Living Well, Ageing Well - Gloucestershire Interventions framework (frailty)

Based on the NHS Right Care Toolkit https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf

Clinical Frailty Scale 1-3 People who are Fit	Clinical Frailty Scale 4-5 People Living with Mild Frailty	Clinical Frailty Scale 6 People Living with Moderate Frailty	Clinical Frailty Scale 7-9 People Living with Severe Frailty
• Promote Healthy lifestyle and Wellbeing • Weight management • Dental Health • Social prescribing support/signposting • Vaccinations/health check • Smoking cessation • Exercise prescription • Sensory check – hearing and eyesight • Sleeping/insomnia • Self-management & information on support services locally and nationally • Keeping mentally active • Maintaining social networks • Education and information on frailty and resilience building • Bereavement support	As pre frail plus: **Priorities:** ❖ **Falls risk assessment - development of resilience plan, information on strength and balance classes** ❖ **Information and access to Social Prescribing and local community support** ❖ **Nutritional Screening, education and advice**	As per mild plus: **Priorities:** ❖ **Comprehensive Geriatric Assessment and holistic assessment , including ReSPECT, Personalised Care Planning (Orange folder), cognition, mobility and falls risk** ❖ **Structured medication review and management** ❖ **MDT approach - to plan and coordinate care**	As per moderate plus: **Priorities:** ❖ **Reassessment and review of Comprehensive Geriatric Assessment , ReSPECT, DNARCPR** ❖ **Continuous review of medication, deprescribing and anticipatory prescribing (where relevant)** ❖ **Whiteboard and MDT approach**

	• Holistic assessment
	  • Mobility
	  • Falls-development of falls resilience plan
	  • Home environment/ minor adaptation/assistive technology
	• Carers Assessment , information on Carers Hub
	• Consider mental health , social isolation and loneliness , maintaining cognitive acuity
	• Sensory services (hearing, eyes, teeth)
	• Information or introduction to ACP, ReSPECT, Me at My Best, red flag tool
	• Information on community transport
	• Long term condition management including symptom management & self-management support
	• Personal Health Budgets
		• Assess: continence, bowel health, sleep, skin health, foot health, pain, mood
		• Commence ACP, ReSPECT, delirium screening
		• Consider community-based rehabilitation / reconditioning classes
		• Management plan and specialist team support for LTC
		• Financial assistance: Personal health budget, attendance allowance
		• Information on LPA
		• Future care and treatment escalation discussions that consider virtual wards, District Nursing, Hospice Care
		• Carers Assessment
			• ACP formulated and recorded
			• Clarify preferred place of care and death,
			• Information sharing EOL and Palliative Care
			• Review future care needs consider virtual wards, District Nursing