British Geriatrics Society
Improving healthcare for older people

BGS

Be proactive: Evidence supporting proactive care for older people with frailty

www.bgs.org.uk/ProactiveCareEvidence

#BGSProactiveCare

Foreword

The Ageing Well Programme, as set out in the NHS Long Term Plan, consisted of three strands – enhanced health in care homes (EHCH), urgent community response and anticipatory care (now renamed as proactive care). However, the arrival of the COVID-19 pandemic meant that roll-out of the proactive care workstream was delayed considerably.

As part of my previous role as National Specialty Advisor for Older People and Integrated Person-Centred Care, I was pleased to work with colleagues from across health, social care and the third sector in developing the framework for proactive care for older people living in the community with moderate and severe frailty. A lot of work over many months went into the development of this framework and everyone involved should be very proud. However, the final published framework was significantly edited before publication and much of the detail around evidence for proactive care was cut.

While this report is not about the delivery of proactive care, the evidence will help colleagues to develop a business case for establishing this type of service in their locality. Therefore, I was delighted to work with the British Geriatrics Society, with NHS England's blessing, to produce *Be proactive: Evidence supporting proactive care for older people with frailty*. It is our hope that colleagues find this document useful when developing these services and that more older people across the UK have their needs identified early and addressed, keeping them healthy and independent for longer.

Dr Eileen Burns MBE
Former BGS President
Former NHS England National Specialty Advisor

Contents

Chapter one: Introduction 3
Chapter two: What is proactive care? 4
Chapter three: What is the evidence behind proactive care? 4
- Case identification 4
  - Prioritising people living with moderate and severe frailty 4
  - Intentionally addressing health inequalities 5
  - Further prioritisation 5
- Holistic assessment and personalised care and support planning 6
- Continuity of care 6

Chapter four: Key personnel 6
Chapter five: Enablers 8
- Workforce development 8
- Digital and data improvements 8
- Place-based governance and decision-making 8

Chapter six: Experience 'I statements' 9
- Case identification 9
- Holistic assessment 9
- Personalised care and support planning 9
- Co-ordinated multi-professional support 9
- Clear plan for continuity of care 10

Chapter seven: Conclusion 10
Contributors 10
References 10

Chapter one: Introduction

In December 2023, NHS England published *Proactive care: providing care and support to people living at home with moderate and severe frailty.* Proactive care (previously known as anticipatory care) is one of the three workstreams of the Ageing Well programme as published in the NHS Long Term Plan in 2019. The framework published by NHS England in December was the result of several years' work by a wide range of people across the UK. The final document published is a succinct guide to proactive care which was derived from a much fuller document outlining the evidence behind this intervention. Colleagues making the case for proactive care in their localities are likely to find the full evidence base useful, and that is the basis of the document that follows. It is published with the consent of colleagues at NHS England and outlines the evidence that was not included in NHS England's publication. We hope that those establishing proactive care services across the UK find it helpful.

Because this document stems from work conducted by NHS England, some of the structures referred to are specific to those existing within the health service in England. However, the principles of proactive care apply across the UK and our examples of best practice are not confined to England.

This document focuses on proactive care and support for those living at home with moderate or severe frailty. Whilst there should be a needs-based approach to identification and intervention, those with frailty will predominantly but not exclusively be older people. Care for people living in care homes is described through the Enhanced Health in Care Homes model in England and similar programmes in the rest of the UK.

As we continue to see good progress in the number of people living longer, the NHS needs to adapt how it provides care to help older people lead healthier, happier lives, living independently for longer. Providing timely, quality and effective healthcare for older people has several facets:

- Support to increase healthy behaviours.
- Timely identification of needs and access to community services.
- Support with stable long-term conditions, utilising self-care and home monitoring.
- Continuity of care.
- Coordinated and personalised care to live well with a ranged of complex needs.
- Urgent care when needed, in the community where appropriate.
- Timely access to frailty-attuned acute care where appropriate.
- Seamless care transfers to support rehabilitation and reablement.
- High quality nursing, with residential care only when needed.
- Timely and high-quality palliative and end of life care when needed.

The number of people aged 65 years and over was estimated to be 21.6 million in 2023 (31.8% of the UK population) and this is projected to increase by 4.9% to 26 million by 2045 (36.7% of the UK population).[1] At age 65 years, people can expect to live on average around half of their remaining life expectancy in good health. However, the likelihood of being disabled and/or experiencing multiple chronic and complex health conditions among those aged 65 years and over increases with age.

As life expectancy increases, so does the amount of time spend in poor health. Therefore, the number of people living with complex and multiple conditions is increasing.[2] There is also considerable inequality with people living in deprived areas or experiencing poverty throughout life more likely to develop frailty earlier than those from wealthier backgrounds.[3]

Chapter two:
What is proactive care?

Proactive care is defined as personalised and co-ordinated multi-professional support and interventions for people living with complex needs. Many systems are already delivering proactive care.[4]

For people with complex needs, healthcare needs to shift from single-condition disease-oriented care to individualised goal-oriented co-ordinated care and support addressing the impact of multiple conditions and extending independence. Evidence suggests bringing about this shift should benefit both people and the health and care systems they use.[5-8]

Anticipating and delaying the onset of poor health and addressing existing consequences of multiple conditions should help to reduce the need for multiple, unplanned and/or urgent interactions with the health system[5,9-13] thereby improving people's experience.[4,14,15]

People living with frailty are the group most likely to benefit from a proactive care approach. Frailty affects up to half of the population aged over 85[16] and costs UK healthcare systems £5.8 billion per year.[17] Around 47% of hospital inpatients over 65 are affected by frailty.[18] Frailty is common – more than one in ten people over the age of 65 live with frailty[7] and it can also affect younger people.[19]

For people living in more deprived areas, life expectancy at birth is lower than people in less deprived areas and people are also more likely to spend more of their lives in poor health.[20] It is expected that the onset of frailty starts earlier for population groups experiencing health inequalities.

Evidence suggests people living with moderate and severe frailty should receive timely, holistic, and personalised care and support in the community to address their range of needs.[6,7] Successful delivery of proactive care is likely to feature case identification, holistic assessment, personalised care and support planning, multidisciplinary working, co-ordinated care and continuity of care and evidence-based support and interventions.

Chapter three:
What is the evidence behind proactive care?

Based on the evidence and on best practice, the following core components for proactive care have been identified:

- Identifying the target population cohort where there is the greatest potential impact on health outcomes and system outcomes.
- Carrying out holistic assessments, such as a comprehensive geriatric assessment.
- Developing a personalised care and support plan that considers wider prevention enablers, in the context of a comprehensive model of personalised care.
- Providing a clear plan for continuity of care, including agreed needs-based follow-up.
- Underpinning all these components, when people receiving proactive care are supported by coordinated multi-professional support, they are likely to have a positive and consistent experience of health and care services.

This chapter sets out the evidence behind each of the core components of proactive care.

Case identification
Prioritising people living with moderate and severe frailty

It is important that population cohorts for proactive care are prioritised based on where there is the greatest evidence of benefit. This could include benefits for the individual such as improved health outcomes and experiences and system benefits such as reduced demand on the health and care system. Prioritisation should also consider where unplanned care data suggests that needs could be identified earlier in the community to ensure cost effective delivery.

Using the latest evidence and analysis of national data, this document suggests that systems prioritise people for proactive care who have moderate and severe frailty, as there is evidence that delivering proactive care should impact on their health outcomes and system usage.[4,5,8-14]

People living with frailty represent a subgroup of the wider population living with multiple long-term conditions who are at especially high risk of experiencing adverse outcomes, including loss of independence, falls, skin breakdown and care home admission. Although most people with frailty have multiple long-term conditions, most people living with multiple long-term conditions do not have frailty.[21]

Jean Bishop Centre – Hull and East Riding

The Jean Bishop Integrated Care Centre was established out of a need to move frailty care from a reactive, crisis-driven model to a preventative, proactive model aiming to deliver integrated, out-of-hospital care. The Centre provides care delivered by a multidisciplinary team which includes geriatricians, nurse practitioners, general practitioners with an extended role in frailty care, pharmacists, occupational therapists, physiotherapists, social workers, clinical support workers, carers' support and volunteers. The service identifies individuals at risk of moderate or severe frailty using the electronic Frailty Index (eFI) and a member of the team contacts the individual to pre-assess their needs and to identify any concerns that the patient may wish to discuss. For patients residing in their own home, a personalised appointment at the Jean Bishop Centre is then arranged taking 3-5 hours, providing all of the interventions that have been identified as necessary for that patient in a single appointment. The same model of care is delivered by a visiting care home MDT for residents living in care homes. Interventions are based on the individual's comprehensive geriatric assessment and individualised care needs.

This model has been shown to benefit both patients and the system. Patients report sustained improvement in emotional and physical wellbeing while system benefits include reduction in unnecessary presentations to emergency departments, reduction in ambulance conveyances and saving GP clinic time.

Cross sector collaboration in Lanarkshire

Using eFI to identify those living with frailty, a group of motivated clinicians in North Lanarkshire came together to work differently to deliver proactive approaches to those with escalating frailty in four practices in Coatbridge and Belshill, North Lanarkshire. This built on preexisting excellent working relationships within the locality and also recognised 'the best way to work as a team is in a team'.

After the COVID pandemic, the team partnered with local charity Equals Advocacy who already had a record of delivering anticipatory care planning (also known as advance care planning) in the community in North Lanarkshire and were keen to test whether they could support older adults with frailty assessments in their own home. Early in the pilot phase it was clear that this was a successful model liked by both older adults, informal carers, and staff across health and social care.

Find out more about the impact this project has on patients and families at: https://vimeo.com/893277530

Evidence also suggests that people with frailty use unplanned care more frequently, as their needs have not been met in the community. Lack of access to proactive and reactive community-based care results in many avoidable exacerbations of ill health.[22]

To help find people who could benefit most from proactive care, local areas should use evidence-based risk prediction tools and clinical validation, supplemented with local knowledge. This will help to identify the population cohort at risk of health deterioration. For example, the second version of the electronic frailty index (eFI2) may be useful to consider (publication due imminently). The eFI2 may provide better discrimination of frailty and risk of adverse outcomes; if this is confirmed on publication, this will be a very valuable addition to risk stratification tools. The eFI2 has been registered with the MHRA as a Class 1 Medical Device and will be made nationally available through implementation into primary care electronic health record systems and can also be provided directly to ICBs and PCN teams as needed.

Intentionally addressing health inequalities

Some systems may include younger individuals living with moderate or severe frailty in their priority cohort, depending on the health inequalities experienced by the populations they serve. For example, people experiencing homelessness often have very early onset of frailty.[23]

The Core20PLUS5 approach defines actions for a target population and outlines five clinical areas of focus to drive targeted action in health inequalities improvement. Integrated Neighbourhood Teams should consider whether those individuals receiving proactive care feature in the Core20PLUS5 population group and, where appropriate, use the actions recommended in this document alongside those outlined in the Core20PLUS5 approach.

Data in healthcare systems may be limited for people from health inequality groups, as their records may be incomplete.[24] As such, used appropriately, local intelligence from healthcare professionals and local third sector may usefully supplement data available through health records.

Further prioritisation

Depending on local capacity to implement proactive care, further prioritisation of this cohort with moderate or severe frailty may be needed using additional indicators. Indicators should be selected based on risk of deterioration and therefore likely use of unplanned care. Examples of additional indications that may be selected:

- People who are frequently using primary care or unplanned care, as this indicates unmet needs and implies issues are being dealt with individually rather than holistically.[25,26]
- People living alone with a limited social network, as these people are more likely to have unmet needs and are at risk of health deterioration.[27]
- People who have had a recent bereavement following the death of someone close to them. This is likely to initiate the onset of rapid health decline,[28,29] which could have been prevented.
- People who present with loneliness, as loneliness is associated with a range of adverse health outcomes, such as effects on mortality, morbidity, health behaviours and healthcare utilisation.[30]
- People who take multiple medications, known as polypharmacy, as it is associated with adverse outcomes such as increased mortality, falls, adverse drug reactions, increased length of stay in hospital and readmission to hospital after discharge.[31-33]

Systems, including Primary Care Networks (PCNs) in England should use their local intelligence functions[34] to help utilise data from across their local health and care system, to support identification of a local area's priority cohort.

Clinical validation is an essential critical part of the process. The eFI and other risk stratification tools are not clinical diagnostic tools; they are tools which identify groups of people who are likely to be living with varying degrees of frailty, but they are not able to do this for specific individuals. Therefore, when the eFI identifies an individual who may be living with frailty, direct clinical assessment and judgement should be applied to confirm a diagnosis. Clinical validation tools could be used for this, eg, a Clinical Frailty Scale such as the Rockwood Clinical Frailty Scale. The diagnosis of frailty should be a clinical decision and discussed with the person, in the same way that any other diagnosis would be discussed.

Lay use of the term 'frailty' does not usually accord with academic and clinical usage and some evidence exists for unintended adverse consequences related to the use of the term. Language such as 'promoting independence' or that which focuses on the issue presented by the person participating in proactive care may be more fruitful (for example, falls risk reduction or memory mobility support).

Processes should be put in place to enable additional people to be offered proactive care, following other health and care system interactions where unmet need may be identified. These interactions could include annual health checks (although these are currently not included within the GP contract and therefore are not routinely offered to older people unless they

The PACT Service – WISHH and 5 Lane Ends PCN

WISHH Community Partnership established that their population included many older people, who were being admitted to hospital unnecessarily due to frailty and falls. These patients were also classed as moderately frail on the e-frailty register.

Using this information and knowing the strain on admissions to secondary care, carers and patients, it was established that this cohort of patients with moderate frailty had greater potential to benefit from proactive care as the service was able to identify these patients earlier in their care and make referrals to existing services, where appropriate, to avoid future crisis. This information was provided by the Public Health data and System1 data. This was the drive and reasoning behind the project for the PACT Service (Proactive Care Team).

The WISHH CP introduced a new, integrated approach to providing holistic, person centred care. The new service is based on a multi-agency holistic approach to providing support, which includes developing community assets and promoting self-care.

are receiving care for multimorbidities), annual single condition reviews, following discharge from hospital, virtual wards, use of urgent community response services or following unpaid carer assessment.

Holistic assessment and personalised care and support planning

Holistic assessment for proactive care should cover:

- Personal and social circumstances, including socio-cultural factors.
- Past medical history and current health and wellbeing needs.
- Mental capacity assessment, particularly around care planning and interventions where appropriate.
- Consideration of assessment under the Care Act 2014 and eligibility for NHS Continuing Healthcare.
- Consideration of carer assessment and a carer support plan.

Following holistic assessment, a personalised care and support plan should be co-produced with the person and the person facilitated to also involve those who are important to them, including family, friends and/or carers, if they wish to do so. Further details about holistic assessment and personalised care and support planning can be found in the NHS England document.[3]

Continuity of care

Continuity of care is defined as the ongoing relationship a person has with a clinical team or a member of a clinical team, and the coordinated clinical care that progresses smoothly as the patient moves between different parts of the health service. This includes relational, management and informational continuity.[35]

Having continuity of care enables personalised care, improves care quality, boosts confidence in medical decision-making and fosters greater job satisfaction for health and care professionals. The absence of continuity of care may lead to medical and psychological harm.[36,37]

Higher physician retention is associated with lower hospital admission rates, even after adjusting for other factors,[38-40] particularly for older people living in the community.[41]

Higher continuity of care consistently leads to lower healthcare utilisation and costs[42] and providing continuity of care reduces the number of GP attendances and use of unplanned care.[43,44] A clear plan for follow-up based on individual need should be developed for each person, including building in flexibility for follow-up if this is needed sooner than expected.

Overall clinical accountability for people will be crucial to effective proactive care. In many cases this is likely to be a named GP. However, for some local areas, this may be a community geriatrician or advanced clinical practitioner.

Chapter four: Key personnel

Proactive care provides an early, multiprofessional and multiagency intervention to prevent deterioration. It may also involve teams and healthcare professionals involved in services such as urgent community response. A range of clinicians and professionals are likely to be needed to support decision-making and care for people living with frailty. Multidisciplinary teams should be formed to support this way of working, with flexible membership to ensure professional expertise is available when needed. Ongoing support and interventions should be delivered through integrated teams working across care settings and disciplines.[45]

This represents a shift to working in multidisciplinary teams which involves bringing together a range of service teams and professionals. Those with more complex needs often receive care from multiple services. This approach aims to bring together relevant services into a single team to better coordinate overall care and reduce the need for slow and bureaucratic formal referral processes. In some areas integrated teams are well developed; in others they are in evolution. The extent of integration varies from an organisational level to close working at the "micro" level without organisational change. The evidence is that closer working, with shared record-keeping, provides best care.

It is envisaged that local primary care services will lead the development of multidisciplinary working, with multiprofessional team members adjusting to meet people's needs. Multiprofessional refers to registered and non-registered health and care professionals from a range of organisations, including primary and community care; secondary care; social care; housing; voluntary, community and social enterprise (VCSE) organisations, to ensure that appropriate holistic support and interventions can be offered. For example, if social isolation and loneliness are highlighted during the holistic assessment, local VCSE organisations are likely to be able to provide social support for the person.

People receiving proactive care should have a named Care Co-ordinator. Care co-ordination should provide people with

a clear point of contact for advice and support. Central to effective care co-ordination is utilising a share health and care record to enable INTs to work to one personalised care and support plan for people receiving proactive care.

A range of evidence-based interventions and support should be considered as part of co-developing the personalised care and support plan.[46] These interventions and support may need to be prioritised or sequenced for maximum impact. While the list of interventions is potentially limitless, those considered as part of the Comprehensive Geriatric Assessment (CGA) process should be included.

For exacerbations of ill health, the integrated neighbourhood team should have direct access to urgent provision, preferably in the community where appropriate, including:

- Urgent community response.
- Virtual wards.

Should admissions occur, the INT should be working with secondary care to support timely discharge.

Above all, it will be important for systems to ensure that proactive care services have strong clinical leadership from someone with expertise in older people's healthcare. While this individual could be a geriatrician, they do not need to be. Clinical leadership could be provided by an advanced clinical practitioner from a nursing or therapy background or a GP.

Whitstable Medical Practice Older Person's Team

The team consists of four advanced clinical practitioners (two physiotherapists and two paramedics) who are all independent prescribers. Along with the team care coordinator they provide specialist care for older people under the care of the practice. They work alongside the GPs and in particular the lead GP for frailty and dementia.

The team provide all the medical care for the care homes in the Whitstable area and also provide home visits for patients with moderate to severe frailty to carry out comprehensive geriatric assessments.

In early 2023, the team developed and launched proactive "Over 75s clinics" and started by inviting all patients aged over 90 years. As of January 2024, 128 patients have been seen in clinic, during which all patients have had a medication review and an opportunity to discuss advance care planning. In order to more clearly prioritise those most at need, the team are now inviting those aged over 80, starting with those with the highest Electronic Frailty Index score. At the time of booking, patients are sent a pre-care planning sheet to complete prior to the appointment to assist them in considering what is important to them and to help guide the conversation during the appointment. The feedback from patients has been excellent with appreciation of the opportunity to discuss all their concerns, having quality time with a clinician and feeling listened to.

Physiotherapist-led service in Solihull

At University Hospitals Birmingham NHS Foundation Trust, two experienced community physiotherapists have been piloting a proactive care approach for the management of frailty across Solihull. The Solihull Community Therapy Service, as a provider of both community rehabilitation and discharge support on Pathway 1,[49] has a clear understanding that a shift from the standard reactive healthcare model to proactive healthcare for the management of people with frailty, is vital. The piloted roles termed 'Community Frailty Practitioners' are working in collaboration with local PCNs and other community services to focus on three different proactive care strands which they can positively influence.

The three strands are:

1. Addressing the needs of the 'revolving door' rehabilitation and falls patients that are referred to community services
2. Carrying out a proactive frailty and falls clinic in the hospital's Locality Hub
3. Actively contacting and offering assessments to patients who are registered through the Electronic Frailty Index by their GP as having either mild, moderate, or severe frailty levels.

This proactive care approach involves thorough assessment through the use of Comprehensive Geriatric Assessment and multi-factorial falls assessments to offer advice, education, onward signposting to specialist services or back to the GP as well as being highly focused on active ageing, self-management and condition management awareness, promotion of local Urgent Community Response Services and individual exercise and movement prescription, equipment prescription and environment review through home assessments.

The proactive focus is having a direct impact on patient healthcare provision through the earlier identification, recognition and management of early deterioration signs, active signposting to required local health, care and voluntary services to enable people to receive the support they need when they need it.

These aspects enable people with frailty to remain well at home and living well for longer, as well as preventing avoidable emergency department attendances and hospital admissions which often result in deconditioning and irreversible loss of functional and physical ability.

Chapter five: Enablers

Workforce development

The workforce is central to the delivery of proactive care. It is important to ensuring a multi-professional team functions with sufficient capacity, the right training and expertise, with the ability to draw on other professions as needed and to flex how it operates to meet the needs of a local population.
Local systems should:

- Develop a workforce plan with partner organisations locally for proactive care based on the prioritised cohort and the local configuration of services required for the integrated neighbourhood team.
- Support systems to work with primary care training hubs and community care training hubs to identify workforce needs and skills gaps and embed new roles and ways of working.
- Explore how a 'one workforce' approach can be used to bring together people and providers across the system. Tools such as Health Education England's Star model[47] support the development of a co-ordinated system-wide workforce transformation and improvement plan.
- Consider how existing recruitment initiatives can be used to develop the workforce for proactive care delivery.

Digital and data improvements

Effective design and delivery of proactive care is built on strong digital infrastructure, connected data, and enabled by Population Health Management expertise.

The standards in the What Good Looks Like framework should be used to digitise, connect, and transform services safely and securely.

Commissioners should consider supporting delivery of proactive care by:

- Supporting people to use technology to help them remain as independent as possible, eg, falls detection technology or acoustic monitoring, with consideration of digital inclusion.
- Prioritising a single shared care record across health and social care for the proactive care population cohort, using approved data standards where available to improve the quality of data.
- Addressing the business intelligence capability needed to deliver proactive care across place and neighbourhood teams, including to identify, validate and prioritise population groups as well as to maintain patient lists at a local level. NHS England has set out good practice guidance to support ICBs in developing cross-system intelligence and analytical functions that can support actionable insights for frontline neighbourhood teams.
- Developing person-level longitudinal datasets and ensuring local population health analytical platforms that enable population segmentation, activity, and impact monitoring, using clinical and non-clinical data drawn from as many settings as possible.
- Ensuring providers have appropriate digital tools and structures in place to enable joined-up, digitally-enabled care and data collection.

It is important that INTs can identify people that are receiving proactive care. A set of metrics should be developed locally to help commissioners determine the impact of providing proactive care, in particular:

- Number of people living at home.
- Use of unplanned care by their target population.

Place-based governance and decision-making

The delivery of proactive care will be heavily dependent on local partnership working between NHS providers, local government, and the voluntary and community sector.

South Somerset Complex Care Team

The Complex Care Team (CCT) in South Somerset was established in 2016, pre-dating Primary Care Networks (PCNs). The CCT consists of an experienced GP, a senior nurse and a band 4 support 'key worker' and covers up to six local GP surgeries. Three CCTs, each aligned to a PCN, provide comprehensive assessments of complex patients (who are often older people living with frailty), coordination and information sharing with GPs, community teams, and secondary care hospital teams.

Shared knowledge between all community teams enables proactive management of patients' social, physical health, mental health and general support needs. TAdvance care planning lowers the risk of a crisis requiring urgent care, ensuring the best chance of care at home when unavoidable deteriorations occur. Multidisciplinary community teamworking enables the right person to look after the patient at the right time.

There are also large benefits for the staff involved within the CCT too. Foundation Year 2 doctors are trained in a shared Complex Care and GP Surgery placement for 4 months, enabling better understanding for the new generation of future primary and secondary care doctors. This service also offers placements for Frailty Trainee Advanced Care Practitioners, enabling relevant learning and building on a holistic approach to patients with complex care and often frailty needs.

The CCT are committed to breaking down barriers to care, always instilling a mentality of 'what can we do to help?', while always remembering: 'There is a patient (family/carer) at the centre of every decision'.

Commissioners should encourage joint executive leadership and system agreements across partner organisations, through shared decision-making and governance.

System leaders should develop and agree a system-wide approach to proactive care that puts people's outcomes and experiences at the centre, with a focus on high-quality care, in line with Shared Commitment to Quality guidance.[50]

All ICSs in England have now established Place-based Partnerships which bring together primary, community and secondary care, local government, the voluntary sector and wider partners to plan and improve health and care services, proactively identifying and responding to population need through adoption of population health management approaches.

In delivering proactive care, systems should consider how they can support their place-based teams with the data and analytical capability described above and ensure that local place-based partnership forums are enabled to make decisions about the delivery of proactive care. A range of case studies are being made available on the Population Health Academy[51] to describe how places are creating governance structures to aid partnership working and service redesign.

Chapter six: Experience 'I statements'

'I statements' show the experience of proactive care from the perspective of an individual receiving care and help to ensure that care is person-centred. 'I statements' are advocated by the Care Quality Commission and developed by National Voices. They should be used as a guide for healthcare professionals delivering proactive care to ensure that their patients are involved with every step of decision making.

Case identification

- I am identified as someone who may benefit from proactive care and am invited to have an assessment of my needs.
- I am provided with clear and accessible information, tailored to be needs, about what proactive care is and the potential benefits. I understand why I have been identified and what I can expect from the holistic assessment. I feel able to decide if I want to accept the proactive care offer.
- I am asked about my requirements and preferences for the holistic assessment, such as who I might want to have with me at the assessment. I can ask any questions I may have.

Holistic assessment

- I meet with a professional who works in health or care to discuss my physical and mental health, social and self-care needs and how they impact on my life.
- Depending on my needs, I may be invited to have further assessments with other professionals.
- I can have a family members, friend, carer or advocate with me during the assessment.

Personalised care and support planning

- I have a conversation with a professional who works in health or social care about what matters to me in my life and what would make my life better. Together we develop a plan about the things that are important to me, my needs and my aspirations.
- I am given all the information I need in advance to prepare for this conversation and in a way that I can understand. This includes information about any legal rights I might have. I can choose who I would like involved in the planning discussion, for example, a family members, carer, advocate or interpreter.
- I can access and share my plan whenever and with whomever I choose, and it can be updated whenever my circumstances change.
- My plan is also shared with professionals who are involved in my care to make sure that they understand who I am and how I want to live my life.
- When developing my plan, I feel heard, and my culture and identity are understood and respected. I am empowered to speak honestly about what matters to me and the support I need and want to manage my health.

Co-ordinated multi-professional support

- After I have had my holistic assessment and developed my personalised care and support plan, a team of professionals who form a multidisciplinary team (MDT) meet to discuss

my needs and make recommendations about what might help me to achieve my aspirations.

- It will be possible for me to attend the MDT meeting should I wish to, but if I am unable to, I know that my views will be presented, and I will be provided with clear information about the discussion. I also know that the discussion is to make recommendations for me rather that decisions about me and that I am in control of my care.

Clear plan for continuity of care

- I have a named person/professional who supports the co-ordination of my care and is my main point of contact. They take the time to understand what is important to me, including my culture and identity.
- They attend MDT meetings where my care is discussed and make sure that I am included in all decision about my care. We discuss what recommendations have been made by the MDT and they make sure I have all the information I need to be able to decide what support I want.
- We have regular reviews to make sure that my care is working for me, and I know I can raise any concerns I have. I can ask them any questions and can contact them whenever my circumstances change, and I need my personalised care and support plan to be updated.
- Based on my needs and what matters to me, the MDT will suggest referrals to other services as needed. This could include health services, social care or services provided by the voluntary sector.
- I am provided with accessible information about available services, in a way that meets my needs. I can decide which services I access and if something isn't working for me, I can speak to my named co-ordinator about making change to my care.

Chapter seven: Conclusion

Delivery of proactive care for older people with frailty is supported by strong evidence which shows improvements in patient experience as well as cost savings for the system. Identifying people at risk of deterioration and intervening early enables older people to live independently for longer and avoids unplanned hospital admissions. Systems across the UK should be supported to implement these services for their older populations.

Contributors

The original NHS England document on proactive care was developed by a team of people from across health and social care, led by Beverley Gallagher and Corrina Grimes. This document has been adapted by Dr Eileen Burns MBE, former President of the BGS and former NHS England National Specialty Advisor, and Sally Greenbrook, BGS Policy Manager.

Thanks also to the many NHS England staff who worked actively on the framework or supported its development. Colleagues in community health services, primary care, social services and the voluntary sector (including care homes) also contributed hugely to the development of the final document.

References

1. Office for National Statistics, 2023. Profile of the older population living in England and Wales in 2021 and changes since 2011. Available at: www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/profileoftheolderpopulationlivinginenglandandwalesin2021andchangessince2011/2023-04-03

2. Office for National Statistics, 2018. Living longer: how our population is changing and why it matters. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongerhowourpopulationischanginandwhyitmatters/2018-08-13

3. Maharani A, Sinclair D, Chandola T, Bower P, Clegg A, Hanratty B, Nazroo J, Pendleton N, Tampubolon G, Todd C, Wittenberg C, O'Neill T and Matthews F, 2023. 'Household wealth, neighbourhood deprivation and frailty amongst middle-aged and older adults in England: a longitudinal analysis over 15 years (2002-2017).' Age and Ageing, 52(3)

4. NHS England, 2023. Proactive care: providing care and support for people living at home with moderate or severe frailty. Available at: https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/

5. Murtgah FEM, et al, 2023. A non-randomised controlled study to assess the effectiveness of a new proactive multidisciplinary care intervention for older people living with frailty. BMC Geriatrics 23:6

6. Nord M, et al, 2023. Costs and effects of comprehensive geriatric assessment in primary care for older adults with high risk of hospitalisation. BMC Geriatrics. 21:263

7. The Health Foundation, 2023. Realising the potential of community-based multidisciplinary teams. Available at: /www.health.org.uk/publications/reports/realising-the-potential-of-community-based-multidisciplinary-teams

8. British Geriatrics Society, 2023. Joining the dots: A blueprint for preventing and managing frailty in older people. Available at: www.bgs.org.uk/blueprint

9. The Health Foundation, 2020. The long-term impacts of new care models on hospital use: An evaluation of the Integrated Care Transformation Programme in Mid-Nottinghamshire. Available at: www.health.org.uk/publications/reports/the-long-term-impacts-of-new-care-models-on-hospital-use-midnotts#:~:text=By%20year%206%20(2018%2D19,care%20initiatives%20is%20often%20mixed.

10. The Health Foundation, 2018. The impact of integrated care teams on hospital use in North East Hampshire and Farnham: Consideration of findings from the Improvement Analytics Unit. Available at: www.health.org.uk/publications/impact-integrated-care-teams-hospital-use-north-east-hampshire-and-farnham

11. Baker A, et al. 2018. Anticipatory care planning and integration: a primary care pilot study aimed at reducing unplanned hospitalisation. British Journal of General Practice. 71(703):e121-e127.

12. Leckcivilize A, et al. 2021. Impact of an anticipatory care planning intervention on unscheduled acute hospital care using difference-in-difference analysis. BMJ Health and Care Informatics. 28(1): e100305

13. Abel J, et al. 2018. Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities. British Journal of General Practice. e803-e810.

14. Stokes J, et al. 2015. Effectiveness of care management for 'at risk' patients in primary care: A systematic review and meta-analysis. PLoS ONE. 10(7)

15. Coulter A, et al. 2015. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews, 3.

16. Clegg A, et al. 2013. 'Frailty in elderly people', Lancet. Mar 2;381(9868):752-62.

17. Han L, et al. 2019. 'The impact of frailty on healthcare resource use: a longitudinal analysis using the Clinical Practice Research Datalink in

England', Age and Ageing. Sep 1;48(5):665-671

18. Doody P, et al. 2022. 'The prevalence of frailty and pre-frailty among geriatric hospital inpatients and its association with economic prosperity and healthcare expenditure: A systematic review and meta-analysis of 467,779 geriatric hospital inpatients', Ageing Research Reviews. Sep;80:101666. Doi: 10.1016/j.arr.2022.101666

19. Mitnitski A and Rockwood K, 2016. 'The rate of aging: the rate of deficit accumulation does not change over the adult life span.' Biogerontology. 2016; 17:199-204.

20. The Health Foundation, 2022. Life expectancy and healthy life expectancy at birth by deprivation. Available at: www.health.org.uk/evidence-hub/health-inequalities/life-expectancy-and-healthy-life-expectancy-at-birth-by-deprivation#:~:text=For%20women%2C%20the%20difference%20is,slightly%20smaller%2C%20at%2018.4%20years.

21. Vetrano DL, et al 2019. 'Frailty and Multimorbidity: A systematic review and meta-analysis.' The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences, 4(5):659-666.

22. Turner G, Clegg A, 2014. Best practice guidelines for the management of frailty: a British Geriatrics Society, Age UK and Royal College of General Practitioners report, Age and Ageing, 43(6):744-747.

23. Rogans-Watson R, et al, 2020. 'Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel.' Housing, Care and Support. 23(3/4);77-91

24. The King's Fund, 2022. What are health inequalities? Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities#:~:text=This%20explainer%20was%20updated%20on,which%20the%20term%20is%20used.

25. NHS England, 2022. Supporting High Frequency Users (HFU) through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches, and Care Co-ordinators. Available at: www.england.nhs.uk/wp-content/uploads/2022/10/BW2066-supporting-high-frequency-users-october-22.pdf

26. NHS England, 2023. Tackling Neighbourhood Health Inequalities supplementary guidance. Available at: www.england.nhs.uk/wp-content/uploads/2023/03/PRN00157-tackling-neighbourhood-health-inequalities-supplementary-guidance-march-2023.pdf

27. Kharicha K, et al. 2007. 'Health risk appraisal in older people 1: are older people living along an "at-risk2 group' British Journal of General Practice. 57(537):271-6

28. Pearce C, et al, 2021. 'Supporting bereavement and complicated grief in primary care: a realist review.' BJGP Open; 5(3)

29. Garcia R, Mahon A, 2021. 'Frailty and spousal/partner bereavement in older people: a scoping review.' Journal of Health, and Social Care Improvement. 4(1)pp.14-23

30. Hawkley LC. 2022. 'Loneliness and health' Nat Rev Dis Primers 8, 22(2022)

31. Milton JC, Hill-Smith I, Jackson SH, 2008. 'Prescribing for older people', BMJ, 336(7644):606-9

32. Caughey GE, et al. 2010. 'Increased risk of hip fracture in the elderly associated with prochlorperazine: is a prescribing cascade contributing?' Pharmacoepidemiology & Drug Safety, 19(9):977-82

33. Caughey GE, et al. 2010. 'Comorbidity in the elderly with diabetes: identification of areas of potential treatment conflicts.' Diabetes Research and Clinical Practice. 87(3):385-93

34. NHS England, 2023. Building an integrated care systems intelligence function. Available at: www.england.nhs.uk/long-read/building-an-ics-intelligence-function/

35. Royal College of General Practitioners, 2016. Continuity of care in modern day general practice. Available at: www.rcgp.org.uk/getmedia/11f26527-5d11-47f2-a593-1a894c2fff1b/Continuity-of-care-in-modern-day-general-practice1.pdf

36. National Institute for Health and Care Excellence, 2019. People's experience using adult social care services: Quality standard QS182. Available at: www.nice.org.uk/guidance/qs182

37. Nowak DW, et al, 2023. 'Why does continuity of care with family doctors matter? Review and qualitative synthesis of patient and physician perspectives. BMC Family Practice. 24(1),9

38. Menec VH, et al, 2006. 'Does continuity of care with a family physician reduce hospitalizations among older adults?' Journal of Health Services Research & Policy. 11(4),196-201

39. Van Loenen T, et al. 2014. 'Organizational aspects of primary care related to avoidable hospitalization: a systematic review.' Family Practice. 31(5), 502-516.

40. Knight C, Mathews M, Aubrey-Bassler K. 2017. 'Relation between family physician retention and avoidable hospital admission in Newfoundland and Labrador: a population-based cross-sectional study. CMAJ Open, 5(3), E597-E603

41. Dyer s, et al. 2022. 'Impact of relational continuity of primary care in aged care: a systematic review.' BMC Geriatrics. 22(1), 56

42. Nicolet A, et al. 2022. 'Association between continuity of care (COC), healthcare use and costs: what can we learn from claims data? A rapid review.' BMC Health Services Research, 22(1), 89

43. Han E, et al, 2023. 'The associations of continuity of care with inpatient, outpatient, and total medical care costs among older adults with urinary incontinence.' BMC Health Services Research. 23(1), 76.

44. Nuffield Trust, 2018. Improving access and continuity in general practice. Available at: www.nuffieldtrust.org.uk/research/improving-access-and-continuity-in-general-practice

45. NHS England, 2022. Next steps for integrating primary care: Fuller stocktake report. Available at: www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

46. Macdonald SHF, et al. 2020. 'Primary care interventions to address physical frailty among community-dwelling adults aged 60 years or older: A meta-analysis. PLOS ONE. 15(2):e0228821

47. NHS England, undated. HEE Star: Accelerating workforce redesign. Available at: https://www.hee.nhs.uk/our-work/hee-star

48. NHS England, 2021. What Good Looks Like Framework. Available at: https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

49. NHS England, 2024. Acute discharge situation report: technical specification. Available at: www.england.nhs.uk/long-read/acute-discharge-situation-report-technical-specification/

50. National Quality Board, 2021. Shared Commitment to Quality. Available at: www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/

51. Future NHS, undated, Population Health Academy. Available at: future.nhs.uk/populationhealth/grouphome (sign in required)

British Geriatrics Society
Improving healthcare for older people

Marjory Warren House
31 St John's Square, London EC1M 4DN

Telephone 0207 608 1369
Email enquiries@bgs.org.uk
Website www.bgs.org.uk
Published November 2024

Registered Charity No. 268762. A company registered in England and Wales No. 1189776