Anticipatory Care Interventions Framework v1.0

Contents

Contents

Introduction to the AC Intervention Framework

The Anticipatory Care operating model (AC model) consists of six components – Case Identification, Holistic Assessment, Personalised Care and Support Planning, Multidisciplinary Working, Coordinated Care and Interventions and Support.

The first five components of the AC model are focussed on identifying people who would benefit from AC, determining their health and wellbeing needs, discussing the support or interventions which could help them, and working in partnership to coordinate their care.

The Interventions and Support component is focussed on delivering activities required to address the needs identified by the above components.

There is evidence of benefit from holistic assessment, personalised care and support planning, multidisciplinary teamworking and care coordination in themselves, but there is even stronger evidence that when brought together as a package they deliver improved health outcomes (x).

Purpose of this framework:

- To help clinicians and other professionals plan and deliver services and supports for those eligible for AC
- To provide a common approach to understanding what interventions and supports may be needed, across all systems and places
- To provide a comprehensive, but not exhaustive, list of interventions and supports that could be provided, while allowing local flexibility to innovate or use established and evidenced local offers
- To promote integrated, personalised care through clinical and non-clinical interventions and supports for both mental and physical health, and activities delivered by a wide range of NHS, social care, VSCE organisations and other potential providers such as housing associations

Using the AC Intervention Framework

What the framework contains:

- A list of categories of interventions and support which could be considered, depending on a person's individual requirements
- A description of what these categories cover
- Some examples of more specific interventions that could be delivered as part of each category
- Links to evidence and resources that will be added to over time.

This AC Intervention framework is part of a suite of materials that will support application of the AC operating model. Additional materials include illustrative 'personas' which show how some of these interventions and supports can be used to improve personalised health outcomes for people.

This Intervention Framework (IF) sets out key areas in which interventions may be effective to address the issues identified during assessment and care planning. **It gives an indication of the types of services** and supports **that might need to be in place to address the AC requirements of individuals.** It should be seen as suggestive rather than prescriptive.

The IF can be used at the level of commissioning, designing or co-producing services collaboratively across the health, care and VCSE sectors.

The IF can also be used by MDTs and professionals coordinating AC for particular individuals, as it gives an indication of options for intervention and supports.

Some areas will already be well served by a range of options that can meet AC. For many clinicians, especially those who are used to working in an integrated, cross-sector way, this framework hopefully sets out a recognisable picture of good practice. It does not intended to overturn any well established and effective ways of working that local teams may have.

For areas which are not as far advanced in planning and implementing AC, the IF aims to provide a structure that can be used to develop the various interventions and supports which may be required by individuals.

Although all areas will be expected to provide interventions in all of these categories, the exact configuration and delivery of them will vary.

For each area implementing AC, identifying the named individuals, groups and services that deliver these interventions and supports locally will be key. **The IF could be used to develop a local directory of services. If such a directory already exists, then it could be checked against the IF to ensure that it meets the needs of AC. This directory would then help MDTs and people receiving AC, and their carers, families and friends, to understand what is available locally.**

Most of the intervention categories could apply to all of the local AC cohort. The IF can be used to understand the likely needs of the local population demographics and also help identify gaps in local provision for the cohorts chosen.

The IF should not be seen as a minimum or maximum standard specification for AC interventions. It is non-exhaustive and is expected to develop as the evidence base for effective interventions and supports grows, and as new interventions are developed.

The strength of evidence for specific interventions and supports is variable. A combination that are personalised to an individual and coordinated as a package of care and support can provide an effective way of addressing the multiple and complex care needs of individuals.

Addressing health inequalities is a national priority and a desired outcome of AC. The Core20PLUS5 approach defines a target population for addressing health inequalities and outlines 5 clinical areas of focus to drive targeted action in health inequalities improvement. MDTs should consider whether those individuals receiving AC feature in the Core20PLUS population group and, where appropriate, use the IF alongside the actions outlined in the Core20PLUS5 approach.

Intervention Categories Overview

AC interventions and supports have been organised into 15 broad categories of positive health and wellbeing outcomes for people receiving AC

These categories are grouped into three main areas, Living Well, General Support to help people live well and Targeted Support for specific health issues.

This is a way of making sense of a rich and varied treatment, care and support landscape, with highly varied means of delivery and of supporting evidence.

Each category lists interventions and supports that specifically target the health and wellbeing outcome for that category, or cross cutting interventions or approaches that can be used for multiple health and wellbeing benefits.

Which interventions are undertaken depend on agreement between the individual and the professionals coordinating Anticipatory Care with them, based on the needs or wants identified during Holistic Assessment and Personalised Care and Support Planning.

For example: Someone with the need and desire to improve their level of exercise could undertake Physio Group Classes, or become part of a peer support group which enables them to exercise along with other people in a similar situation.

Living Well

1. **Understanding and managing health better**
2. **Behaviours to improve health and wellbeing**
3. **Enabling movement and physical activity**
4. **Better diet, nutrition and healthy weight**

General Support

5. **Social prescribing**
6. **Regaining skills and functional ability**
7. **Support with issues related to the home environment**

Targeted Support

8. **Mental wellbeing, loneliness and isolation**
9. **Reducing the risk of falls and fractures**
10. **Support with cognitive and memory problems**
11. **Managing medications safely and effectively**
12. **Continence support and avoiding urinary tract infections**
13. **Addressing specific conditions, symptoms and pain**
14. **Treatment and support for alcohol, tobacco and other drug dependence**
15. **Palliative and End of Life Care**

Cross-cutting interventions comparison table

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Access to food banks				●	●		●				●			●	
Access to green/growing space			●	●	●	●	●	●							
Befriending services	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Carer, friends and family support and education	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Community and other Mental Health services	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Community frailty service, or community frailty hubs	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Community pharmacy advice	●	●		●	●	●	●	●	●	●	●	●	●	●	
Community volunteers and support groups	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Digital hubs in community pharmacy	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
NHS digital weight management programme	●	●	●	●				●							
Training and support to access digital services	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Early intervention and access to home aids and adaptations			●			●	●		●	●		●			
Health and wellbeing coaching / motivational interviewing	●	●	●	●	●	●	●	●		●	●	●	●	●	
Health behaviour change coaching and psychosocial interventions	●	●	●	●	●	●	●	●		●	●	●		●	
Health checks inc. ear, eyes and oral	●	●		●		●	●	●	●	●			●	●	
Industrial scale strength and balance training	●		●		●	●			●				●	●	
Medication review	●		●	●	●	●		●	●	●		●	●	●	
Mental wellbeing support	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
My Planned Care	●	●						●				●			
ORCHA App Library	●	●	●	●	●	●		●	●	●					
Peer support	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Personal Assistance Services	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Personal Health Budgets	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Providing information about benefits of increased physical activity	●	●	●		●	●		●		●	●				
Social Care Assessment (to ensure people have a care account)		●		●	●	●	●	●	●	●	●	●	●	●	
Social economic support & advice	●	●		●	●	●	●			●				●	
Social prescribing assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Social prescribing link worker	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Social prescribing support on isolation prevention	●	●	●	●	●	●	●	●	●	●	●		●	●	
Support group referral	●	●	●	●	●	●	●	●	●	●	●	●	●		●
Supported self-management	●	●		●	●	●	●	●		●	●	●	●		
Transfer to more appropriate housing setting					●	●	●	●	●	●				●	●

These interventions feature in multiple Intervention Categories. On the slides that follow they are listed in the grey boxes. This table shows how they are spread across all the categories and where they are not generally associated with a particular category.

Living Well

1. Understanding and managing health better
2. Behaviours to improve health and wellbeing
3. Enabling movement and physical activity
4. Better diet, nutrition and healthy weight

General Support

5. Social prescribing
6. Regaining skills and functional ability
7. Support with issues related to the home environment

Targeted Support

8. Mental wellbeing, loneliness and isolation
9. Reducing the risk of falls and fractures
10. Support with cognitive and memory problems
11. Managing medications safely and effectively
12. Continence support and avoiding urinary tract infections
13. Addressing specific conditions, symptoms and pain
14. Treatment and support for alcohol, tobacco and other drug dependence
15. Palliative and End of Life Care

1. Understanding and managing health better

Description: Information, advice, education or training to help people understand their own health or people they care for better and manage their own conditions or risks

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Provide nutritional information (such as nutrition wheels)
- Undertake educational programmes, in a range of formats, to better understand personal health issues, such as long term conditions, and how to manage them, may be linked to a wide range of other interventions
- Hydration advice for individuals and/or carers
- Provide education resources in multiple languages, formats and settings, to accommodate a full range of educational needs, sensory impairment and cultural needs.
- Undertake educational programmes for 'healthy ageing' that encourages healthy feet, mouth, teeth; drinking alcohol sensibly; seeking help with mental health support, getting a hearing and eye test; keeping an active mind; sleeping well; attending physical health checks, and keeping safe at home, keeping warm.
- Training, education and engagement provided by Health and Wellbeing Advocates
- Health education and awareness training provided by specialist charities such as Age UK

Supporting Information

Wessex AHSN Nutrition wheel: explanatory guide

Improving health literacy to reduce health inequalities-PHE

BDA-the importance of hydration

NHS Health information in multiple languages

Department of Health-Wellbeing across the life course

NHS-Someone to speak up for you (advocate)

Health and wellbeing advice-Age UK

NHS Better Health - Drink less

NHS Digital Weight Management Programme (National tier 2 weight management service)

2. Behaviours to improve health and wellbeing

Description: Ways of by helping individuals (or their carers) change their behaviour and develop new strategies to improve their health and wellbeing.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Smoking cessation / tobacco dependence services that provide behavioural support and pharmacotherapy.
- Alcohol identification and brief advice (IBA).
- Wellbeing interventions such a green therapy or ‘men in sheds’ groups
- Social support (groups or individuals) and networking to address loneliness & isolation
- Activities/support for mental health and wellbeing provided by charities like Age UK which are focussed around behavioural change
- Conversations about what matters to the person
- Referral, and education, to routine screening for example diabetic eye screening and bowel cancer screening

Supporting Information

Health Coaching – Quality Framework; Health Education England

Behaviour change: individual approaches; NICE Public health guideline [PH49]

How health coaching can help patients manage their own health (OARS framework resource)

Supporting Behaviour Change; Royal College of Nursing

Health Coaching Implementation and Quality Summary Guide

Behaviour change techniques in personalised care planning for older people: a systematic review

NHS - Universal Principles for Advance Care Planning (ACP).

NHS Screening

NHS Digital Weight Management Programme (National tier 2 weight management service)

3. Enabling movement and physical activity

Description: Activities focussed on improving fitness, mobility and physical function.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Accessible and affordable walking/ leisure/ activity opportunities (supported by active travel initiatives)
- Virtual group consultations (e.g. strength and balance, 'chair yoga', etc)
- Access to physical activities – links with VSCE and local authority and school sports facilities
- Physio group classes (in person)
- Getting and keeping active
- Access to Active Partnerships
- Support for mental health needs impacting on fitness and mobility

Supporting Information

NHS Live Well - Physical activity guidelines for older adults

NHS Live Well – Exercise: Physical activity guidelines for adults aged 19 to 64

Providing physical activity interventions for people with musculoskeletal conditions;

We are undefeatable UK

Active Partnerships, engaging communities, transforming lives

Uniting the movement-Sport England Strategy

Active at Home Booklet to download

Keeping Well This Winter Booklet to download

YouTube: Exercises to improve strength and balance

Making Movement Your Mission

Later Life Training

Deconditioning post COVID. A suite of resources from the National Falls Prevention Coordination Group

NHS Digital Weight Management Programme (National tier 2 weight management service)

4. Better diet, nutrition and healthy weight

Description: Preventing or reversing problems associated with poorer nutritional intake; including being over or under weight; cardiovascular disease; fitness; and improving enjoyment of life.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Provide nutritional information (such as nutrition wheels)
- Dietetics input and collaborative plan utilising a 'Food First' based approach
- Access to / review of supplements, where addressing the person's diet alone is insufficient, still utilising the 'Food First' approach
- SLT assessment and interventions for people with swallowing difficulties
- NHS weight loss programme
- Health coaching to tackle obesity, using motivational interviewing or techniques like OARS (Open-ended, Affirming, Reflecting, Summarising) model
- Healthy eating food co-operatives, reducing cost of healthier eating
- Eating disorder services
- Support for people with depression that impacts on their nutrition

Supporting Information

Comprehensive Geriatric Assessment in Primary Care Settings: Weight loss and nutrition issues; British Geriatrics Society

Enhanced service specification - Weight management

NHS Better Health – Lose Weight

NHS Live Well - Keeping your weight up in later life

NHS Live Well - Managing weight with a learning disability

Eating well: Children and adults with learning disabilities - Nutritional and practical guidelines

NHS Live Well - Underweight adults

Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition; NICE Clinical guideline [CG32]

Implementing a Food First approach to tackle malnutrition in Doncaster; The Malnutrition Task Force

Food First/Food Enrichment; BAPEN

Wessex AHSN Nutrition wheel: explanatory guide

NHS Digital Weight Management Programme (National tier 2 weight management service)

General Support

5. Social prescribing

Description: Health and wellbeing interventions accessed via a social prescribing link worker or community connector.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Working with a Social Prescribing Link Worker (SPLW)
    - Local options to help getting active such as: Local walking clubs, gardening clubs / groups, befriending services for trips to the shops, etc
- Connection with local community based on what matters to the individual through existing community groups / community assets
- Referral to mental health teams if appropriate
- Local Area Co-ordination (LAC)

Supporting Information

Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions

HEE - Social prescribing at a glance North West England

Social prescribing evidence map: Technical report; Arsyllfa Lechyd Cyhoeddus Cymru, Public Health Wales Observatory; Public Health Wales NHS Trust

General Support

6. Regaining skills and functional ability

Description: Support with restoration of skills, function, physical and emotional resilience, along with promotion of independence.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Reablement recovery and rehabilitation (including occupational therapy, physiotherapy and other therapy services)
- Home modifications and adaptations for independent living to support independence. Can be provided by Home improvement agencies / other home improvement charities
- Support to access the Disabled Facilities Grant
- Assessment of sensory function (sight, hearing, balance etc.)
- Assessment of functional ability to perform activities of daily living
- NHS New Medicine Service
- Assistive technology - e.g. Home modifications, adaptations and assistive technology to support independence

Supporting Information

Intermediate Care SCIE highlights

The benefit of adding a physiotherapy or occupational therapy intervention programme to a standardized group-based interdisciplinary rehabilitation programme

Housing Design and Community Care: How Home Modifications Reduce Care Needs of Older People and People with Disability

Age UK-Home adaptations to simplify home tasks-Disabled Facilities Grant

HM Government - Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England

Assessment of Sensory Function in the National Social Life, Health, and Aging Project-NCBI

Benefits of rehabilitation-physio-pedia

NHS New Medicine Service

General Support

7. Support with issues related to the home environment

Description: Support for people in all housing circumstances and tenures e.g. home owners, renters (private, social and supported housing), aimed at tackling unhealthy, unsuitable, precarious housing issues that impact on health and wellbeing and/or supporting moves.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

UNHEALTHY HOMES

- Property standards & 'safe and well' checks – homes free from hazards, unintentional injury, safe from harm; door access/security systems, fire electrical and gas safety
- Housing conditions – Local authority advice and support; handyperson services providing small repairs, minor maintenance and odd jobs in and around the house
- Fuel poverty support – to homes that are warm and affordable to heat

UNSUITABLE HOMES

- Housing options services – Information and advice on housing choices, Help to move packages enabling people to move to more suitable accommodation
- Aids and adaptations - Disabled facilities grants; housing assistance including assistive technology in the home to enable independence, accessibility and movement
- Housing management - Decluttering and cleaning; advice and support on moves

PRECARIOUS HOUSING AND SUPPORT TO TRANSITION/PATHWAYS

- Homeless prevention and response – Advice, guidance and practical housing support and tenancy sustainment to prevent homelessness, including welfare benefit advice and debt counselling/rent or mortgage arrears; access to temporary and settled accommodation to alleviate homelessness e.g., refuges, foyers, hostels
- Care and support pathways – 'home first' from hospital; 'step down/up' and crisis accommodation; intermediate care and reablement services; referral for supported housing such as extra care housing; access to floating support; domiciliary care
- Other accommodation and related support services to support moves from homelessness e.g., outreach teams or to enable independent living e.g., domestic abuse services
- Family and neighbourhood support – access to social prescribing, peer-to-peer support or other community-based services

Supporting Information

GENERAL

Improving health and care through the home: MoU

Housing Learning and Improvement Network (the Housing LIN)

UNHEALTHY HOMES

Local authority help with housing repairs

FIRE PREVENTION, GAS SAFETY AND ELECTRIC SAFETY ADVICE

Fire safety for carers and support workers advice

Home Safety, falls prevention in later life

Hoarding: A Report into Best Practice

Home improvement and handyperson services (Foundations)

National Evaluation of the Handyperson Programme

UNSUITABLE HOMES

Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England

A guide to planning and delivering home adaptations

Investment in housing adaptations, improvements and equipment – evidence review

Self-assessment tool to assess whether your home still works and what you can do

Foundations Adaptations Triage tool

Room to Improve: The role of home adaptations in improving later life

PRECARIOUS HOUSING AND SUPPORT TO TRANSITION/PATHWAYS

Referrals to local authority homelessness prevention and response services

VCSE HOMELESSNESS PROVIDERS – Homeless Link and Street Support Network

Integrated health and social care for people experiencing homelessness

Homelessness: applying All Our Health and Inclusion Health: applying All our Health

Managing transfers of care from hospital – housing (change 9)

Improving care transfers from hospital for people experiencing homelessness

Transition between inpatient hospital settings and community or care home settings for adults with social care needs

Local authority interventions to improve quality in supported housing

Targeted Support

8. Mental wellbeing, loneliness and isolation

Description: Ways to improve mental health and social wellbeing needs of a person.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Links to community volunteers/ assets - VCSE underpinning community anchors for this
- Advocacy
- IAPT
- Charities such as Age UK , MIND and Independent Age provision of various activities/support for mental health and wellbeing
- Training and support to access digital services
- Community and other Mental Health services
- Bereavement support
- Peer support for people with a learning disability
- Integrated early care pathway for autism
- Ensuring annual health checks for those living with severe mental illness

Supporting Information

The community mental health framework for adults and older adults, Section 3.2 Functions of community mental health services in this Framework

Comprehensive Geriatric Assessment in Primary Care Settings: Patients presenting with depression; British Geriatrics Society

Older people with social care needs and multiple long-term conditions; NICE guideline [NG22] Section 1.6 Preventing social isolation

Leeds Older People's Forum Resources Reports, toolkits and case studies (Time to Shine Project)

Exploring how to develop effective services to reduce loneliness; Housing LIN

Community Hubs: A partnership approach to creating community based services for older people in Gloucestershire; Housing LIN

The financial care for integrated mental health services and supported housing pathways; Look Ahead Care and Support

An integrated early care pathway for autism

NHS - Annual health check for people with severe mental health conditions

Targeted Support

9. Reducing the risk of falls and fractures

Description: Actions taken to help reduce risk of accidental falls and any resultant injuries, for people at high risk of falls or challenges afterwards during recovery.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- NICE multifactorial falls assessment and plan
- Medical assessment to investigate clinical conditions that may contribute to falls risk, including assessment for postural hypotension
- Community falls prevention services
- Strength and balance training / services
- Use of the Falls Management Exercise (FaME) toolkit
- Falls risk focussed medication review
- Falls risk and general household assessments, such as identifying need for decluttering, by other agencies e.g. fire service
- Housing provider assessments/decluttering services
- Assistive technology, adaptations and home monitoring
- Fall detectors / alarms
- Falls-drop in clinics
- Eye health/vision and sensory function assessments
- Examination of feet and footwear
- Safe slipper replacement service
- Podiatry assessment
- Secondary care services for co-morbidities contributing to falls
- Support and coaching to overcome fear of falling, which could otherwise lead to reduced mobilisation and associated depression
- Osteoporosis diagnosis
- Falls and Fragility Fractures services and Fracture Liaison services

Supporting Information

Falls in older people: assessing risk and prevention – Multifactorial Assessment and Multifactorial Interventions: NICE Clinical guideline [CG161]

Falls in older people – Multifactorial Interventions; NICE Quality standard [QS86]

Comprehensive Geriatric Assessment in Primary Care Settings: Patients presenting with mobility and balance issues

Falls: Applying All Our Health; Office for Health Improvement and Disabilities

All our health – Falls and Fractures: e-Learning for Health / Public Health England training resource

A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community

Best MSK Programme - Musculoskeletal Networks; Arthritis and Musculoskeletal Alliance

UK chief medical officer's physical activity guidelines

Falls Assistant falls prevention and self-management tool-NHS 24 SCTT

Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults, Public Health England

National Falls Prevention Group Webinars and Resources

Bedside vision assessment tool-RCP

Targeted Support

10. Support with cognitive and memory problems

Description: Assessment, treatment, care or support for people who may have cognitive or memory issues.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Assessment of cognition using a validated tool
- Local services for diagnosis of dementia including baseline assessments for people with Downs Syndrome
- Provide access to support pre and post diagnosis
- Aids and advocacy support for people with cognitive and Communication needs
- Transfer to more appropriate housing, access adaptations service or assistive technology
- Wellbeing and social support services to maintain links and delay decline in cognition
- Voluntary sector support groups and services
- Advanced care planning
- Identification of delirium
- Functional assessment if indicated, to assess need for adult social care support
- Cognitive stimulation therapy
- Dementia review

Supporting Information

Comprehensive Geriatric Assessment in Primary Care Settings: Mental capacity issues

Best practice in memory services: learning from across England

Next Steps helps you to find the right support, at the right time, while waiting for your memory assessment appointment

Circles of Support for People with Dementia - Evaluation Report

Housing for people with dementia - are we ready? – APPG on Housing and Care for Older People

Dementia and housing: an assessment tool for local commissioning

Dementia and people with learning disabilities: making reasonable adjustments – guidance

Someone to speak up for you (advocate)

Targeted Support

11. Managing medications safely and effectively

Description: A structured, critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Structured medication reviews (annual as part of PCN DES).
- Community pharmacy NHS Discharge Medicines Service (review patients on discharge)
- Community-based support to help people be confident with or compliant w/ or manage their medication including assessment and support for medication utilisation (e.g. can the person get the lid of the childproof container? do they need an aid to give themselves their eye drops? do they need a "dossett" system or other form of daily dose reminder?)
- Annual uptake of vaccinations: Vaccine uptake must include a clear focus on the Core20PLUS5 clinical priority of chronic respiratory disease, with a focus on driving uptake of vaccines that reduce ineffective exacerbations and emergency hospital admissions due to those exacerbations, including flu, pneumonia and COVID-19.
- Provide medication leaflets in easy-read format and multiple languages
- Provide information/guidance on cultural/ religious/dietary requirements
- Arrangement of blood monitoring when needed

Supporting Information

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes; NICE guideline [NG5]

Medicines optimisation; NICE Quality standard [QS120]

Comprehensive Geriatric Assessment in Primary Care Settings: Medication review

The national influenza immunisation programme 2021 to 2022

Stopping over medication of people with a learning disability, autism or both (STOMP)

Targeted Support

12. Continence support and avoiding urinary tract infections

Description: Helping an individual achieve and maintain control of their bladder or bowel functions, or find ways of managing this and preserve dignity if full control is not possible, including emotional support.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Continence assessment and management plan in primary / community care
- Specialist continence clinic or urology clinic
- Support and coaching for lifestyle changes
- Signposting to Self Management resources (e.g. Bladder/ bowel foundations)
- Provision of continence supplies and antibiotic therapies for UTIs
- Community catheter nurses and trial without catheter clinics
- Pelvic floor muscle exercise training
- Emotional and psychological support

Supporting Information

Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care

Minimum Standards for Continence Care in the United Kingdom

CGA in Primary Care Settings: Patients presenting with urinary incontinence

A 'Trial Without Catheter at home' programme at the Royal Victoria Infirmary

Pelvic floor dysfunction: prevention and non-surgical management: NICE guideline [NG210]

How continence problems can affect mental health -Bladder and Bowel UK

Constipation and people with a learning disability

13. Addressing specific conditions, symptoms and pain

Description: Support, specialist advice, care and treatment for specific conditions and symptoms, whether related to mental or physical health, including a particular focus on the symptoms that cause a person the most problems, especially pain.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Specific care or treatment for named clinical conditions, high case complexity, or when required, provision of appropriate specialist services
- Assessment and optimisation of management of LTCs with due regard for frailty when present
- Review by primary care or geriatrician if complex long terms condition(s) is/are poorly managed
- Pain management with regular reviews (ensuring pain recognition)
- Health behaviour change coaching and psychosocial interventions
- Support for the mental health impacts of physical conditions, such as high rates of anxiety associated with Parkinson's disease
- Support for the physical effects of mental health conditions and ensuring annual health checks for those living with severe mental illness, people with SMI are at greater risk of poor physical health and have a higher premature mortality than the general population with 2 in 3 deaths due to physical illness that can be prevented
- Remote monitoring of BP and other vital signs
- Use of smart care technology in a home setting to access remote care and support to maintain independence
- NHS @home pathways, such as BP Monitoring @ home or Proactive Care @home
- Assessment and optimisation of symptom control
- Screening for cancers in line with the Core20PLUS5 clinical area of focus of early cancer diagnosis (aiming stage 1 or 2)
- Blood pressure and cholesterol monitoring and optimisation in line with the Core20PLUS5 clinical area of focus for cardiovascular disease

Supporting Information

Comprehensive Geriatric Assessment Toolkit for Primary Care Practitioners: British Geriatrics Society

RESTORE2

Identifying early signs of worsening health in a person with a learning disability

Dis DAT Tool

Wong-Baker FACES pain rating scale

Non Communicating Adult Pain Checklist

Early diagnosis-cancer NHS

Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain

Targeted Support

14. Treatment and support for alcohol, tobacco and other drug dependence

Description: Support and treatment for dependence on alcohol and other psychoactive substances and the associated health and social harms.

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Systematic screening in acute hospitals
- Referral to Alcohol Care team (in acute hospital)
- Referral to in-house Tobacco Dependence Service (acute and mental health inpatients, maternity services)
- Referral to community addiction services
- Management of physical consequences of alcohol withdrawal
- Motivational interviewing

Supporting Information

Alcohol change UK - Get help now

NHS - Find alcohol addiction support services

Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers

Drug misuse and dependence: UK guidelines on clinical management

Neptune - Novel Psychoactive Treatment: UK Network

Alcohol Care Team Innovation and Optimisation Network (ACTION)

NCSCT Online Training: Very Brief Advice on Smoking (VBA+)

ELFH / HEE: Alcohol and Tobacco Brief Interventions

NCSCT Online Training: Stop Smoking Practitioner training and certification

Coexisting severe mental illness and substance misuse: community health and social care services

Targeted Support

15. Palliative and End of Life Care

Description: Support for individuals, and their carers and families, in the last year of their life to enable them to live as well as possible

Specific interventions: Non-exhaustive suggestions of interventions specific to this category

- Proactive early identification of people likely to be in their last year of life
- Holistic assessment encompassing physical, psychosocial, emotional, spiritual and cultural needs
- Initiate conversations about what matters most to the person in order to live well now as well as planning for the future (advance care planning) and consideration of Lasting Powers of Attorney
- Consider referral to specialist palliative care to support complex cases (does not have to be long term)
- Home aids and adaptations to optimise function
- Optimise symptom management through physical and non-physical measures
- Rationalise medicines and deprescribe if appropriate
- Ensure information and arrangements are in place for the person, carers and urgent care services to meet unscheduled needs, especially out of hours, including anticipatory clinical management plans
- Offer to submit DS1500/SR1 to support application for benefits under special rules and refer for Personal Health Budgets or Continuing Health Care funding (fast track if rapidly deteriorating)
- Assess and address family and carer needs, including bereavement support
- Connect person with community support – e.g. faith leaders, day hospice, befriending services, compassionate community initiatives, death cafes

Supporting Information

Universal Principles for Advance Care Planning

Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

RCGP Daffodil Standards and other resources for palliative and end of life care

Providing spiritual care-Marie Curie

Special Rules for benefits

Carers Support Needs Assessment

Caring for people experiencing homelessness in palliative care

Supporting information for the overall framework

Evidence review: Anticipatory care interventions for adults with case complexity; Solutions for Public Health (SPH) on behalf of the NHSE/I Ageing Well Programme June 2020

Supporting adult carers; NICE guideline [NG150]

Older people with social care needs and multiple long-term conditions;

The Community Mental Health Framework for Adults and Older Adults; Royal College of Psychiatrists overview

The community mental health framework for adults and older adults

Behaviour change: individual approaches; NICE Public health guideline [PH49] Recommendation 8 Ensure interventions meet individual needs

Standards framework for shared-decision-making support tools, including patient decision aids; NICE Corporate document [ECD8]

Comprehensive Geriatric Assessment Toolkit for Primary Care Practitioners

Comprehensive Geriatric Assessment in community settings

Population Health Management Academy – Case Study Series

Understanding and aligning link worker and community capacity building activity: A place-based approach in York and Wakefield - Summary of Learning and Recommendations

'The ten billion dollar question' Embedding Prevention in Older People's Services – 10 'high-impact' changes;

Eye care and people with learning disabilities: making reasonable adjustments

What works in inclusion health: overview of effective interventions for marginalised and excluded populations