Implementing Proactive Care for People Living with Frailty

A Practice Resource

V1.0 May 2025

For support with implementation, workforce development and to access resources please contact Year of Care at enquiries@yearofcare.co.uk.

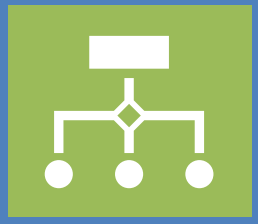
To find out more about Year of Care please see our website www.yearofcare.co.uk.

Implementing Proactive Care

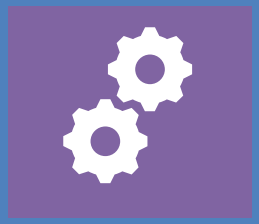
Toolkit main menu – use this to navigate to each section

Context
What is Proactive Care?

Measuring what matters
Monitoring and evaluation



Creating a Process for Delivering Proactive Care



Supplementary slides

Developing your Proactive Care Team

This resource has been developed to support teams and organisations in the design and delivery of proactive care. It is based on the *Year of Care* approach to **personalised care and support planning** and shares key learning, practical advice and tools from the successful implementation of a pilot proactive care programme within the North East and North Cumbria.

Thanks to Keswick & Solway and Carlisle Healthcare PCNs for their expertise and willingness to test this approach, and to North East North Cumbria ICB for funding and supporting the project. The full project report can be accessed **here.**

CONTEXT

What is Proactive Care?

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Guidance on Proactive Care

In 2023 the NHS published **Proactive Care: providing care and support for people living at home with moderate or severe frailty***.

It defined proactive care as ***personalised and co-ordinated multi-professional support and interventions for people living with complex needs.***

It identified 3 core aims of proactive care which are central to the content of this toolkit:

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

It also detailed 5 core components of proactive care:

- Identifying the **target cohort**
- Completing a **comprehensive holistic assessment** (information gathering)
- Holding a **personalised care and support planning conversation** and developing the plan
- Delivering care that is **coordinated** and **multiprofessional**
- Providing **continuity of care**

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

Why do we need Proactive care?

To improve outcomes for people	To help manage demand and improve systems
• Living with multiple long-term conditions is associated with reduced wellbeing, increased risk of functional decline and increased mortality[2]	• Those with long term conditions are more likely to develop frailty- two-thirds of over 65s will have multiple long-term conditions by 2035[5]
• People with multiple long-term conditions increasingly report less favourable experiences of care[3]	• Frailty affects up to half the population over 85 and costs £5.8 billion per year[6]
• People want focus on more personalised care, they want to be partners in decisions about their care and to be seen as a whole person[4]	• The number of people aged 80 or over is set to double from more than 3 to 6 million in the next 40 years[7]
• People value care that is coordinated with continuity of relationships, time to talk and be listened to, preventative services and access to community support closer to home[3]	• Those who are 65 or over are more likely to be admitted to hospital, making up 47% of all inpatients nationally[8]

Increasing waiting times, growing demand for emergency and unplanned care and workforce challenges all contribute to pressure in the system

Why do we need Proactive Care?
The person's perspective

Individuals living with complexity often report receiving care that is fragmented, task focused and not centred around the things that are most important to them. This can be demonstrated through the case of Eric.

- Age 84 and living with frailty
- Multiple long term conditions including diabetes and COPD
- Recurrent falls
- 5 admissions in 12 months
- Bewildered by multiple professionals and appointments
- Losing confidence and becoming isolated and lonely
- Often doesn't get the opportunity to talk about what's important to him

In the current system Eric has (over a 3-month period):

- **24** separate contacts
- **13** different assessments
- **20** different professionals
- Several **referrals** made to other services

IMPACT

- Task-based episodes of reactive care
- Lack of coordination
  - multiple professionals/teams involved
  - multiple assessments and treatment plans
- Potential gaps in care provision
- No one written plan to support Eric with day-to-day management of his health or this issues that matter to him

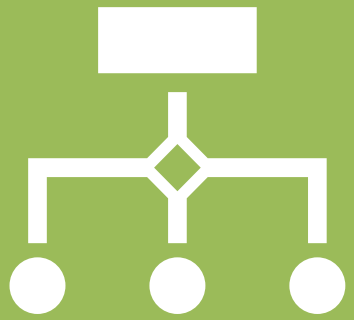
What does good proactive care look like?

Personalised proactive care should support people to manage their health conditions and live well for longer. This helps to improve patient experience and outcomes while reducing unnecessary medical activity in an already overstretched health and social care system.

The purpose of high-quality proactive care is to:

- **Notice people** who are living with complexity and who are at risk of using lots of unplanned care
- **Provide earlier support and access to preventative interventions**; offering the right care from a small team who know the person well
- **Ensure good clinical care**, based on what can really make a difference and focusing on what is most important to the person
- **Avoid duplication** and improve coordination of care
- Work with people to **understand their preferences and wishes** for the future and their care needs



AN INDIVIDUAL'S JOURNEY: CREATING A PROCESS FOR IMPLEMENTATION

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Example Principles for the delivery of Proactive Care

People like Eric highlight that care is often reactive, uncoordinated and not always focused on what matters most. As a result of thinking about people like Eric, we developed a set of principles that guide the way we work and the development of our proactive care process.

Do	Don't
Focus on a way of working that is proactive and preventative, and anticipates future needs	Deliver reactive care or wait for a crisis to happen
Support people to be involved in their care and have greater choice and control	Take over and create dependency or make decisions for people
Provide care that is coordinated and ongoing	Duplicate work with multiple professionals completing multiple assessments, which get in the way of hearing people's real concerns
Support people to live and die well	Make assumptions about what will work for people
Focus on what matters to people and what will make the most difference to them	Only focus on the concerns of professionals
Streamline assessments and focus on having meaningful conversations to ensure the person's thoughts, wishes and worries are heard	Let the assessment templates or 'ticking boxes' get in the way of a meaningful conversation
Consider all aspects of a person's life that may impact on their health and utilise their strengths and assets	Neglect other members of the household and community support
Ensure a person's preferences and plans are recorded and shared for other professionals to act upon	Start from scratch with people without checking records for previous conversations/plans

How to deliver Proactive care

The process for delivering proactive care was developed based on the principles and shaped by the Year of Care approach to personalised care and support planning.

Essential elements of personalised proactive care

Identification

Identify and invite target cohort

Preparation

Support patients to highlight concerns, thoughts and wishes

Information gathering

Holistic assessment supported by patient preparation

Care and Support Planning conversation

Collaborative working between patient and professional to develop a personalised care and support plan

Ongoing review, support and care coordination

Support to access preventative interventions and specialist advice through a named care coordinator with regular planned reviews

MDT review

Planned

Ongoing

Coordinated

Collaborative

Each stage will be explored in more detail in the following slides

Identifying those for Proactive Care

To identify those who would benefit most from proactive care, local teams should use evidence-based tools alongside clinical judgement and local insight.

People with moderate to severe frailty are likely to benefit most from proactive care.

Due to the nature of frailty this group often includes those with multiple long-term conditions, those using lots of unplanned care and people affected by health inequalities.

Moderate and severe frailty

Those living with moderate and severe frailty are at higher risk of adverse health outcomes and hospitalisation.

Earlier intervention can support them to live independently and stay healthier for longer.

People living with multiple long-term conditions

Most people with frailty have multiple long-term conditions and are at high risk of adverse outcomes such as loss of independence and falls.

High intensity users

People with frailty use emergency and unplanned care more frequently, including both primary and secondary care.

Health inequality groups

Those from health inequality groups are more likely to develop frailty and long term conditions earlier in their lives.

Identifying those for Proactive Care cont.

Example criteria for identifying your cohort

- People living with moderate/severe frailty
- People with long term conditions who are no longer able to attend primary care for a review
- People identified by the MDT, practice staff or other colleagues
- People aged over 80 who are not known to health services
- High users of unplanned care within GP practice or community services
- Older people from a health inequality group
- Taking multiple medications (polypharmacy)
- Living alone with limited social network
- Recently bereaved
- Specific clinical conditions e.g. Parkinsons, dementia

Top Tips:

- Use **population health data ad local intelligence** to identify groups most likely to benefit from proactive care
- Ensure **accuracy of coding** through the use of eFI2 and robust systems for clinical verification using the clinical frailty scale (CFS)
- **Make teams and services aware** of the proactive care offer, who it is for and how it can be accessed
- **Consider expanding the proactive care offer** to other groups, relevant to local need; this may include those with complex physical and mental health conditions

Inviting Individuals

People identified for proactive care may not understand why they have been 'selected' and so it is important to support them to prepare to ensure they:

- understand the support offer and how it might help or be of benefit to them
- understand what would happen and how the care and support would work
- see the connection between the MDT/proactive care service and their own GP practice
- have the opportunity to take part in, or decline, the service and involve carers, friends and relatives

Suggested ways to invite people

- A key member of staff could make a phone call to the patient to explain the service, gain consent and arrange an appointment for an information gathering visit.
- This could be followed by a letter/leaflet (available from Year of Care) explaining the purpose and role of the service alongside a preparation prompt to help them prepare for the information gathering visit.

Contact Year of Care to request a copy of ***'Finding the Words'*** – a resource with ideas about the words that might be used to describe proactive care to patients; first impressions are important!

Top Tips

- **Develop clear processes** for inviting people to proactive care
- **Consider health literacy** and develop easy read leaflets/letters
- Take care with language when describing the offer
- **Promote the proactive care service** and its benefits to the local practice population

Preparation: Encouraging greater involvement in care

Preparation is an important element in delivering care that is personalised. Both the professional and the person should have the opportunity to be prepared for the proactive care process.

The role of preparation

The aim of preparation for the professional is to:

- Clinically review the case notes, to understand medical history and relevant information and to identify tests, assessments and checks required for good care
- Identify engagement in preventative strategies such as vaccinations and health screening and any other health or social care providers involved in an individual's care
- It also allows time for MDT discussion about the person and any potential 'red flags' or professional concerns

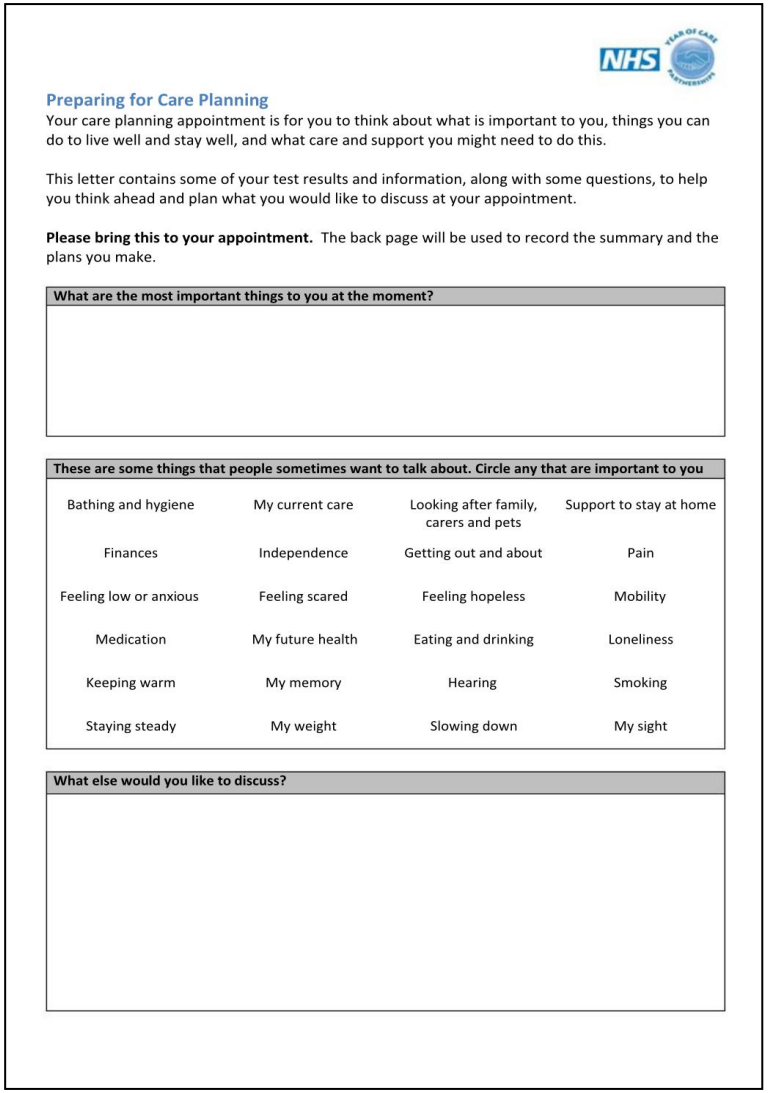
The aim of preparation for the person is to:

- Ensure they understand the offer of care and how things will be done
- Have time to consider things and gather their own thoughts about their health and care and what matters to them ahead of the personalised care process - this can be supported by providing a preparation prompt in advance of the appointment
- Provide the opportunity for families, friends and carers to be able to share their thoughts and concerns where appropriate

Top Tips

- Ensure **long term condition management is considered** as part of proactive care
- **Develop appropriate local tools** to support people to feel prepared

Examples of preparation to support greater involvement



Preparing for Care Planning

Your care planning appointment is for you to think about what is important to you, things you can do to live well and stay well, and what care and support you might need to do this.

This letter contains some of your test results and information, along with some questions, to help you think ahead and plan what you would like to discuss at your appointment.

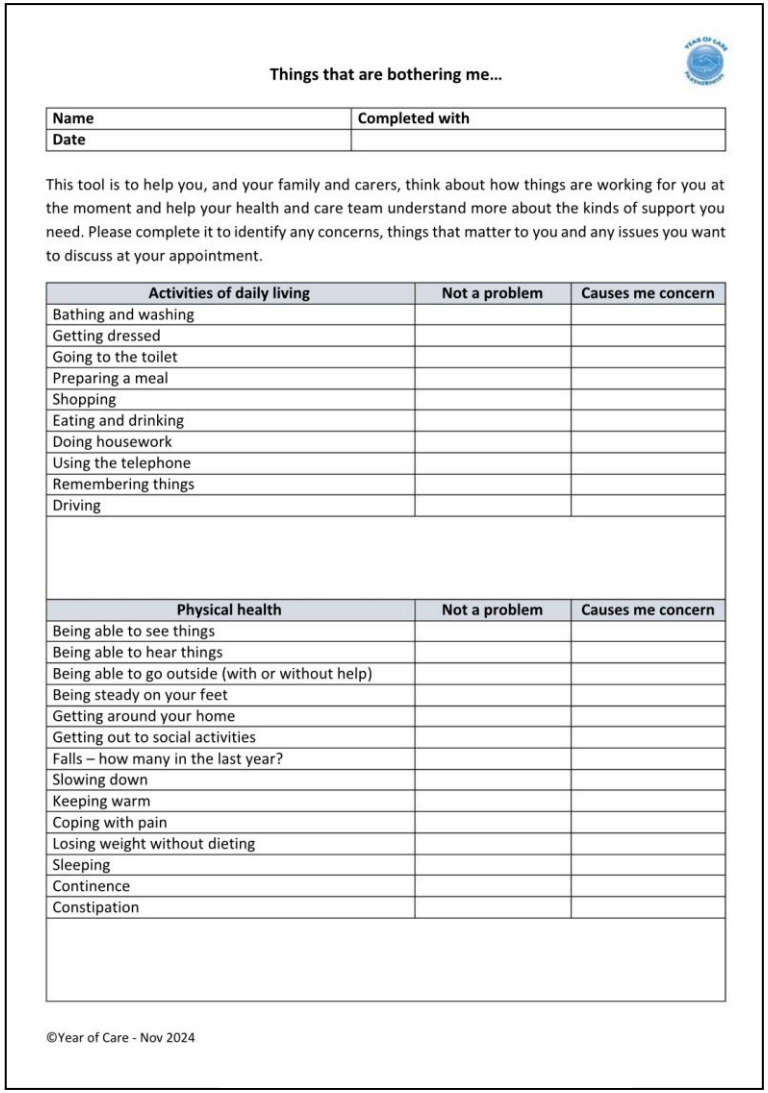
Please bring this to your appointment. The back page will be used to record the summary and the plans you make.

What are the most important things to you at the moment?

These are some things that people sometimes want to talk about. Circle any that are important to you

Bathing and hygiene	My current care	Looking after family, carers and pets	Support to stay at home
Finances	Independence	Getting out and about	Pain
Feeling low or anxious	Feeling scared	Feeling hopeless	Mobility
Medication	My future health	Eating and drinking	Loneliness
Keeping warm	My memory	Hearing	Smoking
Staying steady	My weight	Slowing down	My sight

What else would you like to discuss?



Things that are bothering me...

Name	**Completed with**
Date	

This tool is to help you, and your family and carers, think about how things are working for you at the moment and help your health and care team understand more about the kinds of support you need. Please complete it to identify any concerns, things that matter to you and any issues you want to discuss at your appointment.

Activities of daily living	Not a problem	Causes me concern
Bathing and washing		
Getting dressed		
Going to the toilet		
Preparing a meal		
Shopping		
Eating and drinking		
Doing housework		
Using the telephone		
Remembering things		
Driving		

Physical health	Not a problem	Causes me concern
Being able to see things		
Being able to hear things		
Being able to go outside (with or without help)		
Being steady on your feet		
Getting around your home		
Getting out to social activities		
Falls – how many in the last year?		
Slowing down		
Keeping warm		
Coping with pain		
Losing weight without dieting		
Sleeping		
Continence		
Constipation		

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Information gathering visit (part of holistic assessment)

To make care truly personalised, it helps to keep assessments or **information gathering** separate from the care and support planning conversation. This way professionals can complete the necessary checks and collect key information, while making space for a more meaningful planning discussion later.

Example of how information gathering can work

The information gathering appointment can be completed by a health care professional (e.g. care coordinator), ideally in the home environment. The health care professional should take a conversational approach to:

- **Explain the proactive care process** and the purpose of their visit
- **Get to know the person** and what matters to them, using any preparation they've done to guide the conversation
- Learn about the person's life, strengths and challenges
- **Gather key information** as part of comprehensive geriatric assessment (CGA) including daily function, social support, psychological wellbeing and the home environment
- **Complete relevant checks** relevant to their long term conditions such as blood pressure, height, weight, phlebotomy and foot checks
- **Involve** family/ friends if the person wishes

It is helpful for information to be recorded on a shared clinical system where it can be easily accessed by other members of the MDT.

Top Tips

- Decide **who will carry out the assessment** or 'information gathering visit' and where (ideally the person's own home)
- Include all elements of holistic assessment, such as those in the **comprehensive geriatric assessment**
- **Agree a shared template** and system for recording information across teams and services so there is one trusted assessment
- Ensure there is a process in place for managing urgent issues

MDT Review

It is recommended there is a planned **MDT review** following the information gathering visit. This could involve just the core team or a wider MDT, if appropriate. The purpose is to:

- **Share knowledge and expertise**
- **Generate options** that can be presented as part of the personalised care and support planning conversation

Example of how the MDT works

Following the information gathering visit key members of the MDT come together to share and review the information about the person, this may include:

- What matters to the person and their key concerns
- How they are managing their long term conditions and medicines, and the support they have to live well
- Whether advanced care planning might be useful and who could support this

The MDT is an opportunity for the team to generate options that may be useful for the person and to develop skills and knowledge within the team. It also helps to inform a decision on the most appropriate professional to 'lead' on the care and support planning conversation.

The MDT should not make decisions on behalf of the person

NHS England published the useful resource below to support MDT working:
Multidisciplinary Team (MDT) Toolkit

Top Tips

- **Senior medical oversight** is recommended to support the team to feel comfortable with managing risk
- Ensure **medicines management** is a core function of the MDT
- Optimise the **use of technology** to create shared records and enable virtual meetings where necessary
- Ensure **people are aware of the MDT** and the function it has for their care

How to deliver Proactive care

The next stage of the proactive care process is the care and support planning conversation. This is a key aspect of the process that is about planning with people; actively creating opportunities for people to express preferences about their health and social care, debate options around self-management, care and treatments, and plan for the future.

Identification
Identify and invite target cohort

Preparation
Support patients to highlight concerns, thoughts and wishes

Information gathering
Holistic assessment supported by patient preparation

Care and Support Planning conversation
Collaborative working between patient and professional to develop a personalised care and support plan

Ongoing review, support and care coordination
Support to access preventative interventions and specialist advice through a named care coordinator with regular planned reviews

MDT review

Planned
Coordinated
Collaborative
Ongoing

Care and Support Planning Conversation

The **personalised care and support planning conversation** is an opportunity for the person and the health care professional to come together as equals and experts to consider ways the individual can best manage their conditions and live well. This conversation gives people an opportunity to reflect on what is important to them, to think about their own personal goals and how they would like to live their life.

How it works

The key named professional facilitates a proactive, preventative conversation focused on what matters to the person in the context of their health and wellbeing. This may include:

- Their main concerns (including those highlighted through patient preparation and information gathering)
- Things they would like to be able to do, or continue to do, to live as well as possible; may include functional tasks, accessing community activities (social prescribing), hobbies and interests
- Raising professional concerns noted by the MDT
- Discussing what might be helpful in supporting them to manage their health now and in the future; this may include things like falls prevention and long-term condition management
- Early conversations about future care needs for example housing, lasting power of attorney, advanced decisions and resuscitation status

Role of the professional

Focus of the conversation

Capturing the conversation – documentation/care and support plans

To be more personalised, care and support plans should be written for and held by the person and be relevant to them. It can be useful to include key information for professionals, especially those involved in emergency or unplanned care. Sharing of the care and support plan across the system would be beneficial to improve coordination and reduce duplication.

Example of how a care and support plan can work

A care and support plan sets out the person's health and wellbeing goals and their preferences and wishes about the future. Actions should be prioritised based on this, and the interventions that will make the most difference. The care and support plan can be printed and shared with the person once complete.

My Care and Support Plan

- Goals for living well and staying healthy
- How to manage deterioration and exacerbations
- Future care wishes and advanced decisions

For professionals and emergency services

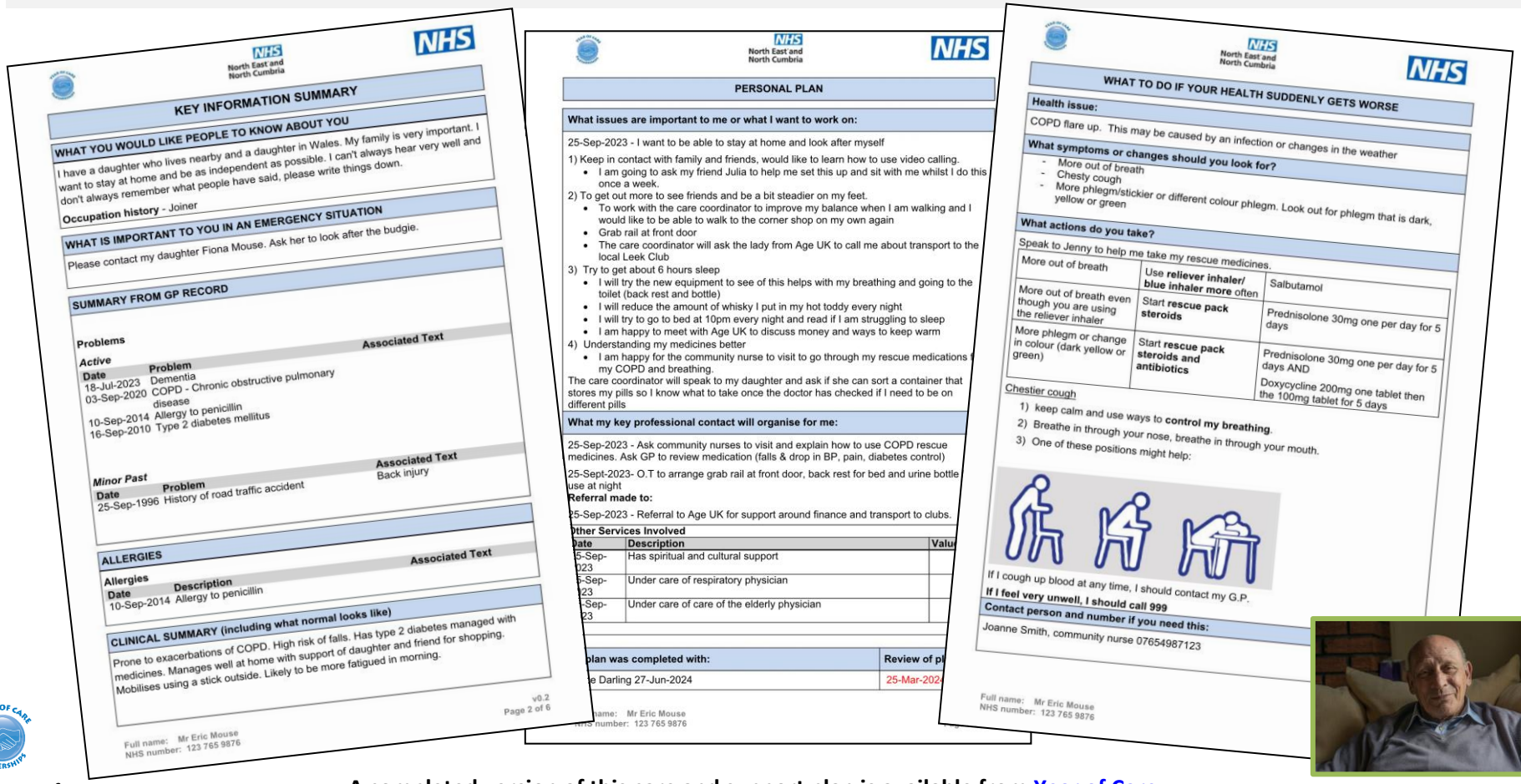
- Key information summary/what normal looks like
- Documented preferences
- Advanced Care Plans (e.g. Deciding Right forms)

Top Tips

- Develop **a locally agreed care and support plan** and system for recording
- Explore **ways to share** this across the system
- Include clear sections for both the individual and professionals
- **Support people to think about the future** e.g. health, housing and care, documenting wishes
- Consider **how advanced care planning can be integrated** in proactive care, including discussions about advanced decisions and lasting power of attorney

Capturing the Conversation - example Care and Support Plan

There are many different versions of care plans across organisations. To be personalised, it would be helpful for individuals to have one main plan that brings together all their health and care needs. Ideally, this would be generated via an intelligent template in the clinical system.



KEY INFORMATION SUMMARY

WHAT YOU WOULD LIKE PEOPLE TO KNOW ABOUT YOU

I have a daughter who lives nearby and a daughter in Wales. My family is very important. I want to stay at home and be as independent as possible. I can't always hear very well and don't always remember what people have said, please write things down.

Occupation history - Joiner

WHAT IS IMPORTANT TO YOU IN AN EMERGENCY SITUATION

Please contact my daughter Fiona Mouse. Ask her to look after the budgie.

SUMMARY FROM GP RECORD

Problems

Active

Date	Problem	Associated Text
18-Jul-2023	Dementia	
03-Sep-2020	COPD - Chronic obstructive pulmonary disease	
10-Sep-2014	Allergy to penicillin	
16-Sep-2010	Type 2 diabetes mellitus	

Minor Past

Date	Problem	Associated Text
25-Sep-1996	History of road traffic accident	Back injury

ALLERGIES

Date	Description	Associated Text
10-Sep-2014	Allergy to penicillin	

CLINICAL SUMMARY (including what normal looks like)

Prone to exacerbations of COPD. High risk of falls. Has type 2 diabetes managed with medicines. Manages well at home with support of daughter and friend for shopping. Mobilises using a stick outside. Likely to be more fatigued in morning.

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Full name: Mr Eric Mouse
NHS number: 123 765 9876

PERSONAL PLAN

What issues are important to me or what I want to work on:

25-Sep-2023 - I want to be able to stay at home and look after myself

1) Keep in contact with family and friends, would like to learn how to use video calling.
   - I am going to ask my friend Julia to help me set this up and sit with me whilst I do this once a week.
2) To get out more to see friends and be a bit steadier on my feet.
   - To work with the care coordinator to improve my balance when I am walking and I would like to be able to walk to the corner shop on my own again
   - Grab rail at front door
   - The care coordinator will ask the lady from Age UK to call me about transport to the local Leek Club
3) Try to get about 6 hours sleep
   - I will try the new equipment to see of this helps with my breathing and going to the toilet (back rest and bottle)
   - I will reduce the amount of whisky I put in my hot toddy every night
   - I will try to go to bed at 10pm every night and read if I am struggling to sleep
   - I am happy to meet with Age UK to discuss money and ways to keep warm
4) Understanding my medicines better
   - I am happy for the community nurse to visit to go through my rescue medications my COPD and breathing.

The care coordinator will speak to my daughter and ask if she can sort a container that stores my pills so I know what to take once the doctor has checked if I need to be on different pills

What my key professional contact will organise for me:

25-Sep-2023 - Ask community nurses to visit and explain how to use COPD rescue medicines. Ask GP to review medication (falls & drop in BP, pain, diabetes control)

25-Sept-2023- O.T to arrange grab rail at front door, back rest for bed and urine bottle use at night

Referral made to:

25-Sep-2023 - Referral to Age UK for support around finance and transport to clubs.

Other Services Involved

Date	Description	Valu
5-Sep-023	Has spiritual and cultural support	
6-Sep-23	Under care of respiratory physician	
-Sep-23	Under care of care of the elderly physician	

plan was completed with:	Review of pl
e Darling 27-Jun-2024	25-Mar-202

name: Mr Eric Mouse
NHS number: 123 765 9876

WHAT TO DO IF YOUR HEALTH SUDDENLY GETS WORSE

Health issue:

COPD flare up. This may be caused by an infection or changes in the weather

What symptoms or changes should you look for?

- More out of breath
- Chesty cough
- More phlegm/stickier or different colour phlegm. Look out for phlegm that is dark, yellow or green

What actions do you take?

Speak to Jenny to help me take my rescue medicines.

More out of breath	Use **reliever inhaler/ blue inhaler more** often	Salbutamol
More out of breath even though you are using the reliever inhaler	Start **rescue pack steroids**	Prednisolone 30mg one per day for 5 days
More phlegm or change in colour (dark yellow or green)	Start **rescue pack steroids and antibiotics**	Prednisolone 30mg one per day for 5 days AND Doxycycline 200mg one tablet then the 100mg tablet for 5 days

Chestier cough

1) keep calm and use ways to **control my breathing**.
2) Breathe in through your nose, breathe in through your mouth.
3) One of these positions might help:

If I cough up blood at any time, I should contact my G.P.

If I feel very unwell, I should call 999

Contact person and number if you need this:

Joanne Smith, community nurse 07654987123

Full name: Mr Eric Mouse
NHS number: 123 765 9876

A completed version of this care and support plan is available from Year of Care.

Ongoing review, support and care coordination

Care and support planning conversations help to discover what's important to individuals and their families. This should inform all actions, activities and referrals made following the conversation. There are different types of interventions and support that should be considered as part of the proactive care offer. Some of these may already exist and others may need developing across the locality in partnership with other teams or organisations.

Example Interventions

- *Self-management programmes*
- *Strength and balance class*
- *Peer support*

Community support

- *Social groups*
- *Men in sheds*
- *Cooking group*
- *IT/technology*
- *Financial advice and support*

Traditional services

- *Memory services*
- *Community matron*
- *Occupational therapy*
- *Pharmacy/medicines review*

Top Tips

- Consider **having a named care coordinator** within the team to act as an advocate and key contact for routine care
- Provide **ongoing support** but only do the things that make a difference; offer support until the end of life
- **Work with the MDT** to minimise referrals and the number of agencies involved
- Develop **clear links and relationships with those delivering 'targeted support'** such as falls prevention, continence and pain management
- Ensure systems and processes are in place to **assess and support the needs of carers** and families
- **Work with wider community organisations** to map and develop opportunities to support self management and ageing well

TEAMS & WORKFORCE DEVELOPMENT

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Teams and Workforce Development

Proactive care aims to support those living with frailty and other complex needs

It is recommended that care is delivered by a **small core team of professionals**, who know the person well, **supported by a wider multidisciplinary team**. This wider team should include a range of professionals and be flexible enough to enable timely access to appropriate advice and expertise, including urgent care. Ideally individual specialists should advise the core team or be brought in for specific issues and interventions.

Primary care can lead the development of these 'integrated neighbourhood teams'

Strong **clinical and managerial leadership** is key, and there should be a shared purpose and understanding of what proactive care aims to achieve. **Collaboration** across organisations is essential to allow care to be more joined up and responsive to individual needs.

Care coordinators can play a vital role in the delivery of proactive care

People value having a **named contact** for advice and support. The scope of this role can be broad and therefore it is important to define the remit and responsibilities, and ensure they have the right **knowledge and skills**. The team will need administrative support to coordinate appointments and reviews.

Building and Developing your Proactive Care Team: Top Tips

Design the team around the people you serve

- Set up a services dedicated to proactive care
- Align to the PCN geography
- Understand your cohort and their needs, and use this to design your team and recruit roles with the right knowledge and skills
- Use flexible contracts and PCN arrangements to support extended roles

Establish strong leadership and clinical governance

- Create a shared vision and purpose across the team
- Have clear clinical and managerial leads with established lines of supervision
- Ensure involvement of a senior medic to support with complex clinical issues
- Consider opportunities for shared IT systems and templates

Establish the MDT

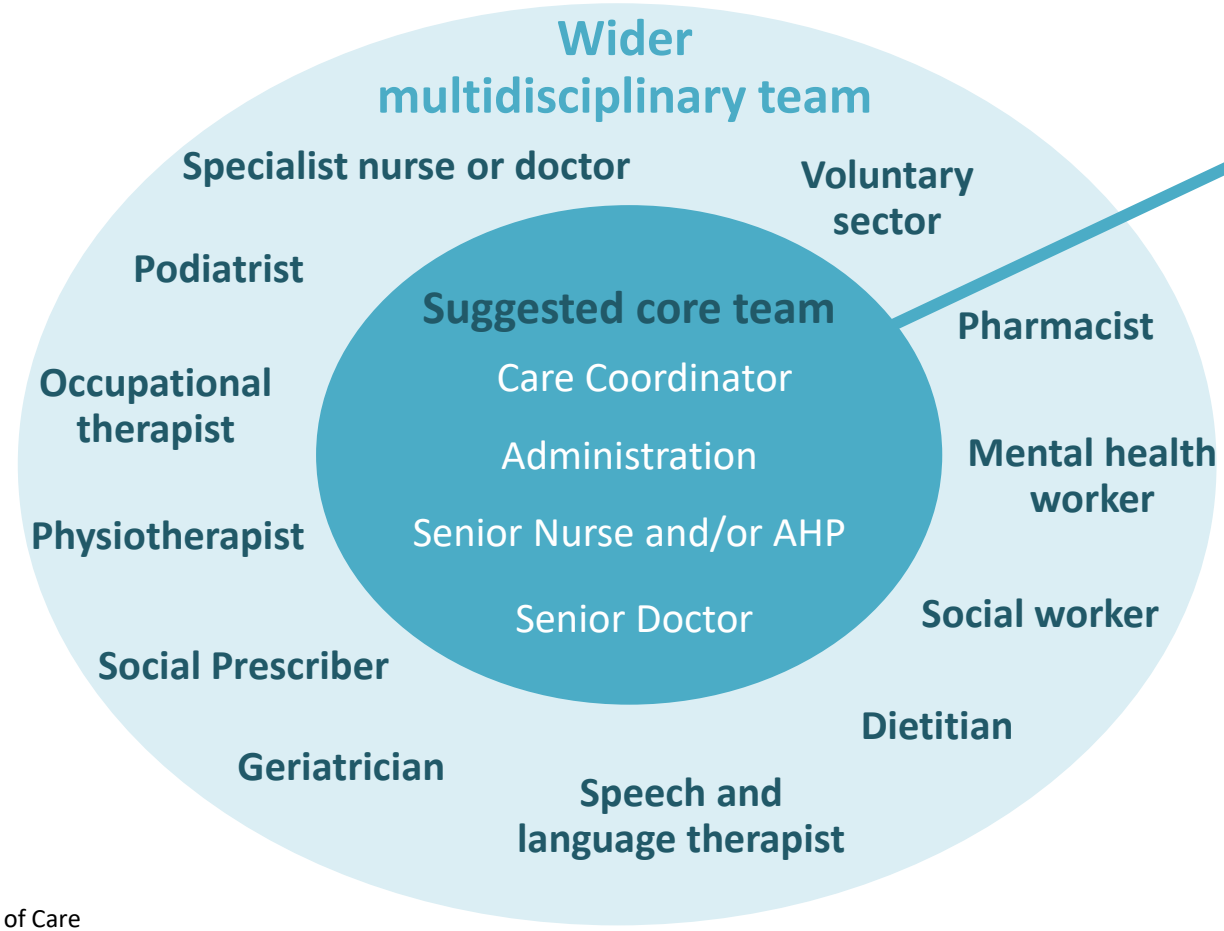
- Decide on core members and roles that will be part of the wider MDT
- Create systems for timely access to the right knowledge, support and supervision
- Create clear links with those delivering other key services such as urgent care e.g. daily huddles

Enable collaborative working

- Consider colocation and dedicated meeting space for the MDT
- Draw in expertise from others rather than sending multiple referrals to multiple services
- Create formal and informal learning opportunities within the team
- Encourage interdisciplinary working such as joint visits and case discussion
- Use virtual platforms where co-location is difficult
- Regularly review effectiveness of the MDT - see Multidisciplinary Team (MDT) Toolkit for helpful tips and advice

Team composition

Some roles are essential in every core team, while others depend on the focus of the service. The **core team acts as a hub** – coordinating care and linking with wider professionals for advice and support. A variety of **skills and functions** is needed to get the best outcomes for people with frailty and complex needs.



With knowledge and skills in:

- Long term conditions
- Frailty
- Medicines management
- Social prescribing
- Advanced care planning
- Care coordination

Workforce Development

To support successful delivery of proactive care it is important that the workforce has the knowledge, skills, behaviours and person-centred values to meet the needs of the cohort who are likely to be living with complex needs.

The team would benefit from having skills and knowledge around a range of topics, including:

- Coherent understanding of the role and purpose of proactive care
- The proactive care and support planning process, and associated tools and IT systems
- The philosophy, style, skills and structure of a personalised care and support planning approach
- Knowledge of long-term conditions and routine management, including self-management, medication and also dementia and common mental health problems
- Identification, assessment and management of frailty, including Rockwood and the CGA
- Advanced care planning and associated tools

For training and implementation support for personalised care and support planning, including proactive care please contact Year of Care at enquiries@yearofcare.co.uk .

For support to develop knowledge around frailty please see the Enhancing Care for Older People Competency Framework.

Workforce Development: Top Tips

Identify the training needs of staff

- Ensure staff understand the purpose of proactive care and how it should be delivered*
- Review the clinical skills within the team and identify training and development needs
- Offer tailored training around personalised care and support planning*

Ensure adequate opportunity for structured learning

- Offer a comprehensive induction period
- Provide mentors, supervisors and facilitated support to assist new teams and individual team members in their development
- Use the MDT meetings and huddles as opportunities for learning and development
- Consider using frameworks such as Enhancing Care for Older People (EnCOP) competency framework to guide learning
- Allocate appropriate time and finance to support learning and development

Develop the skills of your care coordinators

- Clearly define the role, core functions and knowledge required by care coordinators
- Support development in key areas such as long term condition management, frailty, care coordination and personalised care
- Provide access to formal* and informal learning opportunities, alongside supervision to build confidence and competence in role

***this can be provided by Year of Care Partnerships**

MEASUREMENT & EVALUATION

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Measuring what matters

It's important to consider the impact of implementing any model of proactive care. It will be important to gather local data from PCNs to measure system readiness, implementation and integration. Ideally, resource use at PCN level should be measured in terms of both the healthcare service utilisation and a broader view encompassing social care, housing, benefits and other community assets.

Example metrics

- Number of acute GP appointments (pre and post intervention)
- Urgent care use (pre and post intervention)
- A&E attendances/emergency admissions (pre and post intervention)
- Number of people on the proactive care caseload
- Number of care and support plans completed
- Number of medication reviews completed
- Number of people with advanced care plans in place e.g. DNACPR, Emergency Health Care Plans, Advanced Decisions
- Number of referrals to supportive interventions such as exercise classes or peer support

These metrics can take time to demonstrate impact so it may be useful to focus on the experience of proactive care from the perspective of the service user and the healthcare professional:

- Patient functional or quality of life measures
- Patient surveys such as questionnaires or rating scales (example available)
- Staff experience measures e.g. staff survey results, monitoring sickness, retention and other workforce trends

Top tips

- **Consider evaluation** when designing the service - what do you want to achieve and how will you measure it?
- Use both **quantitative and qualitative** measures
- Use evaluation to inform, develop and enhance service provision

SUPPLEMENTARY SLIDES

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Relevant National Guidance

- The NHS Long Term Plan and the Next steps for integrating primary care: Fuller Stocktake report advocates for personalised proactive care delivered through multidisciplinary teams
- The NICE Multimorbidity guidance supports proactive care to reduce disease burden, improve quality of life and enhance independence
- The Chief Medical Officer report (2023) advocates for a more preventative approach, specifically for older people
- The British Geriatric Society "Be Proactive: delivering proactive care for people living with frailty" (2024) provides a raft of evidence for working in this way as well as providing recommendations for implementation

References

1. **NHS England** (2023) *Proactive Care: providing care and support for people living at home with moderate and severe frailty.* The guidance can be accessed here. Further information on Proactive Care can be found on the FutureNHS Platform.

2. **National Institute for Health and Care Research NIHR** (2021) *Multiple long-term conditions (multimorbidity): making sense of the evidence*. doi: 10.3310/collection_45881. Available ay Making sense of the evidence: Multiple long-term conditions (multimorbidity) - NIHR Evidence

3. **Richmond Group of Charities** (2023*) One in four: A manifesto for people with multiple health conditions.* Available at https://www.richmondgroupofcharities.org.uk/-

4. **Health watch** (2020) What People want from the next 10 years of the NHS. Available at What people want from the next ten years of the NHS | Healthwatch

5. **Kingston A, Robinson L, Booth H, et al (2018)**. Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model. Age Ageing. 2018

6. **Han L, et al**. (2019). '*The impact of frailty on healthcare resource use: a longitudinal analysis using the Clinical Practice Research Datalink in England*', Age and Ageing. Sep 1;48(5):665-671

7. **Centre for Ageing Better**. *State of ageing 2023.* Available at Summary | The State of Ageing 2023-24 | Centre for Ageing Better

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