British Geriatrics Society
Improving healthcare for older people

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Response from British Geriatrics Society to RCGP's consultation - Towards a Future Vision for General Practice

1. General practice today

What kind of service should general practice provide to patients in future? How should this drive improvements in health outcomes?

The British Geriatrics Society (BGS) is the professional body of specialists in the healthcare of older people in the United Kingdom. We have a strong interest in the effectiveness of primary care and the role of general practice in driving improvements in health outcomes. Our vision is of a society where all older people receive high quality, patient-centred care when and where they need it.

Based on our experience and expertise in working with older people, our view is that there are some significant changes to general practice that would result in better health outcomes for all older people, whether they are living with mild, moderate or severe frailty, or are staying relatively healthy and ageing well.

An increased focus on the prevention of deterioration and the optimisation of independence is needed for people living with multiple long-term conditions. Identifying frailty at an early stage and providing earlier interventions for those people at greatest risk of developing frailty is central to this. Stratifying frailty using frailty identification tools such as the electronic frailty index (e-FI) for patients aged 60 and above, and those people most at risk of adverse events, including hospitalisation, nursing home admission and death should be fully embedded in the service provided by general practice. BGS warmly welcomed the introduction in 2017 of the routine frailty identification requirements for GPs. However, the use of e-FI requires clinical correlation and the risk that false positives and negatives will sometimes arise from use of a statistical tool must be considered and addressed as part of the frailty identification process.

Service provision which better recognises and reflects the ways in which older people's health conditions fluctuate would be helpful. By this we mean ensuring continuity of care so that older people with significant frailty are not "admitted to" and "discharged from" various components of services, for example, district nursing services and intermediate care. Instead recognising their need for joined up care and support, with an understanding that their disease trajectory will cause fluctuations in need would help to ensure timely access to healthcare and avoid repeated assessments before care can be re-started[1].

As part of the future service BGS envisages general practices becoming hubs for community based multi-disciplinary teams that have the capacity to offer Comprehensive Geriatric Assessment (CGA). Evidence for CGA shows that in community settings complex interventions in people with frailty can reduce hospital admission and the risk of re-admission in people recently discharged from hospital[2]. There are significant benefits

from a multidimensional holistic assessment for an older person, which considers health and wellbeing and leads to the formulation of a plan to address issues of concern to the older person, and their family and carers.

1. Barker I, BMJ 2017;356:j84 Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data
2. British Geriatrics Society; (2016) What is Comprehensive Geriatric Assessment (CGA) and why is it done?

2. The role of the GP

How should the role of the GP develop in future?

Future developments should ensure that the GP is at the heart of community-based healthcare and general practice is the central hub for community-based health care. This requires sufficient resourcing, funding and capacity and strong team working within general practice and across all primary care services.

What are the barriers and enablers to achieving this?

GPs need to extend their skills in key areas of management of frail older people, and to work as part of multidisciplinary teams to provide evidence-based care. They may require protected time to do so.

Enabling the GP to proactively deliver earlier interventions for groups of people at greatest risk of developing frailty is dependent in part on resources. The benefits of timely treatment for conditions that limit independence, such as foot health, chronic pain, visual and hearing impairment, incontinence and malnutrition cannot be overstated – sufficient investment in workforce and service provision is a key enabler for the provision of services which are fundamentally important in supporting older people's health and wellbeing.

A group of GPs within BGS have demonstrated an appetite for a new approach which enables some GPs to work partially or exclusively in roles with older people, for example, in care homes and intermediate care facilities. Evidence has emerged of a lack of specific training and accreditation as well as confusion over appraisal, revalidation, employment status and indemnity provision. They have demonstrated an impact on retention in General Practice, with some of the members of the group acknowledging that they would have left the profession within the ability to work in this particular area. Recognising and supporting these roles would improve the ability to offer community-based comprehensive care for older people.

3. The GP in the wider practice team

How should the wider practice team develop in future?

BGS considers the development of the wider practice team to be absolutely central to the effectiveness of GP services and the delivery of primary care that meets the increasing needs of the older population.

All health and care professionals working with the GP will need to have an understanding of frailty, so that understanding is widespread amongst professionals (including key voluntary sector staff) who are working with older people living with frailty. Primary care professionals who focus on the needs of older people living with frailty should be supported to develop their skills and to meet the criteria for appraisals and revalidation.

Making best use of the invaluable input of nurses and therapists who have appropriate training and experience (including, but not only, those with advanced skills), as part of community-based MDTs, and their input into assessments and care plans.

Ensuring people with frailty have someone who can be their 'Care Navigator' who supports them in accessing support from a range of health and social care services. Depending on local arrangements they may be either a clinician or a well-trained non-clinical member of staff and they would often be the first point of contact[1].

1. Goldhart et al (2014). Healthcare Quarterly 17(3): 61-69 *Integrated client Care for Frail Older Adults in the Community: Preliminary Report on a System-Wide Approach.*

What are the key barriers and enablers to achieving this?

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. A national workforce strategy that supports this would be extremely helpful. BGS's full position on workforce issues is set out in the response with submitted to Health Education England's consultation earlier this year.[1]

1. https://www.bgs.org.uk/policy-and-media/bgs-response-to-consultation-on-workforce-strategy

4. The GP in the wider health care system

How should general practice relate to the wider health care system in future?

The role of general practice in the wider health care system is crucial to delivering better health outcomes for older people.

GPs and primary care teams must be connected more effectively with colleagues in secondary care so that the valuable information held about the patient, their support systems and wishing regarding their future care can be shared. This will help to facilitate decision-making, if the patient presents to secondary care, regarding appropriateness of admission or in planning for discharge.

We have referred already to the critical role of the multi-disciplinary team. One of our priorities for the future development of community based, multi-disciplinary working in primary care settings is the broadening of the MDT so that mental health and social work staff are a core part of the team, linked to GP services. This would help to avoid older people undergoing multiple assessments, and the duplication of resources that this involves. It also means that more people would be able to access services closer to where they live.

Ensuring greater availability of Consultant Geriatrician time in community settings and offering Comprehensive Geriatric Assessment by community-based MDTs – in some areas this will require resource reallocation. We see this as an important way of strengthening the services that an older person can access through primary care.

What are the key barriers and enablers to achieving this?

While there are good examples of general practice working closely and collaboratively to improve care and patient experience, there is much more that needs to be done to embed these in system design. There are a range of models that are already working well but they tend to be 'one-offs'. In 2016 the RCGP and BGS jointly published a report showcasing examples of innovative approaches to delivering integrated care for older people with frailty which provide good evidence for the ways in which we would like to

see general practice working as part of the wider health care system, as a matter of course rather than as exceptional examples that have been developed as a result of proactive individuals findings ways to work around barriers[1].

There are a range of barriers that need to be addressed. These include:

- The need for technology which enables ease of communication so that systems are linked and GPs can access patient records from other settings, and make electronic referrals, is well known but has not yet been fully addressed
- Workforce planning to increase the number of Geriatricians available to work in tandem with primary care colleagues in the community is an important means of achieving the successful delivery of more community-based healthcare
- Culture change is an often over-looked barrier which needs proper recognition and committed leadership to ensure that changes to general practice and closer working with a range of health professionals in primary care settings are fully embedded and deliver successful outcomes.

1. British Geriatrics Society and Royal College of General Practitioners (2016) *Integrated care for older people with frailty. Innovative approaches in Practice*.