British Geriatrics Society
Improving healthcare for older people

Joining the dots:
A blueprint for preventing and managing frailty in older people

EXECUTIVE SUMMARY

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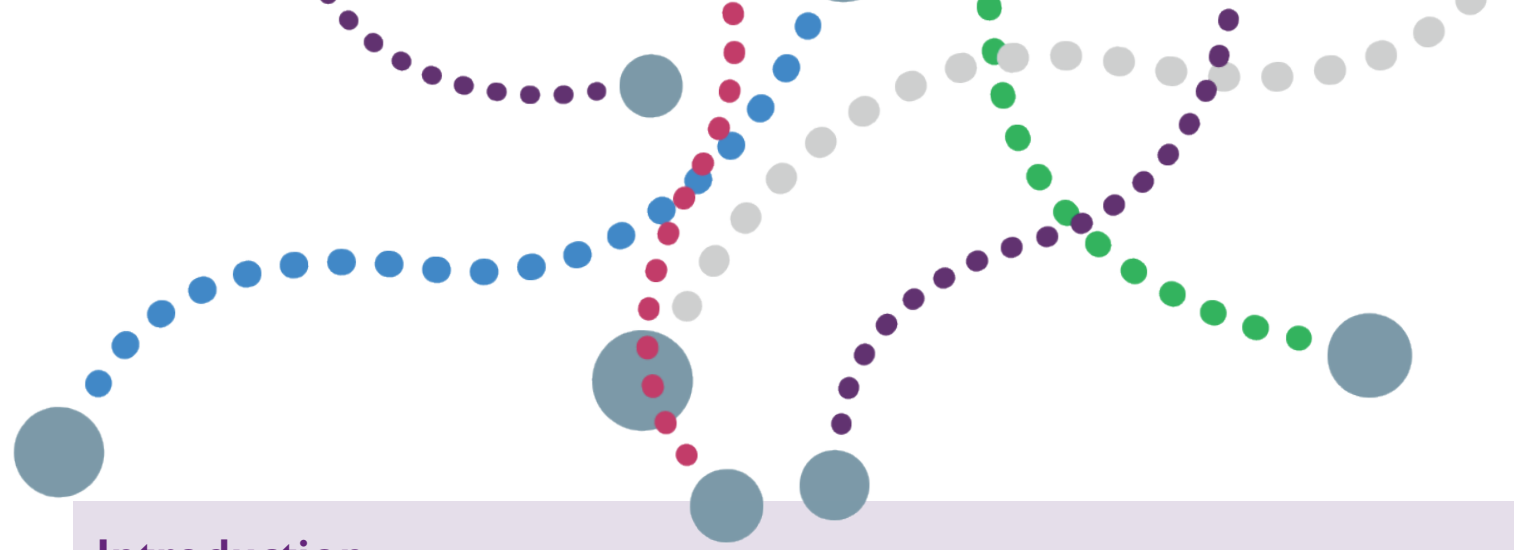
#BGSBlueprint



Introduction

The population of the UK is ageing, with particularly fast growth in the oldest old age groups – by 2045, the number of people aged 85 and above will have almost doubled.

Older people are already the largest user group of health and social care services. When services work for older people, they are more likely to work for the rest of the population. It is therefore essential that commissioners place older people and their health and social care needs at the centre of strategic planning and commissioning processes.

This document has been written by Professor Anne Hendry, BGS Honorary Secretary and Honorary Professor at the University of the West of Scotland, alongside an expert working group. Within it, we set out seven system touchpoints and outcomes that should be considered when planning and commissioning health and social care for older people, alongside 12 actions that systems should take to create the conditions for high-quality integrated care for older people.

The blueprint is aimed primarily at system leaders and commissioners of health and social care services for older people. We hope that it will assist these senior decision-makers to understand and implement the core features of age-attuned integrated care for older people.

This is a short summary of the full document *Joining the dots: A blueprint for preventing and managing frailty in older people*. The full 24-page version can be downloaded from **www.bgs.org.uk/Blueprint**

Executive summary

Older people have diverse, often complex, needs, and health and care services need to respond to that complexity and heterogeneity. This document aims to be a Blueprint to show what good-quality age-attuned integrated care for older people can look like.

BGS members around the country report differences in the way that older people's health and care is delivered in their area. Variations range from different ways urgent and crisis care is delivered to whether or not there is a specialist outpatient clinic or day hospital for older people. Systems should of course plan and deliver care and support that meets the needs of the population they serve. However, as the population ages, it is vital that health and care commissioners address the needs of older people living with frailty.

Frailty affects up to half of the population aged over 85[1] and costs UK healthcare systems £5.8billion per year.[2] Around 47% of hospital inpatients aged over 65 are affected by frailty.[3]

But frailty is not an inevitable part of ageing, and putting in place measures to slow its onset or progression should be a priority for every commissioner across the UK. Prevention and reversal of frailty enables people to live independently for longer and helps to reduce demand for emergency care and long-term support.

With this in mind, the BGS has set out seven 'system touchpoints' that should be included when planning and commissioning health and social care for older people. The BGS was pleased to participate in the core group that steered the *I'm Still Me* project.[4] We have taken inspiration from this narrative for coordinated support for older people in developing the Blueprint and have woven the *I'm Still Me* statements through the touchpoints to create person-centred outcomes.

It is important to note that this is not a pathway. Care rarely takes a pathway approach. Many older people will simultaneously require care or support drawn from several of the touchpoints described. Others will only experience a few touchpoints or may have repeated contact with one. Every individual is different. It is important that commissioners invest in all of these elements together to create a comprehensive 'wrap around' system of care that supports older people to age well and live well at home for longer.

The seven touchpoints

Enabling independence, promoting wellbeing

I am able to stay healthy for longer and supported to be independent in an age friendly community where I can maintain social contact as much as I want, take part in activities that are important to me, and am recognised for what I can do rather than assumptions being made about what I cannot.

This touchpoint encompasses physical, mental, emotional and spiritual health. Regular exercise, good quality nutrition and social contact can help older people to remain healthier and more independent for longer. A combination of age friendly environments and targeted approaches are needed to support older people to remain physically active and reduce their risk of falls and fracture, with specific effort for those with communication, cognitive, sensory or physical impairments.

Population-based proactive anticipatory care

I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me. I can make my own decisions, with advice and support from family, friends or professionals if I want it.

Older people at risk of ill health and poor outcomes must be identified and proactive interventions offered to support them to remain well and independent. Emerging evidence shows that this approach can improve continuity and coordination of care and reduce emergency attendances. Proactive care can include interventions such as structured medication reviews, ensuring that older people are only taking medications that are likely to be beneficial for them. In the long term, the approach aims to reduce healthcare inequalities and improve system outcomes.

Integrated urgent community response, reablement, rehabilitation and intermediate care

If I fall or become acutely unwell, I can get the right help at the right time from the right person at home, or closer to home, and a team of professionals coordinate my care and support my recovery.

Many older people who experience an acute illness or decompensation of a frailty syndrome prefer to receive healthcare at home or closer to home when this can be provided safely and effectively. All localities should offer a high-quality multi-professional integrated urgent community response (UCR) that provides both intensive short-term hospital-level care at home through Hospital at Home, and goal-oriented home-based and bed-based intermediate care services that optimise recovery through reablement and rehabilitation.

Frailty-attuned acute hospital care

My risk of poor outcomes and support needs are identified and addressed throughout my hospital stay. Those who matter to me are recognised as being key to my independence and quality of life.

Older people with frailty account for a significant amount of hospital admissions and often have poor experiences and outcomes from urgent care. Many older people with frailty admitted to hospital as an emergency could be fit to return home on the same day if they were assessed, diagnosed and treated swiftly on arrival at hospital. Pathways attuned to the needs of older people with frailty are needed across the whole hospital, including pre-operative assessment and peri-operative care.

Reimagined outpatient and ambulatory care

I have more joined-up care and can see the right people for the right amount of time in a single clinic visit.

The need to adjust the traditional outpatient model for older people is increasingly pressing. There is growing evidence for personalised patient-initiated follow up, albeit more studies are needed to assess outcomes for older people. Older people often have multiple conditions, visit multiple specialists and clinics and have to retell their story many times. This is both frustrating and wasteful. Innovations such as one-stop frailty clinics and community-based ambulatory care hubs and clinics can help to improve patient experience and ensure that already stretched services operate more efficiently.

Enhanced healthcare support for long term care at home and in care homes

I can build relationships with people who support me. All my health and care needs are considered together and my care and support help me live the life I want to the best of my ability in the place I call home.

Care homes are home to around 400,000 older people with frailty. The average care home resident is 85 years old, has six medical diagnoses and takes eight medications. The majority of residents have high care needs and are in the last two years of life. When comprehensive geriatric assessment, co-ordinated multidisciplinary care and care management are organised around the care home and recognise the care home staff's vital contribution, residents, families and staff are more satisfied and less likely to require hospital services.

Co-ordinated, compassionate end of life care

At the end of my life I, and those who matter to me, am supported to experience a good death in my preferred place of care.

End of life care for older adults living with multiple health problems and frailty is different from dying with a single disease. The range of trajectories of decline includes sudden death, slow progressive deterioration (such as in advanced dementia), catastrophic events (such as stroke or hip fracture), and periods of prolonged uncertainty associated with fluctuating episodes of acute illness, delirium or functional decompensation. An end of life care model integrating the principles of palliative, geriatric, and rehabilitative medicine is needed.

The ambitions, service interventions and enabling actions in our Blueprint are relevant for all health and social care systems that aspire to enable older people to age well and live well at home for longer. Implemented together, they will help achieve better outcomes for older people, carers, families and communities and realise greater value for health and care systems.

Our 12 recommendations

Recommendation 1

Demonstrate strong system leadership that creates a shared vision for healthy ageing and preventing and managing frailty.

Recommendation 2

Appoint a senior officer or non-executive Board member with a specific role to seek ongoing assurance on the quality of health and social care for older people and their carers.

Recommendation 3

Publish baseline, then annual, State of Ageing reports on system-wide outcome indicators related to care for older people including feedback from patients and carers to reflect their experience.

Recommendation 4

Develop a system-wide strategy and costed implementation plan for a population health approach to the prevention and management of frailty, including a specific focus on dementia and falls.

Recommendation 5

Commission or deliver inter-professional education aligned with the Skills for Health Frailty Core Capabilities Framework and which builds capacity for Comprehensive Geriatric Assessment, quality improvement and integrated practice in all disciplines across the system.

Recommendation 6

Develop an integrated Workforce Plan to build adequate specialist and generalist multidisciplinary capacity and skill mix to care for older people with complex needs.

Recommendation 7

Protect and preserve the right to rehabilitation for all older people who need it, in line with the principles outlined by the Community Rehabilitation Alliance.

Recommendation 8

Publish an older people equality and diversity impact assessment and action plan.

Recommendation 9

Engage and involve older people, carers and communities as equal partners with health and social care professionals in co-design, delivery and monitoring the impact of these services and support.

Recommendation 10

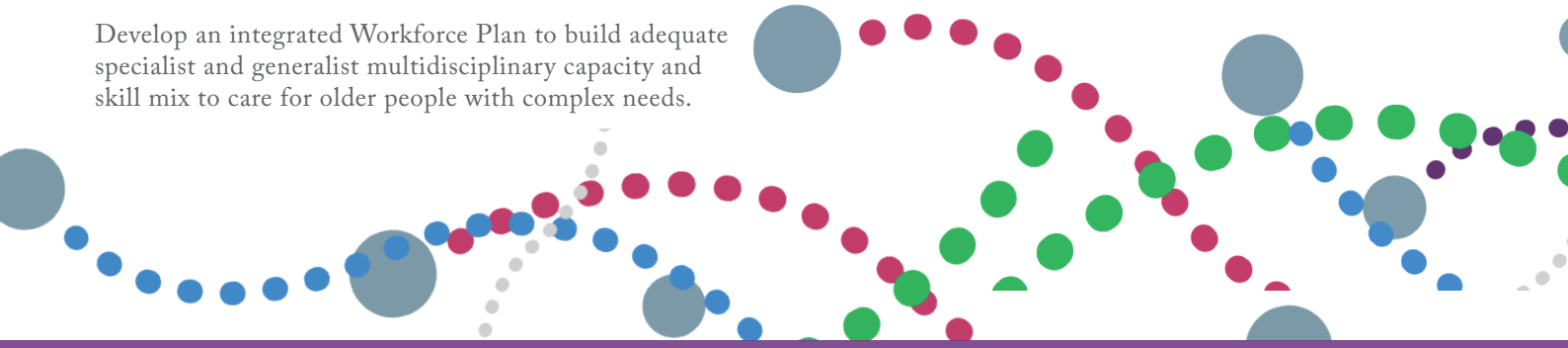
Provide support to enable the lived experience of older people and carers, including those with dementia and mobility, sensory or communication needs, to inform quality improvement and assurance.

Recommendation 11

Work with public health, housing, community and voluntary sector partners to build social capital, mobilise community assets and adopt place-based approaches to create inclusive, compassionate age- and dementia-friendly communities.

Recommendation 12

Make use of existing guidelines and resources and the expertise held within the BGS community.



BGS stands ready to support health and care systems to create the conditions for change.

We have a multidisciplinary membership of over 4,600 healthcare professionals and have extensive expertise across policy and communications, education, training and research. Our members work across the four nations of the UK and across acute, primary, community and social care. We urge leaders from all integrated care systems to work with us to ensure that the services they commission or provide for their older citizens, patients and carers are the best they can possibly be.

References

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3. Doody et al. 2022. 'The prevalence of frailty and pre-frailty among geriatric hospital inpatients and its association with economic prosperity and healthcare expenditure: A systematic review and meta-analysis of 467,779 geriatric hospital inpatients', Ageing Research Reviews. Sep;80:101666. doi: 10.1016/j.arr.2022.101666
4. National Voices, 2014. I'm still me: A narrative for coordinated support for older people. Available at: **www.nationalvoices.org.uk/publications/our-publications/im-still-me** (accessed 7 February 2023)

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