British Geriatrics Society
Improving healthcare for older people

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Professor Lord Narendra Patel
Chair
House of Lords Science and Technology Select Committee
House of Lords
London
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14 September 2020

Dear Lord Patel,

Science and Technology Select Committee Inquiry: Ageing: Science, Technology and Healthy Living

The British Geriatrics Society (BGS) welcomes this opportunity to contribute to this important inquiry. The BGS is the membership association for professionals specialising in the healthcare of older people across the UK. Founded in 1947, we now have over 4,000 members, and we are the only society in the UK offering specialist expertise in the wide range of healthcare needs of older people. Older people are the main users of health and social care services and their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for rehabilitation and social support call for specialist clinical skills. Our members (geriatricians, nurses, GPs, old age psychiatrists, allied healthcare professionals and researchers) provide high quality care for older people as multidisciplinary teams during acute illness, chronic illness, rehabilitation and at the end of life, both in hospital and community settings.

1. **We have heard that one of the challenges to living well in old age is that medical conditions are treated in silos, which means older people with multimorbidities may have to visit multiple specialists. Is this the case in your experience?**
    - **What are the main challenges this presents from a clinical perspective, and from a patient perspective?**
    - **Are there any practical ways that this can be avoided or reduced?**

Yes, it is a challenge to ensure that older people are considered as a whole person, as opposed to a collection of medical conditions. Some conditions are best managed by the relevant specialist team to ensure the best outcomes (eg cancer treatments, acute stroke, acute cardiac events and chronic renal disease). However treating each condition in isolation leads to fragmented, poorly coordinated care that makes it harder for older patients to manage their conditions and more difficult for patients and clinicians to reach the right decisions about the benefits and burden of treatment for the patient. Siloed care also increases the risk of harm as a result of gaps in communication and higher risk of medication related side effects.

Older people can have different and atypical patterns of disease presentation and are more likely to experience frailty – a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Stress factors such as acute illness, injury or a change in environment for a person with frailty are likely to result in adverse health outcomes and loss of independence.

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These problems can be tackled if experts in older people's healthcare are involved in the treatment of older people. In a hospital or community setting this is often a geriatrician and a multidisciplinary team who undertake a comprehensive assessment of all of their conditions and develop a personalised treatment and care plan for the patient's physical, mental, psychological and social support needs. Another solution is the development of liaison services where geriatricians provide advice and support to improve the care of older people receiving surgical or orthopaedic care. However, most older people living with multiple long term conditions are cared for in the community, and a GP with an interest in older people's care or an advanced nurse practitioner may be the most appropriate person to coordinate the comprehensive assessment and manage an older person's care.

Older people are the main users of both primary care and hospital care. Therefore most of the NHS workforce need better knowledge and skills in managing frailty and undertaking comprehensive geriatric assessment. BGS has developed a Frailty Hub on our website and has a wide array of resources and education that support the national Framework of Core Capabilities for Frailty[i].

The British Geriatrics Society has partnered with the Royal College of Physicians on the Diploma in Geriatric Medicine, an additional qualification for healthcare professionals who regularly come into contact with older people. While this qualification is currently aimed at GPs, old age psychiatrists and trainees, we would encourage uptake by other specialities and hope to expand access to this qualification to nurses and other healthcare professionals specialising in the care of older people.

It is also important that healthcare professionals caring for older people take the time to understand what is important to their patient. Making the right clinical decision for, and with, an individual is a complex process, balancing clinical evidence, experience, resources and patient, family, professional and cultural perspectives. Healthcare professionals must listen to older people and their families to understand the priorities of the patient and plan care accordingly.

2. **We have also heard in evidence that current medical practice relating to older adults can give rise to polypharmacy, as older people are treated for multiple conditions by different specialists in parallel. What challenges are associated with polypharmacy, particularly for older people?**
    - **Is there enough clinical pharmacology expertise within the health system, to provide advice and guidance on appropriate combinations and dosages of drugs, and where does this expertise tend to sit (eg, hospitals, GPs, pharmacists)?**
    - **How common is it for recommended dosages to be too high for older people, and does this worsen the issues of polypharmacy?**

Polypharmacy becomes inappropriate when the risks of multiple medications for an individual begin to outweigh their potential benefits. This is a particular problem in older

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people prescribed different treatment for their multiple conditions. The challenges associated with this are numerous. Firstly, there is often not much known about how the medications interact with each other and as such, side effects can occur that are unforeseen. While medicines are of course strictly tested before being used in a patient population, they are usually tested on younger people with only one medical condition. They are very rarely tested on older people with multiple long term conditions. As such, usually very little is known about how medicines interact with each other and how effective they will be in an older population.

Secondly, as we age, our bodies' ability to break down drugs reduces, meaning that the impact of taking many medications is greater in older people. In addition, many people lose weight as they age which means that the amount of a drug available to the body increases. This is often not taken into consideration when planning doses meaning that medicines intended to treat blood pressure, incontinence and pain can increase an older person's tendency to fall.

Many preventive medicines may not realise their anticipated benefits when they are prescribed for individuals at, or nearing, end of life care. This is a particular consideration for residents in nursing homes where potentially inappropriate medications are more likely.

Many (although not all) older people also have cognitive difficulties, making it difficult for them to keep track of the medicines they are taking, especially if they need to be taken at different times of the day. Older people must be supported to take the medications that they are prescribed. In addition, some older people, as detailed in the case studies provided in Age UK's 2019 report *More Harm Than Good*[ii], stop taking the medication prescribed to them because they dislike the side effects or find it inconvenient and time consuming to take them. Often they do not tell their healthcare professionals that they have stopped taking medication, making it difficult for healthcare professionals to help them to manage their medicines and their long term conditions.

Involvement of clinical pharmacists in hospital multidisciplinary teams is one of the best approaches to reduce inappropriate polypharmacy. Medication reviews are important on discharge from hospital and there are important new roles for pharmacists in community intermediate care teams as well as in primary care. Older people must have regular structured medication reviews with a healthcare professional (usually a GP or clinical pharmacist) to discuss dosing of medications and consider discontinuing unnecessary medications. It is important than patients and carers are involved in this process to ensure that the decisions made are understood by patients and they agree to the care plan that is developed as a result. It is also important that the outcome of this process is communicated to other healthcare professionals involved in the patient's care to ensure that others do not restart medications that have been stopped.

3. **Are GPs given the training and tools to provide holistic care for someone with multimorbidities? What are the challenges of treatment older people with multimorbidities in a primary care setting?**
    - **How could GPs be better supported to provide holistic care for older people?**

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- **Is there enough coordination between primary and secondary care regarding the care of older people?**

General practice is the cornerstone of the NHS. Its core strength is the GP as medical generalist with expertise in holistic care, managing undifferentiated presentations and caring for people with chronic and complex needs. However the GP contractual system has historically incentivised recognising and responding to individual conditions and very few GPs have had specific training in caring for older people living with frailty. At BGS, we believe this needs to change. Most GPs will see older people more than any other patient group and while recognition of clinical frailty is increasing, many GPs lack the time, knowledge, skills and multidisciplinary resources to do this well. We see much promise in the development of Primary Care Networks (PCNs) and a proactive and multidisciplinary Anticipatory Care approach. The BGS's GeriGPs group aims to bring together GPs with an interest in caring for older people to share knowledge and encourage more GPs to consider specialising in caring for our ageing population.

Coordination between primary and secondary care (and social care) has traditionally been very poor and, to a large extent, this remains the case. Some geriatricians are working in the community alongside extended primary care teams within new models of integrated community services or care networks that support older people with complex needs to remain at home and in care homes. Often healthcare professionals working in different settings use different IT systems, making seemingly simple things like sharing patient records difficult and almost impossible. However, it must be said that during the COVID-19 pandemic, we have seen rapid innovation across the health and social care pathway, with integration occurring where it wasn't considered possible before. Work is underway to ensure that the gains made during the pandemic are not lost as we adjust to a 'new normal'.

We have heard that the Comprehensive Geriatric Assessment potentially offers one route to provide a holistic assessment of the needs of the older people (including a review of their medication, their social and environmental circumstances and their functional status).

- **In your experience, is the CGA used in primary care, and if so, how widely? If it is not used, why not?**
- **If used correctly could CGAs help to extend healthy lifespan and reduce the impacts of multimorbidities?**
- **Do CGAs involve social care services as well?**

Comprehensive Geriatric Assessment (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 reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly.

While conducting CGA in a hospital setting would traditionally have been the domain of geriatricians, CGAs conducted in the community will usually be led by a GP. In 2019,

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BGS published a guide for conducting CGA in primary care settings[iii] and a CGA toolkit for primary care practitioners[iv].

The CGA process requires coordination to ensure that the experience is positive for both the patient and their families. As older people's needs are frequently complex and always unique, those coordinating the process must display advanced communication skills in addition to their clinical knowledge to ensure purposeful and timely assessment. Therefore coordination of CGA can be undertake by any member of the health and social care team but is best carried out by someone the patient and their family trusts and with whom they can have open and sensitive discussions.

In many cases this will be the patient's GP – especially if they have known the patient for some time and have been involved in other aspects of their care. Nurses are also well placed to manage the complexity of assessment in an efficient way drawing together the different strands to coordinate a personalised treatment plan in which the patient and their family share their aspirations and choices. Nurses have a duty to act as patient advocate, empowering people to make shared decision; these roles are set out within their standards of conduct, performance and ethics.

In cases where there is particular complexity, or where there are concerns about underlying diagnosis or treatment options, a geriatrician working in a community setting could be involved in, or lead, CGA. While social care colleagues can and should be involved in the CGA process, in reality, health and social care work in siloes and social workers are often not involved. However, during the pandemic, as mentioned above, we have seen integration where it has not been deemed possible before. As such, we are hopeful that social care colleagues will be more involved in CGA in future. An important trigger for a joint CGA is when social care considers an assessment for long term care.

4. **Are geriatricians the best placed specialists to oversee a system involving more holistic care for older people, or should these clinicians work more closely with other specialists (e.g) cardiologists, rheumatologists)? Or, are clinicians with broader 'cross-specialisms' needed?**
    - **If geriatricians are best placed, do we have enough of them?**
    - **If changes to the system of specialisms is required, at what point in medical training would changes be needed?**

While BGS firmly believes in the value of a multidisciplinary team and encourages members from all disciplines to join, we believe that geriatricians have a unique role to play as the only specialty with a focus on acute illness and rehabilitation of older people with frailty. Geriatrics is the largest medical specialty and the need for geriatricians will only increase as the population continues to age.

Older people are the NHS' core activity with people aged over 65 responsible for using 65% of acute hospital bed days, comprising more than 50% of surgical patients and using nearly half the NHS budget. Geriatricians play and must continue to play a leading role in education, training, research and development to continually improve clinical quality and safety. If the NHS as a whole is to be age attuned, geriatricians and

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specialist old age teams will be needed to support training of other healthcare professionals in the care of older people in hospital and community settings.

More geriatricians are always needed – the 2018-19 RCP census found that 72% of Higher Specialty Trainees and 59% of consultants in geriatric medicine reported that a gap in the rota occurred daily or weekly[v], showing that more geriatricians are certainly needed. However, while we will always need hospital-based doctors, the NHS is moving towards a model of providing more care in the community and this is often preferred by patients. As such, we need more geriatricians to work in the community as well as in a hospital setting.

5. **Does the NHS Long Term Plan adequately address the changes required to provide better care and support for older people, particularly those with multimorbidities?**
    - **What other changes within the health system would you recommend?**

The commitments in the Ageing Well component of the NHS Long Term Plan, specifically enhanced health in care homes, anticipatory care and urgent community care, have the potential to transform services for older people in England. We have seen steps to implement some of these measures but it is important that the commitments are not watered down. The Long Term Plan very much included a focus on frailty which was welcome. However, since the publication of the Long Term Plan, we have seen a move towards widening the scope to more care groups. We do not believe that this would be in the best interest of older people and recommend that the Ageing Well programme is firmly focused on older people. We would like to see greater pace around the urgent community response component as well as clarity about recurrent funding to allow recruitment of staff to reach the required community capacity.

We see much promise in the development of Primary Care Networks and welcome the potential for additional funding to enable GPs to have more time to manage people who have complex care and support needs or complex social circumstances. The introduction of PCNs and joined-up working with community services marks a turning point in aligning and delivering services that support older people to lead happy, healthy, and independent lives.

6. **Is the Government's target of five more years of healthy and independent life by 2035 achievable? What are the main barriers to achieving the target with regards to the healthcare system?**

    - **The Grand Challenge also aims to reduce inequalities in healthy ageing. Is the current structure of the healthcare system a contributor to these inequalities?**

In order to achieve the Government's target, a bigger focus will be needed on prevention in later life including older people. Broader lifestyle messages around smoking cessation, alcohol consumption, optimal nutrition, healthy weight and physical activity are relevant to older people and the messages must make that clear. Much of the Government's

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policy on prevention in later life has been aimed at helping people to remain at work and contribute financially to society for longer. However, the prevention agenda must be seen more broadly as the pursuit of healthy ageing: creating opportunities for older adults to contribute to society, and to stay safe, connected, happy and healthy at home for as long as possible.

Social isolation and loneliness are increasingly recognised as major public health issues. Their impact on physical and mental health is comparable to the adverse effects of smoking or alcohol. Tackling this requires collaboration with community and voluntary sector partners. BGS recently held a webinar with the Royal College of Psychiatrists, the British Red Cross, the Royal Voluntary Service and the House of Lords to discuss the unique challenges of loneliness in older people and the impact of the pandemic.

The onset of frailty and dependency can be prevented or delayed. This requires an age attuned and integrated system that enables rapid access to evidence based CGA, treatment and rehabilitation for older people with acute illness and loss of function. Older people need information, advice and support to help them stay well and to manage their health conditions. Those with greater needs and higher risk of adverse outcomes can be identified using the electronic frailty index to enable earlier and better targeting of tailored interventions.

Prevention is, and should be, the cornerstone of geriatric medicine. So much of what geriatricians, nurses, GPs and allied health professionals working with older people do is aimed at achieving better health outcomes, allowing their patients to stay well, retain or regain independence and remain at home or return home from hospital as quickly as possible. In 2019, BGS published *Healthier for Longer*, outlining ways that healthcare professionals can support their patients to remain healthy and independent in later life.[vi]

7. **What are your observations regarding older people's health and healthcare, in relation to the COVID-19 pandemic and future impacts? For example:**
    - **In what ways have multimorbidities (or other issues) complicated the treatment of older people with COVID-19, and would you recommend any changes to the configuration of healthcare services for older people ahead of future stages of this pandemic (or different pandemics)?**
    - **Do healthcare services have the capacity and coordination to treat the longer-term health implications for older people who have survived COVID-19?**
    - **Has the pandemic changed (or reinforced) any of your views about the approaches to healthcare for older people?**

As we move out of this wave of the pandemic, we have an opportunity to reframe NHS services around the needs of older people. Older people are the biggest users of health and social care services and it is not unreasonable for their needs to be at the centre of planning as we move forward. NHS services must be better prepared to identify and

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manage frailty and dementia across the continuum of care – primary care, urgent care services, hospital care, rehabilitation, and in care homes. Older people have a high risk of delirium - an acute deterioration in mental functioning arising over hours or days, triggered mainly by acute illness, surgery, trauma, or drugs. Delirium contributes to poor outcomes including falls, increased length of hospital stay, new institutionalisation, and mortality and may cause considerable distress to patients and families. Isolation and the communication and sensory impairment associated with PPE and physical distancing increase the risk and consequences of delirium for older adults with cognitive and sensory impairment.

We are extremely concerned about the increased numbers of older people who will have new onset or worsening frailty as a result of the lockdown and shielding guidelines. We are hearing from our members about patients presenting at Emergency Departments having fallen and stating that they had previously attended falls prevention classes or similar but such services were cancelled during the pandemic.

Rehabilitation services will be essential going forward, both for older people who have had COVID-19 as well as those who have been shielding during the pandemic and have deconditioned as a result. We are concerned that rehabilitation services so far have not focused on older people. We believe they must do to ensure that the long term impact of COVID-19 on individuals is minimised and we reduce the demand on services as a result of dependency created. BGS has established a short life working group in this area.

The pandemic has shone a light on care homes with many care homes feeling isolated and unsupported, particularly at the beginning of the pandemic. This has highlighted the need for more healthcare professional support to care homes. BGS provided guidelines for care homes and has a working group preparing a policy position on increasing the quality of healthcare support and clinical governance for care homes. The COVID-19 pandemic has exposed the gaps in social care and put social care in the public consciousness more than ever before and we welcome the taskforce looking at what changes need to be put in place now to prepare for a possible second wave of COVID-19 on top of winter pressures. BGS has fed in through the sub-group focused on older people and people with dementia.

COVID-19 has also moved death and dying to the centre stage. While end of life care has always been an integral part of care for older people, the acute and rapid nature of COVID-19 changes the pace and focus of that care. Clinicians and carers need to give both the best physical care possible and also provide the human contact and comfort to older people who are dying – ideally provided by those they love. BGS has published

The quality and sustainability of future health and care services will be improved by digitally enabled care that scales up adoption of remote and mobile health monitoring in the community, ensures health and care information systems are fully interoperable and enables clinicians working in different settings to access and interact with patient records and care plans wherever they are based. Virtual consultations have rapidly scaled up during the pandemic allowing clinicians to speak to patients who are shielding, self-isolating or unable to travel to hospital or GP surgery. Although video-consultation aids

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assessment, diagnosis and communication, telephone consultations may be more suitable for older people who are not digitally connected.

As mentioned above, we have seen levels of integration across the NHS and social care and primary and secondary care that were deemed impossible before the pandemic. Progress has been made quickly towards providing a better, more joined-up service for patients while protecting both patients and healthcare professionals from contracting COVID-19. It is essential that the gains made during the pandemic are not lost as we move towards creating a 'new normal' within the health and social care services. BGS has highlighted some of the changes that our members have made to their services during the COVID-19 pandemic and published these examples in our report *Capturing beneficial change from the COVID-19 pandemic*[vii].

Thank you for the opportunity to contribute to this inquiry. If you have any questions about our submission or wish to discuss in more detail, please contact our Policy Manager, Sally Greenbrook at s.greenbrook@bgs.org.uk.

Yours sincerely,

Professor Tahir Masud
President

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[i] https://www.bgs.org.uk/policy-and-media/new-%E2%80%98one-stop-shop%E2%80%99-for-frailty
[ii] Age UK, 2019, *More Harm Than Good: Why more isn't always better with older people's medicines*. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/medication/190819_more_harm_than_good.pdf (accessed 8 September 2020)
[iii] https://www.bgs.org.uk/resources/1-cga-in-primary-care-settings-introduction
[iv] https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners_0.pdf
[v] Royal College of Physicians, 2019: *Focus on physicians: 2018–19 census (UK consultants and higher specialty trainees)*. Available at https://www.rcplondon.ac.uk/projects/outputs/focus-physicians-2018-19-census-uk-consultants-and-higher-specialty-trainees (accessed 8 September 2020)
[vi] https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-11-04/BGS%20Healthier%20for%20Longer.pdf
[vii] https://www.bgs.org.uk/policy-and-media/beneficial-innovations-from-covid-19