Beyond Reactive Care: Improving Outcomes for Frail Patients

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Introduction

Frailty drives repeat home visits and emergency department attendances, reflecting gaps in proactive, coordinated care. Within Belper PCN, challenges in data quality, coding, and care planning limit effective management of high-risk patients. This project aims to improve identification of frail patients, strengthen multidisciplinary team (MDT) working, and enhance clinician engagement. By targeting high-frequency service users, it seeks to reduce acute demand and improve personalised, community-based care and patient outcomes.

Aims

- Improve frailty identification
- Strengthen multidisciplinary team working
- Reduce acute demand through personalised care

Methodology

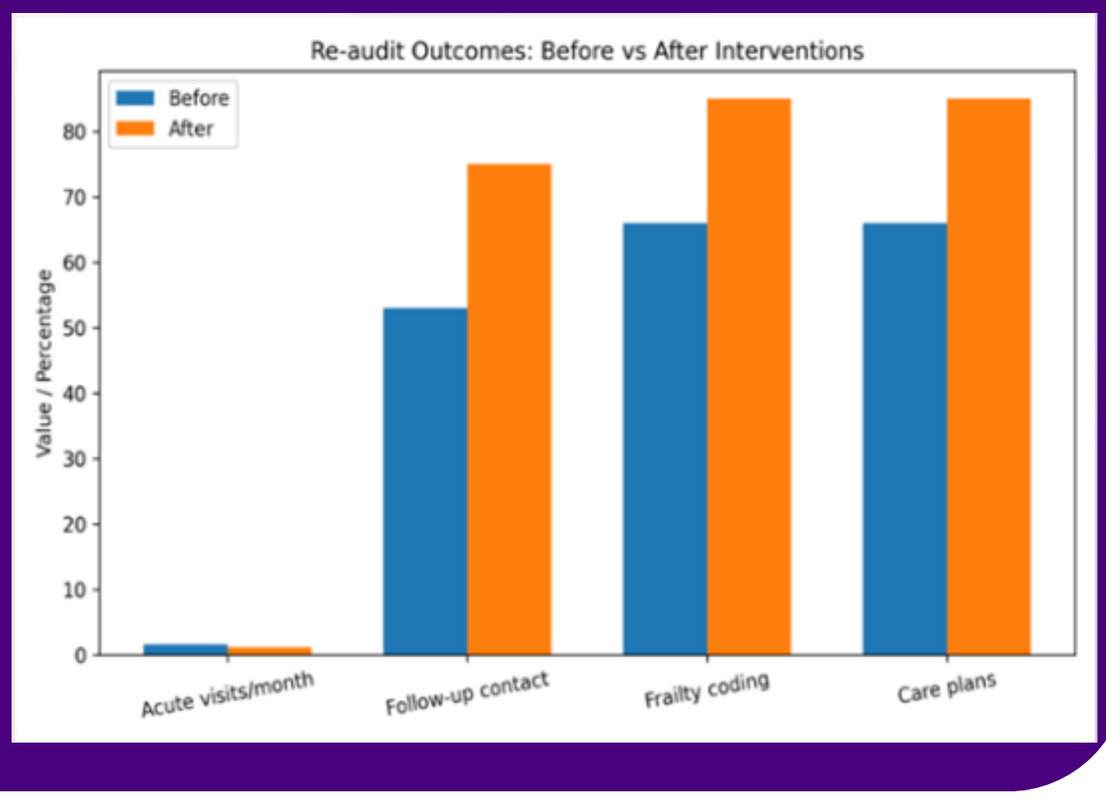
1. Planning and Research
- Audited high-frequency home visits and ED users across four PCNs.
- Analysed key themes and shared findings at key forums.
- Engaged PCN staff through a survey.

2. Design and Development
- Developed proactive visit criteria and a new Team Up rota system.
- Implemented a Falls Level 2 service.
- Delivered Ageing Well event and frailty education sessions.

3. Testing and Evaluation
- Re-audited high-frequency cohort to assess impact.
- Identified ED cohort driven by complex needs rather than frailty.
- Improved frailty coding and proactive visit.
- Developed a new MDT to support patients with complex needs.

Results

- Identified gaps in frailty identification, care planning and follow up, with poor continuity of care.
- Demonstrated low ED admission in this cohort despite high complexity, with significant patient deterioration over time (26% mortality in first audit: 47% in re-audit cohort).
- Delivered frailty education sessions across the PCN and Derbyshire GP network on frailty identification, coding and CGA.
- Implemented RAIDR risk stratification, identifying that frequent ED attendances are associated with complex needs rather than frailty.
- Established an MDT approach for high-intensity/ complex patients
- Delivered the Ageing Well Belper frailty prevention event in partnership with PCN and neighbourhood organisations, promoting preventative and community-based ageing well support.
- Re-audit demonstrated reduced acute visits (1.6 → 1.2/ month), improved follow-up (53% → 75%), increased frailty coding and care planning/ RESPECT forms (66% → 85%), and better continuity of care.



Impact and Benefits

- Improved proactive identification and management of frail and high-intensity patients across the PCN. Increased frailty coding, follow-up contact, care planning, and MDT working, supported more coordinated and anticipatory care delivery.
- Clinician engagement and education improved awareness of frailty identification and coding processes, while proactive Team Up visits reduced reliance on reactive acute demand. Also highlighted the importance of addressing wider health inequalities within high-intensity service users.
- A scalable model for proactive community care, supporting long-term reductions in avoidable acute demand, improved continuity of care for vulnerable patients, and potential cost savings through reduction in avoidable hospital admissions and wider acute system pressures.

Conclusion

This project demonstrated that proactive identification, education, and MDT working can improve the management of frail and high-intensity patients. The fellowship supported improvements in frailty coding, continuity of care, advance care planning, and proactive follow-up.

The work highlighted that high-intensity service use is often associated with wider health inequalities, rather than frailty alone. The project provides a scalable model for proactive neighbourhood working across PCNs, with potential to improve patient outcomes, reduce avoidable hospital utilisation, and support more sustainable use of healthcare resources.

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