√ cent

NHS

East Hampshire, Fareham and Gosport
Primary Care Trusts
3rd Floor Raebarn House
Hulbert Road
Waterlooville
Hants
PO7 7GP

Tel: Code A
Fax:

16th June 2006

Dr Althea Lord FRCP
Community Geriatrician
Gosport War Memorial Hospital
Bury Road
Gosport
PO12 3PW

Dear Althea

Re: The First Eighteen Months of Community Geriatrics

Thank you very much for sending me a copy of your report "The first eighteen months of Community Geriatrics". I shall read the report with interest. I am sure that you have copied it to other colleagues such as Ann Smith, Jane Pike and colleagues within the department of Older People's Medicine.

I understand that you have been successful in obtaining the new role in New Zealand and I would like to take this opportunity to congratulate you in your new appointment and to thank you for all you have done in South East Hampshire. Your report will set out the things you have achieved whilst you have been here, along with your other colleagues and we will now seek to build on these in the future.

I am sure that we will have plenty of opportunity to see each other before you leave for New Zealand, and I would be very interested to know where you will be working there and the role you will be undertaking.

Yours sincerely

Code A

John Wilderspin
Chief Executive

Cc: Ann Smith, Dr Ann Dowd

31/5/6

JOHN WILDERSPIN

Dear John,

This is a posted summary of my role as community Geriatrician.

Regards,

Althea.

Fareham and Gosport NHS
Primary Care Trust

Community Health Services
Gosport War Memorial Hospital
Bury Road
Gosport
Hants
PO12 3PW

Tel:
Fax: Code A

With compliments

John W

East Hampshire NHS
Primary Care Trust

Report referred to in item 4.3 of minutes of Intermediate Care Strategy Group meeting held on 26th May.

Raebarn House
Third Floor
Hulbert Road
Waterlooville
Hampshire
PO7 7GP

Tel:
Fax: Code A

PMP1401

With compliments

NHS

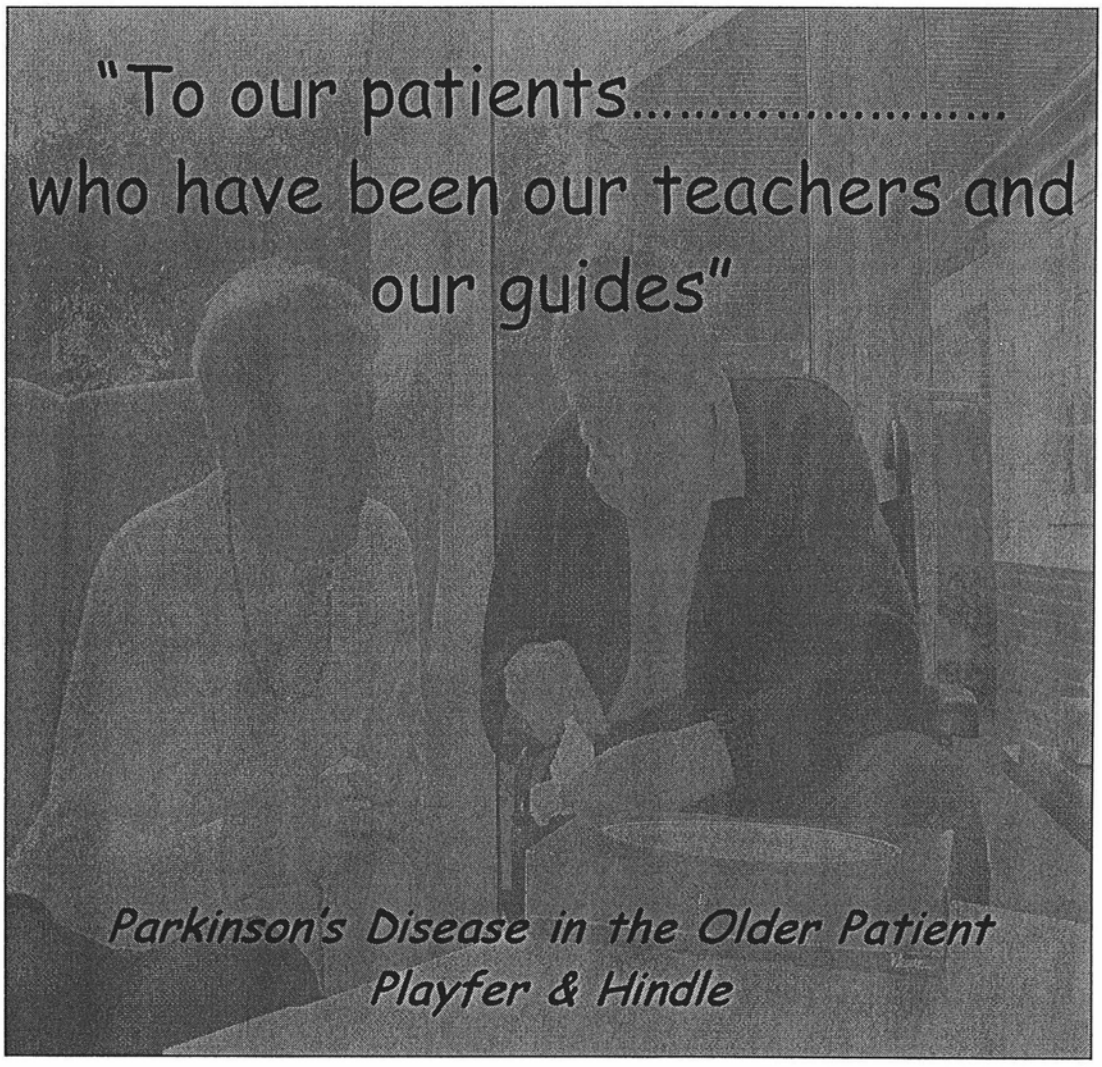
East Hampshire, Fareham and Gosport
Primary Care Trusts

The First Eighteen Months of Community Geriatrics

(July 2004 – December 2005)

A Personal Account

Dr. Althea Lord FRCP
Fareham & Gosport Primary Care Trust
May 2006


"To our patients.....
who have been our teachers and
our guides"
Parkinson's Disease in the Older Patient
Playfer & Hindle

CONTENTS

Introduction

This is an account of the 1st 18months that I spent as a Community Geriatrician for Fareham & Gosport Primary Care Trust. The appointment followed 12 years as a Consultant Geriatrician in the Department of Medicine for Older People in Portsmouth. My interest in Day Hospitals and Parkinson's Disease, led to a weekly session with the Community Enabling Service. At the outset, I was uncertain and even sceptical that community services were the way forward but was encouraged by Rosemary Salmond and her dream for the Community Enabling Service. The next page contains a summary of her vision and this is followed by my personal philosophy in delivering community geriatrics.

The ability to see patients in a variety of settings – home, care home, outpatients, day hospital, or on the ward in the community hospital has ensured continuity of care and enhanced the patient journey. I have been privileged to be able to deliver this service and have particularly enjoyed being able to assess and communicate with patients in their own homes, and now have the confidence that a complete assessment is possible outside a hospital setting. Except for radiology examinations all other basic examinations can be carried out in the community. The specialist nurses in Parkinson's Disease, Continence, COPD, Heart Failure, and Leg Ulcers have been invaluable in contributing to safer assessment and management in the community. The League of Friends of St. Christopher's Hospital, Fareham was generous in providing me with a portable ECG machine, pulse oximeter, sphygmomanometer, and Doppler probe. I also carry an ophthalmoscope, tendon hammer, peak flow meter, glucometer and the necessary equipment for phlebotomy. Medical and Psychiatry notes are reviewed and summarised for all new patients.

The efficacy of community geriatrics has been difficult to assess. There is no validated tool and so a Patient Satisfaction Survey (adapted from the PSQ 18) and a General Practitioner survey were carried out. These results have been summarised. Of note, is that the system that we have set up for community visits and follow-ups to include test results has been 100% successful with no follow-ups or results of tests missed in almost 2 years.

The suggestions at the end of the report are my personal comments for further development of the service and I do hope that they will be considered.

Community Enabling Service in Fareham and Gosport

The development of intermediate care services in Fareham and Gosport began with representatives from all community and therapy professions meeting to agree a vision of what we hoped to achieve and to name the service 'The Community Enabling Service' (CES.)

The following became our guiding principles:

1. An intermediate care service should be an integral part of the existing range of community services, including those provided in a Community hospital and should not be a stand alone service through which patients would pass.
2. Access to the service would be through a centralised administrative point.
3. There would be a generic assessment tool which would be completed by the first professional to meet the patient.
4. All professionals would share the same office base
5. Patients could access the total range of Community Nursing and Therapy services that they required without referral from their GP.
6. Referrals could be from secondary care consultants, GPs, Community Nursing, Therapists and Social Services. Patients could not refer themselves.
7. The service would aim to treat the individual where possible in their own home, would aim to avoid hospital admission if appropriate and would aim to enable a smooth timely transfer from hospital to home so reducing the length of stay.

Extra investment was provided to enable all professional groups to increase their establishment and develop this new way of working. Some additional consultant geriatrician sessions were also provided. Representatives of all professionals providing a service formed a steering group which continues to meet monthly to help sort out the operational issues.

From this basis the CES has continued to evolve and develop. A significant development was the appointment of a Community Geriatrician which secured the clinical credibility of the service to those referring. Similarly Nurse Specialists for Parkinson's Disease, Multiple Sclerosis, continence management and tissue viability were appointed to ensure robust clinical governance.

Other developments were the creation of a team to actively work with the elderly and vulnerable to prevent repeat admissions to the acute sector, the formalising of a single point of access and the adoption of the Hampshire standardised single assessment tool.

The single and most notable achievement of the CES has been the increase in inter professional working which has resulted in a robust network of services to support individuals in the Fareham and Gosport community.

Rosemary Salmond
Former Adult Services Manager
Fareham & Gosport PCT

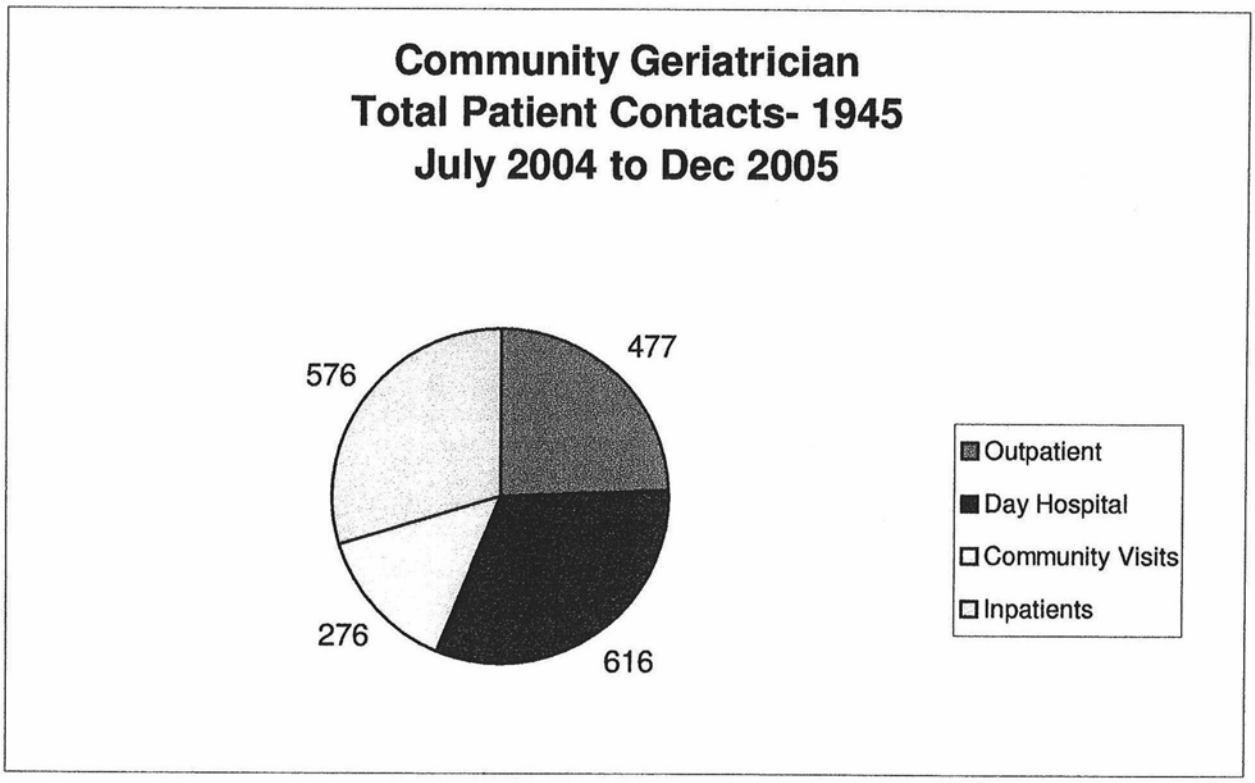
Philosophy of Community Geriatrics

1) Practice good Geriatric Medicine as first described by Marjory Warren (1935)
- Old Age is not a disease
- Accurate diagnosis is essential
- Many illnesses in the elderly are remediable
- Bed rest without reason in dangerous

2) Deliver patient centred care with accurate and comprehensive diagnosis, assessment and treatment at home or close to home, thereby preventing unnecessary admission to hospital.

3) Function as a member of an interdisciplinary community team of health and adult (social) services accepting informal referral, communicating and working with the other members of the team while involving the General Practitioner prior to an assessment being undertaken.

4) A positive attitude - "Yes we can"



This excludes patient contact on the Medical Assessment Unit and weekend cover of the acute Elderly Medicine wards at Queen Alexandra Hospital.

Activity	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	TOTAL
Home visit (New)	8	7	9	9	4	4	9	13	9	9	3	8	*131*
Home visit (Reviews)	2	0	0	5	5	4	8	0	15	7	3	11	*91*
RH visit	4	2	2	0	1	2	1	0	1	2	1	1	*28*
NH visit	3	1	1	1	3	2	0	4	1	3	1	2	*26*
OP New	7	10	10	8	10	5	6	6	6	4	4	5	*129*
OP F/U	20	19	27	10	18	19	21	14	20	12	16	16	*348*
DDH New	3	7	2	2	4	5	7	2	7	4	7	6	*64*
DDH Rev	9	13	12	21	19	11	20	7	10	15	9	15	*222*
DDH PD New	2	1	0	1	1	1	2	0	3	3	2	4	*23*
DDH PD Rev	24	15	9	14	20	12	26	14	14	19	11	19	307
													1369
Daed. Discharges (Up to Sept 05)	3	7	13	12	11	17	11	13	8	0	0	0	*137*
Sultan Ward (From Oct 05)	0	0	0	0	0	0	0	0	0	13	21	21	*55*
Total discharges													*192*
3 Consultant contacts per patient (LOS 20 days)													**576**
Total Patient Contacts													**1945**

Activity	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04
Home visit (New)	11	7	9	1	8	3
Home visit (Reviews)	1	8	6	1	12	3
RH visit	2	2	2	3	1	1
NH visit	4	0	0	0	0	0
OP New	11	5	10	3	9	10
OP F/U	30	17	28	13	28	20
DDH New	0	1	3	0	2	2
DDH Rev	15	11	11	5	10	9
DDH PD New	1	0	1	0	0	1
DDH PD Rev	32	13	22	12	18	13
Daed. Discharges (Up to Sept 05)	3	7	8	5	9	10
Sultan Ward (From Oct 05)	0	0	0	0	0	0

COMMUNITY VISITS

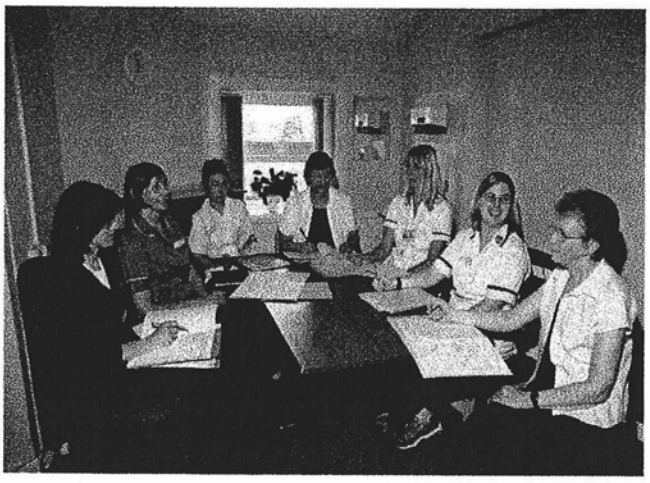
These were mostly undertaken at the request of the General Practitioner (GP) and requests may have come directly to the Community Geriatrician or via the Single Point of Access. Occasionally referral letters to Outpatients or Day Hospital indicated that a patient's mobility was significantly impaired and/or that a patient was a resident in a Care Home. In such instances the patient was initially assessed at home.

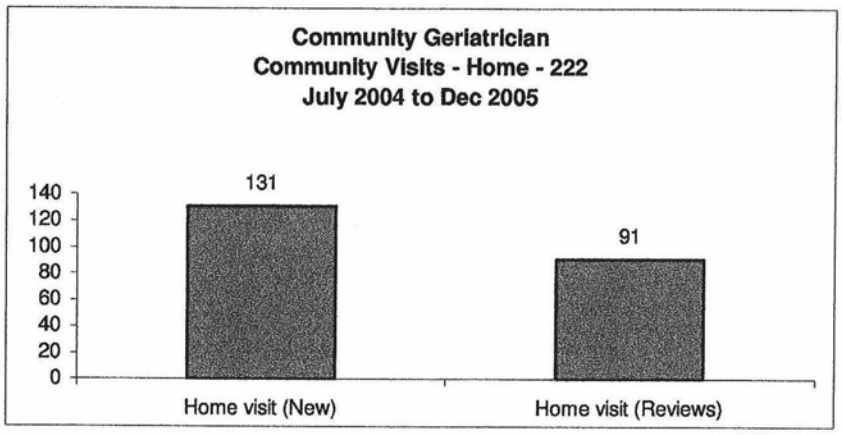
Very rarely a member of the interdisciplinary team felt that a specialist medical opinion was required and referred the patient to the Community Geriatrician having discussed this initially with the GP. In all instances where the GP hadn't initiated the medical referral a fax back form was sent out asking for the current diagnoses, current medication and issues that the Community Geriatrician should be addressing. This form was faxed back and the visit then arranged. This was so that the GP was aware of specialist intervention.

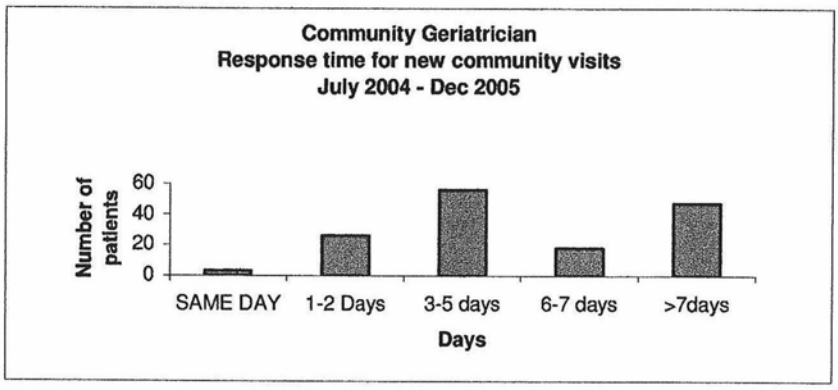
The assessments included a comprehensive clinical evaluation and where appropriate diagnostics to include blood tests, ECGs, pulse oximetry which could all be done at home. If radiological examination or 24 hour BP, ECG monitoring or spirometry was required, patients attended Dolphin Day Hospital on a single visit for diagnostics to be carried out. These results were returned to the Community Geriatrician for appropriate follow-up to be carried out.

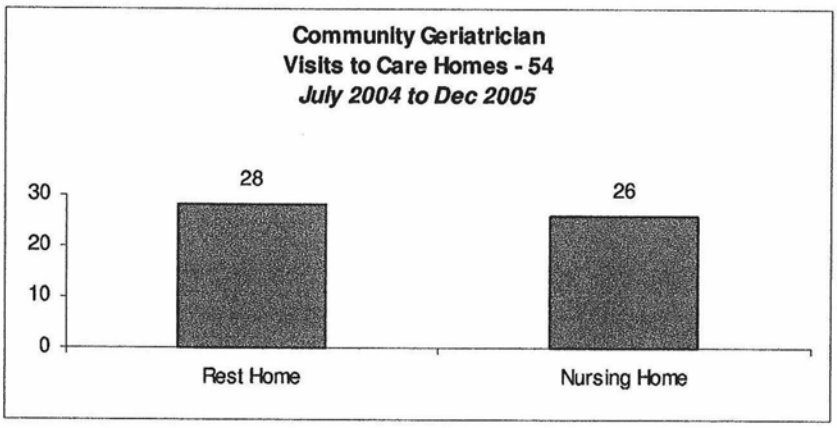
Community visits provide good and comprehensive assessment at home and have helped prevent admission. Some of the assessments facilitated long-term condition management, and in the majority this was Parkinson's Disease.

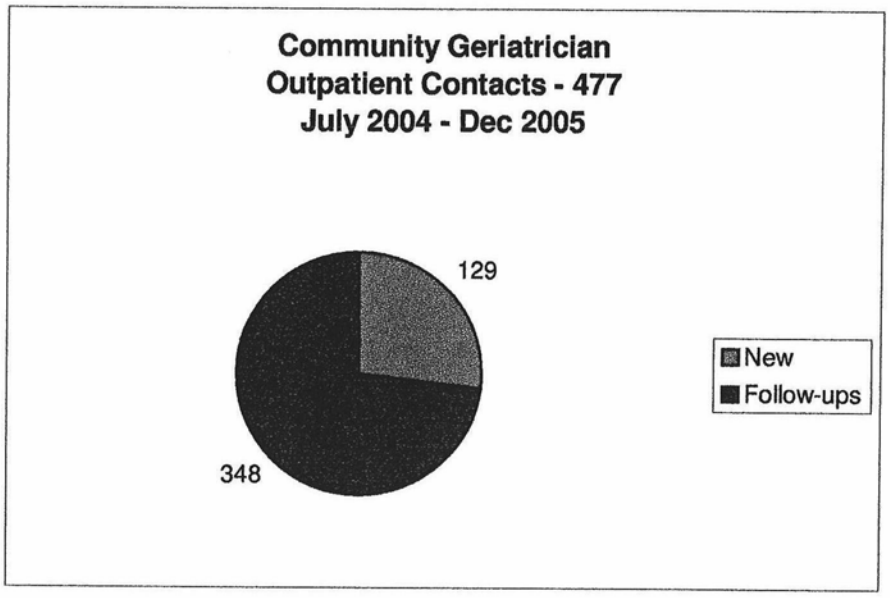
In some instances hospital admission needed to be facilitated and this was usually because patients were acutely unwell and this was usually associated with unexplained hypotension and/or hypoxia. It was also possible to stabilise a patient medically at home prior to surgery so that the time spent in hospital was a minimum. This required 2 Consultant visits 10 days apart, daily visits from the District Nursing team who was already involved and knew the patient well and 2 sets of blood tests a week apart.

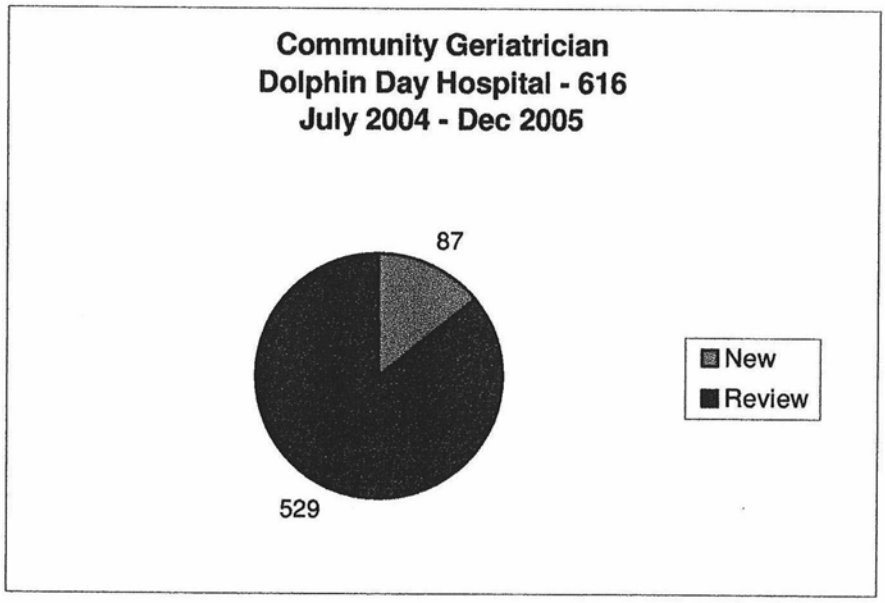



Community Geriatrician
Community Visits - Home - 222
July 2004 to Dec 2005
140
120
100
80
60
40
20
0
131
91
Home visit (New)
Home visit (Reviews)


Community Geriatrician
Response time for new community visits
July 2004 - Dec 2005
Number of patients
60
40
20
0
SAME DAY
1-2 Days
3-5 days
6-7 days
>7days
Days


Community Geriatrician
Visits to Care Homes - 54
July 2004 to Dec 2005
30
20
10
0
28
26
Rest Home
Nursing Home


Community Geriatrician
Outpatient Contacts - 477
July 2004 - Dec 2005
129
348
New
Follow-ups


Community Geriatrician
Dolphin Day Hospital - 616
July 2004 - Dec 2005
87
529
New
Review

Other roles of the Community Geriatrician

1) Inpatient Care – Initially this was for half of Daedalus Ward (General Rehabilitation).

From October 2005, in order to help with patient flow over the winter months, patients were admitted to Sultan Ward under the care of the Community Geriatrician if there was capacity not used by GPs on the bed fund at GWMH. Most of the patients were transferred from the MAU, or elderly medicine, general medicine, orthopaedics and surgery. There were some admissions direct from the community. This was delivered with only one weekly session and was initially undertaken as a pilot but has continued to the present.

2) End of Life decisions in Care Homes – a few of these were undertaken and involved discussions with patients, relatives, the interdisciplinary team, GPs and Care Home staff. This is time consuming and needs involvement of a senior clinician.

3) Participation in the acute on-call roster with an equal share of on-calls, Post Take Ward Rounds (Morning and afternoon) and weekend acute ward cover at QAH with the other Geriatricians.

4) Monthly teaching sessions were set up in Gosport War Memorial Hospital for medical, nursing and allied health professionals in primary and secondary care, Elderly Medicine and Old Age Psychiatry and are well attended and continue. Teaching is also undertaken for Elderly Medicine, SHO Core Curriculum and F1/F2 training sessions for Portsmouth Hospitals.

5) Developed the Policy for Transfusion in Day Hospitals. During July 2004 and Dec 2005, 31 transfusions were carried out in Dolphin Day Hospital.

6) Set up referral procedure and systems for community visits to ensure medical and psychiatry notes are available, rapid communication (fax and letter), documentation of phone conversations, GP involvement when referred by a nurse or AHP, checking on outstanding results. The database of patients seen on community visits has been set up and is maintained by the PA.

7) IT Issues – Instrumental in obtaining additional networked terminals for the wards and day hospital in GWMH to aid access to pathology and radiology. Issues relating to the filing of correspondence on the T drive are being sorted.

8) Locality lead for Fareham & Gosport PCT as part of the Operational and Management Team in Elderly Medicine.

Community Nursing Support to Community Geriatrician

The Community Geriatrician role has been well supported by trained nursing staff in the community. These teams were previously District Nursing and Managed Care Teams which will in the future work together as a single Community Nursing Team.

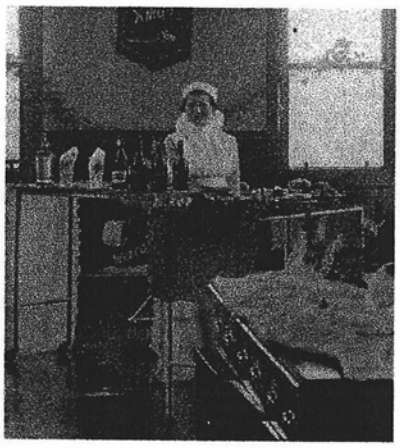
For a short period the Community Geriatrician had the support of an E Grade Staff Nurse who was part of the Intermediate Care Nursing Team but also had been seconded for a year to Adult Services and was also a qualified Care Manager. She had a case load of 20 patients mostly referred to her by the Community Geriatrician.

Although the numbers were small, the following illustrate her invaluable contribution:

1) Patient 1 – 80 year old lady with severe aortic stenosis (not fit for valve replacement), partially sighted, cerebrovascular and peripheral vascular disease, recurrent Polymyalgia Rheumatica and leg ulcers. Had been followed up in outpatients for about 3 years but got too frail to attend. Admitted after a fall to a respite care bed in a rest home but within a few weeks needed nursing care and transfer to a nursing home was achieved without a hospital admission. Nursing support ensured that placement was quickly sorted out and medical and nursing issues handed over to nursing home staff. This lady didn't have a single hospital admission since she 1st had contact with the community geriatrician in February 2002. She passed away in the nursing home in December 2005.

2) Patient 2 – 78 year old man with hypothyroidism (new diagnosis), COPD, renal impairment, cerebrovascular disease, falls, polypharmacy. Had one visit in July 2005 from Community Geriatrician and subsequent follow-ups by Intermediate Care Nurse. To date he hasn't had a hospital admission.

The nursing support to the community geriatrician is vital so that medical care can be safely delivered in the community. This includes medicines management, co-ordination of care with other disciplines, communication with patients and relatives and facilitating the medical management, including diagnostics under the guidance of the community geriatrician. There is a definite role in emergency admission avoidance and also reduces the need for specialist follow-up.



(GWMH – X'Mas 1937)

Involvement in Parkinson's Disease

The Community Geriatrician's interest in Parkinson's Disease has led to clinical involvement with approximately 120 patients. Of these 110 have management shared with the Parkinson's Disease Nurse Specialist (PDNS) and the rest being patients with essential and other tremors or where the diagnosis of Parkinson's Disease is uncertain and hence referral to the PDNS has not been made.

The majority of patients are seen in Dolphin Day Hospital where 23 new patients and 307 follow-ups were seen. These are patients who need involvement of the interdisciplinary team. There is dedicated and regular attendance by a Specialist Registrar in Elderly Medicine for the Day Hospital session. Smaller numbers (mostly patients with early Parkinson's Disease or in the Maintenance phase of the disease) are seen in outpatients and the frailest are seen in the community.

Every attempt has been made to ensure that patients with Parkinson's Disease have a regular review at least every 6 months and this is in line with the NICE guidelines which will be published later this year.

Additional involvement in this area

- Parkinson's Disease Steering Group for the Cluster
- Education in Primary and Secondary Care
- Participating and hosting meetings of the Southern PD Forum
- Mentoring and coaching for the Parkinson's Disease Academy UK
- Audit on Medication Issues in Patients with Parkinson's Disease and subsequent actions with a re-audit planned for later this year. (This was presented as a poster at the BGS Meeting in April 2005 and also published in Age & Ageing last year).
- Successful presentation to the Medicines and Formulary Group for inclusion of Pramipexole in the district formulary.

This continues to be delivered without dedicated sessional time.

Patient Satisfaction Survey

40 postal questionnaires were sent out by the Community Geriatrician to 30 patients and 10 to carers. There is no validated questionnaire for use by specialists and hence the Short Form Patient Satisfaction Questionnaire (PSQ18) was adapted and statements on financial aspects excluded. Responders were also encouraged to send in free hand comments. Replies were anonymous and returned to Dr. David Jarrett, Consultant Geriatrician who collated the replies.

The response rate was 88% with 1 patient also being a carer. Of those who responded 17 had been visited in the community (home or care home), 17 seen in Day Hospital, 20 seen in outpatients and 3 also had inpatient contact with the Community Geriatrician.

26 patients had 4 or more contacts, 6 had 3 contacts and 3 had 2 contacts.

Copying Letters to Patients – 91% had letters to the GP copied to them and 86% found them useful. 1 Patient didn't.

There was 100% agreement that the community geriatrician

1) was good at explaining the reason for medical tests
2) that the medical care received was just about perfect
3) was careful to check everything when treating and examining

There was 100% disagreement that the community geriatrician

1) was in too much of a hurry when examining the patient
2) ignored some of the things a patient said
3) provided medical care that dissatisfied patients

97% felt that they were treated in a friendly and courteous manner (1 patient agreed and disagreed)
97% did not feel that the doctor was impersonal or business like
97% didn't doubt the doctor's ability to treat
94% disagreed that the appointment was inconvenient for the carer/family
86% did not feel that they had to wait too long for an appointment
77% didn't doubt the diagnosis, 11% did and 8% were uncertain

Some quotes from the free hand comments:

"Dr Lord was my life saver sorting out the right treatment for my heart and kidney failure very quickly"

"We have been very pleased and impressed with the service. Dr. Lord obviously sets a good example which brings out the best in all the staff. Congratulations."

"She is very professional whilst maintaining a friendly nature"

"I have great respect for Dr Lord's ability to treat me."

".....specialist care and support is not available from a GP. I would have found caring for my mother more difficult without the advice, kindness, care and concern shown....."

"..... fully explained everything in detail to the relatives who have been present and to myself or my nurses"

".....never hurried me during consultation and as I have Parkinson's disease this is most helpful....."

".... Every confidence in the doctor and could wish for no better treatment."

".... She will always listen to what one has to say and will help sort out any problems if she can."

"Dr Lord sets the standards to which all doctors should aspire and all patients seek."

Summary of the patient and carer responses to the modified PSQ18

	Strongly Agree	***Agree***	***Uncertain***	***Disagree***	***Strongly disagree***
The doctor was good about explaining the reason for medical tests	26	9			
The medical care I have been receiving is just about perfect	22	13			
I have sometimes wondered if the doctor's diagnosis was correct	1	3	3	10	17
At consultations the doctor has been careful to check everything when treating and examining me	23	12			
I had to wait too long for an appointment			3	12	18
The appointment was not convenient for me/my family/my carer		1		14	19
The doctor was too impersonal and business like towards me				10	24
The doctor treated me in a very friendly and courteous manner	28	6			1*
The doctor was in too much of a hurry when treating me				8	27
I am dissatisfied with some things about the medical care I received				12	23
The doctor ignored some of things I said				14	21
I have some doubts about the doctor's ability to treat me				6	28

* 1 responder ticked strongly disagree and agree on the same form.

GP Survey of Community Geriatrics Service (Fareham & Gosport PCT)

The Practice Managers of the 23 GP Practices in Fareham & Gosport Primary Care Trust were posted a questionnaire. This could either have been filled by individual General Practitioners or collectively by all the partners.

Replies were faxed back to the Community Geriatrician. The response rate was 63% (69 replies).

4 Questions were asked:

1) Have you referred patients to the Community Geriatrician?
   Yes – 48.
   11 GPs said they hadn't referred but 8 Community Visits had been carried for 2 of the practices.
2) Was the response timely? – **Yes – 48.**
3) What benefits have you had from the Community Geriatrician Service?
4) What improvements could be made to the existing Service?

The answers to questions 3 and 4 are represented in the graphs on the 2 following pages.

Some comments from General Practitioners:

"Best outcome for housebound patients who previously refused to go to QAH"

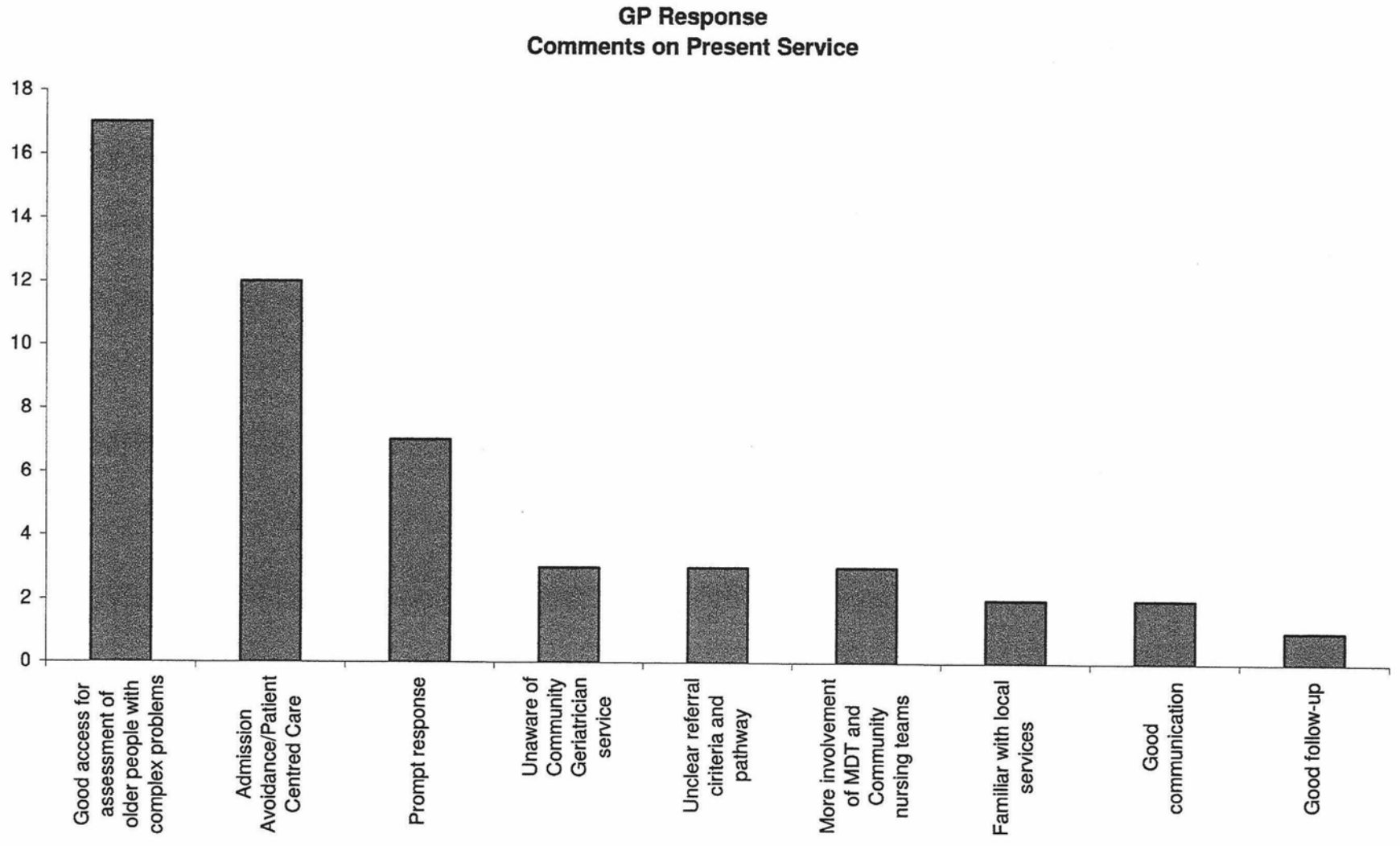
"Support with difficult cases and avoidance of hospital admissions"

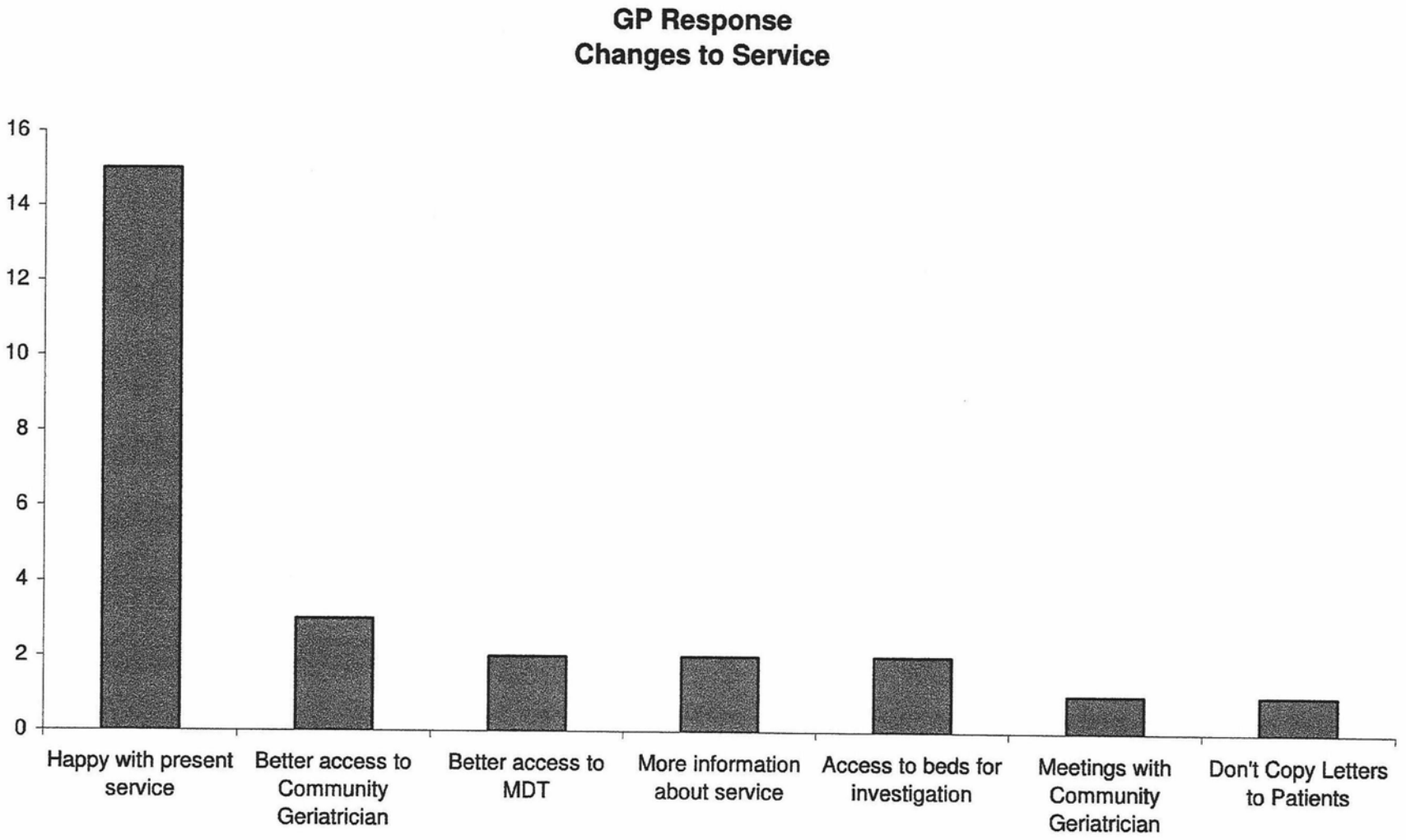
"Enables me to more confidently manage cases at home"

"Advice and support in managing complex cases in the community"

"Don't know about the service"

"More information about the service"


GP Response
Comments on Present Service
18
16
14
12
10
8
6
4
2
0
Good access for assessment of older people with complex problems
Admission Avoidance/Patient Centred Care
Prompt response
Unaware of Community Geriatrician service
Unclear referral ciriteria and pathway
More involvement of MDT and Community nursing teams
Familiar with local services
Good communication
Good follow-up


GP Response
Changes to Service
16
14
12
10
8
6
4
2
0
Happy with present service
Better access to Community Geriatrician
Better access to MDT
More information about service
Access to beds for investigation
Meetings with Community Geriatrician
Don't Copy Letters to Patients

Comments and suggestions

Community Geriatrics delivers high quality patient centred care and for a more effective service, I wish to suggest:

1) Community Geriatricians together with the community matrons and primary care colleagues will in future provide the continuity of care that is essential for good quality patient care for frailer older people with multiple pathology. This would facilitate 'pulling' patients out in a timely fashion following admission to hospital.

2) The Community Geriatrician should have a co-coordinating role working closely with community nursing team and community matrons to ensure that diagnosis is accurate and management to include medicines management is delivered safely. This would also include the supervision of non-medical prescribers and enhancing their confidence in prescribing.

3) Safe delivery of inpatient care in a community hospital requires an additional 2nd weekly session by a Specialist Registrar/Staff Grade and also support of a senior nurse in Elderly Medicine in order to ensure that the basics of good geriatric nursing are delivered and the interdisciplinary team work maintained.

4) Management in Care Homes – Diagnosis, medication, plans for treatment in the event of a crisis, should be clarified soon after admission and at regular intervals with end of life decisions being in place and agreed.

5) Community Geriatricians should have an active role in planning and development of community services and Long-Term Conditions.

6) There must be recognition that the Community Geriatrician contributes effectively to emergency care by seeing patients at home or close to home and hence undertake a reduced share of the acute on-call and Post Take Ward Rounds.

7) Dedicated sessional time for Parkinson's Disease which has increasing incidence in older people and is a condition which is mostly managed in the community. This could be carried out by a lead Geriatrician with an interest in PD working through each of the 4 day hospitals.

8) Specialist Registrar training in Community Geriatrics – Should include a block of 3 – 4 weeks spent entirely in the community gaining experience and competencies as outlined by the Primary and Continuing Care Special Interest Group of the British Geriatrics Society. This will provide continuity which is lacking in the present work schedules.

9) A cohesive district wide service requires 3 Community Geriatricians – 1 each for Fareham & Gosport, East Hants and for Portsmouth City.

10) Recognition by Primary and Secondary Care, Community and Hospital, Health and Social Services that good, safe and effective care can be delivered, but adequate resources are essential.

Thank You

- To Iris Jenkins, my PA, for setting up and maintaining the database. Her hard work, enthusiasm and loyal support are greatly appreciated.

- To all those in the Community Enabling Service, Fareham & Gosport Primary Care Trust and the Department of Medicine for Older People who helped set up and develop the Community Geriatrician role.

- To my many friends and colleagues – you know who you are.

Althea Lord
May 2006.

NHS

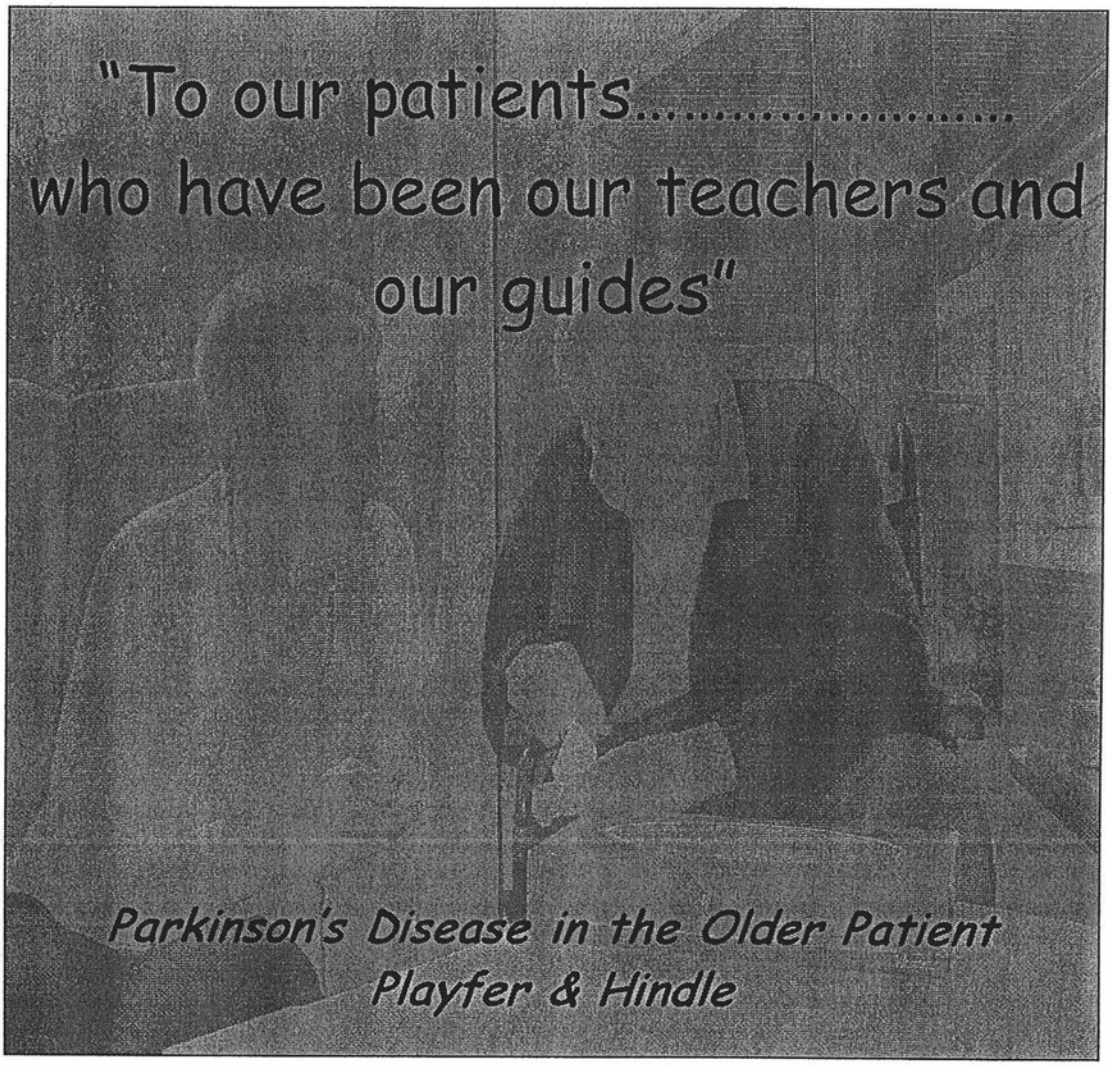
East Hampshire, Fareham and Gosport
Primary Care Trusts

The First Eighteen Months of Community Geriatrics

(July 2004 – December 2005)

A Personal Account

Dr. Althea Lord FRCP
Fareham & Gosport Primary Care Trust
May 2006


"To our patients.....
who have been our teachers and
our guides"
Parkinson's Disease in the Older Patient
Playfer & Hindle

CONTENTS

Introduction

This is an account of the 1st 18months that I spent as a Community Geriatrician for Fareham & Gosport Primary Care Trust. The appointment followed 12 years as a Consultant Geriatrician in the Department of Medicine for Older People in Portsmouth. My interest in Day Hospitals and Parkinson's Disease, led to a weekly session with the Community Enabling Service. At the outset, I was uncertain and even sceptical that community services were the way forward but was encouraged by Rosemary Salmond and her dream for the Community Enabling Service. The next page contains a summary of her vision and this is followed by my personal philosophy in delivering community geriatrics.

The ability to see patients in a variety of settings – home, care home, outpatients, day hospital, or on the ward in the community hospital has ensured continuity of care and enhanced the patient journey. I have been privileged to be able to deliver this service and have particularly enjoyed being able to assess and communicate with patients in their own homes, and now have the confidence that a complete assessment is possible outside a hospital setting. Except for radiology examinations all other basic examinations can be carried out in the community. The specialist nurses in Parkinson's Disease, Continence, COPD, Heart Failure, and Leg Ulcers have been invaluable in contributing to safer assessment and management in the community. The League of Friends of St. Christopher's Hospital, Fareham was generous in providing me with a portable ECG machine, pulse oximeter, sphygmomanometer, and Doppler probe. I also carry an ophthalmoscope, tendon hammer, peak flow meter, glucometer and the necessary equipment for phlebotomy. Medical and Psychiatry notes are reviewed and summarised for all new patients.

The efficacy of community geriatrics has been difficult to assess. There is no validated tool and so a Patient Satisfaction Survey (adapted from the PSQ 18) and a General Practitioner survey were carried out. These results have been summarised. Of note, is that the system that we have set up for community visits and follow-ups to include test results has been 100% successful with no follow-ups or results of tests missed in almost 2 years.

The suggestions at the end of the report are my personal comments for further development of the service and I do hope that they will be considered.

Community Enabling Service in Fareham and Gosport

The development of intermediate care services in Fareham and Gosport began with representatives from all community and therapy professions meeting to agree a vision of what we hoped to achieve and to name the service 'The Community Enabling Service' (CES.)

The following became our guiding principles:

1. An intermediate care service should be an integral part of the existing range of community services, including those provided in a Community hospital and should not be a stand alone service through which patients would pass.
2. Access to the service would be through a centralised administrative point.
3. There would be a generic assessment tool which would be completed by the first professional to meet the patient.
4. All professionals would share the same office base
5. Patients could access the total range of Community Nursing and Therapy services that they required without referral from their GP.
6. Referrals could be from secondary care consultants, GPs, Community Nursing, Therapists and Social Services. Patients could not refer themselves.
7. The service would aim to treat the individual where possible in their own home, would aim to avoid hospital admission if appropriate and would aim to enable a smooth timely transfer from hospital to home so reducing the length of stay.

Extra investment was provided to enable all professional groups to increase their establishment and develop this new way of working. Some additional consultant geriatrician sessions were also provided. Representatives of all professionals providing a service formed a steering group which continues to meet monthly to help sort out the operational issues.

From this basis the CES has continued to evolve and develop. A significant development was the appointment of a Community Geriatrician which secured the clinical credibility of the service to those referring. Similarly Nurse Specialists for Parkinson's Disease, Multiple Sclerosis, continence management and tissue viability were appointed to ensure robust clinical governance.

Other developments were the creation of a team to actively work with the elderly and vulnerable to prevent repeat admissions to the acute sector, the formalising of a single point of access and the adoption of the Hampshire standardised single assessment tool.

The single and most notable achievement of the CES has been the increase in inter professional working which has resulted in a robust network of services to support individuals in the Fareham and Gosport community.

Rosemary Salmond
Former Adult Services Manager
Fareham & Gosport PCT

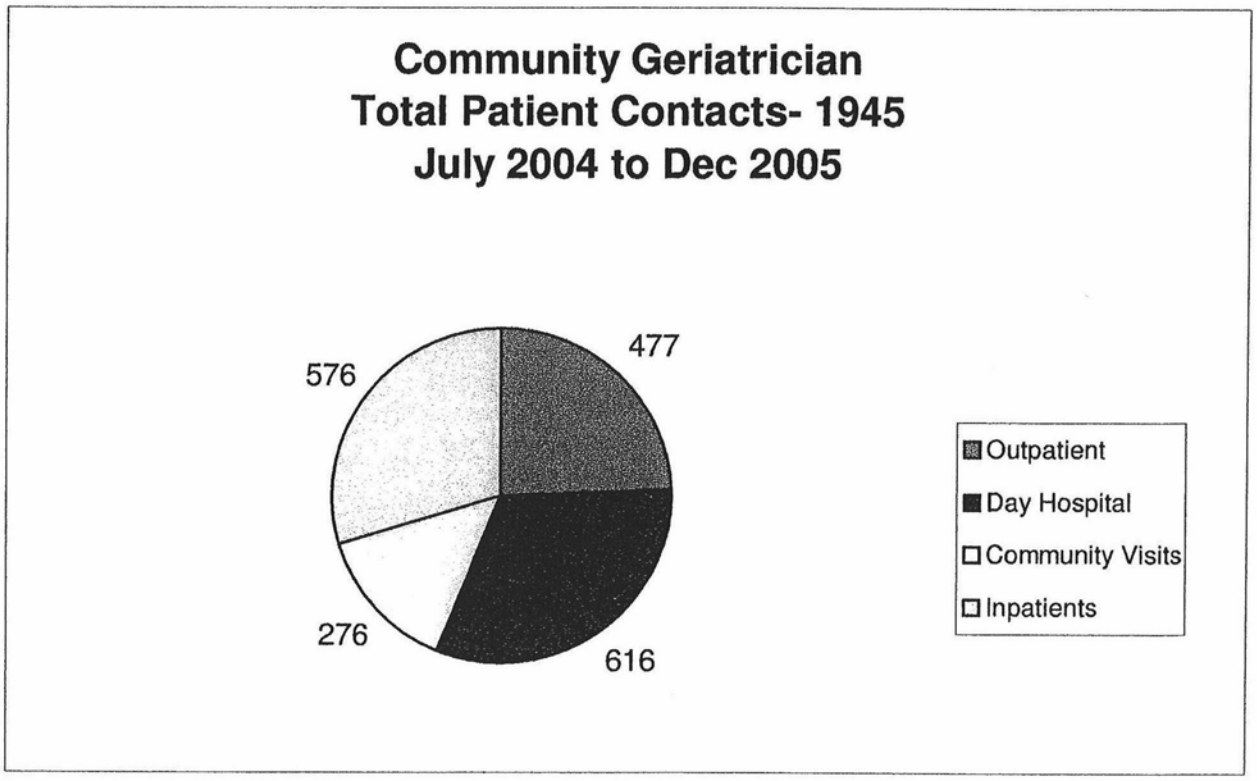
Philosophy of Community Geriatrics

1) Practice good Geriatric Medicine as first described by Marjory Warren (1935)
- Old Age is not a disease
- Accurate diagnosis is essential
- Many illnesses in the elderly are remediable
- Bed rest without reason in dangerous

2) Deliver patient centred care with accurate and comprehensive diagnosis, assessment and treatment at home or close to home, thereby preventing unnecessary admission to hospital.

3) Function as a member of an interdisciplinary community team of health and adult (social) services accepting informal referral, communicating and working with the other members of the team while involving the General Practitioner prior to an assessment being undertaken.

4) A positive attitude - "Yes we can"



This excludes patient contact on the Medical Assessment Unit and weekend cover of the acute Elderly Medicine wards at Queen Alexandra Hospital.

Activity	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	TOTAL
Home visit (New)	8	7	9	9	4	4	9	13	9	9	3	8	*131*
Home visit (Reviews)	2	0	0	5	5	4	8	0	15	7	3	11	*91*
RH visit	4	2	2	0	1	2	1	0	1	2	1	1	*28*
NH visit	3	1	1	1	3	2	0	4	1	3	1	2	*26*
OP New	7	10	10	8	10	5	6	6	6	4	4	5	*129*
OP F/U	20	19	27	10	18	19	21	14	20	12	16	16	*348*
DDH New	3	7	2	2	4	5	7	2	7	4	7	6	*64*
DDH Rev	9	13	12	21	19	11	20	7	10	15	9	15	*222*
DDH PD New	2	1	0	1	1	1	2	0	3	3	2	4	*23*
DDH PD Rev	24	15	9	14	20	12	26	14	14	19	11	19	307
													1369
Daed. Discharges (Up to Sept 05)	3	7	13	12	11	17	11	13	8	0	0	0	*137*
Sultan Ward (From Oct 05)	0	0	0	0	0	0	0	0	0	13	21	21	*55*
Total discharges													*192*
3 Consultant contacts per patient (LOS 20 days)													**576**
Total Patient Contacts													**1945**

Activity	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04
Home visit (New)	11	7	9	1	8	3
Home visit (Reviews)	1	8	6	1	12	3
RH visit	2	2	2	3	1	1
NH visit	4	0	0	0	0	0
OP New	11	5	10	3	9	10
OP F/U	30	17	28	13	28	20
DDH New	0	1	3	0	2	2
DDH Rev	15	11	11	5	10	9
DDH PD New	1	0	1	0	0	1
DDH PD Rev	32	13	22	12	18	13
Daed. Discharges (Up to Sept 05)	3	7	8	5	9	10
Sultan Ward (From Oct 05)	0	0	0	0	0	0

COMMUNITY VISITS

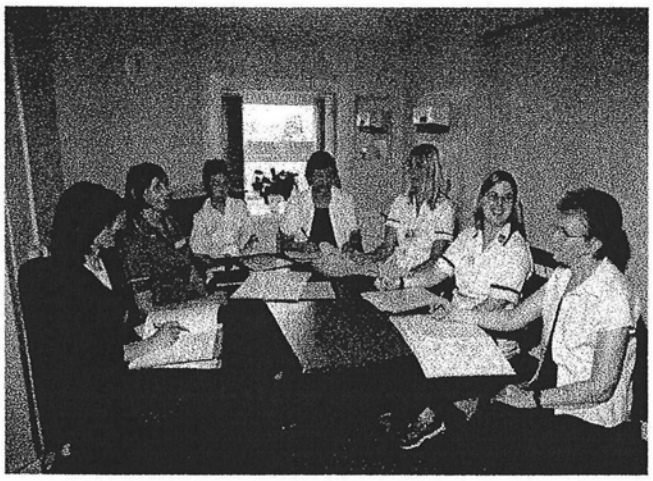
These were mostly undertaken at the request of the General Practitioner (GP) and requests may have come directly to the Community Geriatrician or via the Single Point of Access. Occasionally referral letters to Outpatients or Day Hospital indicated that a patient's mobility was significantly impaired and/or that a patient was a resident in a Care Home. In such instances the patient was initially assessed at home.

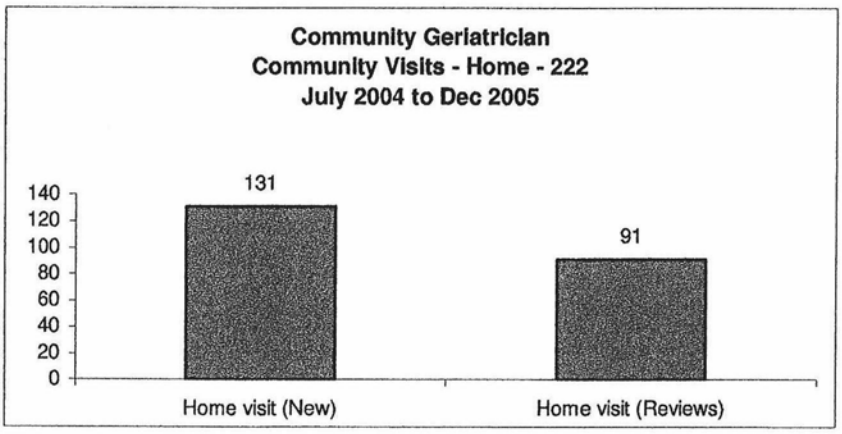
Very rarely a member of the interdisciplinary team felt that a specialist medical opinion was required and referred the patient to the Community Geriatrician having discussed this initially with the GP. In all instances where the GP hadn't initiated the medical referral a fax back form was sent out asking for the current diagnoses, current medication and issues that the Community Geriatrician should be addressing. This form was faxed back and the visit then arranged. This was so that the GP was aware of specialist intervention.

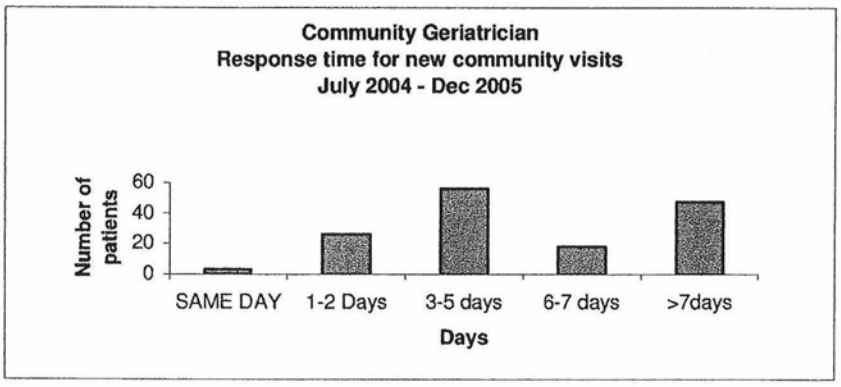
The assessments included a comprehensive clinical evaluation and where appropriate diagnostics to include blood tests, ECGs, pulse oximetry which could all be done at home. If radiological examination or 24 hour BP, ECG monitoring or spirometry was required, patients attended Dolphin Day Hospital on a single visit for diagnostics to be carried out. These results were returned to the Community Geriatrician for appropriate follow-up to be carried out.

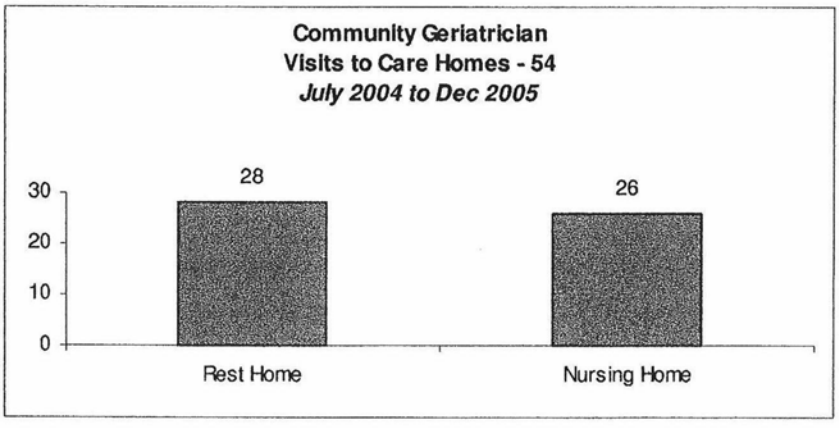
Community visits provide good and comprehensive assessment at home and have helped prevent admission. Some of the assessments facilitated long-term condition management, and in the majority this was Parkinson's Disease.

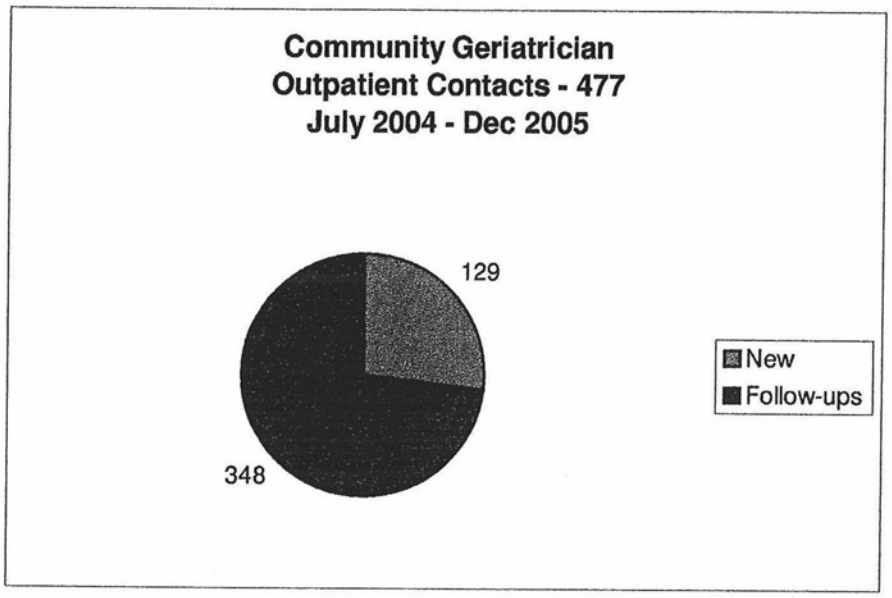
In some instances hospital admission needed to be facilitated and this was usually because patients were acutely unwell and this was usually associated with unexplained hypotension and/or hypoxia. It was also possible to stabilise a patient medically at home prior to surgery so that the time spent in hospital was a minimum. This required 2 Consultant visits 10 days apart, daily visits from the District Nursing team who was already involved and knew the patient well and 2 sets of blood tests a week apart.

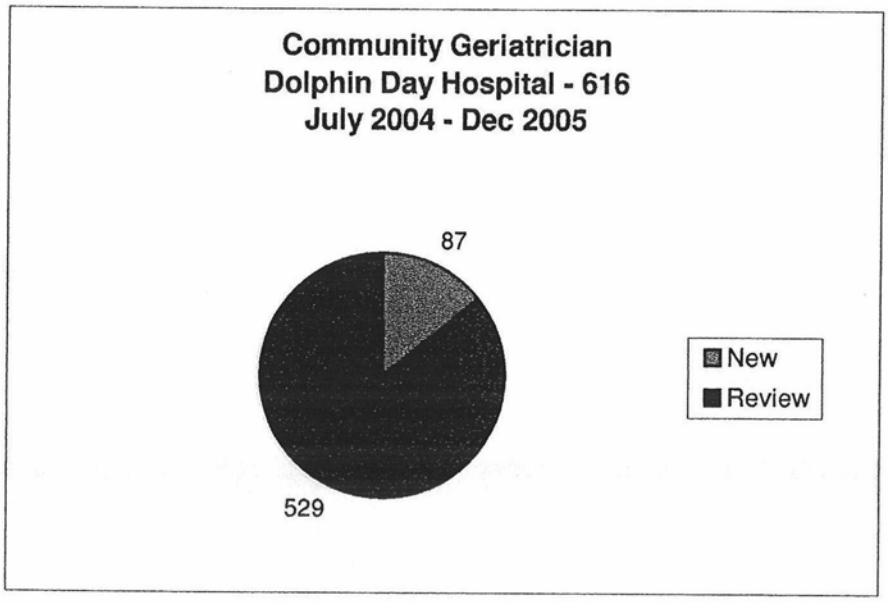



Community Geriatrician
Community Visits - Home - 222
July 2004 to Dec 2005
140
120
100
80
60
40
20
0
131
91
Home visit (New)
Home visit (Reviews)


Community Geriatrician
Response time for new community visits
July 2004 - Dec 2005
Number of patients
60
40
20
0
SAME DAY
1-2 Days
3-5 days
6-7 days
>7days
Days


Community Geriatrician
Visits to Care Homes - 54
July 2004 to Dec 2005
30
20
10
0
28
26
Rest Home
Nursing Home


Community Geriatrician
Outpatient Contacts - 477
July 2004 - Dec 2005
129
348
New
Follow-ups


Community Geriatrician
Dolphin Day Hospital - 616
July 2004 - Dec 2005
87
529
New
Review

Other roles of the Community Geriatrician

1) Inpatient Care – Initially this was for half of Daedalus Ward (General Rehabilitation).

From October 2005, in order to help with patient flow over the winter months, patients were admitted to Sultan Ward under the care of the Community Geriatrician if there was capacity not used by GPs on the bed fund at GWMH. Most of the patients were transferred from the MAU, or elderly medicine, general medicine, orthopaedics and surgery. There were some admissions direct from the community. This was delivered with only one weekly session and was initially undertaken as a pilot but has continued to the present.

2) End of Life decisions in Care Homes – a few of these were undertaken and involved discussions with patients, relatives, the interdisciplinary team, GPs and Care Home staff. This is time consuming and needs involvement of a senior clinician.

3) Participation in the acute on-call roster with an equal share of on-calls, Post Take Ward Rounds (Morning and afternoon) and weekend acute ward cover at QAH with the other Geriatricians.

4) Monthly teaching sessions were set up in Gosport War Memorial Hospital for medical, nursing and allied health professionals in primary and secondary care, Elderly Medicine and Old Age Psychiatry and are well attended and continue. Teaching is also undertaken for Elderly Medicine, SHO Core Curriculum and F1/F2 training sessions for Portsmouth Hospitals.

5) Developed the Policy for Transfusion in Day Hospitals. During July 2004 and Dec 2005, 31 transfusions were carried out in Dolphin Day Hospital.

6) Set up referral procedure and systems for community visits to ensure medical and psychiatry notes are available, rapid communication (fax and letter), documentation of phone conversations, GP involvement when referred by a nurse or AHP, checking on outstanding results. The database of patients seen on community visits has been set up and is maintained by the PA.

7) IT Issues – Instrumental in obtaining additional networked terminals for the wards and day hospital in GWMH to aid access to pathology and radiology. Issues relating to the filing of correspondence on the T drive are being sorted.

8) Locality lead for Fareham & Gosport PCT as part of the Operational and Management Team in Elderly Medicine.

Community Nursing Support to Community Geriatrician

The Community Geriatrician role has been well supported by trained nursing staff in the community. These teams were previously District Nursing and Managed Care Teams which will in the future work together as a single Community Nursing Team.

For a short period the Community Geriatrician had the support of an E Grade Staff Nurse who was part of the Intermediate Care Nursing Team but also had been seconded for a year to Adult Services and was also a qualified Care Manager. She had a case load of 20 patients mostly referred to her by the Community Geriatrician.

Although the numbers were small, the following illustrate her invaluable contribution:

1) Patient 1 – 80 year old lady with severe aortic stenosis (not fit for valve replacement), partially sighted, cerebrovascular and peripheral vascular disease, recurrent Polymyalgia Rheumatica and leg ulcers. Had been followed up in outpatients for about 3 years but got too frail to attend. Admitted after a fall to a respite care bed in a rest home but within a few weeks needed nursing care and transfer to a nursing home was achieved without a hospital admission. Nursing support ensured that placement was quickly sorted out and medical and nursing issues handed over to nursing home staff. This lady didn't have a single hospital admission since she 1st had contact with the community geriatrician in February 2002. She passed away in the nursing home in December 2005.

2) Patient 2 – 78 year old man with hypothyroidism (new diagnosis), COPD, renal impairment, cerebrovascular disease, falls, polypharmacy. Had one visit in July 2005 from Community Geriatrician and subsequent follow-ups by Intermediate Care Nurse. To date he hasn't had a hospital admission.

The nursing support to the community geriatrician is vital so that medical care can be safely delivered in the community. This includes medicines management, co-ordination of care with other disciplines, communication with patients and relatives and facilitating the medical management, including diagnostics under the guidance of the community geriatrician. There is a definite role in emergency admission avoidance and also reduces the need for specialist follow-up.

(GWMH – X'Mas 1937)

Involvement in Parkinson's Disease

The Community Geriatrician's interest in Parkinson's Disease has led to clinical involvement with approximately 120 patients. Of these 110 have management shared with the Parkinson's Disease Nurse Specialist (PDNS) and the rest being patients with essential and other tremors or where the diagnosis of Parkinson's Disease is uncertain and hence referral to the PDNS has not been made.

The majority of patients are seen in Dolphin Day Hospital where 23 new patients and 307 follow-ups were seen. These are patients who need involvement of the interdisciplinary team. There is dedicated and regular attendance by a Specialist Registrar in Elderly Medicine for the Day Hospital session. Smaller numbers (mostly patients with early Parkinson's Disease or in the Maintenance phase of the disease) are seen in outpatients and the frailest are seen in the community.

Every attempt has been made to ensure that patients with Parkinson's Disease have a regular review at least every 6 months and this is in line with the NICE guidelines which will be published later this year.

Additional involvement in this area

- Parkinson's Disease Steering Group for the Cluster
- Education in Primary and Secondary Care
- Participating and hosting meetings of the Southern PD Forum
- Mentoring and coaching for the Parkinson's Disease Academy UK
- Audit on Medication Issues in Patients with Parkinson's Disease and subsequent actions with a re-audit planned for later this year. (This was presented as a poster at the BGS Meeting in April 2005 and also published in Age & Ageing last year).
- Successful presentation to the Medicines and Formulary Group for inclusion of Pramipexole in the district formulary.

This continues to be delivered without dedicated sessional time.

Patient Satisfaction Survey

40 postal questionnaires were sent out by the Community Geriatrician to 30 patients and 10 to carers. There is no validated questionnaire for use by specialists and hence the Short Form Patient Satisfaction Questionnaire (PSQ18) was adapted and statements on financial aspects excluded. Responders were also encouraged to send in free hand comments. Replies were anonymous and returned to Dr. David Jarrett, Consultant Geriatrician who collated the replies.

The response rate was 88% with 1 patient also being a carer. Of those who responded 17 had been visited in the community (home or care home), 17 seen in Day Hospital, 20 seen in outpatients and 3 also had inpatient contact with the Community Geriatrician.

26 patients had 4 or more contacts, 6 had 3 contacts and 3 had 2 contacts.

Copying Letters to Patients – 91% had letters to the GP copied to them and 86% found them useful. 1 Patient didn't.

There was 100% agreement that the community geriatrician
1) was good at explaining the reason for medical tests
2) that the medical care received was just about perfect
3) was careful to check everything when treating and examining

There was 100% disagreement that the community geriatrician
1) was in too much of a hurry when examining the patient
2) ignored some of the things a patient said
3) provided medical care that satisfied patients

97% felt that they were treated in a friendly and courteous manner (1 patient agreed and disagreed)
97% did not feel that the doctor was impersonal or business like
97% didn't doubt the doctor's ability to treat
94% disagreed that the appointment was inconvenient for the carer/family
86% did not feel that they had to wait too long for an appointment
77% didn't doubt the diagnosis, 11% did and 8% were uncertain

Some quotes from the free hand comments:

"Dr Lord was my life saver sorting out the right treatment for my heart and kidney failure very quickly"

"We have been very pleased and impressed with the service. Dr. Lord obviously sets a good example which brings out the best in all the staff. Congratulations."

"She is very professional whilst maintaining a friendly nature"

"I have great respect for Dr Lord's ability to treat me."

".....specialist care and support is not available from a GP. I would have found caring for my mother more difficult without the advice, kindness, care and concern shown....."

"..... fully explained everything in detail to the relatives who have been present and to myself or my nurses"

".....never hurried me during consultation and as I have Parkinson's disease this is most helpful....."

".... Every confidence in the doctor and could wish for no better treatment."

".... She will always listen to what one has to say and will help sort out any problems if she can."

"Dr Lord sets the standards to which all doctors should aspire and all patients seek."

Summary of the patient and carer responses to the modified PSQ18

	Strongly Agree	***Agree***	***Uncertain***	***Disagree***	***Strongly disagree***
The doctor was good about explaining the reason for medical tests	26	9			
The medical care I have been receiving is just about perfect	22	13			
I have sometimes wondered if the doctor's diagnosis was correct	1	3	3	10	17
At consultations the doctor has been careful to check everything when treating and examining me	23	12			
I had to wait too long for an appointment			3	12	18
The appointment was not convenient for me/my family/my carer		1		14	19
The doctor was too impersonal and business like towards me				10	24
The doctor treated me in a very friendly and courteous manner	28	6			1*
The doctor was in too much of a hurry when treating me				8	27
I am dissatisfied with some things about the medical care I received				12	23
The doctor ignored some of things I said				14	21
I have some doubts about the doctor's ability to treat me				6	28

* 1 responder ticked strongly disagree and agree on the same form.

GP Survey of Community Geriatrics Service (Fareham & Gosport PCT)

The Practice Managers of the 23 GP Practices in Fareham & Gosport Primary Care Trust were posted a questionnaire. This could either have been filled by individual General Practitioners or collectively by all the partners.

Replies were faxed back to the Community Geriatrician. The response rate was 63% (69 replies).

4 Questions were asked:

1) Have you referred patients to the Community Geriatrician?
   Yes – 48.
   11 GPs said they hadn't referred but 8 Community Visits had been carried for 2 of the practices.
2) Was the response timely? – **Yes – 48.**
3) What benefits have you had from the Community Geriatrician Service?
4) What improvements could be made to the existing Service?

The answers to questions 3 and 4 are represented in the graphs on the 2 following pages.

Some comments from General Practitioners:

"Best outcome for housebound patients who previously refused to go to QAH"

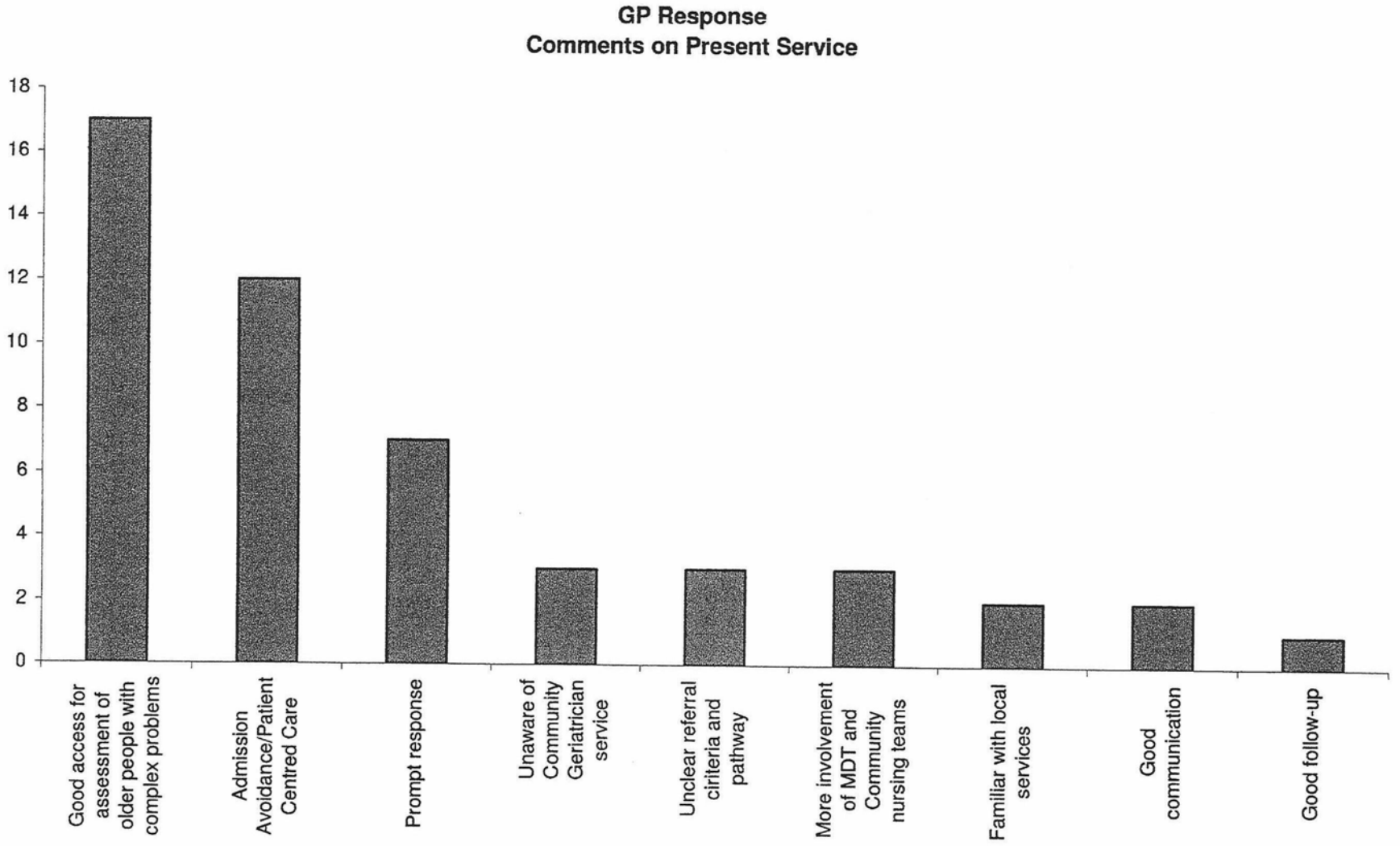
"Support with difficult cases and avoidance of hospital admissions"

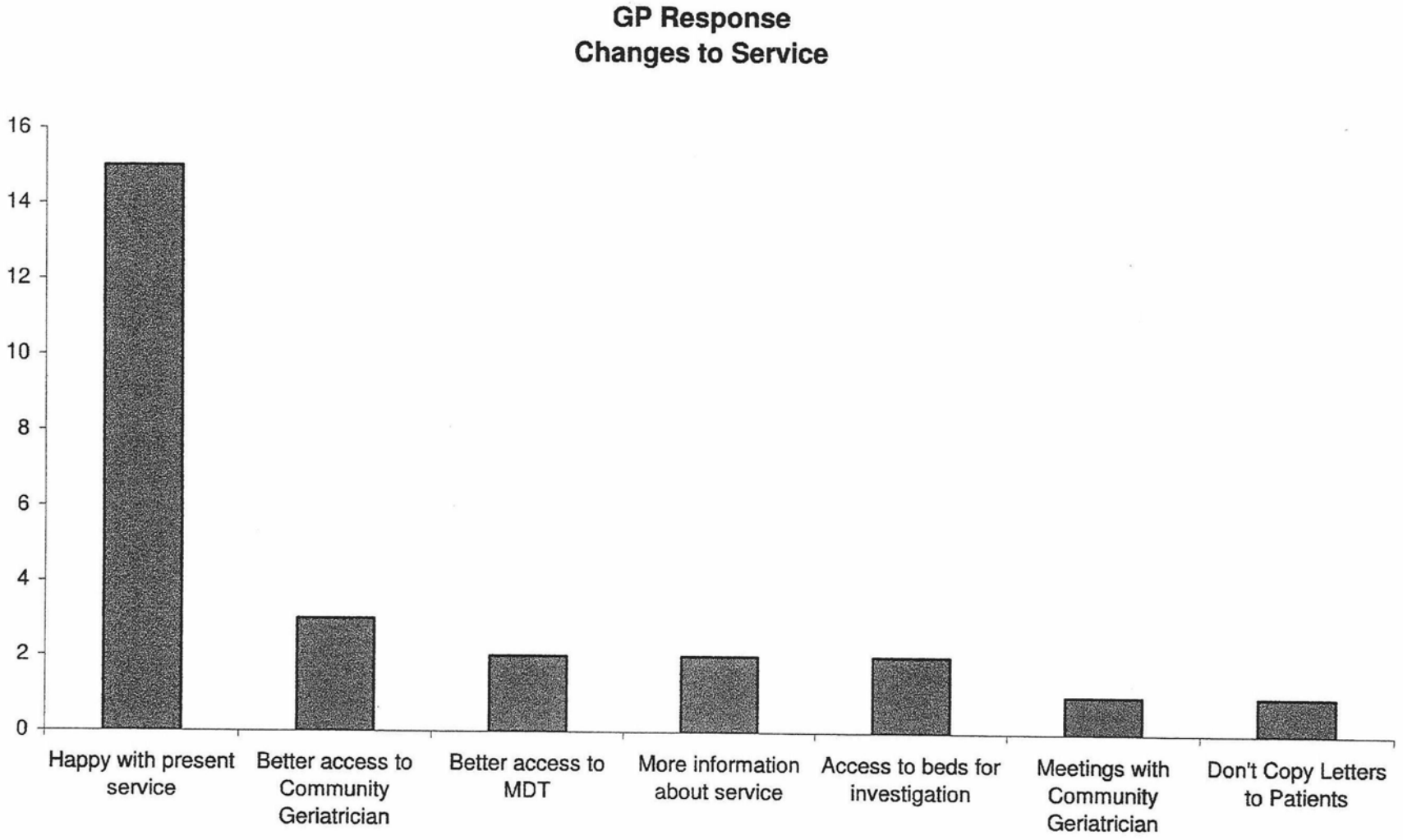
"Enables me to more confidently manage cases at home"

"Advice and support in managing complex cases in the community"

"Don't know about the service"

"More information about the service"


GP Response
Comments on Present Service
18
16
14
12
10
8
6
4
2
0
Good access for assessment of older people with complex problems
Admission Avoidance/Patient Centred Care
Prompt response
Unaware of Community Geriatrician service
Unclear referral ciriteria and pathway
More involvement of MDT and Community nursing teams
Familiar with local services
Good communication
Good follow-up


GP Response
Changes to Service
16
14
12
10
8
6
4
2
0
Happy with present service
Better access to Community Geriatrician
Better access to MDT
More information about service
Access to beds for investigation
Meetings with Community Geriatrician
Don't Copy Letters to Patients

Comments and suggestions

Community Geriatrics delivers high quality patient centred care and for a more effective service, I wish to suggest:

1) Community Geriatricians together with the community matrons and primary care colleagues will in future provide the continuity of care that is essential for good quality patient care for frailer older people with multiple pathology. This would facilitate 'pulling' patients out in a timely fashion following admission to hospital.

2) The Community Geriatrician should have a co-coordinating role working closely with community nursing team and community matrons to ensure that diagnosis is accurate and management to include medicines management is delivered safely. This would also include the supervision of non-medical prescribers and enhancing their confidence in prescribing.

3) Safe delivery of inpatient care in a community hospital requires an additional 2nd weekly session by a Specialist Registrar/Staff Grade and also support of a senior nurse in Elderly Medicine in order to ensure that the basics of good geriatric nursing are delivered and the interdisciplinary team work maintained.

4) Management in Care Homes – Diagnosis, medication, plans for treatment in the event of a crisis, should be clarified soon after admission and at regular intervals with end of life decisions being in place and agreed.

5) Community Geriatricians should have an active role in planning and development of community services and Long-Term Conditions.

6) There must be recognition that the Community Geriatrician contributes effectively to emergency care by seeing patients at home or close to home and hence undertake a reduced share of the acute on-call and Post Take Ward Rounds.

7) Dedicated sessional time for Parkinson's Disease which has increasing incidence in older people and is a condition which is mostly managed in the community. This could be carried out by a lead Geriatrician with an interest in PD working through each of the 4 day hospitals.

8) Specialist Registrar training in Community Geriatrics – Should include a block of 3 – 4 weeks spent entirely in the community gaining experience and competencies as outlined by the Primary and Continuing Care Special Interest Group of the British Geriatrics Society. This will provide continuity which is lacking in the present work schedules.

9) A cohesive district wide service requires 3 Community Geriatricians – 1 each for Fareham & Gosport, East Hants and for Portsmouth City.

10) Recognition by Primary and Secondary Care, Community and Hospital, Health and Social Services that good, safe and effective care can be delivered, but adequate resources are essential.

Thank You

- To Iris Jenkins, my PA, for setting up and maintaining the database. Her hard work, enthusiasm and loyal support are greatly appreciated.

- To all those in the Community Enabling Service, Fareham & Gosport Primary Care Trust and the Department of Medicine for Older People who helped set up and develop the Community Geriatrician role.

- To my many friends and colleagues – you know who you are.

Althea Lord
May 2006.