Elderly Medicine and Community Care

The following is a proposal to establish an enhanced service to support care of vulnerable elderly patients in a community setting.

There has been considerable discussion in recent months about the problems faced by elderly patients who may not be optimally supported in the community. This leads to increased admissions and delayed discharges and the subsequent problems for the rest of the health economy in terms of blocked beds and pressure on health and social services systems.

Elderly Medicine has historically been regarded as an in-patient service with outreach facilities to support the community. If there is serious intent to change the model of care for the elderly population it is proposed that this be changed so that it is, at least in part, seen as a community service with in-reach facilities

The positive benefits for patients would be:

- Reduced admissions to a 'hostile' hospital environment.
- Earlier discharge to their own place of residence.
- Reduced risk of infection exposure.
- Reduced dependency levels which tend to follow hospitalisation.
- Reduced levels of confusion which tend to occur in the vulnerable elderly when removed from a familiar environment.

The positive benefits to the health and SSD system would be:

- Less pressure on in-patients beds
- Less outliers
- Less disruption to elective lists
- Less pressure on DGH clinical – especially junior doctor – staff.

It is important, however, to recognised that the group of vulnerable elderly to whom this service might apply are very high risk and any changes in service delivery initiated for whatever reason must be safe and audited for effectiveness.

There are a number of schemes in place in the community which cater for the vulnerable elderly population:

- Traditional in-hours and out-of-hours primary care
- Community nursing services
- Older persons' health care coordinators
- Rapid response
- Community Rehab teams
- Continuing Care
- Domiciliary visits by Elderly Medicine and EMH consultants
- CPNs for EMH
- OT / Physio
- SSD – Welcome Home etc

Many of the schemes at present in place are not well coordinated, may not be working optimally, have not been adequately evaluated and do not have the benefit of coordinated clinical leadership.

For the future there are proposals to:

- Develop an Elderly Assessment Unit at Petersfield Hospital to test a model of care which, if proven successful, may be more generally applicable and become incorporated into the new Oak Park Community Hospital.
- Commence a domiciliary stroke service.
- Provide Nurse Practitioner services for elderly patients in residential care.
- Test models of community care for a more dependent and more seriously ill group of elderly patients than are at present catered for.

There is, therefore, an opportunity for a clinical leader to:

- Provide clinical support to patients being cared for in continuing care and community hospitals.
- Provide input into Elderly Assessment Units / Day Hospitals in the community
- Provide clinical domiciliary support for patients being cared for in their own homes and advice for their GPs.
- Develop the multidisciplinary teams working [including SSD] in domiciliary settings to support an increasingly complex patient case-mix.
- Develop diagnostic availability to support this group of patients.
- Liaise with EMH services.
- Liaise with OOH service providers.
- Liaise with in-patient [DGH] services.

It is important that the proposed clinical leader also has available support for auditing the outcomes of community schemes and is in a position to carry out research to develop the scientific basis of elderly community care.

The proposal is to establish a full time post of 'Community Elderly Medicine Physician'.
The post holder would have admitting rights to community and DGH beds and work in conjunction with his/ her colleagues in the Department of Elderly Medicine.
Applicants could be considered from the present Elderly Medicine consultants in which case a traditional replacement appointment would be required.
The exploration of a joint appointment with the University of Portsmouth should be considered.
The post should also carry with it a 'development' budget to provide the means to create a 'Department of Community Care'.
Although there will be cost implications for this proposal it would be expected that the ensuing savings, either in reality or reflected in increased efficiency, would be attractive to the PCT and health community.

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