

Our priorities for the NHS 10 year plan





The British Geriatrics Society is the membership organisation for all healthcare professionals engaged in the treatment and care of older people across the UK. Since 1947 our members have been at the forefront of transforming the quality of care available to older people. BGS's vision is for a society where all older people receive high quality, patient-centred care when and where they need it.

In 2018, seventy years after the founding of the NHS, the challenges of meeting the needs our ageing population require increased financial investment, accelerated system reform across health and care services, and a clear plan and strong, consistent commitment to delivering it. Research confirms that prevalence of multi-morbidity among older people continues to grow. Older people may have several chronic conditions with fluctuating impacts occurring simultaneously together with mental ill health, such as depression, dementia and other forms of cognitive impairment. At a time when Government has announced increased funding for the NHS, and the publication of a 10 year plan for how best to use this funding, BGS has set out its priorities for the forthcoming plan.

Our priorities include a reform of the way services are delivered so that more care and treatment is available in community settings. We are calling for this to be built into the development and delivery of the NHS 10 year plan. We believe it is the best way to achieve better health outcomes for older people, and to realise the benefits of financial investment. We are also calling for a financially sustainable approach to social care, which is critical to the success of any plans for the future of the NHS.

Our priorities for the NHS 10 year plan are:

1

Greater investment in community-based, multidisciplinary working in primary care settings

- Significant investment is needed to deliver more care and treatment in the community, and this requires a more proactive, planned and evidence-based approach. We are optimistic because this journey has already begun in the NHS England new care models.¹ To fully realise the benefits a clear strategic focus is required on prevention, optimising independence, and better health outcomes for older people, using multidisciplinary teams embedded in primary care services as a vehicle for improvement.
- Broadening the multi-disciplinary team so that mental health and social work staff are a core part of the team, and it is linked to GP services, is part of the reform that needs to be made if we are to deliver a strategic and joined up service. One of the benefits of this approach is that it helps to avoid older people undergoing multiple assessments, and the duplication of resources involved. It also means that more people would be able to access services closer to where they live.



2

Integration, and continuity of service

- Person-centred care requires a fully integrated service model which ends the divide between health and social care. It also requires a move away from traditional divides between primary, intermediate and hospital care, and a change in commissioning practices. A strategic approach to ensuring continuity of service is urgently required to meet the health and social care needs of the increasing numbers of older people living with frailty, dementia, complex needs and multiple long-term conditions.
- For older people with significant frailty the need for ongoing, joined-up care and support would be better met through practical recognition of the fluctuations in need that they experience, which require a flexible response. By this we mean an end to being 'admitted to' and 'discharged from' various components of services each time their condition deteriorates or improves, for example, intermediate care and district nursing services.
- Cross-service continuity is essential for an effective transition between hospital and home or care home. For example, Comprehensive Geriatric Assessment might begin in a hospital-based frailty unit and be completed and reviewed in the community or vice versa.
- Ensuring that electronic and non-electronic records are shared with all health and care professionals who have a clinical need for timely access has been an aspiration for a long time and is essential to the delivery of a fully integrated service. We call for increased investment and prioritisation to make this a reality for everyone. The enhanced summary care record may be one key tool in achieving this for older people.

3

Better identification of frailty among older people and earlier intervention

- Frailty is a long-term condition affecting older people in which loss of reserves means that minor changes lead to an increased risk of serious adverse outcomes.ⁱⁱ There is good evidence to show that early identification and intervention can prevent some aspects of deterioration and enable people to live independently for longer. We believe that delivery of more health care in primary care settings, alongside a fully integrated service, will support the earlier identification of frailty and therefore earlier intervention.



- By using frailty identification tools such as the electronic frailty index (e-FI)ⁱⁱⁱ in primary care settings as well as acute settings, an increasingly strong evidence base will develop which offers an excellent opportunity to inform service design and planning, and to adapt interventions, based on individual needs.
- A clear programme of interventions designed around a population health management framework using established models of long-term condition management is needed to support older people before their frailty progresses from mild to moderate or severe. Earlier interventions for groups of people at greatest risk of developing frailty have the potential to make a significant difference to health outcomes and overall wellbeing. This includes, for example, timely treatment for conditions that limit independence, such as foot health, chronic pain, visual and hearing impairment, incontinence, and malnutrition.^{iv}

4

Increased capacity in intermediate care

- Services which provide a link between acute hospital and home play a critical role in the health of older people who need rehabilitation, re-ablement and sub-acute treatment. Delays in access to these services have considerable costs, both to health outcomes for older people and to the NHS. The critical role of occupational therapists, physiotherapists, district nurses and other allied health professionals needs to be more fully recognised in the planning and funding of healthcare for older people.

5

Wider access to comprehensive geriatric assessment (CGA) and personal care plans

- CGA is a process of care comprising a number of steps that include a multi-dimensional holistic assessment of an older person's health and wellbeing, and leads to the development of a plan which is revised and re-assessed at appropriate intervals. Evidence shows that it is effective in reducing mortality and improving independence for older people admitted to hospital as an emergency.^v In community settings the evidence shows that complex interventions in people with frailty can reduce hospital admission and risk of readmission in people recently discharged from hospital.^{vi}



- NHS England has recognised the benefits of CGA and recommended the BGS CGA toolkit as a resource for primary care. In practice, there is a long way to go in ensuring that CGA is used for all older people who would benefit from it, and personalised care plans are in place for all older people with frailty, dementia and complex and multiple long-term conditions. We recognise the resource implications, but believe that investment in more health services being delivered in the community can help to address these, notwithstanding the need for increased investment in the workforce. Increasing opportunities for geriatricians to work with primary care professionals is a key means of ensuring that all older people who need a personal care plan have one.

6

Workforce strategy

- A much more flexible approach to staffing is needed if greater flexibility in where a person is cared for is to be achieved; for example, employment contracts that allow for co-location. It also requires changes in education and training so that health professionals are prepared for the challenges that community-based working brings. We view this as one of the essential changes that must be built into any long term plans for the NHS.
- There is an urgent need for more geriatricians and other specialists in older people's healthcare. At present, workforce supply and the level of unfilled vacancies in some parts of the country is a particular problem for our specialty. The current and future demands of demographic change require a greater number of geriatricians, specialist nurses and allied health professionals with expertise in the care of older people.
- Demographic change means that all health and care professionals will be working mostly with older people. Increased education and training in frailty as a specific medical condition, and enhanced knowledge and expertise in treating people living with multiple long term conditions, are essential if we are to have a workforce that can meet the healthcare needs of our changing and ageing society.
- Including competencies in the management of older people in curricula, guidance, professional and quality standards for professionals who are not specialists in older people's healthcare is a key component in improving the quality of healthcare for older people.

7

Healthy ageing

- BGS aims to raise awareness among healthcare professionals of the role of ‘living well’ in preventing disease in later life. We cannot prevent the ageing process but there is clear evidence that keeping fit and maintaining a healthy lifestyle helps to prevent frailty.
- The new plan should prioritise the social determinants of health. We would like to see cross-government commitment to identifying and addressing the health impacts of policy decisions and for this to be built into national and local policy development. We believe there is scope for public health bodies to take on a stronger role in championing and promoting awareness and understanding of the health impacts of policy and decision-making beyond the sphere of health and social care.

8

Measuring success

- BGS believes changes to measuring success are required and that success measures should be person-centred. By this we mean patients setting goals for themselves and success being measured against the achievement of those goals. This would support an assets-based and person-centred approach to care. We view success measures linked to patients’ goals an essential part of wider-system level measures and would like see a broad focus on measures relating to use of primary care, home care and quality of life, alongside those that cover acute hospital admissions from hospitalisation.

References

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