British Geriatrics Society
Improving healthcare for older people

Be proactive:
Delivering proactive care for older people with frailty

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#BGSProactiveCare

Contents

Foreword

Proactive care plays a vital role in delaying the onset of frailty, maintaining older people's independence, and reducing avoidable periods of ill health. Last year, the BGS highlighted the importance of proactive care in *Joining the Dots: A blueprint for preventing and managing frailty in older people* by highlighting it as one of seven key touchpoints to support older people to age well.

We were pleased that the long-awaited NHS England Guidance on proactive care was published last year. Previously known as anticipatory care, proactive care is one of the three original streams of the Ageing Well programme, as detailed in the NHS Long Term Plan. While we remain disappointed that the initial promised funding for the programme was cut, the guidance provides a crucial framework.

In October 2024, the BGS published *Be proactive: Evidence supporting proactive care for older people with frailty*. This first publication provides evidence to help colleagues build business cases for proactive care in their locality. Our second publication, *Be proactive: Delivering care for older people with frailty*, acts as a roadmap to support the delivery of proactive care services for older people with moderate to severe frailty. With the NHS England guidance as an overarching framework, we propose colleagues use both BGS documents to deliver evidence-based proactive care.

To deliver proactive care, we recognise colleagues require both appropriate infrastructure and policy locally and nationally. As such, our second report provides eight recommendations requiring action from commissioners, policymakers, providers and healthcare professionals at local, regional and national levels. We urge anyone involved in commissioning proactive care services to seek the expertise and resources available from the BGS.

We know that the provision of proactive care services varies greatly across the UK, creating unequal health outcomes for older people. However, we also know there are many exemplary proactive care services across the four nations, and we believe the same principles apply to the organisation and delivery of proactive care across the UK. As with all our work at the BGS, we have been pleased to work with our multidisciplinary members who provided invaluable insights and content to inform the report. I would like to thank all those involved. Now, it is crucial that proactive care is prioritised and embedded across all primary and community settings to ensure older people live well and stay independent for longer.

Professor Jugdeep Dhesi
BGS President Elect

Executive summary

Frailty is common in older people, affecting more than one in ten people over 65 living in the community[1] and up to half of the total UK population over 85.[2] As the UK population continues to age, these figures are expected to increase and likely to double by 2045 with associated implications for healthcare systems.[1] Despite this, frailty is not an inevitable part of ageing.

As outlined in *BGS's Joining the dots: A blueprint for preventing and managing frailty in older people*, older people need a comprehensive 'wrap around' health and social care system that supports healthy ageing and maximises functional independence.[1] To achieve this, the blueprint sets out seven system touchpoints that should be included when planning and commissioning health and social care for older people.

One of these vital touchpoints is 'population-based proactive anticipatory care', which identifies older people at risk of ill health and poor outcomes and offers them personalised interventions to remain well for longer. This publication will explore this touch point in further depth, focussing on proactive care for older people with moderate to severe frailty receiving care in community and primary care settings. The document is aimed at healthcare professionals, clinical leaders, policy makers, and commissioners and acts as a roadmap for delivering proactive care for older people with frailty.

Building on the recent NHS England proactive care guidance, *Proactive care: providing care and support for people living at home with moderate or severe frailty*, [2] this publication outlines how to deliver proactive care against the five NHS core components and three key enablers. It also outlines eight key recommendations for the successful implementation of proactive care services across the UK. It will complement BGS's *Be proactive: Evidence supporting proactive care for older people with frailty,*[3] which outlines the evidence base for proactive care. Users will be able to utilise all three documents when designing proactive care services, with the NHS England guidance document acting as key framework and starting point, BGS's evidence document as a business case, and this document as roadmap for implementing the NHS England framework and delivering services. *(Refer to Appendix 2 for a diagram outlining this roadmap).*

Core components

Case identification

A wide range of different approaches can be used to identify people that may benefit from proactive care services. This includes using human knowledge; analysing admission, discharge and caseload data; receiving referrals; and using algorithms to identify people from databases. The electronic frailty index (eFI) is a tool that uses data from a patient's electronic health record to identify and grade the severity of frailty and can be used alongside other criteria to identify a cohort. Once identified, tools such as the Clinical Frailty Scale (CFS) can be used to confirm diagnosis.

Holistic assessment

Once a patient has been identified, a holistic assessment, such as a Comprehensive Geriatric Assessment (CGA), should be used to assess their needs. The assessment should include physical, functional, social, environmental, and psychological assessments, alongside a medication review. The Geriatric 5Ms framework can be used as a framework for holistic assessments, focusing on mind, mobility, medication, multicomplexity, and what matters most to patients.[4]

Personalised care and support planning

Following on from holistic assessments, individuals should be supported with a personalised care and support plan. Proactive care services should develop a format for care planning, focussing on falls prevention, nutrition advice, social care support, medication reviews, advanced care planning, and emergency care plans, such as ReSPECT forms. Plans should include preventative strategies to address common issues associated with frailty, including vaccinations, regular screening, and proactive management of chronic conditions.

Co-ordinated and multi-professional working

At a minimum, the core proactive care team should consist of a GP with an interest in frailty, an Advanced Clinical Practitioner, and a Care Co-ordinator. If resource is available, the core team can extend to include professionals from mental health services, pharmacy, social care, therapy and geriatric medicine. Effective communications should be implemented, such as a regular multidisciplinary team (MDT) meeting, and sufficient training and development opportunities available.

Continuity of care

Continuity of care is essential to ensure that proactive care interventions are being implemented. The core proactive care team should liaise with service providers and the relevant members of the multidisciplinary team to ensure that proactive care is being delivered. Frailty is not a static process and therefore follow up is needed to see how the patient's condition has changed over time.

Key enablers

Flexible workforce

It is important that the multidisciplinary proactive care team is supported to work across organisational boundaries, with sufficient capacity and training opportunities. The team should have an understanding of frailty and associated issues such as falls, immobility, delirium, incontinence, multi morbidity, and polypharmacy. A shared workforce plan across the partner organisations outlining ways of working and training opportunities for staff should be developed.

Shared care record

Information sharing is vital for proactive care services as it requires multidisciplinary interventions across a range of health and care organisations. It is important that the core proactive team has access to all electronic patient records, including general practice, community services, hospitals and social care. If this is not possible, they should have access to all the shared records available in the area.

Clear accountability and shared decision-making

Shared decision-making and governance between provider organisations are essential to the success of proactive care services. When designing the service, local leaders should agree on the aim of the service and develop shared values. Holistic care often consists of many overlapping services such as physical health, mental health, psychological services and social services as well as community and voluntary care services.

It is important that all these services work from shared values focussed on what matters most to the patient. Data collection and outcome measures should also be considered when designing the service. Services should consider using patient reported outcomes or functional measures, such as Activities of Daily Living (ADLs) and patient experience measures. As outcome measures for proactive care are difficult to implement, process measures may provide another approach to demonstrate the value of an intervention.

Recommendations for delivering proactive care

1. Proactive care services should be aligned to the approximate geography of a Primary Care Network (PCN)/Primary Care Cluster (PCC) or equivalent, with a dedicated proactive care team in each equivalent area across the UK.
2. Policy makers and commissioners should prioritise national funding and contractual arrangements to ensure that proactive care is available to all older people living with frailty in the community.
3. Leadership is vital to the delivery of successful proactive care services, and it should be supported and nurtured through training opportunities and protected funding.
4. Outcome measures are vital in evaluating the success of proactive care interventions and should always be implemented when new services are launched. National guidance on how to measure the impact of proactive care interventions should be published, and investment is needed in clinical research and IT infrastructure focussed on data collection and evaluation.
5. Proactive care services should be staffed by a core multidisciplinary team, consisting of at least one GP with an interest in frailty, one Advanced Clinical Pratitioner, and one Care Co-ordinator. A gold standard team would include professionals from social care, mental health services, therapies, pharmacy and geriatric medicine.
6. Local and national investment in training and development opportunities for the multidisciplinary team working in proactive care is needed, including mandatory frailty training, training in communication, leadership, and coaching, and education on the wider health and care system.
7. A culture of flexible and cross organisational working should be embedded in proactive care services, which requires good working relationships across services. A shared proactive care workforce plan across the partner organisations in each PCN/PCC or equivalent should be developed.
8. Services across the UK should use BGS's *Be proactive: Evidence supporting proactive care for older people with frailty*[3] to make the case for proactive care services in their local area, and use *Be proactive: Delivering proactive care for older people with frailty* as a roadmap for implementing services.

Chapter one: Introduction

Background

In June 2023, the British Geriatrics Society (BGS) published *Joining the dots: A blueprint for preventing and managing frailty in older people*.[1] The publication acts as a blueprint to illustrate what good-quality age-attuned integrated care for older people looks like and makes the case for investing in services that prevent and manage frailty in older people. The blueprint sets out seven touchpoints of care that should be available to older people and makes 12 system recommendations. One of these vital touchpoints is "population-based proactive anticipatory care" which highlights the importance of care that targets people at risk of poor health and social outcomes to offer tailored support to stay healthier for longer.

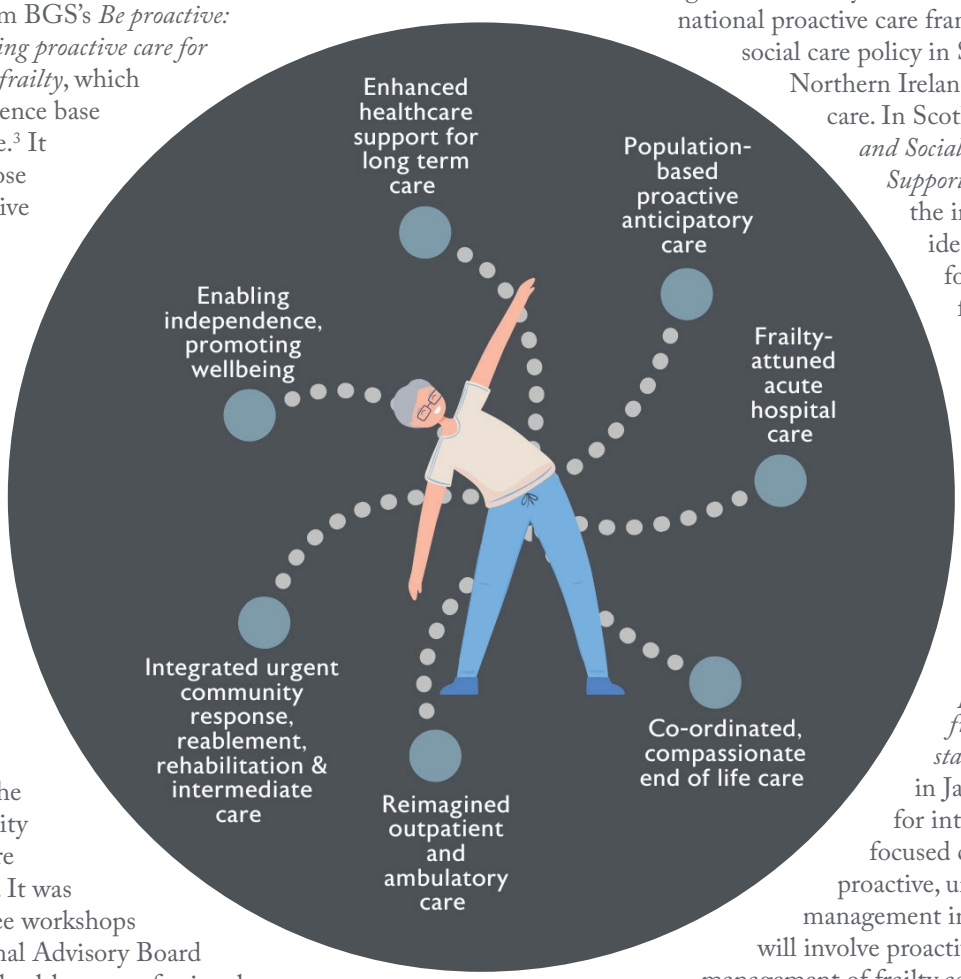
This publication will explore the touchpoint in further depth, specifically focusing on proactive care aimed at older individuals with moderate or severe frailty receiving care in primary and community settings. This expands on NHS England's *Proactive care: providing care and support to people living at home with moderate and severe frailty*,[2] which is one of the three workstreams of the Ageing Well programme as published in the NHS Long Term Plan in 2019.[5] Mapped onto NHS England's five core components and three enablers of proactive care, this document acts as a roadmap on delivering proactive care for older people with frailty. It follows on from BGS's *Be proactive: Evidence supporting proactive care for older people with frailty*, which outlines the evidence base for proactive care.[3] It is hoped that those designing proactive care services will use all three documents in both making the business case for proactive care and delivering it.

How was this publication developed?

This publication was developed by members of the BGS's Community and Primary Care Group (CPCG). It was informed by three workshops with a Professional Advisory Board consisting of 21 healthcare professionals from a range of healthcare backgrounds and locations, held between March – May 2024. The workshops focussed on the benefits of proactive care approaches, barriers and enablers to the implementation of proactive care services, approaches to the identification of people with frailty, and how proactive care can be implemented into the wider health policy system.

Proactive care policy

In December 2023, NHS England published guidance on proactive care, outlining how it can be used to provide care and support for people living at home with moderate or severe frailty.[2] The guidance builds on previous reports calling for a transition to proactive care for patients living with frailty in the community. This includes the Fuller Stocktake, which calls for a healthcare system that better anticipates and manages the needs of individuals with frailty through more integrated, proactive, and community-centred care.[6] Outlined methods include the identification of patients with frailty and targeted delivery of interventions to prevent crisis, integrated care to support improved transitions of care, place-based models of care, and investment in Multidisciplinary Teams (MDTs). Similarly, the *England Chief Medical Officer's annual report 2023: health in an ageing society* highlights the importance of maximising the independence of older people through the promotion of healthy ageing.[7] This will prevent and delay the onset of frailty in older people and in turn reduce hospital admissions, which has increased over the last 15 years.[8] This requires investment and a re-focus on care delivered within community and public health settings.



Whilst England is the only nation in the UK with a national proactive care framework, health and social care policy in Scotland, Wales, and Northern Ireland also features proactive care. In Scotland, the 2017 *Health and Social Care Standards: My Support, My Life* emphasised the importance of early identification and support for individuals with frailty.[9] In 2024, the Ageing and Frailty draft standards for the care of older people were published with 11 standards, which included the proactive identification of people living with frailty.[10] In Wales, the *Older people and people living with frailty: integrated quality statement* published in January 2024 called for integrated community focused care to provide proactive, urgent and crisis care management in the community. [11] This will involve proactive identification and management of frailty as a long-term condition to prevent, delay, reverse or slow down its progression. Finally, in Northern Ireland one of the four core priorities of the Northern Ireland Frailty Network is the early identification of frailty to deliver more efficacious management of frailty.[12]

The NHS England proactive care guidance is a crucial starting point for Integrated Care Boards (ICBs) and provider organisations designing and implementing proactive care.[2] The guidance identifies five core components of the proactive care approach and three enablers:

Core components

1. **Identifying the target cohort for whom there is the greatest potential impact on health and system outcomes.**
2. **Carrying out holistic assessments, such as a Comprehensive Geriatric Assessment**
3. **Developing a personalised care and support plan**
4. **Delivering Co-ordinated multi-professional interventions to address the person's range of needs.**
5. **Providing a clear plan for continuity of care, including an agreed schedule of follow-ups**

Key enablers

1. **Flexible workforce**
2. **Shared care record**
3. **Clear accountability and shared decision-making**

The NHS England guidance identifies the importance of proactive care but lacks specific details about how to implement proactive care services in local areas and at larger scales. Whilst it is a key starting point, the BGS is disappointed in the absence of funding for the programme compared to what was originally proposed.[13] This document aims to build on the NHS England guidance through outlining how to deliver the five core components and three key enablers of proactive care.

Audience

Supporting primary and community care services to deliver proactive care programmes is in the interest of the wider health system. However, given the broad range of challenges, coordinated action is required incorporating the whole multidisciplinary team. This document aims to be a useful guide for healthcare professionals, clinical leaders, commissioners, and system designers wishing to set up proactive care services within primary and community care settings in their local areas. It also provides commissioners and policy makers with key recommendations on how to set these services up on a larger scale. Whilst we use the NHS England guidance as a starting point, the principles outlined in this document can be implemented across all four nations.

What is proactive care?

Defining proactive care

Frailty is not an inevitable part of ageing, and proactive care aims to reduce or delay negative health outcomes through targeting those at risk of frailty and tailoring health interventions to support them live well for longer. It aims to delay the onset of health deterioration, maintain independent living, and reduce avoidable periods of ill health, thereby reducing unplanned care. [2] Most healthcare interactions for older people with frailty take place in primary care, and it is therefore a crucial setting for proactive care services to be implemented. [14] Within primary and community care, there is an increasing focus upon proactive models of care to identify, assess and manage older people with frailty to mitigate the negative impacts of frailty on individuals and healthcare systems.[15] Importantly, this transforms care from being reactive, fragmented, and episodic to personalised, community-based, and coordinated.[16]

Benefits of proactive care

There is significant scope for proactive care delivery within primary and community care systems to improve patient-centred outcomes and system-centred outcomes. Benefits to patients include improved quality of life, reduction in loneliness/isolation, reduction in carer burden, and the maintenance of independence.[17] In turn, this can lead to wider healthcare system benefits, such as reduced hospital admissions and re-admissions.

Target cohort for proactive care

The NHS England guidance on proactive care focuses on people with moderate to severe frailty living in their own homes, excluding those with mild frailty. Most healthcare professionals working with older people will be caring for those with moderate to severe frailty, and therefore, our focus will also be on this cohort. The BGS recognises the importance of targeting those with mild frailty and the biggest system impact may be had by targeting this cohort. However, due to the high number of older people with mild frailty, this will require a different preventative screening approach, focussing largely on public health interventions incorporating exercise, nutrition, and overall wellbeing.[18]

The evidence base

There are conflicting concepts around frailty, its measurement and its relationship to multiple long-term conditions, ageing and disability.[19] Despite this, there is a broad consensus that the impact of frailty on individuals and care systems warrant a proactive inter-professional primary care approach to identification, assessment and management. [20]

There is evidence that proactive care programmes for patients with frailty are beneficial, with trials in the UK and Netherlands reporting reduced functional decline, improved quality of care, improved wellbeing, and improved quality of life.[21-23] Individualised care planning, including medicines optimisation and regular review, has been identified as the intervention with the strongest evidence base for sustaining independence in older people in the community.[24] Similarly, continuity of care has been identified as vital in proactive care service's success and delivery.

Sport for Confidence

Sport for Confidence have employed an Occupational Therapist (OT) to support patients with frailty either in their own homes or within care homes to increase their physical activity levels, reduce social exclusion, and maintain independence. Funded through the Additional Roles and Reimbursement Scheme (NHS England), the OT works across The Brentwood Primary Care Network and provides a strong link between GPs, leisure centres, and other community-based opportunities that enable people to get the support they need to stay healthier for longer. Find out more here:

www.sportforconfidence.com/our-services/occupational-therapists-in-primary-care.

Currently, the implementation of proactive care programmes is based on evidence-informed rather than evidence-based practice, which can prove challenging for commissioners. However, clinical research and quality improvement will lead to adjustments and redesign of proactive frailty interventions and help support the development of new knowledge and evidence for this patient group.[25]

The ability for different localities to implement proactive care programmes for patients with frailty is dependent on funding and workforce pressures. Despite this, current evidence highlights four key themes for the successful delivery of proactive care services. Firstly, the ability for a service to deliver Comprehensive Geriatric Assessment (CGA) is a priority. CGAs should provide patient centred assessments to identify symptoms or functional decline, including screening tools such as the PRISMA-7 questionnaire, Gait-Speed (four-metre walk), and timed-up-and-go tests.[26] Secondly, the identification of a clearly defined group of patients is pertinent. Depending on the size of the proactive care programme, this can range from annual screenings with frailty tools, to the identification of individuals with a high number of primary care contacts, home visits, medications, or medical conditions.[27] The type of intervention needs to be tailored depending on size, resources, and aims. Thirdly, it is important that proactive care programmes are resourced sufficiently.[28,29] While there appears to be general support for proactive care programmes from GPs, there are concerns that under resourced interventions will lead to high workloads without benefits.[28,29] Finally, integration with the broader health and social care system is beneficial to support wider components of care, such as nutrition, social interaction, and exercise. Examples include linking to social prescribers, referrals to day centres or community hubs, and integration with the third sector.

BGS's *Be proactive: Evidence supporting proactive care for older people with frailty* provides further information on the evidence base behind proactive care. This document outlines detailed evidence which was originally gathered to inform the NHS England guidance document and has been published with the approval of NHS England. Healthcare teams will be able to use this evidence to build business cases for proactive care services.

Chapter two:
Delivering proactive care

Proactive care services often start from different places. Some have started from a system wide prioritisation of proactive care with senior leadership support and dedicated funding. Others have started from the enthusiasm of individual clinicians at Trust, PCN/PCC or practice level. The way that services are set up will be dependent on geography, available funding, infrastructure, and workforce. Advice from healthcare professionals who have set up proactive care services is to "Start Small Think Big," and to "Start from where you are". Whatever the starting point, there are some key steps to setting up a proactive care service that can be applied to all proactive care services in primary and community care settings. Following the five core components and three key enablers outlined in NHS England's proactive care guidance, this chapter outlines how to deliver proactive care services for older people living with frailty.

Core component one: Case identification
Identify the cohort the service will focus on and develop an approach for case identification

Most services initially focus on older people with moderate and severe frailty living in their own home. People with mild frailty and complex health and care problems will also benefit from the care co-ordination provided by proactive care services, with some services including them in their cohort. Areas with high levels of deprivation may have higher levels of younger people with frailty and therefore may choose to lower the age for the service. As the service develops, the cohort it supports may expand to include different criteria such as older people with stroke, dementia, brain injury and chronic neurological conditions including Parkinson's disease and multiple sclerosis.

Proactive care services can use a wide range of different approaches to identify people suitable for interventions. This can be as simple as looking at admission and discharge information or as complex as using algorithms to identify people from system data.

The electronic frailty index (eFI) is a tool that uses data from a patient's electronic health record to identify and grade the severity of frailty. Data reports using eFI alone can be used but they often produce large lists of people, some of whom may not have frailty. Therefore, BGS members recommend using eFI with other criteria to improve accuracy.

Data report criteria options include:

- System-wide data reports
  - Moderate frailty + multiple long-term conditions (LTCs)
  - Moderate frailty + severe polypharmacy and/or high-risk medication prescription (e.g antipsychotics)
  - Moderate and severe frailty + no GP encounter in 6 months
  - Older people using multiple services
  - locally defined cohorts based on social deprivation and other factors (e.g. hospital admissions or readmission frequency)

- PCN/ PCC and practice level data reports
  - Frailty + Parkinson's disease
  - Frailty + depression and anxiety
  - Frailty + no GP contact for over a year
  - Frailty + increasing home visit requests
  - Over 75 and not on a chronic disease register

The data reports generate valuable lists, but a human is often needed to screen the lists to find appropriate individuals. Services use a variety of different ways to screen the lists. Options include reviewing practice records, sending out a questionnaire asking about frailty markers, and telephoning patients and carrying out a telephone assessment based on frailty markers.

The second version of the eFI (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.

Other services' caseloads or waiting lists can be used to identify suitable people, such as community matron caseloads, adult social care waiting lists, and adult community occupational therapy waiting lists. Some services also find suitable patients through referrals from health and care professionals rather than data sources. This may be more effective in established services once professionals are aware of the service, its aims, and impact. BGS members recommend promoting the service and encouraging the multidisciplinary team to use their own judgement to identify older people who would benefit from a comprehensive health and care review and personalised care plan.

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. Therefore, when an individual is identified who may be living with frailty, direct clinical assessment and judgement should be applied to confirm a diagnosis. The Clinical Frailty Scale (CFS) is used by most services to identify people for proactive care interventions. CFS is used to screen people on lists produced by data reports and is used as a basis for referrals. It is advised that each service trains health and care staff to ensure they understand the CFS and how to use it.

Most services use a range of methods to find suitable people with data reports being used to identify people initially and referrals identifying more people as the service becomes more established. Decide how your service will initially find, screen and assess suitable patients, but be willing to be flexible and adapt your process as the service develops.

Core component two: Holistic assessment

Agree the process for delivering holistic assessments, such as CGA

Consider which member of the core proactive care team will be carrying out the Comprehensive Geriatrics Assessment (CGA) and where this will take place. In most services, the initial assessment is carried out by an ACP with support from a Care Co-ordinator. Initial assessments can be carried out in a range of settings such as community clinics, GP surgeries and the patient's own home. People with mild or moderate frailty are more likely to be seen in a clinic or GP practice and people with severe frailty are usually seen at home.

Home visits provide useful information about the patient's home environment that cannot be seen in a clinic, but they can be time consuming and expensive. Limited access to rooms in community clinics and GP practices, compounded by poor access to transport means that some people who could attend a clinic are unable to do so. This increases the number of home visits and reduces the number of assessments that can be carried out by the service. In some areas, free transport schemes are available to bring patients to community clinics and GP surgeries, such as the Good Neighbour scheme. One practice-based service that used a Good Neighbour scheme enabled 70% of people with moderate or severe frailty to attend. Services should source rooms in GP surgeries and community clinics and free transport, if possible, to increase the service capacity.

When designing the service, the format of initial holistic assessments should be agreed. A holistic assessment should include physical assessment, functional, social and environmental assessment, psychological components and a medication review. The Geriatric 5Ms framework includes five areas of focus: mind/mentation, mobility, medications, multicomplexity, and what matters most, and can be a good framework for a holistic assessment.[4] Services should include family and informal carers in the assessment if appropriate.

Most services use an electronic template for the CGA, and this should be set up before the service starts seeing patients. Training for staff on using the template should be provided to ensure consistency.

Core component three: Personalised care and support planning

Develop an approach to personalised care and support plans

Services should develop a format for a personalised care and support plans. This can be anything from a discussion with the patient and their carer to a detailed document that is shared with the patient, GP practice, and other services involved in their care. Key aspects of the plan usually focus on falls prevention including strength and balance training, nutrition advice, social care support, medication reviews, advance care planning and emergency care plans such as ReSPECT forms. The plan should include preventative strategies to address common issues associated with frailty. This includes vaccinations, regular screening (e.g., for osteoporosis), and proactive management of chronic conditions. It is important to also consider lifestyle modifications such as physical activity, balanced nutrition, and social engagement.

A process for sharing the CGA and personalised care and support plan with other organisations should be developed. This is particularly important for advance care plans, Treatment Escalation Plans and ReSPECT forms.

Involve family and caregivers

Involving and supporting family and caregivers in the care process is an important consideration. Provide education on frailty management, coping strategies, and resources available. Engaging caregivers helps in ensuring that the patient's needs are met and can improve overall care outcomes.

Core component four: Co-ordinated and multi-professional working

Promote proactive care and engage senior leader support

It is important to identify and engage the support of senior stakeholders with the funding and power to prioritise the development of the proactive care service. Depending on your location in the UK, this might be your local Integrated Care Board, Health and Social Care Partnership, Health Board, Health and Social Care Board, Trust leaders, PCN Clinical Director, Primary Care Cluster or GP Partners in a GP Practice. With the current lack of funding of proactive care across the UK, this may be a challenge but tools such as BGS's *Be proactive: Evidence supporting proactive care for older people with frailty* can be used to make a business case.[3] Support your case by sharing evidence that proactive care works, share patient stories of substandard care where proactive care would have made a difference, and stories of how proactive care has reduced duplication and fragmentation of services. The case studies in this document alongside BGS's evidence publication can help build the case.

Identify and support proactive care leaders

Effective implementation of proactive care depends on motivated leaders with a vision, and this should be factored into funding requirements. Identify the leaders for the service at the start and ensure that they are supported with protected time and training opportunities. Both clinical and managerial leadership is beneficial but in smaller services, clinical leaders may do the job of both. Leaders should be provided with training in negotiating skills, service development, and project management. Providing networking opportunities can help leaders to share new ideas and provide mutual support.

Agree proactive care team membership for service

Core team membership

At a minimum, the core proactive care team should consist of a GP with an interest in frailty, an Advanced Clinical Practitioner, and a Care Co-ordinator. If the resource is available, a gold standard core team can include professionals from mental health services, pharmacy, social care, therapy and geriatric medicine. Core team membership will vary depending on whether there are funded roles available, if there is protected time for existing staff, the size and demographic of the population, funding, and local resources.

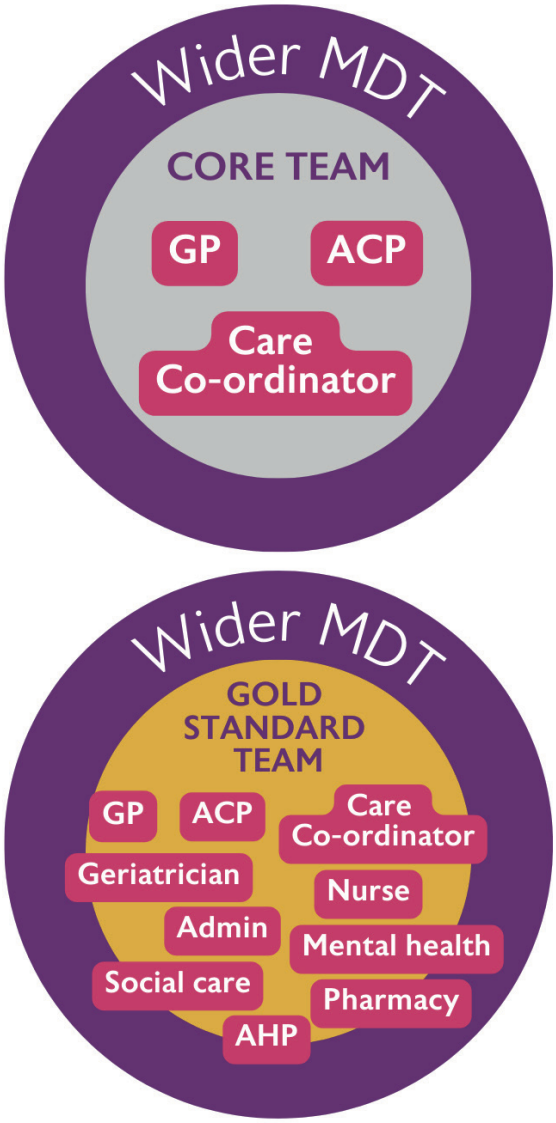
Advanced Clinical Practitioners

The core team should include highly trained professionals who are able to manage a complex caseload, such as ACPs from either nursing or allied health professions. It is more important that they have the right mindset rather than belonging to a specific profession as generic skills for managing people with frailty can be acquired. Availability of highly trained experienced staff is limited so staff should be offered training and support on the job if needed.

Care Co-ordinators

Care Co-ordinators are non-clinical staff who help to Co-ordinate and navigate care across the health and care system. They are vital members of the core team, providing support to reduce the fragmentation between health and social care. A key part of the role is forming relationships with patients, carers and families to help improve the continuity of care by acting as a connector between health and care teams. They are often the main link in the MDT to social care services, local authority services, and voluntary organisations. They can provide skilled administrative support for the core team by reviewing day to day referrals and hospital discharges and flagging up patients suitable for the proactive care service. In some teams, the Care Co-ordinators help to identify cases by reviewing lists of people identified via data reports and phoning patients at home to assess their degree of frailty. They can also help to promote the proactive care service to external organisations.

Figure 1: Proactive care team



GPs

GPs are crucial members of the core proactive care service team, contributing medical knowledge and acting as a link between general practice and other services. Some GPs are employed by community services and acute trusts to work in proactive care, while others are employed directly by PCNs/PCCs or equivalents and general practices. In some smaller proactive care services, GPs are given dedicated protected time within their existing role to work for the proactive care service. Funding is often a barrier for GPs wishing to work in proactive care.

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 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

Administrative services

Administrative support can release clinical time and is often overlooked. Larger services require in-house administrative support while smaller services may need to rely on administrative support from the community services, PCNs/PCCs and GP practices where they work.

Agree the infrastructure required for the proactive care service

Employment

The core team can be employed by a community or acute trust, a PCN/PCC or equivalent, a general practice or a combination of any of these. As long as the service can function as one team, the employing organisation is not important. Where line management arrangements are outside the core team, it is important that the line manager has an understanding of frailty and the aims of the proactive care team.

Core team location

It is important that all core team members have a shared base where they can meet up on a daily basis. It is helpful if the core team is co-located with the community teams, allowing collective responsibility, open conversations, reflection and debriefing. It also makes it easier for MDT members, such as geriatricians, who may only be available once a week to be part of the team. However, although helpful, co-location with community services is not essential. Some PCN/PCCs and practice led services are co-located in GP surgeries allowing close communication with other practice based multidisciplinary team members.

Service hours and cover

Proactive care services usually operate standard working hours as they do not generally deliver an urgent response. Some services offer an urgent response during working hours for people known to them who have fallen or need urgent support at home, but this is not usual practice. Smaller proactive services often do not have arrangements for cross cover for holidays or sick leave and work is left for the clinician to pick up when they come back to work. Services with larger core teams have enough staff to cross cover so can provide a full service within their standard operating hours. It is important to consider how the work will be covered when staff members are on leave or sick.

Supervision and mentoring

Access to supervision and mentoring for core team members is advisable and should be set up at the start of the service.

Recruit the core team

Before starting the recruitment process, consider not just the experience and skills of the person but also their key principles. Ensure that the job descriptions and advertisements are adapted accordingly.

This may include the following key principles:

- Share the core values of what you want to deliver
- Are team players who are committed to the purpose of the whole team, not just their own function
- Are diverse (this will bring greater breadth to the team)
- Keen to develop professionally
- Can work autonomously

Create a local induction and training package for new workers joining the team, which includes becoming familiar with:

- The values and goals of the proactive care service
- Each other (can include team building exercises)
- The venue and the area they will be working in
- The multi-professional team they will be working with
- Skills required and specific areas of training such as coaching, leading MDTs, compassionate leadership, and IT skills
- It may also involve shadowing a neighbouring proactive care team, if available.

Set up regular MDT meetings at practice or PCN/PCC or equivalent level

Regular multidisciplinary meetings are key to ensuring that the necessary multidisciplinary interventions are delivered. They provide dedicated time to review patients as a team, have case discussions, establish clear and simple referral pathways, and help members to get to know each other. MDT meetings can be face-to-face or virtual or a combination of both. Virtual meetings help some members to attend but may impede team building, informal information sharing and learning. A stable team with regular attendance by the same people helps to establish and maintain effective team working.

MDT meetings should be set up for each PCN/PCC, and at practice level as well if preferred. As well as the core team, MDT meetings should include a community matron, community nurse, a social worker, a mental health professional, a PCN/practice pharmacist and a geriatrician (if available) as a minimum. Other services attending MDT meetings can include intermediate care and community rehabilitation teams.

Promote the service

Proactive care is a new concept for many health and care professionals, requiring a change in culture and heavy promotion. For bigger services, a system-wide promotion exercise may be needed, aimed at health and care professionals, the local authority, voluntary organisations and the wider public. For smaller services, promotion to local referrers may be sufficient. It can take time to build up referrals so if the service is struggling to get numbers, keep the referral process simple, do not reject referrals, and spread the word.

Launch the service

Launch the proactive care service when the induction is fully complete, not before. Consider a mini proactive care service, such as in one general practice, for the first eight weeks while ensuring that everything is in place. This will allow time to refine any processes and make sure that the core team is confident in their roles. If everything is going well, roll out the function earlier than eight weeks. Provide regular supervision for all team members and keep an eye on how the service is developing so that any issues can be managed promptly.

Core component five: Continuity of care

Provide a clear plan for continuity of care, including an agreed schedule of follow-ups

A holistic assessment or CGA and personalised care plan is of no value if the plan is not implemented. Follow-up is required to ensure that suggested interventions have been put in place. This may include ensuring that a referral to social care has been received and a social care package organised if needed, the medication has been changed, the home adaptations have been put in place, and the patient has been able to attend the strength and balance training. Part of the core team's function is to liaise with other services and follow up to ensure that multidisciplinary interventions have taken place and review how the patient condition has changed over time. It is important to recognise that frailty is not a static condition and follow up is essential in ensuring that interventions are working.

Involve and support family members and caregivers in the care process if appropriate. Provide education on frailty management, coping strategies, and resources available. Engaging family and caregivers helps to ensure that the patient's needs are met and can improve overall care outcomes.

Enabler one: Flexible workforce

Ensure the service is sufficiently resourced

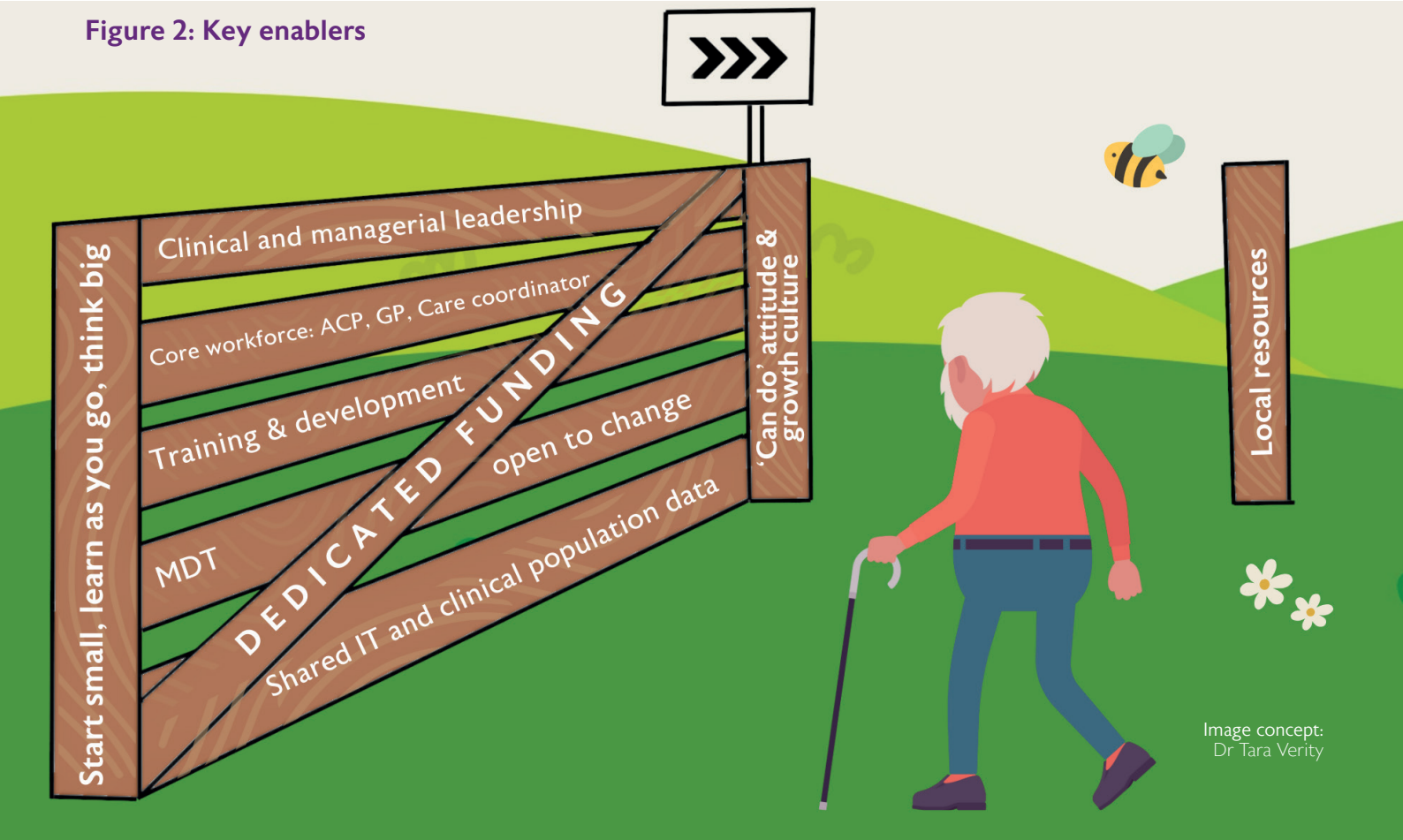
A flexible multidisciplinary workforce, working across organisational boundaries is central to the delivery of proactive care. The service needs to be sufficiently staffed, with a minimum core proactive care team consisting of one GP, one ACP, and one Care Co-ordinator. As outlined, this can expand to professionals from mental health services, pharmacy, social care, therapy and geriatric medicine if the resource is available.

Ensure training and development needs are met

The proactive care team will need to be supported through training opportunities to ensure that they have the necessary skills to care for older people with frailty, and to work across organisational boundaries. Meeting the training and development needs of the core team will not only enhance the skills of the team, but support recruitment and retention. All MDT members require an understanding of frailty and knowledge of frailty syndromes such as falls, immobility, delirium, incontinence and side effects of medication. The NHS document *The Frailty Framework of Core Capabilities* outlines the core capabilities for health and care staff working with older people with frailty.[30] Training resources include the BGS's frailty elearning course which covers the identification of frailty and interventions to improve outcomes for those with frailty.[31] Communication skills training is also important for all MDT members to work across organisational boundaries. Other useful training areas for ACPs in particular include:

- Advanced communication skills
- Advance care planning and completion of Treatment Escalation Plans and ReSPECT forms
- Common mental health problems and use of screening tools for anxiety and depression
- Diagnosis and management of dementia and delirium

Figure 2: Key enablers



For GPs, the recently published RCGP GPwER in frailty framework offers a benchmark and recommendations for professional development and progression within this role.[32] It covers how and where care is delivered, services that interface the role, and to how to develop and maintain the role. Access to a geriatrician and psychiatrist for older adults for clinical advice is valuable to enhance skills in medical management of older people but not essential.

Multidisciplinary team working and mentorship with a doctor helps non-medical team members to enhance their medical knowledge and aids understanding of diagnosis and prognosis which are key factors in management of older people with frailty. Access to a community geriatrician and a social worker can help the team work through complex situations.

Develop a shared proactive care workforce plan at service level

To ensure the proactive care team is supported with the appropriate staff resource, training opportunities, and ways of working, new services should create a shared workforce plan between partner organisations outlining how the service will work. This should outline members of the proactive care team, methods of cross-organisational working, and training requirements.

Enabler two: Shared care record

Ensure the proactive care team has access to shared care records

Information sharing is vital for proactive care services as it requires multidisciplinary interventions across a range of health and care organisations. If possible, ensure that core team members have access to all electronic patient records, including general practice, community services, hospitals and social care. If this is not possible, ensure that they have access to all the shared records available in the area.

Enabler three: Clear accountability and shared decision making

Establish clarity on the aim of the service and develop shared values

Spend time during the development of the proactive care service with local leaders to agree the aim of the service and develop shared values. Common aims of proactive services for older people with frailty include:

- Improve care for people with frailty
- Bring together a team to deliver effective services for older people with frailty
- Improve communication between the organisations looking after the patients
- Reduce fragmented care and duplication
- Reduce higher cost work which is unable to fully meet the need of the person
- Improve job satisfaction of those providing care

For older people with frailty, providing the holistic care they require within the community can be challenging. Holistic care often consists of many overlapping services such as physical health, mental health, psychological services and social services as well as community and voluntary care services. Multidisciplinary community team working enables the right person to look after the patient at the right time and place. Therefore, it is important that the teams share the same values of delivering patient centred care around what matters most to people and working together to provide the best quality care for patients. Time spent on discussing the aim of the service and how leaders will work together helps to ensure the service runs as smoothly as possible and will minimise conflict in the future.

Agree a process for data collection and evaluation

Data collection and outcome measures should be agreed when developing the service. It is possible to measure the reduction in hospital admissions and the length of stay, but it can take years for proactive care to have an impact. Consider using patient reported outcomes or functional measures, such as Activities of Daily Living (ADLs). It can be difficult to measure patient reported outcomes in proactive care as the person may not recognise the intervention as proactive care, especially when it is being delivered as part of the MDT. Patient experience measures, such as asking "do you feel better, the same or worse?" are a simple measure of a service which can demonstrate patient perceived value. As outcome measures for proactive care are difficult to implement, process measures may provide another approach to demonstrate the value of an intervention. There is evidence that elements of proactive care work, so potential proxy measures may include the number of MDT meetings, CGAs completed, medication reviews undertaken, referrals to strength and balance classes, and advance care plans completed.

Set realistic expectations

It is important to set realistic expectations when developing the service. It can take time to set up a service and tailor it to the skill set of the team, especially as it requires healthcare professionals to work in a new way across the MDT. People will need time to develop into these roles and there will need to be Co-ordinated efforts to make this work. It will also take time for referrals to build up, and for patients, carers, and referrers to understand the service. If the ambition is to set up a large service, flexibility and tailoring to the local area is vital. Building relationships with the wider MDT may also take time and will

The North West Surrey Locality Hubs Service

The North West Surrey Locality Hubs Service is an integrated community-based service for older people with frailty, covering physical and mental health, and assessing care needs. Patients can be referred to the service if they are registered with a North West Surrey GP practice, are over the age of 65, and have a Clinical Frailty Scale of 4-8. There are three hubs based in community hospitals, and patients can be transported by free community transport. The hubs are staffed by GPs, matrons, hub coordinators, pharmacists, mental health practitioners, and social workers. The service carries out a multi-disciplinary proactive assessment to identify patient needs, provides advice and treatment, signposts to suitable services, and enables appropriate interventions to be put in place before patients reach a crisis point. Once patients have been seen they stay on the hub's caseload for life and hub coordinators stay in contact with those with complex needs. Find out more here: www.bgs.org.uk/proactivecasestudies

depend on the history of the service. For example, where there is not an existing MDT in place or local relationships are poor, the process will be even slower.

Allow the service to develop over time using Quality Improvement methodology

The proactive care team can grow over time according to local need but should stay true to its original values. Use data collected to review the service and improve its offer, using the plan-do-study-act (PDSA) cycle or other quality improvement methods. Gather feedback from all members of the MDT, referrers, patients, carers, and adjust the service based on the feedback. Remember to share your experiences with other proactive care services and those wishing to set up their own services.

Develop relationships and governance structures with local services

When developing proactive care services, time should be spent investigating all the services in the area for older people with frailty, including hospital services, community services, primary care, social care, local authority services and voluntary organisations. It is important that connections are made between organisations at the start of the service. This may take time, particularly if there is no well-established multidisciplinary team in place locally. Of particular importance is building strong links with broader community-based services, such as community falls services, urgent community response services, Hospital at Home, community nursing teams and community hospitals. Ensure that clear referral pathways are developed, alongside open routes of communication. Encourage team members to get to know people in other services, so they can phone other health and care professionals rather than making a referral, which enables learning and knowledge exchange. Working closely with other organisations involves learning a new way of working, which reduces duplication and fragmentation. To ensure effective cross organisational working, leadership and system agreements should be put in place across partner organisations to ensure alignment of service delivery.

Chapter three: Recommendations for delivering proactive care

In this chapter, the BGS sets out eight key recommendations which are crucial to the success of proactive care services across community and primary care settings in the UK. These recommendations require action from a range of commissioners, policymakers, providers and healthcare professionals at national, regional, and local levels and should be the building blocks for all involved in proactive care to aim and advocate for.

There are a wide range of approaches to the delivery of proactive frailty care, tailored to location, population size, funding opportunities, workforce, deprivation and the infrastructure available. Examples include MDTs employed by community and acute trusts, PCN level services led by a single ACP, to practice level services using protected time for existing staff. In some locations, services are predominantly led by community teams incorporating primary care whilst others are solely led by primary care teams. Despite differences, the delivery of proactive care will require working across teams and settings to reduce duplication, facilitate shared learning, and improve the quality of referrals. Whilst it is important that proactive care teams must develop according to their local population, the following key recommendations should be applied across all services.

1. Proactive care services should be aligned to the approximate geography of a Primary Care Network (PCN)/ Primary Care Cluster (PCC) or equivalent, with a dedicated proactive care team in each equivalent area across the UK.

In England, GP practices have joined together to form PCNs based around populations of 30,000 – 50,000 patients. Integrated Neighbourhood Teams (INTs) are starting to develop around PCNs, with the aim of shared ownership for improving the health and wellbeing of the PCN population. Teams from across PCNs, wider community services providers,

secondary care teams, social care teams, and voluntary care organisations will work together to share resources and information, and form MDTs dedicated to improving the health and wellbeing of a local community and tackling health inequalities.[6]

In Scotland, GP Clusters are typically groups of between five to eight GP practices in a close geographical location. Their purpose is to encourage GPs to participate in quality improvement practices, and to contribute to the oversight and development of local practices.[33] Health and Social Care Partnerships, (HSCPs) deliver integrated services provided by Health Boards and Councils in Scotland, of which proactive frailty care would be one such service. Each partnership is jointly run by the NHS and local authority, with a total of 31 HSCPs across Scotland based upon geographical and population factors.[34]

In Wales, there are 64 Primary Care Clusters (PCCs), which bring together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. These PCCs are instrumental in commissioning community-based services.[35]

In Northern Ireland, there are 17 GP Federations with the aim to support practices and to deliver the transformation agenda. They work across a wide number of local health and social care agencies to implement innovative strategies to benefit the local population.[36] The federations align geographically with Integrated Care Partnerships (ICPs) that serve approximately 25–30 practices covering 100,000 population. ICPs are groups of health and social care providers that work together to improve the health and wellbeing of their population focussing on improving services for people with long term conditions and older people with frailty.[37]

The size of a proactive care service should align approximately with the local infrastructure as described in the four nations. A vital component of this infrastructure should be the utilisation of the MDT to provide proactive, personalised care to older people with complex needs, as highlighted in the Fuller Stocktake.[6] This requires a shift from a psychosocial model of care to a more holistic population-based approach that supports the health and wellbeing of the whole community. Teams need to be co-located around the needs of the local population, with a mix of primary and secondary care expertise to wrap around older individuals at risk of frailty, as outlined in the BGS Blueprint.[1]

Targeting proactive care services at older people with frailty will likely be a priority for many PCNs/PCCs or equivalents, especially as the UK's population continues to age. This is particularly important for rural and coastal areas where the growth in the older population is expected to accelerate at a faster rate.[7] The majority of healthcare that older people receive is in primary and community settings and many of the teams in community services, local authority services and voluntary organisations work with older people more than any other group. Therefore, services will already have the building blocks for an MDT to provide proactive care for older people. A dedicated core proactive care team for each PCN/ PCC or equivalent will create strong links between general practice, and the wider MDT, ensuring that the proactive care service is implemented and integrated across the PCN/cluster.

Proactive Care in Frimley Integrated Care System

In the Frimley ICS, shared care records identify patients with moderate frailty plus ten long term conditions, and patients who have moderate to severe frailty plus no interaction with a GP in the last six months. Local areas can layer criteria on top of this based on population needs, such as level of deprivation. Frailty navigators telephone the patients and arrange to visit them at their home to undertake the more basic parts of a CGA. Next, the patient is discussed at an MDT meeting, and a suggested list of interventions are taken back to the patient and actioned by different members of the team. Find out more here: www.bgs.org.uk/proactivecasestudies

2. Policy makers and commissioners should prioritise national funding and contractual arrangements to ensure that proactive care is available to all older people living with frailty in the community.

Across all four nations, there is a lack of funding for proactive care services with reactive services, such as Urgent Community Response, Hospital at Home and Same Day Emergency Care being prioritised. Currently, there is no national policy on preventing and reversing frailty, and therefore, proactive care services vary greatly across the UK. This has resulted in huge variations in funding opportunities, with some areas receiving funding through ICBs, PCNs, and Additional Roles Reimbursement Scheme (ARRS) funding whilst others using their core budget to fund protected time for existing staff to deliver proactive care services. In areas where no dedicated funding is available, it is often impossible to set up proactive care services. Recurrent national funding and guidance is vital to ensure that consistent and reliable proactive care services are available to all older people who need it.

Proactive care is reliant on cross-organisational working. Contractual requirements on all stakeholders across acute, community, primary, and social care settings to prioritise proactive care in the community would help ensure organisations are incentivised to work together to deliver proactive care and remove referral barriers.

3. Leadership is vital to the delivery of successful proactive care services, and it should be supported and nurtured through training opportunities and protected funding.

Setting up proactive care services requires strong compassionate clinical leadership. BGS members inform us that proactive care services are often set up due to the enthusiasm of individual healthcare professionals and clinical leaders. For example, individual healthcare professionals who have persuaded ICBs and Health Boards that proactive care is worth investing in; Community Geriatricians who have worked with colleagues to create a proactive care service using existing resources; and PCN Clinical Directors and practice GPs who have encouraged colleagues to commit time and resources into setting up proactive care services. This often involves clinical leaders taking on additional unpaid work to set up and develop the service. Small services may depend on one individual to establish the service, create the processes, and develop the links across the system. This is a leadership challenge, requiring individuals with significant leadership skills and commitment. Clinical leaders should be identified,

supported, and nurtured with protected funded time to carry out their leadership role. Training and development opportunities are also vital, such as structured leadership training through national or regional bodies and informal mentoring with other clinical leaders.

Alongside leadership, an effective operation manager who understands the aims of proactive care is needed to support and steer service improvements. They also have a role in supporting team members to change and in negotiating new ways of working with external teams and organisations. Key qualities of operational managers include experience with service development and negotiating skills.

Working in proactive care can be challenging, requiring flexibility and resilience. Clinical leaders and operational managers have a role to play in easing challenges through setting a good workforce culture, keeping morale up, and providing training opportunities.

Keeping Well approach, Caddington Surgery General Practice

Caddington Surgery takes a person-centred approach to care for older people with moderate to severe frailty. Patients with frailty are identified through quarterly searches on the practice's electronic record searching for eFI scores; information from letters; and "soft intelligence red flags" from the wider team, including receptionists and pharmacists. Patients are supported through an initial 'fact finding' conversation with a Care Co-ordinator; a keeping well ACP or GP assessment; and ongoing follow up via a recall system. The approach involves the whole team, including nurse practitioners, GPs, receptionists, pharmacists, social prescribers, and care co-ordinators. Find out more at: www.bgs.org.uk/proactivecasestudies

4. Outcomes measures are vital in evaluating the success of proactive care interventions and should always be implemented when new services are launched. National guidance on how to measure the impact of proactive care interventions should be published, and investment is needed in clinical research and IT infrastructure focussed on data collection and evaluation.

It is vital that proactive care services measure the value of the service to ensure that the service meets the needs of the population and improvements are made. Decisions on how to measure outcomes should be made before the service is rolled out. It is difficult to measure the impact of proactive care, with commonly used measures, such as hospital admissions and early hospital discharge, less effective as this is not the primary outcome of proactive care. The primary aim is to maintain independence in older individuals, which is difficult to measure in the short term and often requires long-term data over three to five years. Additionally, suitable data, such as use of paid carers and care home admissions are not routinely collected. Options include patient reported outcomes, patient experience measures, and process measures. National guidance on how to measure the impact of proactive care would be beneficial, alongside clinical research evaluating the clinical utility of different approaches.

Data collected should be reflective of the complex nature of CGA styled interventions and should involve patient centred outcomes and patient voices. Data collection and analysis is time consuming and should be supported by the broader health ecosystems to provide evidence of systems working in localities. Demonstration of effectiveness in a robust manner is difficult for complex interventions, but important for commissioners and funders.

5. Proactive care services should be staffed by a core multidisciplinary team, consisting of at least one GP with an interest in frailty, one ACP, and one Care Co-ordinator. A gold standard team would include professionals from social care, mental health services, therapies, pharmacy and geriatric medicine.

Proactive care in community and primary care settings requires a core team who work together to deliver what the patient needs rather than working to tightly defined pathways. At a minimum, the core team should include a GP with an interest in frailty, an ACP, and a Care Co-ordinator. A gold standard core team would also include professionals from social care, mental health, therapies, pharmacy, and geriatric medicine.

Highly trained professionals, such as nurses, AHPs, therapists, and paramedics, are essential when managing complex caseloads but are in limited supply. Training and development of senior healthcare professionals to case manage complex cases should be a priority for the NHS workforce plan.

Many GPs are interested in working in proactive care for people living with frailty, but funding is often not available to enable this. In England until recently, GPs have been excluded from the ARRS funding used to employ staff across PCNs. A recent welcome change to this policy means GPs can now be employed under ARRS across PCNs, but only if they are less than two years post GP qualification. Currently still excluded are the significant numbers of experienced GPs (many

active members of the BGS) who have been developing skills and interest in frailty. This is potentially a waste of an existing workforce resource. If the ARRS policy was extended to allow employment of any GP to proactive frailty roles across PCNs the impacts of this welcome change could be much greater for preventative frailty work.

Community Geriatricians would be valuable resource for proactive care services, however, there are currently not enough to meet the needs of the ageing population.[38] There is significant variation across the UK in the number of geriatricians available to care for older people. The BGS is calling for a UK-wide target of one consultant geriatrician per 500 people aged 85 and over. This would help to ensure that community geriatricians could play a key part in proactive care for older people across the UK.

When working well, proactive care services have the potential to aid recruitment and retention as it allows staff to manage patients better which increases job satisfaction.

6. Local and national investment in training and development opportunities for the multidisciplinary team working in proactive care is needed, including mandatory frailty training, training in communication, leadership, and coaching, and education on the wider health and care system.

Proactive care team members need not only knowledge and understanding of frailty and complex care but the confidence, emotional intelligence and flexibility to build relationships with people within their teams and in other organisations and to work across organisational boundaries. National bodies and professional organisations should ensure that fully funded training and development opportunities are available for people working in proactive care. This should cover not only knowledge of frailty and frailty syndromes but understanding of the wider health and care system, advanced communication skills, and training in leadership and coaching skills.

It can be quite challenging to change longstanding ways of working and work in an integrated team with people from very different backgrounds. Team building opportunities and joint training should be provided for newly created multidisciplinary teams to help them develop as a team. Networking events across regions are a good way to share new ideas and provide mutual support.

7. A culture of flexible and cross organisational working should be embedded in proactive care services, which requires good working relationships across services. A shared proactive care workforce plan across the partner organisations in each PCN/PCC or equivalent should be developed.

Successful proactive care services rely on a united team that has a shared vision of person-centred care and permission to work outside of organisational boundaries. This is facilitated by trust and good working relationships within the MDT. At the heart of proactive care services is empowering people, both patients and staff, to deliver what is right for the patient. Healthcare professionals need to be equipped with the skills, agency, and flexibility, to work as a team to support each other in a new way of working. It is vital that time is spent while developing the service for the team to make links with external agencies to develop relationships and build trust. This will create a wider MDT who work together to avoid duplication, improve quality of referrals and ensure smooth coordination of care.
It can take a long time to develop the skills and confidence to work in a different way. It requires a strong team, good clinical leadership, a supportive team manager and a consistent service. It is important to set realistic expectations during the early stages of the service to allow the team to develop into their roles.

To ensure the proactive care team is supported with the appropriate staff resource, training opportunities, and ways of working, new services should create a shared workforce plan between partner organisations outlining how the service will work.

8. Services across the UK should use BGS's *Be proactive: Evidence supporting proactive care for older people with frailty* to make the case for proactive care services in their local area, and use *Be proactive: Delivering proactive care for older people with frailty* as a roadmap for implementing services.

NHS England's *Proactive Care: Providing Care and Support for People Living at Home with Moderate or Severe Frailty* emphasises the need for systematic identification and assessment of individuals with frailty, enabling early intervention tailored to their specific needs.[2] It outlines five core components and three key enablers as a framework for delivering proactive care. BGS's *Be Proactive: Delivering Proactive Care for Older People with Frailty* expands on this framework, providing a roadmap for the delivery of proactive care. It acts as a guide for services in personalising care plans, fostering effective communication and coordination among multidisciplinary teams, and empowering patients to take an active role in managing their health. By focusing on continuous monitoring and adapting care plans to reflect changes in patients' conditions, organisations can not only improve health outcomes but also promote a more sustainable healthcare model that anticipates and responds to the evolving needs of older individuals living with frailty. It complements BGS's *Be proactive: Evidence supporting proactive care for older people with frailty*, which outlines the evidence base supporting proactive care.[3] Healthcare professionals and clinical leaders will be able to use the evidence document as a business case for delivering proactive care and use the delivery document as a roadmap for implementing services. Together, the evidence and delivery documents create a robust framework for delivering effective, person-centred care in the community.

Chapter four: Conclusion

With population ageing and older people living for longer periods with frailty, there is an increasing need for proactive care interventions to target older people with moderate and severe frailty to ensure they live well and stay independent for as long as possible. Proactive care aims to be a cost saving approach which incorporates tailored and targeted interventions to ensure that the onset of poor health is delayed, individuals maintain independence, avoidable period of ill health are reduced, and older people enjoy healthier lives in the way the matters most to them. This prevents avoidable hospital admissions or readmissions, reduces length of stay in hospitals, and reduces the need for social care. It should be embedded across all community and primary care settings, and co-ordinated funding and contracting is needed to ensure this becomes a reality.

Appendix 1: Examples of existing proactive care services

The BGS has collected a list of case studies from our members across the UK, illustrating existing examples of proactive care services in primary and community settings. The full list of case studies can be found on the BGS website at: **www.bgs.org.uk/proactivecasestudies**. The table below is intended to be guide for users to navigate to sample case studies of interest, depending on setting, pathway, and the type of advice sought. Please refer to the webpage for full details, including a longer list of case studies.

Setting	Name	Pathway	Does the case study include the voice of patients and staff?	What were the main lessons learnt?	What does the case study illustrate?
One Primary Care Network	Sport for confidence	Led by one Occupational Therapist (OT) funded through Additional Roles Reimbursement Scheme. The OT leads on proactive frailty assessments and interventions.	The case study includes patient stories.	• Patients were new to the idea that OTs can have an impact on patient function.	• How to Identify and support leaders • How to decide on how to measure outcomes • How to agree on process evaluation • How to develop relationships with local services
Single GP practice	Caddington Surgery	Team wide recognition of people with frailty needing assessment and management of long-term conditions. The service uses ARRS-funded roles.	The case study includes patient stories and quotes from staff.	• Ringfenced time enables proactive care to work. • Treating frailty like a long-term condition with recall is easier for GPs to manage.	• How to agree processes for assessment • How to implement continuity with regular recall • How to develop relationships with local services
Two Primary Care Networks	North Devon Anticipatory Care	MDT based proactive frailty assessment and intervention. It was a GP initiated community services collaboration which spread to a second PCN.	The case study includes quotes from patients and staff.	• Keep case identification simple. • Structure the MDT to be time efficient and a learning place. • Keep "what matters most" to older person at the heart of proactive care plans.	• How to enable a workforce with mindset and skills to deliver proactive care • How to decide how to measure outcomes at start of service • How to allow the development of the service using feedback.
Primary Care Network and Community NHS Foundation Trust collaboration	Moreton and Meols PCN and Wirral Community NHS Foundation Trust	Shared PCN and community trust core team assess and follow up with patients with frailty identified through referrals and data searches.	The case study includes quotes from patients and staff.	• Pooling staff resource from the community trust and the PCN to look after patients with complex needs reduces rather than increases staff workload. • Proactive care improves staff experience. • The service enables the team to work better together. • The service removes referral barriers and enables sharing of records. • Case identification by referral augmented by monthly data searches fills the team's capacity. • Patient tracker tools enable follow up. • Feedback to GP surgeries demonstrates value.	• That proactive care services should be aligned to the approximate geography of a PCN /cluster. • Trust and relationships are at the core of proactive care. • How to agree core team membership and infrastructure. • How to access information sharing. • How to agree process and plan for continuity and follow ups.

Continues on following page

Appendix 1: (continued)

Setting	Name	Pathway	Does the case study include the voice of patients and staff?	What were the main lessons learnt?	What does the case study illustrate?
One Primary Care Network	Hatters Health	Clinical Director initiated community trust collaboration operating across one PCN. Patients are identified through birthday card over 75 checks, proactive housebound frailty checks. It involves collaborative dementia support.	The case study includes quotes from patients and staff.	• Equip healthcare professionals to use the holistic 5M 5Q assessment tool. This helps people to understand frailty in the wider psychosocial context and identify 'whole person needs' • Documentation using the 5 Ms tool helps to share a simple summary of patient needs and proactive care planning decisions with other professionals. Share this by enhancing the summary care record.	• How to agree processes for assessment • How to train and develop staff • How to upskill care co coordinators • How to develop a relationship with local services and resources
GP led collaboration with community services and acute trust	Islington PAWS	System wide (acute, community, primary care) involving CFS screening for moderate frailty for proactive care.	The case study includes a case story and quotes from staff.	• Offer earlier interventions for patients. • Collaboration is rewarding for staff, and it reduces duplication.	• How to get clarity on the aim of service and develop shared values • How to promote proactive care and engage senior leader support • How to share IT • How to identify a cohort
One Primary Care Network	The PACT service, WISHH and 5 Lane Ends PCN	Initiated by a community partnership (prior to PCN formation), which continued when PCN formed using ARRS funded roles. Individuals are identified through GP referrals and data. Home assessments are completed by upskilled care coordinators, followed by MDT review.		• Spread ideas to other PCNs locally. • Work on evaluation and QI.	• How to interact with the wider MDT. • Importance of training and development. • Allowing the service to develop over time using QI
Acute trust and single Primary Care Network collaboration	Keeping Well Dunstable Hub	The initiative is based in a newly built hub led by geriatricians. Care coordinators identify GP patients likely to benefit form holistic assessment and intervention.	The case study includes staff and patients quotes.	• The personalised patient care plans can include access number to virtual ward. • Strength and balance classes running alongside the clinic allow group learning for home exercises.	• How to promote proactive care and engage senior leader support. • How to facilitate information sharing. • How to develop relationships with local services.

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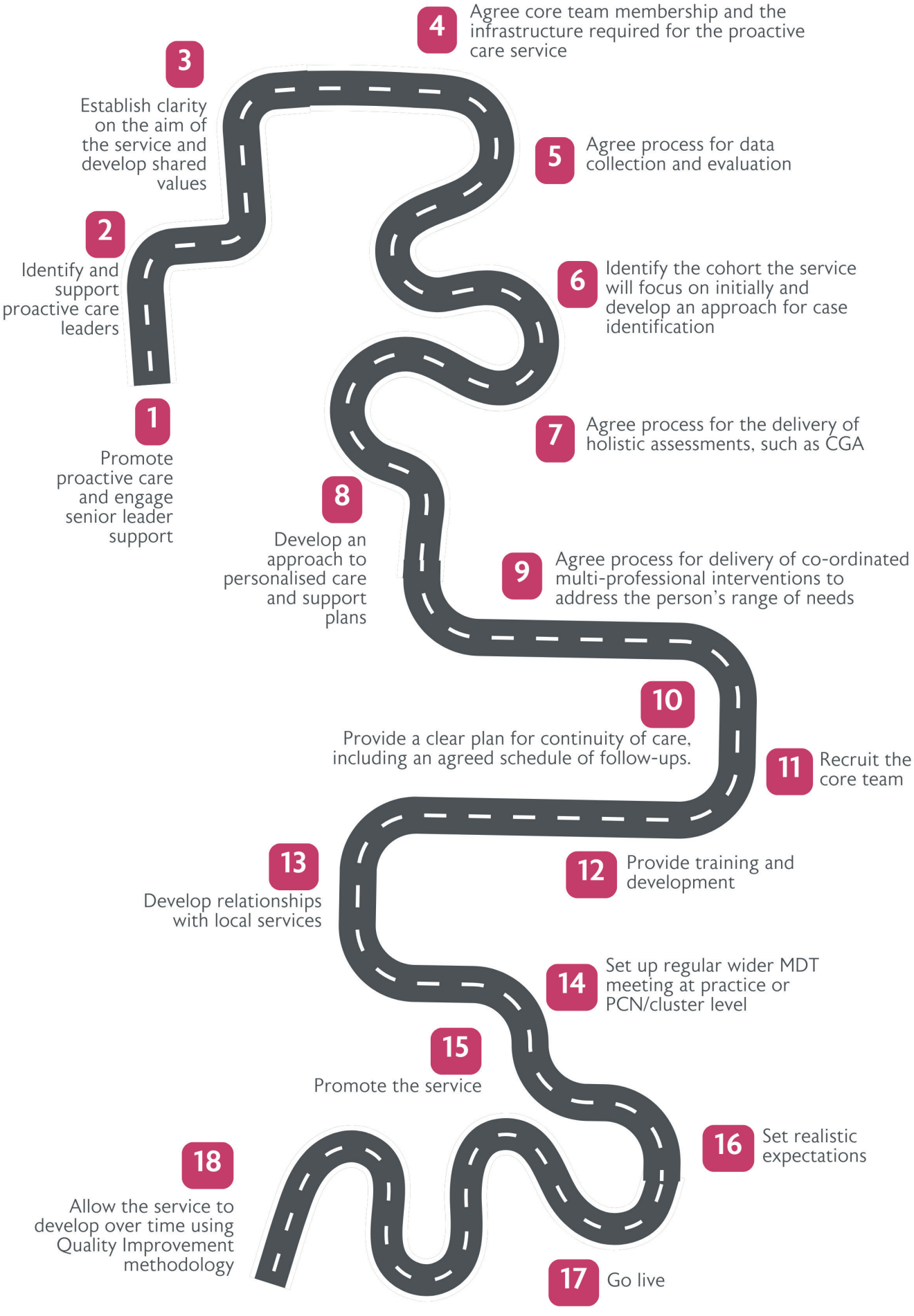
Appendix 1: (continued)

Setting	Name	Pathway	Does the case study include the voice of patients and staff?	What were the main lessons learnt?	What does the case study illustrate?
Three Complex Care Teams (CCTs) aligning with three Primary Care Networks	South Somerset Complex Care Team	CCTs consists of a GP, senior nurse, and band 4 support key worker aligning to a PCN. They provide comprehensive assessments of complex patients, coordination and information sharing with GPs, community teams, and secondary care hospital team.		• CCTs are committed to breaking down barriers to care, always instilling a mentality of 'what can we do to help?', while always remembering that 'There is a patient (family/carer) at the centre of every decision'. • Spread skills for frailty and complex care for the future by offering training placements for Advanced Care Practitioners and Foundation Year 2 doctors	• How to instil a workforce with the mindset and skills for delivering proactive care. • Importance of training and development. • Trust and relationships are at the core of proactive care. • Regular wider MDT meeting is important. • How to promote the service.
Three integrated hubs (each aligned with three PCNs)	The North West Surrey Locality hub service	Integrated MDT in three hubs receives referrals from any local health or social care professional within North West Surrey. Patients have to have a clinical frailty score of 4-8 and aged over 65. The hubs provide assessment, signposting, carer support, and follow up.	The case study includes quotes from patients and carers	• Over time, experiencing the benefits of a proactive frailty service and collaborative working changes siloed cultures and mindsets.	• How to promote proactive care and establish senior leader support. • How to establish a core team • How to access information sharing • How to develop relationships with local services
Two Primary Care Networks	Frimley	Population health data is used to identify a cohort for frailty assessments by the MDT. Initially a geriatrician-initiated project in one PCN, which spread to two PCNs.	The case study includes quotes.	• Patients do not like the term "frailty" • Face to face assessment and "what matters most" discussions with patients vital before an MDT discussion.	• Importance of a workforce with mindset and skills for delivering proactive care. • How to establish clarity on the aim of the service and shared values • How to identify the cohort • How to access to information sharing • Importance of setting realistic expectations • How to start small and take stock local resources.
One integrated care centre covering 15 PCNs	Jean Bishop Centre	Patients are referred to the centre which provides a comprehensive assessment from the MDT.		• Patients report sustained improvement in emotional and physical wellbeing. • System benefits include reduction in unnecessary presentations to emergency departments, reduction in ambulance conveyances and saving GP clinic time.	• Leadership for proactive care should be supported and nurtured. • How a culture of proactive care can grow. • Community geriatrician leadership enabled MDT culture growth. • How to develop relationships with local services.
Four GP Practices in collaboration with a local charity	Lanarkshire	MDT approach identifying patients through eFI and team knowledge to offer a holistic needs assessment to produce a care plan.		• Interventions had an impact on social care and rehabilitation referrals. • Assessments by third sector partners were a positive experience for patients.	• How to develop relationship with local services. • How to develop a effective multidisciplinary working.

Appendix 2: Roadmap for setting up a proactive care service



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- **Dr Liz Lawn,** BGS Honorary Treasurer; and retired GP
- **Lucy Aldridge,** BGS Policy Co-ordinator

Acknowledgements

With our thanks to the following BGS members who took part in three advisory board meetings to inform the content of this report:

- **Dr Lucy Abbott,** Consultant Geriatrician and Chief of Service for Community Services and Older Peoples Medicine, Frimley Park Hospital; and NHS England South East Regional Clinical Advisor for Frailty
- **Dr David Attwood,** Associate Medical Director, Livewell Southwest; Chair of the Healthy Ageing Programme Board, NHS Devon; and GP with Special Interest in Older People, Pathfields Medical Group.
- **Dr Michael Azad,** Consultant Geriatrician, Nottingham University Hospitals NHS Trust.
- **Dr Eileen Burns,** Former BGS President; and Former NHS England National Specialty Advisor.
- **Anne Child,** Pharmacy and Dementia Specialist Lead, Dementia Care Mapper.
- **Emily Harrison,** Senior Specialist Pharmacist and Independent Prescriber in Elderly Care and Frailty, Dorset County Hospital NHS Foundation Trust.
- **Dr Adrian Hayter,** Medical Director, Royal College of General Practitioners; and GP, Runnymede Medical Practice.
- **Professor Anne Hendry,** Senior Associate, International Foundation for Integrated Care (IFIC); Honorary Professor, University of the West of Scotland; Honorary Physician, NHS Lanarkshire Research and Development Department.
- **Dr Rod Kersh,** Consultant Community Physician, Partner, Manor Field Surgery, Maltby; and Divisional Director Therapies, Dietetics and Community Care, Rotherham NHS Foundation Trust.
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- **Dr Jennifer Sutton,** Project Lead (Council for Allied Health Professions Research), Royal College of Occupational Therapists.
- **Dr Ana Talbot,** Consultant in Medicine for Older Adults, University Hospitals Monklands; and Honorary Senior Clinical Lecturer, University of Glasgow.

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Published November 2024

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