

Effective healthcare for older people

Position statement on primary care for older people

This paper sets out our views on how primary care can deliver better health outcomes for older people. We call for the changes required to achieve this to be built into the Government's long term plans for the NHS.

Introduction

The **British Geriatrics Society** (BGS) is the professional body of specialists in the healthcare of older people in the United Kingdom. Our vision is of a society where all older people receive high quality, patient-centred care when and where they need it. We have a strong interest in the effectiveness of primary care and the successful delivery of the NHS Five Year Forward View. We welcomed the increased investment included in the GP Forward View published in 2016 and the commitment to new models of care. We ask that this be built on now through the development and delivery of the NHS Long Term Plan due to be published this Autumn.

The identification and treatment of the effects of frailty in older people is now a core part of primary care. Our view is that there are some significant changes that would help to support and strengthen the delivery of primary care for older people living with frailty, whether mild, moderate or severe, and as people approach the end of life. They would help to ensure that older people are able to access the right care at the right time, would focus on prevention of deterioration and optimisation of independence, and help to better realise the benefits of financial investment.

We continue to call for increased financial investment in health and social care at a level that is sufficient to deliver high quality, patient-centred care, and for system wide reform in the longer term.

Identification and stratification

Frailty is a long-term condition affecting older people in which loss of homeostatic reserves means that minor changes in health lead to increased risk of serious adverse outcomes¹. There is good evidence to show that early intervention can prevent some aspects of deterioration and enable people to live independently for longer.

The introduction in 2017 of the requirement for GPs to practice routine frailty identification for patients who are 65 and over, and those most at risk of adverse events (including hospitalisation, nursing home admission and death), is a development which we warmly welcomed. By using frailty identification tools such as the electronic frailty index (e-FI)² (backed up by clinical correlation) in primary care settings there is an increasingly strong evidence base to inform service design and planning, and to adapt interventions to better meet individual need.

Embedding planning, support and services in the community

As part of BGS's work we aim to raise awareness among healthcare professionals of the role of 'living well' in preventing disease. While keeping fit and maintaining a healthy lifestyle helps to prevent frailty² we cannot prevent the ageing process. Our view is that a significant shift is needed to deliver more care and treatment in the community, and that this shift requires a more proactive, planned and evidence-based approach. We are optimistic because much of the evidence and some of the tools required to deliver it already exist. Our vision is about ensuring that there is a clear strategic focus on prevention, optimising independence, and better health outcomes for older people, using multidisciplinary teams embedded in primary care services as a vehicle for improvement. Aligned financial incentives, clear leadership, a collaborative culture, and IT which supports integrated care are key to success of this approach. Clear evidence exists for this model of care.^{4,5,6,7}



What we mean by this is:

- Earlier interventions for groups of people at greatest risk of developing frailty
- Identifying frailty among the older population so that ongoing support, monitoring and proactive treatment focused on prevention is offered, rather than reactively treating someone through a series of unplanned health events
- Having a clear programme of interventions designed around a population health management framework using established models of long-term condition management that support older people through mild, moderate and severe frailty
- Sufficient flexibility to deal with fluctuating levels of need and ensure a holistic approach;
- Cross service continuity; for example, Comprehensive Geriatric Assessment might begin in a hospital-based acute frailty unit and be completed and reviewed in the community or vice versa
- Within service, continuity of care such that older people with significant frailty are not “admitted to” and “discharged from” various components of services (eg intermediate care, district nursing services); rather, their need for ongoing and joined up care and support is recognised, with an understanding that their disease trajectory will cause fluctuations in need⁸
- An urgent community based response to an acute frailty syndrome so that if a patient’s needs can be met appropriately at home, the risk of hospital admission and the attendant risks of deconditioning and possible loss of independence are reduced, with a likelihood of reduced risk of care home admission
- A service that avoids duplication of assessments.

Some of the steps to achieving this include:

- Providing training so that an understanding of frailty is widespread in those health and care professionals (and key voluntary sector staff) encountering frail older people
- Supporting GPs in developing their knowledge and skills in writing care and support plans which are used as living documents and co-produced with patients and families. Multidisciplinary teams (MDTs) can share this role so that the most appropriate person writes the care plan. While the GP’s role in providing continuity of medical care is central, the GP does not always need to be the person who writes the care plan
- Making best use of the often 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 plans⁹
- Ensuring greater availability of Consultant Geriatrician time in community settings and offering Comprehensive Geriatric Assessment by community-based MDTs. In some areas this may require resource reallocation. We see this as an important way of strengthening the services that an older person can access through primary care¹⁰

- Broadening the multi-disciplinary team so that mental health and social work staff are embedded within it and it is linked to the GP’s services^{11,12}
- 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 services¹³ 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
- Supporting flexibility in where a person is cared for by supporting more flexible staffing, for example through employment contracts that allow for co-location. This (for example) may include the co-location of voluntary sector staff in primary care settings
- Ensuring that electronic and non- electronic records are shared with all those health and care professionals who have a clinical need for access in a timely way, facilitating cross service continuity. (The use of the enhanced summary care record may be one tool to facilitate this)
- Proactive care for care home residents including (where appropriate) the offer of an opportunity to make an advance care plan
- Utilising the resources of the voluntary sector both to support older people and to case find (where appropriate)
- Providing support for family carers.¹³

Widening access to Comprehensive Geriatric Assessment (CGA) in primary care settings

CGA is a process of care comprising a number of steps. Initially a multidimensional holistic assessment of an older person considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is revised and the plan re-assessed at appropriate intervals.

Evidence shows that CGA is effective in reducing mortality and improving independence for older people admitted to hospital as an emergency compared to those receiving usual medical care.⁹ In community settings the evidence shows that complex interventions in people with frailty can reduce hospital admission and can reduce risk of re-admission in people recently discharged¹⁴. Using existing tools such as the e-FI and the Fit for Frailty guidance¹⁵ helps to identify people who will benefit from CGA.

The recognition in the Next Steps on the Five Year Forward View published in 2017 of the benefits of CGA and the recommendation of the CGA toolkit as a resource for primary care is a positive development. In practice there is still a long way to go in ensuring that CGA is used for all who would benefit from it.

Workforce planning to increase the number of Geriatricians available to work in tandem with primary care colleagues in the community is important, no less so than reflection on how those primary care colleagues who focus on the

needs of frail older people can be supported to develop their skills and to meet the criteria for appraisal and revalidation. Expansion of training opportunities for nurses who wish to develop enhanced skills is also a critical factor to success of this strategy.

Measuring success

We believe 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, and may also result in the avoidance of interventions that might be unwarranted, depending on the level of frailty a person is living with. We view success measures linked to patients' goals as an essential part of wider system level measures, and would like to see a broader focus on measures relating to use of primary care, home care and quality of life alongside those that cover acute hospital admissions from hospitalisation.



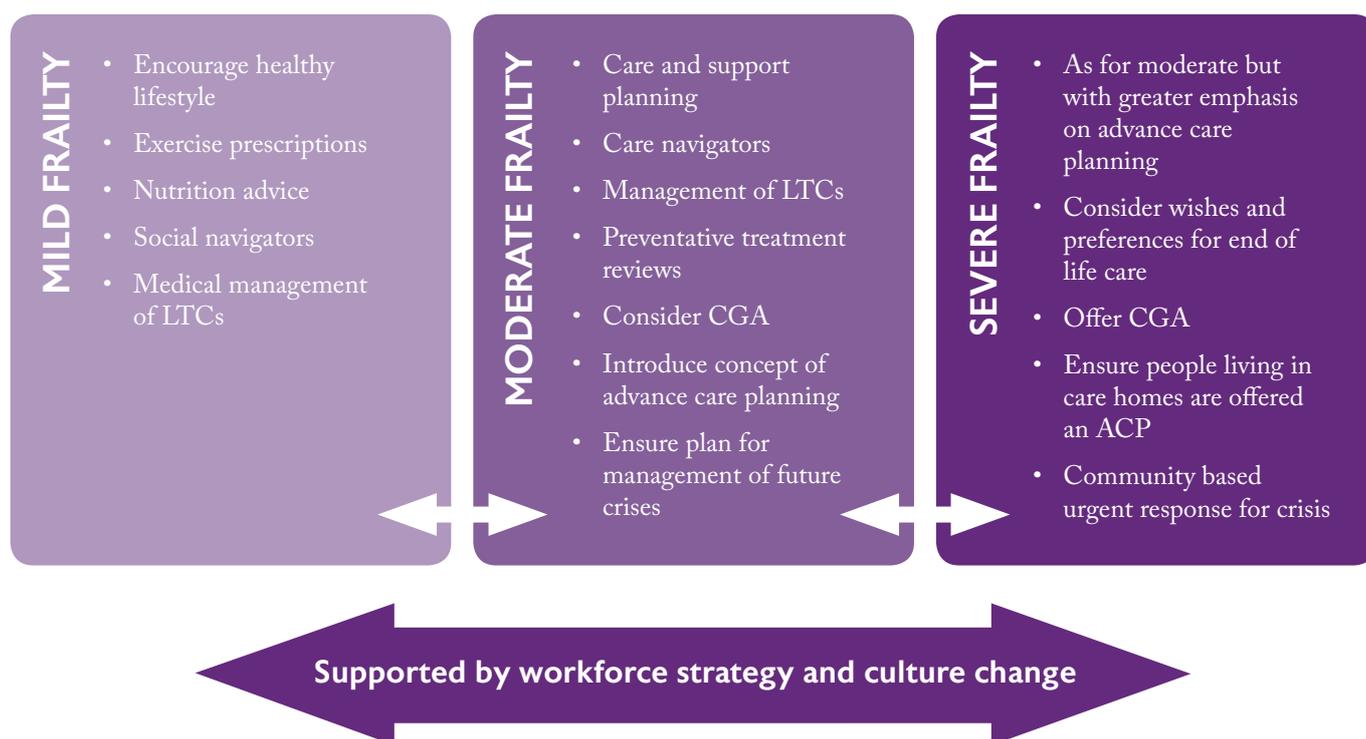
Reflections

We support NHS England's plans which are consistent with our strategy in this area. The role of the GP is crucial in the development and delivery of the services we have described. Community health, mental health, adult social care and secondary care staff must also work together to remove organisational barriers and disincentives. Clearly the current trend to falling levels of community nurses and social care funding are barriers to the work which needs to be done. NHS England could consider how GP involvement in frailty services might be rewarded under the "Quality and Outcomes Framework", perhaps by an extension of the responsibilities of the frailty requirement in the current GP contract.

Current pressures on health and social care mean that we remain a long way from achieving consistently high quality and integrated healthcare for all older people. Our view is that within primary care there is the potential for significant benefits to be realised by better identification of frailty among older people and people with a high likelihood of developing frailty, and by introducing changes in where and how we work together to meet people's health and care needs. We support accelerated system reform and investment that is focused on community based, multidisciplinary working in primary care settings.

This will result in greater focus on prevention and maintenance of independence, better health outcomes for older people and more effective use of resources. Increased financial investment is urgently required at the same time as system reform.

We have set out an outline of the approach we support



References and resources used in this guidance

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