

Ensuring equity and quality of care for elderly people

The interface between geriatric medicine and general (internal) medicine

Summary of a report of a working party of the Royal College of Physicians

Members of the working party

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Recent developments in the philosophy and practice of health care delivery are accompanied by advances in medical knowledge and demographic change that will result in an even greater number of older people needing medical care. Responsibility for the provision of medical care for those aged 65 years and over is currently shared between many different disciplines and this is a reflection of the evolution of geriatric medicine over the last century.

The Royal College of Physicians report on the interface between geriatric and general (internal) medicine considers emergency and specialist medical services for older people as well as the process of commissioning and providing these services in the light of current advances. The training of doctors who will be caring for ill older people is also considered. Recommendations, reproduced in full here, are made to improve the quality of medical care that older people receive from hospital based services.

The provision of acute emergency medical care is at present based on one of three models; the traditional, age related, and integrated models of care. The report describes the evolution of the specialty of geriatric medicine and the formative influences that have resulted in this diversity. There is, as yet, no evidence to decide which of these models is to be preferred. Resources and research will decide which will be best

for local conditions. Recommendations are made to help ensure a high quality of service whichever system is adopted.

The access of older individuals to specialist services (geriatric and non geriatric) as well as the impact of health service reforms is discussed. Specialist geriatric services including rehabilitation and continuing care are reviewed in some detail with further recommendations regarding these areas.

The chapter on training re-emphasises the College's view that experience in geriatric medicine at general professional training level is advantageous not only for those seeking a career in the specialty of geriatric medicine but also for those hoping to become consultant general physicians. The report also welcomes trends to improve training of general practitioners in geriatric medicine.

The business of defining the health care needs of an older population and designing strategies to meet them in keeping with the current move away from hospital based health care delivery towards the primary sector is a major challenge. An important section of the report includes recommendations covering the commissioning and contracting process as well as specific service provision.

There is little doubt that closer integration of the acute geriatric and general medical services should result in improved quality and accessibility of health care for this vulnerable majority of patients as well as in improved training of doctors.

RECOMMENDATIONS

Acute services

- 1 Admission for acutely ill patients should be offered without delay regardless of age.
- 2 The acute unit should have a clearly defined and written operational policy and a strategy for the development of acute emergency care for old people, whether on the traditional, age-defined or integrated model.
- 3 Whatever the local pattern of care designed by the general and geriatric medicine physicians may be, the patient's need for admission should not

become an issue on grounds of age. A general practitioner seeking admission for an elderly person should not be involved in a 'justification exercise'. A single referral point for general practitioners to ensure the rapid admission of an ill person and thereby rapid referral to the most appropriate service soon after admission should be the aim.

- 4 Closer liaison between physicians in geriatric medicine and the accident and emergency department will both benefit patients and improve junior medical staff training.
- 5 Medical and nursing staff of receiving units must be trained appropriately in the assessment and care of elderly people, wards must be properly equipped, and patients must have ready access to relevant investigations and specialist advice. This means that all acute medical patients, regardless of age, should be admitted to the district general hospital.
- 6 Transfers between wards on more than one occasion should be avoided. Admission arrangements should ensure allocation to the most appropriate specialist team as soon as possible.
- 7 Management protocols for individual conditions, such as myocardial infarction and gastrointestinal haemorrhage, that have been agreed between specialists and physicians in geriatric medicine, will help to ensure proper management of such acute illness in elderly individuals.
- 8 Transfer of patient care between colleagues in geriatric and general (internal) medicine should occur at a senior level.
- 9 Research is recommended to determine the most efficient and effective of the three models of acute medical care provision: the traditional model, the age-defined model or the integrated model.

Specialist services (geriatric and non-geriatric) for elderly people

- 10 Outpatients clinics in departments of geriatric medicine should have access to all necessary diagnostic facilities.
- 11 Commissioning bodies should ensure that access for elderly patients to specialist (non-geriatric) facilities is as good as that for younger individuals, and that age is not used as an exclusion criterion in admission policies to specialist units.
- 12 Referral by general physician colleagues of elderly patients to the day hospital should be encouraged.
- 13 Clinical directorates should periodically audit domiciliary visits in both general and geriatric medicine.
- 14 An apparent need for continuing care should always initiate a full enquiry into the underlying reason.
- 15 Only after full evaluation, adequate treatment and, if necessary, home assessment should a person be

admitted to continuing care accommodation.

- 16 All consultants who treat elderly inpatients should be constantly aware of the need to plan their discharge from the day of admission.
- 17 Health authorities should not reduce the number of continuing care beds without ensuring the availability of a commensurate number of private and voluntary sector beds, and should retain some NHS beds for very heavily dependent patients and/or those with behavioural problems. A procedure should be outlined to be followed by districts intending to reduce the number of long-stay beds for elderly patients. This procedure should include a consultation process.
- 18 Health authorities should ensure that environmental standards and quality of care in their accommodation are of a high standard and equal to that available in the good private sector provision.
- 19 Health authority registration officers should make detailed enquiries about medical care when registering a new nursing home to ensure local general practitioners can provide the necessary level of care.
- 20 There is a need for governments to clarify the rules concerning whether and under what medical circumstances continuing care for individual patients is to be funded by health authorities or local authorities.

Training

- 21 The Royal College of Physicians has already recognised the desirability of experience in geriatric medicine at General Professional Training level. Further efforts must be made to facilitate such experience in the training of future consultant physicians in all specialties by fostering the inclusion of such posts in rotational training programmes and improving the educational value of SHO posts in geriatric medicine.
- 22 Only 40% of vocational training trainees currently gain experience in geriatric medicine. This proportion should be increased. The value of such experience cannot be overemphasised.
- 23 The additional qualification of the Royal College of Physicians Diploma in Geriatric Medicine is commended to those practitioners and bodies responsible for a major provision of health care to elderly people in the community and private institutional care.
- 24 Closer co-operation between the specialties of geriatric medicine and rehabilitation medicine in the training of future consultant physicians in these specialties is of great importance.
- 25 A geriatrician should be included in all Royal College of Physicians visiting teams inspecting SHO posts in geriatric medicine for general professional training.

'The business' of health: commissioning and providing for elderly individuals

Detailed recommendations are given in the full report.

- 26 Services for elderly people should provide acute, rehabilitative and continuing and palliative care in both the hospital and community setting with a range of skills to achieve optimal autonomy for elderly individuals.
- 27 All those who may be involved in the medical management of acutely ill elderly individuals should

have had some training in geriatric medicine, particularly those involved in the acute emergency care of old people.

- 28 The commissioning process should include not only input from general practitioners but also from an appropriately trained and experienced geriatrician.

**NEW
TITLE**

Ensuring equity and quality of care for elderly people
Copies of the full report can be obtained by sending a cheque for £9.00 (Overseas price £11.00) to: The Publications Department, Royal College of Physicians, London NW1 4LE.

**NEW
TITLES**

GERIATRIC DAY HOSPITALS Their role and guidelines for good practice

A report of the Research Unit of the Royal College of Physicians and the British Geriatrics Society

This report arose from an interprofessional workshop and two large national studies of the work of geriatric day hospitals. It reviews the purposes for which geriatric day hospitals are used and the research evidence for their effectiveness. The report gives clinical guidelines for good practice, and suggests actions for future research and development.

Contents

Introduction • Methods • Background • Measuring the outcomes and cost of geriatric day hospitals • Effectiveness of geriatric day hospitals • Guidelines for geriatric day hospital care • Research and development in geriatric day hospital services • Conclusion—purchasing day hospital care.

Price £10.00 (including p&p) (overseas £12.00), ISBN 1 873240 78 3. A4 Report 31 pages. Obtainable from the Royal College of Physicians.

CLINICAL AUDIT SCHEME FOR GERIATRIC DAY HOSPITALS

Prepared by the Research Unit of the Royal College of Physicians

The audit scheme for use in geriatric day hospitals has been produced to be used in conjunction with the above report. It is intended for use by staff working in the geriatric day hospital to carry out clinical audit. By using the scheme they can assess the quality of care, set objectives for improvements and repeat the audit at a later date in order to evaluate progress.

The audit scheme comprises instructions and audit sheets which can be photocopied as required. The scheme provides audits both of the day hospital (staffing, policy and practice) and for patients (admissions, attenders and those discharged). A patient satisfaction questionnaire is also provided.

Price £12.00 (including p&p) (overseas £14.00) ISBN 1 873240 79 1. A4 Report. Obtainable from the Royal College of Physicians.