ROYAL PHARMACEUTICAL SOCIETY

British Geriatrics Society
Improving healthcare for older people

Briefing on *Joining the dots: A blueprint for preventing and managing frailty in older people* published by the British Geriatrics Society

1. About the Blueprint

The British Geriatrics Society (BGS) published *Joining the dots* in March 2023 to show what good quality, age-attuned, integrated care looks like for older people. The document makes 12 recommendations for systems across seven touchpoints of older people's healthcare, from population-based proactive care through to compassionate end of life care. The original publication can be found online https://www.bgs.org.uk/blueprint

This document is highly relevant to pharmacy teams as they commonly interact with older people living with frailty. This briefing aims to show where pharmacy professionals in all areas of practice can add value across the system for this important group of people using NHS services and how pharmacy teams can contribute to the report's recommendations.

2. Leadership:

Strong leadership is crucial to ensuring that older people's healthcare is prioritised at a system level. *Joining the dots* recommends that systems should 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 families.

To support this, pharmacy leaders should:

- Demonstrate strong system leadership that creates a shared vision for healthy ageing and preventing and managing frailty. Improving how services work for older people living with frailty and how the pharmacy profession contributes to services holds the key to many of the problems currently experienced by the wider system. This could include contributing to population health management approaches to identify older people living with frailty who are most at risk or those who could be better supported, to prevent avoidable hospital admissions.
- Investigate how good practice in supporting older people living with frailty is currently incentivised in their area. What are the levers that can be used to improve medicines optimisation for older people living with frailty? These might include:
    - sharing data such as the polypharmacy dashboard[i]
    - incentivising structured medication reviews (SMRs)/ polypharmacy reviews to optimise medicines and avoid adverse effects from inappropriate polypharmacy
    - helping people remain independent with their medicines
    - improving transfer of care with medicines

- Ensure workforce plans are in place to deliver the pharmacy workforce needed to provide high-quality care for older people living with frailty now and into the future. This includes access to and effective utilisation of specialist skills.
- Co-design services with older people and their families.
- Ensure quality of services by measuring outcome indicators including feedback from patients and families.

3. Education and Training

It is essential that all pharmacy teams providing care for older people have the skills and knowledge to care for people with frailty and other conditions associated with ageing. Training on frailty should be developed at an undergraduate level and embedded in postgraduate training across all sectors in the four countries of the UK.

There are several frailty e-learning options available free of charge that can help pharmacy teams provide better care and support for older people living with frailty, including a BGS module aimed at Tier 3 healthcare professionals.[ii]

4. Identification of Frailty

Pharmacy teams caring for older people should consider how frailty is identified in their area of work. Some pharmacy staff may identify frailty during their usual interactions with older people, by using tools such as the clinical frailty scale.[iii] Pharmacy staff may also wish to consider whether people who are assessed as living with frailty are identifiable via shared electronic records and whether teams could contribute to the sharing of frailty status. Examples of when this could be useful include on admission to help tailor treatment or in setting rehabilitation goals.

5. Caring for older people living with frailty

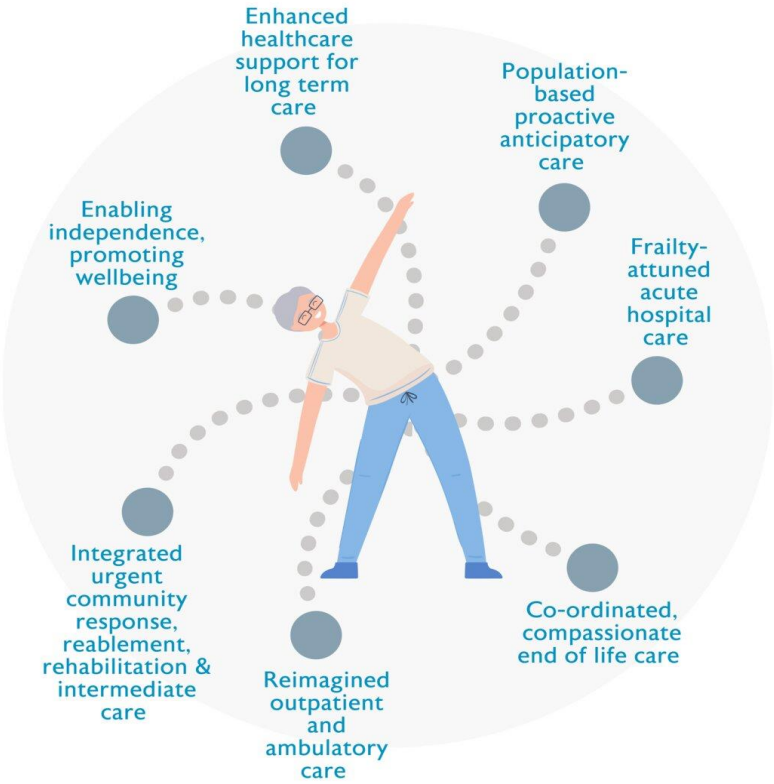
Frailty is common in older people with up to half of those aged 85 and over living with frailty. Most of these people will not just be living with frailty, they are likely to be living with one or more other long-term conditions as well. Pharmacy teams caring for people living with frailty should consider the following:

- What does an individual's level of frailty mean for their goals, and how might their medicines be affected by their current status?
- Ensure principles of shared decision-making are applied uniformly.
- Older people living with frailty who have cognitive impairment should be supported to make decisions where they are able to.
- Inclusive, dementia-friendly environments should be in place in all pharmacy settings.
- Transfer of care is a high-risk area for older people, especially those living with frailty, with studies showing that 1 in 3 older people will suffer medication-related harm after a care transition.[iv] Pharmacy teams can educate older people and/or their families about any medicine changes, ensure documentation is accurate and refer onto services who can support older people living with frailty after a care transition where appropriate e.g. discharge medicines service.
- Single condition guidelines and standard targets such as those for blood pressure do not address the needs of older people living with frailty and can cause harms if applied uniformly rather than treating the older person as an individual. Older people living with frailty are usually excluded from the clinical trials that provide the evidence base for guidelines.

6. Touchpoints for older people living with frailty

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. Often systems are fragmented and care is not joined up. *Joining the dots* outlines seven touchpoints where older people with frailty are likely to interact with the healthcare system. This section of the document highlights how pharmacy teams can help to provide care across each of these touchpoints by working together across organisations and systems to provide integrated medicines optimisation (MO) for older people living with frailty. This may include community pharmacy highlighting older people who would benefit from structured medication reviews (SMRs) by primary care pharmacy teams, secondary care teams using the discharge medicines service (DMS) in England and community services teams working with primary care pharmacy teams.

Figure 1: System Touchpoints



- *Enabling independence, promoting wellbeing:* Public health messages are important and an area where pharmacy teams at all points in a person's health journey and particularly community pharmacy can contribute. Regular exercise, particularly strength and balance training, reduces falls and partially reverses or slows the progression of frailty. Inadequate nutritional intake is an important modifiable risk factor for frailty and falls.
- *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 usually within primary care or community settings. Proactive care often involves multi-disciplinary teams (MDTs) working together to support older people living with frailty and deliver the elements of comprehensive geriatric assessment (CGA). Pharmacy should be part of these MDTs e.g. providing clinical expertise around medicines optimisation and SMRs. NHS England has issued guidance on proactive care for people living with moderate to severe frailty[v] and it is included in the primary care network direct enhanced service.[vi] NICE has information available on improving care and support for people living with frailty[vii] and Scotland has developed the Ageing and Frailty Standards.[viii] Welsh government has an integrated quality statement that references multiprofessional teams and multiprofessional care records.[ix]
- *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. Pharmacy teams should be involved in integrated urgent community response services including reablement, virtual wards including hospital at home,[x] rehabilitation and intermediate care.[xi]
- *Frailty-attuned acute hospital care:* Older people with frailty account for a significant number 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. Older people living with frailty are often complex and may not be treated within older people's medicine so it is important that hospital pharmacy teams outside this specialty are able to care for this cohort. Appropriate training of early-career pharmacists in older people's medicine and specialist pharmacy support is essential. Pharmacy teams should be supporting acute care at the front door e.g. in Emergency Departments; acute frailty services; assessment areas such as same day emergency care (SDEC); orthogeriatric services and other acute services that deliver CGA such as peri-operative medicine for older people and older people's oncology services; hospital discharge and discharge to assess services.
- *Reimagined outpatient and ambulatory care:* Older people living with frailty often have multiple long-term conditions and have multiple outpatient appointments with different specialists which is time-consuming, frustrating and wasteful. Innovations such as one-stop frailty clinics and community-based ambulatory care hubs and clinics can help to improve patient experience. Pharmacy teams should support such hubs and clinics.
- *Enhanced healthcare support for long-term care:* 400,000 older people living with frailty are care home residents and the average person in this cohort takes eight medicines. Pharmacy teams are often heavily involved with care home residents ensuring the safe use of medicines and providing SMRs e.g. in line with the Enhanced Health in Care Homes framework in England.[xii] Pharmacy teams in all sectors should

ensure that medicine changes are communicated across settings and that they work with the care home to ensure medicines optimisation is effective and does not introduce additional problems.

- *Coordinated, compassionate end of life care:* 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. Pharmacy teams can support people coming towards the end of their life with SMRs and providing advice and support around anticipatory and palliative care medicines.

7. Conclusion

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 and how the pharmacy profession contributes to services holds the key to many of the problems currently experienced by the wider system. That is why it is vital that the pharmacy profession plays its part in providing a sustainable integrated model of care for older people.

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[i] https://www.nhsbsa.nhs.uk/access-our-data-products/epact2/dashboards-and-specifications/medicines-optimisation-polypharmacy
[ii] https://www.bgs.org.uk/resources/frailty-hub-education-and-training
[iii] https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf
[iv] https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.15419
[v] https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/
[vi] https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/
[vii] https://stpsupport.nice.org.uk/frailty/index.html
[viii] https://www.healthcareimprovementscotland.scot/publications/ageing-and-frailty-standards/
[ix] https://www.gov.wales/older-people-and-people-living-frailty-integrated-quality-statement-html
[x] https://www.rpharms.com/about-us/news/details/new-rps-interim-professional-standards-for-virtual-wards
[xi] https://www.bgs.org.uk/Rehab
[xii] https://www.england.nhs.uk/community-health-services/ehch/