

**Supporting routine
frailty identification
and frailty care
through the GP
Contract 2017/2018**

NHS England INFORMATION READER BOX**Directorate**

Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference: 06767

Document Purpose	Guidance
Document Name	Supporting routine frailty identification and frailty through the GP Contract 2017/2018
Author	NHS England
Publication Date	26 April 2017
Target Audience	GPs
Additional Circulation List	
Description	The new 2017/2018 GP contract introduces routine frailty identification for patients who are 65 and over from 1 July 2017. This guidance provides GPs and Primary Care with a summary of the core contract requirements in relation to frailty within the contract and includes signposting to further support.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	N/A
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Document Status

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Gateway Ref: **06767**

Document Title: Supporting Routine Frailty Identification and Frailty Care through the GP Contract 2017/2018

Version number: 1.0

First published: 26/04/17

Prepared by: NHS England, Long Term Conditions Unit, Medical Directorate

Classification: OFFICIAL

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1 Introduction

The GP contract requires routine frailty identification for patients who are 65 and over.

The first paragraph of the Five Year Forward View notes that support for older people living with frailty, along with mental health and cancer, is one of the three areas that the NHS faces 'particular challenges'. Frailty has been described as the most problematic expression of population ageing¹ in part because it can be difficult to distinguish those living with frailty from those who aren't. The introduction of routine identification of frailty can help general practice to address this and provide an opportunity to target and improve care and support for older people with the greatest need. Moving from opportunistic to systematic population based identification of frailty can help reduce inequalities, improve access to care and enable the needs of individuals to be met through early, proactive targeted and appropriate interventions.

Not all older people are frail, and not all people living with frailty are old. However it is important to identify older people who are living with frailty so that we can stratify populations of older people by risk of future health and care utilisation. This will ensure that health and other preventative or supportive interventions are appropriately organised and targeted.

Frailty can help us predict who is likely to have a fall, become dependent on other people to help with basic care tasks, experience an unplanned admission to hospital or a care home and die within the next year. Frailty is also associated with anxiety, depression and a poorer quality of life.

NHS England's Older People's [webpage](#) contains information, support and resources on improving care for older people.

¹ Clegg et al: Age and Ageing 2016; 45: 353–360

2 Six step contract process



3 Aims

To help meet the challenge of providing support for older people living with frailty by:

- Proactively identifying older people (aged 65 and older) who are living with frailty and stratify populations by severity using an evidenced based tool (such as the electronic Frailty Index (eFI²³) supplemented by clinical judgement.
- Focusing on a small number of key evidence-based interventions that is, falls risk identification and annual medication review to support people living with severe frailty.
- Promoting use of the additional information in the Summary Care Record (with appropriate patient consent) to share key healthcare information across different care settings thereby supporting more integrated and appropriate care for people living with frailty. For example, by helping ambulance staff and hospitals to more easily identify people living with frailty at the onset of an admission, expediting acute frailty interventions linked to best practice and avoiding interventions or care approaches which may be inappropriate for acutely unwell people living with varying degrees of frailty.

4 Contract requirements

Practices will use an appropriate tool, e.g. Electronic Frailty Index (eFI) to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty, the practice will:

- deliver a clinical review providing an annual medication review and;
- where clinically appropriate discuss whether the patient has fallen in the last 12 months and;
- provide any other clinically relevant interventions.
- In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this by seeking informed patient consent to activate the enriched SCR⁴.

² eFI has been tested with over 900,000 patient records and uses existing coded data from the electronic primary care record to identify frailty in people aged 65 years or over. It is the winner of the Healthcare IT Product Innovation category at the EHI 2016 Awards and Innovation Category at the Royal College of Physicians' (RCP) Excellence in Patient Care Awards 2017.

³ Clegg et al: Age and Ageing 2016; 45: 353–360

⁴ For further guidance on patient consent, see ['patient consent and considerations for patients who lack capacity to consent'. \(PDF, 345.5kB\)](#)

5 Data and monitoring

Practices will code clinical interventions for this group appropriately. Data will be collected on:

- the number of patients recorded with a diagnosis of moderate frailty
- the number of patients with severe frailty
- the number of patients with severe frailty with an annual medication review
- the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months
- the number of severely frail patients who provided explicit consent to activate their enriched SCR.

NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This data will not be used for performance management or benchmarking purposes.

For further information please see NHS Employers [website](#) and summary documents.

6 Coding

Information on the recommended coding and data collections can be found via NHS Employers Technical requirements for 2017/18 GMS contract changes document: www.nhsemployers.org/GMS201718

7 Process and supporting guidance at a glance

Requirement	Information	Guidance/resources
<p>Identify all patients over 65 and assess their level of frailty using an appropriate tool (for example, the electronic Frailty Index (eFI)). Following clinical confirmation record the diagnosis (mild, moderate or severe) in the patient record.</p>	<p>This will involve 1) risk stratification of all 65 and above to identify those that are moderate and severe frail 2) verification that each of the individuals match the clinical assessment using a secondary check, for example established clinical knowledge of the patient and/or applying the clinical frailty scale (CFS). To confirm that frailty is likely to be present in a particular patient gait speed or PRISMA-7 self-rating tool can be used to prompt further direct clinical assessment and/or application of the CFS. This will then lead to a coded diagnosis of frailty at moderate or severe level on the health record (and where permission granted, on the SCR).</p>	<p><u>NICE guidance</u></p> <ul style="list-style-type: none"> • NICE Guideline NG56: Multimorbidity Clinical Assessment and Management <p><u>Tools and guidance</u></p> <ul style="list-style-type: none"> • eFI user Support Hubs (SystemOne, EMIS and Vision) • Clinical Frailty Scale Coding –see below ‘Consistency in Read Coding’ <p><u>Best practice / examples</u></p> <ul style="list-style-type: none"> • Frailty awareness for GPs Frailty overview and animation • Frailty Blog by Martin Vernon
<p>Where a patient does not already have an enriched Summary Care Record (SCR) to seek informed patient consent to activate the enriched SCR.</p>	<p><u>Creating SCRs and including additional information</u></p> <p>The SCR is created automatically through clinical systems in GP practices and uploaded to the Spine. It will then be updated when further changes are made to the GP record.</p> <p>Additional information can be added to the SCR, with explicit patient consent, by the GP. The information can be included automatically by changing the patient's SCR</p>	<p><u>Tools and guidance</u></p> <ul style="list-style-type: none"> • Additional information in SCR - Guidance for GPs to use SCR to make more information available across care settings. Includes benefits of enriching the SCR. • Guidance regarding SCR additional information for patients who lack the capacity to consent to an SCR with additional information 'Patient consent and considerations for patients who lack capacity to consent'. (PDF, 345.5kB) • Viewing SCRs with additional information.

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Requirement	Information	Guidance/resources
	consent status.	Download the viewer guidance for healthcare staff (PDF, 1.7MB) to understand the changes that additional information brings when viewing the SCR. A condensed two sided SCR viewer guide (PDF, 178.1kB) for healthcare staff is also available.
<p>For patients identified as living with severe frailty, the GP practice will deliver, as clinically appropriate, a clinical review as follows:</p>		
<p>An annual falls check</p>	<p>Frailty can help predict who is likely to have a fall. Effective, planned, evidence based approaches to falls and fracture risk reduction are of key importance to the health and wellbeing of people living in our communities and those that care for them. The routine identification of those most vulnerable of falling will allow GPs to target those interventions at individuals who are most likely to benefit.</p>	<p><u>NICE guidance</u></p> <ul style="list-style-type: none"> • NICE Guideline 161: Falls in older people: assessing risk and prevention <p><u>Tools and guidance</u></p> <ul style="list-style-type: none"> • Falls and fractures consensus statement • Toolkit for General practice in supporting older people living with frailty.
<p>An annual medication review.</p>	<p>The use of multiple medications by older people living with frailty is likely to increase the risk of falls, adverse side effects and interaction. Hence the need to individualise the interpretation of national guidelines for single long term conditions in the context of multimorbidity in general and frailty in particular.</p>	<p><u>NICE guidance</u></p> <ul style="list-style-type: none"> • Medicines optimisation set out in NICE NG5 https://www.nice.org.uk/guidance/NG5 • NICE Quality Standard 6 – structured medication review. • NICE Guideline NG56: Multimorbidity Clinical Assessment and Management <p><u>Tools and guidance</u></p> <ul style="list-style-type: none"> • Polypharmacy: Guidance for Prescribing in

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Requirement	Information	Guidance/resources
		<p data-bbox="1400 240 1563 272"><u>Frail Adults</u></p> <ul data-bbox="1350 280 1843 312" style="list-style-type: none"><li data-bbox="1350 280 1843 312">• <u>STOPP/START tool user guide</u> <p data-bbox="1350 355 1727 387"><u>Best practice / examples</u></p> <ul data-bbox="1350 395 2029 496" style="list-style-type: none"><li data-bbox="1350 395 2029 496">• <u>BMJ 10 minute consultation</u> how a GP could potentially complete a medications review in a consultation.

8 Glossary of key terms

<p>Five Year Forward View</p>	<p>The NHS Five Year Forward View was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care. It has been developed by the partner organisations that deliver and oversee health and care services including Care Quality Commission, Public Health England and NHS Improvement. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.</p>
<p>Electronic Frailty Index (eFI)</p> <p>(available on your GPSOC i.e. EMIS, SystemOne and Vision)</p>	<p>The eFI uses existing electronic health record data to identify and severity grade frailty. The eFI has been developed using the cumulative deficit model of frailty, whereby frailty is defined on the basis of the accumulation of a range of deficits, which are clinical signs (e.g. tremor), symptoms (e.g. breathlessness), diseases (e.g. hypertension) and disabilities. It has undergone internal and external validation in a retrospective cohort study using data from around 1 million patients in the ResearchOne and THIN databases.</p>
<p>Frailty</p>	<p>Frailty is characterised by loss of resilience that means you do not bounce back quickly after an acute illness, accident or other stressful event. Frailty (rather than age) is predictive of having a fall, becoming dependent on other people to help with basic care tasks, unplanned admission to hospital, a care home and death.</p>
<p>Severe frailty</p>	<p>People are 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).</p>
<p>Moderate frailty</p>	<p>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.</p>
<p>Mild frailty</p>	<p>These people often have more evident slowing, and may need more help with finances, transportation, heavy housework, medications. Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.</p>

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Summary Care Record (SCR)	The SCR is an electronic record of important patient information, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care.
Enriched SCR	A SCR that that contains additional information and which the patient has consented to being shared / available to view by authorised staff in other areas of the health and care system involved in the patient's direct care.
Multimorbidity	Multimorbidity refers to the presence of 2 or more long-term health conditions, which can include: <ul style="list-style-type: none">• defined physical and mental health conditions such as diabetes or depression• ongoing conditions such as learning disability• symptom complexes such as frailty or chronic pain• sensory impairment such as sight or hearing loss• alcohol and substance misuse.