Seamless care for older people: service improvement on the frontline ‘Interface Geriatrics’

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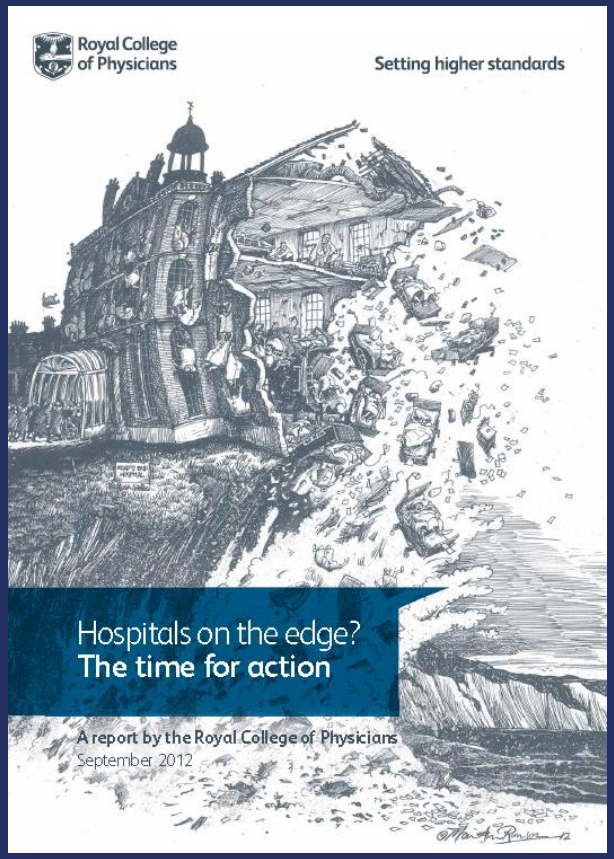
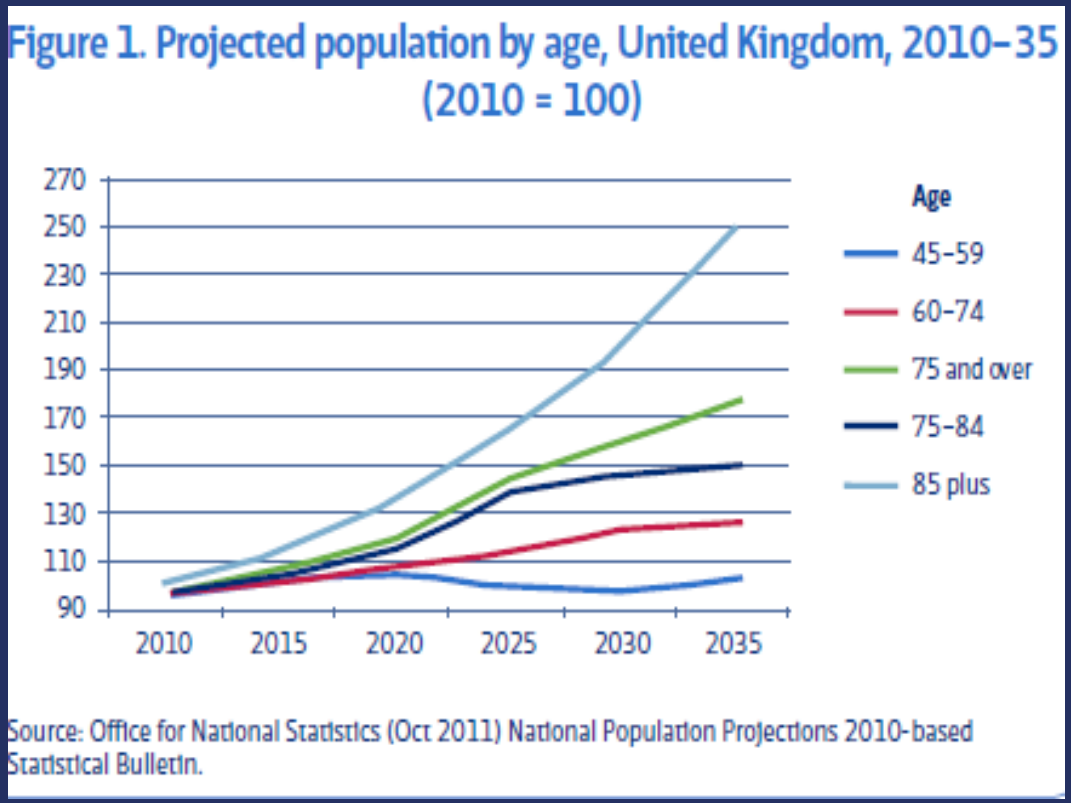
Why frail older people?

- Demographics
- Clinical challenge
- Evidence based solutions

Why frail older people?

- Demographics



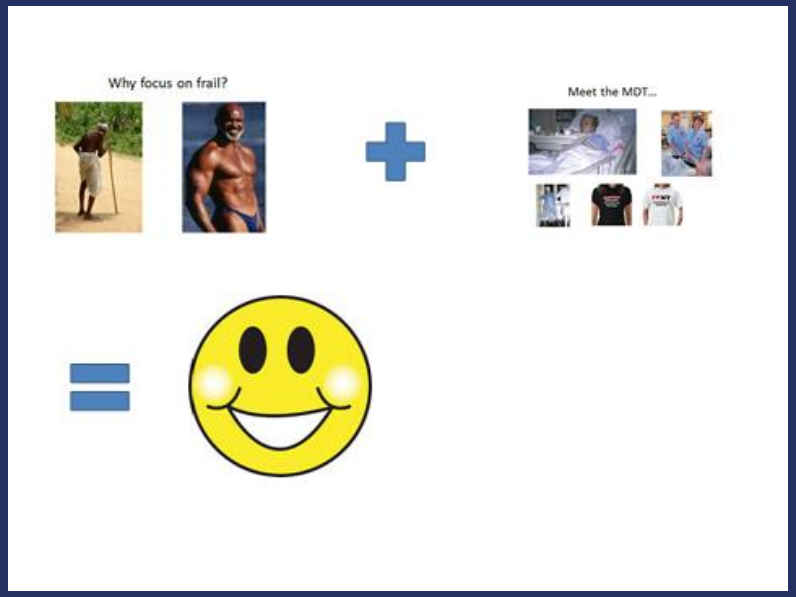


Why frail older people?

- Clinical challenge
  - Non-specific presentations
    - DEMENTIA
  - Multiple comorbidities
    - GENERALISM vs SPECIALISM
  - Homeostatic failure
    - REHABILITATION vs ACUTE MEDICINE
  - Differential challenge
    - PERVERSE INCENTIVES

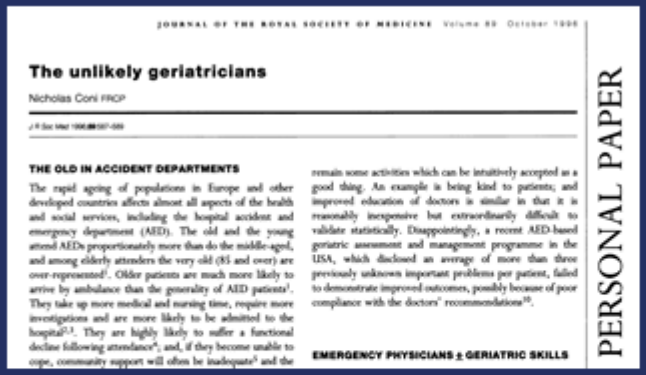
Why frail older people?

- Evidence based solutions
  - Comprehensive Geriatric Assessment (CGA)
  - Lots of evidence
    - Units better than liaison



So what's the problem?

- Not enough CGA & too much specialism
- 'Integrated care'
- Fractured care pathway
  - Acute vs rehabilitatio
  - Different (competing
  - 'CCG lottery'



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PERSONAL PAPER

The unlikely geriatricians

Nicholas Coni FRCP

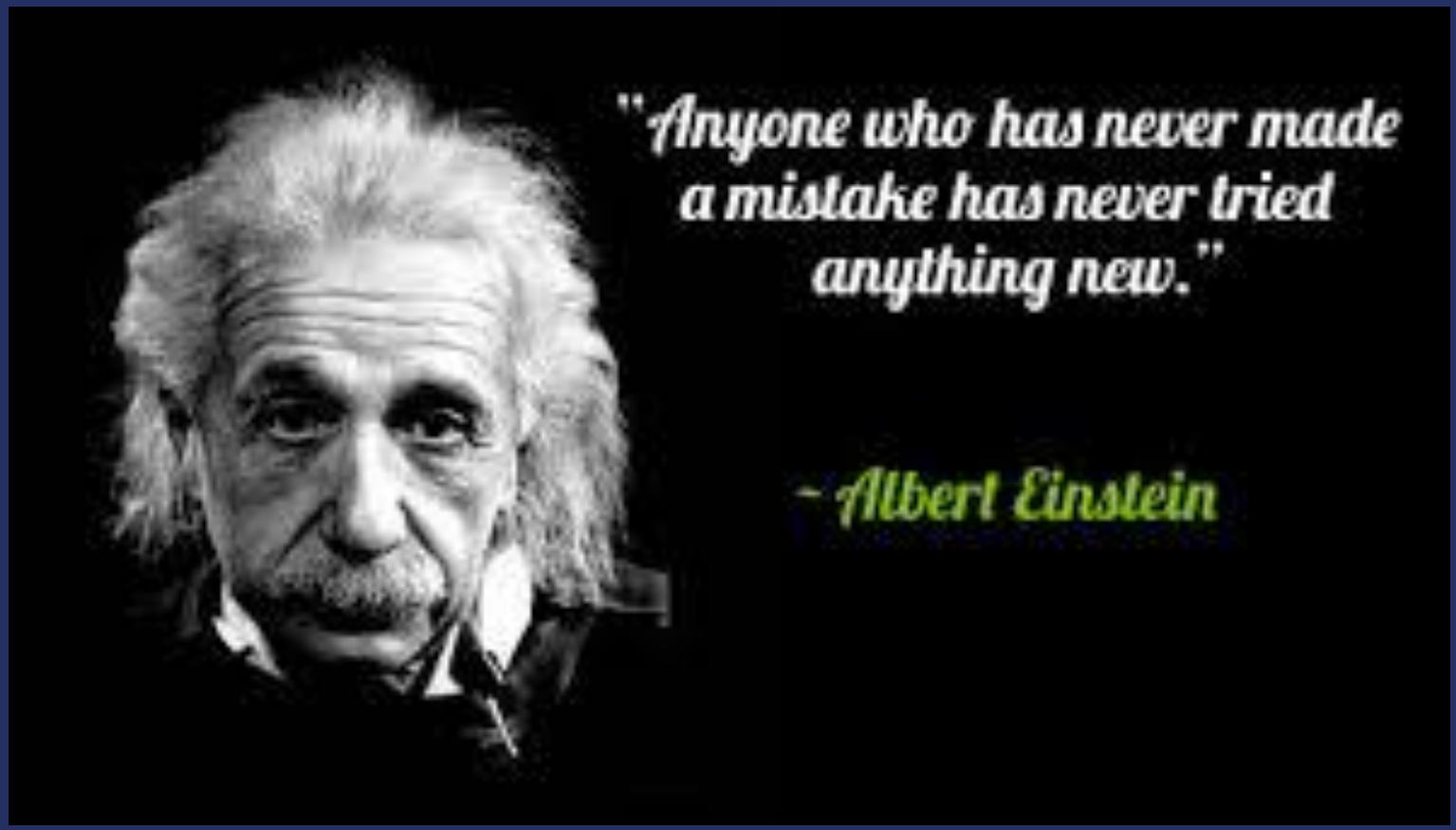
THE OLD IN ACCIDENT DEPARTMENTS

The rapid ageing of populations in Europe and other developed countries affects almost all aspects of the health and social services, including the hospital accident and emergency department (AED). The old and the young attend AEDs proportionately more than do the middle-aged, and among elderly attenders the very old (85 and over) are over-represented[1]. Older patients are much more likely to arrive by ambulance than the generality of AED patients[1]. They take up more medical and nursing time, require more investigations and are more likely to be admitted to the hospital[2,3]. They are highly likely to suffer a functional decline following attendance[4]; and, if they become unable to cope, community support will often be inadequate[5] and the remain some activities which can be intuitively accepted as a good thing. An example is being kind to patients; and improved education of doctors is similar in that it is reasonably inexpensive but extraordinarily difficult to validate statistically. Disappointingly, a recent AED-based geriatric assessment and management programme in the USA, which disclosed an average of more than three previously unknown important problems per patient, failed to demonstrate improved outcomes, possibly because of poor compliance with the doctors' recommendations[10].

EMERGENCY PHYSICIANS ± GERIATRIC SKILLS

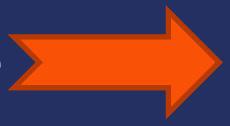
'Geriatrics is too important to be left to geriatricians. We are all geriatricians now, and geriatric medicine should be like a caretaker government-self-appointed to instruct others how to do it, and then to preside over its own demise.'

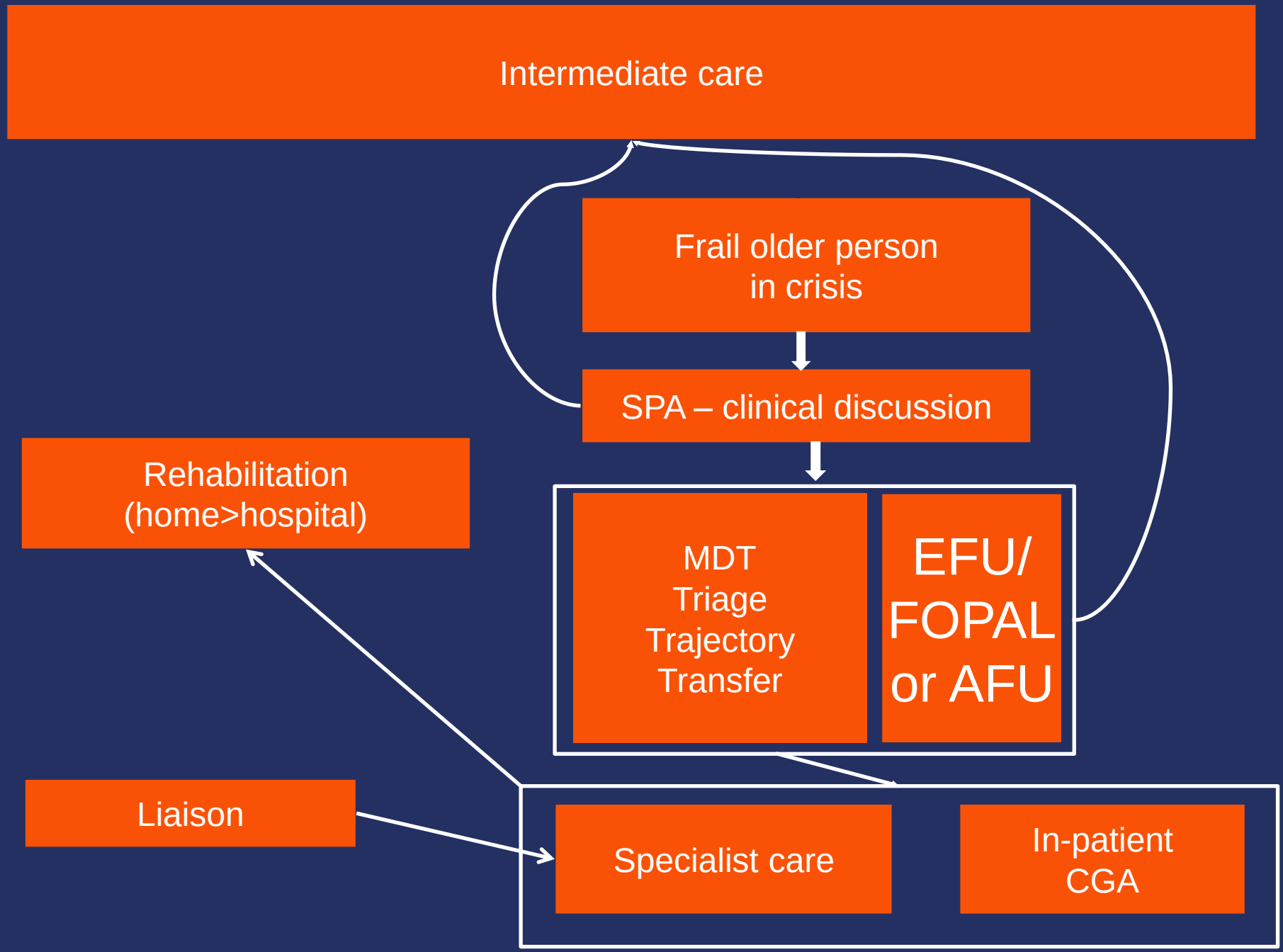
It is not just about more geriatricians…



Integrated clinical pathways for frail older people

What we did…

- Integrated take  dedicated geriatric take
- Vertically integrated services for frail older people
- Focussed comprehensive geriatric assessment, including social care
  - At and across the interfaces;
  - Coordinated and communicated
- Horizontal integration (ED and GER)
- Whole system, collaborative leadership


Intermediate care
Frail older person in crisis
SPA – clinical discussion
Rehabilitation (home>hospital)
MDT
Triage
Trajectory
Transfer
EFU/ FOPAL or AFU
Liaison
Specialist care
In-patient CGA

Outcomes: ED 85+

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A controlled evaluation of comprehensive geriatric assessment in the emergency department: the 'Emergency Frailty Unit'

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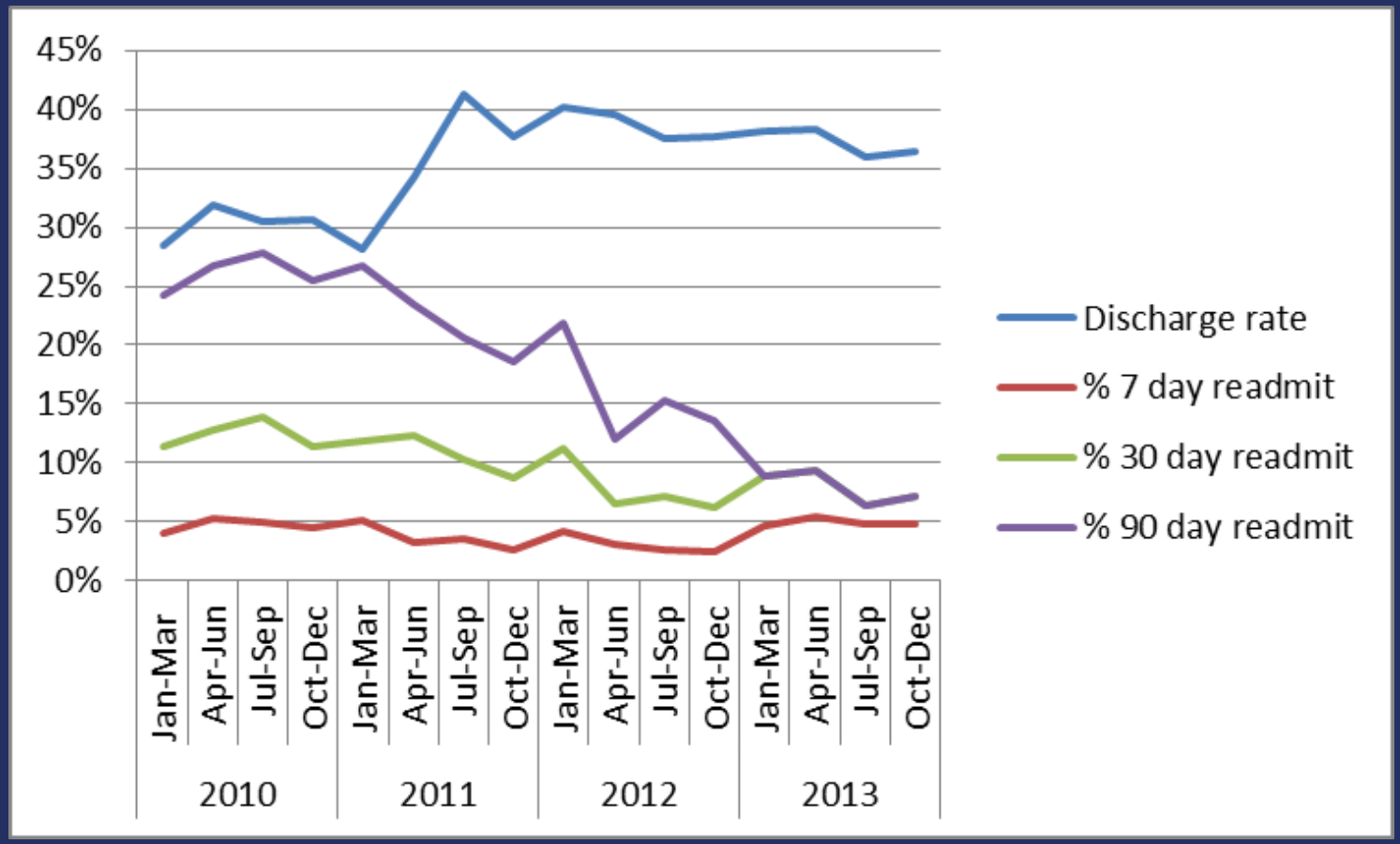
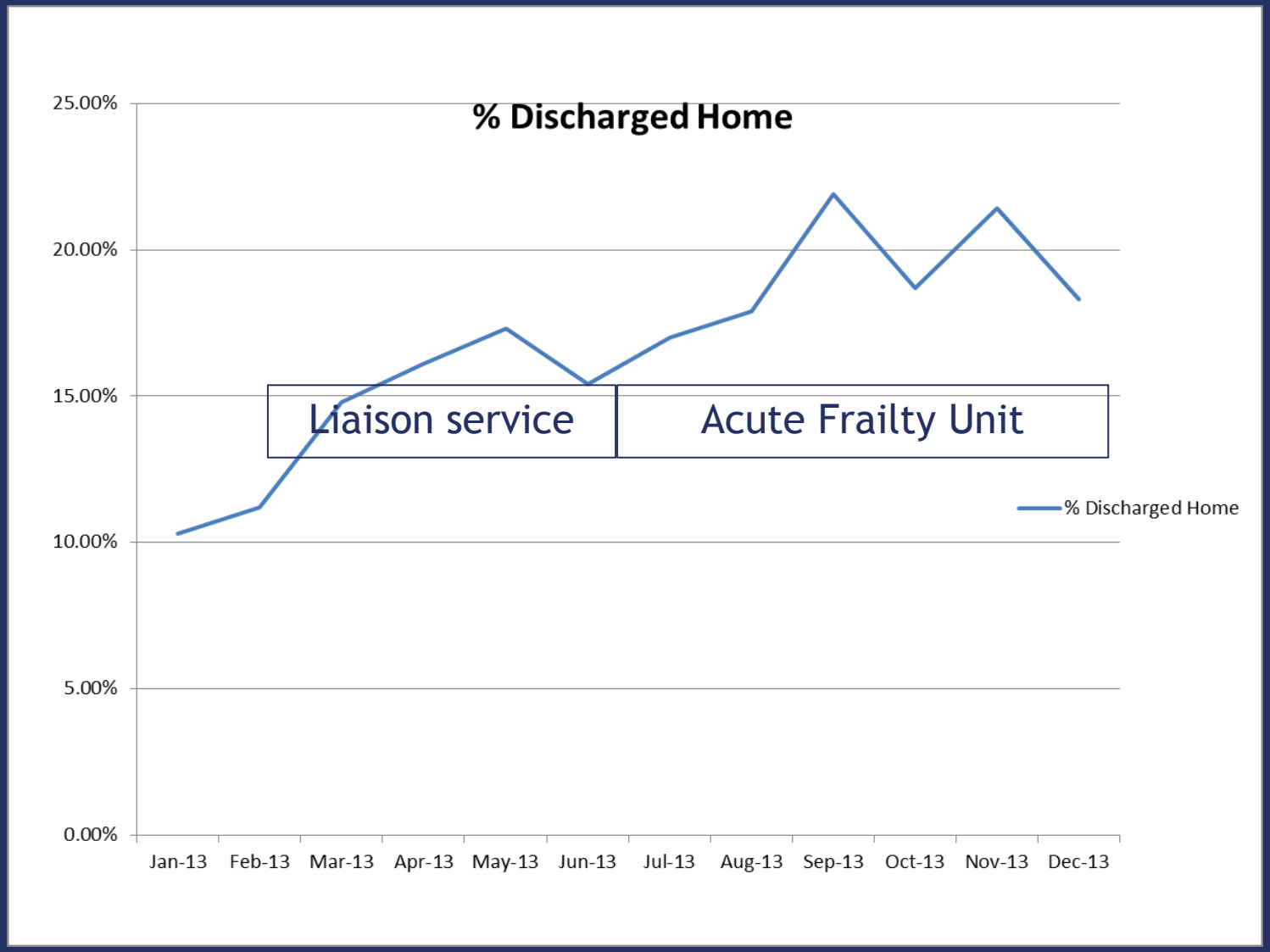


Outcomes: 85+ discharged from AFU



Take home messages

- Care for frail older people is core business
- Early CGA effective and efficient
  - The earlier the better
  - ‘Separate, not separatist’
- Needs strong interface with community services
- Clinical pathway needs to drive integration not vice versa