DHSC workforce plan – evidence from the British Geriatrics Society

British Geriatrics Society
Improving healthcare
for older people

Date Published:
November 2025

The three shifts

Older people use health and social care services more than any other population group. That said, most older people are not in hospital and they do not want to be in hospital. They prefer care that they can access closer to home. Much of the care for older people is already delivered in primary or community care. Members of the British Geriatrics Society have been delivering care in or close to their patients' homes for many years.

Hospital at home services

Provision of hospital level care in an individual's home environment is not new but it has been greatly expanded in recent years, spurred on by the COVID-19 pandemic. Hospital at home, also known as virtual wards, give acutely unwell patients the opportunity to either avoid hospital admission entirely, receiving all of their care at home, or to be discharged from hospital earlier than they would otherwise be able to, to receive the remainder of their care at home from a hospital at home team.

Hospital at home teams use digital monitoring and home visits to provide hospital level care to patients in their own homes. This is not a replacement for domiciliary care or care that would traditionally be provided in a primary or community care setting. People cared for by a hospital at home team are acutely unwell and would need to be admitted to hospital if the hospital at home service was not available. Evidence shows that outcomes from hospital at home treatment are as good as outcomes for people treated in hospital. There is also evidence that hospital at home is beneficial for service delivery and is cost-effective. An evaluation of a Liverpool heart failure virtual ward compared healthcare utilisation within 30 days for patients receiving care on the virtual ward to a control group receiving inpatient care. The service supported a 36% absolute reduction in A&E activity and an 11% absolute reduction in NHS 111 activity for patients receiving virtual ward care.[i] Mortality and readmissions were significantly lower for those treated on the heart failure virtual ward compared to inpatients at one, three, six and twelve

months. The virtual ward cohort also experienced a reduction in hospital-related adverse outcomes such as hospital-acquired infections, adverse drug reactions and falls.[ii] An evaluation of 29 virtual ward pathways across South East England, encompassing 22,000 virtual ward admissions, found that virtual wards providing an alternative to admission are associated with a positive impact on avoidable non-elective hospital activity. On average, one non-elective admission 'avoided' was shown to be correlated with 2.5 virtual ward admissions, with some more mature virtual wards achieving a 1:1 association between the 'avoided' non-elective admissions and virtual ward activity. This evaluation shows that virtual wards are a clinically- and cost-effective alternative to hospital admission and they become more cost-effective as they mature as they are more able to identify patients who would otherwise be in hospital and gather the skills to manage them.[iii]

A National Institute of Health Research (NIHR) randomised control trial of admission avoidance Hospital at Home services with Comprehensive Geriatric Assessment (CGA) for patients over the age of 65 concluded that Hospital at Home is a cost-effective alternative to hospitalisation for selected older people. The evaluation looked at costs for six months following the patient receiving treatment and found a mean difference of -£2547 for Hospital at Home patients, compared to those receiving inpatient care, due to the higher cost of hospital admission, reduced length of stay for Hospital at Home patients, and reduced need for residential care.[iv]

Hospital at Home is a multidisciplinary endeavour with the workforce with services often provided by advanced clinical practitioners (ACPs) or Consultant Practitioners from a nursing or allied health professional background. Services are often overseen by a geriatrician or GP with specialist advice available when required. This model of working is particularly useful in areas where geriatricians may not be readily available and therefore their limited capacity is used as efficiently as possible. This also ensures that all members of the team are working at the top of their licence.

Proactive care

Proactive care services are also being rolled out across the country with the aim of identifying people with or at risk of developing frailty and intervening early to prevent or delay deterioration of their condition. This means that people are more likely to be able to live independently for longer and are less likely to need hospital or other medical treatment.

Core components of proactive care include identifying the target population cohort, carrying out holistic assessments, developing a personalised care and support plan and providing a clear plan for continuity of care. When people receiving proactive care are supported by multi-professional support, they are more likely to have a positive and consistent experience of health and care services. A range of clinicians and

professionals are needed to support the delivery of proactive care for people living with frailty. Multidisciplinary teams should be formed to support this way of working, with flexible membership to ensure that professional expertise is available when needed.

Workforce is central to the delivery of proactive care. It is important to ensuring a multi-professional team functions with sufficient capacity, the right training and expertise, with the ability to draw on other professions as needed and to flex how it operates to meet the needs of a local population. Local systems must be supported to:

- Develop a workforce plan with partner organisations locally for proactive care based on the prioritised cohort and the local configuration of services required for the integrated neighbourhood team.
- Work with primary care training hubs and community care training hubs to identify workforce needs and skills gaps and embed new roles and ways of working.
- Explore how a 'one workforce' approach can be used to bring together people and provides across the system.
- Consider how existing recruitment initiatives can be used to develop the workforce for proactive care delivery.

Multi-professional working

It is important to note that older people's healthcare is a multi-professional endeavour. There are currently not enough experts in older people's healthcare to care for the current population of older people or for the ageing population. Geriatricians are a key part of the healthcare team caring for older people and BGS estimates that in order to fulfil a ratio of one geriatrician per 500 people aged 85 and over, an additional 1,846 geriatricians will be needed by 2030.[v]

Geriatricians are specialists who have a wide breadth of knowledge and are highly experienced in general medicine. Other generalists – including GPs, emergency physicians, and general medical teams – also provide a significant proportion of care to older people. Workforce planning must ensure that generalists are equipped with the skills and support to deliver age-attuned care, and that clear referral pathways to specialists are in place

Barriers

With professionals from across the team involved in the delivery of older people's care, role blurring and blending is crucial to ensure that team members can all do similar tasks. This is particularly important in community based care to make the most efficient use of the workforce available and, for services such as Hospital at Home, to ensure that patients do not have multiple visits by different professionals.

Advanced Clinical Practitioners (ACPs) play a vital role in delivering care to older people, particularly in community and Hospital at Home settings. Their ability to work autonomously, prescribe, and lead care planning makes them essential to multidisciplinary teams. Workforce planning must include pathways for ACP development and deployment, especially in underserved areas.

Modelling assumptions

The population is ageing. This must be the central assumption for all workforce modelling for health and social care. The number of people of pensionable age is projected to rise from 12 million in mid-2022 to 13.7 million in mid-2032. The number of people aged 85 and over is projected to almost double from 1.7 million in 2022 to 3.3 million in 2047.[vi] This is cause for celebration, attributable to advances in medicine and healthier lifestyle and has been borne out by an increase in life expectancy over the last 40 years. However, healthy life expectancy is decreasing, meaning that many older people are spending more of their lives in poor health.

The population is now also living with higher levels of multimorbidity (defined as the presence of two or more long-term health conditions). 67% of people aged over 74 have multimorbidity which means they live with two or more long-term health conditions.[vii] By 2035, 17% of people aged 65 and over will have four or more conditions compared to 9.8% in 2015.[viii] The population is also living with higher levels of dementia than ever before. 982,000 people in the UK are estimated to be living with dementia and it is estimated the number will increase to 1.4 million by 2040.[ix] Most people with dementia will have multiple other health conditions so need holistic care and support that is well-coordinated. Increasing numbers of people are also living with frailty which affects up to half of people aged 85 and over[x] and costs UK healthcare systems £5.8billion per year.[xi] More people than ever before have complex care needs and the current workforce is not prepared for this.

The other crucial component that should be taken into consideration when modelling future healthcare needs is where the population most in need is. While the entire population is ageing, it is not ageing at a consistent rate. As detailed in the Chief Medical Officer's 2023 report, rural and coastal communities are ageing at a faster rate than urban areas. This is largely due to people retiring to these communities. This poses a challenge to the delivery of healthcare in these communities. Many people move to these areas, often away from their families and support networks, when they are relatively fit and healthy. However, this may mean that as they age and decline in health, they will not have familial/informal support available to them nearby. People living in rural and coastal communities are also less likely to have easy access to healthcare

services and may have to travel some distance, particularly for hospital-based services. This is a particular challenge for older people who may no longer be able to drive.

Recruitment to health and social care roles in rural areas is also a challenge across all roles. While geriatric medicine overall has a fill rate of 80%, rural areas in particular struggle to recruit to geriatric medicine trainee roles. There is also a mismatch in training posts with resident doctors in some parts of the country struggling to find jobs while roles in other parts of the country go unfilled. The workforce plan should consider whether less popular parts of the country could offer incentives for newly qualified healthcare professionals to work in those areas.

In order to care for the ageing population, all healthcare professionals must be able to provide appropriate care to older people. We need more specialists in older people's healthcare including geriatricians, GPs, nurses, allied health professionals and pharmacists with expertise in caring for older people. However, the demand from the ageing population means that increasing the numbers of professions specialising in older people's care groups will never be sufficient. With the exception of those working in paediatrics and obstetrics, most healthcare professionals will care for older people more than any other population group. Over a third of new cancer diagnoses are in people aged over 75[xii] and more than two thirds of deaths from heart and circulatory diseases are in older people.[xiii]

In addition to increasing workforce numbers, it is therefore essential that all healthcare professionals possess the core competencies required to care for older people living with frailty, dementia and multimorbidity. This includes skills in comprehensive geriatric assessment, shared decision-making, polypharmacy management and communication with patients and families. The BGS Frailty e-learning module[xiv] is one example of how these competencies can be embedded across the workforce. It is currently available free of charge to all health and social care professionals, and we would suggest that it is made a mandatory requirement for those working with older people, regardless of professional background.

Productivity gains

BGS members across the country are making changes to deliver frailty-attuned care to older people. All BGS members are working within an environment of limited resources and therefore are having to transform services without access to additional money or workforce.

Hospital at Home services use point of care testing to reduce the need for older people to attend outpatient clinics for tests and scans. This is more convenient for patients and

reduces demand on hospital or clinic based services. Hospital at Home services also utilise wearable and remote technology to enable patients to be monitored remotely, removing the need for healthcare professionals to visit patients unless clinically necessary.

Services such as the Jean Bishop Integrated Care Centre in Hull are also making use of digital stethoscopes which enable remote examination. Care assistants are trained to use digital stethoscopes which can be listened to by a more senior clinician in the clinic who can then make a diagnosis based on what they are hearing. This enables a small team to cover a large geographical area more easily.

Services are beginning to explore the use of artificial intelligence (AI) across a range of functions that support older people's care. While AI-powered medical transcription tools are helping reduce administrative burden – with staff at the Jean Bishop Centre estimating a 40–60% time saving in clinical documentation – the potential of AI extends far beyond note-taking. AI is increasingly being used to support clinical decision-making, risk stratification, and early identification of frailty or deterioration through predictive analytics. Remote monitoring systems enhanced by AI can detect subtle changes in health status, enabling timely interventions and reducing avoidable hospital admissions. For an older person wanting to stay at home, or as close to home as possible, these AI tools can be life changing.

As these technologies mature, it is essential that staff are supported to adopt and adapt to AI tools safely and effectively, with appropriate training and governance to ensure quality and equity in care delivery.

Culture and values

Healthcare professionals who choose to work with older people are often motivated by the holistic nature of the specialty. Their roles require them to care for the whole person and weigh up the benefits and harms of treatment in a person-centred way, always focusing on what matters most to the individual. Enabling healthcare professionals to get job satisfaction through shared decision-making not only delivers better care; it is also more efficient as it leads to fewer hand-offs and delays. Workforce planning should take this into account, especially as the health system's largest user group is older people.

In autumn 2023, the BGS surveyed our membership about the current state of the workforce and specifically asked what innovative solutions have been implemented to cope with current staffing pressures. A full write-up of the survey results can be found here: https://www.bgs.org.uk/BGSworkforce. The solutions highlighted the importance

of the multidisciplinary team and flexibility in job roles to enable a better work/life balance for staff. This in turn has an impact on wellbeing and retention. The following quotes outline some of the solutions that individual services have employed.

‘Offering post as band below with training. Or readvertising a revised post at a different band where there will be candidates.’ – Consultant Geriatrician

‘We have open recruitment, so RN, RMN or AHP. Full time or part-time, various hours offered to support work life balance. Also offer apprenticeships and ACP development pathways.’ – Occupational therapist

‘Created integrated roles across urgent care community, ambulance service (falls car) and ED frailty team.’ – Consultant practitioner

Flexibility in work promotes a good work/life balance and means that people are more likely to be satisfied in their role and remain in post for longer. Many of the respondents to our membership survey highlighted changes that they have made to their working hours to protect their wellbeing and, in some cases, enable them to remain in work for longer.

As plans for the future workforce progress, it will be important to ensure that healthcare professionals are supported to work less than fulltime (LTFT). The ability to work LTFT enables people to combine their clinical work with academic work or other responsibilities such as caring for younger or older relatives. Increasing numbers of trainee doctors are working LTFT – within the BGS membership around 4% of our total members have told us that they work LTFT but this rises to around 7% for our trainee members. This must be factored into workforce planning.

‘I reduced my working hours significantly one year ago, which has had a clear positive impact on my emotional/mental and physical wellbeing’ – Consultant geriatrician

‘I retired and returned, dropped a day, and hope this will make a difference.’ – Consultant geriatrician

Supporting healthcare professionals who are approaching retired age to remain in post for longer is also crucial to the long-term sustainability of the workforce. Almost half of consultant geriatricians (47%) are expected to reach the age of 60 in the next decade. Additionally, 30% of geriatricians are expected to reach the age of 65, and 24% of geriatricians are expected to be 67. The average intended retirement age was reported as 62, and 44% of consultants are expected to reach this age in the next ten years. This equates to 1,025 consultants potentially leaving the workforce.[xv] By offering more flexibility in hours and work, these people can be supported to remain in post for longer.

Hybrid roles also offer variety in work and help people to stay interested and inspired. As healthcare services shift from hospital to community, BGS members are finding value in working across both settings. This enables them to still support healthcare

delivered in hospital, while also caring for older people in their own homes or in care homes. While these roles are still relatively rare, there is scope for more healthcare professionals to work in the community more. Older people use health and social care services more than any other group and most older people are not in hospital and do not want to be in hospital. By providing more hybrid roles, more older people can be supported to remain well in their own homes.

Additional comments

There is a desperate need for better workforce data disaggregated by role, setting and skill level and to be made publicly available. While we appreciate that this consultation exercise is about ways of working rather than numbers, it is important to know the starting point. There is currently very little information in the public domain about the healthcare professionals caring for older people, particularly about the non-medical workforce. It is crucial to know who is currently caring for the health services' biggest user group to ensure that workforce planning is future-proofed for an ageing population.

---

[i] Rasoul, D et al. (2024). 'Economic evaluation of the Liverpool heart failure virtual ward model'. European Heart Journal- Quality of Care and Clinical Outcomes. 3 (11). Economic evaluation of the Liverpool heart failure virtual ward model - PubMed

[ii] Sankaranarayanan, R et al. (2024). 'Telehealth-aided outpatient management of acute heart failure in a specialist virtual ward compared with standard care'. ESC Heart Failure. 11 (4). Telehealth-aided outpatient management of acute heart failure in a specialist virtual ward compared with standard care

[iii] PPL (2024), 'South East Region Virtual Wards Evaluation'. Microsoft PowerPoint - ANONYMISED - South East Region Virtual Wards Evaluation - Final version 1.3

[iv] Shepherd, S et al. (2022). 'Hospital at Home admission avoidance with comprehensive geriatric assessment to maintain living at home for people aged 65 years and over: a RCT'. Health and social care delivery research, 10 (2) NIHR Journals Library

[v] British Geriatrics Society. (2023). 'The case for more geriatricians: Strengthening the workforce to care for an ageing population.' Available at: https://www.bgs.org.uk/moregeriatricians (accessed 5 November 2025)

[vi] Office for National Statistics. (2022). 'National population projections: 2022-based'. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2022based (accessed 22 October 2025)

[vii] NICE. (2023). 'Multimorbidity: How common is it?' Available at: https://cks.nice.org.uk/topics/multimorbidity/background-information/prevalence/ (accessed 22 October 2025)

[viii] National Institute for Health and Care Research. (2020). 'Multi-morbidity predicted to increase in the UK over the next 20 years'. Available at: https://evidence.nihr.ac.uk/alert/multi-morbidity-predicted-to-increase-in-the-uk-over-the-next-20-years/ (accessed 22 October 2025)
[ix] Alzheimer's Research UK. (2024). 'Prevalence and incidence of dementia'. Available at: https://dementiastatistics.org/about-dementia/prevalence-and-incidence/ (accessed 22 October 2025)
[x] Clegg, A et al. (2013). 'Frailty in elderly people'. Lancet. Mar 2;381(9868):752-62.
[xi] Han, L et al. (2019). 'The impact of frailty on healthcare resource use: a longitudinal analysis using the Clinical Practice Research Datalink in England'. Age and Ageing. Sep 1;48(5):665-671.
[xii] Cancer Research UK. (2022). 'Cancer incidence by age'. Available at: https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/age#heading-Zero (accessed 24 October 2025)
[xiii] British Heart Foundation. (2025). 'UK Cardiovascular Disease Factsheet'. Available at: https://www.bhf.org.uk/-/media/files/for-professionals/research/heart-statistics/bhf-cvd-statistics-uk-factsheet.pdf (accessed 24 October 2025)
[xiv] British Geriatrics Society. (2023). 'Frailty - Identification and Interventions.' Available at: https://www.bgs.org.uk/frailtyelearning (accessed 5 November 2025)
[xv] British Geriatrics Society. (2024). 'The state of the consultant geriatrician workforce: An analysis of the RCP census'. Available at: https://www.bgs.org.uk/CGworkforce (accessed 24 October 2025)