Version 4– May 2018

Framework for identifying patients with Frailty using eFI and Rockwood

eFI and Rockwood equivalent scores + using clinical judgment		
eFI score	**Rockwood score**	**Advice**
0-0.12 Fit	1 Very Fit, 2 Well, 3 Managing well	Information and advice for those who are independent and are able to manage their own needs
0.13-1.24 Mild Frailty	4 Vulnerable, 5 Mild Frailty	Prevention and early intervention services for people at risk of deteriorating physical and mental health, Activities of Daily Living (ADLs) and who have multiple or complex needs
0.25-0.36 Moderate Frailty	6 Moderate Frailty	Intermediate services for people with deteriorating functional skills and abilities; in need of rehabilitation, recovery or reablement; at risk of admission to a care home
>0.36 Severe Frailty	7 Severe Frailty, 8 Very Severe Frailty, 9 Terminally Ill	Out of Hospital services care for people who are acutely ill and at risk of admission to hospital or are in, or have recently been admitted to, acute hospital

Forward thinking
Resilient
Active
Informed in
Later life

	eFI 0-0.12 and Rockwood 1-3 Managing Well	**eFI 0.13-0.24 and Rockwood 4-5 Vulnerable / Mild Frailty**	**eFI 0.25-0.36 and Rockwood 6 Moderate Frailty**	**eFI >0.36 and Rockwood Score 7-9 Severe Frailty**
Patient Criteria	• Reducing mobility or increase falls • Comorbidities and conditions relating to ageing • Age 65+ is a guide but not a restricting criteria • No active disease symptoms/ medical conditions at risk of not being well controlled • While not dependent on others for daily help, often symptoms limit activities • Subtle impairment of ADLs • Social isolation • Emerging memory or behavioural issues	• Increased falls • Memory loss • Often have more evident slowing and need help in high order ADLs (finances, transportation, heavy housework, medications) • Identified organic and/ or functional mental health problems that affect functionality and ability to recover and rehabilitate. • Malnutrition (MUST score) • Dehydration risk	• History of unscheduled admissions • Multiple planned care appointments • Require help and assistance with ADLs (especially mobility)	• More dependent for personal care, from whatever cause (physical or cognitive) • Patient at risk of admission to acute hospital • Require facilitated discharge from hospital • Lack of capacity • Severe impairment of ADLs • End of Life care
	Plus this ...	Plus this ...	Plus this ...	
Interventions	• Consider best place for care (home, residential, nursing) • Start care planning. Consider DNACPR or ReSPECT. Understand what is important to them (assets based) • Patient education: #FrailtyFocus/ Patient Activation Measure (PAM)/ self-care and self-management • Signposting to various voluntary/faith groups • Smoking weight and alcohol programmes • Vaccination programmes (influenza, pneumococcal and shingles) • Effective medicines optimisation e.g. bone health and polypharmacy • Engagement with voluntary sector • Carer support and assessment • Regular long-term condition reviews • Maintain strength and balance • Primary Prevention Services (e.g. Healthy Home) • Adaptations, equipment and practical support in the home • Continence	• Out of hours service access • Social care assessment for help • Prevention and early intervention for mental health (MH) conditions such as depression and anxiety through access to Improvement Access to Psychological Therapies (IAPT), to prevent decline in both physical and mental health conditions • Holistic assessment/ Comprehensive Geriatric Assessment (CGA) and wellbeing plan • Frailty Clinic • Falls prevention • Use of Telecare and Telehealth to support self-care	• Rapid assessment clinic • Access reablement services to reduce dependence on high intensity, long term support (Enhanced Recovery and Support at Home, Community Response Team) • End of Life early planning • Lasting Power of Attorney discussions	• Facilitated discharge from hospital if admitted • Funeral planning
	Plus this ...	Plus this ...	Plus this ...	
Roles delivering interventions	GP, Nurse Practitioner, Mental Health Practitioner, voluntary and faith sector, Hampshire Fire and Rescue, Hampshire County Council, Community Pharmacist, Practice Support Pharmacist, Hampshire Constabulary, talking therapies (iTalk), social groups, Community Transport Services, voluntary wellbeing lines, Allied Health Professionals (occupational therapists, physiotherapists, dieticians, speech and language therapists), Citizens Advice Bureau, Continence team, friends, family and loved ones.	Interface Geriatrician (Mid Hants), Proactive Care (Mid Hants), Integrated Care Team (ICT), Specialist Nurses, Consultant Nurse for Frailty, Social Workers, South Central Ambulance Service	Enhanced Recovery and Support at Home, Interface Geriatrician (Mid Hants), Palliative Care Team (awareness and planning), Hospice, care agencies, specialist medical teams, nursing and care homes, South Central Ambulance Service, Admiral Nurses	Palliative Care Team (actively involved)

Developed by North Hampshire CCG and Southern Health