BRITISH GERIATRICS SOCIETY

For better health in old age

31 St John's Square, London EC1M 4DN, England
Tel: +44 (0) 20 7608 1369 Fax: +44 (0)20 7608 1041 Email: policy@bgs.org.uk
Website: www.bgs.org.uk

HOUSE OF LORDS SELECT COMMITTEE INQUIRY ON THE LONG-TERM SUSTAINABILITY OF THE NHS,
SUBMISSION FROM THE BRITISH GERIATRICS SOCIETY

23 September 2016

Executive Summary

BGS believes that the future sustainability of the NHS is dependent on ensuring that people with the right skills, training and specialist expertise are available to meet the needs of the rapidly increasing numbers of older people living with frailty, dementia and multiple, complex long-term conditions, and that re-modelling to deliver services through a person-centred approach to care, which includes a review of social care and its funding, is essential.

Introduction

1. The British Geriatrics Society (BGS) is the professional body of specialists in the healthcare of older people in the United Kingdom. Our membership is drawn from doctors practising geriatric medicine including consultants, doctors in training and general practitioners, nurses, allied health professionals, researchers and scientists with a particular interest in the care of older people and the promotion of better health in old age. BGS has 3,500 members who work across England, Scotland, Wales and Northern Ireland.

2. BGS welcomes this opportunity to present a written submission to the Committee's Inquiry on the long-term sustainability of the NHS. We have noted the Committee's specific interest in UK Government policy and practice, and whether their strategies are sufficiently long-term, as well as what might usefully be done in practical terms to guarantee the sustainability of the NHS. We have ordered our submission under the main themes that are the focus of the Committee's Inquiry.

Resource, funding and demand issues

3. Financial viability. As the Inquiry recognises, the current model of health and social care is not financially viable in the long-term. Since 2000 the UK has significantly increased its spending on health, but as a percentage of GDP it is still lower than the EU average[i], and it has been predicted that by 2030/31 the funding gap will be £28 billion at a minimum and could be as much as £58 billion[ii]. The Health Foundation project that the funding gap for adult social care will be £6 billion by 2020/21 and £13 billion by 2030/31[iii], and the Office for Budget Responsibility projects that UK spending on health and care as a percentage of GDP is due to drop from 7.4% in 2016 to 6.9% in 2020. They also predict we may need to raise the proportion to 8.8% of GDP, which represents an increase of £100 bn[iv].

4. Spending on social care. Our view is that the inter-dependent nature of health and social care services mean that the long-term sustainability of the NHS can only be secured if there is sufficient

investment both health and social care. The fall in social care spending has led to some people being unable to access the care they need leading to poorer health outcomes, an increased likelihood of presenting at A&E, and people remaining on an acute hospital ward for longer than necessary. This has a negative impact on the health of older people with frailty which deteriorates with every additional day spent on an acute ward. The King's Fund briefing, *Deficits in the NHS 2016,* provides an up to date analysis which shows that despite transfers of NHS budget, social care has not kept pace with the increase in demand.

5. Reviewing social care and its funding. We therefore believe that a new approach to funding of social care is required so that it is fully integrated with health care provision and addresses the current lack of ring-fencing for social care budgets. A fundamental review of the future of social care funding by Government would be an extremely helpful step in the journey towards ensuring the effectiveness of the NHS in the long-term. The King's Fund's independent Commission on the Future of Health and Social Care in England, chaired by the economist Kate Barker, provides a helpful basis for further work. The report published this September by the King's Fund and Nuffield Trust, *Social Care for Older People, Home Truths*[v] is also helpful in showing how reductions in central government grants to local authorities have been passed on to care providers in the form of reduced fees. The case studies in *Home Truths* show the devastating impact on older people's lives that under-investment in primary and community health services, combined with the challenges faced in social care, is having. For providers of social care dependent on local authority funding it is the quality and continuity of care of older people which is being compromised, and our members are seeing the knock-on effects of that when older people present at A&E departments and when their discharge from hospital is delayed because of lack of capacity in the social care sector.

6. Intermediate care. Investment in intermediate care is also critical if the NHS is to be sustainable. Services which provide a link between home and acute hospital for older people who need rehabilitation, re-ablement, or sub-acute treatment are essential in supporting older people in regaining independence after they have had an acute health issue. The National Audit of Intermediate Care[vi] shows that intermediate care services are key to reducing financial, quality and activity pressures being experienced in secondary care and the care sector. It provides evidence which shows that 92% of people maintained or improved their dependency score in when they accessed intermediate care in community settings, and 93% maintained or improved their dependency score in bed based intermediate care. The critical role of occupational, physio and speech therapists needs to be understood, prioritised and built into any future re-design of the NHS. Delays in access have considerable costs, both to the health outlook for an older person and to the NHS. We have been encouraged by recommendations in the report by the Care Quality Commission published in July, *Building Bridges, Breaking Barriers,* which highlighted the need for increased capacity in services which provide a key link for older people between home and acute hospital.

7. Demand management. When demand management is discussed it is usually in the context of seeking to find ways of reducing demand on services. While it is difficult to quantify, our experience is that many older people under use health and care services because they are reluctant to ask for help, or they assume that a particular health condition is a natural part of ageing and cannot be treated.

8. Engaging the public. Our submission is based on the assumption that health and social care will be delivered through a model paid for by general taxation. At present there isn't a clear public mandate for a new funding model for health care. We consider that full open consultation and engagement with the public to be an essential ingredient of any proposals for changing the basis on which the NHS is currently funded.

Workforce

9. Addressing the current workforce crisis. The long-term sustainability of the NHS is partly dependent on its current viability. There is an urgent need for more geriatricians and specialists in older people's health care. Data collected by the Royal College of Physicians (RCP) shows that "geriatric and acute medicine has consistently had the largest number of posts being advertised, but they also

consistently have the largest number of posts that cannot be filled."[vii] At the same time there is a major GP and community nurse workforce crisis. The RCP report, *Underfunded. Underdoctored. Overstretched. The NHS in 2016* provides a wealth of data on workforce, and shows that between 2013 and 2015 the number of doctor vacancies increased by 60%. It also shows that there are not enough doctors in training to meet demand[viii] We welcome the wide range of initiatives at local, regional and national level, that are underway to improve access to and quality of health care, but we are concerned that these risk being undermined by the lack of adequate numbers of doctors, nurses and other health care professionals.

10. Training. The rapidly increasing number of people living with long-term and multiple conditions, mean there is a need for more generalist health professionals who have been fully trained in the specific needs of older people. As part of that training we would like to see the capacity for Comprehensive Geriatric Assessment (CGA) developed and delivered more widely. CGA is an interdisciplinary process focused on diagnosing an older person's medical, psychological and functional capability. There is a strong evidence base showing that use of CGA enhances an older person's overall resilience, and when it is used following an emergency admission to hospital it increases by 25% the patient's likelihood both of being alive and of being able to live in their own homes six months later[ix].

Models of service delivery and integration

11. The current health care system is based on a model developed at a time when life expectancy was 65 for men and 70 for women, and 48% of the population died before they reached 65. Health service design has been disease focused, which does not serve well people with multiple and long term medical conditions, including older people living with frailty.

12. The future health care system, if it is to cope with the rapid increase in the numbers of older people using it, needs to be based on person-centred design which enables all patients, including older people, to express what they want and need from health care systems so that they receive the most appropriate treatment. Measures of care should focus on what matters most to older people and their families. This includes end of life care, with person centred care that fully involves families and carers, and supports professionals in recognising when it is appropriate to move from treatment to palliative care.

13. Fully integrated services. NHS service design based on person-centred care requires a move to a fully integrated service model which ends the divide between health and social care, and a move away from the "tendency to 'silo' pathways of care"[x] which we have referred to in more detail in paragraphs 6-7 above **.**

14. Better support for people with dementia is required in any re-modelling of the NHS, given that as many as 40% of hospital admissions are for people over 75, and 1 in 4 beds in acute hospitals are occupied by someone with dementia. They may not have an acute reason for admission but may have reached a crisis and there is not sufficient support outside a hospital setting to manage the crisis. Once admitted to hospital they are more likely to experience an overall deterioration in health. BGS calls for a new strategy for people living with frailty, dementia, complex needs and multiple long-term conditions, which ensures access to comprehensive geriatric assessment, personalised care plans for treatment and long-term follow-up for all older people with frailty, dementia and complex and multiple long-term conditions.

15. Use of technological solutions in service design. We agree with a statement by the Birmingham Policy Commission that "technological support for older people can contribute to health ageing, if the support is sensitively developed and applied" [xi]. We fully recognise the benefits of technological support in health and social care, but at the same time caution against an over reliance on it, particularly when it comes to expectations of what can be achieved in terms of prevention.

Prevention and public engagement

16. Prevention and treatment of frailty in older people. We know that disability-free life expectancy is rising more slowly than life expectancy, and that most people aged 75 and over have one or more health conditions, and 1 in 4 of those aged 85 and over are frail. [xii] We caution against the use of overly ambitious outcome targets if there is not the evidence to support their achievement. Whilst prevention and treatment strategies together can have excellent outcomes, we must not overlook the basic realities of ageing which mean that older people will always have health issues that need treating. This needs to be taken account of when incentives to keep people healthy for longer are being developed .

17. Community and tertiary provision. The roles of community geriatricians, community nurses and other specialist health professionals, are key to enabling older people to remain independent and living in their own homes for as long as possible. While there are limits to how far preventative strategies can go in avoiding people needing to access health services, the benefits of tertiary service provision for older are significant. For example we might not be able to prevent some older people falling and sustaining fractures, but the benefits of helping them to re-gain their previous level of mobility following a fracture are key to maintaining independence. We are therefore keen to ensure that future strategies for prevention and public health draw on the clinical knowledge of the ageing process.

18. Availability of age-appropriate infrastructure. The provision of accessible age-appropriate housing and other infrastructure, including transport, is an essential ingredient in considering strategies to guarantee the sustainability of the NHS. Age UK point to the need for attractive housing alternatives that promote healthy lifestyles and meet the needs and wants of older people, and the difficulties of getting simple home adaptations and repairs carried out quickly and affordably[xiii]. At BGS our members are regularly seeing patients who are well enough to be discharged from an acute hospital ward, but whose lack of appropriate housing, means that their discharge is delayed.

Digitisation of services, big data and informatics

19. Rationalisation and accessibility of records and better integration of data. We can only deliver fully integrated, person-centred care if we have a system which allows the use of person-held records in a single assessment document that is available across specialisms and settings, so that clinicians and other professionals have immediate access to the full picture regarding the patients they are treating. The Care Quality Commission recently highlighted that older people often have multiple care plans that are not being routinely linked, and what where initiatives to enable integration have been successful they have often been short-term with only partial or temporary funding[xiv]. Investment in systems that support the full development of up-to-date integrated records and plans is an important part of improving health care for older people, whose health and care needs can change rapidly. They are also essential to being able to measure health outcomes, and to ensuring that what matters most to older people and their families is fully measured and improvements can be tracked over time.

Conclusion

20. The Committee's Inquiry is of fundamental importance to our members and those older people they work with. We wish to support the Inquiry in any way we can and would be very happy to discuss our submission with the Committee and to attend an oral evidence session if called on to do so.

Professor David Oliver
President, British Geriatric Society

Dr Eileen Burns
President-Elect, British Geriatrics Society

i. Filling the gap. Tax and fiscal options for a sustainable UK health and social care system. The Health Foundation. 2015 http://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf

ii. http://www.health.org.uk/health-and-care-funding-nutshell#Current%20spending%20on%20health%20care%20and%20financial%20performance http://www.health.org.uk/publication/filling-gap

[iii] Filling the gap. Tax and fiscal options for a sustainable UK health and social care system. The Health Foundation. 2015 http://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf

[iv] Fiscal sustainability and public spending on health. OBR, 2016 http://budgetresponsibility.org.uk/fiscal-sustainability-analytical-paper-published-today/

[v] Social care for older people. Home truths, the King's Fund, Nuffield Trust, 2016

[vi] National Audit of Intermediate Care, NHS Benchmarking, 2015 http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf

[vii] Census of consultant physicians and higher speciality trainees in the UK, 2014-15, RCP, 2015

[viii] Underfunded, underdoctored, overstretched. The NHS in 2016. Royal College of Physicians. 2016 https://www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016

[ix] Comprehensive geriatric assessment for older adults admitted to hospital, Ellis G, Whitehead MA, O'Neill D, Lanhorne P, Robinson D, 2011 http://www.ncbi.nlm.nih.gov/pubmed/21735403

[x] https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

[xi] *Healthy Ageing in the 21st Century: the best is yet to come*, Birmingham Policy Commission, 2014, http://www.birmingham.ac.uk/Documents/research/policycommission/healthy-ageing/Healthy-Ageing-Policy-Commission-Report.pdf

[xii] *Crisis in health and social care*, Age UK report, citing ONS statistics on life expectancy www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and wales/2011-13/rfd-1.xls

[xiii] Housing in later life, Age UK, 2014. http://www.ageuk.org.uk/Documents/EN-GB/Political/Age%20UK%20ID201813%20Housing%20Later%20Life%20Report%20-%20final.pdf?dtrk=true

[xiv] Building bridges, breaking barriers. Care Quality Commission, 2016. http://www.cqc.org.uk/sites/default/files/20160712b_buildingbridges_report.pdf