System Wide Frailty Network (SWFN) Toolkit

Version 1 – August 2023

Click here to get started

1 Adopt a proactive frailty attuned person-centred approach

2 Involve patient and public partners

3 Understand the needs of your population living with frailty

4 Embrace digital technology

5 Integrate around person, place and at system level

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Introduction

The Ageing Well programme within the NHS Long Term Plan aims to promote older people's independence and person-centred care, reduce inequalities and reduce institutionalisation[1]. In parallel, the creation of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) have been designed to integrate health and social care providers into a unified system (Figure 1).

Figure 1: Integrated care systems at a glance

Integrated care systems (ICSs)

Key planning and partnership bodies from July 2022

NHS England
Performance manages and supports the NHS bodies working with and through the ICS

Care Quality Commission
Independently reviews and rates the ICS

Statutory ICS

Integrated care board (ICB)

Membership: independent chair; non-executive directors; members selected from nominations made by NHS trusts/foundation trusts, local authorities, general practice; an individual with expertise and knowledge of mental illness

Role: allocates NHS budget and commissions services; produces five-year system plan for health services

Cross-body membership, influence and alignment

Integrated care partnership (ICP)

Membership: representatives from local authorities, ICB, Healthwatch and other partners

Role: planning to meet wider health, public health and social care needs; develops and leads integrated care strategy but does not commission services

Influence

Influence

Partnership and delivery structures

Geographical footprint	Name	Participating organisations
System Usually covers a population of 1–2 million	**Provider collaboratives**	NHS trusts (including acute, specialist and mental health) and as appropriate voluntary, community and social enterprise (VCSE) organisations and the independent sector; can also operate at place level
Place Usually covers a population of 250–500,000	**Health and wellbeing boards**	ICS, Healthwatch, local authorities, and wider membership as appropriate; can also operate at system level
	Place-based partnerships	Can include ICB members, local authorities, VCSE organisations, NHS trusts (including acute, mental health and community services), Healthwatch and primary care
Neighbourhood Usually covers a population of 30–50,000	**Primary care networks**	General practice, community pharmacy, dentistry, opticians

The King's Fund

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A key aim of this organisational integration is to support professionals to coordinate care for older people better, developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharge from hospital. Furthermore, there will be additional support for people living in care homes, carers, people with dementia and those in the end-of-life phase.

In combination with an enhanced urgent care response, for example through the development of Same Day Emergency Care (SDEC) for older people living with frailty[2], there is now an opportunity to implement a whole system approach for older people living with frailty, as outlined in the NHS Right Care Toolkit for frailty[3], the British Geriatrics Society[4] and GIRFT programme.

Box 1: What is frailty?

Frailty is defined as a *physiological syndrome characterised by decreased reserve and diminished resistance to stressors, resulting from cumulative decline across multiple physiological systems, and causing vulnerability to adverse outcomes*[5]. Frailty constructs have been validated in numerous community and hospital settings[6-8].

The fundamental utility of the frailty framework derives from its strong relationship with health status and resource use for older adults. There are two broad approaches to capturing frailty:

- At the population level using electronic systems to segment the population, such as the electronic Frailty Index[6] (primary care) or the Hospital Frailty Risk Score[9,10] (secondary care).
- For individual patient assessment, it is best to use the Clinical Frailty Scale (CFS), based on how the person was two weeks ago, as this will give a more contemporaneous result that can inform, (but not direct clinical decision making. See here for more on frailty assessment

Developing the workforce

Essential to achieving a whole system approach for older people living with frailty is ensuring a sustainable workforce with overall balance between supply and demand across all staff groups as outlined in the NHS People Plan. The workforce are part of the sociotechnical system that interacts with all areas of the health and care system, it is crucial to the delivery of services and impacts the potential to meet existing and future patient needs. However, current workforce shortages are causing significant challenge and raising concern about the system's ability to deliver safe high quality care within a complex health and care system. Health policy is now driving transformation, and we must think differently with long-term and fully funded comprehensive workforce policies to support the design and development of a workforce to meet evolving needs[1]. Health Education England designed a toolkit for multi-disciplinary teams to guide a one workforce approach, to not only bridge the workforce gap but to improve quality by drawing on a broader range of skills and competencies. You can find out more about workforce predictions here.

Introducing the System Wide Frailty Network Principles

Using a network approach based on the model for improvement, we are working across England to support a system-based approach to improving services for older people. To support this approach, we have worked with stakeholders to develop a set of principles that systems can use:

1. Adopt a proactive frailty attuned person-centred approach
2. Involve patient and public partners
3. Understand the needs of your population living with frailty
4. Embrace digital technology
5. Integrate around person, place and at system level
6. Develop systems to communicate with all stakeholders
7. Leaders should encourage and measure systems thinking
8. Embed and enable a Quality Improvement approach
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TOOLKIT NOTE
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Principle 1

Adopt a proactive frailty attuned person-centred approach

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There will be different models including primary care and community multi-disciplinary team (MDT) hubs, which can be tiered according to the level of complexity. The key is to remain close to the evidence, using Comprehensive Geriatric Assessment (CGA) as the organising construct[11,12]. The 'offer' is anticipatory care, which needs to be individualised and informed by frailty and patients' preferences. For some it will be medicines rationalisation, falls assessments or social prescribing, whereas for others it might be advance care planning. It is essential to be proactive rather than reactive and share information across the system to avoid duplication and ensure actions are captured and acted upon iteratively.

Deciding where to begin can be tricky when faced by such a big issue but the main thing is to make a start. There is no correct answer – supporting the most severely frail with advance care planning is one approach[13]. Another approach might be exercise (resistance training) and protein-energy nutritional support to slow the progression of sarcopaenia[14]. Work with your stakeholders, clinical and professional, to decide where you want to start and build from there. Creating a whole system approach for frailty will take years, not months, so be strategic.

Ideally, there should be standardised assessment templates (CGA-based), which draw together all of the relevant information in one place. This should be supplemented by a face to face assessment by one of the MDT team members best placed to interact with the patients (depending upon their primary issue – physio/nursing etc.) and elicit face to face measures such as Clinical Frailty Scores, 'what matters to me' or physical assessment such as the Timed Up and Go test. Such 'first assessors' should be trained in at least Level Two frailty competencies, preferably Level Three (see resources section). Shared care records are essential to the success of such initiatives, all relevant team members need to be able to see and update the clinical record.

There will be a wide range of agencies in your system that can help support the delivery of holistic care, such as social care/voluntary sector/ local communities including borough councils/social prescribers/health coaches. Are you engaging with these teams?

Configure frailty attuned crisis responses, including support for first responders

Proactive care has limited potential to prevent frailty crises hence the importance of embedding frailty identification and holistic assessment throughout the patient pathway[15]. Crises will occur, so the system needs to be ready to respond wherever and whenever these happen – responses will depend upon the local context. There is evidence for holistic care models offering improvements in patient and service outcomes in primary care (including Hospital at Home)[16,17], emergency departments[18,19] and secondary care[11].

It is crucial to ensure that the response delivers evidence-based care in line with pre-existing wishes/the advanced care plan etc. There should be provision for 7 days a week and extended hours for out of hospital services/SDEC for older people living with frailty. The evidence is now robust for Hospital at Home, SDEC and geriatrician led front door frailty services with in-patient care when needed[20]. The aim is to ensure that when required, the crisis response is holistic, coordinated, focused and time limited when it occurs.

Silver phone

There are emerging case studies of senior clinical decision makers supporting real-time assessments of older people with crises in their own homes using a range of digital enablers (Accurisk, Consultant Connect, FaceTime, GoodSAM) to support first responders such as paramedics (Hull, Warwick, Frimley, Leicester, North Central London), first contact practitioners etc. Initial data suggests that such support can reduce conveyance rates by up to 50%, and enable more place based care, for example linking in with Virtual Wards[21].

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Involve patient and public partners

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Public involvement can improve the quality and person-centredness of your system, as well as serving the broader democratic principles of citizenship, accountability and transparency. The UK Standards for Public Involvement in Research can be accessed here.

People who are the intended beneficiaries of services have a right to have a say in their development. Public involvement can also help empower people who use health and social care services, by providing them with the opportunity to influence and ensure relevance of any changes.

Members of the public will have personal knowledge and experience relevant to your service developments or be able to provide a more general societal perspective. They will have lived experience of one or more health conditions and of using services. Members of the public will also bring their experiences of being part of specific communities or groups.

Understand the experience of care

As part of any improvement approach, we encourage teams to study the experiences of service users through experience-based design (EBD). Gathering data on the experience of service users and staff is vital to inform co-design and ensure improvements are centred on service users' needs.

This methodology can be used to focus on one element of the system or be used to explore the end-to-end pathway provision for older people living with frailty across the system from a service users' perspective.

EBD provides another element to measurement and can be a powerful dimension of measurement to triangulate the data you use to drive improvements.

Working with the public to co-design services is a fairly new approach and teams find this methodology very effective when working with this group to harness their feedback. The aim of EBD is to gain insight to understand how our services make people feel. Once we understand the emotional journey through our services, we can work with stakeholders to design better experiences for service users, staff and carers. The Frailty team at NHS Elect have used EBD with sites across their improvement networks. This has resulted in a tool developed with older people living with frailty to capture their experiences when using services, looking at their journey and the emotional response interventions trigger. Data collected and analysed allows an emotional map of users journeys to be created. Using this analysis stakeholders work together inclusive of patients and carers to understand what can be done to improve the service to focus on what matters to them.

Read more about a large-scale patient experience study here

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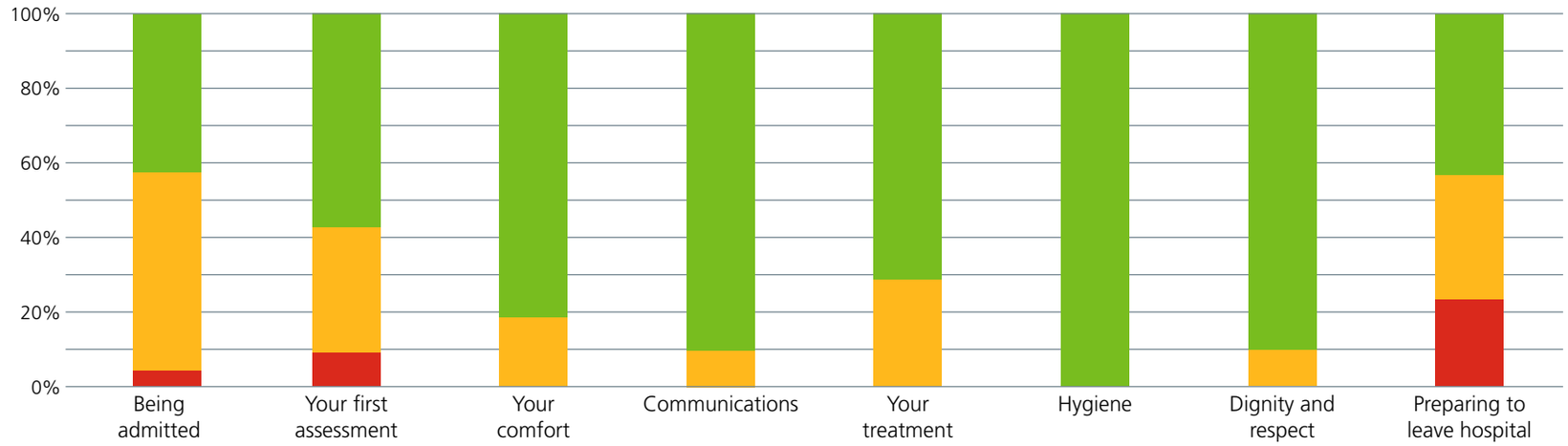
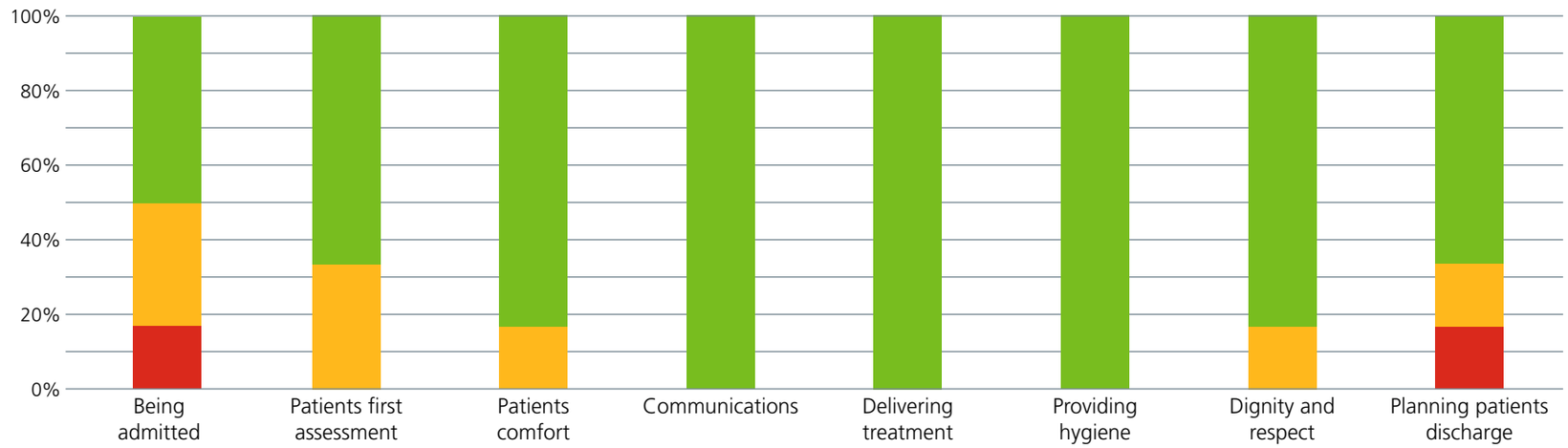
It is also really useful to understand the experience of staff at work, particularly how they feel delivering the components that matter to service users. To achieve this, data is collected from working in the service. This data is analysed to create an emotional map which is then viewed alongside the patient map (see below).

Whilst this is not particularly scientific, this comparison will reveal any disconnect or differences between service users and staff. It is common for staff to be pleasantly surprised about feelings expressed by service users. Often staff are more critical and feel service users are unhappy when the data does not show this. This can be very morale boosting for staff as well as providing a framework for productive improvement conversations.

Patient map



Staff map



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Understanding staff experience

It is also very useful to take an EBD approach to understand what is needed to support staff to have happier working lives. During the pandemic we worked with a cross section of clinical and non-clinical staff to undertake a large-scale staff experience study.

To complete this we worked with the group to develop 'touch points' common to most staff on a typical working day. Once agreed, the EBD survey was distributed widely to gain an insight into how staff feel and what we can do to improve their working lives.

Results from this study are summarised on the emotional map below and you can access the full study here.

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Understand the needs of your population living with frailty

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Frailty can be identified across systems using tools such as the electronic Frailty Index[6] (eFI, derived from primary care records) or the Hospital Frailty Risk Score[10] (HFRS, derived from secondary care records). Either tool will be able to identify clusters of patients with frailty and relatively high risk of resource use. Which tool to use will be guided by local choice and ease of implementation[22].

Frailty dashboards

At the system level, the initial risk stratification might use the eFI or HFRS but add in additional information as it becomes available and proves relevant e.g. social deprivation scores. Dashboards should integrate different data sources (primary care, secondary care, social care, mental health) to make them system-wide, which will allow a more refined targeting of the holistic response. Ideally, you should be able to drill down from the whole system through to Primary Care Network and individual general practice levels. The key is to ensure that the data being shared with practitioners is acceptable, believable, and actionable. If lists are too long, they risk paralysing the recipients into inaction for fear of being overwhelmed. Theographs can nicely illustrate the increasing intensity of care provision (health or social), which can be a signal that more assertive and holistic case management is required.

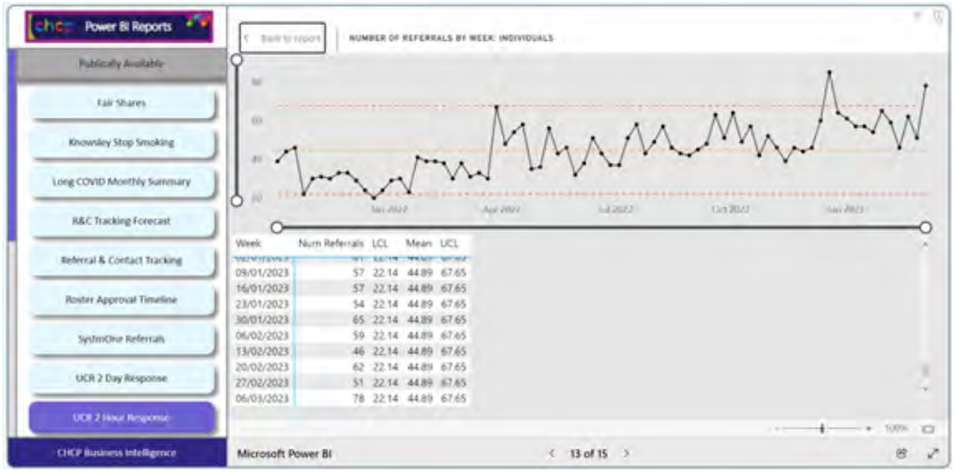
You might aim to create one version of a frailty register that can be updated in near enough real time by providers across the system (e.g. Warwick, Wirral), a real-time, dynamic frailty registry. Desirable characteristics include:

- that ny advance care plan or treatment escalation plan is visible across all of the system
- the registry alerts the team when a patient has been admitted
- feedback to case managers the results of admissions
- patient centred outcome measures that can be fed back at the clinician (micro), service (meso) or system (macro) levels.

The more advanced systems (Coventry & Rugby, Wirral) will be able to undertake modelling which will indicate which segment of the population health pyramid should be focused upon to derive the greatest benefit at the system level across a range of outcomes. They will also be able to draw upon additional sources of information to refine targeting, such as social care (Liquid Logic) or even fire service data (safe and well checks). In mid-2022, there will be a systems dynamics tool available that can support such modelling (NIHR Funding and Awards).

It is important that all members of the system have the time and opportunity to review and process the data from the dashboard, so the system does not jump to conclusions and wherever possible existing beliefs and assumptions do not cloud decision-making. This will help to develop systems thinking. Systems may consider using mental processes such as the Ladder of Inference developed by organisational psychologist Chris Argyris to support these discussions.

Example of a frailty dashboard



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Case study

Pathfields Tool

Dr David Attwood, and colleagues at Pathfields Medical Group found that the current two step approach of case-finding frailty (to take all patients with eFI moderate to severe and to apply clinical judgement to see if diagnosis of frailty was present) was time-consuming and generated a list of patients many of whom did not have frailty. So, they developed the Pathfields Tool. They have found that for every five patients the Pathfields Tool finds with frailty, the eFI would roughly detect two and be falsely negative in the other three.

The best way to envisage the Pathfields Tool is akin to a weighted eFI. The evidence, coupled with observations in primary care, showed that most patients with undiagnosed frailty are in the following groups:

1. Age >90
2. Living with dementia
3. Live in a care home
4. eFI severe
5. Housebound (evidenced by needing a home visit in last 12 months)

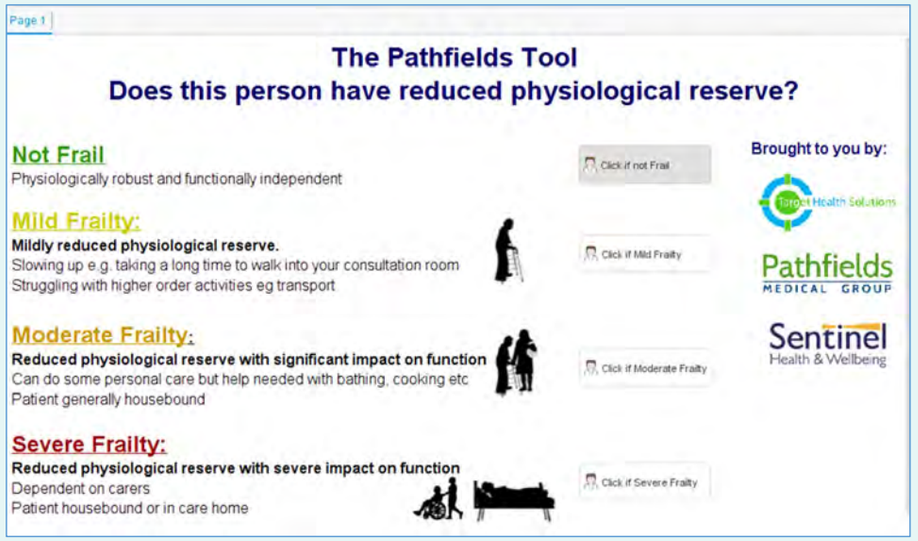
Dr Attwood has programmed the primary care IT (SystmOne) so that if a patient in any of the above groups makes contact with primary care, on saving the record the popup opposite is triggered.

If the GP knows the patient, they push a button and the patient is coded (if a clinician codes mild, moderate, or severe frailty the CFS score 5,6, and 7 is also added respectively). The system then goes dormant for a year before waking up and inviting the clinician to reassess when the patient next makes contact.

Mild frailty will be missed in the above groups as these patients are still able to get into GP surgeries for their annual reviews. In this situation, the Pathfield team employs a two-step approach, which involves another pop-up and the nurses/HCAs being asked "compared to someone who is fit and well and a similar age, was this patient struggling to get up from the chair and walking slower?" (based on a timed up and go test but without the measures and timing). If they answer "yes", the patient would be added to the list of patients eligible for clinician assessment of frailty.

Having the ability to accurately systematise mild frailty case-finding has been highly positive for population health management as the team now has the potential to intervene early in the natural history of frailty.

This technology has been streamed across the locality and could potentially be deployed nationally for free. A modified version is available for EMIS practices.



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Frailty virtual wards

When reviewing processes and interventions in the older persons pathway, teams should consider the use of digital technology, for example to connect teams of clinicians together.

In Coventry and Warwick teams are working across the system to stream older people with health needs to the best place for them.

Point of care testing

Access to basic investigations can enhance clinical decision making in the community setting. There is an increasing array of near patient diagnostic tests available for simple investigations such as renal function, blood counts and C-reactive peptide (Camden).. Close cooperation with SDEC services for frailty can augment this in a focused manner – only testing that which is meaningful and relevant, with patients rapidly returning home for ongoing care by the Hospital at Home team.

Remote monitoring

A wide range of remote monitoring is available to support care closer to home. Based on our experience to date, one of the more patient friendly is Current Health, but other brands are available!

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Integrate around person, place and at system level

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Aside from organisational integration, which is important and can reduce duplication, attention needs to be paid to 'micro-level' clinical integration between teams.

Elements to facilitate this integration might include:

- Attention to Maslow's hierarchy of needs – ensuring that basic needs are attended to – pay, workspace, access to premises
- Regular joint tea huddles, joint training, joint working on clinical pathways
- 'Safe' workshops which allow anonymised voting on ideas to generate a shared common vision and driver diagram to acknowledge everyone's perspective, but also allow democratic prioritisation
- Use of mental processes like the Ladder of Inference from organisational psychologist Chris Argyris to support the processing of data and the Iceberg Model by Peter Senge[23] to avoid working in silos and understanding patterns and outcomes from decisions made by teams.

Other higher level integration elements should address shared IT systems/ access and whole system measurement (measures that are meaningful at different levels of the system). The most sophisticated systems will use Outcome Based Commissioning to encourage teams to work together to improve patient outcomes.

The most successful integrated systems have integrated acute and community teams, and joining up operational teams can help to facilitate this integration. Further principles of integrated care can be found in this Local Government Association document.

Case study

Colleagues in Bedfordshire, Luton and Milton Keynes wanted to treat a greater number of patients within the community, leading to better patient outcomes and experience, with less reliance on acute admissions that can lead to hospital acquired harm and deterioration, whilst improving system integration.

To support this, they took a system approach to information including system governance and engagement, a population health data management warehouse, data strategy including information governance, supporting a single source of truth for all secondary use data and supporting performance and outcomes indicators. Further information is available in this presentation from Charles Wheatcroft, Programme Manager, BI & Analytics Programme, from July 2022.

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Develop systems to communicate with all stakeholders

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When leading change at a very localised level or across system-wide Quality Improvement Programmes, stakeholder engagement is a core activity that is crucial.

It can help us to:

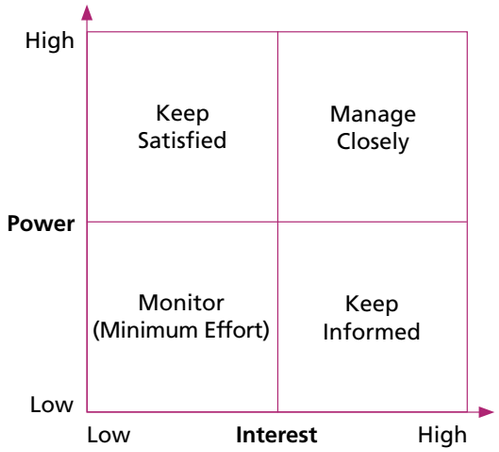
- Diagnose any problems/issues
- Identify new solutions
- Measure the improvements
- Gain consensus and support for improvement
- Ease implementation of changes
- Enhance outcomes and experience

Stakeholders are people directly involved in the immediate improvements being made, as well as those who may be on the periphery of a project but are in positions of influence that can impact on its success. Within a systems context this includes system level leaders who can support rollout and scaling up once proof of concept has been established.

A commonly used tool for stakeholder mapping is Mendelows Power/Influence Matrix (Figure 2). This enables you to map stakeholders and develop engagement strategies to manage them effectively. Using this approach, you plot out where your stakeholders actually are, rather than where you want them to be, and is best done as a team to discuss, debate and plan. For instance, you may have a powerful stakeholder who is disinterested in the project, yet you are dependent on their involvement. Once this is identified, the team can discuss what approach should be employed to get them engaged.

Approaches will vary, depending on each group. GPs for example generally don't want you to sell to them, but instead prefer tours and education, emails or communications via the Primary Care Network, or practice visits. Senior leaders will potentially want to know facts, data, impact, outcomes, and progress reports.

Figure 2: Mendelows Power/Influence Matrix



Staff in general don't want to be told what to do. Instead, a range of techniques such as newsletters, staff briefings, team briefs, social media, presentations, departmental visits and free lunches should be used.

Service user involvement is a central part to all QI work. See Principle Two for more detail on this.

Whilst stakeholder mapping can be a reasonably straightforward process, subsequent relationship building and communications take time and persistence, as reflected by Felicity and Nicola, two hospital geriatricians leading work to develop frailty services in an acute surgical setting:

"This was hard. Whilst the inpatient service had credibility, as new consultants we had less, and no contacts. We spent 3-6 months meeting with consultants in surgical and anaesthetic specialities, attending consultant meetings and MDMs to try to capture relevant contacts. We built a directory of helpful people e.g. who to contact to get a rapid ECHO, cardio opinion etc. We had support from the Exec but he also allowed us to be broad in our aims.

Personally, we think this has been the most important part of the project. We now feel we know key people in the pathway and are being asked for our opinion when the new peri-operative lead is looking to re-design the pathway." September 2022

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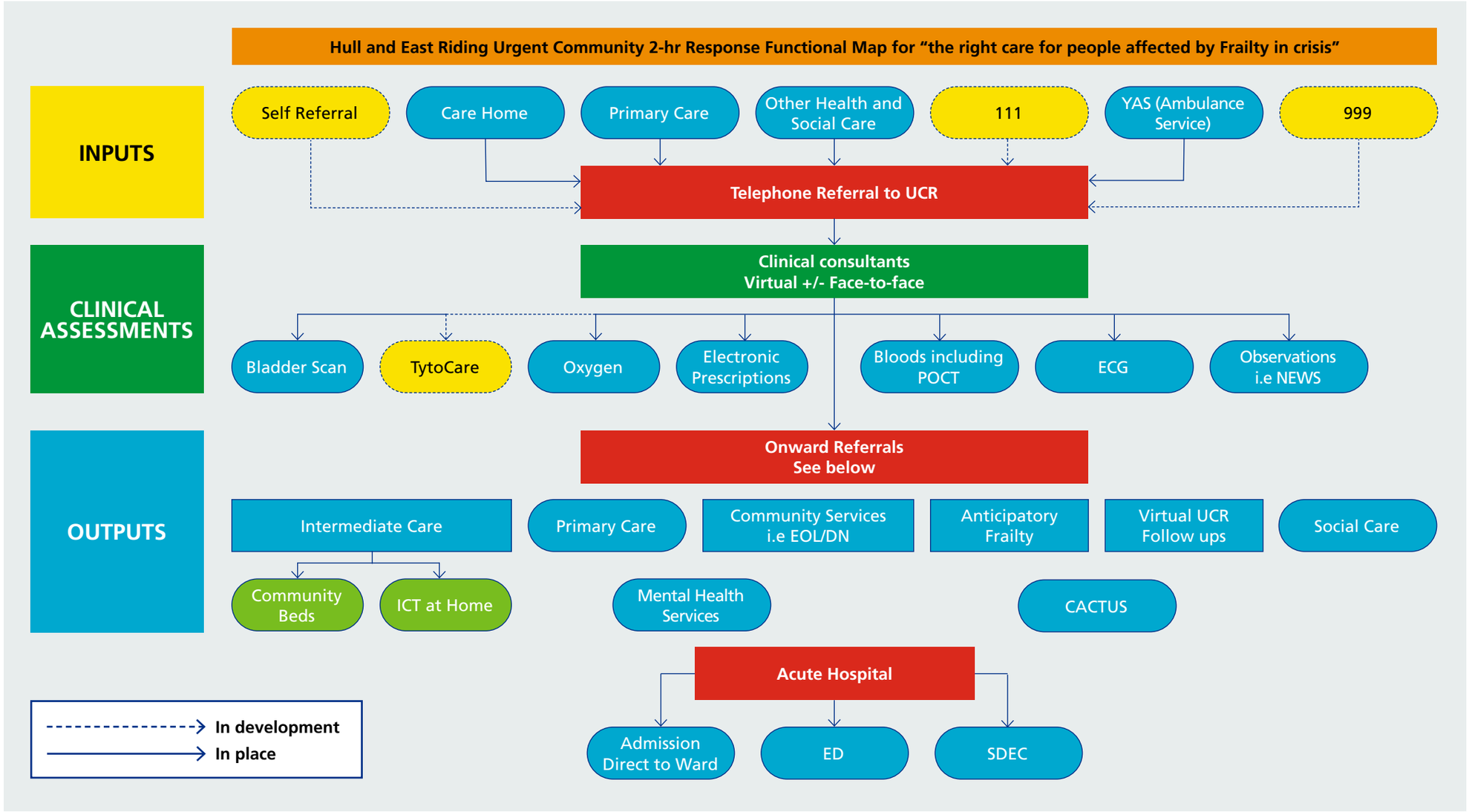
Nicola and Felicity described their stakeholder map as a living document that they revisited often over the course of the project, adding/moving stakeholders through the different phases of their work.

When undertaking system level work particularly, stakeholders can be broad, diverse and require consideration regarding phasing commensurate to where changes are being made. The team at Hull and East Riding formed to set up their Urgent Community Response had many stakeholders, as their functional map illustrates below. The team focused on different points of access in sequence, then engaged stakeholders accordingly.

Early support of SWFN team



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The Proactive Care team from Barnsley is set out below. Here, their starting point was to identify organisations, then to identify the individuals and teams within in each organisation to link with.

Ultimately, the key to this approach is seeing your project or improvement from a stakeholder perspective and understanding how they want you to engage with them, take time to discuss their issues and goals. Ideally understand how you align their goals to yours for mutual success and strong engagement.

Proactive Care team

BARNSLEY CVS

NHS Barnsley Hospital NHS Foundation Trust

NHS Barnsley Clinical Commissioning Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Barnsley Healthcare Federation

healthwatch Barnsley

BARNSLEY Metropolitan Borough Council

BARNSLEY Hospice

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Principle 7

Leaders should encourage and measure systems thinking

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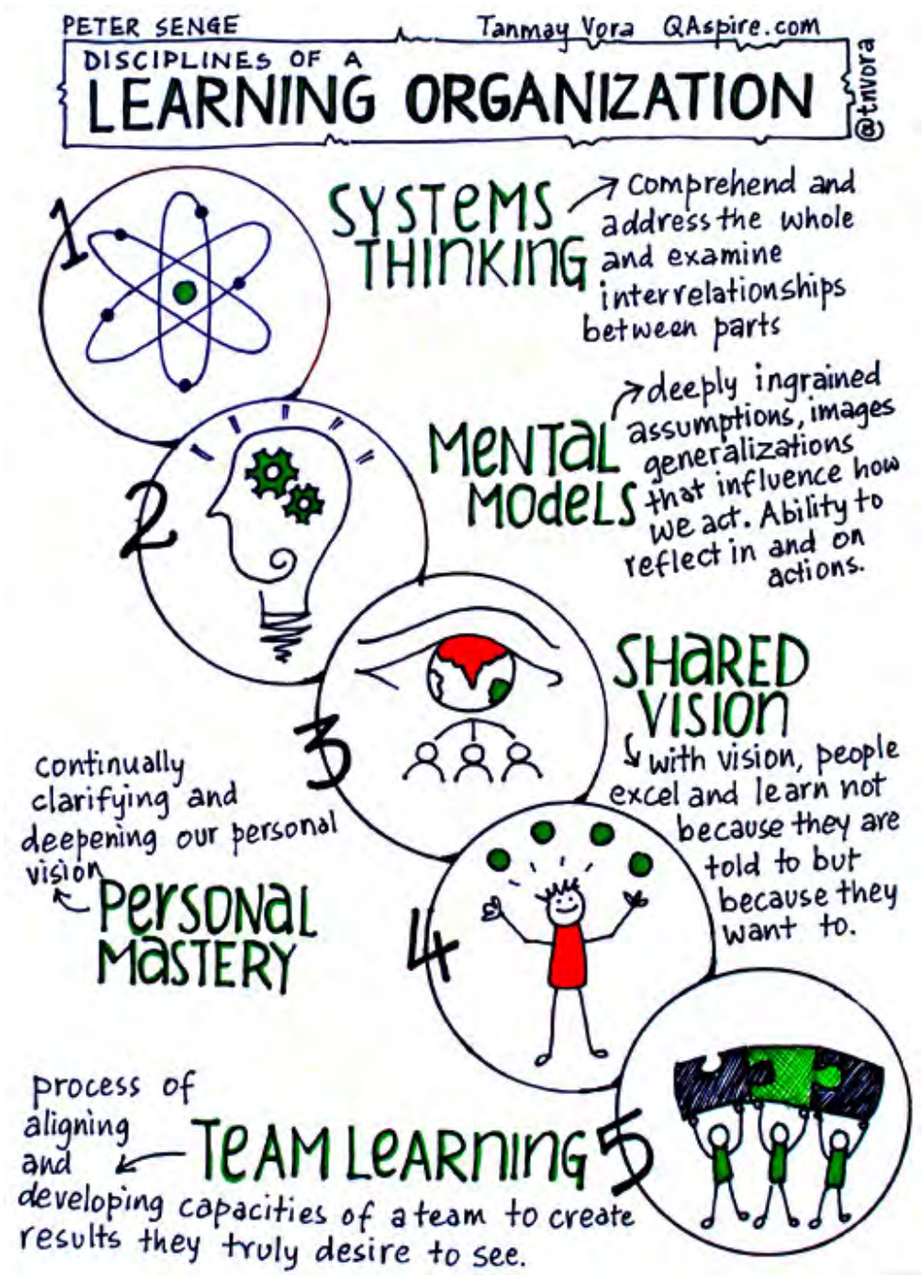
Health and social care communities which have attenuated admissions of people aged 85+ prioritised developing a shared vision and strategy, with sustained implementation of a suite of interventions – ICSs and STPs provide an opportunity to implement this best practice[24].

The role of the leader in systems is to support colleagues with understanding the principles of systems thinking and how to apply this to the network programme. The leader in systems should start by creating a common understanding of what is meant by the 'system' rather than assume everyone already understands what this is.

Have you identified all of the stakeholders in the system and the relationship between all individuals and organisations? What are the power dynamics that exist which will impact on outcomes (Figure 3). Identifying these will help towards developing systems thinking as well as identifying the conditions for change.

What are the mental models that exist in the system? These are the existing beliefs and assumptions individuals and partnerships within the system naturally bring to discussions and teamwork. Identifying these and understanding them will help develop systems thinking further and also support system-wide transformational change.

Figure 3: Systems Thinking (from Peter Senge)



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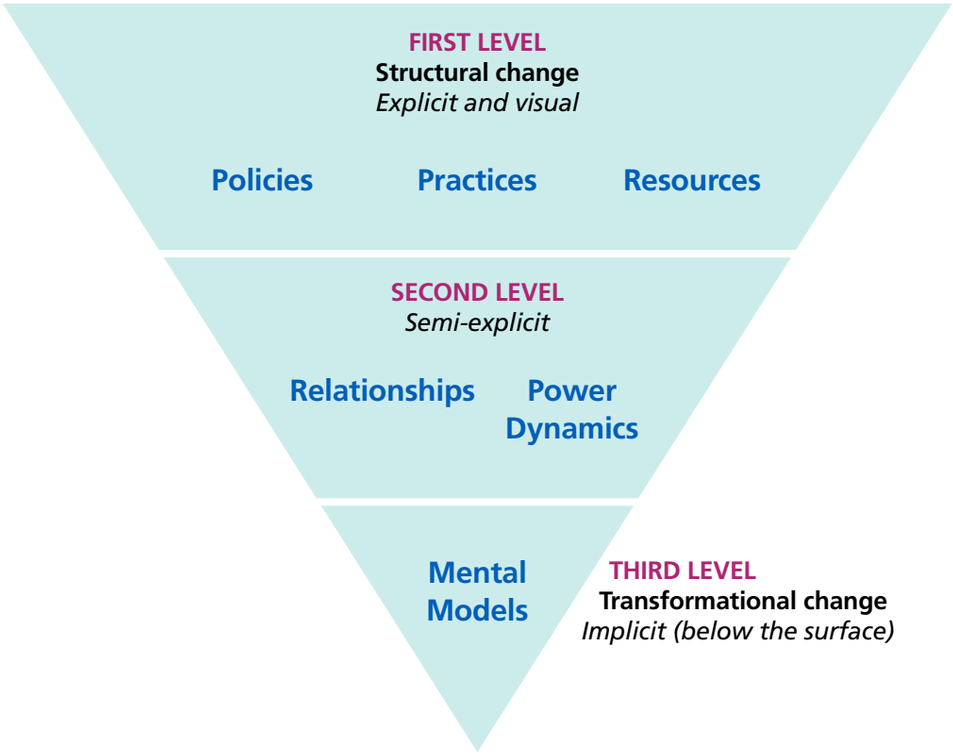
Effective leadership in systems requires a different thinking in our 'mindset' and approach to accountability; it is no longer enough to hold others accountable for their impact on us, but also to hold ourselves and our organisation accountable for the impact on others. Leaders in systems should look to change the mindset of colleagues by asking them to not focus on their interests but to identify shared interests. Systems thinking is about moving away from silo working to collaboration and from thinking about my organisation to reflecting on the wider system. The principles of systems thinking which leaders should focus on embedding are as follows:

Characteristics of complex systems	Principles of practice
Context	Guide and support others to understand what is the issue and the system(s) in which it exists. Leaders are required to help diagnose complex and sustainable challenges and issues.
Connections	Support colleagues to stop seeing things in isolation. Everything in a complex system is connected, events in one part affect other parts. Systems need to work collaboratively on shared visions or objectives and leaders are required to seek, initiate, build, and facilitate partnerships and coalitions for change.
Patterns	Help the system understand that cause and effect is not linear or one directional. Avoid the rush to blame or see others (individuals or organisations) as the problem. Leaders need to be able to describe relationships, stop looking for cause and effect and seek patterns.
Perspectives	System leaders must help change the mindset of others in that no one perspective is right. The leader's job is to help triangulate diverse perspectives and support colleagues to remain open to different ways of seeing and innovative solutions.

Six conditions of systems change



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Embed and enable a Quality Improvement approach

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The Model for Improvement (see the diagram opposite), is an approach that can be applied to any improvement project, as much to whole system frailty as to any other area. This model underpins a Quality Improvement (QI) approach and is very useful to help teams structure and deliver improvement plans.

The model for improvement is made up of two parts:

- Three questions to help shape your approach. These can be addressed in any order.
- The Plan-Do-Study-Act (PDSA) cycle that is designed to help teams test ideas and potential changes to understand if they deliver an improvement.

The three questions are designed to enable teams across any system to develop a clear aim that provides a shared purpose. Once this is agreed local teams can work together to adopt an approach to achieve the ambition. The aim should be time specific and measurable which leads nicely to establishing measures. Using data from these measures will enable you to understand which ideas are having the desired impact.

The QI objective is to test 'ideas' for change using the PDSA approach. This provides a structure to plan improvements, observe the results and act on the results in a real work setting. Key to this is doing small scale tests of change whilst learning from each test before scaling up any changes.

When applying the model for improvement, it is crucial to form the right team. For system frailty you should include the following:

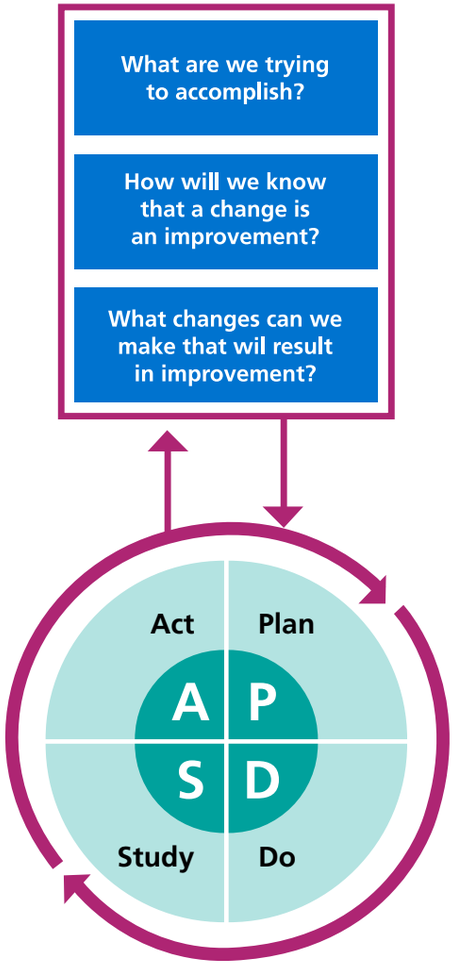
- A clinical leader
- Technical expert
- Project manager
- Executive sponsor
- An analyst
- Patient or service user

Effective QI teams need the above members in their improvement teams to ensure all elements of QI are covered. There may be more than one individual operating in each area, but all these areas should be represented to drive improvement successfully.

The principle of QI applies as much to whole system frailty as it does to any other area. When developing dashboards, testing community frailty hubs, rapid response teams, or developing your SDEC response, start small and build iteratively, using small amounts of focused data collection to evaluate your PDSA cycles.

Do you have in place partnerships between different system providers that can work together using quality improvement to ensure success?

Model for Improvement



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Promote a Measurement for Improvement mindset

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In system wide frailty development, Measurement for Improvement can be used to identify areas for improvement and as a lever to test and subsequently implement change. There are several strands to this work, including:

- Using existing tools to understand the frailty opportunity. Use the national frailty opportunity identifier in the national view tab to combine NHS provider trusts to create a "system wide" view. This will give you a great list of improvement opportunities for any business case or baseline. You can access this tool by contacting ncdr@england.nhs.uk and learn more from this short YouTube clip.
- Frailty registries. eFI is typically updated yearly, but to be relevant for day-to-day operations it might need to be updated daily or monthly.
- Linking existing registries to create a single frailty registry may be a good tool to help create the early infrastructure for populating any Theographs.
- Enabling MDTs across organisational boundaries, using Theographs to graphically display single high usage patients.
- Using existing measurement for improvement QI tools, such as functional mapping will help with cross organisational boundaries system understanding and identifying unintended consequences of changes to the system.
- Using ambulance data to understand the flows of frail patients across the system.
- Consider counting your frailty registries as a system wide measure: one system = one score, more scores = more systems.

Outcome measures

Outcomes important to older people extend beyond resource use and longevity[25]. Informed by the International Consortium on Health Outcome Measures report for older people, outcomes should include patient, carer and system level. Candidate measures include:

- Patient and carer-centred: participation in decision making, autonomy and control, mood and emotional health, loneliness and isolation, pain, activities of daily living, frailty, time spent in hospital, overall survival, carer burden, polypharmacy, falls and place of death.
- System centred: primary care use, hospital use, days in hospitals (super spell), intermediate care use.

Standard definitions for many of these metrics are described in NHS reports such as Getting It Right First Time (GIRFT), NHS Benchmarking (acute care, intermediate care) and Right Care. Work is ongoing to develop patient centred outcomes in the urgent care context[19,26].

Other measures might include how many databases capture frailty. Ideally, there should be one dynamic, real-time registry across the system.

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Principle 10

Make ‘frailty’ everyone’s business through education and training

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Having a measure of the size of the population of older people living with frailty allows the education and training requirements to be measured. Different levels of frailty training will be needed by different groups, for example:

- Health Education England Tier 1
- Health Education England Tier 2
- Tier 3 for specialists e.g. British Geriatrics Society materials (see resources section)

Locally targeted training will be needed to supplement the generic competencies, addressing local pathways (Directory of Services) and processes of care.

The Accelerated Roles Reimbursement Scheme (ARRS) supports Primary Care Networks by introducing new roles (e.g. first contact practitioners such as social prescribers, clinical pharmacists, MSK practitioners, mental health etc). Equally the development of Advanced Clinical Practitioners (ACPs) across the differing areas within the system offers an opportunity to support an integrated frailty approach. Does your system have a strategy for their deployment, supervision, education and training? Do you have plans to build in frailty competencies and help build ACPs in frailty?

Do you work in a learning system? Are system wide events identified, discussed and reflected upon at an MDT and the system level, akin to clinical learning from morbidity and mortality meetings?

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Resources

- Data saves lives: reshaping health and social care with data (draft) – Department of Health & Social Care – September 2021
- FHIR vital signs profiles – NHS Digital
- NOMED CT Browser – NHS Digital
- Acute Frailty Network
- Specialised Clinical Frailty Network
- NHS RightCare – Frailty
- Acute Sector – NHS Benchmarking Network
- Community Sector – NHS Benchmarking Network
- Geriatric Medicine – Getting It Right First Time (GIRFT)
- Enhanced Health in Care Homes: How is it for you? – British Geriatrics Society

Learning resources

Frailty Programme – e-Learning for Healthcare (elfh)

NHS England resources

The Acute Frailty Network (AFN) has developed a number of Moodle online learning modules, such as Mrs B's Frailty Journey, as well as modules on Quality Improvement, Experience Based Design (EBD) and Measurement for Improvement.

British Geriatrics Society resources

React To Frailty resources

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