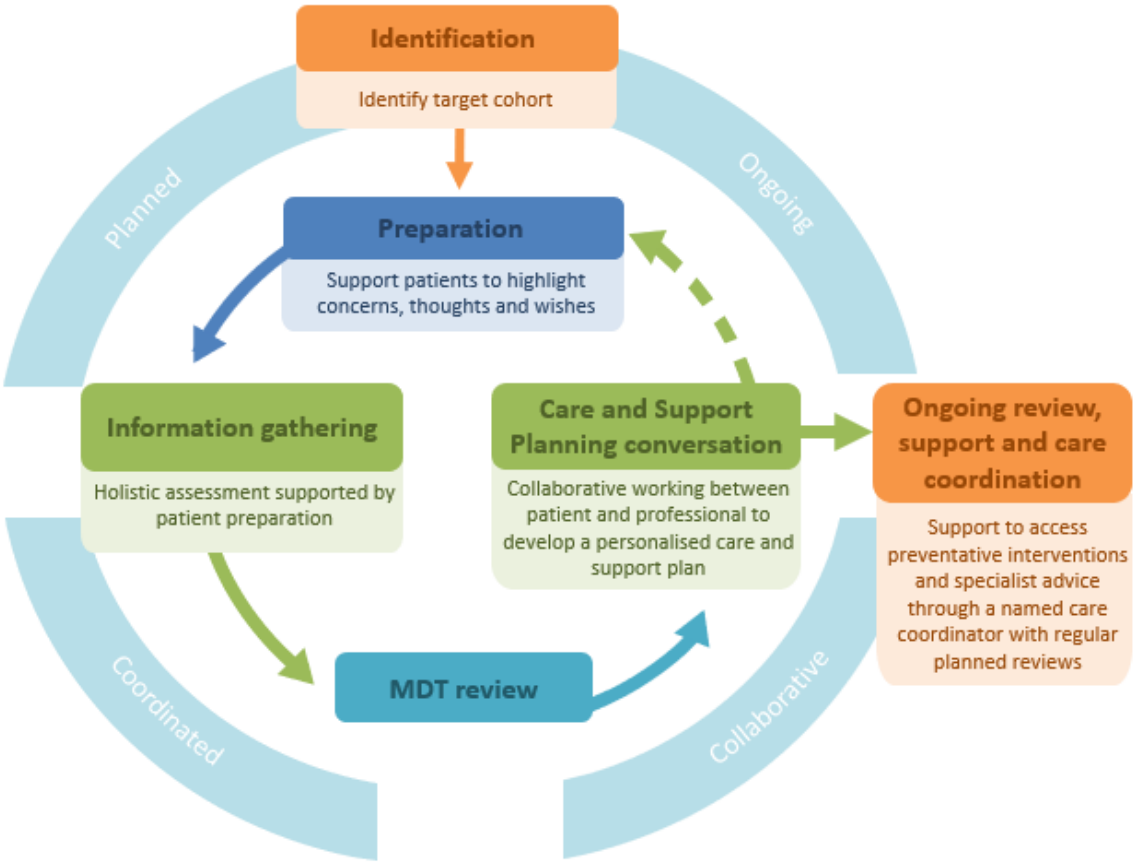
Resources to match the personalised care and support planning steps for those living with frailty

Background

People living with frailty are often unable to get to the surgery and may not be included in routine personalised care and support planning (PCSP). These resources have been prepared by Year of Care Partnerships to support PCSP for people with frailty in a community setting.

PCSP is an approach which retains the clinical benefits of frailty assessment whilst re-focussing the approach around the person.

Steps and stages of PCSP for people with frailty



Informing people about the service

People may not understand why they have been identified for proactive care. A phone call may be helpful to start to build relationships, support engagement and to help people to understand the offer; this can be followed up with written information about the service.

The following may be helpful:

- *'Finding the words'*
  Document that provides some guidance on how to phrase the offer over the phone with tips around language and structure

- *'Leaflet to introduce the team/service'*
  Introduces the team and purpose of the personalised proactive care service.

- *'An invitation letter'*
  Introduces the person to PCSP, explains the benefits and what will happen next.

Patient self-assessment

People living with frailty are often identified in practices by using a combination of electronic screening tools (for example, the electronic frailty index (eFi)). The resulting frailty score is then clinically validated.

Documents you may want to use are:

- *'Letter to accompany the self-assessment tool'*
  Asks the person to complete the self-assessment tool which is based on the clinical frailty score.

- *'Self-assessment tool'*
  A self-assessment tool based on the clinical frailty score. The person can use this to self-assess their own level of frailty which will need to be validated by clinical review. This could be posted to your identified cohort and the practice would need to consider how this information is returned to the practice (for example it could be returned by post or the patient could be telephoned and asked their score).

Preparation (patient prompts) for reflection ahead of the PCSP conversation

Frailty review appointments may previously have involved the health care professional assessing the elements included in the comprehensive geriatric assessment (CGA). These elements have been incorporated into the following tools which could be shared with the person before the consultation reducing the time spent completing assessment tools during conversations.

- *'Preparing for care planning – frailty'*
  This document is designed specifically for those living with frailty and includes a space for the patient to write what's important, alongside a noticeboard of topics that they might wish to raise.

- *'Things that are bothering me'*
  A reflective prompt that supports the person to identify issues and concerns which they want the professional to know about, it can form part of 'self-assessment' against the domains of comprehensive geriatric assessment.

- *'My medicines'*
  This is populated by the surgery with medications prescribed to the individual and this is sent out to the individual in advance of their PCSP. It helps the person reflect on their medications and highlights any concerns or issues with the medications or difficulties the person may be having accessing or taking them.

- *'Falls Prevention Leaflet'*
  This document enables the person to record and think about any falls they may have had in the last 12 months. This can be used to facilitate a more detailed discussion around falls prevention and management.

This information collected about the person's conditions, preferences and function may inform multi-disciplinary team meetings which in turn could ensure that the most appropriate professional can carry out the PCSP conversation.

'Comparison of items in Brief CGA and Year of Care document 'Things that are bothering me''
This comparison lays out the fields usually collected in the Brief CGA that are covered by the 'Things that are bothering me' document. It also shows the extra information collected by the 'Things that are bothering me' document.

My personal plan

- *'Care and support plan'*
  This document should be completed as a result of PCSP conversations with the person. A copy should be kept in the person's home and 'owned' by the person. It includes information that people want professionals to know about them, a personal plan and information for the person on what to do if things deteriorate or in an emergency.

- *'Example care and support plan (completed following care and support planning conversation)'*
  This document is an example of a completed care plan.