Fit for Frailty

Part 2 - Developing, commissioning and managing services for people living with frailty in community settings

Developed by the **British Geriatrics Society**
and the **Royal College of General Practitioners**
in association with Age UK

How to use this guide

This summary guide is for General Practitioners, Geriatricians, Health Service Managers, Social Service Managers and Commissioners of Services for older people.

A fuller and more detailed edition of the guide, including case examples, is available as a free download on our website (http://www.bgs.org.uk/campaigns/fff/fff2_full.pdf).

This guide forms the second part of our 2 part consensus guidance on frailty in community and outpatient settings. Part 1, entitled, Fit for Frailty - Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings (available for download from the British Geriatrics Society (BGS) website - www.bgs.org.uk [Select Resources/Campaigns/Fit for Frailty.

What is Frailty?

▶ Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people with frailty are at risk of unpredictable deterioration in their health resulting from minor stressor events.

Looking for Frailty

▶ Older people should be assessed for the presence of frailty during all encounters with health and social care personnel (including reception and clerical staff).

▶ Gait speed, the timed-up-and-go test and the PRISMA questionnaire are recommended assessments for identifying frailty (full details are available in the part 1 guidance).

▶ Identifying frailty at a practice level using existing health record data is an emerging and attractive possibility.

Managing Frailty – Services need to:

▶ Ensure all older people identified as living with frailty receive a comprehensive review of medical, functional, psychological and social needs, based on the principles of comprehensive geriatric assessment.

▶ Make available interventions for older people with frailty which improve overall physical, mental and social functioning, using a goal-orientated rather than a disease-focused approach, taking account of individual needs and personal assets, rather than deficits.

▶ Develop shared care and support plans by involving older people with frailty, their families and carers throughout all stages of the process.

▶ Remember that many people with frailty will have cognitive impairment and dementia or vice versa. Older people with dementia and frailty will have especially complex care needs, requiring a judicious approach to care planning.

▶ Consider end of life care planning for older people with frailty if there is evidence of declining ADL function, unstable long-term conditions, advancing dementia or systemic features indicating severe frailty, including weight loss and severe exhaustion.

▶ Be fully integrated across health and social care systems, because those with frailty stand to gain most through an integrated approach. Likewise, a service which addresses the whole pathway across primary care, community care including social care and secondary care is likely to be the most successful.

▶ Establish joint working between primary care, ambulance service, community teams, geriatricians and old age psychiatrists to attend to the complex medical, functional, social and psychological aspects of frailty more effectively.

▶ Signpost older people with frailty to relevant local authority, domiciliary care and voluntary sector services.

▶ Provide real and safe alternatives to hospital admission when an older person with frailty is unwell, recognising the potential health risks of hospitalisation.

▶ When hospital admission is clinically appropriate, overcome historical barriers between health and social care to develop pathways to pull older people with frailty out of hospital and prevent unacceptable delayed transfers of care.

Managing Services – Training and Education

▶ Develop local training and education packages structured around the application of comprehensive geriatric assessment in frailty for multi-professional teams working in primary, community , intermediate care and secondary care to maximise the sharing of skills.

Managing Services - Evaluation

▶ Consider process measures including waiting time to be seen for comprehensive geriatric assessment and delayed transfers of care from hospital when developing and evaluating frailty interventions.

▶ Consider self-reported outcome and experience measures that are relevant for older people with frailty when developing and evaluating frailty services, including quality of life, loneliness, pain, function and harms (e.g. falls, adverse medication events).

▶ Consider outcomes that are relevant for local health services, including reduction in excess bed days, reduction in outpatient visits, reduction in primary care consultations, patient safety and improved staff recruitment and retention.

▶ Remember that desired outcomes such as reduced unplanned admissions and reduction in health and social care costs may take time to achieve and are unlikely to be seen in the immediate aftermath of a service or structural change. These outcomes are also unlikely unless there has been a change in working practice at scale (demonstrated through the process measures outlined above).

Commissioning and Developing Services

▶ Structural changes may help develop new models of proactive, person centred care for older people with Frailty. General Practice Federations, within general practice and new models of funding and commissioning, including joint health and social care commissioning and whole systems frameworks within secondary and community care. All these changes will need a workforce which is flexible in working across boundaries and interfaces and which challenges traditional training pathways.

▶ It is essential that all services are bound together within some form of integrated contractual framework since commissioning for community services in isolation is unlikely to be effective. This means that in England, commissioners need to consider new models of collaborative commissioning, working with providers rather than being too reliant on market solutions.

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