Healthcare Improvement Scotland

Foundations for community frailty services

Healthcare Improvement Scotland Ageing and Frailty Standards (2024)

Core features of a community frailty service

- Multidisciplinary and multiagency integrated frailty team.
- Clearly defined care pathways for older people living with frailty.
- Processes in place for care coordination and shared decision-making.
- Focus on proactive and preventative care as well as urgent response.

"Frailty services should be designed to support people to maintain independence and remain in the community as much as possible. This requires a fundamental shift in culture towards proactive, preventative and integrated services."

Healthcare Improvement Scotland, Ageing and Frailty Standards (2024)

Frailty identification

- System in place to identify older people living with frailty using a recommended or validated tool.
- Staff are trained and knowledgeable about clinical frailty scores.

Frailty assessment

- Access to comprehensive geriatric assessment or comparable assessment.
- Clear information of the outcome of an assessment and what to expect in future.
- Proactive reassessment and follow up where required.

Integrated care coordination

- Multidisciplinary team responsible for delivery and coordination of frailty services.
- Clear referral pathways and key point of contact.
- Access to person led care, future care planning and polypharmacy review.

Urgent community response to deterioration in health

- Urgent assessment and access to appropriate community-based support, including Hospital at Home.
- Rapid response from emergency services where needed.

Key enablers

- Joint leadership across operational management, general practice, geriatricians, nursing, allied health professionals and adult social care.
- Strong relationships with the third sector and community supports.
- Executive leadership sponsor.
- Links to local governance frameworks.
- Continuous data led improvement in partnership with patients, families and carers.
- Clear system-wide strategic vision for integrated delivery of services for older people living with frailty.
- System to share learning and promote professional development.
- Robust and skilled workforce with the knowledge and time to support older people living with frailty.