CENTRAL EAST ICB · FRAILTY BEST PRACTICE CONFERENCE

# An Integrated Frailty Offer, Built Locally

*Delivering proactive frailty care at Manor View Practice — using the resource we already have.*

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Cranfield University · 16 July 2026

THE PROBLEM

# A case we can act on — without waiting for funding

**1**

## Frailty is the national priority

The DHSC/NHS England Neighbourhood Health Framework (March 2026) names people with frailty, care home residents and those at end of life as the priority cohort for integrated neighbourhood teams.

**2**

## The evidence is already settled

The Integrated Frailty evidence base (v11, June 2026) is clear on what works: Comprehensive Geriatric Assessment, supervised exercise plus nutrition, medication review and proactive identification before crisis.

**3**

## But the money doesn't reach us

The strongest financial case — admission avoidance — is a system saving. It does not release cash at practice level. So we didn't wait: we redesigned around resource we already hold.

## So we built it from what we have

**In-house physiotherapist**
*falls prevention & strength*

**Pharmacists with care-home experience**
*structured deprescribing*

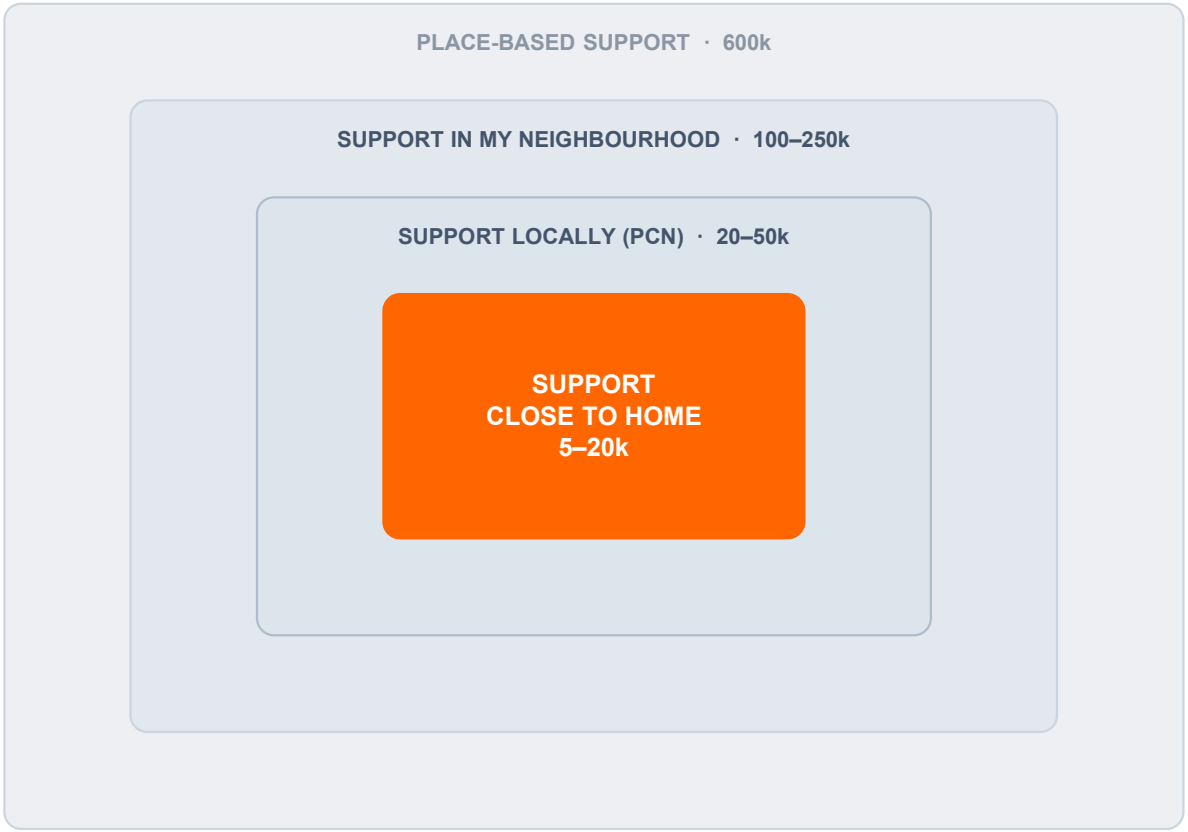
**Social prescribers**
*loneliness & community offers*

**GP & wider practice MDT**
*assessment & coordination*

***Benefits we can actually realise — locally.***

THE CONTEXT

# Where our offer sits: closest to the patient




## Manor View operates at the two inner tiers

The GP-registered and PCN footprint — where we know the patient, hold the record, and can act fastest. Our job is to make the innermost ring deliver, and to hand off cleanly to the outer tiers when a patient needs them.

## What the outer tiers add

Frailty virtual hospital · Hospital at Home · care-coordination at the front door · transfer-of-care hub — provided across the system by partners such as CLCH and the acute trust.

*Operating model adapted from Central London Community Healthcare (CLCH) NHS Trust — "Operating Model Through a Frailty Lens", Central East Frailty Conference, July 2026.*

THE COHORT

# Who we found: an EMIS search of our frail patients

**559**

patients with a Rockwood score of 6+

*Our working frailty register — the moderate-to-severe cohort where proactive care changes outcomes.*

**176**
housebound

**180**
in care homes

**193**
on 5+ repeat meds

**132**
a fall in last 12m

**266**
a registered carer (48%)

**135**
a UCLA-3 loneliness score

**225**
on a nutritional supplement

**197**
on vitamin D

## The gaps this surfaced

**193**
have a ReSPECT form (only 35%)

**9**
ever referred to bladder & bowel

**28**
on Zopiclone or Memantine

**29**
with a Serious Mental Illness

THE COHORT

# Why proactive care: the contact burden this cohort carries

**6,313**

**GP contacts in 12 months**

*from this cohort alone*

**11.93**

**mean contacts per patient**

*among those with ≥1 contact*

**58**

**contacts by a single patient**

*the highest attender*

**The insight**

**Reactive demand is heavily concentrated.** Some patients are seen more than 50 times a year — and this is GP contact only; it excludes nurse and HCA time. Comprehensive Geriatric Assessment lets us get ahead of the crises that drive those contacts, rather than absorbing them one appointment at a time.

THE INTERVENTION

# Our model: identify, assess, intervene, review

## 1 IDENTIFY

EMIS search on Rockwood 6+ builds the register and risk-stratifies it — housebound, polypharmacy, falls, loneliness.

## 2 ASSESS

Comprehensive Geriatric Assessment (CGA) — in clinic, at home, or on the Better Health Bus for those who can't reach us.

## 3 INTERVENE

Targeted by need: group clinics, deprescribing, physio, social prescribing, nutrition — delivered by our own team.

## 4 REVIEW

Monthly MDT and care-home ward rounds keep plans live, update ReSPECT, and re-stratify as people change.

### Every step runs on resource we already hold

- In-house physiotherapist
- Care-home-experienced pharmacists
- Social prescribers
- GP & practice MDT

THE INTERVENTION · FLAGSHIP 1

# Community Frailty Group Clinics

We bring frail patients together for a facilitated, clinician-led group appointment — shared education, peer support, and individual review in one visit. It turns repeat one-to-one contacts into proactive, planned care.

**Proactive, not reactive** — planned reviews replace a stream of unplanned appointments

**Peer support built in** — patients learn from each other and feel less isolated

**CGA at scale** — assessment and care-planning delivered efficiently across the cohort

**A Regional Vanguard model** — the East of England exemplar others are adapting

**NHS England Group Clinics Vanguard Programme**

**2nd**

highest-scoring practice nationally

**East of England representative**
for the national Group Clinics Vanguard — selected to develop and share the model across the region.

***Led by Ben Rutherford, Patient Care Team Lead & Vanguard Clinics Lead.***

THE INTERVENTION · FLAGSHIP 2

# Reaching the housebound: bringing CGA to the patient


*The Better Health Bus (Hertfordshire County Council) — taking assessment out to people who can't reach us.*

**176** of our 559 are housebound

*The people most likely to deteriorate unseen are the ones least able to come to us. So we go to them.*

**Better Health Bus** A mobile clinic space for CGA where a home isn't suitable — bloods, obs, medication review and care-planning in one visit.

**Internal home-visiting resource** Our own team delivers CGA in the patient's home for those who can't travel at all.

**Started, not planned** 20 comprehensive geriatric assessments completed so far — reaching people who can't come to us.

THE INTERVENTION · FLAGSHIP 3

# Care homes: a pharmacist on every ward round

180 of our cohort live in care homes. We strengthened the monthly ward-round process so a pharmacist — one with care-home experience — now reviews medication alongside the clinical team, every round.

**2.3**

**medicines deprescribed per patient, on average**

*across the reviewed cohort — fewer falls, less confusion, lower anticholinergic burden.*

## Why it matters

193 of our cohort are on 5+ repeat medicines; 28 are on Zopiclone or Memantine. Polypharmacy is a direct driver of falls, cognitive impairment and functional decline. Structured review (STOPP/START, STOPPFrail) at every cycle is core clinical content — not an add-on.

### Monthly rhythm

Pharmacist embedded in the standing care-home ward round — not a one-off review.

### Care-home expertise

Reviewers who know this population and the deprescribing evidence.

### Feeds the record

Changes update the shared plan and trigger ReSPECT conversations where needed.

THE INTERVENTION

# The wider assessment, in action

**132**

## Falls & strength

Our in-house physiotherapist runs falls-prevention and strengthening for the 132 who fell in the last year — the single most evidenced frailty-reversal intervention.

**135**

## Loneliness

Social prescribers proactively capture UCLA-3 loneliness scores and signpost to community offers — 135 scores recorded and acted on this year.

**225**

## Nutrition & recipes

225 are on a nutritional supplement. We're writing frailty-friendly recipes to build protein and calories through food first — reducing supplement prescribing.

**197**

## Active Practice & vitamin D

197 are on vitamin D. As a signed-up Active Practice (Sport in Herts), we embed movement and sensible supplementation — for patients and staff alike.

THE INTERVENTION

# Closing the gaps the search exposed

*A proactive search doesn't just find need — it finds what we've been missing. These are the gaps we're now working through systematically.*

**35%**

## ReSPECT

Only 193 of 559 have a ReSPECT form. Advance care planning is essential at CFS 6–9 and reduces unwanted admissions — so it's now a standing item in every CGA and MDT.

**9**

## Bladder & bowel

Just 9 have ever been referred to the bladder & bowel clinic — a striking under-referral in a frail cohort. We're building continence review into assessment.

**29**

## Serious Mental Illness

29 have an SMI flag. Mental-health and cognitive screening is a prerequisite for safe CGA, so we screen and coordinate rather than treat frailty in isolation.

THE EVIDENCE

# What we've delivered so far — and what we'll measure

*We're early, and honest about it. These are activity numbers, not yet outcomes — but they show the model is live and moving.*

## DELIVERED SO FAR

**20** comprehensive geriatric assessments completed

**2.3** medicines deprescribed per patient (avg.)

**135** UCLA-3 loneliness scores captured & acted on

## WHAT WE'LL MEASURE NEXT

- CFS improvement in the mild/moderate cohort (target ≥1 point in 30–40%)
- Unplanned admissions & A&E from care homes (evidence base: 15–40% reduction over 24m)
- ReSPECT completion rate across the 559
- GP contact rate in our highest attenders — the 6,313 baseline
- Deprescribing sustained at review, and supplement prescribing volume

THE LEARNING

# What others could adopt — or adapt

1 **Start with a search, not a business case** The EMIS search on Rockwood 6+ is free, fast, and turns an abstract 'frailty problem' into 559 named people with specific, actionable needs.

2 **Build from existing resource** You may already employ the physio, pharmacist and social prescriber you need. Redesigning how they work beats waiting for cash that admission-avoidance won't release at practice level.

3 **Go to the people who can't come to you** The housebound are the highest-risk and least-seen. A mobile clinic plus home CGA reaches them before the crisis.

4 **Let the data pick the intervention** Every number in the search maps to a workstream. The gaps (ReSPECT, continence) are as valuable as the needs.

5 **Group clinics scale CGA** The vanguard model turns repeat 1:1 contacts into planned, proactive, peer-supported care.

NEXT STEPS

# Where we're taking this

CO-PRODUCTION

1

## Working closer with our PPG

Bringing our Patient Participation Group into the design — testing what frail patients and carers actually want from group clinics and proactive review, and building the offer around their priorities.

DATA & PARTNERSHIP

2

## Triangulating high attenders with a Delphi dashboard

Working with CLCH to cross-reference our highest-attending patients against the Delphi dashboard — sharpening risk stratification so the most complex patients reach the right tier of the operating model.

THREE TAKE-HOME MESSAGES

## 1 Frailty is a search away.

A Rockwood 6+ EMIS search turned an abstract problem into 559 named people — and told us exactly what to build.

## 2 You can start without new money.

We built a proactive frailty service from a physio, pharmacists and social prescribers we already employ.

## 3 Go to the patient.

Group clinics, the Better Health Bus and home CGA reach frail people before the crisis — and get ahead of the contacts driving demand.

**Dr Husain Khaki** · GP Partner **Ben Rutherford** · Patient Care Team Lead & Vanguard Clinics Lead

*Manor View Practice · East of England Group Clinics Vanguard · Central East Frailty Conference, 16 July 2026*