• Proactive Case Management for Older People living with Frailty in South Worcestershire
Innovations in the delivery of care for older people

Date: 18 Jun 2014
Venue: The King's Fund, London W1G 0AN
Event type: One-day conference
Fit for Frailty

Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings

A report by the
British Geriatrics Society
in association with the Royal College of
General Practitioners and Age UK
June 2014

Part 2: Developing, commissioning and managing services for people living with frailty in community settings

Guidance for GPs, Geriatricians, Health Service managers, social service managers and commissioners of services

A report by the
British Geriatrics Society and
the Royal College of General
Practitioners
in association with Age UK
January 2015

South Worcestershire
Clinical Commissioning Group
AVOIDING UNPLANNED ADMISSIONS
ENHANCED SERVICE: PROACTIVE CASE FINDING AND CARE REVIEW FOR VULNERABLE PEOPLE

GUIDANCE AND AUDIT REQUIREMENTS

A programme of action for general practice and clinical commissioning groups

NHS England Gateway reference: 0152C
Promoting Clinical Excellence
Local Improvement Scheme - 2015/16
Frailty Component
Appendix one: Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine waiting.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up," and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high priority tasks (dishes, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (sitting, standing) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy of months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.
• Comprehensive Assessment using Proactive Care Assessment Templates – imputing directly onto GP systems - EMIS

• Development of the personalised Care Planning including advance care planning if appropriate

• In depth medication review with pharmacist required or usage of STOPP-START tool

• Multi-disciplinary team review required
Successes

As of 02.03.2016:

- 4067 Frailty Codes on SW GP systems
- 2650 Care plans
- Language of frailty common place
- Hospital admissions for over 75s falling/stabilizing
New Models of Care
**The South Worcestershire MCP**

<table>
<thead>
<tr>
<th>Predominantly healthy and not affected by frailty</th>
<th>Developing signs of frailty but not on the frailty register</th>
<th>In the top 2% most frail and recorded on the frailty register</th>
<th>In the 2:37 of the population that are most dependent on health and social care</th>
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<tbody>
<tr>
<td>The majority of the population that has self managed conditions or currently has no requirement for on-going care.</td>
<td>X% of the population showing early signs of frailty that need close monitoring to prevent deterioration.</td>
<td>2% of the population identified by GP practices through review work</td>
<td>2% identified by the segmentation analysis based on system spend</td>
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</tbody>
</table>

**PILOT FOR THE MCP**
2% of the population in on the frailty registers, expanding to......

**INTENDED CORE FOCUS OF THE MCP**
...Up to 4% of the population from both groups, to capture both those already requiring high cost support for frailty and those who are about to imminently.

**BROADER SCOPE OF THE MCP**
X% of the population who are currently or at risk of suffering from frailty – ie those who are showing signs of moving towards the right hand columns but are not currently amongst the most frail or complex patients.
A New Care Paradigm for Older People Living with Frailty

TODAY

‘The Frail Elderly’
(i.e. a label)

Presentation late & in crisis
(e.g. delirium, falls, immobility)

Hospital-based: episodic, disruptive & disjointed

TOMORROW

“An older person living with frailty"
(i.e. a long-term condition)

Timely identification for preventative, proactive care
by personalised care and support planning

Community-based, person centred, co-ordinated care & support
**June 14**

- ‘The Frail Elderly’ (i.e. a label)
- Presentation late & in crisis (e.g. delirium, falls, immobility)
- Hospital-based: episodic, disruptive & disjointed

**March 16**

- “An older person living with frailty” (i.e. a long-term condition)
- Timely identification for preventative, proactive care by personalised care and support planning
- Community-based, person centred, co-ordinated care & support

**March 18**

- Person Centred Care and Support regardless of place of care for older people living with frailty
- SW Alliance Board (GPs community Social Care)
- SW MSCP

GPs Hospital Social Care VCS Community Staff All working independently