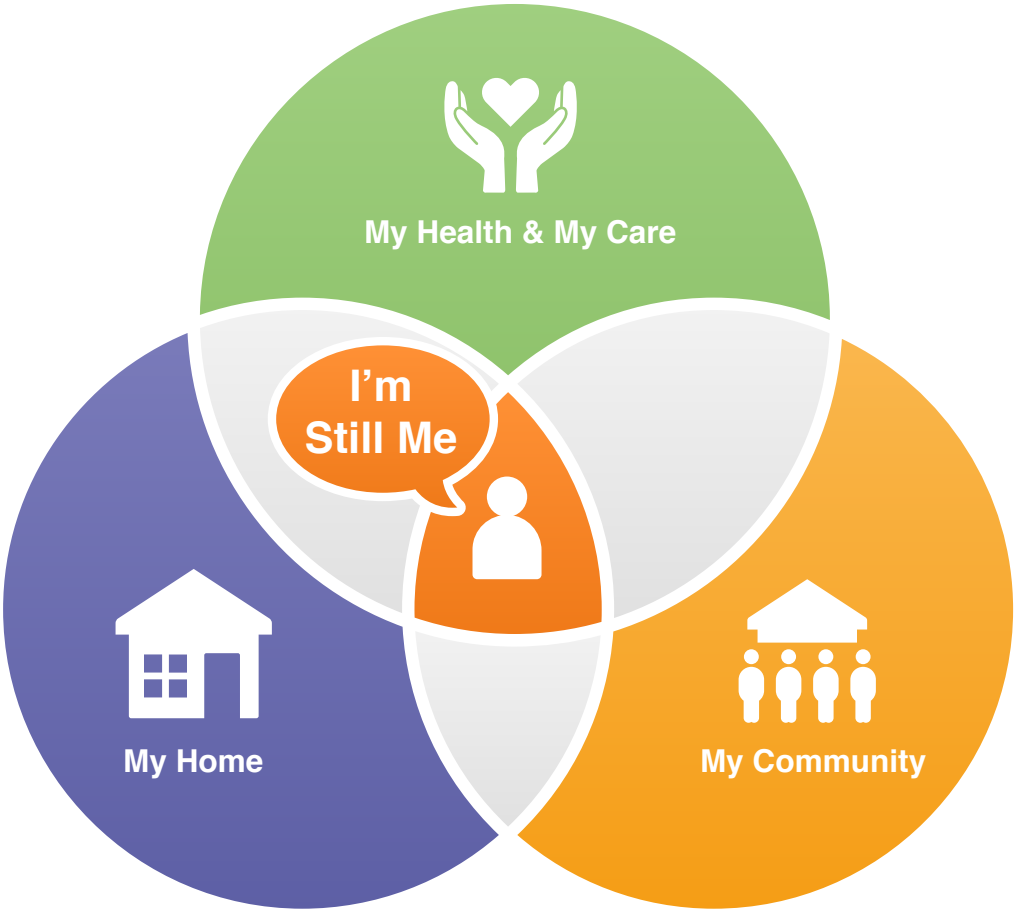


Frailty

A framework of core capabilities

Skills for Health

NHS

Acknowledgements

This framework was commissioned by Health Education England and NHS England. This is a joint partnership publication by Skills for Health, NHS England and Health Education England.

Development of the framework was steered by a project management group chaired by Dr Dawn Moody, Associate National Clinical Director for Older People and Integrated Person-Centred Care, NHS England. Project management was provided by Colin Wright, Frameworks Development Manager, (Skills for Health) and Hilary Wyles, Senior Consultant, (Skills for Health).

We are extremely grateful to members of the project management group for providing their guidance, expertise and support, in particular to Stephanie Hambleton (East Cheshire NHS Trust) for arranging consultation interviews and to David Russell for the plain English edit of the final text.

The project management group included representatives of the following organisations:

- Age UK
- British Geriatric Society
- Centre of Excellence in Safety for Older People (CESOP)
- Chartered Society of Physiotherapy
- East Cheshire NHS Trust
- Foundations (National Body for Home Improvement Agencies)
- Heath Education England
- Local Government Association
- NHS RightCare
- NHS England
- Royal College of General Practitioners
- Skills for Health

In addition, we would like to thank the representatives of the following organisations which participated in the project Expert Group:

- ADASS (Association of Directors of Adult Social Services in England)
- Birmingham & Solihull Mental Health NHS Foundation Trust
- British Dietetic Association
- British and Irish Orthoptic Society
- College of Paramedics
- College of Podiatry
- Hampshire Hospitals NHS Foundation Trust
- Hants Fire & Rescue Service
- Herefordshire Council (Adults & Wellbeing)
- Independent advisor: John Lumley, Emeritus Professor of Vascular Surgery
- Newcastle Gateshead Clinical Commissioning Group
- NHS Chiltern Clinical Commissioning Group
- North West Ambulance Service NHS Trust
- Petersfield Community Hospital
- Royal Bournemouth and Christchurch Hospital NHS Foundation Trust
- Royal College of Occupational Therapists
- Royal College of Nursing
- Society & College of Radiographers
- South Kent Coast Clinical Commissioning Group
- Stoke on Trent City Council
- Southern Health NHS Foundation Trust

We are also grateful to the many other people who provided comments and feedback on drafts of the framework during the project in particular, those living with frailty and their carers who participated in consultation interviews and the 140 respondents to the online consultation survey.

Further detail of how the framework was developed is presented in **Appendix 3**.

Finally, we wish to thank the trustees of the Institute of Ageing and Health in the West Midlands for funding further research to evaluate the impact of this framework.

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

NHS England Publications Gateway Reference: 08406

Contents

Foreword

It is frustrating to hear older people so often 'defined' by their need for health and care services, and these needs so often referred to as a "burden" or in terms of "unnecessary" admissions to hospital. This focus on concerns over the "cost" and "pressure" of helping more of us to live well in later life can distract from the many benefits, achievements and opportunities that come with an older and ageing society.

There is instead a need to define and deliver an approach to care that builds upon the strengths of individuals, families and communities, and helps make the most of every contact an older person has with health, care or other services. It is too often the case that opportunities to intervene early have been missed and a very real need for care arises that might otherwise have been avoided. Furthermore, health issues that do not fit the neat boundary of a single condition or organ may end up going unaddressed. For some older people and their families, this is not only distressing and painful but can completely change the trajectory of their remaining years.

Though many older people will live in good health and hopefully experience a relatively short period of poor health at the end of their life, many others will be much more susceptible to ill health.

"Frailty", in simple terms is precisely that: even small shocks can have a big impact on a person and their ability to bounce back from these shocks can be much more difficult.

Historically, professionals seeing someone as "frail" could mean they were thought of as "too difficult" or that "nothing could be done", even if only sub-consciously. Older people living with frailty and their carers deserve much better. No matter where, or from whom, an older person is receiving care, they should expect to receive support that fully recognises and understands their needs; that seeks out and takes account of their individual wishes and preference; and that focuses as much on the things they can do as it does on the health challenges they may be living with.

We know that older people can be very uncomfortable with the word "frailty", and this is understandable. However, by focusing on the things we know are important to improving their care and wellbeing, we can help to make the term 'frailty' a passport to the kind of support that makes a real difference to their health and lives.

I am very pleased to support this frailty core capabilities framework and hope it will support a positive and long-lasting shift in how we work with older people to identify, understand and meet their needs.

Baroness Sally Greengross OBE

Baroness Sally Greengross has been a crossbench (independent) member of the House of Lords since 2000 and Co-Chairs four All-Party Parliamentary Groups: Dementia, Corporate Social Responsibility, Continence Care and Ageing and Older People. Sally is Chief Executive of the International Longevity Centre and is a former Director General of Age Concern.

Introduction and background

Health Education England and NHS England commissioned the development of this core capabilities framework to improve the effectiveness and capability of services for people living with frailty.

Frailty is a long term condition related to the ageing process in which multiple body systems gradually lose their in-built reserves. It is now widely recognised as a state of reduced resilience and increased vulnerability, which results in some older people becoming more vulnerable to relatively minor changes in their circumstances which can lead to a deterioration in their health and/or ability to live independently. It is estimated that around 50% of people over the age of 65 are living with some degree of frailty and some who experience frailty earlier in life[1].

People living with frailty are less able to adapt to stress factors such as acute illness, injury or changes in their environment, personal or social circumstances, and such changes are more likely to result in adverse health outcomes and loss of independence.

There is some evidence to suggest that the term frailty might not resonate with older people or their family members or care givers. However, frailty is a useful concept because it can help us to recognise and provide for the needs of people living with this long term condition. We, therefore, use the term 'frailty' in this framework, although recognise that many people living with frailty might not recognise themselves as such, but may more often describe themselves using terms such as 'I'm slowing down'. One of the aims of this framework is to empower people living with frailty, as well as their family, friends and carers, to understand the condition, make the most of available support and to plan effectively for their own current and future care needs.

Frailty also remains a new area for much of the workforce and work is now needed to position frailty as a long term condition and underpin it with the upskilling of the workforce. Recent research has highlighted the current variation and inconsistency in education and training and the siloed working that still exists between different sectors and professions which can be particularly problematic in care of older people[2]. This framework aims to identify and describe the skills, knowledge and behaviours required to deliver high quality, holistic, compassionate care and support. It provides a single, consistent and comprehensive framework on which to base review and development of staff.

Better identification of frailty and better understanding of how to support people to live well with frailty is increasingly recognised as one of the key challenges for health and care systems in the 21st Century. In England, support for older people living with frailty is acknowledged as a priority in the NHS Five Year Forward View and Next Steps on the Five Year Forward View.

The framework builds upon, and is cross-referenced to, existing core skills frameworks such as those for statutory/mandatory subjects, dementia, end of life care and person-centred approaches (details of these frameworks are available at: www.skillsforhealth.org.uk/cstf).

Further information on the development of this framework is presented in **Appendix 3.**

1. Clegg A et al (2016), Development and validation of an electronic frailty index using routine primary care electronic health record data
2. Picker Institute/Dunhill Medical Trust (August 2018): Exploring education and training in relation to older people's health and social care

Scope of the framework

The framework will be applicable to health, social care and other employers, employees, people living with frailty, carers, the community, the public and also to educational organisations which train students who will subsequently be employed in the workforce.

The framework aims to describe **core capabilities.** For the purposes of this framework we are using the following definitions:

Core: common and transferable across different types of service provision.

Capabilities: the underpinning knowledge, skills and behaviours which give a person the potential to become competent - capabilities can be the outcomes of education, training or experience.

The scope of this framework is described in 3 tiers (see page 9 for further details):

Tier 1: Those that require general awareness of frailty.

Tier 2: Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

Tier 3: Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

Beyond the scope of this framework, further guidance for Advanced Clinical Practice is available at: https://hee.nhs.uk/our-work/advanced-clinical-practice/multi-professional-framework

Other relevant frameworks are also referenced in each capability.

Structure of the framework

The framework begins with a description of values and behaviours which underpin all capabilities in this framework.

The framework then comprises 14 capabilities, which are numbered for ease of reference and grouped in 4 domains:

Domain A. Understanding, identifying and assessing frailty

Domain B. Person-centred collaborative working

Domain C. Managing frailty

Domain D. Underpinning principles

This does not indicate a prescribed pathway, process or hierarchy. Full coverage of all capabilities may also be achieved by teams, in which case some team members may find that not all capabilities are relevant to their individual role.

Within each of the capabilities, the required knowledge, skills and behaviours are presented for 3 tiers, relevant to particular people or practitioners, i.e.

The person or practitioner will:

Be aware of...	has an awareness of a concept
Know…	utilise previously learned information
Understand…	demonstrate a comprehension of the facts
Be able to…	apply knowledge, understanding and skills to actual situations
Analyse…	examine and break information into component parts in order to evaluate the significance and interrelatedness of each component
Synthesise…	build a structure or pattern from diverse components
Evaluate…	present or defend opinions by making judgements based on informed reflective critical thinking and underpinned by critical self-awareness[3]

Most outcomes at tiers 1 and 2 describe awareness, knowledge, understanding and application, although there are some outcomes (particularly at tier 3) which may include analysis, synthesis and evaluation.

The outcomes for each capability should together indicate the minimum content for the design and delivery of teaching and learning for each tier.

The outcomes are written as broad statements e.g. ‘The person or practitioner will: be aware of / know / understand / be able to…’ This provides scope for the framework to be applicable across a wide range of contexts and setting.

3. This approach is derived from Bloom’s Taxonomy (Bloom B, 1956),

About the three tiers

The core capabilities described in the framework are defined for **three tiers:**

Tier 1 Those that require general awareness of frailty.

This tier is relevant to people living with frailty, as well as their family, friends and carers, to ensure they are making the most of the support on offer and can plan effectively for their own current and future care needs. This tier is also for all those working in health, social care and other services who have contact with people with frailty including those who will go on to further training at tiers 2 and 3.

This tier will be relevant to you if:

- you are an interested member of the public
- you are living with frailty
- you support someone living with frailty
- you work in adult health, social care sector or other sectors

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

This tier is for those who provide care and support for people living with frailty as part of their work, but who would not be responsible for complex decisions regarding management of frailty.

This tier may be relevant to you if you work in;

- health or social care (including home care and care homes)
- emergency services
- housing support
- local authority services

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

This tier is for those with responsibility for complex decision-making and to whom others refer for management, guidance and support.

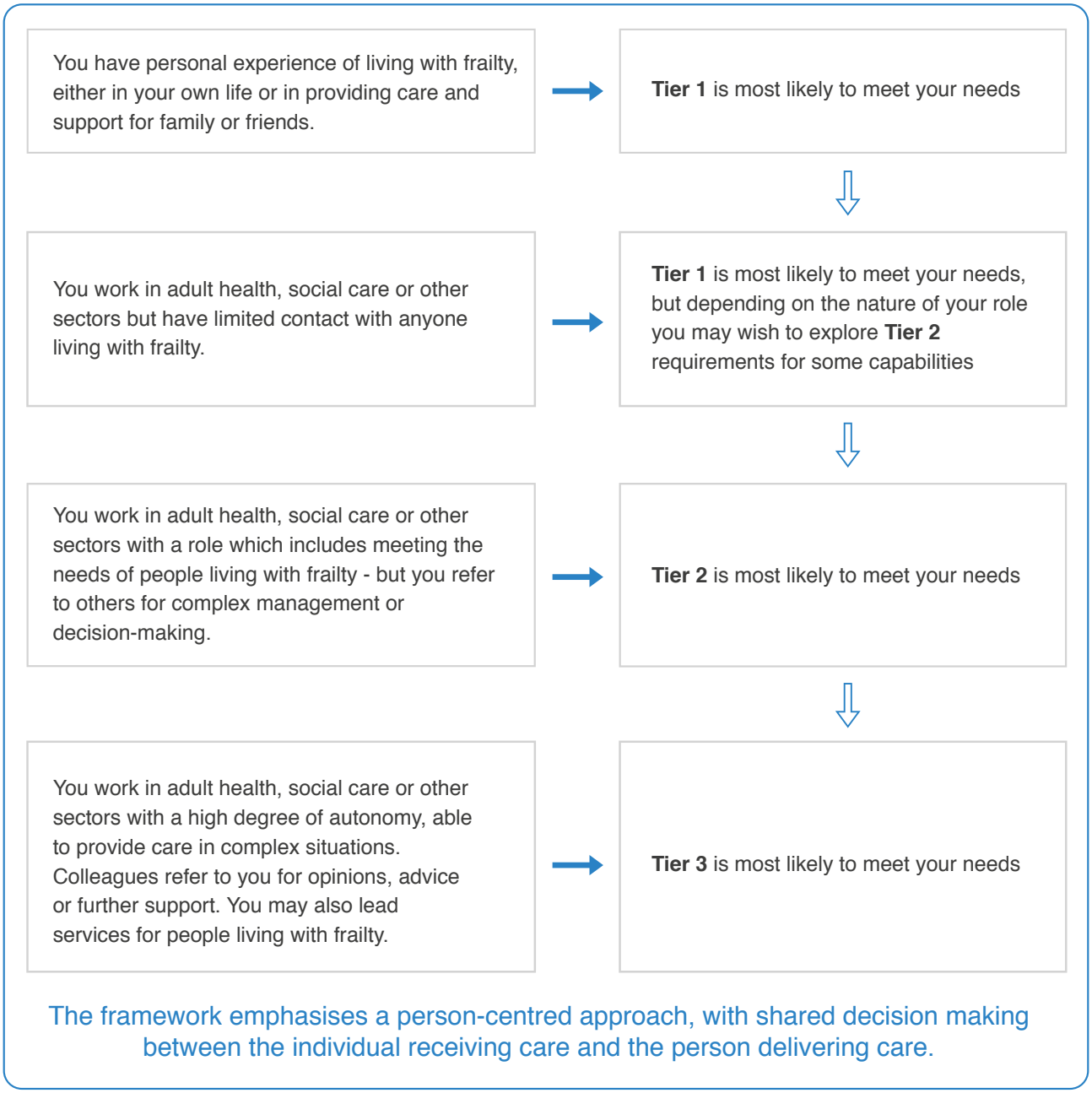
This tier may be relevant to you if you work in;

- health or social care (including home care and care homes)
- emergency services
- housing support
- local authority services

The framework is incremental, i.e. tiers 2 and 3 assume that the person or practitioner possess the skills and knowledge at preceding tiers (to minimise unnecessary repetition). Those generally at tier 1 or 2 may also wish to explore some capabilities at higher tiers.

Additional specialist or organisation-specific skills and knowledge are outside the scope of the framework. Such additional capabilities may be locally determined to meet needs in specific settings, for example according to local context, risk assessment or policy.

Figure 1 below illustrates the relevance of the three tiers to different audiences:



Who is this framework for?

People living with frailty and their family, friends and carers

The framework can be used by people living with frailty to understand how to make the most of the support on offer and to plan effectively for their own current and future care. In particular, the framework highlights that people living with frailty must be able to make informed choices about effective care and support alongside healthcare and other practitioners, i.e. to participate in shared decision-making.

Tier 1, therefore, includes a community development approach to care which encourages individuals to look beyond traditional care provision, ask 'what is important to me?' and how this could be achieved alongside care and support from health, social care and other professionals. This might include: the strengths and abilities of people with frailty; the strengths and abilities of their family, friends and carers; and the potential of the community to provide care and support. This way of working that considers the strengths and potential of individuals and communities is often described as an 'asset-based' approach to care.

Practitioners – individuals and teams

The framework sets out clear expectations for those working in health, social care and other services to be clear about the requirements of roles and transferable skills. It can be used to review and recognise how capabilities are shared across teams and to conduct formal or informal training needs analysis, comparing current skills and knowledge with required skills and knowledge. The framework also provides a structure for career progression and engagement in continuing professional development and/or revalidation.

Service providers

The framework enables managers to demonstrate that staff meet core capabilities or have developmental plans in place to meet the nationally recognised framework. This underpins the continuing professional development of practitioners to ensure their practice remains up-to-date, safe and effective.

A further aspiration in providing this framework is to support service improvement through development of a flexible and adaptable multi-professional workforce to support new models of care. Organisations can use the framework to review their current arrangements for people living with frailty; the aim is to ensure all staff have an awareness of frailty and those who regularly work with people living with frailty are skilled in areas such as assessment, prevention and supported self-management advice in accordance with their scope of practice.

Use of this national framework also supports organisational and system-wide effectiveness and efficiencies by encouraging the delivery of education and training that is focused on developing core capabilities and optimises opportunities for inter-professional learning. In so doing, it should help to increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery and strengthen skill mix and team-working.

Service commissioners

The framework enables commissioners of services to specify minimum standards of care for people living with frailty; it sets out clear expectations about what different 'tiers' of the workforce are able to do. It also supports service improvement, for example by using the framework to review current service provision for people living with frailty and to support collaborative approaches to commissioning.

Education and training providers

The framework helps those who design and deliver training and development opportunities to focus on the key capabilities that learners need to achieve, which in turn will guide the content to be included and the use of appropriate learning and teaching strategies. The framework can also be used to support the analysis of learning needs and assessment; the principles of assessment are presented in **Appendix 2**.

In particular, by using the framework to inform the design of education and training curricula, universities and colleges can ensure that the core capabilities are appropriately reflected within intended learning outcomes. This will help ensure that students on placements or new graduates entering the workplace have already gained the core capabilities when they enter practice and when practitioners prepare to take on a new role.

Figure 2 below represents the range of people and services to whom this framework applies:

The capabilities in this framework are consistent with the '**I statements**' developed by National Voices, UCL Partners & Age UK (2014):

Independence

- I am recognised for what I can do rather than assumptions being made about what I cannot
- I am supported to be independent
- I can do activities that are important to me
- Where appropriate, my family are recognised as being key to my independence and quality of life

Community interactions

- I can maintain social contact as much as I want

Decision making

- I can make my own decisions, with advice and support from family, friends or professionals if I want it

Care and support

- I can build relationships with people who support me
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me
- Taken together, my care and support help me live the life I want to the best of my ability

Ref: National Voices, UCL Partners & Age UK (2014), I'm Still Me: A Narrative for Coordinated Support for Older People at: https://www.nationalvoices.org.uk/sites/default/files/public/publications/im_still_me.pdf

return to contents page

Values and behaviours

The following values and behaviours for health, social care and other staff underpin all the capabilities in this framework and focus on the expectations of people with frailty, their family and carers. These values and behaviours are supplementary to any existing legal, regulatory and ethical requirements or codes relevant to professional bodies and employers.

The practitioner will:

a) show people respect and compassion, without judging them

b) be patient and really listen

c) show interest in people, and that you understand their perspective, preferences and what is important to them, their families and their carers

d) value and acknowledge the experience and expertise of people, their families, their carers and support networks, enabling choice and independence as far as is practicable

e) act with integrity, honesty and openness, seeking to develop mutual trust in all interactions with people, their families, carers and communities

f) be committed to ensuring integrated current and future care, support and treatment, through working in partnership with people, teams, communities and organisations

g) value collaborative involvement and co-production with people to improve person-centred design and quality of services

h) recognise, respect and value peoples' differences and challenge negative stereotyping (e.g. in age, race, disability, sexuality, gender, religious, ethnic and cultural backgrounds)

i) recognise that people with impaired cognition or learning disabilities and their families have the same human rights as others

j) take prompt action where there is an issue with the safety or quality of care, raising and escalating concerns where necessary

k) take responsibility for one's own learning and continuing professional development, and contributing to the learning of others

return to contents page

Domain A.
Understanding, identifying and assessing frailty

Introduction

Life expectancy is increasing and many people are enjoying healthy lives in older age. However, at the same time some older people have reduced resilience and increased vulnerability to relatively minor changes in their circumstances, which can lead to deterioration in their health and ability to live independently. This condition is now recognised as frailty and is often described by individuals with the condition as a feeling that they are slowing down, losing strength or finding it more difficult to perform everyday tasks. Frailty becomes more common as age increases. However, it is not an inevitable consequence of getting older and can also occur at a younger age, for example vulnerable groups (such as the homeless) with a lower mortality rate may experience frailty earlier in life. Identifying people who are living with frailty, therefore, offers an important opportunity to identify those people who are at greatest risk of deterioration in their health, wellbeing and ability to live independently.

Increasing the awareness and understanding of frailty amongst individuals, families and communities, as well as amongst practitioners working with older people at different levels and across a wide range of settings, is the first important step towards improving outcomes for people living with the condition. Capabilities in identifying and assessing frailty are needed to enable people living with frailty to understand their condition and to have access to the most appropriate care and support at every stage of their journey.

Capability 1. Understanding frailty

Key outcomes

Tier 1: Those that require general awareness of frailty.

The person will:

a) know what is meant by the concept of frailty as a long term condition of reduced resilience and increased vulnerability to deterioration as a result of relatively minor stress factors

b) be aware how living with frailty affects and is affected by many different aspects of a person's life (including the person's physical health, immobility, mental health, loneliness, cognitive function and their social and home environment)

c) be aware that frailty is becoming more common due to an ageing population

d) know that, although frailty becomes more common as people get older, it is not an inevitable consequence of ageing and can be applicable in all age groups

e) be aware that the extent of a person's frailty can change (up or down) over time and can be influenced by lifestyle or other factors

f) be aware that people living with frailty are more at risk of confusion, falls, incontinence, problems with mobility and side effects of medication

g) know where advice, support and information can be obtained for people with frailty, families and carers

Tier 2: Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand the concept of frailty as a long term condition and recognise all stages from emergence to end of life care

b) know the five conditions often associated with frailty (known as the frailty syndromes) and how they commonly present, i.e.

- delirium
- recurrent falls
- sudden deterioration in mobility
- new or worsening incontinence
- medication side-effects

c) understand that frailty syndromes may be a first presentation of frailty

d) understand the importance of early recognition and timely management of frailty syndromes, e.g. that there are interventions to improve independence and quality of life for people living with frailty

Tier 3: Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) understand the concepts of the 'phenotype' and 'cumulative deficit' models of frailty

b) understand frailty as a complex and multi-dimensional state linked to other concepts including multi-morbidity, disability, dependency and personal resilience

c) understand the importance of a comprehensive multi-dimensional model in assessing and managing older people with frailty, e.g. the Comprehensive Geriatric Assessment (CGA)

d) be able to identify the underlying causes for each of the five frailty syndromes

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 1: Dementia awareness

return to contents page

Capability 2. Frailty identification and assessment

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) be able to recognise the physical characteristics of frailty, e.g. weight loss, poor nutrition and hydration, fatigue, weakness, reduced physical activity and general 'slowing down'

b) know that in frailty it is usually the number of things that have 'gone wrong' and the inability to do everyday tasks that is more important than the exact nature of the individual problems (examples of 'problems' may include poor vision, hearing or mobility, loneliness, history of falls and memory loss, as well as diagnosed long term physical and mental health conditions)

c) be aware that health and care professionals have ways of assessing frailty, which can help in planning appropriate care and support

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand the importance of identifying people with frailty in planning healthcare or support interventions

b) understand the importance of both proactive and reactive approaches to frailty identification

c) be able to explain the need for an assessment of frailty with sensitivity and in ways that are acceptable to the person and appropriate to their communication needs

d) understand that people may not like to recognise themselves as living with frailty and may be unwilling to acknowledge or disclose problems

e) understand the importance of equal access to frailty assessment, e.g. for people from diverse communities or with specific needs (such as sensory or cognitive impairment)

f) understand reasons for caution about assessing frailty in a person who is acutely unwell

g) understand the concept of a 'frailty index' as a means of measuring frailty[4]

h) understand that a person's degree of frailty can change (up or down) over time

i) be able to use relevant frailty screening and assessment tools in accordance with local policy such as Gait (Walking) Speed Test; Time Up and Go (TUG) Test; PRISMA-7 Questionnaire; Edmonton Frail Scale; Clinical Frailty Scale also known as the Rockwood Score

j) be able to document assessment decisions and know what to do next

k) understand one's own role in initiating, contributing to, or referring on for a multi-disciplinary comprehensive and holistic assessment of frailty, often known as Comprehensive Geriatric Assessment (CGA)[5]

4. A frailty index is a measure of the health status of individuals - as a proxy measure of aging and vulnerability to poor outcomes. This is distinct from the electronic frailty index (eFI) which is a specific tool which uses data that is routinely available in the GP electronic health record to identify and severity grade frailty.

5. Comprehensive Geriatric Assessment (CGA) is a process of care comprising a number of steps. Initially, a multidimensional holistic assessment of an older person considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly. Some bodies prefer to call it a comprehensive older age assessment (COAA). It is also referred to as geriatric evaluation management and treatment (GEMT). Ref: http://www.bgs.org.uk/cga-toolkit/cga-toolkit-category/what-is-cga/cga-what)

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) be able to carry out a comprehensive and holistic assessment of frailty (e.g. CGA) in partnership with people living with frailty and as part of a multi-professional team

b) be able to act on the findings of a comprehensive and holistic assessment of frailty in partnership with people who have frailty, their family and carers and the multi-professional team

c) understand how the nature of factors contributing to the degree of frailty can provide insight to the underlying causes of frailty and, therefore, offer some potential to guide interventions

d) be aware of the experience of a person with frailty and their family and carers and be able to communicate with sensitivity about the assessment of frailty and related implications

e) know how to enrol the person with frailty in post-assessment care and support planning and associated interventions

f) be able to promote and evaluate approaches to frailty identification and assessment

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 2: Dementia identification, assessment and diagnosis
- End of Life Care / Subject 6: Assessment and care planning in end of life care

return to contents page

Domain B.
Person-centred collaborative working

Introduction

Every person living with frailty has his or her own unique background, culture, values and experiences, which will in turn influence their personal preferences, needs and priorities in all aspects of their life. Taking a person-centred approach to care, which recognises, values and builds upon this individuality, is essential in helping to achieve the best outcomes for people living with frailty. Effective and sensitive communication that takes account of individual characteristics, needs and circumstances is required to develop supportive, caring relationships with people living with frailty. It is also needed to build and support the networks of care that enable people living with frailty to maintain their independence and enjoy the best possible quality of life, whatever the extent of their frailty and the circumstances of their life.

Families and carers provide the key foundation for this care for many people who are living with frailty. However, due to the complex and multidimensional nature of frailty, people living with the condition also often benefit from the involvement of a wide range of other people and organisations. In order to achieve the best outcomes, these individuals and organisations must work in close partnership with individuals living with frailty, their families, carers, and of course with each other.

Developing capabilities which will enable person-centred care, including the communication skills required for families, carers and practitioners from a wide range of disciplines to work together in an integrated way, as collaborative partners in care, will help people living with frailty to do the things that are important to them and to achieve the best possible quality of life.

Capability 3. Person-centred approaches

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) understand and respect that people living with frailty are experts in their own lives

b) understand and be willing to support the diverse needs and wishes of people, which may differ from one's own

c) understand that person-centred care includes all elements of a person's life that are important to them, not just their symptoms or limitations

d) understand that a person's life story, including their individual cultural and religious background, can offer insight into their priorities and wellbeing

e) know who is important to the person and who they see as 'leading' their care and support (which may be the person themself)

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) be able to make a person the focal point of their own care and support, prioritising their wishes and beliefs to support them to retain independence, choice and dignity

b) understand frailty as a multi-dimensional condition and how different aspects of a person's life contribute to overall wellbeing and quality of life[6]

c) understand the important contribution that supporting individual decisions and choices, and supporting self-care, can make to improving quality of life for people living with frailty and helping them to achieve their goals

d) understand that a person's needs and wishes may change over time

e) understand the importance of the strengths and resilience that people, families, carers and circles of support can have within themselves and their home environment[7]

f) be aware of key legislation relevant to mental capacity, deprivation of liberty, equality and human rights

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) be able to assess the needs, concerns and priorities of people and those important to them in a person-centred way, and support them to meet these needs

6. Different aspects will include: Social environment, physical environment, systems of care, acute health events, psychological status and multimorbidity (Ref: Frailty Fulcrum)
7. This is often described as a 'strengths' or 'asset based' approach

b) be able to support people to understand positive risk and shared decision-making by:

- understanding the priorities and outcomes that are important to a person
- explaining in non-technical language all the available options (including the option of doing nothing)
- exploring with the person the risks, benefits and consequences of each option and discussing what these mean in the context of their life and goals
- supporting the person to be able make the decision and/or agreeing together the way forward
- be aware of established health coaching tools and techniques

c) be able to work with people living with frailty and others to co-produce a care and support plan that balances interventions with the needs and wishes of the person

d) understand how the interactions of different aspects of an individual's life are dynamic and how vulnerabilities in some areas of a person's life might be overcome by promoting resilience in other areas

e) be able to use people's feedback and person-centred outcomes to co-produce improvements in services with those who use them

f) understand the implications of relevant legislation and guidance for consent and shared decision-making (e.g. mental capacity legislation and NICE guidance).

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 4: Person-centred dementia care
- End of Life Care / Subject 1: Person-centred end of life care
- Person-Centred Approaches / Step 1. Conversations to engage with people / Step 2. Conversations to enable and support people

Care Certificate at: www.skillsforhealth.org.uk/care-certificate

- Standard 5. Work in a person-centred way

return to contents page

Capability 4. Communication

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) know the importance of communicating effectively and compassionately

b) know the value of really listening and recognise how one's own communication can support or hinder communication as a two-way process

c) be aware of common barriers to communication for people with frailty and the importance of any required support to enable successful communication (e.g. spectacles, hearing aids)

d) be able to adapt verbal communication to a pace, level, and style, which takes account of people's wishes and abilities including sufficient time to process and respond to questions

e) be aware of the importance of non-verbal communication, e.g. body language, visual images and the appropriate use of touch

f) be aware that signs of distress and behaviours may be a means for communicating unmet needs

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) be able to communicate sensitively with people and those important to them in a non-judgemental, empathetic, genuine, collaborative and supportive manner that is appropriate to them and their abilities and preferences

b) be able to use active listening skills and open questions to support people and those important to them to express their feelings, preferences and needs alongside their strengths and abilities

c) be able to recognise situations, circumstances or places which make it difficult to communicate effectively (e.g. noisy, distressing or emergency environments), and have strategies in place to overcome these barriers

d) understand how different customs and preferences, including religious and cultural customs, may impact communication

e) recognise when and how to seek help or refer a person for support with communication needs

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) demonstrate how effective communication creates opportunities to identify goals and actions for supported self-care, and to build the necessary motivation and confidence to carry out the necessary changes

b) demonstrate the importance of effective communication with family and carers and the expertise that they may be able to offer to support effective communication with the person with frailty

c) be able to adapt communication to overcome barriers, which may include where someone has additional care, support or communication needs, e.g. a learning disability, cognitive impairment or sensory impairment

d) lead and contribute to the development of practices and services that meet the communication needs of people with frailty

e) understand how effective communication can help to engage people with frailty in service development

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 5: Communication, interaction and behaviour in dementia care
- End of Life Care / Subject 2: Communication in end of life care
- Person-Centred Approaches / Core communication and relationship building skills

Care Certificate at: www.skillsforhealth.org.uk/care-certificate

- Standard 6. Communication

return to contents page

Capability 5. Families and carers as partners in care

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) understand what it means to be a 'carer'

b) understand what support, services and resources are available for families and carers, including practical and emotional support services, and know how to access them

c) be aware that a person may be eligible for allowances or benefits and know where to seek advice

d) be able to recognise the changes that occur in the progression of frailty

e) be aware of specific mechanisms available to support the interests of a person living with frailty, such as lasting power of attorney

f) be able to access a Carer's Assessment and resultant support

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand the significance of family, carers and social networks in planning and providing care and the importance of developing partnerships with them

b) understand the complexity and diversity in family relationships and arrangements and the impact that caring for a person living with frailty may have on them

c) understand the importance of recognising and assessing a carer's own needs for example, including respite and the needs of younger carers

d) be aware that the needs and/or objectives of carers and the person living with frailty may not always be the same

e) understand potential socio-cultural differences in the perception of the care-giving role

f) be able to communicate compassionately, effectively and in a timely manner with partners in care, recognising that some carers also have communication problems

g) be able to support family and carers to access and use information and local support networks

h) understand the duty of local authorities to undertake carers' assessments

i) be able to support family and carers in considering options and making decisions

j) be able to gather information about a person's history and preferences from family and carers

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty

(Tier 1 & 2 outcomes plus the following).

The practitioner will:

a) understand the potential for dilemmas arising where there are differing needs and priorities between people living with frailty and their carers and know how to deal with these situations

b) be able to assess a carer's psychological and practical needs and know the relevant support available, including where the carer may also be living with frailty

c) understand the importance of resources to support personalisation in care, e.g. the impact of access to personal budgets and other financial support or constraints

d) be able to contribute to, or influence, the development of practices and services that meet the needs of families and carers

e) understand legislation relevant to carers and carers' rights

f) understand key legislation relevant to mental capacity, deprivation of liberty, equality and human rights

g) be able to facilitate access to further support around legal issues (e.g. lasting power of attorney)

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 9: Families and carers as partners in dementia care
- End of Life Care / Subject 9: Support for carers

return to contents page

Capability 6. Collaborative and integrated working

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) be aware of the range of different agencies and professionals who may be involved in the care of people living with frailty

b) know who is involved in each individual's care and be able to work in partnership with them

c) know whom to contact with any issues or questions about a person's care and support

d) be aware that health and care professionals may ask for a person's consent to share information to enable more integrated working and understand the value of giving this consent

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand the importance of effective integrated working across health, social care, community and voluntary sectors to optimise patient, or population care for people living with frailty

b) know the range of services which may be involved in inter-professional collaboration, for example; primary care, ambulance service, mental health practitioners, fire and rescue service, police, community teams, care homes, housing support, geriatricians, old age psychiatrists and end of life care

c) be able to work in partnership with others, exploring and integrating the views of wider multi-disciplinary teams to deliver care in a co-ordinated way, showing an understanding the role of others, to meet the needs of people living with frailty and those important to them

d) be able to share information, including that which relates to a person's wishes, in a timely and appropriate manner with those involved in a person's care, considering issues of consent, confidentiality and ensuring that, where information is already available, the person is not asked to provide the same information repeatedly

e) understand referral criteria and pathways of care to meet the needs of people living with frailty and those important to them

f) understand and work within one's personal and professional scope of practice and know how and when more specialist advice or support should be sought

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) be able to establish integrated working between different organisations and across different settings of care

b) be able to work collaboratively to attend to the complex medical, functional, social and psychological aspects of frailty more efficiently and effectively, e.g. reducing gaps or duplication in care and developing a more flexible workforce

c) be able to engage in challenging conversations with other professionals, demonstrating a commitment to partnership working to facilitate care

d) understand how to work effectively in collaboration with service commissioners

e) be able to develop oneself and others and contribute to organisational development in relation to care and support for people living with frailty

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- End of Life Care / Subject 8: Working in partnership with health and care professionals and others

return to contents page

Domain C.
Managing frailty

Introduction

Frailty is now recognised as a ‘long term condition’, meaning that it develops over a period of time and then emerges as a progressive condition that a person will live with for the rest of their life. Alongside this gradual progression, people living with long term conditions such as frailty also tend to experience intermittent episodes during which their condition deteriorates for a while, before improving once again to some extent.

Understanding that this is the typical course for frailty helps to identify a range of opportunities at various stages of the condition when timely and targeted intervention can have a positive impact, either by slowing the onset or progression of frailty, or by helping to reduce or reverse acute exacerbations. Factors have also been identified that increase the risk of developing frailty in the first place and this in turn highlights opportunities for primary prevention of frailty. The model of care for long term conditions encourages early diagnosis and focuses upon a systematic, preventative and proactive approach to care, thus enabling opportunities for secondary prevention of the progression or exacerbation of frailty at every stage of the condition, from diagnosis through to end of life care.

Developing capabilities in prevention, risk reduction, and a range of specific actions to support living well with frailty and maintaining independence, will enable people and practitioners to deliver timely, high quality interventions that will in turn improve the outcomes and quality of life for people living with the condition.

Capability 7. Preventing and reducing the risk of frailty

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) know that if recognised early, there are interventions to improve independence and quality of life for people living with frailty

b) understand the importance of exercise, physical activity, diet and hydration for preventing and reducing the risk of frailty

c) be aware that factors such as smoking, obesity and inactivity increase the risk of frailty

d) understand the risks associated with social isolation and the importance of social networks and communities for people living with frailty and their carers

e) understand the positive and/or negative impact the home environment may have on people living with frailty

f) be aware of and be able to access services such as health checks, free eye and hearing tests and home safety checks

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) be able to act on day-to-day interactions with people to encourage changes in behaviour that will have a positive impact on the health and wellbeing of individuals, communities and populations, i.e. 'Making Every Contact Count' [8]

b) know how to effectively communicate messages about healthy living according to the abilities and needs of individuals

c) be able to facilitate access to sources of health promotion information and support

d) understand approaches to prevent or reduce the risk of frailty syndromes

e) understand the importance of early recognition and timely management of frailty syndromes

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) understand the impact that a range of social, economic, and environmental factors can have on outcomes for people with frailty, their carers and their circles of support

b) be able to facilitate environmental change such as thermal comfort, adaptations, or moving to new accommodation

c) understand factors that may impact on the ability to make changes such as patient activation and health literacy

8. http://www.makingeverycontactcount.co.uk/

d) be able to facilitate behaviour changes using evidence-based approaches such as motivational interviewing, health coaching and supporting self-management

e) be able to measure, monitor and report population health and wellbeing, health needs, risk and inequalities and use of services

f) be able to promote population and community health and wellbeing, addressing the wider determinants of health and health inequalities

g) be able to work collaboratively across agencies and boundaries to improve health outcomes and reduce health inequalities

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 3: Dementia risk reduction and prevention

Public Health Skills and Knowledge Framework 2016 (Public Health England) at: https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf

return to contents page

Capability 8. Living well with frailty, promoting independence and community skills

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) be able to support people living with frailty to meet their daily living needs, including both practical and emotional needs

b) understand the importance of home and a 'caring network' (family, friends and others around an individual) in enabling people with frailty to live well

c) understand that supporting someone living with frailty and those important to them goes beyond health and social care intervention and the potential the community has to offer in providing care and support

d) know how to support people living with frailty to access local services including voluntary and community initiatives which would promote their interests, social life, safety and community involvement

e) be able to use a wide range of networks, saying yes to offers of help and learning how to ask for help when needed

f) know how to obtain information on assistive technologies and/or equipment for people living with frailty

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand how to recognise and respond to cultural, spiritual and sexual needs of people living with frailty

b) understand how activities can be adapted to suit a person's changing needs and the contribution that assistive technology can make

c) know how to adapt the home to promote independence, privacy, maintain orientation, thermal comfort and safety (e.g. to reduce risk of falls) with referral to experts where required

d) understand that people should be seen within the context of their own community and be supported to participate and contribute to this as they wish

e) understand the concept and principles of a community development, asset-based approach to care and support for people living with frailty

f) be able to support people living with frailty and those important to them to consider their network of support (referred to as a 'caring network') which may extend beyond immediate family and friends

g) be able to develop the practical skills of people living with frailty and those important to them to enhance networks, including saying yes to offers of help and learning how to ask for help when needed

h) understand how mental capacity legislation promotes an individual's independence, i.e. that individuals have the right to make their own decisions wherever possible

i) understand the value of multi-disciplinary teams involving and including people from outside health and social care, e.g. housing support workers, community development workers, community leaders, individuals and their caring networks

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) be able to contribute to the development of practices and services that meet the individual needs of people living with frailty

b) understand the principles, processes and options for self-directed support and be able to help people access this if desired

c) understand the role of social prescribing in referring people to a range of local non-clinical services

d) be able to provide specific advice and guidance on changing or adapting the physical and social environment to ensure physical safety, comfort and emotional security

e) be able to lead on the introduction of assistive technology for a range of purposes, including to support self-care, monitoring, community support and meaningful activity

f) understand, engage with, influence and strengthen the community to provide support for people living with frailty and those important to them, e.g. by facilitating learning opportunities for community development

g) promote and support effective relationships between communities, public bodies, voluntary organisations and other agencies that facilitate wellbeing for people living with frailty

h) promote the benefits of developing community skills and engaging with the local community amongst colleagues and senior managers/board members in relation to improving outcomes for people living with frailty and those important to them

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 8: Living well with dementia and promoting independence
- End of Life Care / Subject 4: Community skills development in end of life care

return to contents page

Capability 9. Physical and mental health and wellbeing

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) understand the importance for people living with frailty to maintain good physical and mental health through exercise, nutrition, hydration, winter warmth and a lifestyle that includes social engagement

b) be able to support a person living with frailty in looking after their health, e.g.

- looking after feet, mouth, eyes and hearing
- getting vaccinations
- taking medicines
- personal hygiene
- attending to any changes in health proactively

c) know how to seek help for physical or mental health issues

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand the complexity of ageing and multimorbidity including, for example, the importance of swallowing, hearing, cognition, vision, skin integrity and continence

b) be able to provide basic advice for a suitable diet for a person living with frailty, and respond appropriately if signs of dehydration are recognised

c) be able to support a person to optimise their mobility and know how to access specific support regarding strength, balance and falls prevention

d) understand the signs of dementia, delirium, anxiety, depression and chronic pain and know how to seek help in addressing these factors

e) understand the role of family and carers in supporting the health and wellbeing of people living with frailty

f) understand the importance of the home and housing-related support in maintaining functional ability, health and wellbeing and managing frailty

g) know how to support people living with frailty to access local services and referral pathways including through primary care and voluntary / community services which would promote their physical and mental health

h) understand that acute illness may present differently in people living with frailty, be able to recognise these signs and respond appropriately

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) be able to make interventions available which would 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

b) understand appropriate responses and treatment options for dementia, delirium, anxiety, depression and chronic pain

c) be able to make management plans which take account of the complexity of ageing and multimorbidity

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 6: Health and wellbeing in dementia care
- Mental Health / Subject 4: Promoting mental health and preventing mental illness

Care Certificate at: www.skillsforhealth.org.uk/care-certificate

- Standard 9. Awareness of mental health, dementia and learning disability

return to contents page

Capability 10. Managing medication

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) be able to support a person living with frailty to access and take the correct medication in the correct form at the right time as prescribed

b) be aware of the importance of regular medication review and recognise that changes in medication may be appropriate over time

c) be aware that over-the-counter medications can have important interactions with prescribed medications

d) be aware of sources of information and guidance regarding medication, e.g. general practitioners and community pharmacies

e) be aware that people living with frailty are more likely to experience medication side effects

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(*Tier 1 outcomes plus the following)*

The person or practitioner will:

a) be able to administer medication safely and appropriately in consultation with people living with frailty

b) be aware of the potential adverse impact of polypharmacy for people living with frailty, including the increased risk of frailty syndromes

c) be aware that physical changes associated with frailty, e.g. kidney and liver function, can change the effects of medication

d) understand that falls, sedation, constipation, abnormal electrolytes and cognitive impairment may be indications of adverse drug reactions

e) understand the importance of recording and reporting side effects and/or adverse reactions to medication

f) know when and how to access a medication review by an appropriate prescriber

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(*Tier 1 & 2 outcomes plus the following)*

The person or practitioner will:

a) understand the range of medication to address common physical and mental health problems of people living with frailty, including the risks associated with how these drugs may interact

b) understand the ethical issues regarding appropriateness of drug treatments in the care of people living with frailty, e.g. minimising use of psychotropic / antipsychotic medication and use of non-pharmacological options

c) be able to communicate information about medications as part of shared decision-making involving people living with frailty

d) understand the importance of regular reviews of prescribed medication, including a person-centred approach and de-prescribing where appropriate

e) be able to undertake a review of polypharmacy for people living with frailty using appropriate tools and in line with current relevant guidance

f) be aware of new and emerging interventions that can be used to enhance the wellbeing of people living with frailty

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 7: Pharmacological interventions in dementia care

return to contents page

Capability 11. Care and support planning

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) understand the importance of having the person's experiences, wishes and priorities included at all stages of care and support planning

b) be able to encourage and support people to express their wishes at every opportunity and make decisions based on their own experience, utilising professional support and guidance where appropriate

c) understand that a person living with frailty has the right to change their mind regarding the sort of care and support they want

d) understand the importance of choice in planning future care and support needs (including palliative and end of life care)

e) be aware of what a person living with frailty can do if they have a crisis, e.g. how to obtain urgent assistance

f) understand the impact of social isolation on people living with frailty

g) understand how to access support to plan future care

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand the content of a person's care and support plans (and advance care plans) and the impact this has on the care and support offered

b) understand the importance of care and support planning being a 'holistic' and person-centred process

c) understand how a person's beliefs, customs, faith, lifestyle, religion, social norms, spirituality and values may affect care and support planning

d) understand when a palliative, end of life or advance care plan would be appropriate and be able to identify people who may benefit from these plans

e) understand that people and those important to them have a choice regarding with whom they choose to discuss care and support planning

f) understand why care and support plans need to be reviewed regularly and in partnership with others, including the person and those important to them, taking account of the changing needs and wishes of the person

g) understand that some people will not wish to be involved in the care and support planning process, and respect this decision

h) be able to communicate and share information in a person's care and support plan or advance care plan effectively with their permission with appropriate others

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) be able to work together to agree a personalised, shared care and support plan (CSP) outlining treatment goals, management plans and plans for urgent care

b) be able to provide information on advance decision planning for people and those important to them and check understanding

c) understand why and how a person's capacity will affect how care and support planning takes place and when a mental capacity assessment may be required

d) know the importance of considering the observations and judgements of family and carers when planning care and support, integrating their observations into care and support plans where appropriate

e) be able to initiate end of life care discussions when appropriate

f) be able to support and record decisions about advance care planning, understanding the difference between advanced decisions and advance statements

g) be able to recognise when a person living with frailty may be approaching end of life

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- End of Life Care / Subject 6: Assessment and care planning in end of life care

return to contents page

Domain D.
Underpinning principles

Introduction

People living with frailty are amongst the most vulnerable in our society and can be at risk of harm if individuals, organisations and systems do not fully understand and respect their needs, whether willfully or through lack of consideration. Fortunately, however, many systems and structures exist to protect the interests, safety and wellbeing of people living with frailty. Promoting capabilities in understanding the nature, purpose and application of these legal and ethical structures is, therefore, vital in helping to protect the safety and wellbeing of people living with frailty.

People living with frailty can also be at particular risk of harm if systems of care are inadequate, ineffective or poorly coordinated. A continuous cycle of development and improvement is, therefore, needed to ensure that people living with frailty have appropriate access to a range of high quality services, able to deliver integrated and person-centred care. In order to achieve this, capabilities are needed that enable people living with frailty both to participate in and benefit from research and evidence-based practice. Capabilities in leadership in service development are also required in every area and at all levels within communities and systems of care.

Capability 12. Law, ethics and safeguarding

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) be aware of the key legal, ethical and safeguarding issues for people living with frailty such as Lasting Power of Attorney, Mental Capacity Act, Equality Act and the Care Act

b) know how advance decisions and lasting power of attorney can be used should an individual lose capacity to take decisions

c) be aware of the principles of eligibility and assessment for health and social care funding and how to obtain further advice

d) be aware of types of abuse which may be especially relevant for people living with frailty

e) be aware of the risk that people living with frailty may become victims of fraud and of the measures that can be taken to reduce this risk

f) know whom to contact for information or if there are concerns regarding legal, ethical or safeguarding issues

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand how duty of care contributes to safe practice

b) be aware of dilemmas that may arise between the duty of care and an individual's rights and a carer's wishes

c) be able to communicate effectively about proposed treatment or care to enable people living with frailty to make informed choices as far as practicable

d) understand and be able to use protocols regarding consent to treatment or care for people who may lack mental capacity

e) understand how 'best interest' decisions may need to be made for those lacking capacity

f) be able to recognise a range of factors which may indicate neglect, abusive or exploitative behaviours

g) know what to do if neglect, abusive or exploitative behaviour is suspected, including how to raise concerns within local safeguarding or whistle-blowing procedures

h) be aware of key legislation relevant to mental capacity, deprivation of liberty, equality and human rights

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) understand the options available when informed consent may be compromised

b) be able to respond to safeguarding alerts / referrals

c) know the evidence-based approaches and techniques to assess neglect or abuse

d) understand the roles and responsibilities of the different agencies involved in investigating allegations of neglect or abuse

e) be able to share safeguarding information appropriately with the relevant agencies

f) be able to take appropriate action if there are barriers to alerting the relevant agencies

g) be able to contribute effectively to assessments for health and social care funding, which includes, for example, understanding the role of housing assets in funding social care

h) understand key legislation relevant to mental capacity, deprivation of liberty, equality and human rights, including concepts such as least-restrictive options and management of actual or perceived risks to people living with frailty or others

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 11: Law, ethics and safeguarding in dementia care
- End of Life Care / Subject 12: Law, ethics and safeguarding
- Statutory/Mandatory / Subject 8: Safeguarding adults

Care Certificate at: www.skillsforhealth.org.uk/care-certificate

- Standard 3. Duty of care
- Standard 4. Equality and diversity

return to contents page

Capability 13. Research and evidence-based practice

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) be aware of the purpose of service reviews and research

b) be able to participate in reviews, research and surveys, including service satisfaction surveys

c) understand what is meant by ‘informed consent'

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) understand the reasons for conducting service evaluation and research

b) be able to participate in service evaluation and research in the workplace

c) understand how people living with frailty, their families and carers may be involved in service evaluation and research

d) be aware of local and national policy and evidence-based practice relevant to frailty and where to find additional information about this

e) be able to judge the value of information, e.g. according to its source or evidence base

f) be able to reflect on practice and learn from experiences

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) analyse how local and national policy and the outcomes of research in frailty care and support can inform and impact on workplace practices and care delivery

b) understand approaches to evaluating services and measuring impact, including the use of outcomes and experience measures reported by people living with frailty, their families and carers

c) understand the ethical issues related to conducting research with people living with frailty, including those who may have a cognitive impairment

d) be able to engage people living with frailty, their families and carers in service evaluation and research

e) critically review evidence to determine relevance to one’s own decision-making

f) be able to share findings of research, audit or evaluation clearly and accurately in written or verbal form

g) understand the importance of continuing professional development to ensure the methods used are robust, valid and reliable

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 13: Research and evidence-based practice in dementia care
- End of Life Care / Subject 14: Improving quality in end of life care through policy, evidence and reflective practice

return to contents page

Capability 14. Leadership in transforming services

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) understand that everyone has a part to play in supporting people living with frailty to have the best possible quality of life

b) be aware of opportunities to provide feedback, or other ways to get involved in helping to shape services

c) know about social networks or groups which provide leadership within the community to support people living with frailty and how to get involved

Tier 2 Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.

(Tier 1 outcomes plus the following)

The person or practitioner will:

a) be able to provide support for colleagues to develop their skills and confidence when working with people living with frailty and those important to them

b) be aware of local and national policies shaping the delivery of care for people living with frailty and how these influence service delivery

c) be aware of the roles and responsibilities of different agencies involved in care and support for people living with frailty and the importance of collaborative working

d) be able to take ownership of understanding the whole journey of care for a person living with frailty and support effective navigation through appropriate care processes

e) be able to demonstrate team practices that champion diversity, equality and inclusion

Tier 3 Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

(Tier 1 & 2 outcomes plus the following)

The practitioner will:

a) understand the key national drivers and policies which influence frailty strategy and service development

b) be able to anticipate and prepare for the future by scanning for ideas, best practice and emerging trends that will have an impact on outcomes for people living with frailty

c) be able to disseminate and promote new and evidence-based practice and challenge poor practice

d) be able to demonstrate leadership in delivering compassionate and integrated person-centred care, including identifying and addressing aspects of culture and practice which may be barriers to this

e) be able to use people's feedback and person-centred outcomes to co-produce improvements in services with those who use them

f) know how to ensure team members are trained and supported to meet the needs of people living with frailty and how to actively engage a multi-disciplinary and multi-organisational approach to care

g) understand the roles and responsibilities of different agencies involved in care and support for people living with frailty and the importance of collaborative working to minimise risks and maximise opportunities at transitions of care

h) understand how integrated service provision that crosses traditional boundaries achieve better outcomes for people living with frailty, including integrating with the community

i) be able to promote team practices that champion diversity, equality and inclusion

NB. These are the common core outcomes, which are applicable in all settings. Additional content will be required for some roles and contexts.

Indicative mapping to other frameworks

Core Skills Frameworks at: www.skillsforhealth.org.uk/cstf

- Dementia / Subject 14: Leadership in transforming dementia care
- End of Life Care / Subject 13: Leading end of life care services and organisations

NHS Leadership Academy (2013), Healthcare Leadership Model:
http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/

return to contents page

Appendix 1.
Glossary of terms

Term	Definition
Activation	A person's knowledge, skill and confidence for managing their own health and healthcare.
Active listening	Fully concentrating on what is being said, including: • Ability to pick up on non-verbal cues • Listening for key words as signposts to emotions • Understanding the meaning of silence • Using body language and facial expression to indicate interest and empathy
Asset-based approach	A way of working that considers the strengths and potential of individuals and communities.
Carer	Someone who spends a significant amount of their time providing unpaid support to a family member or friend.
Comprehensive Geriatric Assessment (CGA)	A process of care comprising a number of steps. Initially, a multidimensional holistic assessment of an older person considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly[9].
Co-production	At the level of individuals, services and systems, co-production means professionals and citizens sharing power to plan, design and deliver support together, recognising that everyone has an important contribution to make to improve quality of life for people and communities[10].
Cumulative deficit model of frailty	Described by Rockwood in Canada, it assumes an accumulation of deficits (ranging from symptoms e.g. loss of hearing or low mood, through signs such as tremor, through to various diseases such as dementia) which can occur with ageing. These combine to create a 'frailty index' which is in turn associated with an increased risk of adverse outcomes[11].
End of life care	Care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.
Frailty	A long term condition particularly related to the ageing process in which multiple body systems gradually lose their in-built reserves. It is now widely recognised as a state of reduced resilience and increased vulnerability, which results in some people becoming more vulnerable to relatively minor changes in their circumstances which can lead to a deterioration in their health and/or ability to live independently.

9. http://www.bgs.org.uk/cga-toolkit/cga-toolkit-category/what-is-cga/cga-what
10. http://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/
11. British Geriatrics Society (2014), Fit for Frailty Part 1

Term	Definition
Frailty index	An approach to quantifying frailty severity based upon the cumulative deficit model of frailty.
Health Coaching	Enabling a person to maximise their own health through raising individuals' awareness and responsibility for their own health. Key characteristics include a focus on a person's goals rather than what professionals think they should do; empowering people to take ownership and responsibility for their health; and helping people plan and break down their goals into manageable steps[12].
Electronic frailty index	A specific tool which uses data that is routinely available in the GP electronic health record to generate a 'frailty index' score that identifies the risk of frailty and frailty severity.
Person	People living with frailty, as well as their family, friends and carers.
Person-centred care	Care that takes account of and actively promotes individuality, rights, choices, privacy, independence, dignity, respect and partnership.
Phenotype model of frailty	A group of patient characteristics (unintentional weight loss, reduced muscle strength, reduced gait speed, self-reported exhaustion and low energy expenditure) which, if present, can predict poorer outcomes associated with frailty. Generally, individuals with three or more of the characteristics are said to have frailty[13].
Practitioner	Those working in health, social care and other services.
Shared decision-making	Putting people at the centre of decisions about their own treatment and care by: • exploring care or treatment options and their risks and benefits • discussing choices available • reaching a decision about care or treatment, together with their health or social care professional or support worker

12. Realising the Value (2016), Realising the Value: Ten key actions to put people and communities at the heart of health and wellbeing
13. British Geriatrics Society (2014), Fit for Frailty Part 1

Appendix 2.
Principles of assessment

A key element of the preparation for individuals to practise will be assessment of achievement of the capabilities, specific to the context of their practice.

Assessment outside of formal programmes of study will need to be valid and reliable and may include: case-based presentation, theoretical and/or practical tests of knowledge, skills and behaviours, critical reflections, portfolio of evidence, etc.

To ensure assessment in the workplace is valid and reliable:

- assessors must be occupationally competent, recognised as such by employers and education providers, and be familiar with the chosen assessment tool
- a range of assessors, trained in the relevant assessments, should be used, including educators with appropriate academic and clinical experience and competent health and care professionals at the required level
- healthcare providers must invest in and support staff to undertake assessment(s) in practice

Work-based assessment must happen within the work setting undertaken by experienced clinicians aware of the benchmark level of capability required for practitioners.

There will be a strong need for collaboration and working across professional and organisational boundaries to ensure that learning and assessment in practice delivers practitioners who consistently meet the required outcomes in all settings.

(Adapted from Health Education England (2017), Multi-professional framework for advanced clinical practice in England)

Appendix 3.
How the framework was developed

Development of the framework was steered by a project management group representing key stakeholders, including: Health Education England, NHS England, Skills for Health, Age UK, British Geriatric Society, Royal College of GPs, and housing, local government and voluntary sector organisations.

A wider stakeholder list was established to include a more diverse range of organisations and individuals that wished to be up-dated on development of the framework and to provide comments or feedback as part of the consultation process. Individuals were able to register their interest in the project from a project web page.

Initial desk research was undertaken to identify key references, resources and significant themes or issues for consideration – further references and resources continued to be identified during the project (see Appendix 4. Current relevant resources and Appendix 5. Bibliography).

Initial iterations of the framework were developed based on the findings of the desk research and consultation with the project management group. On 23 January 2018 expert representatives of a wider range of stakeholder organisations met as a project expert group to review the first draft framework. Subsequently, during February and March 2018 a wider online consultation survey was conducted, with a total of 140 respondents and based on analysis of these survey outcomes, further amendments and refinements were undertaken. Consultation interviews were also conducted with people living with frailty and their carers to review and refine the final draft. A plain English edit was completed in April 2018, leading to a final meeting of the project management group on 1 May 2018.

Appendix 4. Current relevant resources

Chartered Society of Physiotherapy (CSP), Falls prevention exercises at:
https://www.youtube.com/watch?time_continue=19&v=n8s-8KtfgFM

General Medical Council (2017), Generic Professional Capabilities Framework at:
http://www.gmc-uk.org/education/23581.asp

Health Education England (2016), Care Navigation: A Competency Framework at:
http://learning.wm.hee.nhs.uk/sites/default/files/ICT_Care%20Navigation%20Competency%20Framework.pdf

Health Education England, Co-ordinated Care at:
http://learning.wm.hee.nhs.uk/node/911

Health Education England, Enhanced Health in Care Homes and Other Care Settings at:
http://learning.wm.hee.nhs.uk/node/889

Health Education England, Self-Care Resources to Support Person Centred Care at:
http://learning.wm.hee.nhs.uk/self-care

NHS North Hampshire Clinical Commissioning Group: Frailty Focus at:
http://www.frailtyfocus.nhs.uk/

NHS Leadership Academy (2013), Healthcare Leadership Model at:
http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/

NHS England (2017), Toolkit for General Practice in supporting older people with frailty at:
https://www.england.nhs.uk/wp-content/uploads/2017/03/toolkit-general-practice-frailty.pdf

NHS England, Year of Care Partnerships at:
https://www.yearofcare.co.uk/

Nottinghamshire Local Workforce Action Board (LWAB), Frailty Toolkit at:
http://www.frailtytoolkit.org/development-of-the-toolkit/ and www.frailtytoolkit.org (Nottingham LWAB)

The Future Planning Project at:
http://www.futureplanning.org.uk

Appendix 5. Bibliography

Age UK & NHS England (2015), A practical guide to healthy ageing at:
https://www.england.nhs.uk/2015/01/healthy-ageing/

Bloom, B. S. (1956). Taxonomy of Educational Objectives. Vol. 1: Cognitive Domain. New York: McKay

British Geriatrics Society (2014), Fit for Frailty Part 1 at:
http://www.bgs.org.uk/campaigns/fff/fff_full.pdf

British Geriatrics Society (2015), Fit for Frailty Part 2 at:
http://www.bgs.org.uk/campaigns/fff/fff2_full.pdf

British Geriatrics Society (2012), Quality Care for Older People with Urgent & Emergency Care Needs – 'Sliver Book' at:
http://www.bgs.org.uk/silverbook/campaigns/silverbook

British Medical Association, Focus on identification and management of patients with frailty at:
https://www.bma.org.uk/advice/employment/contracts/general-practice-funding/focus-on-identification-and-management-of-patients-with-frailty (British Medical Association)

BMJ Opinion (2014) Recognising frailty in older people at:
http://blogs.bmj.com/bmj/2014/06/18/gillian-turner-recognising-frailty-in-older-people/

Clegg, Young, Iliffe, Rikkert & Rockwood (2013), Frailty in elderly people, Lancet. 2013 Mar 2;381 (9868):752-62 at:
https://www.ncbi.nlm.nih.gov/pubmed/23395245

Harrison, Clegg, et al Managing frailty as a long term condition Age Ageing 2015 Sept 44(5) 732 et seq at: http://www.improvementacademy.org/documents/Projects/healthy_ageing/Age%20Ageing-2015-Harrison%20et%20al%20Frailty%20as%20a%20LTC.pdf

Health Education England (2017), Multi-professional framework for advanced clinical practice in England at: https://www.hee.nhs.uk/sites/default/files/documents/HEE%20ACP%20Framework.pdf

Health Education England, Skills for Care and Skills for Health, The Care Certificate Standards at:
http://www.skillsforhealth.org.uk/images/projects/care_certificate/Care%20Certificate%20Standards.pdf

Moody D, The Frailty Fulcrum at:
https://www.england.nhs.uk/blog/dawn-moody/

National Institute for Health Research (2017), Comprehensive Care: Older people living with frailty in hospitals at:
www.dc.nihr.ac.uk/themed-reviews/comprehensive-care.htm

National Voices, UCL Partners & Age UK (2014), I'm Still Me: A Narrative for Coordinated Support for Older People at:
https://www.nationalvoices.org.uk/sites/default/files/public/publications/im_still_me.pdf

NHS England, Age UK, Carers Trust, Carers UK, Public Health England (2016), A practical guide to healthy caring at:
https://www.england.nhs.uk/wp-content/uploads/2016/04/nhs-practcl-guid-caring.pdf

NICE Guideline [NG16] 2015, Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset at:
https://www.nice.org.uk/guidance/ng16

NICE Guideline [NG27] 2015, Transition between inpatient hospital settings and community or care home settings for adults with social care needs at:
https://www.nice.org.uk/guidance/ng27

NICE Quality Standard [QS136] Transition between inpatient hospital settings and community or care home settings for adults with social care needs at:
https://www.nice.org.uk/guidance/qs136

NICE Guideline [NG56] 2016, Multimorbidity: clinical assessment and management at:
https://www.nice.org.uk/guidance/NG56/chapter/Recommendations#how-to-assess-frailty

NRC (2018), A workforce competency framework for enhanced health, March 2018, vol 20. No 3

Oliver, Foot, Humphries Making our health and care systems fit for an ageing population 2014; ISBN 978 1 909029 279 at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

Picker Institute/Dunhill Medical Trust (August 2018): Exploring education and training in relation to older people's health and social care at: http://www.picker.org/wp-content/uploads/2018/08/P3159_Dunhill-Medical-Trust_Older-peoples-care-staff-training_FULL-Report_SAB-HH-AJP-JK_120718_FINAL.pdf

Public Health England (2016), Public Health Skills and Knowledge Framework 2016 at:
https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf

RCGP/BGS (2016), Integrated care for older people with frailty: Innovative approaches in practice at:
http://www.rcgp.org.uk/about-us/news/2016/november/joining-up-care-for-older-people-with-frailty.aspx

RCGP (2016), The RCGP Curriculum: Professional & Clinical Modules: 3.05 Care of Older Adults at:
https://www.gmc-uk.org/-/media/documents/RCGP_Curriculum_modules_jan2016.pdf_68839814.pdf

RCSLT (2018) Curriculum Guidance for the pre-registration education of Speech and Language Therapists: Available at: https://www.rcslt.org

Skills for Care (2015), The common core principles to support self-care at: http://www.skillsforcare.org.uk/Documents/Topics/Self-care/Common-core-principles-to-support-self-care.pdf

Skills for Health (2017), Statutory/Mandatory UK Core Skills Training Framework (CSTF) at:
http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework

Skills for Health, Health Education England and Skills for Care (2017), End of Life Care Core Skills Education and Training Framework at:
http://www.skillsforhealth.org.uk/services/item/536-end-of-life-care-cstf-download

Skills for Health, Health Education England and Skills for Care (2015), Dementia Core Skills Education and Training Framework at:
http://www.skillsforhealth.org.uk/services/item/176-dementia-core-skills-education-and-training-framework

Skills for Health & Health Education England (2017), Person-Centred Approaches at:
http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download

Frailty
A framework of core capabilities

Skills for Health

NHS