**Wessex AHSN Community Frailty Audit Questions**

1. Do you have a frailty lead for developing services within your PCN for people living with frailty?
2. How is your Local Authority engaged with your PCN in providing frailty related services?
3. How are your Voluntary Services supporting people living with frailty in your PCN?
4. Name of person completing the audit
5. Email address of person completing the audit
6. Your PCN name
7. Role within PCN
8. Have you considered the needs of people living with frailty and how it relates to your current frailty
   8.a. If you have mapped your service provision for people living with frailty, may we contact you to obtain a copy of the documentation or to discuss further?
9. The Electronic Frailty Index (e-FI) is a risk stratification tool and needs to be supplemented with a further frailty screening tool. Within the primary care setting do you validate your local e-FI score with another
   9.a. If yes, which screening tools do you use to validate the e-FI Score? You are able to choose more than one
10.1.a. Primary Care - If the service within your PCN identifies people living with frailty how often does this
10.1.b. Primary Care - Is the identification of frailty information accessible to other organisations?
10.1.c. Primary Care - Do patients and carers have access to their information?
10.2.a. Community Care - Physical Health - If the service within your PCN identifies people living with frailty
10.2.b. Community Care - Physical Health - Is the identification of frailty information accessible to other
10.2.c. Community Care - Physical Health - Do patients and carers have access to their information?
10.3.a. Community Care- Mental Health - If the service within your PCN identifies people living with frailty
10.3.b. Community Care- Mental Health - Is the identification of frailty information accessible to other
10.3.c. Community Care- Mental Health - Do patients and carers have access to their information?
10.4.a. Social care - If the service within your PCN identifies people living with frailty how often does this
10.4.b. Social care - Is the identification of frailty information accessible to other organisations?
10.4.c. Social care - Do patients and carers have access to their information?
10.a. Please detail any innovative approaches to identification of frailty and sharing of this information
11. Have relevant staff within your PCN undertaken training on frailty?
   11.1.a. Primary Care - Frailty
   11.2.a. Community - Physical Health - Frailty
   11.3.a. Community - Mental Health - Frailty
   11.4.a. Social Care - Frailty
12. Have relevant staff within your PCN undertaken training on how to develop and discuss anticipatory care planning with people living with frailty? This would include end of life planning and wellness plans.
   12.1.a. Primary Care - Anticipatory care plan training
   12.2.a. Community - Physical Health - Anticipatory care plan training
   12.3.a. Community - Mental Health - Anticipatory care plan training
   12.a. Social Care - Anticipatory care plan training
13. Have relevant staff undertaken health behaviour change approach training e.g MECC, health coaching, motivational interviewing, communication approaches etc?
   13.1.a. Primary Care - Health behaviour training
   13.2.a. Community - Physical Health - Health behaviour training
   13.3.a. Community - Mental Health - Health behaviour training
   13.4.a. Social Care - Health behaviour training
14. There is a relationship between impaired cognition and the causes of frailty. If a person living with frailty is showing evidence of self neglect or are disengaging with services, have relevant PCN staff received training
   14.1.a. Primary Care - Capacity/Best interest decisions
   14.2.a. Community - Physical Health - Capacity/Best interest decisions
   14.3.a. Community - Mental Health - Capacity/Best interest decisions
   14.4.a. Social care - Capacity/Best interest decisions
15. Is there frailty awareness training provided to voluntary sector organisations within your PCN?
16. Is there an integrated frailty care pathway within your PCN, that includes you and other local organisations? If your answer is no, please go to question 19.
17. Is the integrated frailty service pathway across the whole PCN or are there separate pathways?
  17.a. If you have developed an integrated frailty pathway, may we contact you to obtain a copy or to discuss specialist frailty services that are available to GPs for people living with frailty within your PCN in the absence of an integrated frailty care pathway. Patient support and information in this context includes care navigators, patient co-ordinators and health and social care navigators.
18.1.a. Specialist Frailty Practitioners - Do you have access to these services?
18.1.b. Specialist Frailty Practitioners - Please detail any issues accessing these services
18.2.a. Community Geriatrician - Do you have access to these services?
18.2.b. Community Geriatrician - Please detail any issues accessing these services
18.3.a. Social Care - Do you have access to these services?
18.3.b. Social Care - Please detail any issues accessing these services
18.4.a. Community Frailty Teams - Do you have access to these services?
18.4.b. Community Frailty Teams - Please detail any issues accessing these services
18.5.a. GP practice pharmacist (medication review) - Do you have access to these services?
18.5.b. GP practice pharmacist (medication review) - Please detail any issues accessing these services
18.6.a. Patient support and information - Do you have access to these services?
18.6.b. Patient support and information - Please detail any issues accessing these services
18.7.a. Falls Service - Do you have access to these services?
18.7.b. Falls Service - Please detail any issues accessing these services
18.8.a. Continence Service - Do you have access to these services?
18.8.b. Continence Service - Please detail any issues accessing these services
18.a. If other, please state service(s)
19. In the long term plan there is reference to the reforms reducing pressure on emergency hospital services. (Section 2: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf) Do you have access to same day emergency care services for people living with frailty?
  19.1.a. For patients living at home - Access to same day emergency care
  19.2.a. Within the hospital setting e.g Same Day Emergency Care (SDEC) - Access to same day emergency
20. Do you have access to step up beds? Step up beds in this context relates to reablement beds
  20.a. If yes, does the whole of the PCN or some of the practices have access to step up beds?
21. Within a primary care setting is there an opportunity for people living with frailty to be discussed within an MDT meeting? If your answer is no, please move onto question 27.
  21.a. If MDT meetings are held, how frequently do they take place?
  21.b. If MDT meetings are held please identify who attends (either face to face or virtually) the MDT discussion? Please choose the options that are relevant.
  21.b.i. If you selected Other, please provide further details
22. Are actions recorded within the patient's record following the MDT meeting?
  22.a. Where are the actions recorded? (free text)
23. Are outcomes recorded in the patient's records following the MDT discussion?
  23.a. Where are these outcomes recorded? (free text)
24. Are these actions and outcomes from the MDT meeting shared with other health and social care
  24.a. If the outcomes and outputs are shared, please indicate who is able to access this information?
  24.b. Are these actions and outcomes from the MDT meeting shared with the patient and/or carers?
25. Are these actions and outcomes from the multidisciplinary team shared with the patient and/or carer?
26. Within your PCN are there areas of good practice/innovation that you would like to share with other PCNs in supporting people living with frailty?
27. Within your PCN are there any issues or potential service improvement projects that could be explored to help support people living with frailty?