CONSULTATION DRAFT

February 2018

Frailty
Core Capabilities Framework

Acknowledgements

To be completed…

Contents

Foreword from

To be completed…

Introduction

To be completed… (Background / policy / drivers for the project)

To include a definition of frailty…

About this framework

Scope of the framework

The framework will be applicable to health and social care employers, employees, patients, carers, the community, the public and also to educational organisations which train students who will subsequently be employed in the health and social care 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 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 those working in health, social care and other services who have limited contact with people with frailty, or as a foundation for further training.

This tier also outlines the capabilities that will support people with frailty in accessing care, as well as their family, friends and carers, to ensure they are making the most of the support on offer and are able to plan effectively for their own current and future care needs. Tier 1 therefore includes a community development, 'asset-based' 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 and social care 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.

The tier will be relevant to you if:

- You are a 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 but have limited contact with anyone living with frailty.

Tier 2 Health and social care staff and others who regularly work with people living with frailty.

In addition to health and social care staff, those who regularly encounter people living with frailty within their working environment may include emergency services, housing support and local authority staff.

Tier 3 Health, social care and other professionals who provide expert care and lead services for people living with frailty.

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.

Add case studies/scenarios to illustrate how the framework tiers apply in different situations/contexts…?

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. This does not indicate a prescribed pathway, process or hierarchy i.e. some capabilities may not be relevant to all practitioners. For example, relevant capabilities may be selected according to the role or experience of practitioners.

Within each capability, the expected outcomes from workforce development and practice are presented i.e.

The person/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[1].

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.

[1] This approach is derived from Bloom's Taxonomy *(Bloom B, 1956),*

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 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 settings.

How to use this framework

To be completed…

e.g. how the framework can be used by commissioners, employers and providers of education and training (including the principles of assessment)…

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

c) Be interested in, and want to understand peoples' perspective, their preferences and what is important to them and their carers.

d) Value and acknowledge the experience and expertise of people, their carers and support networks.

e) Act with integrity, honesty and openness, seeking to develop mutual trust in all interactions with people, their 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 (e.g. in race, age, disability, sexuality, gender, religious, ethnic and cultural backgrounds).

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

Refs: Person-Centred Approaches (SfH & HEE 2017), RCGP Curriculum (2014), Common Core Principles and competencies… (SfC & SfH 2014), GMC Generic Professional Capabilities (2017).

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To be developed and validated through further consultation…

Domain A. Understanding, identifying and assessing frailty

Introduction

Concise introduction to the domain to be completed…

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

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, mental health, cognitive function and their social and home environment)

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

f) 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 *(Tier 1 outcomes plus the following).*

The person or practitioner will:

a) understand the concept of frailty as a long-term condition

b) know the five conditions often associated with frailty (known as the frailty syndromes[2]) and how they commonly present i.e.

- delirium
- falls
- immobility
- incontinence
- medication side-effects

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

[2] Add diagram to represent frailty syndromes (possibly as an appendix)?

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

Tier 3 Health, social care and other professionals who provide expert care and 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 multimorbidity, disability, dependency and personal resilience

c) understand the importance of a 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 Education & Training Frameworks:

- Dementia / Subject 1: Dementia awareness

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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, fatigue, weakness, slow walking speed and reduced physical activity

b) know that in frailty it is usually the number of things that have 'gone wrong' 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 *(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 appropriate and acceptable to the person

d) 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)

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

f) understand the concept of a 'frailty index' as a means of measuring frailty

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

h) 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; Clinical Frailty Scale or Rockwood Score

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

j) know when and how to refer a person for a comprehensive and holistic assessment of frailty, often known as Comprehensive Geriatric Assessment (CGA)

Tier 3 Health, social care and other professionals who provide expert care and 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 affected 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 Education & Training Frameworks:

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

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Domain B. Person-centred collaborative working

Introduction

Concise introduction to the domain to be completed…

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, that 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 themselves).

Tier 2 Health and social care staff and others who regularly work with people living with frailty *(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[3]

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

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[4].

[3] Different aspects will include: Social environment, physical environment, systems of care, acute health events, psychological status and multimorbidity (Ref: Frailty Fulcrum)

[4] This is often described as a 'strengths' or 'asset based' approach

Tier 3 Health, social care and other professionals who provide expert care and 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

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

c) be aware of established health coaching tools and techniques

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

e) 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 on other areas

f) be able to use peoples' feedback and person-centred outcomes to coproduce improvements in services with those who use them

g) understand the implications of relevant legislation and guidance for consent and shared decision making (e.g. 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 Education & Training Frameworks:

- 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

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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 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

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

Tier 2 Health and social care staff and others who regularly work with people living with frailty *(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 on communication

Tier 3 Health, social care and other professionals who provide expert care and 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) understand the barriers to communication which may include where someone has additional care, support or communication needs e.g. learning disabilities, 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 Education & Training Frameworks:

- 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

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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 able to recognise the changes that occur in the progression of frailty

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

e) 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 *(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

b) understand the importance of developing partnerships with family members and carers

c) understand the impact that caring for a person living with frailty in the family may have on relationships

d) understand the importance of recognising and assessing a carer's own needs, including respite

e) be aware of the complexity and diversity in family arrangements

f) be aware that the needs of carers and the person living with frailty may not always be the same

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

h) be aware of the impact on younger carers and their concerns

i) be able to communicate compassionately, effectively and in a timely manner with partners in care

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

k) understand the duty of local authorities to undertake carer's assessments

l) be aware that a person may be eligible for an allowances or benefits and be able to signpost appropriately

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

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

Tier 3 Health, social care and other professionals who provide expert care and 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 needs of families and carers

b) be able to assess a carer's psychological and practical needs and know the relevant support available

c) understand the potential for dilemmas arising where there are differing needs and priorities between people living with frailty and their carers

d) 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

e) understand legislation relevant to carers and carers rights

f) 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 Education & Training Frameworks:

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

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Capability 6. Collaborative and integrated working

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

a) know who is involved in a person's care and be able to work in partnership with them

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

c) be aware that health and care professionals may ask for a person's consent to share information to enable more integrated working.

Tier 2 Health and social care staff and others who regularly work with people living with frailty *(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. Inter-professional collaboration may include for example; primary care, ambulance service, fire and rescue service, police, community teams, housing support, geriatricians, old age psychiatrists and end of life care.

b) 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

c) 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 confidentiality and ensuring that where information is already available, the person is not asked to provide the same information repeatedly

d) understand referral criteria and pathways of care to meet the needs of people living with frailty and those important to them considering the common acute presentations including frailty syndromes

e) 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 who provide expert care and lead services for people living with frailty *(Tier 1 & 2 outcomes plus the following).*

The practitioner will:

a) be able to establish integrated working (e.g. across health, social care, community and voluntary sectors) to attend to the complex medical, functional, social and psychological aspects of frailty more effectively

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

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

d) be able to develop self and others 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 Education & Training Frameworks:

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

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Domain C. Managing frailty

Introduction

Concise introduction to the domain to be completed…

Capability 7. Prevention and risk reduction

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 physical activity diet and hydration for preventing and treating the physical aspects of frailty

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

d) understand 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 tests and home safety checks.

Tier 2 Health and social care staff and others who regularly work with people living with frailty *(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'

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 who provide expert care and 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

d) be able to facilitate behaviour change 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 Education & Training Frameworks:

- Dementia / Subject 3: Dementia risk reduction and prevention

Public Health Skills and Knowledge Framework 2016 (Public Health England)

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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

b) understand the needs of people living with frailty for day to day closeness with others e.g. sharing thoughts and feelings

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

d) 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

e) 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

f) be able to apply the practical skills of enhancing networks: saying yes to offers of help and learning how to ask.

g) 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 *(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

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

d) be able to incorporate assistive technology to support self-care and meaningful activity

e) 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

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

g) understand that the support needs of people living with frailty and those important to them are wide ranging and extend far beyond the care, support and treatment provided by health and care professionals

h) be able to support people living with frailty and those important to them to access local community groups and services and to understand the benefit this could bring

i) 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

j) 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

k) 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 who provide expert care and 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

c) be able to support people living with frailty and their families to access self-directed support if desired

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

e) 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

f) be able to lead on the introduction of assistive technology to support self-care, monitoring, community support and meaningful activity.

g) understand, engage with, influence and strengthen the community to provide support for people living with frailty and those important to them

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

i) facilitate learning opportunities for community development in relation to people living with frailty

j) 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 Education & Training Frameworks:

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

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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 and a life style 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

Tier 2 Health and social care staff and others who regularly work with people living with frailty *(Tier 1 outcomes plus the following).*

The person or practitioner will:

a) be able to support a person to optimise strength, balance and falls prevention

b) be aware of the impact of delirium, depression and social stressors and know how to seek help in addressing these factors

c) understand the role of family and carers in supporting the health and well-being of people living with frailty

d) understand the importance of the home and housing related support in maintaining health and wellbeing and managing frailty

e) know how to support people living with frailty to access local services and referral pathways including voluntary and community services which would promote their physical and mental health.

Tier 3 Health, social care and other professionals who provide expert care and 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 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 the signs of dementia, anxiety, depression and delirium and appropriate responses and treatment options.

c) understand 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 Education & Training Frameworks:

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

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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 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

Tier 2 Health and social care staff and others who regularly work with people living with frailty *(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

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

d) be able to recognise adverse drug reactions including falls, sedation, constipation, electrolyte disturbance and cognitive impairment

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

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

Tier 3 Health, social care and other professionals who provide expert care and lead services for people living with frailty *(Tier 1 & 2 outcomes plus the following).*

The 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

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

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 knowledge of pharmacological interventions that can be used to enhance the well-being 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 Education & Training Frameworks:

- Dementia / Subject 7: Pharmacological interventions in dementia care

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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 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 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 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 *(Tier 1 outcomes plus the following).*

The person or practitioner will:

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

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

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

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

e) 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

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

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

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 who provide expert care and lead services for people living with frailty *(Tier 1 & 2 outcomes plus the following).*

The practitioner will:

a) be able to generate 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 how a person's beliefs, customs, faith, lifestyle, religion, social norms, spirituality and values may affect care and support planning

d) 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

e) know the importance of considering and acting on the observations and judgements of family and carers when planning care and support, integrating their observations into care and support plans

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

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

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 Education & Training Frameworks:

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

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Domain D. Underpinning principles

Introduction

Concise introduction to the domain to be completed…

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

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

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

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

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

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

Tier 3 Health, social care and other professionals who provide expert care and 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) understand the importance of sharing safeguarding information with the relevant agencies

f) know the actions to take if there are barriers to alerting the relevant agencies

g) know how 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.

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 Education & Training Frameworks:

- 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

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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 *(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 who provide expert care and 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) critically review evidence to determine relevance to own decision-making

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

f) 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 Education & Training Frameworks:

- 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

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Capability 14. Leadership in transforming services

Key outcomes

Tier 1 Those that require general awareness of frailty.

The person will:

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

b) 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 *(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 demonstrate team practices that champion diversity, equality and inclusion

Tier 3 Health, social care and other professionals who provide expert care and 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) understand the importance of demonstrating leadership in delivering compassionate person-centred care

e) be able to use peoples' feedback and person-centred outcomes to coproduce 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

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

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 relevant national standards or frameworks

Core Skills Education & Training Frameworks:

- 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/

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Delivery of training, education and learning opportunities

To be completed - with reference to the Person-Centred Approaches framework…

Behaviour change

…

Co-producing training

…

Reflective practice

…

Continuous Improvement

…

Methods for delivering training

…

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Appendix 1. Glossary of terms

Term	Definition
To be completed…	To be completed…

Appendix 2. How the framework was developed

To be completed…

Appendix 3. Current relevant resources

To be further developed throughout the project…

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: 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: 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

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

Appendix 4. References and sources

To be further developed throughout the project… e.g.

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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

Moody D, The Frailty Fulcrum 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

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

Public Health England (2016), Public Health Skills and Knowledge Framework 2016: 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: file:///C:/Users/cwright/Downloads/RCGP-Integrated-care-for-older-people-with-frailty-2016.pdf

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