GPs at the Deep End

Pioneer Scheme Day-release programme

Wednesday 9th May 2018

Horselethill Road, Glasgow

Care of the Elderly in the Deep End

With Dr Jennifer Burns, geriatric consultant GRI

Introduction

Life expectancy has doubled between 1841 and 2011. This was initially due to improvements in the care of the younger population, e.g. the introduction of childhood immunisations. However now there have been improvements in older population health, for example in chronic disease management. The age-dependency ratio has therefore altered in recent years.

The population is estimated to remain at 20-25% over 65 year olds so if we can find ways of managing this population now, then it should not change too much in future. The main carers for the early retired are spouses and their children.

Older peoples services: Mental health services have defined cut offs however would include e.g. dementia in younger patients. However, younger peoples services are not inclusive of e.g. those with depression or anxiety.

Data shows that there has been an increase in emergency admissions in elderly population but this has perhaps not taken into consideration for example the impact of treatment on the frail/elderly (eg antiplatelet therapy). Patients now undergo a frailty assessment pre-chemotherapy at the Beatson

Ageing and Exercise Capacity

We need to encourage exercise in our elderly populations. Unless limitation such as severe OA, then exercise. Exercise capacity is affected by primary ageing, secondary ageing, social and psychological factors, environmental insult and trauma.

Alcohol

- 20% of admissions to elderly wards are alcohol related
- Common presentation is of loss of partner and/or work/routine which leads to loneliness resulting in unhealthy drinking habits
- Prevalence of alcohol related brain injury is increasing
- Royal college of psychiatry advises the reduction of recommended units from 14 to 11 in elderly
- CAT service is not good for older people – is there an option to create a separate service?

Frailty

- 10% of over 65s in Scotland frail, and 42% "pre-frail"
- Increased comorbidity and frailty results in a different presentation
- Different ways to measure - Rockwood scale/John Hopkins criteria
- HIS "Think Frailty" tool
- Evidence suggests that if a patient has a comprehensive geriatric assessment as an inpatient then they will have better outcomes
- Most geriatric work is seeing patients in crisis i.e. during admission – is there a way to identify potential issues earlier and prevent crises?
- E Frailty Index – GP study involving proactive contact with the patient post discharge (daily meeting with electronic discharge letters)
- Prevention and health promotion to compress the healthy life expectancy versus life expectancy gap

Glasgow Geriatric Services

- Step-up beds – North East (potentially new unit in South)
- North east rehab service includes physio, OT, CPN, Nurses, pharmacist. HSCP with link to geriatrician via rehab team, also on call consultant
- Day hospital – urgent referrals will be seen within 3-4 days for e.g. recurrent falls, acute back pain with known osteoporosis, unexplained weight loss, family concerns, non-specific illness to prevent admission. However, be aware that day hospital does not fall into the pathway for urgent suspected cancer so no quick access to colonoscopy/CT (therefore refer to specialty where possible). Routine referrals for e.g. infusions, falls classes, Parkinsons disease clinic, exercise classes
- Intermediate care
    - Scottish government initiative "home is best" so there is an agreement that patients are never discharged straight from hospital to a nursing home as there may be an option to go back home after a longer period of assessment +/- rehabilitation.
    - In Glasgow city these "step down" units are Golfhill, Northgate and Ashton Grange
    - 4 weeks funded care with a rehab team, lead by social work
    - 1/3 patients get back to their own home

- Can't get overnight checks direct from hospital but can get from intermediate care
- If intermediate complex care or palliative, then a patient can be discharged directly to either Greenfield Park or Fourhills nursing home
    - Approximately 2-3 admissions and 2 deaths per week
    - 25% die within 2 weeks
    - Another 25% die within 2 months
    - Useful if hospice deem patient not to have any complex palliative care needs
    - 4 weeks "free care"

Discussion about residential and nursing home organisation of care: some areas have an advanced nurse practitioner/single point of management. If there is no dedicated GP per nursing home ?regular meetings to discuss patients

Learning from other areas: Dundee and Aberdeen ("Silver City") both have more community-based geriatric care but this is more difficult to establish in Glasgow due to the number of different health boards but can it be done via clusters with a dedicated consultant geriatrician per cluster? Lanarkshire have a nursing at home service.

3rd sector:

- Parkinsons UK have a welfare worker
- Bield Housing and Richmond Fellowship have quality due to charitable support but continual issue with sustainability

Resources

- Drink wise age well - https://drinkwiseagewell.org.uk/about/where-we-work/glasgow/
- Good morning service - https://www.goodmorningservice.co.uk/