

Driver diagram 2022

What are we trying to achieve

People living with or at risk of frailty have improved experience of and access to person centred, co-ordinated health and social care

By *[Insert Locally Agreed Date]*:

- More people over 65 are identified earlier as living with frailty
- People living with frailty, carers and family members report positive experiences of health and social care services
- Health and social care teams report improved integrated working

We need to ensure...

Early identification and assessment of frailty

People living with frailty, carers and family members access person-centred health and social care services

Leadership and culture to support integrated working

Which requires...

- Use of reliable tools and shared language to identify frailty and those at risk of frailty
- Timely delivery of Comprehensive Geriatric Assessment
- Proactive reassessment and responsive multidisciplinary and multi-agency intervention

- Resources, services, and community assets which support prevention and empower people to self-manage
- Proactive person-centred care planning, management and end of life care
- Timely and equitable access to clearly defined care pathways
- Effective care co-ordination to improve experience of care
- Health and social care services are responsive to changes in an individual's level of frailty

- Strategic leadership which supports integrated working
- Integrated multidisciplinary and multi-agency working
- Co-producing services with people, families and carers with lived experience
- Compassionate leadership to promote psychological safety and staff wellbeing
- System for learning