NHS
North East and
North Cumbria

Proactive frailty care resources

Other useful presentations:

Proactive frailty care event slides

Proactive frailty care event executive summary

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Proactive frailty care

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves resulting in a potential for serious adverse outcomes after a minor stressor event or change. However, frailty varies in severity; is not static; it can be made better and worse; and is not an inevitable part of ageing; it is a long-term condition in its' own right.

Proactive care is defined as personalised and co-ordinated multi-professional support and interventions for people based on their needs and what matters to them.

- Understanding risk factors and signs of frailty will help early identification and support for people at most risk.
- ***Meet Jackie:*** A real-life story of a person living through different stages of frailty, exploring the care offered, what works and its outcomes - Jackie's Story | Explore Aging Solutions

Aims of proactive frailty care:

1. Delay the onset of health deterioration, where possible
2. Maintain independent living
3. Reduce avoidable exacerbations of ill health, thereby reducing use of unplanned care

Core components

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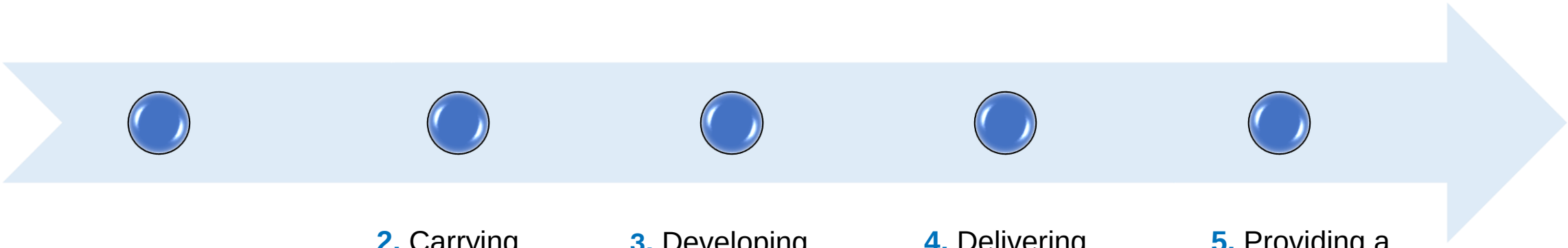


1. Identifying target cohorts for who there is the greatest potential impact on health and system outcomes

2. Carrying out holistic assessments

3. Developing personalised care and support plans

4. Delivering co-ordinated interventions to address the person's range of needs

5. Providing a clear plan for continuity of care

NHSE Guidance Dec 2023 - Proactive care: providing care and support for people living at home with moderate or severe frailty

1. Identifying people living with moderate to severe frailty for proactive care

Use Population Health Management to identify and prioritise people who may benefit from proactive care.

STEP ONE: Improve the identification and diagnosis of frailty:

- Check the NENC frailty identification report for your total number of people (in high-risk cohorts) **yet** to be assessed for frailty *AND* run your EMIS and S1 search to generate a list of people (this will identify approximately 80% of your predicted prevalence of frailty in your practice).
- Consider other high-risk cohorts of people to help identify the remaining 20% of people living with frailty.
- Diagnose and classify frailty 'clinically' using a validated tool and the correct SNOMED codes.

STEP TWO: Identify which people living with frailty would benefit from proactive frailty care:

- Run your RAIDR risk stratification tool to generate a list of people.
  - **Note:** The RAIDR tool excludes people in care homes and with severe mental health problems but can be used to identify people experiencing health inequalities or in high use of secondary care services.
- Discuss in your Neighbourhood MDT which individuals would *most* benefit from proactive care and prioritise appropriately.
  - **Note:** Check the rules and governance for sharing Patient Identifiable Information between MDT members.

2. Carrying out a comprehensive holistic assessment

Personalised Care Institute

- A website covering all aspects of Universal Personalised Care for health and care professionals based on ‘what matters’ to people - https://www.personalisedcareinstitute.org.uk/

British Geriatric Society

- BGS CGA toolkit with 18 chapters covering what CGA is and its application in clinical settings **-** https://www.bgs.org.uk/resources/resource-series/comprehensive-geriatric-assessment-toolkit-for-primary-care-practitioners

iCGA Health Call Report (PDF)

- A feasibility study looking at the utilisation of a Health Call built CGA application in a PCN within Gateshead with key future recommendations for improvement.

Reasonable Adjustments resources:

- Reasonable Adjustment Flag « Learning Disability Network
- Reasonable Adjustment Flag - NHS England Digital

- A clinician with assessment and clinical decision-making skills should carry out a review of the person’s health and care records to identify any professional concerns prior to undertaking a holistic assessment of needs.
- The format can be determined locally but should be based on the principles of the Comprehensive Geriatric Assessment - ***please see the BGS link opposite for greater details on the process and delivery of the CGAs in primary care.***
- The key professional's and person’s [with / without family or carer] conversation should be based on shared-decision principles and ‘what matters’ to the person - exploring concerns, goals and support is needed for the best outcomes based on their needs.
- Reasonable adjustments should be used depending on the person’s need and wishes.

3. Developing a personalised care and support plan

The **Comprehensive Personalised Care Model** sets out how to achieve Personalised Care through six, evidence-based standard components - https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/ :

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets.

NENC Deciding Right – Advanced Care Planning

- A suite for resources and documents for professionals to support Advance Care Planning conversations and delivery - Deciding right Resources - Northern Cancer Alliance Northern Cancer Alliance

NENC Clinical Digital Resource Collaborative (CDRC)

- Free to use digital frailty SystmOne and EMIS resources (e.g. frailty search, care planning templates, CGA templates)
  - SystmOne: Care for Frail Patients - Clinical Digital Resource Collaborative
  - EMIS: Care for Frail Patients - Clinical Digital Resource Collaborative

- Personalised Care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs.
- A care plan sets out the person's health and wellbeing goals and their wishes about the future.
- The care plan is used to document the decisions and actions from the conversation and can be printed and shared with the patient [and other professionals if necessary].
- The care plan is the property of the patient.

4. Delivering co-ordinated interventions to address the person's range of needs

Healthy ageing

- Activity, smoking cessation, alcohol consumption
- Diet and nutrition
- Tackling loneliness and social isolation
- Early identification of dementia
- Sensory loss and screening

Mild frailty

- Social prescribing
- Falls prevention and risk assessment
- Addressing polypharmacy and structured medication reviews

Moderate to severe frailty

- Comprehensive geriatric assessment
- Personalise care and support planning
- MDT working
- Crisis response and hospital at home
- Supported discharge, and intermediate care
- ACP and end of life care

- Care and support planning conversations should help to discover what's important to the person [including their family].
- The information gathered through conversations should inform all actions, activities and referrals made by professionals and the MDT.
- There is evidence for impactful interventions across a person's life course such as Healthy Ageing, targeted support and Care Coordination

Healthy Ageing and Frailty Care 'what works' Report (PDF) – Northeast Quality Observatory report looking at impactful interventions across the frailty spectrum with associated metrics and a summary of evidence.

5. Provide a clear plan for continuity of care

NENC Enhanced **C**are of **O**lder **P**eople (EnCOP) Competency Framework

- Specific to the needs of the older population, the Competency Framework provides a standardised and integrated approach to workforce development across the whole care system from those providing essential care to specialist and advanced level practice - https://frailtyicare.org.uk/making-it-happen/workforce/

MDT resources

- Resources From Wessex Health Innovation Frailty MDT Toolkit **-** https://healthinnovationwessex.org.uk/projects/442/mdt-frailty-toolkit
- Health Education England MDT Working - https://www.hee.nhs.uk/sites/default/files/documents/HEE_MDT_Toolkit_V1.1.pdf

RCGP Continuity of Care Toolkit

- Toolkit which shares the learning and experiences from practices who have been improving their continuity over a two-year period based around 6 steps from setting out your ambition to implementation **-** https://elearning.rcgp.org.uk/mod/book/view.php?id=12895

RCGP GPwER Frailty Framework and a typical day for a GP as part of INT

- Guidance for GPs who work with teams and people living with frailty - recommendations for professional development - https://www.rcgp.org.uk/your-career/gp-extended-roles/purpose-of-frailty

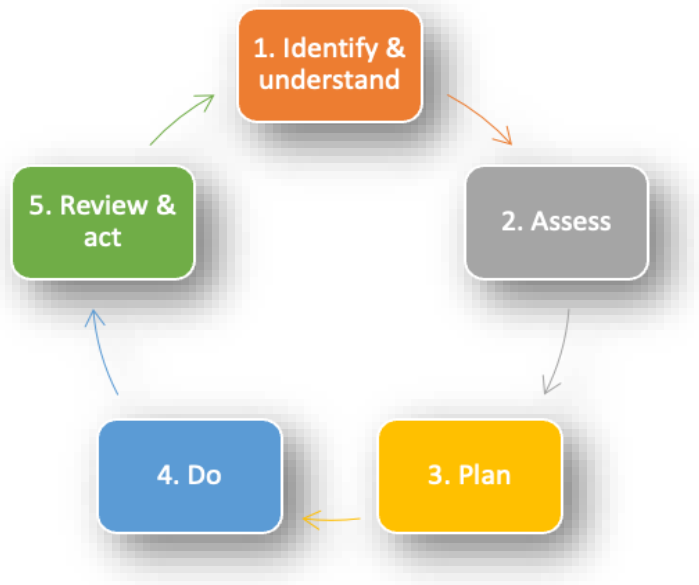
NHSE 'expanding your workforce' – resources on ARRS roles, estates, education and training and MDT working - https://www.england.nhs.uk/gp/expanding-our-workforce/

- Understand the MDT will be part of the entire process but not make decisions for the person.
- Establish a named key professional who provides oversight, a clear point of contact for continuity and coordination.
- Map out and develop a knowledge of local services.
- Create a small team who works with the person, to optimise relational, managerial and informational continuity and build trust.
- Create a process to allow for expertise between professionals via formal and informal communication routes.
- Embed VCSE as team members in addition to care and health professionals.
- Establish direct access to and from urgent care and recovery services enabling continuity

Measurement and evaluation

Measurement and Evaluation

- **Proactive Frailty Care Study**
  - Feasibility study in 2 PCNs in North Cumbria
  - Early evaluation to explore the views and experiences of staff from the North Cumbria Pilot
- **NENC Ageing Well Dashboards**
  - Proactive Frailty Care Dashboard (*available mid-September*)
  - Proactive Frailty Care event data pack
  - Other NENC dashboards related to frailty e.g., ageing well, care homes etc.
    - See 'request guide' for access to the above dashboards
- **Resources for evaluation**
  - ICB evaluation template with key questions
  - An example 'logic model' for setting up MDT working
  - Qualitative Measurement Summary - measurements tools that can be used to assess impact
  - ICB evaluation team webinars available 2025
- **National evaluation of Anticipatory Care Interventions**
  - Evidence map - Anticipatory-care-evaluation-evidence-map-v1-002.pdf
- **General resources for evaluation**
  - NHS Evaluation Toolkit
  - The Health Foundation



- The three main aims of Proactive Frailty Care include:
  1. Delay the onset of health deterioration, where possible
  2. Maintain independent living
  3. Reduce avoidable exacerbations of ill health, thereby reducing use of unplanned care
- It might also be helpful to consider short, medium and long-term measurement and adopting a service improvement methodology.

Other useful resources

Other useful resources

- **NHS Year of Care**
  - Implementing Proactive Care for People Living with Frailty: A Practice Resource – https://www.yearofcare.co.uk/wp-content/uploads/2025/05/Implementing-proactive-care-toolkit-V1.0.pdf

- **National policy and guidance**
  - NHSE Guidance Dec 2023 - Proactive care: providing care and support for people living at home with moderate or severe frailty
  - British Geriatric Society – Be proactive – Delivering proactive care overview - Be proactive: Delivering proactive care - Overview | British Geriatrics Society
  - Anticipatory Interventions Framework – overview of proactive care interventions and impact - 2.-Anticipatory-Care-Interventions-Framework-.pdf
  - A service user questionnaire may be helpful to determine patient satisfaction. An example questionnaire can be found here - Devoloping a Frailty Coding Framework for the MYCaW questionnaire
  - Solutions for Public Health worked with NHSEI Ageing Well Team and stakeholders to develop several resources related to anticipatory care - https://www.sph.nhs.uk/highlights/anticipatory-care-resources/

- **Digital resources**
  - The information standard for personalised care and support plans.
  - Set up a Teams channel for the members of your MDT - https://support.nhs.net/knowledge-base/virtual-mdts/