British Geriatrics Society
Improving healthcare for older people

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

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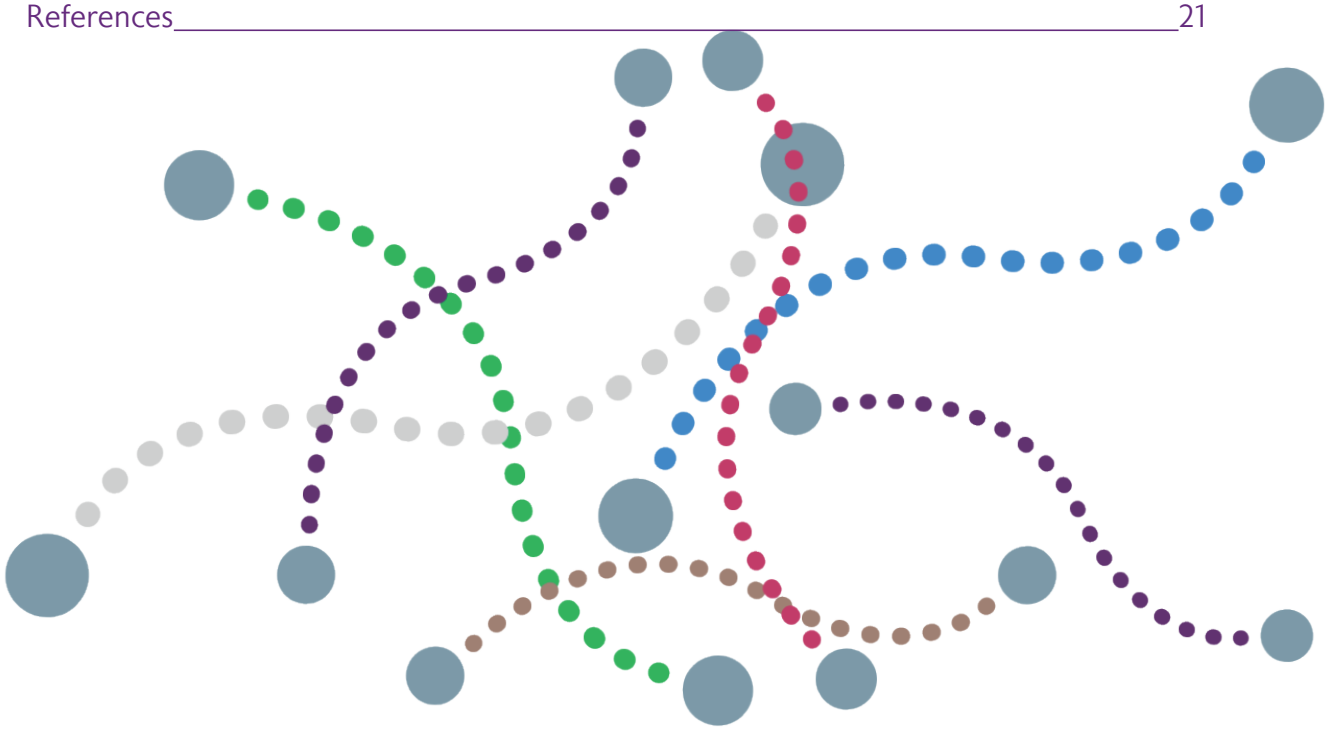
#BGSBlueprint

Contents



Chapter one: About this report

Foreword

Older people use the NHS and social care services more than any other age group and as the population continues to age, the demand for such services will continue to grow. People are living for longer with more complex conditions in older age and often require specialist care from a range of professionals across the multidisciplinary team. At the same time, new organisations across the UK are taking on responsibility for commissioning health and social care services and it is essential that they get this right for older people. If services work for older people, the biggest user group for health and social care, they are more likely to work for everyone else.

Across the UK, health and social care services are currently failing older people. At the time of publication the NHS is in crisis, struggling to deal with the worst winter in the service's history as well as trying to recover from the COVID-19 pandemic. However, many of the issues plaguing the NHS and social care are long-standing, including years of under-investment and failure by successive UK and devolved governments to reform social care. There is insufficient capacity within the current workforce and inadequate workforce planning to meet the needs of the ageing population. Health and social care staff are exhausted and spend much of their time trying to deal with the immediate crisis. This short-term approach cannot continue: the time to change is now.

Collectively we need to realise the gains from integrating health and social care services, invest in a sustainable interdisciplinary workforce and completely rethink how services are organised. This will make them work for the benefit of older people, so that older people can access the high-quality care and support they need at a time and place that is appropriate to them. Investment in older people's health and social care means that older people are supported to remain healthy and independent for longer, and are less likely to require emergency hospital admission and premature admission to long term care. This in turn relieves pressure on stretched services and avoids costs associated with escalating dependency.

Some of those responsible for commissioning integrated health and social care may not be familiar with the evidence around good care for older people. It is with this in mind that we offer this Blueprint. It sets out why investing in high-quality, joined-up care for older people improves outcomes for older people and their carers, reduces demand, increases the resilience of health and social care systems, and delivers economic and societal benefits. We have provided some case studies showcasing how services can be designed and delivered to meet the needs of an older population living with frailty and other complex health conditions. These build on the examples in our previous joint publication with the Royal College of General Practitioners.[1] The Blueprint is intended to be a helpful guide for senior decision makers who are planning and commissioning integrated care for older people.

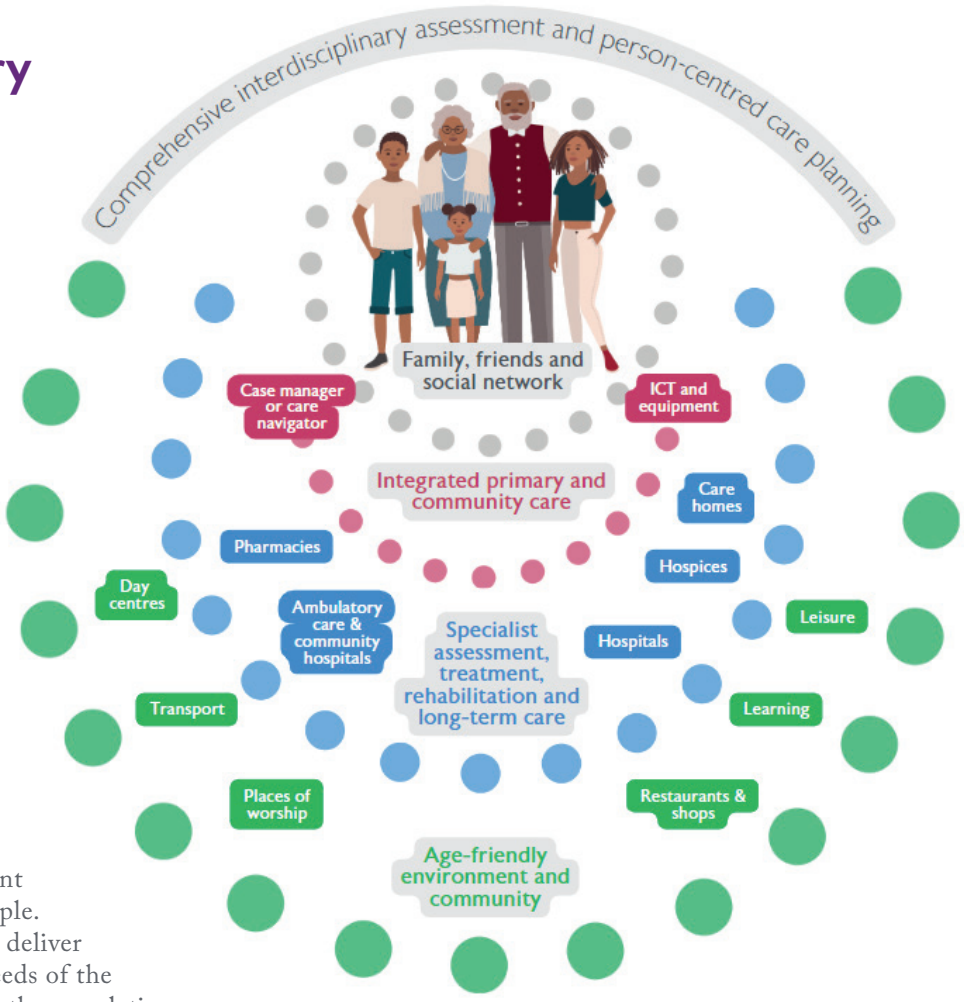
The BGS has a wide range of resources to support the development of services for older people living with frailty. Our 4,600 members work in a range of multidisciplinary roles across acute, primary and community care settings across the four nations of the UK and share the same goal – to improve healthcare for older people. We urge anyone involved in the commissioning of integrated care for older people to engage with the expertise of the BGS and its members to ensure that they get it right for the people they serve.

Professor Adam Gordon
BGS President

Professor Anne Hendry
BGS Honorary Secretary and lead author

Executive summary

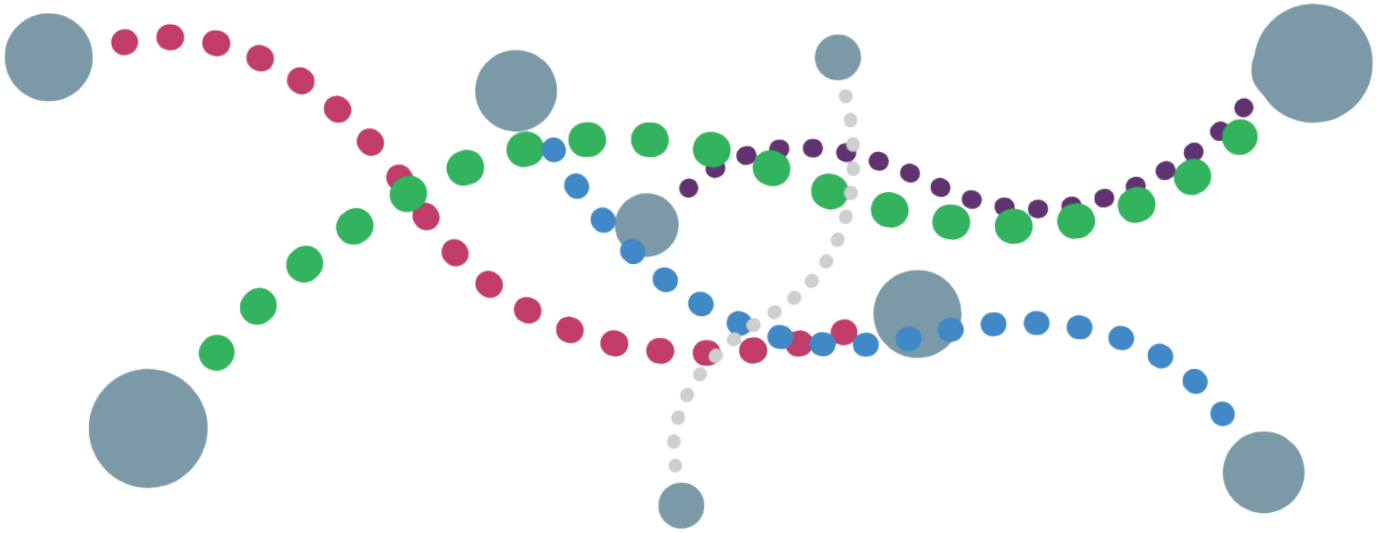
Older people have diverse, often complex, needs, and health and care services need to respond to that complexity and heterogeneity. This document aims to be a Blueprint to show what good-quality age-attuned integrated care for older people can look like.



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[2] and costs UK healthcare systems £5.8billion per year.[3] Around 47% of hospital inpatients aged over 65 are affected by frailty.[4] 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.[5] 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.



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.

Navigating this report

This Blueprint aims to set out how organisations taking on responsibility for integrated health and social care services for the first time can organise their services to best meet the needs of the older people within their communities. We start by explaining why we have chosen to publish this document at this time and who we consider our audience. In this chapter we collate twelve recommendations for systems which are included within the main text of our Blueprint.

Chapter two looks specifically at the population that this Blueprint applies to – older people, including those living with frailty. In this chapter, we outline how we have tried to keep older people at the heart of this document and set out what works for older people from the perspective of best practice and what matters to older people. We discuss the rapidly ageing population, explain why frailty is of particular significance and pose some challenges for system leaders to consider. This chapter also discusses population approaches to frailty in the UK, including the electronic frailty index, and outlines the particular workforce challenges facing older people's healthcare.

Chapter three turns to system touchpoints, reflecting where there is evidence and pointing to case studies that can support systems to make the required changes. This chapter looks specifically at seven interdependent areas of older people's healthcare: enabling independence, promoting wellbeing; population-based proactive anticipatory care; integrated urgent community response, reablement, rehabilitation and intermediate care; frailty-attuned acute hospital care; reimagined outpatient and ambulatory care; enhanced healthcare support for long term care at home and in care homes; and co-ordinated, compassionate end of life care.

We conclude with an offer to help system leaders across the UK to commission the right care for their older populations with support from the resources and expertise of the BGS.

Chapter two: Setting the context

Introduction

The organisation of health and social care services across the four nations of the UK seems to be forever evolving, with responsibility for commissioning services continuously moving between organisations. In England in particular, new Integrated Care Boards have been charged since July 2022 with the commissioning of health and social care services with a greater focus on service integration and population health. 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.[6] It is therefore essential that commissioners ensure older people and their health and social care needs are central to the new strategic planning and commissioning processes. Older people are 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. With this in mind, the primary audience for this document is system leaders and commissioners of health and social care services for older people. We hope that it will help these senior decision-makers to better understand the core features of age-attuned integrated care for older people. We intend to publish an abridged version of this document at a later date for a wider audience of healthcare professionals, patients and system partners.

Why a focus on older people is important

A longer life brings many opportunities for older people, particularly when they experience good health, have strong social networks, and live in an environment which values their contributions and supports them to live the lives they choose. However, for many adults, later life brings declining physical and mental health, all too often compounded by inequity of access and missed opportunities for interventions that help to maintain their independence and wellbeing.

This means older people are more likely to experience frailty - a 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. The consequences of escalating frailty are adverse outcomes such as disability and its consequences, frequent hospital admissions and increasing demand for long-term social care support.[2]

The COVID-19 pandemic shone a light on systemic ageism, exacerbated existing inequalities, and increased the harm experienced by older citizens from loneliness and isolation, deconditioning, poor mental and physical health and digital exclusion.[7,8] These factors further increase demands on our health and social care systems that were already facing significant challenges from:

- A social care system in crisis, contributing to older people staying in hospital longer than medically necessary due to the lack of care packages available in the community – this was highlighted through the BGS's Timely Discharge blog series in 2021.[9]
- An unprecedented elective care backlog, generating further dependency and increasing demand for social care, rehabilitation, mental health, primary and community services.
- A workforce that is under-resourced, over-stretched and underpaid. While data about the full older people's healthcare workforce is lacking, we know from analysis of the Royal College of Physicians census that vacancies across geriatric medicine are common.[10]
- A growing number of older people experiencing fuel poverty and food insecurity.
- Facilities that are not fit for purpose for older people with dementia or a physical disability.
- Lack of interoperable IT and information governance arrangements across providers.

The pandemic also demonstrated what can be achieved when professionals and organisations work together more creatively and with local communities: better collaboration and trust, and an ability to pivot, innovate and make changes at pace, as highlighted in BGS's two reports about beneficial innovations during the pandemic.[11,12] The COVID pandemic and its ongoing aftermath have placed additional pressure on a system that was already stretched by years of under-funding. However, a significant opportunity to rethink how services are delivered now exists. As integrated care systems move to a statutory footing in England and corresponding arrangements evolve further across the UK, this is an ideal time for urgent action to prevent, identify and manage frailty to improve the lives of older people and those who care for them and to build greater resilience in our health and social care systems.

Why frailty matters

In this section we discuss why frailty is such an important issue for the delivery of older people's healthcare and why all organisations responsible for commissioning health and care services should consider frailty as a priority. While there are many health conditions that are common in older age, our members have specific expertise in the management of frailty along with other conditions. We challenge system leaders to consider the following questions about the impact of frailty on their communities and on the services they commission or provide.

How many people in your community are living with frailty?

Frailty is common – more than one in ten people over 65 years in the community live with frailty. Frailty also affects over half of adults in hospital or care home settings.[13] Does your system understand the current demand associated with frailty?

How will this number change in the coming years?

Frailty is increasing as people are living longer with multiple long-term conditions.[14] The number of people in the UK over the age of 85 is set to double by 2045,[6] with up to half of this age group living with frailty.[1]

Does your system understand the complexity of frailty?

Many people with frailty will have cognitive impairment and dementia and vice versa, increasing the complexity of their care needs. As frailty is often associated with functional impairments, it requires a restorative or enabling approach beyond the scope of a traditional biomedical chronic care model. Older people with frailty often experience five common syndromes:

- Falls (e.g. collapse, legs give way, found lying on the floor)
- Immobility (e.g. sudden change in mobility, 'gone off legs', stuck on toilet)
- Delirium (e.g. acute or worsening of pre-existing confusion, or short-term memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Medication-related harms

Does your system understand the impact of frailty on individuals, families and society?

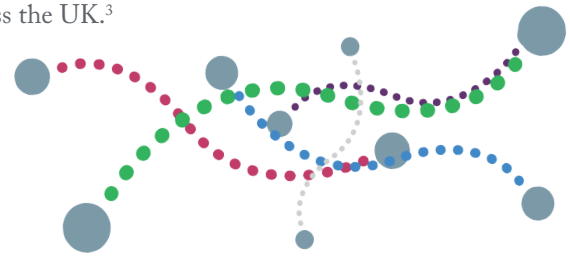
Frailty is life-limiting – even after adjusting for long-term conditions, socio-demographic, and lifestyle factors, the presence of frailty is associated with higher mortality.[15]

Frailty affects us all - If we do not change the way we support older people to age well, we can anticipate a dramatic increase in frailty-related disability and dependency, a negative impact on quality of life, morbidity and mortality, further escalation of acute and long-term health and care costs, and an increase in the human and economic costs of unpaid caregiving.[16] This is an urgent call to change the way we provide care and support for older people and to make our health and care systems face up to frailty.

How well does your system currently manage frailty?

Frailty is generally not managed well – too often, early signs of frailty are not recognised, resulting in missed opportunities for early intervention contributing to higher numbers of older people presenting in crisis.

Suboptimal management of frailty is expensive – frailty and multimorbidity are strong predictors of healthcare utilisation.[17] The extra annual cost to the healthcare system in England per person with frailty was calculated at £561.05 for mild, £1,208.60 for moderate and £2,108.20 for severe frailty, using 2013/14 reference costs. This equates to £5.8billion per year, across the UK.[3]



Case studies

- The **Kent Integrated Dataset** (KID)[18] links health and social care data for more than two million people. The KID analysis of health and social care spending on people aged over 65 by their level of frailty demonstrates the need for system-wide understanding and action on frailty.
- **Midlothian Health and Social Care Partnership** applied the electronic Frailty Index (eFI) to their population over 65 years and linked this information with patient-level data on use of healthcare services. This resulted in costs for cohorts with different levels of frailty. The observed healthcare costs for over 65s in Midlothian were extrapolated to illustrate Scotland-level costs for older people with different levels of frailty.

Through use of data, both systems were able to show the impact of frailty on spending and proactively identify individuals with mild or moderate frailty whose condition could be reversed.

What steps is your system taking to prevent and reverse frailty?

Preventing frailty also improves brain health – modifiable risk factors for frailty are also risk factors for dementia so a health promotion and preventative approach will impact on both conditions.[19]

Frailty is potentially reversible, especially in its earlier stages, and can be managed well by comprehensive assessment and tailored interventions, rehabilitation, care and support.[20] In addition to the direct benefits for older people and their carers, families and communities also benefit as preventing or delaying frailty and disability improves wellbeing and participation.

For all of the above reasons, it is important to ensure that older people's health and care is considered as its own entity and not subsumed into general adult services. We know from the experience of the pandemic that a specific voice for older people is needed to ensure that their interests are not overlooked. Integrated systems must have cross-cutting leadership focused specifically on care for older people. This should include having a Board non-executive member or senior officer whose specific role is around assuring the quality of health and social care for older people and their carers. This individual should be responsible for co-creating a shared system-wide vision for healthy ageing and the prevention and management of frailty, and for the publication of an annual statement reporting on progress against this vision.

The experience of the COVID-19 pandemic showed that a specific voice for older people is needed to ensure that their interests are prioritised. The pandemic exposed an ageism within society and the healthcare needs of older people were not prioritised, despite evidence that they were at greatest risk.[21] It should be obvious that frailty and ageing are everybody's business. However, it is necessary but not sufficient to continually make this point. Predicated representation and leadership is required, supported by data emphasising the importance of a focus on older people's healthcare. System leaders should have access to regular reports on how their system is performing to support this important overlooked majority.

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.

The role of Comprehensive Geriatric Assessment

One of the cornerstones of older people's healthcare, with a strong evidence base, is the assessment and management process known as Comprehensive Geriatric Assessment (CGA). This multidimensional approach that includes physical, cognitive, functional, social and psychological components, is the gold standard, most evidence-based method to prevent and manage frailty syndromes and their complications using interventions tailored to the needs of the individual.[22] It encompasses accurate diagnosis, discussion of prognosis and shared decision-making around interventions that include: exercise, particularly strength and balance training, adequate nutrition, management of long-term conditions focused on functional ability and enabling independence, and avoiding adverse events from inappropriate polypharmacy. Multi-component interventions are more effective than single interventions. The effective application of CGA for older people in acute hospital settings improves independence, reduces harms associated with deconditioning, delirium and polypharmacy, and reduces length of stay, unplanned re-admissions and the need for long-term care.[23] These gains depend on having an appropriately trained multi-professional team of doctors, nurses, allied health professionals, pharmacists and social workers focused on holistic assessment of the patient's needs and wishes with, where appropriate, involvement of those who matter to them. Assessment leads to a personalised care plan that prioritises and implements interventions in a coordinated way. The team manages the individual's conditions and care needs in a balanced, holistic way, particularly where treatment of one condition may worsen another. Enabling independence, respecting autonomy, promoting shared decision-making and anticipatory care planning, with the appropriate support where cognitive or communication challenges exist, are important elements of the CGA approach.

While CGA in acute settings – whether in emergency and unscheduled care, perioperative medicine or cancer care settings – is highly evidence-based, the level of evidence is less well developed for CGA in the community and primary care settings,[24] and in those with the most advanced stages of frailty. This probably reflects the operational complexities in bringing diverse community-based professionals together as a virtual team. Nonetheless, evidence is emerging for the judicious application of multidimensional assessment and interventions in primary care tailored to the needs of individuals living with frailty.[25] There is growing international evidence of effectiveness and positive outcomes from a coordinated, interdisciplinary CGA approach in the community.[26,27,28,29] Perhaps the best examples at scale are from the PACE Programme in the US[30] and the PRISMA system in Quebec.[31] A success factor in seven international case studies of effective models of integrated care for older people with complex needs[32] was moving from a service-orientated care pathway to a population-orientated system model with comprehensive wrap-around care and support.

Integrated care for frailty

A systematic review by the European Joint Action Advantage concluded integrated care for frailty requires effective chronic care, timely acute care, plus enablement and rehabilitation to optimise functional ability, particularly at times of a deterioration in health, or when moving between home, hospital or care home.[33] This review informed the integrated model of care and support to prevent and manage frailty developed by 22 European countries between 2017 and 2019.[34]

This integrated model comprises:

- Screening to identify individuals with, or at risk of, frailty;
- CGA and personalised care and support planning in all care settings;
- Tailored interventions such as exercise (particularly strength and balance training), adequate nutrition, and structured medications reviews to optimise appropriate polypharmacy;
- Reablement, rehabilitation and intermediate care to promote independence and recovery at times of transition from hospital and after illness;
- Advance care planning that considers treatment escalation plans and preferences for end of life care;
- Provision of equipment, adaptations and assistive technologies.

These elements are mutually reinforcing - individual elements are more effective when implemented together as a bundle of interventions across the health and care system and framed within an enabling environment and age-friendly community. The World Health Organisation guidance to achieve Integrated Care for Older People (ICOPE) was informed by a systematic review of evidence[35] and by a Delphi study to reach consensus on the key actions that would be needed to deliver the ICOPE approach.[36]

These actions map well to the European Frailty Prevention Approach[37] and can be grouped as five themes:

1. Engage and empower people and communities
2. Support the coordination of services delivered by multidisciplinary providers
3. Orient services towards community-based care
4. Strengthen governance and accountability systems
5. Enable system-strengthening

Population approaches for frailty in the UK

Commissioning services for older people starts with understanding the assets in local communities and the needs of the local population. Stratifying the population into groups with different levels of complexity helps to target interventions and resources to where they will have most impact.

The electronic Frailty Index (eFI)[38] uses coded data extracted from the GP electronic health record to identify an individual's

risk of frailty, expressed as a 'Frailty Index' (the number of deficits present/the total number of deficits being assessed). Deficits include coded clinical conditions, disabilities, and relevant symptoms or abnormal laboratory results. The eFI categories have been validated against a range of outcomes for older people: emergency admissions to hospital; emergency bed days; care home admissions; and mortality. The eFI can be applied to the older population to tailor interventions to the four categorisations of frailty which range from 'fit' to 'severely frail':

- **Fit** - a population-level approach with information and advice on active and healthy ageing
- **Mildly frail** - as above plus personalised self-management information, advice and support
- **Moderately frail** - as above plus holistic care and support planning, structured medication review plus CGA by a multidisciplinary team
- **Severely frail** - as above plus case management and palliative/end of life care.

Case studies

- This tiered approach to frailty has been adopted by **Staffordshire and Stoke on Trent ICS.** Their Healthy Ageing and Managing Frailty in Older Age strategy[39] aims to improve healthy life expectancy and reduce health inequalities for older people in the area. It describes ambitions to develop new models of holistic care and a radically different workforce model with the right capacity to meet the changing patterns of illness as a result of population ageing.
- **One Devon**'s population health management strategy for older people builds on a locally commissioned enhanced service for West Devon and on evidence from the Pathfields model.[40] Use of this tool identified more patients living with frailty than use of the eFI alone and enabled more patients to receive earlier interventions.
- **Frimley ICS** identified frailty as a priority and established a whole-system Frailty Advisory Board to drive an integrated approach to frailty within their localities. The group identified areas for improvement by benchmarking against the Right Care Frailty Toolkit.[41]

This approach to identifying frailty has helped systems to prioritise resources in their areas and may be particularly effective in areas with a high proportion of older people such as coastal communities and towns with many care homes.

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.

Building workforce capacity and capability

Older people and their carers require timely access to a wide range of generalist and specialist care and support delivered by primary care, community services, acute care, social care, housing, community and voluntary partners as well as specialist palliative care services. Rising demand from demographic change increases the need for more geriatricians, nurses, allied health professionals, pharmacists, GPs and social workers with specialist expertise in assessment and care for older people. At present, workforce shortages and the level of unfilled vacancies in some parts of the country are a particular problem for the delivery of healthcare for older people.

Whilst all members of the multidisciplinary team face major workforce challenges, the current state of the Consultant Geriatric Medical workforce is the most well described[42] and likely reflects similar challenges facing other disciplines. Over two thirds of respondents in a UK survey by the Royal College of Physicians reported specialist vacancies and over 70% were working additional hours to cover gaps. Almost half of Geriatric Medicine Consultants are within 10 years of their intended retirement age. This ageing specialist workforce is compounded by an increasing trend towards less than full time (LTFT) working (currently 23%). LTFT working enables people to work more flexibly and allows them to balance their clinical workload with other aspects of their personal or professional lives. This is to be welcomed and encouraged. There is an urgent need to train more specialists in older people's healthcare to provide direct clinical care and to build the capability of generalists to prevent and manage frailty across the system. Yet it takes an average of 16 years from entering medical school to complete specialist training. The need for innovative and effective workforce solutions has never been greater nor more urgent.

Upskilling the workforce

Demographic change means that the majority of the health and care workforce will care primarily for older people and therefore need the knowledge and skills to be able to deliver care and support for older people, regardless of their specialty. Education and training in frailty as a specific condition, and enhanced knowledge and expertise in caring for people with multiple long-term conditions, are essential if we are to have a workforce that can meet the changing healthcare needs of our ageing society. Including guidance and competencies in the management of frailty in educational curricula and in quality standards for professionals who are not specialists in older people's healthcare is needed to help skill up the wider workforce to deliver healthcare for older people.

The Skills for Health Frailty Core Capabilities Framework[43] provides a single, consistent and comprehensive framework on which to base staff development. The framework builds on, and cross-references, other core skills frameworks for dementia, end of life care and person-centred approaches.

The 15 core capabilities in the framework are defined for three tiers of stakeholder:

- **Tier 1:** Those that require general awareness of frailty
- **Tier 2:** Health, social care and others who regularly work with people living with frailty
- **Tier 3:** Health, social care and other professionals who provide expert care and lead services for people living with frailty.

BGS's Frailty E-Learning module is a comprehensive resource that covers the skills, knowledge and behaviours expected of healthcare professionals involved in the health, care and support of people living with frailty. This course is aimed at Tier 3 capabilities and skills - all health, social

care and other professionals who provide expert care and lead services for people living with frailty. This e-learning module has been in use for some time and organisations such as King's College London University Hospitals NHS Foundation Trust have enrolled staff across several departments in the course. BGS has recently reached an agreement with NHS England to update the content and make it freely available to all NHS staff.[44]

The **Diploma in Geriatric Medicine** is a qualification run by the Royal College of Physicians and BGS which enables healthcare professionals to demonstrate their knowledge and experience of the healthcare of older people. It is open to professionals from any specialty and provides recognition of knowledge, skills and understanding of managing frailty and the chronic conditions experienced by older people.

Case studies

- **Frimley ICS** has introduced:
  - A system-wide e-learning package, based on Frailty Core Capabilities Framework (tier 1)
  - Frailty training for ICT staff.
  - An in-house degree module through University of West London (tier 3) run annually.

  Future plans include developing a Tier 2 frailty training package for health and social care staff who regularly work with people living with frailty.
- **Dorset HealthCare**'s online frailty module provides a basic level of information to increase the knowledge of all staff who come into contact with people who may have frailty. GP practices are encouraged to promote completion of this module by all reception/admin and clinical staff to help develop practice based and locality level support to identify people who have mild frailty.

Maximising the workforce

Investment to develop the right current and future workforce capacity needs to be matched by support to build effective interdisciplinary teams if we are to make the best possible use of scarce resources. High-performing teams are characterised by people who respect and trust each other, and enhance each other's contributions.[45] Each member has the professional agency to operate at the upper end of what their skills and licences permit, rather than be constrained by overly hierarchical, siloed structures that limit their contributions.[46] Development opportunities to enhance skills and scope of practice can strengthen the contribution of professionals to the MDT, improve their experience and enhance care outcomes. Teamwork and individual judgement are particularly important in care for older people with multiple health and social care needs, where benefits of interventions and potential harms have to be balanced carefully.

There are not enough healthcare professionals currently working in older people's care and in the long term, more people will need to be recruited to all roles across the multidisciplinary team. In the interim however, there are steps that can be taken to increase capacity in older people's healthcare. The promotion of newer roles such as advanced clinical practitioners and physician associates can help to alleviate pressure in older people's healthcare. SAS Grade doctors should also be encouraged to specialise in older people's medicine. SAS doctors comprise almost 20% of all doctors in the UK (rising to 30% when locally employed doctors are included)[47] – this role is and will continue to be essential in the ongoing healthcare of older people.

In addition to this, there is a growing group of GPs who have taken on extended roles in frailty across a variety of settings. This enables them to champion care of the older population in proactive and urgent care settings working across different organisations. These new positions provide sustainability and resilience across the different workforces.

There has been substantial disinvestment in rehabilitation services in recent years. The opportunity to recover from illness and to regain independence should be seen as a right for all. It is essential that systems work to understand the rehabilitation needs of their older populations and invest in the workforce and estate needed to support both home and bed-based rehabilitation for older people.

Recommendation 5: Commission or deliver inter-professional education that is aligned with the Skills for Health frailty core capabilities framework and 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.[48]

Older people at the heart of our blueprint

The complex needs of older people are at the heart of our Blueprint. Older people are living longer than ever before. This is a triumph and should be celebrated as it reflects advances in medicine and healthier lifestyles throughout the life course. However, for many people, this also means more years spent in ill-health and increased numbers of people with frailty and multimorbidity. The healthcare needs of this age group are complex and diverse and this must be taken into account when commissioning services for older people. The group of BGS members responsible for this document used their combined expertise to ensure that the recommendations in this Blueprint acknowledge the range of needs experienced by older people. The BGS was pleased to participate in the core group that steered the *I'm Still Me* project[5] and we have taken inspiration from it in developing the Blueprint. Older people have not had a sufficient voice in the planning and delivery of health services. The NHS has traditionally been organised by disease or condition and is not currently set up to care for the multiple complex needs that many older people have. The health and social care system was not designed to care for an ageing population. Systems and services have therefore grown without the automatic inclusion of older people in service design and evaluation. However, the population has changed with many more people living into old age with increasing health and care needs. Older people account for around 40% of hospital

admissions[49] and occupy around 60% of hospital inpatient beds at any given time.[50] Failure to plan with the needs of this group in mind will result in a health and social care system that does not meet the needs of the population it serves.

One feature of stressed and disorganised care systems is the unintended muting of the patient voice.[51,52,53] The principles of 'what matters to me' and the 'Realistic Medicine'[54] movements remind us to ensure a personalised approach to care, based on shared decision-making heavily influenced by the individual's wishes and priorities for their care. Experience has demonstrated this can reduce waste and treatment burden – expressed in patient time, staff time, or other resources – and improve the experience for people who receive care and for their carers.[55,56] For the sake of current and future users of health and social care, we cannot afford to tolerate systems that mute the patient voice, fail to support collaboration and personal or professional agency, or devalue the most effective forms of leadership and teamwork.

BGS calls for all Integrated Care Boards and their system partners from health, social care, housing, third and independent sectors to recognise that their core user group is older people. Well-designed systems take seriously the perspective and lived experience of people who use their services. Involving older people and their carers in the design, delivery and evaluation of care and support helps to ensure responsive, flexible services that respond to their needs.

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 ongoing quality improvement and assurance.

What matters to older people

The *I'm Still Me*[5] narrative provided valuable insight into what older people want to see from health and social care. A more recent survey conducted by Yorkshire & Humber's Older People with Frailty Applied Research Collaboration identified the top priorities of older people living with moderate or severe frailty.[57]

The top two priorities were:

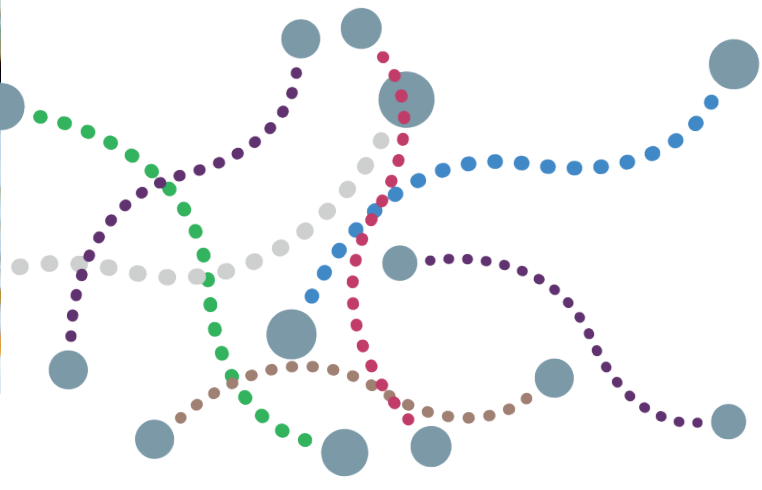
- **Staying in my own home** - living in my own home for as long as I can, with support if I need it.
- **Staying independent** - being able to undertake daily and social activities.

Other priorities included:

- Making decisions with family or friends, carers and health professionals about any care or support I might need in the future.
- Having more joined-up care.
- Health and care professionals having a better understanding of the experiences and needs of older people.
- Having a better understanding of my physical or mental health conditions(s) and symptoms.
- Having more information about my physical or mental health condition(s) and what I can do to manage my symptoms.
- Worrying less about falling.
- Doing more exercise/physical activity.
- Having better support for vision loss or impaired vision.
- Having a range of housing choices, where help is provided if I need it.

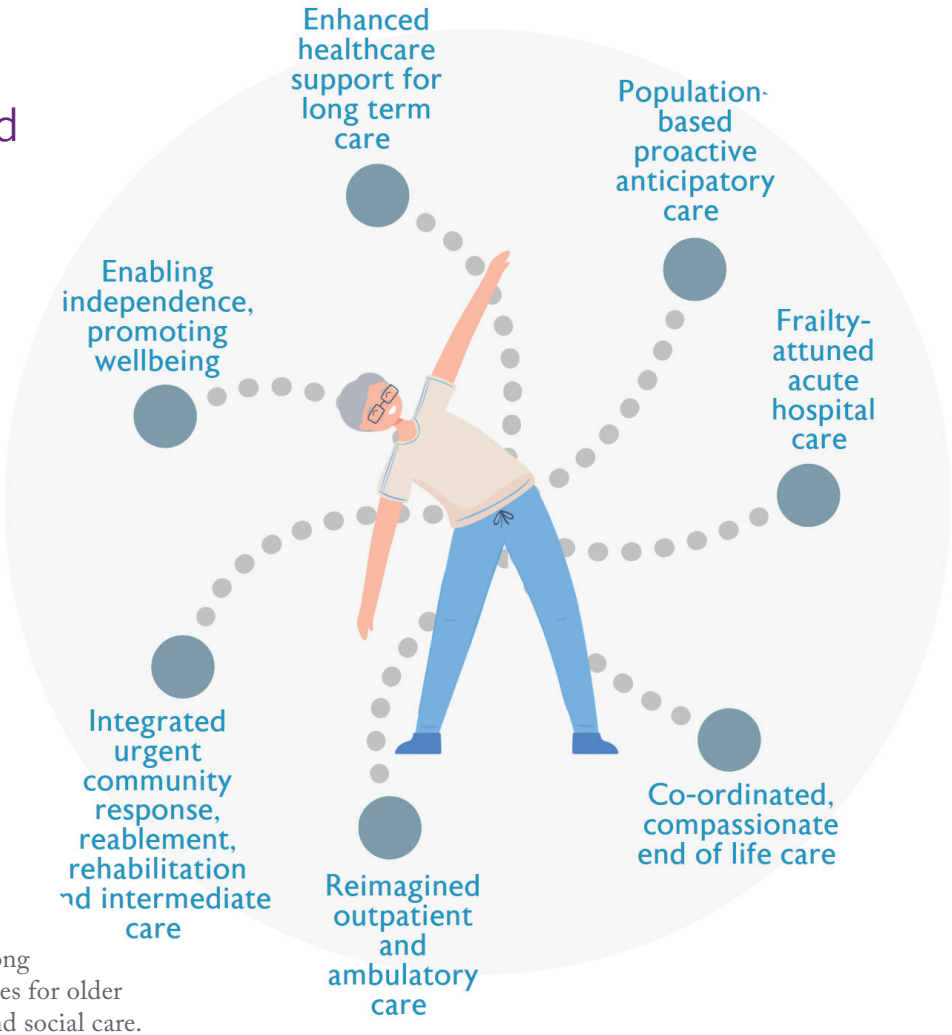
In light of the above, it is important for ICSs to consider how they can best support older people to be independent and live well for longer in their own homes. Some of the solutions may not appear to be directly related to healthcare. For many older people (and others) with complex health needs, healthcare may be a secondary consideration. Systems will therefore need to work with local communities and partner organisations to create inclusive communities that support older people to age well and live well at home for longer. Investing in prevention and supporting people to live independently for longer impacts upon their use of health and care services and will reduce costs in the longer term.

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.



Chapter three:
System touchpoints and examples

This section of our blueprint describes the key touchpoints of care and support for older people across the system, from prevention through to end of life care. It describes the evidence-based approaches and interventions that are required to prevent and manage frailty across the continuum of care. These are interdependent and mutually reinforcing and should be designed as 'wrap around' services that are available for all older people, wherever and whenever they are needed.



Services that are designed around the needs of older people will reduce the number of people admitted to hospital as an emergency, promote early discharge home, and ensure that fewer people are readmitted to hospital or to long term care. This in turn improves outcomes for older people and reduces costs for the NHS and social care.

Enabling independence, promoting wellbeing

Wellbeing encompasses physical, mental, emotional and spiritual health. Loneliness and social isolation are associated with higher mortality, increased risk of coronary heart disease, stroke, high blood pressure, depression and suicidal thoughts, and contribute to frailty and dementia risk as much as physical inactivity.[58] There is strong evidence that regular exercise, particularly strength and balance training, reduces falls and partially reverses or slows progression of frailty.[59] Inadequate nutritional intake is an important modifiable risk factor for frailty and falls and is highly influenced by social determinants such as poverty, food insecurity and social isolation. Action needs psychosocial solutions as described in the Eat Well Age Well programme.[60] Age-friendly Communities[61] enable people of all ages to live healthy and active later lives, live at home for longer, participate in the activities that they value, and contribute to their communities. Targeted approaches and support are needed to fully involve people with communication, cognitive, sensory or physical impairments.

Other useful resources

- BGS Healthier for Longer (2019): www.bgs.org.uk/healthierforlonger
- World Guidelines on Falls Prevention and Management (2022) https://academic.oup.com/ageing/article/51/9/afac205/6730755

Case study

Make Movement Your Mission (MMYM), developed by the Later Life Training charity, broadcasts freely accessible 15 minute 'movement snacks' three times per day on Facebook (live and recorded) and YouTube. The key message, 'sit less, move more' applies to all ages and abilities. Participants (age 40 to 90+ at home and in care settings) include people with neurological or musculoskeletal conditions that need regular movement to slow progression or reduce symptoms. Participation and activity levels are promoted by support from the online instructor, Facebook messages pre and post live sessions, peer support, and self-motivation from noting improvements in balance and posture. Feedback indicates that the regular short movement snacks are felt to be achievable, provide a routine and offer opportunities to engage with others. In an independent evaluation, 90% of respondents said they moved more frequently and regularly every day; 53% reported better quality of life; and up to half reported improvements in activities of daily living (ADLs). Participants on waiting lists for joint replacement were kept mobile and had less pain.

Other examples

- **Mid & East Antrim Agewell Partnership (MEAAP),** Ballymena, Larne & Carrickfergus, Northern Ireland www.meaap.co.uk/impactagewell
- **Age Friendly Manchester** www.manchester.gov.uk/info/200091/life_over_50/8388/find_out_about_age_friendly_manchester

Population-based proactive anticipatory care

Proactive anticipatory care targets people at risk of poor health and social outcomes in order to offer tailored support to stay well. Individuals at risk of poor outcomes are identified using validated population level screening tools combined with professional judgement. Those with significant or escalating risk are offered a comprehensive multi-disciplinary assessment and appropriate interventions co-ordinated by a local multidisciplinary team of healthcare, social care and community or voluntary service partners working together. The older person and their carer or family will be involved in developing a personalised care plan based on their goals and preferences. Emerging evidence shows that the approach can improve care continuity and coordination and reduce emergency attendances. In the long term, the approach aims to reduce healthcare inequalities and improve system outcomes.

'Polypharmacy', the prescribing of multiple medicines, increases the likelihood of adverse effects, impacting significantly on health outcomes and use of health and care resources.[62] Structured medication reviews[63] to ensure appropriate polypharmacy are a core element of anticipatory care for older people. Scotland introduced an evidence-based seven steps approach and guidance on how to undertake medicine reviews for people with multiple morbidities and/or frailty. Guidance and tools are available at **www.polypharmacy.scot.nhs.uk.**

Case studies and examples

- **North Lanarkshire HSCP** developed an innovative collaboration between the health/ social care locality team, primary/secondary care professionals and a voluntary sector partner to provide person-centred, anticipatory care for older adults with escalating levels of frailty and high risk of deterioration in the community. Initially the holistic frailty assessment was completed by a Health Visitor band 5. Covid-19 prompted an innovative partnership with Equals Advocacy (EA) who already had a track record in facilitating Anticipatory Care Planning (ACP). With initial support EA workers were able to undertake home frailty assessment focussed on 'What Matters to Me'. Moving to a virtual MDT format has saved time and travel. Attendees include Advocacy Worker, Primary Care Senior Decision maker, Older People's Community Mental Health Team, Care at Home Manager, Advanced Clinical Services Pharmacist, Frailty Specialist, Community Nursing and Community Rehabilitation Team Lead. The MDT developed six standard interventions for all and additional tailored interventions depending on need. The Advanced Clinical Services Pharmacist within the MDT has resulted in improved pharmaceutical outcomes and reduced inappropriate polypharmacy. A formative evaluation is underway.

Other examples

- **Proactive Telecare** provided by Delta CONNECT, West Wales
  www.deltawellbeing.org.uk/delta-connect

Other useful resources

- NHS England Anticipatory Care operating model and intervention framework **https://future.nhs.uk/CommunityHealthServices/groupHome** (login required)
- BGS Community Case Studies **www.bgs.org.uk/resources/community-geriatrics-video-case-presentations**
- BGS Anticipatory Care Blog Series **www.bgs.org.uk/AntCare**
- PrescQIPP Polypharmacy and Deprescribing Polypharmacy and deprescribing | **PrescQIPP C.I.C**
- RPS Polypharmacy Getting our medicines right 2019 Polypharmacy: Getting our medicines right (**rpharms.com**).

Integrated urgent community response, reablement, rehabilitation and intermediate care

Many older people who experience an acute illness or decompensation of a frailty syndrome prefer to receive healthcare at home or closer to home. 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 Virtual Wards[64] and Hospital at Home[65], and goal-oriented home-based and bed-based reablement and intermediate care services that optimise recovery through rehabilitation.[66] Together, these services reduce risk of deconditioning, delirium and hospital-acquired infection, improve hospital flow, support older people to regain independence and reduce demand for readmission and long-term support.[67] Close working between hospital same-day assessment units, primary care teams, ambulance providers, community rehabilitation, and intermediate care and reablement services is required to ensure an efficient and sustainable integrated network of UCR and intermediate care services. Although UCR is most often reactive in response to a crisis, it should include proactive elements such as realistic care planning and treatment escalation discussions based on what matters to the person and their preferred place of care. Success requires a multi-professional team led by clinicians who can provide CGA, first line diagnostics and create both acute and rehabilitation care plans.[68] Technology can be used to enhance proactive care by monitoring for early signs of deterioration.

Effective care for older people with frailty requires early mobilisation in hospital, rapid establishment of rehabilitation goals, and continued therapy input until their condition has stabilised. Older people leaving hospital often do not have access to the rehabilitation services they need to support their recovery. Rehabilitation must be available to older people leaving hospital, regardless of whether they are discharged to their own home, a care home or other setting. Where delayed transfers of care to community rehabilitation services are unavoidable, rehabilitation should commence in hospital. Older people with rehabilitation goals should not be transferred to a care home or community bed without assurance of appropriate rehabilitation being available. Without rehabilitation, older people being discharged from hospital experience further deterioration of their health. Already on average 15% of older people being discharged from hospital are readmitted within 28 days. With each admission their level of frailty and care needs increase, generating even more demand for health and social care at home or in a care home.

Case studies and examples

- The **Western Health and Social Care Trust** in Northern Ireland established a Hospital at Home (H@H) service in rural County Fermanagh. Initially restricted to four Care Homes, the service now supports older people at home across the County. Current staffing is a less-than-fulltime Lead Consultant, two WTE Specialty doctors, ten WTE Nurses, three WTE Health Care Assistants and one WTE Pharmacist. The service provides acute care for between four and six patients per day seven days per week with over 97% of patients assessed within two hours of referral. 82% were identified by GP or ambulance colleagues. The remainder were early facilitated discharges from the acute hospital. For 229 patients managed between December 2020 and May 2022, median length of stay was 5.5 days. There were no complaints or reports of adverse incidents. Any deaths during or within 30 days of H@H care are discussed at the Acute Hospital's Morbidity and Mortality meeting, to support assurance and learning and to increase the visibility of H@H to acute clinicians. There is a need to build productive alliances with primary care and with the local Ambulance service to enhance acute care options for older patients. Through linking with Ambulatory and Geriatric Clinic services, generalist and palliative care services, and specialist community respiratory and cardiac services the team aim to build a productive, bureaucratically-light suite of options for acute care and follow-up to best meet the needs of older people in the local community.

Other examples:

- **The Frailty Support Team in the New Forest**[69] www.bgs.org.uk/resources/community-geriatrics-video-case-presentations
- **Heathlands Intermediate Care Unit** www.fhft.nhs.uk/news/new-unit-praised-by-patients

Other useful resources

- BGS Community Case Presentations: **www.bgs.org.uk/resources/community-geriatrics-video-case-presentations**
- Midlothian's Hospital at Home story **https://sharingandlearningonline.wordpress.com/hospital-at-home**

Frailty-attuned acute hospital care

Older people with frailty account for a significant amount of hospital admissions and often have poor experiences and outcomes from urgent care.[70] 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. The Geriatric Medicine: GIRFT Programme National Specialty Report[71] highlights there is much that hospital staff can do to improve the quality and safety of care and contribute to holistic and anticipatory care for older people with frailty: proactive identification of frailty and delirium, early comprehensive geriatric assessment alongside interventions to reduce harm and improve outcomes, and better coordinated transfers of care to the community. Despite evidence that CGA can improve care outcomes and experience, implementation in hospitals remains patchy outwith geriatric medical units. This contributes to considerable variation between hospitals for many quality metrics.[72] Other contributing factors to this unwarranted variation are systematic differences in recognition and management of frailty and delirium, prevention of deconditioning, and in discharge practice. Solutions require pathways attuned to the needs of older people with frailty across the whole hospital. Guidance on managing frailty in acute care can be found in the Silver Book II.[73]

These integrated pathways should include the following elements:

- **Acute care at the front door** - Emergency medicine specialists and geriatricians worked together to develop shared competencies in frailty and emergency care to enable early holistic assessment of older people in urgent care in order to alter their care trajectories and to improve experience and outcomes.[74] The work was supported by a common vision, trusted relationships and joint education and training between the two specialties.
- **Acute frailty services** routinely and systematically identify frailty in people attending Urgent and Emergency Care services. They consider the personalised needs, including the level of frailty and degree of illness, and are supported by clear reliable hospital-wide pathways aligned to the level of frailty identified.
- **Same day emergency care (SDEC)** can allow specialist senior clinicians to care for patients on the day they arrive at hospital as an alternative to admission, removing delays for patients requiring investigation and/or treatment. Patients with conditions such as frailty can be assessed, diagnosed and treated without being admitted to a ward and, if clinically appropriate, return home on the same day. Some episodes of care may require follow-up for review and/or treatment to eliminate the need of overnight admission. SDEC can provide an opportunity to embed the acute frailty pathway within an Acute Trust. This may be particularly effective when linked with integrated frailty services. These services include integrated primary and acute care models (GPs working in hospital or interface geriatricians working in A&E departments) or community models with neighbourhood health and social care teams wrapped around GP practices.

- **Orthogeriatric services and Perioperative medicine for Older People undergoing Surgery (POPS)** Increasing numbers of older people undergo emergency or elective surgery.[75] Clinician-reported, patient-reported and process-related outcomes are poorer in older surgical patients compared to younger people.[76] Clinical and cost effectiveness data show that older surgical patients who receive CGA-based perioperative care have better outcomes and experience in both emergency and elective surgical settings.[77] However, implementation of such services remains patchy[78] as evidenced in national audits of falls and fragility fractures. A new guideline[79] coordinated by the Centre for Perioperative Care and the BGS covers all aspects of perioperative care relevant to adults with frailty undergoing elective and emergency surgery.
- **Dementia management** – 944,000 people in the UK are living with a diagnosis of dementia and this is projected to increase to 1.6 million people by 2050.[80] The cost of dementia to the economy is projected to nearly double by 2050, from £25billion in 2021 to £47billion.[81] A quarter of hospital beds are occupied by older people who have dementia and the majority of people who have dementia have at least one or two other long-term conditions – only 12% of people with dementia have no co-morbidities.[82] Older people with dementia are at higher risk of poor health outcomes when they present at urgent care settings and may spend longer in emergency departments. Patients with dementia may have vague symptoms or be unable to report their symptoms, resulting in higher rates of burdensome or invasive testing.[83] Further advice on managing dementia in an urgent care setting can be found in the **Silver Book II (www.bgs.org.uk/SilverBook2).**
- **Delirium management** – Poorly identified, assessed and managed delirium not only extends length of stay but can cause significant distress for patients, carers and staff. The Frimley ICS introduced a specific delirium pathway that runs for up to 12 weeks, recognising that delirium takes time to resolve. Inpatients with possible delirium are referred to the acute frailty team who undertake a comprehensive geriatric assessment and suggest a management plan. If the patient's discharge care needs have increased as a result of delirium, increased funding is available and continues until review by an integrated care team comprising mental health/GP/community matrons and social care. The team review patients at six and 12 weeks and assess if the delirium has resolved, or if they need to stay on the pathway. If a new cognitive baseline has been reached care is then funded through the usual arrangements. Further advice on managing delirium can be found in the **BGS Delirium Hub** (**www.bgs.org.uk/DeliriumHub**).
- **Reducing deconditioning** – The University Hospitals of North Midlands NHS Trust began a national 'Sit up, get dressed, keep moving' campaign to raise awareness of how to prevent deconditioning. This campaign encourages older people in hospital to be active and supports healthcare professionals to help their patients to remain active. This supports older people's recovery, reducing the chances of them being readmitted to hospital in the days following discharge. Their work is complemented by an international campaign to enrich the last 1000 days for older people with frailty. #endPJparalysis[84] (**https://improvement.nhs.uk/resources/our-endpjparalysis-journey**)/
- **Hospital discharge and D2A pathways** – The NHS England National Health and Social Care Discharge Taskforce[85] identified 10 best practice initiatives that should be implemented in every trust and system to improve discharge and flow. The recommended approach includes framing delays to discharge as a potential harm event. The best practice initiatives are similar to the Home First principles and actions in Scotland's Discharge without Delay programme.[86] Both programmes promote Discharge to Assess[87] at home or in the community and acknowledge the need to ensure capacity for intermediate care and rehabilitation to optimise recovery after discharge to improve outcomes for people and reduce further demand for services.

Other useful resources

- Silver Book II
  www.bgs.org.uk/resources/resource-series/silver-book-ii
- Acute Frailty Network
  www.acutefrailtynetwork.org.uk
- Scottish Care of Older People (SCoOP) Project
  www.bgs.org.uk/resources/scottish-care-of-older-people-scoop-project
- Right time, right place: Urgent community-based care for older people
  www.bgs.org.uk/righttimerightplace

Reimagined outpatient and ambulatory care

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. The Covid 19 pandemic forced new ways of working to be adopted at rapid pace. We can now learn from and adapt these innovations. The Royal College of Physicians has called for a shift from traditional outpatient models in order to embrace technology, improve patient experience and reduce the carbon impact. 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.

A rapid review[88] found outpatient telemedicine for older people was beneficial, cost effective, and well received by patients. Whilst due consideration must be given to the risk of digital exclusion, there are many advantages to embracing technology to enable new models of ambulatory and outpatient care for older people.

Advantages for the older person:

- Decreased need for transport to attend clinic; the home environment is more comfortable.
- Decreased requirement to wait in hospital waiting rooms/corridors for appointments.
- Increased opportunities for family members or translators to 'dial in' and participate.
- Increased opportunities for multi-professional input in a single appointment.
- Opportunities for remote monitoring to allow early recognition of physical problems, or ongoing assessment of existing issues in real time.

Advantages for the health and care system:

- Decreased numbers of 'Did Not Attend (DNA)' due to issues with hospital transportation systems.
- Increased efficiency with a greater number of telephone appointments feasible.
- Decreased carbon footprint of outpatients with fewer in-person attendances.

Systems should be integrated to provide the right care to the patient in the format that is most appropriate to them. Systems will ideally be flexible, patient-centred and work towards a hybrid model that utilises the benefits of remote telehealth whilst embracing face to face one stop clinic models if appropriate. We understand however that systems are under a lot of pressure and that providing a fully flexible service may not be achievable immediately.

Other useful resources

- **Royal College of Physicians (RCP) - Outpatients: the future – adding value through sustainability**
  www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability

Case studies and examples

- **Hull and East Riding** provides a hybrid proactive / reactive Community Frailty Anticipatory Care Model in an area with high levels of health inequalities and deprivation. A specialist Frailty MDT includes Consultant Community Geriatricians, GPs with Extended Roles (GPwER) in Frailty, Advanced Nurse Practitioner, Pharmacist, Pharmacy technician, Social worker, OT and PT, Carers Support service, Clinical Support Workers and Chaplain. The team offer CGA as a one stop ambulatory care model at the Jean Bishop Integrated Care Centre, with dedicated ambulance transport support. A virtual CGA is also delivered weekly for those living in rural / remote locations. Observed benefits include good Patient Reported Outcome Measures (PROMs) for individuals, a reduction in use of unscheduled primary and secondary care, high levels of staff satisfaction, innovative workforce development and successful recruitment into a historically under resourced service area and location.
- **The Jean Bishop Integrated Care Centre** - YouTube

Other examples

- **Lancashire and South Cumbria Health and Care partnership**'s Hot clinic:
  https://www.flowcoaching.academy/case-studies
- **Dwyfor Primary Care Cluster**
  www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability
- Virtual geriatric perioperative care clinic, **North Bristol NHS Trust**: *Age and Ageing* 2021;50:1391–1396 https://doi.org/10.1093/ageing/afab066

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

Care homes are home to around 400,000 older people with frailty.[89] The average care home resident is 85 years old, has six medical diagnoses and takes eight medications.[90] 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 vital contribution of the care home staff, residents, families and staff are more satisfied and less likely to use hospital services.[91,92] Access to specialist expertise in dementia and end-of-life care is essential.[93] BGS *Ambitions for Change*[94] makes 11 recommendations for how healthcare delivered in care homes can be improved.

Integrating healthcare support with long term social care at home is less well-developed and researched, with the exception of time-limited episodes of intermediate and palliative care. Homecare staff are important members of the MDT as are family and friends who deliver most long-term care and must be identified, supported and considered equal partners in community teams.

Case studies and examples

- **Rushcliffe** in suburban Nottinghamshire has a 1:1 relationship between GPs and care homes, with GPs supporting quality improvement and co-ordination of care in addition to routine primary care. The enhanced service specification comprises regular scheduled visits to care homes and proactive review of medications and care plans accompanied by community nurses who offer peer support, training, signposting and review of direct referral pathways to community services. Regular meetings between NHS and care home staff build relationships and a care home managers network is facilitated by Age UK. The service achieved a 40% reduction in emergency admissions to hospital from care homes, 50% reduction in avoidable admissions for ambulatory care sensitive conditions, and a 43% reduction in Emergency Department attendances.
- **Nottingham City Care Home Vanguard** established a 1:1 relationship between GPs and care homes, with contractual specification for regular visits and scheduled proactive review of medications. A dedicated Care Homes Nursing Team provided all community nursing input into care homes in the locality, including proactive assessment and case management of all new residents. The service established specific MDTs to work with care homes around dementia care and falls prevention, streamlining referral pathways to minimise bureaucracy and delays. Care home staff and managers were actively involved in service design and service-level decisions about care homes and in structured training and forums for staff and managers. The service achieved 34% reductions in emergency admissions and 39% reduction in potentially avoidable admissions, contributing to a trend towards cost savings. Staff, resident and carer satisfaction with care delivery was higher than for comparator sites.

Other examples

- **South Sefton Care Home Improvement Project** www.southseftonccg.nhs.uk/get-informed/latest-news/ccg-scheme-to-improve-support-in-care-homes
- **Tameside and Glossop Integrated Care NHS Foundation Trust's digital hub** https://tamesideandglossopicft.nhs.uk/services/digital-health-services

Other useful resources

- British Geriatrics Society. Ambitions for change: improving healthcare in care homes **www.bgs.org.uk/ambitions-for-change**
- The impact of providing enhanced support for care home residents in Rushcliffe - The Health Foundation **www.health.org.uk/publications/the-impact-of-providing-enhanced-support-for-care-home-residents-in-rushcliffe**
- Reducing hospital admissions in older care home residents: a 4-year evaluation of the care home innovation Programme (CHIP). BMC Health Serv Res 2020;20:94. **doi:10.1186/s12913-020-4945-9**

Co-ordinated, compassionate end of life 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 associated with delirium or functional decompensation.[95] As recovery from acute illness in the context of severe frailty is uncertain, parallel planning for recovery or deterioration is essential. Recognition of advanced frailty and incurable illness should trigger early sensitive and evolving conversations related to the benefit versus burden of active treatment, the identification of realistic personalised goals of care related to current circumstances as well as a shared understanding of future goals and wishes.[96]

Integrated Care Boards in England have a duty to commission palliative care services.[97] The principles of palliative care are fully consistent with both CGA and person-centred care: meticulous assessment of problems, open communication with patients, families, and other stakeholders, setting realistic goals and expectations, good understanding of potential therapies and their likelihood of success, minimisation of treatment burden, anticipating and planning for the future, and attention to social, emotional, psychological, and spiritual aspects of care.[98] A model integrating the principles of palliative, geriatric, and rehabilitative medicine and care is needed.[99] Integrated health and social care with access to expert generalists is as important as access to specialist palliative care to enable the best possible end of life care for older people.

Case studies

- The **Geripall** service in Sutton, Surrey aimed to improve the clinical pathway for people with advanced frailty (CFS 7-9) approaching the end of their lives. To be included, patients must be registered with a Sutton GP, have late-stage dementia or other neurodegenerative conditions, be at risk of recurrent unplanned admissions and have no specialist palliative care needs. Referrals are accepted from: Acute Frailty Unit and staff, other medical and surgical areas, Rapid Response Team in community, or social services.

  A frailty consultant provides advice as and when required and a Geri GP works three sessions supporting a Band 7 nurse. The nurse is responsible for:

  - Communicating with patients, family, carers, ward staff and discharge team, convening a family conference if required
  - Reviewing medication, prescribing "just in case" medicines, and updating records accordingly
  - Advance Care Planning
  - Fast Track referral for CHC funding, and follow up in the community including by phone and through visits, referring to appropriate agencies as needed
  - Communicating with the patient's GP and other agencies as required.
  - Service outcomes are reduced length of stay, reduced readmission at end of life, improved carer and patient involvement and experience of care.

Other examples

- **The Bromley Care Coordination Team**
  www.stchristophers.org.uk/leaflet/bromley-care-co-ordination-at-st-christophers-information-for-professionals

Other useful resources

- BGS End of life Care in Frailty Guidance
  ww.bgs.org.uk/resources/resource-series/end-of-life-care-in-frailty
- Ambitions Framework
  www.england.nhs.uk/wp-content/uploads/2022/02/ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf
- NHS England Specialist palliative and end of life care services: Adult service specification January 2023
  www.england.nhs.uk/publication/service-specifications-for-palliative-and-end-of-life-care-adults

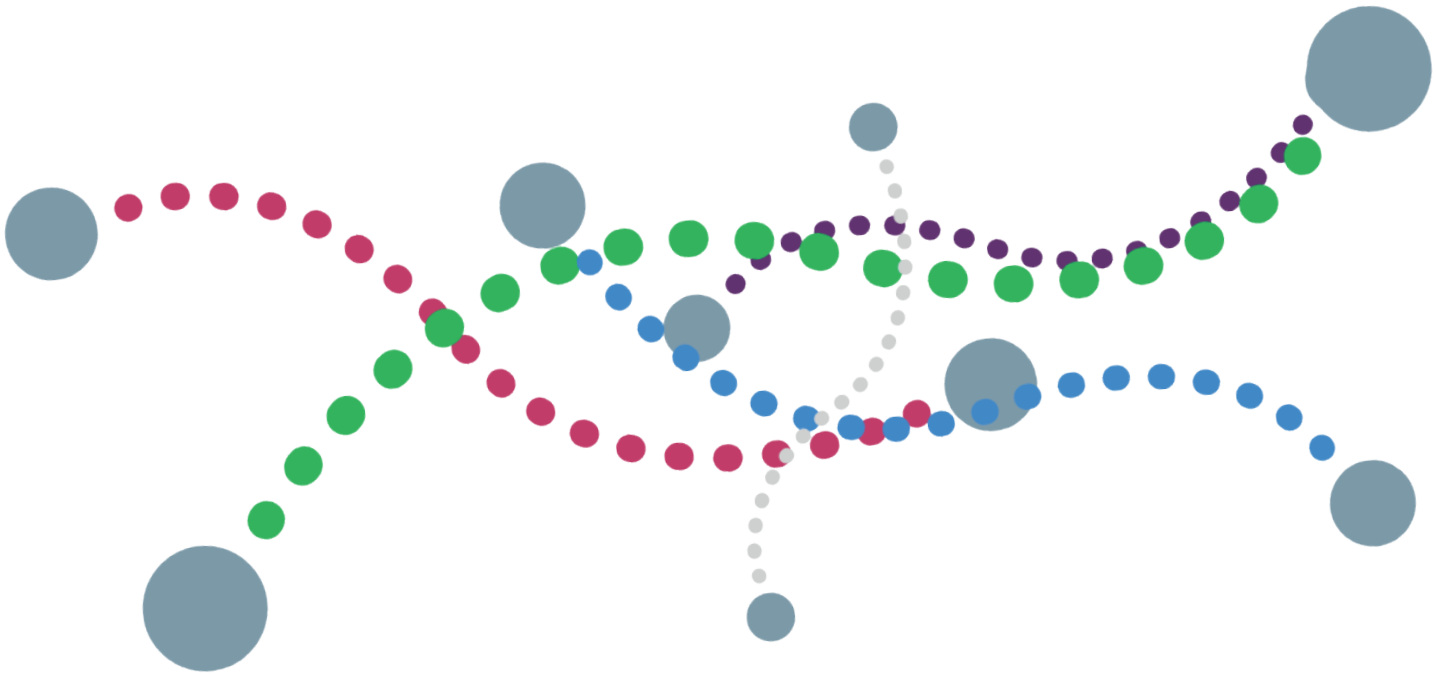
Chapter four: Conclusions

Integrated organisations across the UK are taking on responsibilities for commissioning health and social care services in different ways. This is a pivotal moment. Strategic planners, commissioners and system leaders must recognise the challenges and opportunities posed by the ageing population and design health and care services that meet the needs of older people, now and for all of us as we age. This is a daunting task at a time when local systems across the UK are under immense pressure. However, there are a wealth of resources available to support senior decision makers as they determine how they can best serve their communities.

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.

Recommendation 12: Make use of existing guidelines and resources and the expertise held within the BGS community.

The right to health and social care is a human right, a principle as valid for older people as anyone else. Older people are the main users of health and social care services, largely due to frailty and multimorbidity. Improving how services work for them holds the key to many of the problems currently experienced by the wider system. That is why it is vital to use the evidence, examples and recommendations set out in this Blueprint to create a sustainable integrated model of care for older people.



Contributors

- **Professor Anne Hendry**, Honorary Secretary, BGS; Honorary Professor, University of the West of Scotland
- **Dr Lucy Abbott**, Consultant Geriatrician, Frimley Park Hospital
- **Jayne Agnew,** Pharmacist, Southern Health and Social Care Trust
- **Đula Alićehajić-Bečić**, Consultant Pharmacist Frailty, Wrightington, Wigan and Leigh NHS Foundation Trust
- **Dr Amit Arora**, Vice President Workforce, BGS; Regional Clinical Director, ECIST- NHS England
- **Kate Bennett,** Clinical Lead Physiotherapist, Solent NHS Trust
- **Professor Andy Clegg**, Co-Chair, BGS Sarcopenia and Frailty Special Interest Group; Professor of Geriatric Medicine, University of Leeds; Honorary Consultant Geriatrician, Bradford Royal Infirmary
- **Dr Esther Clift,** Chair, BGS Nurse and AHP Council; Professional Adviser, NHS England & Improvement; Consultant Practitioner in Frailty, Southern Health NHS Foundation Trust
- **Professor Jugdeep Dhesi**, President Elect, BGS; Consultant Geriatrician, Guy's and St Thomas's NHS Foundation Trust; Honorary Professor Geriatric Medicine, King's College London; Deputy Director, Centre for Perioperative Care; Clinical Lead, NHS Elect POPS network
- **Dr Tom Downes**, Vice President Clinical Quality, BGS; Consultant Geriatrician and Clinical Lead for Quality Improvement, Sheffield Teaching Hospitals
- **Dr Prem Fade**, Co-chair, BGS End of Life Care Special Interest Group; Consultant Physician/Geriatrician, Lymington New Forest Hospital
- **Dr Deb Gompertz**, Clinical Lead Complex Care South Somerset
- **Professor Adam Gordon**, President, BGS; Professor of Care of Older People, University of Nottingham; Consultant Geriatrician, University Hospitals of Derby and Burton NHS Foundation Trust
- **Sally Greenbrook**, Policy Manager, BGS
- **Dr Ruth Law**, Deputy Honorary Secretary, BGS; Consultant in Integrated Geriatric Medicine and Clinical Lead for Care of Older People, Whittington Hospital
- **Lucy Lewis**, Consultant Practitioner, NHS@Home, Wiltshire Health and Care
- **Sarah Mistry**, Chief Executive, BGS
- **Dr Lara Mitchell**, Consultant Physician Older People's services QEUH, South Sector, NHSGGC; National Clinical Lead Frailty, Healthcare Improvement Scotland
- **Professor Caroline Nicholson**, Co-chair, BGS End of Life Care Special Interest Group; Professor of Palliative Care and Ageing; HEE/NIHR Senior Clinical Lecturer; Honorary Nurse Consultant St Christopher's Hospice
- **Dr Marianne Plater**, Community Geriatrician, Lymington New Forest Hospital
- **Dr Mark Roberts**, Consultant Geriatrician, Western Health and Social Care Trust
- **Dr Jane Youde,** Consultant Geriatrician, Derby Teaching Hospitals NHS Foundation Trust; Clinical Director of Audit and Accreditation, RCP London

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British Geriatrics Society
Improving healthcare
for older people

Marjory Warren House
31 St John's Square, London EC1M 4DN

Telephone 0207 608 1369
Email enquiries@bgs.org.uk
Website www.bgs.org.uk
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