

Proactive care for frailty

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Abstract

Many providers aspire to scale up proactive care that prevents escalation of health and care needs, delays onset of disability, and reduces demand for emergency department attendance or admission to hospital or care home. NHS England offers guidance on personalised and coordinated multi-professional support and interventions for people with moderate or severe frailty. This article reflects on the growing international evidence for an integrated proactive approach for older people with frailty and why investing in high-quality, joined-up care for older people across the whole system improves outcomes for people, reduces demand for services, increases system resilience, and delivers economic and societal benefits. Facing up to frailty requires creative whole system workforce planning and development that will be challenging to deliver in the current financial and recruitment context yet all the more worthwhile as scaling up proactive care has the potential to be a game changer.

Key words: Comprehensive geriatric assessment; Frailty; Proactive care; Integrated care

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Proactive care for older people with frailty

Across the UK, many providers aspire to scale up proactive care that prevents escalation of health and care needs, delays onset of disability, and reduces demand for emergency department attendance or admission to hospital or care home. Commissioners, providers and professionals alike will welcome the recent publication by NHS England (2023) offering guidance on personalised and co-ordinated multi-professional support and interventions for people with moderate or severe frailty - a dynamic long-term condition in which multiple body systems gradually lose their in-built reserves, resulting in an increased risk of unpredictable deterioration from minor events.

Frailty matters

From both a population health and a delivery perspective, it makes sense to focus proactive care on people with frailty as they use health and social care services more than any other group. The prevalence of frailty increases with socio-economic deprivation and population projections show we can expect a dramatic rise in age related frailty and associated disability, dependency, morbidity and mortality, significantly increasing health and care demand and costs as described by Han et al (2019). Frailty can be readily identified with validated screening tools as discussed by Clegg et al (2013) and its consequences can be reduced if it is managed well by comprehensive assessment, accurate diagnosis, discussion of prognosis and shared decision-making about tailored interventions to promote functional ability, enable independence, and avoid harm from inappropriate polypharmacy. The *Joining the Dots* report by the British Geriatrics Society (2023) details why investing in high-quality, joined-up care for older people across the whole system improves outcomes for people, reduces demand for services, increases the resilience of health and care systems, and delivers economic and societal benefits. The publication outlines seven 'system touchpoints' to address when planning and commissioning health and social care for older people and highlights practical examples from across the UK.

What works

NHS England's Proactive Care framework cites the *Joining the Dots* report but is rather muted on the growing international evidence for an integrated proactive approach for older

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people with frailty. The systematic review by Ho et al (2023) reported an increase in the chance of living at home, reduced mortality and improved cognitive and functional ability associated with complex community interventions involving holistic assessment and care planning. However, as Sum et al (2022) note, there are often barriers to implementing the required coordinated and interdisciplinary approach, including enabling access to the information required to plan and provide the right care and support, regardless of discipline or care setting. Despite this caveat, evidence from recent prospective studies is promising.

The study by Berntsen et al (2019) of an integrated intervention across primary and secondary care in Norway for multi-morbid older patients with frailty at risk for emergency (re) admissions reported a reduced risk of high-level emergency care, substantially reduced mortality risk and increased use of low-level planned care. Nord et al (2021) confirmed these findings in their prospective, pragmatic, matched-control multicentre trial of Comprehensive Geriatric Assessment in 19 primary care practices in Sweden over 2 years. They reported a reduction in hospital stay with no significant differences in outpatient visits or mortality and a significant reduction in health care costs in the intervention group.

Mas et al (2023) report promising outcomes for older patients receiving a complex multidisciplinary intervention by primary care teams and geriatricians in Catalonia with increased time spent at home and reduced demand for emergency department attendance and length of hospital stay. The increase in primary care resources to deliver proactive and personalised care was more than offset by the hospital costs avoided resulting in an overall cost reduction for the system.

Of course, proactive care won't prevent all acute care episodes. Indeed, the evidence base for proactive care is strongest when it is well integrated with transitional and intermediate care. Many older people with frailty prefer to receive short-term enhanced care at home for episodes of acute illness. Hospital at home reduces risk of deconditioning, delirium and hospital-acquired infection and is a cost-effective alternative to acute care as shown by Singh et al (2022). Commissioners must balance investment in proactive care with continued investment in community alternatives to acute care for older people including Hospital at Home, discharge to assess pathways, reablement capacity and enhanced capability of community and voluntary organisations to work alongside health and care professionals.

Building workforce capability

Scaling up proactive care for people living with frailty may seem a big ask with a social care system in crisis and an unprecedented elective care backlog creating even further dependency and demand for under-resourced and over-stretched acute and community services. Despite these challenges, or perhaps because of them, wise integrated systems will invest in a workforce to deliver proactive care, understanding this is an essential 'invest to save' spend that will improve the lives of older people and those who care for them, and also stem the increasing demand for acute and long-term care. NHS England's Proactive Care framework does not address interventions for mild frailty, largely because good health and wellbeing in later life needs much more than good healthcare. For example, inadequate nutritional intake, an important modifiable risk factor for frailty and falls, is highly influenced by social determinants such as poverty, food insecurity, loneliness and social isolation. Many professionals from health, social care, housing services, along with community and voluntary service partners, unpaid carers, families, friends and social networks will contribute to care and support for people with mild frailty. Facing up to frailty requires creative whole system workforce planning and development.

Conclusions

The evidence for proactive integrated care is clear yet there is no new national funding to support integrated systems in England implement the guidance. This will challenge systems in the current financial climate. To transform care and support, integrated systems must view proactive care as core business and fund implementation from core budgets. Are our systems prepared to invest in primary and community services to build the required community capacity and capability? Are our hospital teams ready to work alongside

community services to support greater continuity and coordination of care? And is our IT infrastructure and governance ready to enable sharing of information? There are a lot of unknowns but there is no doubt the prize is worthwhile. Scaling up proactive care for older people with frailty has the potential to be a game changer.

Key Points

- Population screening and early identification of older people with frailty is achievable using validated tools.
- Comprehensive geriatric assessment by specialist led multidisciplinary teams is effective for preventing and managing frailty in all care settings.
- Proactive care prevents escalation of health and care needs, delays the onset of disability, and reduces emergency department attendances and admissions to hospital or care home.
- Integration of proactive care with intermediate care services across primary care, community and hospital teams is key for maximum impact.
- Balanced investment and workforce development are required across the continuum of care to make a meaningful and sustained impact on current system pressures.

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Author contributions

AH and RL contributed to the conception of the work. Both authors contributed substantially to the work, read, drafted, edited and approved the final manuscript and agreed to be accountable for all aspects of the editorial.

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