Community services currency guidance: frailty and last year of life

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1. Background and introduction

Community services are often defined by what they are not and although services in different organisations may share a name, they frequently have different professional definitions and modes of delivery across England. The development of community currencies presents an opportunity to focus on needs-based systems of service design, delivery and payment definitions.

Development of community currencies began in 2017, five distinct patient groups were identified and defined through discussions with the clinical leadership in NHS England, and other stakeholders. Task and finish groups were established, comprising of subject matter experts for that particular patient group. Overall direction was set by an Expert Reference Group.

Each task and finish group were responsible for the development of a currency appropriate for the needs of these distinct populations;

- Children and Young People with disabilities
- Long Term Conditions
- Single Episodes of Care
- Frailty
- Last Year of Life

In 2019, NHS England published A New Approach To Supporting Community Healthcare Funding - Testing and Guidance. This document set out the process undertaken to develop the currencies, detailed each currency and the next steps for testing these currencies across the community sector.

The testing and further development of the community currencies continues. The Pricing and Costing team have proposed the publication of two currency models for use from 2021/22; Frailty and Last Year of Life. This document will:

- Provide detail on the currency model
- Describe the process require to collect the required information for the currency models.
- Describe the process for submitting this data via national data sets.
- Provide an overview of the ongoing development and refinement of these currencies.

For more details about currencies, the national tariff and payment see the NHS payment system pages on our website.

2. Frailty currency model

Development of the frailty currency model began by agreeing a suitable definition. The task and finish group agreed the following definition as most suitable:

> "a long-term health condition characterised by loss of physical, emotional and cognitive resilience as a result of the accumulation of multiple health deficits. Frailty is progressive, typically erodes functional, cognitive and/or emotional reserves and increases vulnerability to sudden loss of independence and adverse health outcomes following a comparatively minor stressor event such as an acute infection or injury. While severe frailty can be comparatively easy to recognise and diagnose, lesser degrees of frailty may be more difficult to differentiate from normal ageing."[1]

People may be frail but have no other long-term health conditions. As with other long-term conditions, frailty can be effectively managed within primary care. There is often a trajectory of slow functional deterioration. Current evidence suggests a 3% accumulation of health deficits each year. However, through effective intervention, this accumulation can be reduced, with the potential to release resources for other health services.

The Toolkit for General Practice in supporting older people living with frailty advises that practices should stratify their population aged 65 and over by degree of frailty into those who are fit (not frail) and those who are living with mild, moderate or severe frailty using the electronic Frailty Index (eFI). It should be noted that a diagnosis of frailty requires clinical judgement and cannot be assumed based on the eFI or any other scoring mechanism alone.

It was therefore decided that the currency should be based on a clinical diagnosis of frailty, combined with a periodic assessment.

There are three levels of frailty in the currency model are mild, moderate and severe. These definitions are clearly defined, reflected in the definitions used in the Clinical Frailty Scale (CFS). The CFS, also knows as the Rockwood Scale, is a widely used assessment which measures a person's frailty from very fit (1) to terminally ill (9). Appendix A provides more detail on each level within the CFS.

[1] NHS England: Toolkit for general practice in supporting older people living with frailty

The currency model defines the levels of frailty as follows:

- Mildly frail (CFS score of 5) – These people often have more evident slowing, and need help in high order IADLS (instrumental activities of daily living – eg finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
- Moderately frail (CFS score of 6) – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help bathing and might need minimal assistance (cuing, standby) with dressing.
- Severely frail (CFS score of 7) – 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.

It is expected that once a patient has been diagnosed as frail, the patient will be assessed using the CFS when accessing a service and then periodically every 6 or 12 months, however this may vary depending on local models of care.

The currency units were designed with three currencies for each level of frailty. For mild and moderate frailty this can be recoverable, stable or progressive. For severe frailty we recognise that this condition is unlikely to be recoverable but that the expected trajectory for individuals living with severe frailty is not yet fully understood. Table 1 sets out the currency model.

Table 1: Frailty Currency Model

Currency unit	Severity	
FR_01	Mild – Recoverable	CFS = 5 at T zero and <5 at time T
FR_02	Mild – Stable	Annual accumulation of deficits ≤ 3% CFS = 5 at T zero and time T
FR_03	Mild – Progressive	Annual accumulation of deficits > 3% CFS = 5 at T zero and >5 at time T
FR_04	Moderate – Recoverable	CFS=6 at T zero and <6 at time T
FR_05	Moderate – Stable	Annual accumulation of deficits ≤ 3% CFS=6 at T zero and at time T
FR_06	Moderate – Progressive	Annual accumulation of deficits > 3% CFS=6 at T zero and >6 at time T
FR_07	Severe – Stable	Annual accumulation of deficits ≤ 3% CFS=7+ at time zero and at time T
FR_08	Severe – Progressive	Annual accumulation of deficits > 3% CFS=7+ at time zero and 8 at time T
FR_09	Severe – End Stage Frailty	CFS=7+ at time zero and 9 at time T

T Zero = at start; T = time scale for assessment to be agreed locally

3. Last year of life currency model

The population covered by the last year of life currency is defined as people in their last year of life and therefore receiving end of life care. Around 500,000 people die each year in England each year but not all deaths are expected. This currency model will classify those patients receiving end of life care as part of their final year (or years) of life. Patients approaching the end of life are expected to have a personalised care plan and be entered on a supportive and palliative care register by their GP

Around 120,000 of these deaths are supported by specialist palliative care each year. This care is already supported by a currency specific to the complex needs of this group, t is therefore excluded from the last year of life currency.

The Last Year of Life currency model builds on the work of the specialist palliative care currency which was published for mandated use in 2017. Further information on the pilot testing process can be found in Developing a New Approach to Palliative Care Funding - Final Testing Report.

The last year of life community currency model, shown in Table 2, applies an internationally proven phase of illness model, combined with a functional status model.

Table 2: Last Year of Life Currency Model

Currency unit	Phase of illness	AKPS functional status
LYOL_01	Stable	Low
LYOL_02	Stable	Medium
LYOL_03	Stable	High
LYOL_04	Unstable	Low
LYOL_05	Unstable	Medium
LYOL_06	Unstable	High
LYOL_07	Deteriorating	Low
LYOL_08	Deteriorating	Medium
LYOL_09	Deteriorating	High
LYOL_10	Dying	
LYOL_11	Deceased	

The phase of illness model consists of five phases: stable, unstable, deteriorating, dying and deceased. Appendix B provides details of the phase of illness assessment definitions.

Functional status is assessed using the Australian modified Karnofsky performance scale (AKPS). The AKPS is an 11-point model which defines a patient's functional status from 100% (normal) to 0% (deceased). For the currency model, the AKPS functional status is concatenated into one of three categories: high (100-80), medium (70-50) and low (40-0). Appendix C provides further details of the AKPS.

4. Community Services Data Set (CSDS)

The Community Services Data Set is a patient level, output based, secondary uses data set. It is able to deliver robust, consistent information about the care delivered by community services. As a secondary uses data set, it intends to re-use clinical and operational data for purposes other than direct patient care, therefore minimising the overall data burden on providers.

The CSDS is managed by NHS Digital and has been in place since October 2017. As a mandatory data set, any provider of publicly funded community care is legally mandated to provide monthly submissions of collected data. The CSDS uses the SNOMED-CT coding system, a structured clinical vocabulary used within the electronic health record.

The NHS England and Improvement Pricing and Costing Team have worked alongside the Casemix Office at NHS Digital to ensure that the data items required to collect the Frailty and Last Year of Life currencies are available and can be submitted to the CSDS. This includes all assessment codes required. By using a nationally mandated data set we have ensured that the currencies can be derived with the minimum of data burden to the provider.

Further information on the CSDS, including Information Standards Notice and Data provision Notices can be found here.

5. Using community currencies for commissioning

Historically, community services have been funded using block contract arrangements. The development of needs-based currencies for community services

offers an opportunity to move towards evidence based pricing which supports a person-centred approach and proactive care management.

The Frailty and Last Year of Life currencies have been developed to support the implementation of a number of different payment options ranging from patient pathways to patient-based budgets.

The publication of these currencies for non-mandatory use in 2021/22 is the first step in a larger programme to develop currencies and payment mechanisms for community based services which support a whole system approach.

The implementation of community currencies will support benchmarking between providers, aid collaboration and assist the commissioning process. This will be further enhanced as development of additional needs based currencies are developed.

6. Future development

During 2021/22, we will be working with a number of providers from across the community sector, including independent providers, to expand our understanding of how community services work locally. We want to understand how best to support collaboration and commissioning of services.

Our development of currencies for children and young people with disabilities, long-term conditions and single episodes of care will also continue, alongside further scoping of patient groups for future currency development.

If you would like to learn more about this process or become a pilot partner as an individual organisation or local system, please contact england.communitycurrencies@nhs.net.

Appendix A – Clinical Frailty Scale

1 Very Fit - People who are robust, active, energetic and motivated. These people commonly exercise regularly. 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 dependant 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 bathing and might need minimal assistance (cuing, standby) with dressing).

7 Severely Frail - Completely dependant 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 dependant, approaching the end of lilfe. Typically, they could not recover even from a minor illness.

9 Terminally Ill - 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.

Appendix B – Phase of Illness

Phase	Start of phase	End of phase
Stable	Patient problems and symptoms are adequately controlled by established plan of care and • Further interventions planned to maintain symptom control and quality of life **and** • Family/carer situation is relatively stable and no new issues are apparent	The needs of the patient and or family/carer increase, requiring changes to the existing care plan (i.e. the patient is now unstable, deteriorating or terminal)
Unstable	An urgent change in the plan of care or emergency treatment is required **because** • Patient experiences a new problem that was not anticipated in the existing plan of care, **and/or** • Patient experiences a rapid increase in the severity of a current problem; **and/or** • Family/ carers' experience changes which impact on patient care	• The new care plan is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. the patient is now stable or deteriorating) **and/or** • Death is likely within days (i.e. patient is now terminal)
Deteriorating	The care plan is addressing anticipated needs but requires periodic review **because** • Patient's overall function is declining **and** • Patient experiences an anticipated and gradual worsening of existing problem **and/or** • Patient experiences a new but anticipated problem **and/or** • Family/carers experience gradual worsening distress that is anticipated but impacts on the patient care	• Patient condition plateaus (i.e. patient is now stable) **or** • An urgent change in the care plan or emergency treatment is required **and/or** • Family/ carers experience a sudden change in their situation that impacts on patient care, and requires urgent intervention (i.e. patient is now unstable) **or** • Death is likely within days (i.e. patient is now terminal)
Dying	Death is likely within days	• Patient dies **or** • Patient condition changes and death is no longer likely within days (i.e. patient is now stable, or deteriorating)
Deceased	Patient has died; bereavement care provided to family/carer is documented in the deceased patient's clinical record.	Case closed.

Appendix C – Australian modified Karnofsky performance scale (AKPS)

	Status Score	Descriptor
High	100%	Normal no complaints; no evidence of disease.
	90%	Able to carry on normal activity; minor signs or symptoms of disease.
	80%	Normal activity with effort; some signs or symptoms of disease.
Medium	70%	Cares for self; unable to carry on normal activity or to do active work.
	60%	Requires occasional assistance, but is able to care for most personal needs.
	50%	Requires considerable assistance and frequent medical care.
Low	40%	In bed more than 50% of the time.
	30%	Almost completely bedfast
	20%	Totally bedfast and requiring extensive nursing care by professionals and/or family
	10%	Comatose or barely arousable
	0%	Dead

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