Geriatrics

The following recommendations were produced by the British Geriatrics Society (BGS) to highlight where resources could be released in NHS geriatrics services, while maintaining or enhancing quality.

Prior discussions had already taken place between the England Council and the UK Management Committee of the BGS, whose ideas fed into this meeting.

Themes

- ‘Best buy’ 1: A geriatrician-led team at or near the front door of every admitting hospital
- ‘Best buy’ 2: People should not go into permanent care without a comprehensive geriatric assessment by a team led by a geriatrician and, where possible, done in the community
- ‘Best buy’ 3: Advance care planning
- Medicines management
- Recognition and treatment of delirium
- Virtual clinics and telephone consultations
- Frequency and expense of litigation
- Integration
- More efficient working practices
- Other examples of best practice

‘Best buy’ 1: A geriatrician-led team at or near the front door of every admitting hospital

There is an increasing number of older people presenting to A&E departments, some of whom are discharged without their underlying problem identified, and some of whom are admitted but kept waiting unnecessarily.

Rather than waiting up to four hours to see a junior doctor, a specialist team led by a geriatrician (and preferably in a physically adjacent unit) could be on hand and to which particular kinds of patients could be immediately triaged.

The service would be for frail older people displaying signs of typical complex co-morbidities. Triage criteria would not be age-based and would not divert those with severe conditions (such as chest pain or fractured neck of femur) to the team.

The team would have close links to community care colleagues such as intermediate care nurses and would aim to get patients supported to go home much more quickly than has previously been possible.

This could either be implemented as an invest-to-save scheme, meaning higher costs in the short term to realise lower costs later on, or, given the strength of evidence of positive outcomes from similar models internationally, 1 could be reconfigured from existing resources in larger departments.

‘Best buy’ 2: People should not go into permanent care without a comprehensive geriatric assessment by a team led by a geriatrician and, where possible, done in the community

The number of people going permanently into care homes is unnecessarily high. As this is a very expensive option for public services, there needs to be proper policing to ensure appropriate placement.

Comprehensive geriatric assessments (CGAs) offer the possibility of finding more creative ways
to support people to continue living at home, yet are not routinely performed prior to care home admission.

CGAs are currently done in hospitals, but this puts off some people who dislike the setting. Establishing centres in community settings, such as community hospitals, where this could be done would increase the number of people coming forward, reducing the number admitted to residential and nursing home care.

Any cost generated by this could be recouped from the reallocation of intermediate care budgets, which are sub-optimal in many, though not all, areas.

While it is currently unclear exactly how this could work, securing close involvement from GP consortia would be beneficial. This might be an early area for consortia to consider commissioning in innovative ways. Ensuring adequate specialist input from geriatricians in this is important.

‘Best buy’ 3: Advance care planning

This is an example of best practice that is not yet routine among geriatricians.

Advance care planning involves tabulating information about the patient’s wishes on appropriateness of admission, investigation, intervention, rehabilitation and end of life. This information is stored in a way that everybody has access to. Palliative care colleagues have already done much of the work to develop this model.

This would ensure that resuscitation would not be attempted in cases where it is inappropriate and against the patient’s wishes.

It would also reduce inappropriate emergency admissions, too many of which are generated by a care home not knowing the person’s wishes, calling the out-of-hours service and leading to a hospital admission. In some cases this can lead to someone spending their final hours in hospital rather than at home.

The process of how to build advance care planning into the existing pathway needs some more discussion. Is discharge planning the right time to have such conversations, or is the clinic afterwards better? Either way, it is important that an existing relationship is in place.

The BGS’ role in this will be to encourage the uptake and spread of learning amongst its members, and to work with leaders in the care homes sector, where the biggest opportunities for improvement exist.

Other recommendations for more effective use of resources

Medicines management

It is hoped that the advent of electronic prescribing will reduce the number of adverse events due to drug interactions.

A more immediate opportunity exists to reduce some of the more common inappropriate prescribing errors that are made, through a zero tolerance drive towards drug recording – all drug charts must give a stop date for a drug, and all must state the patient’s allergies.

The problem, in the view of the BGS, is not a lack of pharmacology knowledge, but a lack of basic systems to support practice, and lax adherence to practices that do exist.

The development by the Royal College of Physicians of a national drug chart is strongly supported by the BGS, and the BGS will endeavour to back up its implementation by disseminating
a culture from the centre that it is unprofessional not to record medication properly, including a stop date. The BGS calls on employers and regulators to join in with this as well.

These changes would reduce costs both through a lower overall drugs bill and through reduction in medication errors leading to the need for further treatment.

The BGS is also supportive of systems such as patient passports, which would enable records on a patient’s medication and allergies and a synopsis of their medical problems to be obtained in a more timely fashion.

**Recognition and treatment of delirium**

Delirium is poorly understood, often unrecognised and inadequately managed in hospitals, yet it is a significant factor in extended lengths of stay and mortality.

Simple measures, if more widely used, would prevent many cases of delirium occurring. An ongoing study by Holt and Young is demonstrating successful results from training healthcare assistants and ward nurses to recognise and prevent delirium.

This could be packaged as a best practice publication badged by the BGS and disseminated nationally. The BGS has produced clinical guidelines on delirium, which include 76 key references. These are available on the BGS website [www.bgs.org.uk](http://www.bgs.org.uk) under ‘Clinical guidelines’ (*Clinical guidelines for the prevention, diagnosis and management of delirium in older people in hospital*).

**Virtual clinics and telephone consultations**

These are best for people with single system problems, for example discussing carotid doppler results, rather than for patients with multi-system disorders and frailty.

**Frequency and expense of litigation**

Geriatricians could make a contribution to reducing the litigation bill in the NHS by being more aware of the main causes of pay-outs. The BGS will therefore produce a postcard advertising the top ten reasons for defence claims in geriatrics and disseminate this to its members.

**Integration**

While not a direct cost saving, the risks around forthcoming vertical integrations in the NHS in England may drive increased costs. The BGS could therefore produce a guide to what works well for older people when integrating vertically.

In seeking to improve GP skills and continuity of care between geriatrics and primary care, geriatricians could consider resurrecting offers of domiciliary visits. These would help to reduce unnecessary admissions, although unlike in the past they shouldn’t have financial incentives attached to them, and there would need to be clear standards on when they should be used. If found useful, domiciliary visits could even be given dedicated time in the geriatrician’s timetable.
More efficient working practices

Hospital working is still sometimes configured around a 9 to 5, five days per week model that is no longer sustainable with the level of 24/7 demand. The BGS recognises the need for this model to change, and believes that geriatricians will play their full part alongside other specialties in supporting this transition.

Other examples of best practice

Rapid access clinics, for example for transient ischemic attacks (TIA) – these exist and are cost-effective, but are not universal.

Interdisciplinary teams – geriatricians should review the skill mix of these teams as in many areas the diversity has been significantly diminished. This is one of the drivers of unnecessarily long length of stay.

In recent years geriatricians have made significant progress exporting their skills in the care of older people to orthopaedic surgeons. The BGS now intends to attempt a similar approach to other disciplines of surgery. Through this project, a link will be established with the Vascular Society.

There are presently few opportunities for geriatricians to benchmark the performance of their departments against each other. Useful measures could include the number of falls in hospital or the number of patients with diarrhoea. Discussions are ongoing nationally around establishing clinical dashboards, and the BGS is supportive of these. The BGS is also supportive of the move towards outcome-focused measures, and has already devised some outcome measures for geriatrics, which it will begin promoting and which have been included in its response to the consultation on outcome measures.

References


Workshop participants

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