Life & Times

Integrated care for older people with frailty:

thoughts after attending the British Geriatrics Society Conference

As part of a quest to find out how to improve care for the ageing population I found myself at the British Geriatrics Society (BGS) Conference in November 2018. There I found hundreds of geriatricians with a wealth of experience and expertise, and a passion to improve the care of the elderly population.

INTERVENTIONS TO PREVENT FRAILTY

In the sessions I attended there seemed to be a focus on the implementation of the Comprehensive Geriatric Assessment. There was abundant evidence that this intervention improved morbidity and mortality for the frail population. Much effort is invested into these assessments as patients enter the hospital and this assessment affects the route of care that the patient follows. Patients with severe frailty fare better with shorter hospital stays and with care given closer to home. Streams of care such as frailty units are being developed to improve this.

I was absorbed by a presentation on predicting frailty at an earlier stage in life. An idea that a smart watch could detect a slowing of our activity and alert us to a reversible decline in our function was discussed. We were challenged that we could be working earlier in the curve of decline to prevent frailty rather than deal with the associated problems. A session on sarcopenia encouraged us to measure grip strength and calculate a muscle decline risk for patients — similar to the cardiovascular risk we already predict. Frailty and its associated lack of function can be prevented by interventions in lifestyle, exercise, and diet.

IMPROVED COMMUNICATION IS NEEDED

It was inspiring to be part of a conference where there was so much vibrancy and energy being devoted to caring for this ever-increasing proportion of our population. However, I was frustrated with the limited

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communication between the specialists in geriatric medicine and primary care. It's frustrating to think about the wealth of knowledge we have of our patients in primary care and how poorly this is communicated to our secondary care colleagues. GPs often know about a patient's function and their support network. Better communication could really reduce the challenge of secondary care physicians carrying out a comprehensive geriatric assessment while a patient is sick and in their department. Equally — how can GPs use what geriatricians know to prevent inappropriate admissions? How can we communicate better or work better collaboratively so GPs have better evidence and experience to support decision making for possible admissions?

Regarding the challenge to be working earlier in the trajectory of decline I nearly stood out of my seat and shouted, *'This is what I do!!!'* Our work in reducing obesity, treating chronic disease, and promoting lifestyle changes all have a significant impact on reducing frailty in later life. Recognising that my efforts really do make a difference was encouraging and inspiring.

THE GERIGPS GROUP

I was invited to a committee meeting for the newly formed 'GeriGPs', a group of GPs specialising in caring for patients living with frailty. Many had portfolio careers and are beginning to work in roles that don't quite fit in either the realms of primary or secondary care. Some worked as 'traditional GPs'. The aim of the GeriGP group is to enhance the holistic care of older people by promoting the role of the GP with an interest in geriatric medicine. Reflecting on the conference, I feel that continuing to develop the links between the Royal College of General Practitioners and the BGS is essential.

More collaborative working between the specialties is fundamental in developing integrated care and innovative approaches for facing the challenge of our ageing population.

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