Frailty Core Capabilities Framework Consultation 8.1.26

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Contents

Tier Descriptors

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, adult 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 individuals who:

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

Examples of indicative roles in Tier 1 (please note that this is a representative, but not exhaustive list)

- Volunteer roles
- Personal assistant
- Care worker
- Administrator

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 individuals who work in;

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

Examples of indicative roles in Tier 2 (please note that this is a representative, but not exhaustive list)

- Healthcare support worker
- Healthcare assistant
- Senior care assistant
- Community support worker
- Housing support worker
- Registered staff

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 individuals who work in;

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

Examples of indicative roles in Tier 3 (please note that this is a representative, but not exhaustive list)

- Social workers
- Service leads/managers
- Specialist allied health professionals
- Senior clinicians
- Practice educators

Frailty Core Capabilities Framework

Domain A: Understanding, identifying and assessing frailty

People are living longer, healthier lives, but some face frailty - a condition where they're more vulnerable to health changes, losing strength, and struggling with daily tasks. It's not just about ageing; it can affect anyone, especially vulnerable groups. Raising awareness and knowledge of frailty as a long-term condition among individuals, families, and health and social care professionals, and being able to identify frailty early, in any setting, to offer tailored interventions is key to improving outcomes.

Capability 1. Understanding frailty			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) know what is meant by the concept of frailty as a long term condition of reduced resilience and increased vulnerability to deterioration because of relatively minor stress factors (for example a minor illness, fall or new medication)	✓	✓	✓
b) be aware how living with frailty affects and is affected by many different aspects of a person's life (i.e. medical, functional, social, psychological and environmental)	✓	✓	✓
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 especially people with serious mental illness, 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 (for example, physical activity, nutrition, and social engagement) or other factors (for example, physical and mental health)	✓	✓	✓

f) be aware that people living with frailty are more at risk of delirium, falls, mobility difficulties, incontinence and side effects of medication and know when to seek help should symptoms worsen	✓	✓	✓
g) understand the concept of frailty as a long term condition and recognise all stages from emergence to end of life care		✓	✓
h) know the five acute presentations 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		✓	✓
i) Understand that new onset of a frailty syndrome indicates an underlying problem and the need for clinical evaluation to find and treat the cause.		✓	✓
j) understand the importance of early recognition and timely management of frailty syndromes, e.g. that there are interventions to improve or maintain independence and quality of life for people living with frailty		✓	✓
k) understand the concepts of the 'phenotype' and 'cumulative deficit' models of frailty			✓
l) understand frailty as a complex and multi-dimensional state linked to other concepts including multi- morbidity, disability and personal resilience			✓
m) understand the importance of a comprehensive multi-dimensional assessment, care planning and management model in assessing and managing older people with frailty often referred to as the Comprehensive Geriatric Assessment (CGA))			✓
n) understand frailty risk stratification to identify individuals at risk of adverse outcomes like hospital admission, nursing home placement and death			✓

Capability 2. Preventing and reducing the risk of frailty and frailty progression			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the importance of physical activity (including structured exercise programmes), nutrition and hydration for preventing and reducing the risk of frailty	✓	✓	✓
b) be aware that factors such as smoking, obesity, drug and alcohol misuse, and inactivity increase the risk of frailty	✓	✓	✓
c) know that if recognised early, there are opportunities to improve independence and quality of life for people at risk of developing frailty and living with frailty	✓	✓	✓
d) understand the social determinants of health and their relationship with frailty, including housing, poverty, loneliness and social isolation, and the importance of social networks and communities for people living with frailty and their carers	✓	✓	✓
e) know how to signpost to relevant voluntary sector or to other organisations to help address loneliness and social isolation	✓	✓	✓
f) understand how sensory impairments impact social isolation, and overall wellbeing for people living with frailty	✓	✓	✓
g) be aware of and be able to access services such as health checks, free eye and hearing tests and home safety checks	✓	✓	✓
h) 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	✓	✓	✓
i) be able to encourage health promotion, prevention and onward referral proactively, taking opportunities when assessing people with frailty		✓	✓

j) understand the evidence base for addressing frailty prevention e.g. physical activity (inclusion of aspect of resistance training), risk factors for frailty and cognitive impairment		✓	✓
k) be able to facilitate access to physical and mental health promotion information and support		✓	✓
l) be able to help to facilitate environmental change such as ensuring appropriate lighting, temperature, adaptations, or moving to new accommodation		✓	✓
m) understand how local and national policy can be developed to address the social determinants of health in relation to frailty			✓
n) understand factors that may impact on the ability to self-manage conditions e.g dementia, sensory impairments			✓
o) understand the impact of taking a 'life course' approach to ageing well and reducing the risk of frailty			✓
p) be able to facilitate behaviour changes using evidence-based approaches such as motivational interviewing, health coaching and behaviour change techniques, such as goal setting and action planning that better support self-management			✓
q) be able to measure, monitor and report on health and wellbeing needs in the community, risk, inequalities and use of services, being aware that some people may lack the digital access or skills to be included in data collection or benefit from digital services			✓
r) be able to interpret trends and use risk stratification for targeted interventions to prevent and manage frailty within a population that would benefit from evidence-based strategies e.g. mild, moderate, severe frailty			✓
s) be able to promote population and community health and wellbeing, addressing the social determinants of health to reduce health inequalities in relation to access, interventions and outcomes			✓
t) be able to work collaboratively across agencies and boundaries to improve health outcomes and reduce health inequalities			✓

Capability 3. Frailty identification and assessment			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) be able to recognise the early signs 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, pain, history of falls and memory loss, as well as diagnosed long term physical and mental health conditions)	✓	✓	✓
c) recognise the importance of contacting health professionals in a timely manner as soon as deterioration is recognised, to enable a coordinated response from multiple agencies.	✓	✓	✓
d) understand the importance of identifying people with frailty in planning healthcare or support interventions		✓	✓
e) understand the importance of both proactive and reactive approaches to frailty identification		✓	✓
f) be able to 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		✓	✓
g) understand that people may not like to recognise themselves as living with frailty and may be unwilling to acknowledge or disclose problems		✓	✓
h) 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 or mental health needs)		✓	✓

i) understand that a person's degree of frailty can change (up or down) over time		✓	✓
j) 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; electronic Frailty Index (eFI); Clinical Frailty Scale also known as the Rockwood Score		✓	✓
k) be able to conduct malnutrition and sarcopenia screening using validated tools e.g. the Malnutrition Screening Tool (MUST), the Patients Association Nutrition Checklist, the SARC-F tool (sarcopenia screening), recognising that sarcopenia may or may not be associated with malnutrition risk and that sarcopenia risk increases in individuals living with obesity		✓	✓
l) be able to lead delivery of an holistic, multidomain assessment, care planning and management process (often called CGA) in partnership with people living with frailty, their families and carers, and as part of a multi-professional team			✓
m) understand the tailored actions required for CGA delivery, for example, structured medications review, resistance exercise training			✓
n) be able to promote and evaluate neighbourhood approaches to frailty identification and management across health and care systems			✓

Domain B: Person – centred collaborative working

Tailored person-centred care is crucial for people living with frailty, recognising their unique backgrounds, values, preferences, wishes and experiences. Effective communication helps build supportive relationships and networks, enabling independence and quality of life. Families and carers are key, but partnership with a range of individuals and organisations across health and social care is also vital. Developing person-centred care capabilities and communication skills enables collaborative care, helping people with frailty achieve their priorities and best quality of life.

Capability 4. Communication			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) know the importance of communicating effectively and compassionately	✓	✓	✓
b) know the value of active 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, dentures)	✓	✓	✓
d) be able to adapt verbal communication to a pace, level, and style, which takes account of people's wishes and abilities including allowing the person sufficient time to process and respond to questions	✓	✓	✓
e) be aware of the importance of non-verbal communication, e.g. body language, eye contact, facial expression, visual images and appropriate physical contact, particularly if the person has cognitive difficulties	✓	✓	✓
f) be aware that signs of distress and behaviours may be a means of communicating unmet needs	✓	✓	✓
g) 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	✓	✓	✓

h) be able to 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		✓	✓
i) 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		✓	✓
j) 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		✓	✓
k) understand how different customs and preferences, including religious and cultural customs, may impact communication		✓	✓
l) recognise when and how to seek help or refer a person for support with communication needs, including the use of translation services		✓	✓
m) 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			✓
n) 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			✓
o) 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, severe mental illness or sensory impairment			✓
p) lead and contribute to the development of practices and services that meet the communication needs of people with frailty			✓

Capability 5. Person-centred care			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand and respect that people living with frailty are experts in their own lives, and their autonomy should be supported	✓	✓	✓
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, including being aware of any possible past trauma to enable trauma-informed care	✓	✓	✓
e) know who is important to the person and who they see as 'leading' their care and support (which may be the person themself)	✓	✓	✓
f) understand that a person's needs and wishes may change over time	✓	✓	✓
g) 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 or mental health needs)		✓	✓
h) 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		✓	✓
i) understand frailty as a multi-dimensional condition and how different aspects of a person's life contribute to overall wellbeing and quality of life		✓	✓

j) 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 their families and carers, and helping them to achieve their goals		✓	✓
k) understand the importance of the strengths and resilience that people, families, carers and circles of support can have within themselves and their home environment		✓	✓
l) be aware of key legislation relevant to mental capacity, deprivation of liberty, equality and human rights		✓	✓
m) 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			✓
n) 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 • being aware of established health coaching tools and techniques			✓
o) 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			✓
p) 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			✓
q) be able to use people's feedback and person-centred outcomes to co-produce improvements in services with those who use them, ensuring addressing any digital exclusion			✓

r) understand implications of relevant legislation and guidance for consent and shared decision-making (e.g. mental capacity legislation and NICE guidance).			✓
Capability 6. Families and carers as partners in care			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
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) understand the duty of local authorities to undertake carers' assessments	✓	✓	✓
d) be aware that a person may be eligible for allowances or benefits, know where to seek advice and access a Carers Assessment and resultant support	✓	✓	✓
e) be aware that families, carers and others may be an advocate for the person and this may be as an official advocate through power of attorney	✓	✓	✓
f) understand the significance of family, carers and social networks in planning and providing care and the importance of developing partnerships with them		✓	✓
g) understand the complexity and diversity in family relationships and arrangements and the impact that caring for a person living with frailty may have on their physical and mental health		✓	✓
h) understand the importance of recognising and assessing a carer's own needs for example, including respite and the needs of older and younger carers		✓	✓
i) be aware that the views of carers and the person living with frailty surrounding aspects of care, may differ		✓	✓

j) understand potential socio-cultural differences in the perception of the care-giving role		✓	✓
k) be able to communicate compassionately, effectively and in a timely manner with partners in care, recognising that some carers also have communication problems		✓	✓
l) be able to support family and carers to access and use information and local support networks		✓	✓
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		✓	✓
o) 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			✓
p) 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			✓
q) 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			✓
r) be able to contribute to, or influence, the development of practices and services that meet the needs of families and carers			✓
s) understand legislation relevant to carers and carers' rights			✓
t) understand key legislation relevant to mental capacity, deprivation of liberty, equality and human rights			✓
u) be able to facilitate access to further support around legal issues (e.g. lasting power of attorney)			✓

Capability 7. Collaborative and integrated working			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) be aware of the range of different agencies and professionals who may be involved in the care of people living with frailty and mental health needs, and be able to work in partnership with them	✓	✓	✓
b) know whom to contact with any issues or questions about a person's care and support	✓	✓	✓
c) understand the importance of effective integrated neighbourhood working across physical and mental health, social care, community and voluntary sectors to optimise continuity of person or population care for people living with frailty	✓	✓	✓
d) 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	✓	✓	✓
e) be able to work in partnership with others, exploring and integrating the views of wider multi-disciplinary teams to deliver care in a coordinated way, showing an understanding of the role of others, to meet the needs of people living with frailty and those important to them		✓	✓

f) 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 and confidentiality, avoiding repeat assessments.		✓	✓
g) understand referral criteria and pathways of care to meet the needs of people living with frailty and those important to them		✓	✓
h) 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		✓	✓
i) be able to role model and lead integrated working between different organisations and across different settings of care			✓
j) understand one's own role in collaborating in an integrated way and leading a multi-dimensional/multi-disciplinary approach to address all the domains of CGA		✓	✓
k) Make best use of resources and workforce available to deliver aspects of CGA, minimizing duplication of effort and maximising various skills (Making Every Contact Count)		✓	✓
l) manage challenging conversations with other professionals, demonstrating a commitment to partnership working to facilitate care			✓

Domain C: Supporting people well to live with Frailty

As a long-term condition, frailty develops over time and progresses. People living with frailty may experience periods where it gets worse, then improves. Understanding this helps identify opportunities for intervention to slow or reverse progression. Factors increasing the risk of frailty highlight opportunities for prevention. Early diagnosis and proactive care enable prevention and management, improving outcomes and quality of life.

Capability 8. Living well with frailty, promoting independence and community skills			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) 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 support system (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 where advice, support and information can be obtained for people with frailty, families and carers	✓	✓	✓
e) be able to support the person 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 and organise support for people to be able to make use of assistive technologies and/or equipment for people living with frailty	✓	✓	✓

g) understand how to recognise and respond to cultural, spiritual and sexual needs of people living with frailty		✓	✓
h) understand how activities can be adapted to suit a person's changing needs and the contribution that assistive technology can make		✓	✓
i) 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		✓	✓
j) understand the concept and principles of a community development, asset-based approach to care and support for people living with frailty		✓	✓
k) 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		✓	✓
l) 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, recognising that a person's mental health eg some people with depression may find it difficult asking for and accepting help.		✓	✓
m) understand how mental capacity legislation promotes an individual's independence, i.e. that individuals have the right to make their own decisions, and should be helped to make their wishes known, eg addressing sensory issues/cognitive difficulties, wherever possible		✓	✓
n) 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		✓	✓
o) be able to contribute to the development of practices and services that meet the individual needs of people living with frailty			✓
p) understand the principles, processes and options for self-directed support and be able to help people access this if desired			✓

q) understand the role of social prescribing in referring people to a range of local non-clinical services			✓
r) 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			✓
s) 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			✓
t) Understand how to engage with, influence, and strengthen community support systems by promoting the benefits of developing community skills among colleagues and leadership, and by facilitating effective relationships between communities, public bodies, and voluntary organisations, to improve wellbeing and outcomes for people living with frailty and those important to them			✓

Capability 9. Physical and mental health and wellbeing			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
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 • proactively attending to any changes in physical or mental health	✓	✓	✓
c) know how to seek help for physical or mental health issues	✓	✓	✓
d) understand the complexity of ageing and multimorbidity including, for example, the importance of swallowing, hearing, cognition, vision, skin integrity, continence, osteoporosis and bone health, falls, dementia and delirium, anxiety and depression		✓	✓
e) be able to provide first line, food-based dietary advice that is tailored to the person's level of frailty and any co-existing health conditions (e.g. swallowing difficulties, cognitive impairment), considering personal preferences, cultural customs and beliefs		✓	✓
f) be able to refer appropriately to dietitians, speech and language therapists, or other relevant specialists to ensure safe, person-centred nutritional care		✓	✓
g) be able to recognise when a person is not drinking enough to maintain adequate hydration, identify barriers to fluid intake, suggest strategies for improvement, and seek support from the MDT where specialist input is required		✓	✓

h) be able to support a person to optimise their mobility and know how to access specific support regarding strength and balance training		✓	✓
i) understand the signs of dementia and delirium, and know how to seek help in addressing these factors		✓	✓
j) understand the signs of anxiety, depression and chronic pain and know how to seek help in addressing these factors		✓	✓
k) understand the importance of the home and housing-related support in maintaining functional ability, health and wellbeing and managing frailty		✓	✓
l) 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		✓	✓
m) understand that acute illness may present differently in people living with frailty, typically as the common acute frailty syndromes and that these undifferentiated presentations need early clinical assessment, diagnosis and management		✓	✓
n) lead delivery of the physical and mental health domains of the CGA as part of a wider MDT approach			✓
o) be able to tailor CGA to 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			✓
p) understand appropriate pharmacological and non-pharmacological treatment options for chronic pain			✓
q) understand diagnosis and management approaches for dementia, delirium, anxiety and depression			✓
r) be able to make management plans which take account of the complexity of ageing and multimorbidity, and lead the diagnosis and management of a wide range of undifferentiated long-			✓

	term conditions (e.g. cardiovascular, respiratory, gastrointestinal, neurological/mental health, renal, endocrine)			
s)	understand the increased vulnerability of people with mental health (MH) and learning disabilities (LD) to developing frailty at a younger age, and be able to utilise Comprehensive Geriatric Assessment (CGA) to identify and intervene early, seeking expertise from LD and MH as appropriate			✓

Capability 10. Managing medication (including prescribed nutrition products)			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) be aware of the importance of medication review and recognise that changes in medication may be appropriate over time, as frailty increases or health changes	✓	✓	✓
b) 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	✓	✓	✓
c) be aware of different medication methods and ways of administering medication, e.g. medicine reminder charts, dosette box, blister pack	✓	✓	✓
d) be aware that over-the-counter medications can have important interactions with prescribed medications	✓	✓	✓
e) be aware of sources of information and guidance regarding medication, e.g. general practice teams, specialist services and community pharmacies	✓	✓	✓
f) be aware that people living with frailty are more likely to experience medication side effects which can lead to crisis presentation and decompensation of frailty	✓	✓	✓
g) be able to administer medication safely and appropriately in consultation with people living with frailty		✓	✓
h) be aware of the potential adverse impact of polypharmacy for people living with frailty, including the increased risk of frailty syndromes (e.g. delirium and falls)		✓	✓
i) be aware that physical changes associated with frailty, e.g. kidney and liver function, can change the effects of medication		✓	✓

j) understand that falls, sedation, constipation, abnormal electrolytes and cognitive impairment may be indications of adverse drug reactions		✓	✓
k) understand the importance of recording and reporting side effects and/or adverse reactions and genuine allergy to medication		✓	✓
l) know when and how to access a medication review by an appropriate prescriber, or individual with appropriate skills and knowledge		✓	✓
m) understand clinical pharmacology relevant to older people living with frailty			✓
n) understand and be able to prescribe the range of medications to address common physical and mental health problems of people living with frailty, including the risks associated with how these drugs may interact			✓
o) understand the ethical issues regarding appropriateness of drug treatments in the care of people living with frailty, e.g. the risk of harm through antipsychotic prescribing for people with dementia and use of alternative ono-pharmacological strategies, seeking specialist advice if requited			✓
p) be able to communicate information about medications, including lack of representation in clinical trial data, as part of shared decision-making involving people living with frailty			✓
q) understand the importance of regular reviews of prescribed medication, including a person-centred approach and de-prescribing where appropriate			✓
r) lead a person-centred structured medicines review of people living with frailty using appropriate tools and in line with current relevant guidance, including taking appropriate responsibility for prescribing/de-prescribing			✓
s) be aware of new and emerging evidence-base and new treatments and pharmacological interventions that can be used to enhance the wellbeing of people living with frailty			✓

Capability 11. Advanced care planning and anticipatory support			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the importance of having the person's experiences, wishes and priorities included at all stages of care and support planning	✓	✓	✓
b) be aware and understand that care and support planning should include plans that inform the person living with frailty, and their support network (families, friends, carers) on what to do and they can contact if they have an urgent crisis	✓	✓	✓
c) know who to speak to regarding how to access support, communicating issues of concern appropriately to plan future care and incorporate parallel planning as an ongoing process	✓	✓	✓
d) Understand that offering advance care planning must be aligned to universal principles for advance care planning		✓	✓
e) 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		✓	✓
f) understand how to recognise, manage and communicate prognostic uncertainty compassionately, openly and honestly with the person, including their families and carers		✓	✓
g) 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		✓	✓
h) 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		✓	✓
i) understand that advance care plans documenting the person's choices/wishes/priorities/goals of care should be shared, on digital record sharing platforms (where available), with all		✓	✓

providers/teams/services across the health and social care system to inform best outcomes for the person			
j) understand that some people will not wish to be involved in the care and support planning process, and respect this decision		✓	✓
k) understand the importance of shared decision-making in care planning to guide and inform care and support, openly discussing the pros, and cons of options (e.g. treatments, interventions, investigation, hospitalisation, management, care) with the person, considering the impact of their stage of frailty, to enable the person to express better informed choices/preferences			✓
l) be able to coordinate and manage end of life and active care in settings other than hospital eg community based setting, virtual ward			✓
m) understand the options for alternatives to emergency department assessment, hospital admissions and hospital-based clinics, with treatment, care, and support through community-based services such as Hospital at Home; Virtual Wards; Urgent Community response teams; integrated neighbourhood teams; Hospice at home.			✓
n) understand the options to avoid the emergency department by using integrated pathways and Same-day Emergency care (SDEC) including frailty units			✓
o) be able to share the options with the person with frailty, their family and carers, explaining the potential risks, benefits and consequences of the options			✓
p) be able to make the appropriate onward referrals			✓
q) understand that people living with frailty can be at greater risk of acute care harm, including delirium, hospital acquired deconditioning, and risks associated with care transitions			✓
r) 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 and treatment			✓
s) be able to explain and provide information on advance decision planning for people and those important to them and check understanding			✓

t) be able to recognise when a person living with frailty may be approaching end of life			✓
u) be able to communicate the uncertainty around recovery and that there may be a need to anticipate end of life			✓
v) 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			✓
w) be able to support and record decisions about advance care planning, understanding the difference between advanced decisions and advance statements			✓

Domain D: Underpinning principles

People living with frailty are vulnerable and at risk of harm if their needs aren't understood or respected. Systems and structures are in place to protect them but need to be understood and applied properly. Poor care systems can also put them at risk, so continuous improvement is needed to ensure access to high-quality, integrated care. Capabilities are needed to support research, evidence-based practice, and leadership in service development to achieve this.

Capability 12. Law, ethics and safeguarding			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
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 a person lack capacity to make or express a decision when required	✓	✓	✓
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 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	✓	✓	✓
g) understand how duty of care contributes to safe practice		✓	✓

h) be aware of dilemmas that may arise between the duty of care and an individual's rights and a carer's wishes		✓	✓
i) be able to communicate effectively about proposed treatment or care to enable people living with frailty to make informed choices as far as practicable		✓	✓
j) understand and be able to use protocols regarding consent to treatment or care for people who may lack mental capacity		✓	✓
k) understand how 'best interest' decisions may need to be made for those lacking capacity		✓	✓
l) be able to recognise a range of factors which may indicate neglect, abusive or exploitative behaviours		✓	✓
m) know what to do if neglect, abusive or exploitative behaviour is suspected, including how to raise concerns within local safeguarding or whistle-blowing procedures		✓	✓
n) be aware of key legislation relevant to mental capacity, deprivation of liberty, equality and human rights		✓	✓
o) understand the options available when informed consent may be compromised			✓
p) be able to respond to safeguarding alerts/referrals			✓
q) know the evidence-based approaches and techniques to assess neglect or abuse			✓
r) understand the roles and responsibilities of the different agencies involved in investigating allegations of neglect or abuse			✓

s) be able to share safeguarding information appropriately with the relevant agencies			✓
t) be able to take appropriate action if there are barriers to alerting the relevant agencies			✓
u) 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			✓
v) 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			✓

Capability 13. Research and evidence-based practice			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the importance of advocating for and supporting greater inclusion of older people with frailty in research	✓	✓	✓
b) be aware of the purpose of service reviews and research	✓	✓	✓
c) be able to participate in service reviews, research and surveys, including service satisfaction surveys	✓	✓	✓
d) understand what is meant by ‘informed consent’ for the purposes of research	✓	✓	✓
e) be able to participate in service evaluation and research within the workplace, engaging people living with frailty, their families, and carers in the process		✓	✓
f) understand how people living with frailty, their families and carers may be involved in service evaluation and research, and provide information on how they may actively participate	✓	✓	✓
g) be aware of local and national policy and evidence-based practice relevant to frailty and where to find additional information about this		✓	✓
h) understand the evidence hierarchy		✓	✓

i) understand research/quality improvement methodologies, including the use of experience and outcome measures reported by people living with frailty, their families and carers			✓
j) be able to interpret findings from research/quality improvement, including evaluation of service changes and policy initiatives, and use findings to inform practice, commissioning and/or policy			✓
k) ensure that methods used for gaining feedback on experiences and outcomes are in a form that supports engagement with the process to maximise inclusion of older people with frailty			✓
l) understand the ethical issues related to conducting research with people living with frailty, including those who may have a cognitive impairment			✓
m) critically review evidence to determine relevance to one's own decision-making			✓
n) be able to share findings of research, audit or evaluation clearly and accurately in written or verbal form			✓
o) understand the importance of continuing professional development to ensure the methods used are robust, valid and reliable			✓

Capability 14. Leadership in transforming frailty services			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand that everyone has a part to play in developing services that support 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	✓	✓	✓
d) 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		✓	✓
e) be aware of local and national policies shaping the delivery of care for people living with frailty and how these influence service delivery		✓	✓
f) 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		✓	✓
g) 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		✓	✓
h) be able to demonstrate team practices that champion equality, diversity and inclusion		✓	✓

i) understand the key national drivers and policies which influence frailty strategy and service development			✓
j) 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			✓
k) be able to disseminate and promote new and evidence-based practice, and challenge poor practice			✓
l) 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			✓
m) be able to collect and use people's feedback and person-centred outcomes to co-produce improvements in services with those who use them			✓
n) be able to contribute to and influence the improvement of digital and electronic health and care records data sharing across organisations, services and teams to facilitate enhanced personalisation and continuity of care, promote more efficient multi-agency care coordination and seamless integrated working between all providers, teams, services and sectors (health, social care, voluntary, social enterprise)			✓
o) be able to drive continuous quality improvement (QI) through performance monitoring, including capturing KPI data metrics that can evidence the delivery of high-quality Frailty proactive care (including palliative and end of life care) across integrated care systems			✓
p) 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			✓
q) be able to contribute to and influence the development of new models of care that promote the delivery of high quality, efficient, multi-agency frailty attuned proactive care in the community through integrated neighbourhood team working and neighbourhood models of care			✓

r) be able to contribute to and influence the development of new models of care that can support urgent community care, higher acuity care needs, in a person's usual place of residence, for improved outcomes for people living with frailty			✓
s) 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			✓
t) understand how integrated service provision that crosses traditional boundaries achieve better outcomes for people living with frailty			✓
u) be able to promote team practices that champion equality, diversity and inclusion			✓