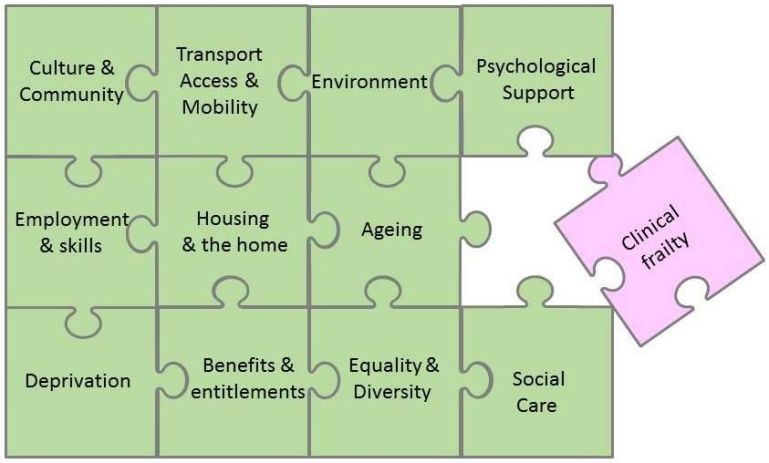
There is a work ongoing within a range of systems in Greater Manchester (GM) which has the potential to develop a comprehensive and holistic approach to addressing people's psychological, social and biological needs. This involves GM residents, patients, health & social care stakeholders, local government, the third sector and many more. It is a complex jigsaw of systems focussed on a wide range of factors (Figure 1). The pieces will all need to fit together to maximise peoples' opportunity to live as well as possible for as long as possible in the environment they wish to live in.

The work of the GM Combined Authority (GMCA) sits within this context as does the work contributing to many of the pieces of the jigsaw, such as that of the GM Health & Social Care Partnership (GMHSCP). The World Health Organisation, for instance, recognised GM as the UK's first age-friendly city region in March 2018[1] and GMCA and GMHSCP are both key partners in meeting the expectations this status carries and the strategic goals of the GMHSCP (see page 7). So a holistic approach to assessment of people's needs and the provision of services is required.

Completing the puzzle

Within this context, there is a need to for health and care systems that meet national requirements, agreements and ambitions. These include the requirements to identify clinical frailty in primary care[2] (as recognised in '*A strategy for an Age-friendly Greater Manchester 2017-2020*') and the need to ensure healthcare professional skills as set out in Health Education England's '*Frailty: A framework of core capabilities*'[3].

Figure 1: The GM 'Living Well' jigsaw has many 'pieces'.



This GM framework document focusses primarily on the content of the clinical frailty piece of the jigsaw and provides an important clinical contribution to the holistic strategic approach set out above. The Collaborative that developed it recognises that there are a wide range of determinants that affect a person's outcomes and experience. In particular, for example, links into ageing, psychological support and social care (Figure 1). Through this framework, the Collaborative seeks to support

[1] https://www.greatermanchester-ca.gov.uk/news/article/287/greater_manchester_becomes_first_age-friendly_city_region_in_the_uk
[2] https://www.england.nhs.uk/publication/supporting-routine-frailty-identification-and-frailty-through-the-gp-contract-20172018/
[3] http://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework

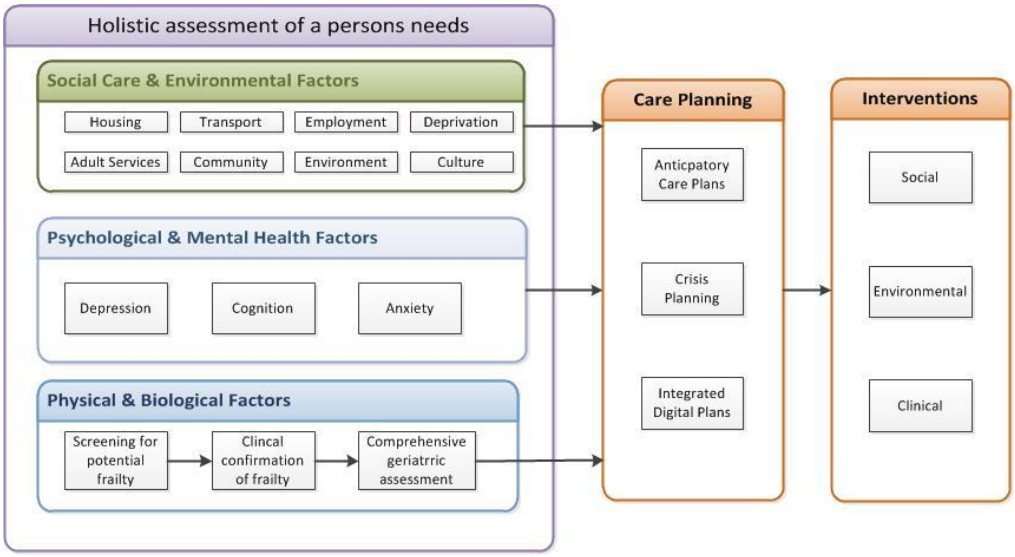
GM stakeholders in addressing the condition as part of achieving GM strategic social policy goals and as a key contribution to improving the lives of the people living with the condition.

Wider aims

Whilst this framework document focusses on a specific condition, it aims to facilitate the development of a holistic assessment covering the full range of social, environmental and clinical factors to maximise people's independent living. This approach proposes that a standardised application of the appropriate tools to identify and assess for clinical frailty can improve the outcomes and experience of people living with the condition. A clinical frailty network (see Section 8) can support the development of such processes and could be used to engage with wider networks of clinicians, particularly those focussed on ageing. So a suggested holistic model is outlined in Figure 2 below (note this denotes 'example factors' and is not designed to be exhaustive).

Integration of frailty into wider health, care and other systems as illustrated in Fig 2 is important as it supports an approach which recognises peoples' strengths and the development of an assets based approach.

Figure 2: Incorporating frailty identification into holistic assessment.



Prevention

This document covers interventions on how to reduce frailty both at the pre-frail stage and once the condition has been established. This is in line with latest systematic review[4]. The proposed approach and standards are designed to support the identification of people likely to become frail ('pre-frail' people), through systematic approaches across all localities. Identification and prevention are key to improving patient outcomes and experience and reducing the costs of care. Interventions to prevent progression can contribute to these goals. Prevention, where possible, can be addressed through action to address modifiable risk factors.

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5771690/

2. Introduction

Background

Clinical 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 framework is intended to challenge any stigma surrounding the condition and it recognises the continuing value of people who develop the it. We need to challenge negative stereotyping and support people 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 the condition can be reversed and some interventions will slow its progression. When it 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 such as social isolation, housing, deprivation and transport infrastructure which underpin the Greater Manchester Age-friendly Strategy.

What do we mean by clinical frailty?

It is important to be clear about what we mean (and don't mean) by clinical 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 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 is based on the Fried[5] 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[6] (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.

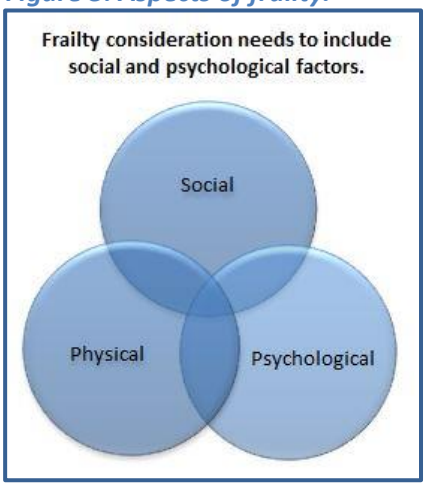
The World Health Organisation defines health as a '*state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity*'. This serves to highlight the point that the causes and impacts of frailty include mental health and socioeconomic factors.

Models & definitions

Frailty is described in many 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 the condition).
2. Frailty phenotype (characterised by an individual's assessed condition).

Figure 3: Aspects of frailty.



The Frailty Index quantifies the comparative risk than an individual may be living with the condition 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.

The Frailty Phenotype defines specific physical symptoms of frailty. This model sees it as a biological syndrome resulting from cumulative decline across multiple physiological systems and defined through individual assessment.

Other operational concepts 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 the condition whereas the frailty

[5] https://academic.oup.com/biomedgerontology/article/56/3/M146/545770#8608074
[6] https://academic.oup.com/ageing/article/45/3/353/1739750

phenotype can be used to describe where a person's frailty sits on the clinical 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 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 2). This will require consideration of the effects of social and environmental policy on those who are or may be living with the condition.

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 have a key interest in the condition and plans already in place, all of which should be considered alongside this framework:

- GM population health outcomes (Figure 3).
- 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 consideration of the contribution to 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 4: Frailty in GM context.

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

AGE WELL

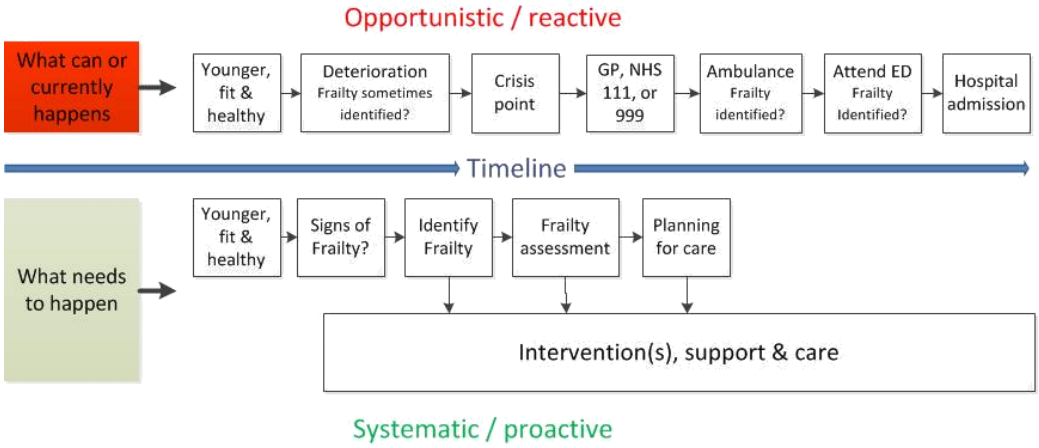
Outcome: *More people will be supported to stay well and live at home for as long as possible.*

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 which is supplemented with a systematic and proactive one (Figure 4).

Figure 5: Frailty timelines.



Language also matters. Frailty is currently 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 clinical 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'[7]. 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 the condition to be carried out as a batch process run on the GP practice register. Such batch running of the eFI is appropriate but should not lead automatically to batch coding. Coding should only be undertaken after further clinical assessment as the eFI is not a diagnostic tool. Batch-coding a Read code diagnosis of frailty is deemed wholly inappropriate by NHS England[8].

[7] https://www.bma.org.uk/advice/employment/contracts/general-practice-funding/focus-on-identification-and-management-of-patients-with-frailty
[8] https://www.england.nhs.uk/wp-content/uploads/2017/04/gms-contract-batch-coding-statement.pdf

3. Vision, mission & objectives

Our vision for services in Greater Manchester

Our vision is of a Greater Manchester that is 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 clinical 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. The focus for the standards will be on the key strategic of:

    a. Identification and assessment
    b. Care planning
    c. Interventions to tackle the condition across the spectrum of the condition

2. Establish a GM Clinical 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: Clinical Frailty is recognised as condition which needs to be addressed as part of a holistic approach to identifying and addressing people's wider needs.

Strategic objective 2: 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 3: 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 4: 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 the condition 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.

Scope and common standards

The scope of this framework 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 framework and would lie with localities, supported by the proposed GM Frailty Clinical Network.

4. Identification of frailty

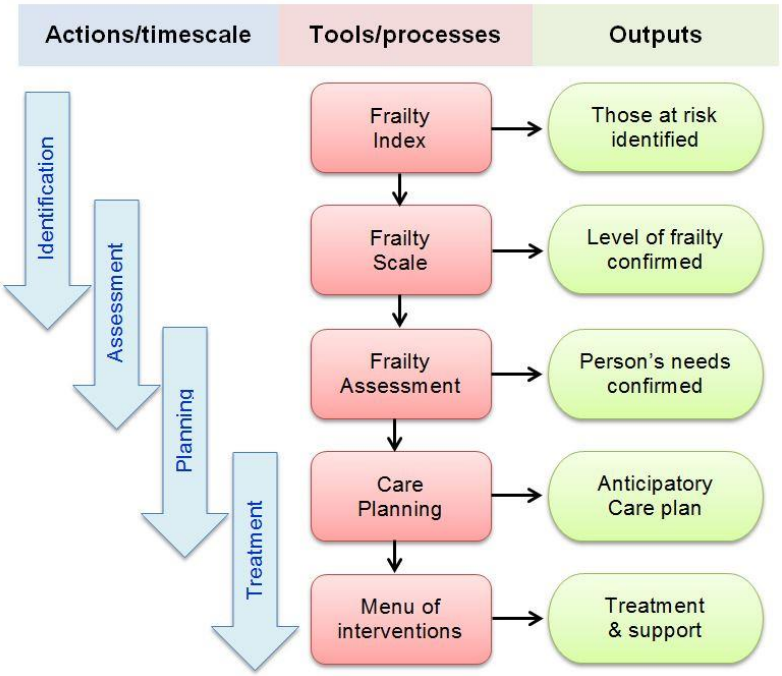
Communicating with patients

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[9]. 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 that have resulted in the identification of frailty, whilst only using the term frail if the person self-identifies as such. 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[10] but that hope should not be misplaced, although optimism is also helpful[11]. Despite frailty being a long-term condition, there are, at least partially, reversible health conditions that contribute to its development or progression, whilst some aspects of can be ameliorated by making the social environment more accommodating to people's needs.

Identification

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 patient journey (Fig 5).

Figure 6: Frailty mapping.



[9] http://psycnet.apa.org/doiLanding?doi=10.1111%2Fj.1939-0025.1989.tb01675.x
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5209342/
[11] https://www.ncbi.nlm.nih.gov/pubmed/9400065

Primary Care

Frailty can and should be identified in a range of different settings. To identify it in primary medical care, NHS England requirements included in the GP contract[12] should be followed. This is a two stage process:

- For all patients over 65, use the 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. An example from Stockport is at a 'Birthday Review' which uses motivational/aspirational interviewing and restorative conversations. Assessment 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 balance13.

It should be noted that the condition 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 in patients presenting with symptoms which may suggest it.

Secondary Care

To identify the condition in secondary care, patients should first be assessed using 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
    or
  - 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.

[12] https://www.england.nhs.uk/wp-content/uploads/2017/04/supporting-guidance-on-frailty-update-sept-2017.pdf

[13] Onambélé GL, Narici MV, Rejc E & Maganaris CN, 2006. Contribution of calf muscle-tendon properties to balance ability in the absence of visual feedback and the effects of ageing. Gait & Posture. 26(3):343-8.

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 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[14], Timed Up and Go Test[15], Gait Speed Test[16] 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; pharmacists, through medicine reviews, are in a position to identify when patients experience difficulty swallowing solid dose forms of medication . It should also 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.

[14] https://www.cgakit.com/fr-1-prisma-7

[15] https://www.youtube.com/watch?v=lAkVr5l7vOs

[16] http://www.bgs.org.uk/gait-assessment/cga-toolkit-category/how-cga/cga-assessment/cga-assessment-functional/cga-function-mobility/gait-and-balance-assessment

Box 1: Reducing falls-related fractures.

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

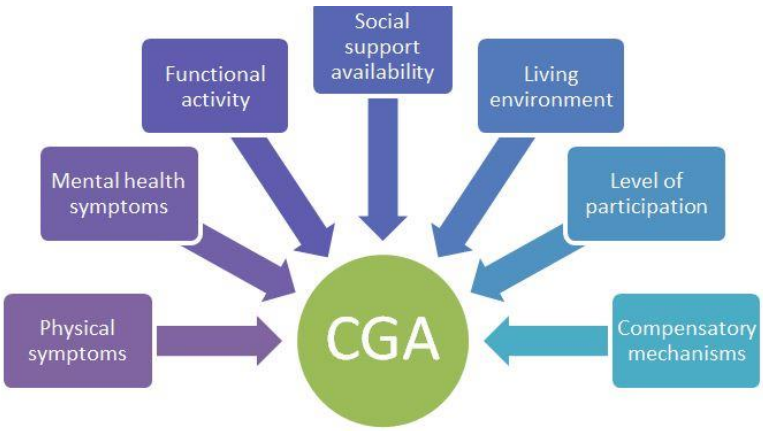
5. Planning for care

Assessing for frailty

Having identified that a person is living with frailty, an appropriate assessment, such as the Comprehensive Geriatric Assessment[17] (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 6).

A systematic review of the CGA found older people were significantly more likely to be well and living at home up to 12 months after an unplanned stay in hospital if their CGA was undertaken 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.

Figure 7: CGA domains listed by the BGS.



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 needs to be asked what concerns them most before proceeding to the formal assessment. The results of the assessment need to be shared with other people (eg family and careers) if the person being assessed feels they need to be made aware of its contents. A wider GM assessment for resilience and independent living, incorporating the CGA, such as that posited in the outline model in Section 1 would go even further in establishing a holistic system of support and care.

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[18]. 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.

[17] http://www.bgs.org.uk/cga-managing/resources/campaigns/fit-for-frailty/frailty-cga
[18] https://www.england.nhs.uk/wp-content/uploads/2017/04/supporting-guidance-on-frailty-update-sept-2017.pdf

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 being made. When a patient is admitted to hospital, this may be from wider 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 demonstrate 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, which could contribute to development of an integrated digital patient record accessible through a GM-wide interoperability hub (see recommendation 5 on page 23). 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[19] (Multimorbidity: clinical assessment & management) contains advice on the identification of frailty and on how to assess for it in 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[20] (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. These should be offered to people who are living with frailty as an alternative to individual appointments.

Box 2: 4AT screening in Salford.

[19] https://www.nice.org.uk/guidance/ng56
[20] 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 service regardless of whether there is a specialist ward if patients require an admission. However, the ethos should be one of "Home First" and hence close working with community services such as hospital at home, age-specific, service emergency team (ASSET[21]), 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[22]).

[21] https://www.iriss.org.uk/resources/irissfm/asset-age-specialist-services-emergency-team
[22] http://www.healthcareimprovementscotland.org/news_and_events/news/news_opac_rie.aspx

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 clinicians should carry out the assessments who are able to provide a measured, clinically appropriate approach to risk
- 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.
- Availability of alternatives to hospital care at weekends as well as during the week

Many people who are living with frailty remain in hospital when this is inappropriate and this risks placing them at greater exposure to 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 patients 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.

CASE STUDY: Frailty MDTs in Tameside & Glossop

From January 2018, GP Practices in Stalybridge, Dukinfield and Mossley began to hold MDTs with of 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.

6. Potential interventions

Types of interventions

Social, environmental and clinical interventions can provide a better quality of life for people living with clinical frailty.

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 the condition. 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 piloted in Salford (see case study box)[23] 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 an key factor in alleviating or exacerbating the impact of the condition. It is important, therefore, that social and environmental policy are developed in alignment and conjunction with health policy. New technologies can increasingly maximise the abilities a frail person retains. Examples of such technology are: lifting cushions and tippers to support a kettle when pouring water. The assessment of patients should indicate what technologies can help them continue with activities of daily living.

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

[23] http://www.malnutritiontaskforce.org.uk/salfords-armband-tackling-malnutrition-with-paper/

There are health related behaviours which, if changed can slow, or may even reverse[24], 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, the condition that can be reduced:

- Falls: the risk may be reduced after comprehensive assessment eg reducing medication that adversely effects balance; sustained strength and balance training, resistance exercise training or Tai Chi home safety checks; both in people's own homes and in case homes; and encouraging the use of outdoor footwear when indoors.
- Fractures: the risk may be reduced by the optimisation of bone health, including bone sparing medications where these are appropriate.

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.

[24] 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 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[25] 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 a 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 the condition, 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.

[25] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5806255/

Box 5: Care navigation in Wythenshawe.

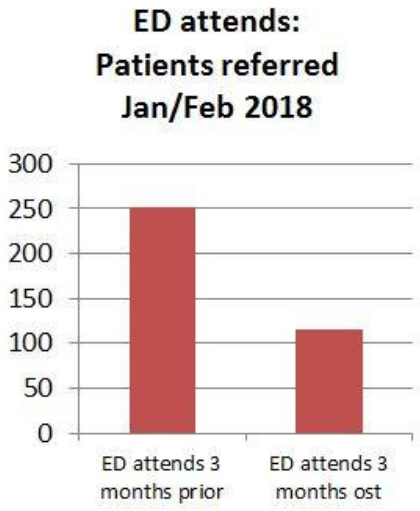
CASE STUDY: Impact of an acute care navigation service on hospital admissions in the vulnerable population

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 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.



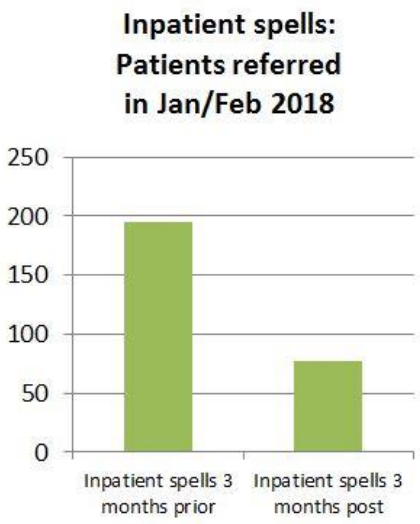
Non-Elective Inpatient Spells: During the three months prior to referral, the patients accounted for 106 inpatient admissions. This equates to 1.49 admissions per patient. There was a reduction of 64 admissions in the 3 months post-referral , which is a 60.4% reduction, or 0.9 admissions per patient

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.

7. 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 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 1overleaf.

Table 1: Frailty identification standards.

DRAFT GM standards for identifying and assessing clinical frailty	
1	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.
2	Patients will be assessed for common undiagnosed reversible conditions (eg heart failure, reversible airways obstruction, incontinence or sensory impairment).
3	Every person aged 65 years and over and frail will have a medications review and falls risk assessment and fracture risk assessment, including use of an appropriate tools (such as FRAT for falls, FRAX or QFracture for fractures) by their GP.
4	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.

Table 2: Frailty care planning standards.

DRAFT GM standards for clinical frailty care planning	
5	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 persons 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.
6	Wherever possible, patients and/or their carers will be supported to self-manage
7	Every clinically frail person will have a single care record visible to all health & social care teams.
8	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.

Table 3: Frailty intervention standards.

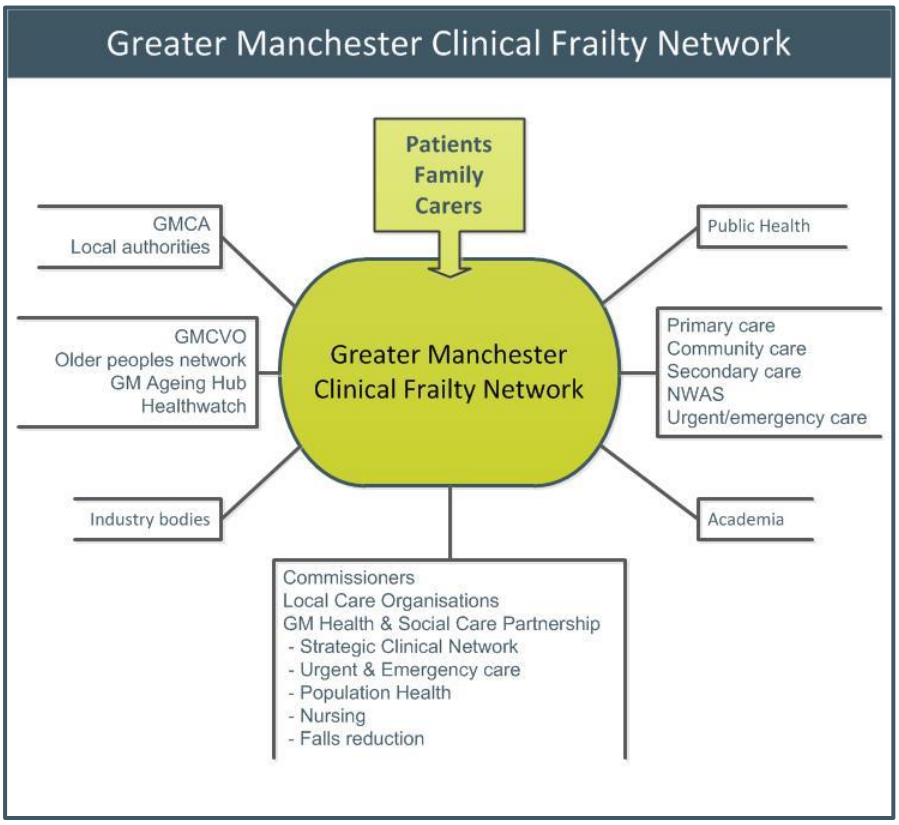
DRAFT GM standards for clinical frailty interventions & care	
9	All people who are diagnosed as frail will have the opportunity to participate in group consultations where appropriate.
10	All health and social care staff will have access to an up-to-date appropriately populated directory of services (including local, neighbourhood, voluntary and informal services).
11	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.
12	All primary, community, secondary & emergency care professionals working with clinically frail people will undergo appropriate frailty training/education.
13	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).

8. Greater Manchester Clinical Frailty Network

To promote the strategic objectives of this Framework 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 (Figure 8) 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. It will not be limited to clinical frailty specialists and will engage clinicians with a broader approach to areas such ageing. 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.
4. Support standards implementation and the development of new and improved clinical pathways.
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 8: The GM Clinical Frailty Network model.



Bibliography

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

BMA: Identification & management of patients with frailty:

- https://www.bma.org.uk/advice/employment/contracts/general-practice-funding/focus-on-identification-and-management-of-patients-with-frailty

NHS England guidance on batch coding:

- https://www.england.nhs.uk/wp-content/uploads/2017/04/gms-contract-batch-coding-statement.pdf

Acceptance of mental illness labels by psychotic patients:

- http://psycnet.apa.org/doiLanding?doi=10.1111%2Fj.1939-0025.1989.tb01675.x

Guidance on routine frailty identification through GP contract:

- https://www.england.nhs.uk/wp-content/uploads/2017/04/supporting-guidance-on-frailty-update-sept-2017.pdf

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:

- http://www.healthcareimprovementscotland.org/news_and_events/news/news_opac_rie.aspx

Delirium screening tool

- https://www.the4at.com/

Salford malnutrition armband:

- http://www.malnutritiontaskforce.org.uk/salfords-armband-tackling-malnutrition-with-paper/

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 Framework 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:

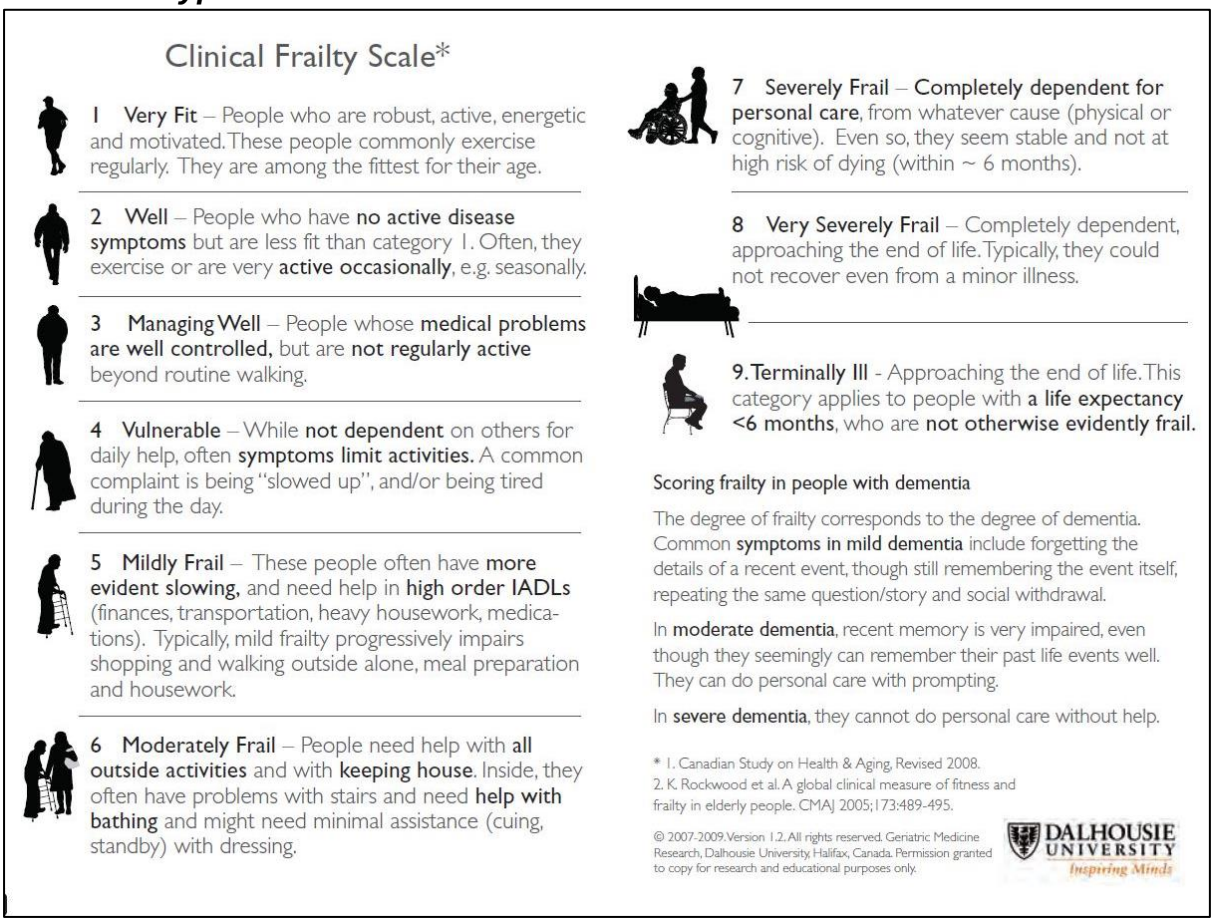
- https://future.nhs.uk/connect.ti/frailtyinprimarycare/grouphome

PHE Falls And Fractures Consensus Statement:

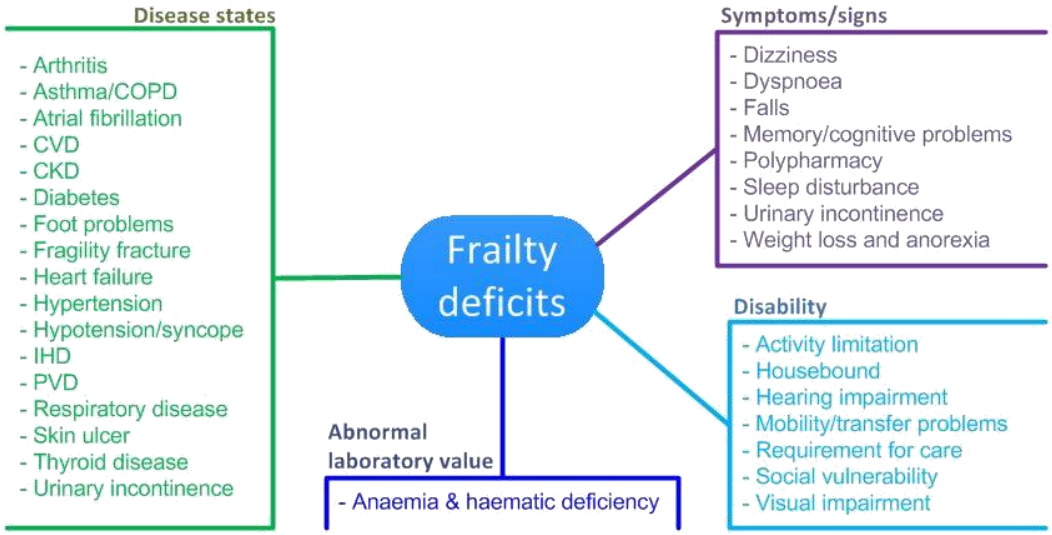
- https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement

Appendix 1: Frailty scale & index

The Phenotype scale



The Frailty Index



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.

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.
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.
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.
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.
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.
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.
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.
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.
Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of moderate or severe frailty, diagnosed using the appropriate tool up to the end of the reporting period, who have given consent to activate their enriched Summary Care Record (SCR) up to the end of the reporting period.

Appendix 3: Care Planning

Care planing 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 aslo 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) evlove 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 approriate 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).

STOCKPORT METROPOLITAN BOROUGH COUNCIL

NHS Stockport NHS Foundation Trust

Enhanced Case Management Goals of Care Record

Person's Name		NHS Number	
Date Completed		Review Date	
Care Coordinator		Care Coordinator Contact Number	

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. To some extent: score 0.5 points. No: score 0 points.)	Score:
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.)	Score:
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.	

Goal setting is a way of thinking about what you want to achieve and motivating you to recognise what you could do to help make this happen.
Goals should be realistic and agreed between you and your care coordinator who will support you to focus on a way of helping you to achieve your goals.

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 v1.0 8.2.18

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.

Agreed needs and outcome as identified in my assessment	Agreed actions and who will do them	When/how often	Review date

Triggers/Crisis and Risk Management Plan			
Think about equipment, fire safety, and support network			
How I know when things aren't going well	How others might know	What I can do	What others can do (friends and family)

Appendix 4: The brief CGA

Brief Comprehensive Geriatric Assessment

Patient Contact	
☐	Home
☐	Care Home
☐	GP
☐	OPD
☐	ED
☐	Frailty
☐	

Clinical Frailty Score (Rockwood Scale): ☐

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

		Baseline (two weeks ago)	Current (today)
Cognition		☐ Within Normal Limits ☐ Mild Cognitive Impairment ☐ Dementia ☐ Delerium ☐ Abbreviated Mental test (AMT) Score: ☐ ☐ Mental Capacity Assessment required Main lifelong occupation:	
Emotional		☐ Within Normal Limits ☐ ↓Mood ☐ Depression ☐ Anxiety ☐ Fatigue ☐ Hallucination ☐ Delusion ☐ Other	
Motivation		☐ High ☐ Usual ☐ Low	
Health Attitude		☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Couldn't say	
Communication	**Speech:**	Within Normal Limits ☐ Impaired **Hearing:** ☐ Within Normal Limits ☐ Impaired	
	Vision:	Within Normal Limits ☐ Impaired **Understanding:** ☐ Within Normal Limits ☐ Impaired	
Strength		☐ Within Normal Limits ☐ Weak **Upper:** ☐ Proximal ☐ Distal **Lower:** ☐ Proximal ☐ Distal	
Exercise		☐ Frequent ☐ Occasional ☐ Not	
Balance	Balance	☐ Within Normal Limits ☐ Impaired	☐ Within Normal Limits ☐ Impaired
	Falls	☐ Falls Number: ☐	☐ Falls Number: ☐
Mobility	Walk inside	☐ Independent ☐ Slow ☐ Assisted ☐ Can't	☐ Independent ☐ Slow ☐ Assisted ☐ Can't
	Walk outside	☐ Independent ☐ Slow ☐ Assisted ☐ Dependent	☐ Independent ☐ Slow ☐ Assisted ☐ Dependent
	Transfers	☐ Independent ☐ Standby ☐ Assisted ☐ Dependent	☐ Independent ☐ Standby ☐ Assisted ☐ Dependent
	Bed (in/out)	☐ Independent ☐ Pull ☐ Assisted ☐ Dependent	☐ Independent ☐ Pull ☐ Assisted ☐ Dependent
	Aid use	☐ None ☐ Stick ☐ Frame ☐ Chair	☐ None ☐ Stick ☐ Frame ☐ Chair
Nutrition	Weight	☐ Normal ☐ Under ☐ Over ☐ Obese	☐ Normal ☐ Under ☐ Over ☐ Obese
	Appetite	☐ Within Normal Limits ☐ Fair ☐ Poor	☐ Within Normal Limits ☐ Fair ☐ Poor
	Swallow	☐ Within Normal Limits ☐ Impaired Fluids ☐ Impaired Solids	☐ Within Normal Limits ☐ Impaired Fluids ☐ Impaired Solids
Elimination	Bowel	☐ Continent ☐ Constipated ☐ Incontinent	☐ Continent ☐ Constipated ☐ Incontinent
	Bladder	☐ Continent ☐ Catheter ☐ Incontinent	☐ Continent ☐ Catheter ☐ Incontinent
ADLS	Feeding	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Bathing	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Dressing	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Toileting	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
IADLS	Cooking	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Cleaning	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Shopping	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Medications	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Driving	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
	Banking	☐ Independent ☐ Assisted ☐ Dependent	☐ Independent ☐ Assisted ☐ Dependent
Sleep		☐ Disrupted ☐ Daytime drowsiness **Socially Engaged** ☐ Frequent ☐ Occasional ☐ Not	

Social

Marital Status
☐ Married
☐ Divorced
☐ Widowed
☐ Single

Lives
☐ Alone
☐ Spouse
☐ Other

Home
☐ House…
☐ Steps…
☐ Apartment
☐ Supported Living
☐ Care Home
☐ Other
Number of levels: ☐
Number of steps: ☐

Supports
☐ Informal
☐ Other
☐ Requires more support
☐ None

Caregiver Relationship
☐ Spouse
☐ Sibling
☐ Offspring
☐ Other

Caregiver Stress
☐ None
☐ Low
☐ Moderate
☐ High

Caregiver Occupation:

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		
Medication	Dose	Date Commenced

	Problem List	Action Required	Action by:
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Long Term Conditions:	
1	
2	
3	
4	
5	

Notes:

☐ For MDT discussion, consider long CGA

☐ Long CGA **not** required, copy of Clinical Frailty score to GP

Outpatient Appointments	
Department	Date and Time

Assessor: .....

(Name, Grade & Signature)

Date: .....

Helen Lyndon and Dr Grant Stevens.: Toolkit for general practice in supporting older people with frailty and achieving the requirements of the Unplanned Admissions Enhanced Service (2014)